PO-CH/NL/0102
PART M

Form M.

SECRET

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Begins: 15/9/88

Ends: 3/10/88.

PO -CH /NL/0102

PART M

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Direction: 25 Years

14/8/95

PO -CH /NL/0102

PART M

chex.nh/mw/33 **UNCLASSIFIED**

FROM: MISS M P WALLACE
DATE: 15 September 1988

MR SAUNDERS

cc PS/Chief Secretary
PS/Paymaster General
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Culpin
Miss Peirson
Mr MacAuslan
Mr Parsonage
Mr D Griffiths
Mr Call

DOCTORS AND NHS REFORM

... The Chancellor asked me to draw your attention to the attached article in today's Independent, which he found interesting.

MOIRA WALLACE

The challenge is to reform the NHS without losing the doctors

Chris Ham considers how to bring accountability into hospital medicine

Kenneth Clarke's move to the Department of Health as part of the summer Cabinet reshuffle has been widely interpreted as a sign that the Government is backing off from radical reform of the NHS. Clarke's appointment may also indicate that challenging doctors' restrictive practices is high on the Government's list of priorities.

During his period as Minister of Health in the early 1980s, Clarke earned a reputation as a politician not afraid to take on the doctors. On that occasion, GPs' practices were brought under tighter control, both in relation to the prescription of drugs and in the use of deputising services. This time around, hospital doctors are likely to receive his attention, for it is their decisions that determine how the bulk of NHS funds are used.

In speculating about how the Government might seek to manage medical work more effectively, it should be emphasised that doctors face an ethical dilemma in deciding whether to assume responsibility for budgets and participate in the management of services. The concern of doctors to do what is best for the individual patient may conflict with the need to set priorities between services, to keep expenditure within agreed limits and to maximise the benefit of services to the population.

Any attempt to integrate doctors into management must acknowledge this conflict and recognise the significant personal commitment of most doctors to provide a high-quality service, often beyond their contractual obligations. Retaining this commitment while achieving a better fit between professional and managerial values is a major challenge. Indeed, if the chosen strategy is not carefully designed, there is a risk that doctors will increasingly exit into private practice and reduce their contributions to the NHS.

What then are the main options available to the Secretary of State? One change that would undoubtedly be widely popular among health service managers would be to transfer hospital consultants' contracts from regional health authorities to district health authorities. This would give district health authorities more influence over the activities of hospital medical staff, particularly if associated with other changes in the contractual position of doctors.

A second option is to give general managers a direct role in appointing consultants. The medical profession has resisted this idea, yet if managers are increasingly expected to meet performance targets entailing changes in medical practice, it is essential to involve them in choosing the doctors whose work they are ultimately responsible for managing.

A further change would allow health authorities to specify in more detail than before the nature of the work to be performed by consultants. This might entail spelling out the kind of clinical work expected; the volume of work required in terms of the number of operations, patients to be treated and outpatient sessions; and the protocols to be used in providing treatment.

Contracts could also contain expectations concerning consultant involvement in medical audit and the management of resources. Doctors have been slow to embrace audit and to participate in reviews with medical peers of their work.

More radically, new consultant staff could be appointed on short-term contracts. The performance of consultants would be regularly reviewed. Clinical competence would be assessed by medical peers and management effectiveness by managers. Unsatisfactory performance would result in the contract being terminated.

In parallel with short-term contracts and performance review, the distinction award system could be refashioned to enable general managers to reward good performance with discretionary salary payments. At present, these awards are determined by doctors and are supposedly made in recognition of clinical and academic excellence. One possibility for the future is to transfer control over distinction awards to general managers who with medical advice would be able to reward exceptional medical performance.

As well as these changes, the Secretary of State will also seek to encourage doctors themselves to become more closely involved in management. Progress has been made in this area. Work currently going on in a number of health authorities, known as the Resource Management Initiative, is testing an experimental approach in which doctors are provided with information about the services they deliver. The Government has emphasised the importance of the Resource Management Initiative and has said that it will be extended throughout the NHS beginning in 1989.

In some of the experiments doctors have taken on management responsibility through appointment as clinical directors. This is the case at both Guy's Hospital and Winchester, where senior consultants have been appointed to manage services such as surgery, medicine and pathology. Early indications suggest that greater financial control has been achieved and improvements in service to patients have also resulted.

Persuading doctors to take on management responsibility in this way may make more palatable the other changes on the Government's agenda. If nothing else, doctors are likely to find it more acceptable to have their activities managed and reviewed by fellow clinicians than by managers. Nevertheless, there is liable to be strong resistance from the BMA.

If the Secretary of State is serious about achieving changes to consultants' contracts, he will have to sweeten the pill. The most obvious way of doing this would be to increase basic salaries for new consultants as a *quid pro quo* for the loss of job security, and to provide generous levels of performance-related pay. Opportunities for private practice may also be increased as the Government encourages the growth of the private sector.

Experience from the US contains some important lessons for the NHS. In the US, the micromanagement of doctors is a growth industry. However, health care costs continue to escalate and doctors rapidly find ways of circumventing controls over their work.

This suggests that an alternative strategy would be to encourage the medical profession itself to strengthen arrangements for self-policing. While this may produce more effective results than tighter control by managers, the difficulty for the Government in pursuing this strategy is that self-policing will fail to fulfil the radical expectations generated by the NHS Review. If fundamental reforms such as a major switch to private health insurance have been ruled out, then challenging doctors' autonomy may well provide a convenient escape route.

The author is a policy analyst at the King's Fund Institute.

THE INDEPENDENT Thursday September 15 1988

cst/jmf.15.9/ch

PERSONAL AND CONFIDENTIAL

FROM: CHIEF SECRETARY
DATE: 15 September 1988

CHANCELLOR

HEALTH

I had a meeting yesterday evening with Ken Clarke to discuss variety of current problems. The four points worth bringing to your attention are as follows.

Nurses' Pay

2 Ken is now convinced that even if we screw down the discrepancies emerging in the nurses' grading exercise the outturn cost is likely to exceed the £803 million allotted by around £100 million (precise sum uncertain). Ken's view is that the original estimate of cost can now be seen to have been wrong and that providing the grading exercise meets our criteria we will have no choice but to meet the extra cost. He assures me that where the exercise does not meet our criteria he will not seek additional funds. It is overwhelmingly likely that he will want a claim on the Reserve for this. I have offered no commitment.

Eye and Dental Tests

3 Ken tells me that the Whips (Lords and Commons) would prefer the Government to make a concession on this although David Waddington's view is that we can win without one. However this will be a messy and difficult business. David Mellor is looking at the Whips' request for potential concessions that could carry a cost of around £20 million. I have indicated to Ken that I am pretty unsympathetic since feeding this crocodile might encourage it to come back.

PERSONAL AND CONFIDENTIAL

Autumn Harassment

4 Ken anticipates another campaign on "underfunding" with threats of cuts and closures, some of which are genuine. He is not in favour of a special autumn concession to alleviate this since he takes the robust view that it would simply encourage further campaigns next year. He hates this crocodile!

PES

5 Ken makes the point clearly that he is seeking a much more generous settlement than last year, since he believes this will be our only effective defence against the lobbying from Health Authorities. The present indications, although we did not discuss figures, are that we are likely to be some way away from agreement in our first meeting. In particular Ken is reluctant to see the sort of retrenchment on capital we had envisaged.

JOHN MAJOR

chex.nh/mw/39 **PERSONAL AND CONFIDENTIAL**

FROM: MISS M P WALLACE
DATE: 16 September 1988

PS/CHIEF SECRETARY

HEALTH

The Chancellor was most grateful for the Chief Secretary's note of 15 September.

2. He commented that we will have to judge the nurses' case on its merits. But the eye and dental tests case has none. It is natural that the Whips would prefer an easier ride, but the Chancellor feels that to concede anything now, after all that has been said, would be a most damaging sign of weakness, and send all the wrong signals, both politically, and in terms of PES.

3. The Chancellor also was delighted to hear that Mr Clarke is preparing to be robust in the face of "autumn harassment"; but the Chancellor is apprehensive about Mr Clarke's position on capital and the Survey more generally.

MOIRA WALLACE

16.9.7

SECRET

FROM: D P GRIFFITHS

DATE: 16 September 1988

1. MR SAUNDERS

2. CHIEF SECRETARY

cc Chancellor *
Sir P Middleton *
Mr Anson
Mr Phillips
Mr Luce *
Miss Peirson
Mr Turnbull
Mrs Butler *
Mr MacAuslan
Mr Potter *
Ms Seammen(A1a and d)
Mr A M White
Mr Binns *
Mr I A S Jones
Mr Sussex
Miss Walker
Mr Wellard
Mr Cafolla
Mr Rayner
Mr Cropper *
Mr Tyrie *
Mr Call

16/9 * without attachments

GRIFFITHS TO C&T 16 SEPT

BRIEFING FOR HEALTH BILATERAL MONDAY 19 SEPTEMBER

I attach the revised briefs you requested. Where there have only been minor changes we have sidelined the amendments. An index of the revised briefs is attached.

Forecast Outcome

2. Our forecast outcome for the programme is now 1243/1514/2047 which produces real increases in HCHS Current (excluding cost improvement programme savings) of 3.5%/2.0%/1.3%. The main differences since our last forecast outcome are that we are no longer scoring the savings from any reduction in the NHS employers' Superannuation contribution; assuming a higher outcome on the HCHS service growth/maintenance and HCHS Capital investment bids (A1c and A6); and reduced savings from the FPS options for reductions. However, we are now expecting higher HCHS efficiency savings than those offered by DoH.

Main Changes to the Briefs

3. On Review Body consequentials (A1a), the bulk of the bid is now to be conceded at the first bilateral, but the element for service growth/incremental drift rejected as before.

4. We have revised the brief on HCHS service growth (A1c) to take account of the results of running the DoH model using different assumptions on unit cost trends. These projections produce figures in the range 260-335/500-565/885-1150 compared with the bid of 400/815/1385 and our forecast outcome of 275/555/900. We have asked for further simulations on the basis of slightly different calculations of past trends which should produce slightly lower projections. This is encouraging but we still recommend that undue weight should not be placed on the model and that affordability should be the essential criterion. However, you may wish to consider asking DoH and Treasury officials to produce a joint paper for a further bilateral showing the range of projections produced by using different assumptions. It would be helpful if we could discuss this at the briefing meeting before the bilateral.

5. On HCHS future pay (A1d) we have included a specific proposal that £40m of the £85m should be reserved for Review Body award costs.

6. The brief on AIDS treatment (A3a) has been slightly revised to take into account new information on costings. We understand that either at the first or second bilateral (probably the latter) Mr Clarke may table slightly lower bids for in-patient and out-patient treatment costs. We have no details of the size of the reduction Mr Clarke may propose but this could warrant a pound for pound scaling down of our forecast outcome.

7. We have produced a separate brief on Project 2000/training costs (A4d). As with a number of other bids DoH have not yet produced sufficient information to justify the extra provision sought but our forecast outcome now assumes the bid is conceded in part rather than deferred until the 1989 Survey.

8. The brief on HCHS Capital investment (A6b and C1) has been rearranged as requested with separate notes for: new hospital building; maintenance; and equipment. That on VAT (A7) has also been revised.

9. On FPS Savings (C2 and 3) we now have a jointly agreed note on the options. This does not differ substantially from the paper we had prepared, apart from a slight increase in the savings expected from increasing prescription charges by 20p per year. Our forecast outcome assumes that the only new saving we will achieve is the introduction of prescription charges for contraceptives and a separate brief has been included on this item.

10. The CFS briefing has been revised to reflect the decision not to press for the abolition of welfare food. The case for pressing the DTF for a discount on the price of liquid milk has been strengthened. We recommend that you avoid any detailed discussion of the other CFS bids at the bilateral.

NHS Review and The Survey

11. We have given further thought to the method by which the additional resources needed to launch some of the NHS Review measures might be provided, given that the announcement of the Review's conclusions will probably come a little while after the Autumn Statement. Most of the measures with resource implications are ones for which bids have been submitted (e.g. RMI and IT for GPs) or for which provision could be made by top-slicing other bids (e.g. a fund for rewarding efficient hospitals could be hypothecated from the service growth money). (There are one or two other measures such as VFM audit and medical accreditation which will have a cost but the amounts involved are likely to be small.)

12. We would recommend that you seek an understanding with Mr Clarke that that part of the PES Settlement which relates to the Review should not be announced with the Autumn Statement but held back until the conclusions of the Review are made public. The relevant package, with estimated first year costs might look as follows:

		£m
(i)	Top-sliced funds for efficient hospitals to tackle waiting lists (found from within service growth provision - A1c)	100 *
(ii)	Improving physical surroundings in hospitals - brightening up waiting rooms etc. (Found from HCHS capital investment money - A6)	50 *
(iii)	Extension of RMI (A4a and A6a)	50
(iv)	IT for GPs (A11)	5
TOTAL		205

* Marker estimates. Precise amounts to be discussed further

13. We think that the themes of such a package - promoting efficiency and improving services to patients - could be presumed as going to the heart of the Review. But the settlement, with real growth in HCHS Current of only some 2.7%, would initially appear less generous than it actually was. It would probably be necessary to include in the Autumn Statement something to the effect that the figures took no account of further measures likely to be announced as part of the Review. The wording of this statement would require some care if expectations are not to be raised unduly, so that £200m was greeted with disappointment. You would need to consider carefully with Mr Clarke exactly where to pitch the initially announced settlement and how to present it.

14. A further variant, favoured by GE, would be to hold this £200m back, but announce it at the same time as reducing employer superannuation contributions, so that it would be funded without recourse to the Reserve, at the same time leaving £100m over for the Review Body awards. This would avoid a presentational problem about the reduced superannuation contributions, eg Opposition claims that the Government had sequestered a legitimate windfall for the NHS. It would also mean that the first £200m of next year's Reserve would not be committed from the start.

D P GRIFFITHS

20.9.3

SECRET

PUBLIC EXPENDITURE SURVEY 1988: HEALTH AND PERSONAL SOCIAL SERVICES

Note of a meeting at 3 pm on 19 September 1988 in the Chief Secretary's room, HM Treasury

Present

HM Treasury	DoH
Chief Secretary	Secretary of State
Mr Phillips	Minister of State
Miss Peirson	Mr France
Mr MacAuslan	Mr Hart
Mr Saunders	Mr James
Mr Griffiths	Mr Lillywhite
Mr Rayner	Ms Stewart
Mr Call	
Miss C Evans	

Scottish Office	Welsh Office
Parliamentary Under Secretary of State	Mr Craig
Mr Rushworth	

The Chief Secretary said that the remit from Cabinet on public expenditure was to remain as close as possible to the planning totals in Cm 288 so that the ratio of GGE to GDP could continue on a declining path, and that running costs should not increase as a proportion of the planning total. The Department of Health bids, which represented a dramatic increase over last year's settlement, were not consistent with this remit and were not the basis for affordable settlement. The NHS had enjoyed a substantial real growth in resources in recent years and there was plenty of scope for improved productivity and efficiency. It would be necessary to consider the relationship between the Survey and the NHS Review and decide how to deal with the Review-related bids; and distinguish between those bids which would have to be dealt with in this Survey and those which might be left until the next PES round.

2. **The Chief Secretary** said that the extent to which he would be able to meet the HCHS bids would depend on what happened on the rest of the HPSS programme. On running costs the problem was that the DHSS had only just been split up and the Management Plan dealt more comprehensively with Social Security than Health. He expected the Department of Health to prepare its own Management Plan in time for the next Survey. However, until a satisfactory plan was available, it would not be possible to reach a three year settlement on Department of Health running costs.

3. **The Secretary of State** recognised that the public expenditure position was difficult but there were particular political problems on his programme. The public perception was that the NHS had been cut back very severely. It was important not least from a financial management standpoint that this impression was corrected. Last year's settlement had been too tight. As regarded the HCHS, the consequentials of the 1988 Review Body awards were the single biggest component of the bids. This was one reason why they were so much higher than the 1987 settlement. He noted that the final costs of the Review Body awards were not yet known as the nurses' regrading exercise was still continuing. It was quite clear that the original estimate of the cost of the nurses' pay award could not be sustained and increased funds for 1988/89 would have to be made available. Regional chairmen had suggested that the award might cost a further £170 million. The Department were not yet satisfied with health authorities' regrading proposals and would resist any attempt by the nursing unions to change the deal they had agreed. But he would be very pleased if the excess cost could be held to £100 million.

4. **The Chief Secretary** said he could make no commitment to provide additional funding. It was for the Department to make its case. He asked why the original cost estimates had proved so inaccurate. **Mr Saunders** pointed out that when agreeing to the regrading the Treasury had been informed that the margin of error in the cost estimate was plus or minus £15m. **The Secretary of State** noted that the Review Body had said that the estimates were based on a very small sample of nursing posts and should therefore be treated with caution; final costs could not be known until the

regrading process had been carried out. It was unfortunate that when the Government committed itself to full funding no qualification was placed on this. There would be an inescapable bill for more funding for the award. The Department were trying to minimise this at the cost of a row with the nursing unions but it would be important to have a defensible figure. **Mr Phillips** said that the consistency of the regrading patterns would need to be examined: it would be important to understand the basis of a further in-year bid.

5. Turning to the FPS, **the Secretary of State** said he would undertake to reverse the defeat in the Lords on the introduction of sight test and dental examination charges but it would be very difficult to deliver unchanged and that he might need to seek the Chief Secretary's agreement to concessions to ensure the support of Government backbenchers. **The Chief Secretary** said he would not be sympathetic to any presentational changes which involved further public expenditure.

HCHS

A1a Review Body consequentials

6. **The Chief Secretary** said that this bid contained an allowance for incremental drift and growth in staff numbers which amounted to £m 13/23/36. This was not strictly speaking a consequential of the Review Body awards. **The Secretary of State** agreed that the bid did contain the allowance for service growth consequential upon bid A1c. If this were removed, bid A1c would need to be adjusted accordingly.

Underlying over-commitment

7. **The Secretary of State** said that the income and expenditure position of health authorities was extremely difficult. Health authorities were able to stay within their cash limits only by means of expedients such as temporary closures, cutbacks on maintenance and transferring money from capital (notably purchase of medical equipment) to revenue. The position could not be sustained. He understood that the Treasury accepted this and did

not challenge the quality of Mr Ian Mills' work. It would be necessary to remove the burden of the over-commitment and restore health authorities' income and expenditure to balance by making this provision for future years. New monitoring systems had been introduced to ensure that the problem did not recur.

8. **The Chief Secretary** said that this problem had been discussed when the Department had submitted its £200 million in-year bid in April. That bid contained an element to prevent planned service reductions. However, he understood that some of these reductions had already taken place and that others involved bringing forward closures which were already in health authorities' plans and which might be desirable. Officials should therefore examine these figures again together with the latest departmental forecasts for the deficit this year. He also asked for more information on the element of the bid relating to cuts in maintenance budgets.

9. **The Secretary of State** said that this represented the estimate of the reductions health authorities had been making in minor capital works and maintenance in order to stay within cash limits. **Mr James** added that the maintenance element in this bid was to restore cuts in maintenance budgets which were already inadequate: that in the capital bid (A6) was to speed up the maintenance programme. He acknowledged that in the past the Department had monitored principally on the basis of cash and this had not been robust enough to identify the divergence between income and expenditure. The quarterly monitoring returns now introduced would now reveal any problem, enabling the Department to take management action.

10. **The Secretary of State** said that information about the extent of the underlying over-commitment was being updated in the light of the most recent management returns from health authorities and this might result in a change to the bid. He noted that the service growth bid (A1c) assumed that this bid was accepted. If the underlying over-commitment was not dealt with, there would be a consequential effect on A1c. **The Chief Secretary** said that the over commitment had been caused in part by the imbalance between the size of the capital and revenue programmes. The extent to

which the capital bids could be cut back would influence how he looked at this bid. He agreed it would be sensible to take some action on the over-commitment if it was affordable to do so.

A1c Service maintenance/development

11. **The Secretary of State** said that this bid was based on a new methodology to calculate what it would cost to produce a given rate of expansion. The bid assumed maintenance of service growth in line with recent past trends. That should be the minimum objective. It would not be defensible to slow down growth below the current rate. **The Chief Secretary** said that this was essentially a volume bid and noted there were other bids to fund increased activity. He asked what assumptions on productivity and unit costs had been built into the Department's model.

12. **The Secretary of State** said that, as had been made clear, no allowance had been included for improved productivity and he agreed that this would need to be examined. However, the biggest advances which had been made in recent years in this area were in relation to length of in-patient stay in hospital. The extent to which this could continue to fall was slowing down. There would be improvements in efficiency but it was important not to be too ambitious. It would not be possible to achieve continuation of past trends unless other areas could be opened up.

13. **The Chief Secretary** said there were still significant differences between Regions regarding length of stay. Alternative assumptions on trends in unit costs and length of stay should be considered since these produced very material differences in the cost projections. For example, if unit costs and length of stay were assumed to change in line with past trends, the bid could be reduced by at least a third. The assumptions on which the Department's bid was based were over-generous and under-ambitious. Officials should undertake further work in this area. However, affordability must be taken into consideration as well.

14. **The Secretary of State** accepted that the Treasury could not commit itself at this stage to a given rate of service growth. He, however, could not contemplate planning to slow down the current growth in service activity. He was prepared to reach an agreement including an allowance for further improvements in efficiency but he would not then be prepared to make any further concessions. A reduction in service growth would not be defensible.

A1d Pay above general inflation

15. **The Secretary of State** explained that it was not his intention to offer generous increases to the Whitley groups across the board. However, it was necessary to introduce more flexibility into the Whitley system and if the bare minimum were provided for Whitley pay there would be no opportunity to do this. It was still the intention to have tight settlements but to press on with restructuring and reward particular target groups where there were staff shortages. There were real problems in recruiting and retaining financial, computing and technical staff for example. **The Chief Secretary** said he did not dissent from the idea of using this proportion of cost improvement programme savings for pay but he was very concerned that this was simply for Whitley groups with nothing for the Review Bodies. It was very important that the 1989 Review Body awards should not be fully funded. This would indicate to the Review Bodies that they did not have blank cheque for the excess cost of the awards. It should be made absolutely clear in the Autumn Statement that some provision was included for the costs of Review Body pay awards, with the money being found from this bid.

16. **The Secretary of State** said he had always thought it was a mistake to fully fund the Review Body awards and agreed with the objective of ensuring that full funding was not taken for granted. However, the arrangements made in previous Surveys had not worked and he had reached the conclusion that it was best to deal with Review Body pay when the awards were known in January. Review

Bodies were convinced they were not responsible for the funding of their awards and sending signals now would be of no use. **The Chief Secretary** responded that the failure to make an allocation for Review Body pay in the settlement would in itself be a strong signal to the Review Bodies. The only way to make it clear to the Review Bodies that the Government was not going to fully fund their awards was to say that there was an allocation for pay in the settlement.

17. **The Secretary of State** said that the bid would have to be recalculated if provision were to be made for Review Body awards. It would be important not to reveal the provision that had been made for pay settlements but it would need to be made clear to the health authorities that some money was to be held back for pay. The change in the timing of the Review Body reports would mean, however, that the authorities could plan a budget for 1989-90 knowing how much provision they had for pay. **Mr France** added that health authorities could be told that there was a general provision for pay awards above inflation but it would not be necessary to identify how much of this was for Whitley or Review Body groups. **The Chief Secretary** said that in that case the Review Bodies could be told that the settlement did include provision for pay and that it could not be assumed that the awards would be fully funded. It would be important to establish what the bid covered before reaching firm conclusions.

C6 NHS superannuation

18. **The Chief Secretary** said it would be necessary to establish how the savings from any reductions in the employer's contribution should be treated. He was concerned that there should be no windfall for health authorities. This would be undesirable in itself and would also create a base for future bids. **The Secretary of State** agreed that there should be no windfall gain for health authorities but presumed the Government had to take notice of the GAD report. **Miss Peirson** noted that the GAD did accept that, if pensions increase were included, the employer contribution would have to increase rather than be reduced. It was a question of

whether the employer contribution could be held at its current level while there was no legal backing for this position. The danger was that the Government might have to reduce the employer contribution in-year.

19.**The Chief Secretary** said that officials should study the matter further, establish the facts and obtain clear legal advice.

B1 Cost improvement programme savings

20. **The Secretary of State** said there would be difficulties in maintaining the cost improvement programme at past levels. The bid reflected the best estimate of what further savings were likely to be feasible. **The Chief Secretary** noted that the bid assumed savings of only 1% per annum (with an additional £50m in 1991-92 for the effects of the RMI) whereas efficiency gains in the past had averaged between 1~ and 1Û% per year. The target was therefore under-ambitious especially considering the size of the bids the Department had put forward. He noted that Mr Moore had agreed last year that it was a contradiction to have declining or flat level of savings when the baseline was growing.

21. **The Secretary of State** said that there was some evidence that faced with high savings targets, some health authority managements might take imprudent measures to achieve them; NAO enquiries suggested that some measures reported as cost improvement savings were in fact service cuts. However, he accepted that the Chief Secretary's point was a fair one andwould look further at the scope for savings. But the position on introducing competitive tendering for clinical services was more complicated than it appeared on the surface. Mr Moore had given a written assurance to the Presidents of the relevant Royal Colleges earlier this year that the Department had no plans for a central initiative on competitive tendering for pathology and radiology services.

22.**The Chief Secretary** said that this flatly contradicted the whole thrust of the NHS Review and there had certainly been no consultation with the Treasury about any such statement. The assurance could not therefore be binding. The Department should also look at other areas for increased cost improvement programme

savings. These areas included estate management and rationalisation; computerisation of administrative and clerical functions; and better targetting of ambulance services. **The Secretary of State** said it was necessary to consider how many rows the Department could take on at any one time.

A2 RAWP Bridging fund

23. **The Secretary of State** said that the need for this bid was essentially political. Colleagues were assuming - in the light of the NHS Review - that RAWP problems would cease. But, this round, he saw no alternative to RAWP. Any new system would have to be phased in gradually; a bridging fund would therefore be essential. **The Chief Secretary** said he could not accept the bid on this basis. It appeared to be seeking to provide additional funds both for RAWP losers and for the RAWP gainers whose targets were reduced by the RAWP review; this was a nonsense.

A3a AIDS Treatment

24. **The Chief Secretary** proposed that only the bid for the first year should be considered. It was extremely difficult to forecast the numbers of AIDS patients and he did not want to put artificial figures in the baseline. **The Secretary of State** agreed that there were uncertainties regarding the future numbers of AIDS patients. The Department was also re-examining the bid on the basis of new information which was coming forward. The fundamental issue was whether funding should be provided on the basis of the total costs of treating AIDS patients or simply the excess costs. It was important to recognise that AIDS was a new epidemic which attacked part of the population who would otherwise be healthy. As the NHS was having to bear the total cost of the epidemic the only sensible course was to provide funding on this basis. The excess cost basis bore particularly heavily on the Thames regions, where AIDS cases in England were concentrated. **The Minister of State** added that AIDS represented such a perceived threat to the general population that every effort should be made to combat it. It would be a mistake to regard AIDS as just another illness: it should be seen as an entirely distinct problem.

25. **The Chief Secretary** said that when this issue had been discussed last year it had been agreed that only the excess costs should be funded. There was no other disease for which hypothecated funding was provided: the NHS received block funding from which it was expected to treat whatever pattern of illness that existed at any particular time. In recognition of the special nature of the AIDS problem specific funding was being provided on the basis of the extra burden imposed per case on health authorities but beyond that it was for the NHS to bear the costs as with the treatment of any other disease.

26. **The Chief Secretary** said that he understood that the latest available information indicated that the costs of treating AIDS were substantially lower than the estimates on which the Department's bid had been based. **The Minister of State** said it was planned to re-examine the estimates in the light of the new information.

A3b AIDS Non-treatment

27. **The Chief Secretary** noted that this was an amalgam of various smaller bids. He had some sympathy towards that relating to the expansion of drug misuse services but any agreement to provide additional resources must be dependent on satisfactory targetting and monitoring arrangements. The bid relating to the control of infection stood on its own merits. However, a large amount of counselling and health education activity was already taking place and he was concerned that there might be double counting in the bid. Similarly, on staff training, he would have expected most courses to have taken AIDS into account already. **The Secretary of State** said that the bids were important but agreed to look at the points raised by the Chief Secretary.

A4 Management and information

28. **The Chief Secretary** said he assumed that the RMI bid was a marker one. He could not agree to provide additional resources for

this initiative until there was a fully worked up proposal. **The Secretary of State** said that this was in hand. **The Chief Secretary** said his position was the same regarding the bids relating to consultants' contracts and junior doctors' conditions. **The Secretary of State** said that the former depended on the NHS Review; a letter on junior doctors' conditions was en route.

29. On Project 2000/training, **the Secretary of State** said that it was important to make progress in this area because of impending shortages of nursing staff. The Government could not announce a new training system and then fail to produce the necessary resources. **The Chief Secretary** said that when the Project 2000 proposals had been agreed there had been an understanding that the increased training costs would be offset by a reduction in the numbers of qualified staff. He had been assured that any costs in the Survey period would be "modest"; the bids could not be described as such. **Mr Saunders** added that it had also been agreed that salaries for student nurses should be replaced by lower bursaries but it was unclear whether their proposed size was yet on public record. **The Secretary of State** said he doubted whether these offsetting savings could be expected to materialise immediately but he would look at the correspondence on the Project 2000 package.

30. **The Chief Secretary** said he had yet to receive any proposals on the bid for more post-basic training places for nurses. He could not agree to any bid in the absence of proper information. **The Secretary of State** said that the bid was to remedy shortages of skilled nurses in some areas. It had been made clear that it was a marker bid pending the results of a survey of shortages, the results of which were due shortly. He undertook then to provide further information.

31. **The Secretary of State** said that the internal market experiments bid was also a marker and he did not believe there was much prospect of spending £30 million in this area in the first year. **Mr Saunders** noted this was another bid, like A2 and A5, to increase activity in the HCHS in addition to the service growth

bid. He asked whether this could be subsumed under the latter. The Secretary of State said that Bid A1c was simply to maintain present policy on services. Any new policy initiatives would require further funding. The Chief Secretary noted that this was a Review-related bid.

A5 Targetted services

32. The Secretary of State said that it was presentationally helpful to be able to announce a few new initiatives which would have only a modest cost. The Chief Secretary said he saw the attraction in this. But there was the problem that the funds provided for previous initiatives continued to be carried forward in the baseline even when the initiatives had ended. It was again a question of what was affordable.

HCHS Capital

33. The Secretary of State said he shared the Chief Secretary's concern about those capital spending projects whuich generated unplanned current expenditure commitments. However, it should be recognised that some capital investment produced current expenditure savings or unlocked sales of sites. He agreed that the methods by which capital was used needed improvement but it would be self-defeating to cut capital. He considered that the balance between capital and current spending was not right - there was not enough capital spending. He accepted the Chief Secretary's concern about overheating in the construction industry; increasing construction costs were already affecting the capital programme. But NHS expenditure was only 3% of the total and should not be singled out as a target for cut-backs. He noted that the option for reductions proposed by the Chief Secretary would amount to a 23% real terms cut in the capital programme - the same as had taken place under the last Labour Government.

34. The Chief Secretary said that the Cyclotron bid was agreed and that he was content with the proposed land sales receipts offered by the Department. However, the capital bids were huge. They implied growth of 34%/43%/38% in gross capital provision over

baseline. In proposing a reduction he had in mind that only a part of the capital programme was for big new hospitals. What was needed was further information about the amounts in the baseline for different kinds of expenditure and the degree to which they represented committed expenditure.

Bid A6a Investment in infrastructure

35. The Secretary of State said that £m 70/75/75 was for equipment replacement. This area had been neglected for years and it was estimated that the average hospital was working on a 20 year replacement cycle. He believed, for example, that the NHS was using the oldest X-ray equipment in the developed world This was unacceptable. The bid was for a doubling of annual provision. The expenditure would be monitored. Similarly, maintenance (for which the bid was £m 100/100/100) had also been neglected for years. The bid was intended to reverse this process.

36. Mr Saunders said that insufficient justification had been provided on the bid for equipment replacement. As regarded maintenance, it was not clear how much provision was already in the baseline and what could be achieved with this money. The Department had nearly reached in 1986/87 the target set for 70% of the NHS estate to be in category A or B condition.

37. It was agreed that officials should prepare a factual paper providing a breakdown of the capital baseline. It should indicate the areas where there was inadequate information. Further discussion of this bid would be deferred until this had been prepared.

A7 Capital Loan fund

38. The Secretary of State said that this was intended to provide a bridging provision for service transfer to release land and resources. Expenditure of this kind was essential for rationalising provision and making current expenditure savings especially in the Central London area. These important initiatives

could not be financed from existing capital provision as it would mean postponing major planned capital investment projects elsewhere.

39. The Chief Secretary said that he was prepared to consider a proposal to top-slice the HCHS Capital Vote for this purpose. But there was no prospect of producing extra provision for a capital loan fund on top of all the other bids submitted by the Department.

A9 VAT

40. The Chief Secretary said that health authorities were to be granted full refunds of VAT paid on new construction. The bid related to a first year cash flow effect which should be absorbed. Ms Stewart noted that refunds would always lag three months behind payments.

FPS

A10 and C2 and 3 FPS Estimating and options for FPS Savings

41. The Secretary of State confirmed that prescription charges would be increased in line with the expectation assumed in the baseline. The new sight test and dental examination charges agreed last year would also be delivered. However, the introduction of further new charges would be politically unacceptable. The chargeable base was too small to make it realistic to offset increases in FPS expenditure.

42. The Chief Secretary said he was grateful for the agreement to increase prescription charges and said that the rest of the FPS Estimating bid was not disputed. He was concerned, however, that the Department apparently considered that all proposals for widening the charging base were not to be worth the row if they generated small savings and too damaging if they raised a lot of money. He considered that removal of the exemption of contraceptives from prescription charges was realistic. There was

agreement on the desirability of introducing compulsory generic prescribing: it was a question of timing and method. And a modest extension to the Selected List should not arouse many complaints.

43. **The Secretary of State** replied that the introduction of charges for contraceptives could provoke a huge row for the sake of £10m per year. He agreed that compulsory generic prescribing was a sensible idea but its introduction was a long way off. The extension of the Selected List was again attractive but ruled out for the present by assurances given to the profession and the pharmaceutical industry. The Primary Care White Paper had said that the Government intended to proceed by voluntary measures in this area and savings in the drugs bill via such methods had been scored in the last Survey. If the savings were found voluntarily, there would be no need to introduce any statutory requirement. If the voluntary measures failed, the possibility of proceeding by compulsion could be re-examined.

44. **The Chief Secretary** said that if worthwhile savings could not be generated for political reasons, there would be less prospect of meeting the other bids. It was therefore important to achieve savings wherever possible.

A11 FPS IT Capital

45. **The Chief Secretary** said that if this IT equipment would help GPs become more efficient there should be cash savings as well as improved productivity. He also questioned the realism of the timetable for expanding the programme which the bid implied. **The Secretary of State** said that he foresaw no cash savings. Giving doctors access to waiting list information would ensure better use of resources but could actually lead to increased costs. It was important to press on with this programme as quickly as possible given its popularity with the general public.

A12 FPS Service improvements

46. The Secretary of State said that this bid was to extend immunisation against Hepatitis B and also to give the Department flexibility to make additions to the Drugs Tariff when the need arose. The Chief Secretary said that the costs of extending Hepatitis B immunisation were only a small part of the bid and should be absorbed. As far as additions to the Drugs Tariff were concerned, he would prefer that the Department made a proper case for funds in-year if necessary rather than building extra provision into the baseline.

Cash limiting the FPS

47. The Secretary of State said that he was attracted in principle to this proposal. However, he did not believe that the FPS could be cash limited overnight. It would be necessary to establish control over the numbers of doctors and dentists in the FPS; over drugs bill expenditure; and over referrals. Even minor changes in these areas would be very controversial. The Chief Secretary said that if the desirability of cash limiting the FPS was accepted, it was necessary to identify the practical problems and establish how they might be overcome. Officials should begin work on this to ensure that the practical problems were not simply cited again in future Surveys.

CFS

48. The Secretary of State said that individually most of the bids were important, so he would be reluctant to reach a global settlement for the programme which left cuts which could not be coped with. The non-cash limited bids were irresistible. However he was prepared to look at ways to reduce the Welfare Food budget.

49. The Chief Secretary said that all CFS expenditure should come within a single cash limited Vote. Abolition of the welfare food programme was attractive in principle, given the anachronistic principles underlying it, but could have a knock-on effect to

Social Security expenditure. The split of the former DHSS made this a much more difficult proposition to handle than at the time of his agenda letter. However, he did think that a reduction in expenditure on the programme was a serious proposition. There were sound arguments for negotiating a price discount of at least 10% with the Dairy Trades Federation. Welfare milk represented a substantial guaranteed sale for the DTF; it removed a credit risk which they would otherwise face; and discounts had been negotiated by other major purchasers including the NHS. If necessary, a new token could be produced to encourage supermarket use, which would help in the negotiations with the DTF. As far as other savings were concerned, Mr Moore had agreed that it was anomalous to provide welfare food for children in nurseries, playgroups and with childminders, although he had afterwards reversed this decision. But Mr Newton had subsequently accepted the policy justification for abolition in his letter of 29 January 1988. Further savings could be achieved by abolishing the subsidy on dried baby milk for Family Credit mothers, which had been agreed for 1988-89 only. The Secretary of State said he would examine these proposals.

50. The Chief Secretary also proposed reducing the age of eligibility for welfare milk from 5 to 4. The Secretary of State said that this would be politically very controversial and would attract criticism on health grounds. He was not prepared to provoke a row on this issue at the same time as he would be having to present controversial proposals on several other fronts.

51. Turning to EC Medical Costs, the Chief Secretary said that these too should be cash-limited and absorbed from within the programme. The Secretary of State replied that there was no choice but to pay the actual cost of treatment: a cash limit could not be applied to a service which could not be controlled. The Chief Secretary said that he was not proposing an individual cash limit for these costs, simply that in-year fluctuations should be absorbed within the overall cash-limited CFS budget. Given the

relative size of the two, this should not present problems. Miss Peirson said that it was common for cash limits to contain elements outside the control of the spending authority. Mr France considered it illogical to cash limit uncontrollable expenditure.

Running costs

52. The Secretary of State explained that this bid was made up of Review Body consequentials, increased staff in special hospitals, and higher provision for youth treatment centres. He queried why this expenditure was included within running costs at all. He felt sure that the prison service, for example, was outside running costs. The Chief Secretary noted that the CFS was treated in the same way as everybody else. In fact the prison service also came within Departmental running costs. Officials should try to agree a 1-year settlement for CFS running costs for 1989-90 in advance of the next bilateral.

Pay and prices (non-running costs)

53. The Chief Secretary said that these small bids should be absorbed. Mr Lillywhite noted that - as Treasury officials were already aware - the Department was already absorbing some £8m on the CFS programme. The Secretary of State said that if the Chief Secretary argued that every individual bid was absorbable the end result would be illogical

AIDS Publicity

54. Mr Lillywhite explained that this bid was to maintain funding of the HEA campaign at this year's level. The Chief Secretary questioned whether continued publicity was needed.

Social worker training

55. The Secretary of State said that this bid was small but important. It would be counterproductive to provoke a row with the CCETSW. The Chief Secretary noted that in agreeing in May to Mr Newton's discussions with CCETSW, he had said he expected offsetting savings to be found to any Survey bid, but none had

been identified. He added that the bid was presented on a UK basis, yet the territorial departments would receive a proportion of whatever provision was made available for the DH programme. The Parliamentary Under Secretary of State, Scottish Office said that the Scottish Office had some doubts about whether they got value for money out of their contribution to CCETSW, given the different basis for training social workers in Scotland.

Nurse recruitment

56. The Secretary of State said that there was a widespread perception that nurses were very low paid. This had an adverse effect on recruitment and needed to be corrected. This year's advertising campaign had been quite successful in correcting misconceptions. But a new campaign would be needed once this year's row was over. The Chief Secretary considered that the 1988 pay award should itself have increased the attractiveness of nursing as a profession and questioned the value of advertising. The Secretary of State noted the importance of presenting counter-arguments to COHSE and NUPE propaganda.

EUROPES

57. The Secretary of State said the main problem was that the EUROPES baseline had been set in 1984 when EC health expenditure had been very low. The Chief Secretary said that the EUROPES arrangements had been endorsed by Cabinet and should be properly applied.

PSS Capital

58. The Secretary of State offered to reduce this bid in line with the higher forecast level of receipts. The Chief Secretary replied that he did not accept that extra receipts should automatically go into higher allocations. Because of changes to the present capital control system, local authorities would take every opportunity to supplement their own expenditure through increased in-year receipts. DH, like other departments, were being asked to reduce their allocations to reflect higher forecast

receipts. The Secretary of State said that he would want to be assured that the PSS programme was not being treated more unfavourably than other programmes.

Assistance to the voluntary sector

59. The Secretary of State said the proposal to restrict support to voluntary bodies to 50% would produce savings of only £0m a year. The Chief Secretary invited the Secretary of State to consider how savings could be made in the Government's assistance to the voluntary sector.

Conclusion

60. The Chief Secretary said that at least one further bilateral would be required. Officials should produce the various further pieces of work which had been commissioned. The Secretary of State said that the main issues were the questions of efficiency savings and productivity; Review Body pay; AIDS; and HCHS Capital. The Chief Secretary said that another important item was the question of NHS superannuation. He suggested that it might be sensible to have a meeting on these large discrete issues.

HM TREASURY
27 September 1988

Carys Evans

MISS C EVANS
Private Secretary

Distribution
Those present
Principal Private Secretary
Sir Peter Middleton
Mr Anson

NH/6/46M

SECRET

FROM: MISS M P WALLACE
DATE: 19 September 1988

PS/CHEEF SECRETARY

cc Sir P Middleton
Mr Anson
Mr Phillips
Mr Turnbull
Miss Peirson
Mr Saunders
Mr Griffiths
Mr Call

BRIEFING FOR HEALTH BILATERAL

WALLACE TO PS/CST 19 SEPT

The Chancellor has seen Mr Griffiths' note of 16 September.

2. He has commented that if the Chief Secretary decides to seek an understanding that Review money should not be announced at Autumn Statement time, but held back until the Review conclusions are public, then the Chancellor greatly prefers the variant discussed in Mr Griffith's para 14 - announcing at the same time as reducing employer superannuation contributions.

3. On the question of whether £200 million will be presentable as the cash outcome of the review (with expectations having meanwhile been built up) the Chancellor's view is that all will depend on the corresponding figures for years 2 and 3. He would be interested to know what they are.

MOIRA WALLACE

pf.dc.FP.19.5 **SECRET**

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Copy 1 of 18

FROM **N I MACPHERSON**
DATE **20 SEPTEMBER 1988**

1. **MR CULPIN**
2. **CHANCELLOR OF THE EXCHEQUER**

cc Chief Secretary
Financial Secretary
Paymaster General
Sir Peter Middleton
Sir Terence Burns
Mr Anson
Mr Phillips
Mrs Case
Mr Turnbull
Miss Peirson
Mr Gilhooly
Mr Saunders
Mr Parsonage
Mr Call

Mr Lewis - IR
Mr Kuczys - IR

MR BAKER'S LETTER ON TAX RELIEF FOR MEDICAL INSURANCE

Mr Baker's letter of 6 September picks up one of a number of arguments which are likely to be directed against the policies on relief for private medical insurance. It is an argument you anticipated when heading off calls for a more general tax relief.

2. A rationale for reliefs for medical insurance is attached. We have also tried to identify the most obvious questions and the defensive line to take. Some of these, particularly that relating to the self employed, are less than convincing.

3. There seems little point in giving Mr Baker the defensive line on education now. It would only encourage him to continue the correspondence, at a time when decisions have already been taken. A brief acknowledgement would appear appropriate, and a draft letter is attached.

N. I. Macpherson

N I MACPHERSON

MACPHERSON TO C X 20 SEPT

Tax proposals for health

1. Tax relief at source on private medical insurance premiums paid for the over-60s. Relief available at marginal rate.

2. A benefits-in-kind exemption for employers' medical insurance schemes which cover all employees on similar terms.

General line

Trying to promote a market in private health care and increase freedom of choice. No need for a general relief for private medical insurance, since large number of employees, employers and self employed can and increasingly do pay for insurance themselves.

Elderly are different. Lose benefit of company schemes. Insurers are reluctant to make much of a market in health insurance for them. Premiums very costly. Need to get market going.

All-employee schemes also a special case worth targeting. Very few of them around and so deadweight cost small. Benefits-in-kind exemption will encourage inclusion of all employees, not just directors and executives, in employers' schemes. Most cost effective way of generating additional private coverage.

(Equitable?)

Q Why relief for health of old but not education of young where people are contracting out of all State provision?

A Market well developed and growing in education, whereas it is not in health insurance for pensioners.

Would be enormous deadweight cost in tax relief for education - over £½ billion on Mr Baker's figures.

Q Plan to withdraw the relief once health schemes well established?

A No tax relief guaranteed forever; but can expect this one to stay for foreseeable future.

Q Why relief at marginal rate?

A This is how most other reliefs (including pension contributions and mortgage interest relief) work.

Q Unfair to self employed. Can't be in an employee scheme.

A Need to target areas which will maximise additional take up of private medical insurance.

Self employed already doing well out of tax/NIC system.

Q What about employees whose employers refuse to set up all employee schemes?

A Up to employees to persuade employers as part of terms and conditions.

Relief for all-employee schemes should encourage employers to cover all employees not just a few executives.

Q Only City firms have all-employee schemes. Further money for fat cats?

A Relief should encourage growth of all-employee schemes in all sectors of the economy. Because they have to cover all employees to get relief, it is not just high paid who will benefit.

Q What about elderly who pay for hip operations direct from taxed income?

A Already a good market in paying direct. Not much of a market in medical insurance for the elderly.

Q Why not relief for work-place nurseries?

A Not a valid comparison. Not all employees would be eligible for a work-place nursery place. Only a limited number of places available. Very substantial benefit (worth over £3000 a year) for favoured few.

Already a thriving market in childcare. Plenty of choice: nannies, childminders, private nurseries (all paid for out of taxed income) and workplace nurseries. No need to distort demand.

DRAFT LETTER FROM THE CHANCELLOR OF THE EXCHEQUER TO MR BAKER

Thank you for your letter of 6 September. The points you make are important and will of course be taken into account in the NHS review. You will appreciate this has yet to be completed.

I am copying this letter to the Prime Minister and Kenneth Clarke.

20.9.5

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 20 September 1988

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Mr Phillips
Mr Luce
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr A M White
Mr Griffiths
Mr Sussex
Miss Walker
Mr Rayner
Mr Call

1988 SURVEY: HEALTH

I attach a draft letter from you to Mr Clarke following up the first health bilateral yesterday.

2. As discussed, the letter starts by challenging Mr Clarke's opening remarks to the effect that adding this year's Review Body money to Mr Moore's settlement last year produces a figure not far short of his £2bn bids. The draft letter points out that if, as you should, you ignore the in-year review body money (since we do not yet know what the 1989 awards will cost), the comparison is between Mr Moore's agreement of £710m and Mr Clarke's bid of £2010m. (This ignores any adjustment to the allocation of local authority current expenditure to PSS, which is scored in the HPSS programme.)

3. There is in fact an even more striking calculation which could be done. This would strip out from the bid/agreement the previous year's review body award, leaving the additional money for improving services. On this basis, Mr Moore agreed to £375m (£710m, less £335m for the 1987 review body awards), while Mr Clarke is bidding for £1380m (£2010, less some £630m for the 1988 awards), or nearly four times as much. But we do not recommend putting the point in this way, since it invites a rather fruitless debate about price versus volume changes, including, for example, estimating changes on the FPS.

4. For the rest, the letter sets out the further work agreed at the bilateral. You might like to note in particular how it is proposed to handle the question of cash-limiting the FPS. We suggest commissioning a paper from the department which would set out what they see as the obstacles to this, and how they could be overcome. While this subject has been discussed in the context of the Review, no paper was formally commissioned by the minutes of the last meeting. So it is well worth asking for such a paper now, even if it is eventually considered in the Review rather than at a further Survey bilateral.

R B SAUNDERS

20.9.1

CONFIDENTIAL

DRAFT LETTER FROM THE CHIEF SECRETARY TO:

Rt Hon Kenneth Clarke QC MP
Secretary of State for Health

PUBLIC EXPENDITURE SURVEY 1988

My office will be letting yours have as soon as possible draft minutes of our bilateral on Monday. But I thought I should write straight away to confirm the main points on which we agreed further work was needed.

2. Could I first take up one point arising from your introductory remarks. If I understood you correctly, you suggested that your net bids were not out of line with what John Moore and I settled last year, if one added £803m for the 1988 Review Body awards to the £710m increase for 1988-89. This is however wrong on two counts. First, £803m is the full cost of the nurses' pay award, including not only the claim on the Reserve in April, but also both the provision for pay increases up to the GDP deflator included in the 1987 Survey settlement and the consequential costs for Scotland, Wales and Northern Ireland. Second, and more importantly, the methodology is incorrect. If you wish to compare the total of your bids with those agreed last year, you need to treat the successive review body awards consistently. Since we do not yet know what the awards will be in 1989, we can only do this by ignoring the claim on the Reserve in respect of the 1988 review body awards and comparing your net bids of £2010m with his agreement to £710m.

3. In other words, your bids are nearly three times the volume of those agreed by John Moore last year.

4. We agreed that our officials should prepare three papers for our next meeting:

a. A note setting out the effects of different assumptions about both activity and productivity on your service growth bid. While your model gives a helpful indication of how different assumptions affect the forecast it is still a relatively untested analytical tool. I would not therefore want to set too much store by its results this year.

b. A paper setting out the present position, and the legal advice we have had so far, on the question of employer contributions to the superannuation scheme.

c. A paper about capital setting out the contents of the baseline (including how much is uncommitted in the later years); what is known about the condition of the capital stock, both equipment and the estate; the effects of applying the reductions proposed by the Treasury; and what targets could be achieved if your bids were accepted.

5. There are in addition several items which our officials need to clarify further. Whether or not we need papers on them will depend how those discussions go.

d. The precise composition of the difference between your bid of 575/605/635 for review body consequentials and the 562/582/599 which I am prepared to offer.

e. What is the Management Board's latest estimate of the income and expenditure deficit likely at the end of 1988-89, and how the gap will be bridged. I should also be interested to know what is the nature of any temporary closures that may be made as part of these measures - for example, whether they simply bring forward closures that would otherwise have occurred. I would also like to know what lag is expected in the receipt of the new quarterly monitoring information, and exactly what management action would be taken by your Department if the returns showed an improvement in the deficit.

f. More up-to-date figures are, I understand, coming available on the cost of AIDS treatment. Officials will clearly need to agree the costings of our two approaches of average or excess cost per case.

g. You agreed that a clearer management plan was needed for the implementation of the Resource Management Initiative. This will need to be available to my officials as soon as possible.

h. My officials still await details of your proposals for post-basic nurse training and for junior doctors.

i. Further discussions are needed between our officials about your running cost bid for 1989-90 (deferring consideration of the bids for the later years until the preparation of your management plan next year).

6. We also discussed the possibility of bringing the FPS within cash limits. You explained that you saw certain difficulties with this. I should be grateful if your officials would let mine have a note setting out what are the principal problems which the department sees with cash-limiting the FPS, and what action, legislative or otherwise, would be needed to overcome them.

7. You are also going to reconsider yourself the level of efficiency savings which might be achieved by the cost improvement programmes, and the ways in which the cost of the welfare food programme might be reduced, including a discount on the purchase of milk from the dairy industry.

8. I am copying this letter to Michael Forsyth and to Peter Walker.

SECRET

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

NP

20/9/88.

Ch/

You asked for a debrief on Health and Home Office bilaterals.

Health was apparently a long grinding session — 5 hours! — with every bid gone through in detail and no offers made on either side. Lots of further work commissioned. Dick's assessment is that the Scorecard forecast outcome now looks perhaps £200m too optimistic. Capital is going to be v. difficult; and our chances of getting anything on prescription charges extensions look minimal. Relationship between AS + Review not discussed. (By the way, you asked how the puny £200m for the year 1 cash outcome would look in years 2 and 3. Dick suggested perhaps £300m and £500m might be — very rough and ready — estimates.) Further letter for CST to send behind.

Home Office seems to have gone rather better. Hurd wants a deal and to avoid Star Chamber. He was pressed hard on prison population projections underlying his capital bids, and has undertaken to reflect further + write again.

NPW.

CHANCELLOR OF THE EXCHEQUER

HONI SOIT QUI MAL Y PENSE

B × P

Thanks. One small pt:

The ground I yielded on perks was not to charge taxing health insurance as a straight perk, but to do so exclusively for schemes that covered all employees (wh. @ present, @ least, only a small minority do). The analogy is with fiscal concessions for all-employee share schemes.

That said, I am prepared to proceed as suggested in para 12. This will need to be flagged up for the 1st occasion the writing group discusses the draft White Paper.

NL.

rc.20.9.01

SECRET AND PERSONAL

349/88
Copy 1 of 8

Ch/ This is half in code. We have told Robert, Hayden + CST of your chat with Mr C, but no-one else. Advice at para 12 stands up whether you are in the know or not. Only worry is: how many battles can we fight at once at pre-Party Conference meeting 4 October? There will be great pressure for something to be said at the Conference + tax relief has been widely trailed (not least by No 10 - see flag X behind) m/pw.

CHANCELLOR

FROM: ROBERT CULPIN
DATE: 20 September 1987

cc: Chief Secretary
Sir Peter Middleton
Sir Terence Burns
Mr Phillips
Mr Scholar
Mr Macpherson

NHS REVIEW: TAX MEASURES

You took stock last week of what Mr Clarke has signed up to - Mr Saunders' minute of 13 September. I think we should also take stock of the tax measures you have accepted.

2. I attach a minute by Mr Macpherson which does that. I asked him to take the letter you received from Mr Baker as the occasion to set out what we have agreed and, broadly, how we would present it. (The letter itself is easy to deal with). This covering note has a smaller circulation.

3. The options you have accepted are much lesser evils than the ones with which we were threatened; and Mr Baker's letter is a salutary reminder of that. If we were still contemplating rebates from National Health Contributions for those who "contract out", I do not really see how, in principle, you could justifiably deny similar rebates to people who contract out of state education. As Mr Baker says, they give up their claim on the state, whereas people who buy private health insurance do not.

4. This is less of a worry now that you have limited the main scheme for tax relief to the elderly. Indeed, if this were the only tax proposal on the table, I think we could ring-fence it, because most people accept that pensioners are different. And I think we could square it with our tax policy in language which is familiar: in general, the policy is to level out tax reliefs and trust to the markets; but in some cases there are no

CULPIN TO CX 20 SEPT

markets; and it may be worth a bit of tax relief to complement other policies to help get them going (Tax Reform pamphlet pp 10-11).

5. The proposal to exempt health insurance from taxation as a benefit in kind is more difficult. I began by thinking that, whatever the tax theology, there is a plain man's defence : we do not want positively to subsidise health insurance through the tax system, but we don't want to penalise it either. (I know that taxation as a benefit in kind is not a penalty, but that is how it is often perceived.) Put another way, it would look a bit odd to encourage private insurance with the left hand and simultaneously tax it with the right.

6. But if we are going to say that some lucky employees can enjoy health insurance out of untaxed income - which is what a benefits-in-kind exemption means - why on earth should the self-employed only be able to buy insurance out of taxed income? If there is anyone who really cannot afford to get stuck in NHS queues, it is surely the self-employed person who is entirely dependent on his or her own resources.

7. And if health insurance is not a taxable benefit, why are workplace nurseries?

8. The plain fact is that the proposed exemption involves unfair discrimination. If I had to explain it to friends who are self-employed, I could not do a very good job.

9. It is not the end of the world. We could probably get away with it. It would not do terrible damage to the tax system. And it would not be a disaster if you had, say, to make health insurance an allowable expense for the self-employed. That would be yet another step towards a general subsidy, but the cost of this alone would presumably only be tens of millions. Nonetheless, the fact remains that the policy proposal we have is quite difficult to defend seriously.

10. You have, of course, been well aware of this all along; but things have moved on since we first went round the course. You have put the threat of contracted-out rebates well behind you (I trust). You have succeeded in moving the debate off demand-boosting onto reform of supply. And there is a new Secretary of State.

as far as I can see

11. I wondered, therefore, whether to advise you to use Mr Baker's letter to reopen the tax options, or at least to give another airing to the issues they raise. Indeed, in the case of the benefits in kind exemption, I am not absolutely certain that you would have formally to reopen anything: it is not clear from our records whether you have formally accepted the exemption or simply agreed to consider it further. But whatever the formal position, I assume that it would simply be too provocative to reopen the tax issues now, on their own; and there is not enough at stake to make this worth while.

Last discussed at mtg on 30/6

"no decision yet taken"

12. I have, however, discussed tactics briefly with Mr Phillips, and we would like to try on you the following suggestion:

- hold your fire until the draft White Paper appears in October

- make the point then that the demand-boosting tax measures sit oddly with the supply-side package which rightly dominates the White Paper

- suggest that they be omitted, on the grounds that they do not fit, are not necessary, and go against the grain of tax policy

- suggest tactfully that they have been overtaken, in the course of the review, by the welcome progress in producing supply side reforms

- say that if, when the White Paper appears, there is genuine concern to do something on the tax side for

pensioners, you will be prepared to do that in the Budget

- but try to bury the proposal to stop taxing benefits in kind.

Does this stand a chance?

ROBERT CULPIN

THE INDEPENDENT

Health service reform will give greater freedom to managers

By Anthony Bevins and Nicholas Timmins

THE BROAD framework of the Government's NHS review has now been agreed, with managers being given more freedom to run hospitals against agreed targets, and with those which treat patients more quickly and economically being rewarded at the expense of those who do not.

The reform will adopt some of the ideas of the internal market, in which hospitals increasingly buy services from each other and the private sector. But the change is likely to be an evolutionary one rather than an overnight switch to a full-blown market approach.

The aims include making it easier for patients to cross health authority boundaries for treatment. Those hospitals which perform well will receive the cash, rather than facing financial crises from treating patients more efficiently.

Any tax concessions for private health insurance are likely to be limited and confined to the elderly, and will come chiefly at the Prime Minister's insistence.

The Treasury is still not keen on the idea, and Kenneth Clarke, the new Secretary of State for Health, told a conference earlier this week that while private provision was of benefit to the NHS it "should be encouraged to find its own level".

The broad shape of the reform was agreed at a meeting earlier this week, with Margaret Thatcher keen to see hospitals become more independent and more accountable. Hospitals may be allowed to opt out of the NHS, thereby becoming self-governing institutions earning their income from NHS contracts and private patients. But the mechanisms of achieving the changes within cash limits have not yet been decided.

The resource management initiatives — in which doctors, nurses and others are given far more information about their use of services and the costs — will be pushed ahead as fast as possible, however, while the Department of Health is working on a rough "tariff" to price treatments which could be available next year. That would make it easier to measure hospitals' performance and direct resources to where they are best used, and for hospitals to buy and sell services.

While Mr Clarke is likely to broadly trail the outline of the reforms at the Tory party conference next month, details are still "fluid" according to insiders and will await a White paper, probably in December.

Regional health authorities may be slimmed down, possibly with their membership changed so that they become more like boards of directors, with more of their services "bought in" from private and independent firms. But ministers appear to want as far as possible to avoid structural reform for its own sake.

Merging family practitioner committees with health authorities has not yet been ruled out, however, and ministers are still considering reforming consultant contracts — making them renewable, and reforming the merit award system so that the extra payments more closely reflect work done for the NHS.

Welsh and Scottish ministers have now joined the review team of the Prime Minister, Nigel Lawson, the Chancellor, John Major, the Financial Secretary to the Treasury, Mr Clarke, David Mellor, the new Minister for Health, and Sir Roy Griffiths, the Prime Minister's adviser on health care. It is to meet regularly over the coming weeks.

■ Mr Clarke moved yesterday to get negotiations over a new contract for family doctors, which have become bogged down, back on the road. Little progress has been made since a White Paper proposing bigger rewards for GPs who provide high-quality services and high levels of immunisation and screening was published last November.

Mr Clarke agreed to further meetings from time to time with the GPs' leaders to review the progress being made in negotiations that are taking place with officials. He told the family doctors that whatever the outcome of the NHS review, their status as independent contractors to the NHS, rather than salaried employees, and their clinical freedom, would not be affected.

NURSING POLICY STUDIES CENTRE

DIRECTOR: DR. JANE ROBINSON

UNIVERSITY OF WARWICK
COVENTRY CV4 7AL

TELEPHONE COVENTRY (0203) 523523
EXT. 3985/2985

JJAR/PSW

21st September 1988

Rt. Hon. Nigel Lawson MP,
Chancellor of the Exchequer,
11 Downing Street,
Whitehall,
London SW1A 2AB.

Dear Chancellor,

New model management: Griffiths and the NHS.

Problems have been reported with the above report, a copy of which was recently sent to you. In some cases the binding has come loose from the pages and the cover has absorbed finger marking.

The University printing department has agreed to make good these defects but has requested that in the first instance the original report should be returned.

I would be grateful if, should you wish to make use of this facility, you could return your report to the above address **before 30th November 1988** and we will make good and return it to you at the earliest possible opportunity.

Yours faithfully,

Jane Robinson

Jane Robinson
Director

Please enclose this slip when returning your report, completing the information to whom it should be returned.

Name .....

Designation.....

Address.....

.....

.....

16.9.2 CONFIDENTIAL

IHG are looking for opportunities in the NHS, since the overseas markets (middle East, largely) in which they have operated to date are no longer expanding so fast. I agree this is an interesting idea but probably for when self-governing hospitals start to become a reality. RR 22/9

FROM: D P GRIFFITHS

DATE: 21 September 1988

1. MR SAUNDERS

2. CHIEF SECRETARY

cc PS/Chancellor
Mr Phillips
Miss Peirson

INTERNATIONAL HOSPITALS GROUP (IHG) : CONTRACT MANAGEMENT OF NHS HOSPITALS

1. You asked for comments on IHG's ideas for undertaking turnkey management contracts for NHS hospitals.

2. IHG's proposal is that they should take over the management of one typical district general hospital in each RHA. They offer various options ranging from simply providing a senior management team, with the hospital staff remaining NHS employees, to a complete turnkey package where the staff would become IHG employees. The contract would be on a cost plus fixed fee basis with IHG installing new management information systems so that it could demonstrate that it was running a more efficient and cost-effective service than a conventionally managed hospital. IHG do have experience of operating turnkey hospital management contracts overseas but so far its involvement in the UK seems to have been limited to a management consultant role.

3. Turning over the management of an NHS hospital to a private company while retaining public ownership of the assets would be the logical culmination of various trends underway in the NHS at present. Many non-clinical support services are already provided by external contractors and, of course, we are now pressing for the contracting out of clinical services. In addition, health authorities are starting to make greater use of facilities provided by private sector hospitals - purchasing operations, community care places etc.

4. Recourse to the private sector to enhance the provision of publicly funded health care is therefore well-established. Provided that IHG (or whoever) were able to make a convincing case

276/9

that that a turnkey management contract could be expected to provide better value for money than a conventionally operated hospital, it would be worthwhile exploring this option when moving towards giving hospitals greater independence from health authorities. (As IHG are thinking in terms of a cost plus contract, the onus would be on them to show that their management would produce lower costs so that the resulting savings more than offset their profit margin.) If IHG's methods are successful, they offer the prospect not only of greater efficiency in the particular hospitals being managed under contract but also of the demonstration effects of the new procedures and practices which could be adopted by other NHS hospitals.

5. As far as the NHS Review is concerned, turnkey management contracts would be fully consistent with the self-governing hospitals and buyers and providers models under discussion. The contract between a health authority and IHG would be similar to that with any other independent hospital. In each case the quantity and quality of the services to be provided would be specified and the contract price agreed. Responsibility for capital investment decisions would also have to be settled (this issue has not yet been fully addressed in the context of the independent hospitals proposal). The role of the health authority would then be to establish that the contract would offer value for money, monitor the contractor's performance and renegotiate the contract periodically.

5. There is also the precedent of the Naval dockyards. New management teams, selected by competitive tendering, have been brought in to run the dockyards. The dockyard staff became employees of the contractors while the ownership of the assets remains with the MOD. The results have been generally successful.

6. However, like self-governing hospitals, turnkey hospital management contracts are probably for the medium/longer term rather than something to introduce immediately. There needs to be a proper system of medical accreditation so that a health authority can be satisfied that the contractor is maintaining and can be shown to be maintaining a proper level of service. The health authority would also want to be confident that it did have

ready access to alternative provision as a temporary back-up in the event of problems. This would obviously be easier in a system where there were a number of competing providers. Equally, for turnkey management contracts to work, the contractor must have the flexibilty to remunerate and deploy staff as they see fit. It would ease industrial relations problems if the present monolithic NHS pay system had been broken up and there was no obvious national 'NHS rate for the job' from which the contractor was seen to be diverging.

D P GRIFFITHS

Copy to
You might pass this to Mr. Phillips, Mr Gilhooly for comment.
4/24.7

Right Honourable John Major PC MP
Chief Secretary to HM Treasury
House of Commons
London SW1A 0AA

4 August 1988
REF: 34/BD3/CO5/JEFS/ag

Dear Chief Secretary

Contract Management of National Health Service (NHS) Hospitals

In recent years there has been a growing recognition of the contribution which private sector management skills can make to the efficient running of the NHS. The appointment of general managers from industry, the establishment of a Management Board, and the contracting out of hotel services to commercial companies are evidence of this Government-led initiative to give tax payers better value for money in the public health sector.

Political considerations may well deter Parliament from ever taking privatisation to its logical conclusions, as far as the NHS is concerned. However, there is a further stage which can and should be explored which takes full advantage of private sector management skills whilst maintaining full public accountability and control.

For many years International Hospitals Group Limited, (IHG), has been managing public sector hospitals on a turnkey basis under contract to Government agencies. Using British management and employing British doctors and nurses, IHG has provided a full range of healthcare services in hospitals built and owned by public authorities. IHG provides all the staff, purchases and maintains all the equipment, orders all the medical supplies, drugs and consumables, and maintains the buildings and fabrics. In addition, IHG conforms to carefully drafted services specifications and adheres to Quality Assurance standards and procedures.

INTERNATIONAL HOSPITALS GROUP LIMITED
Head and Registered Office: Stoke Park, Stoke Poges, Slough. SL2 4NS
Telephone: (0753) 73222 Facsimile: (0753) 35855 Telex: 849169 IHG UK
DOE Licence No. SE 10971 Registered in England No. 1482891 VAT Reg. No. 225 8505 64
Medical Board
Professor Sir Gordon Robson CBE, DSc, FRCS, FFARCS; Professor Sir Geoffrey Slaney KBE, MSc, ChM, FRCS;
Sir Richard Bayliss KCVO, MD, FRCP
INTERNATIONAL GROUP, FIRST COMPANY ESTABLISHED 1870

Until recently, IHG's management contracts have been for hospitals in the Middle East, but of late District Health Authorities have been coming to IHG to ask for assistance with managing difficult departments such as out-patients, support services and medical records.

Although IHG has willingly responded to these requests we now believe the time is right for a more comprehensive approach to contract hospital management which will bring benefits to patients as well as to the hard-pressed Health Authorities.

Please find enclosed a copy of our proposal, I am sure this concept will be of interest and I would welcome the opportunity to discuss it with you at your convenience.

Yours sincerely

JOHN E F SEVENOAKS
Director

enc:

P.A.

PMP.

chex.nh/mw/52 **SECRET AND PERSONAL**

Copy No 9 of 11

FROM: MISS M P WALLACE
DATE: 21 September 1988

MR CULPIN

cc Chief Secretary
Sir P Middleton
Sir T Burns
Mr Phillips
Mr Scholar
Mr MacPherson

NHS REVIEW: TAX MEASURES

The Chancellor was most grateful for your minute of 20 September.

2. He has noted that, as you know, the ground yielded on perks was not to cease taxing health insurance as a benefit in kind, but to do so exclusively for schemes that covered all employees, which at present, at least, only a small minority do. The analogy is therefore with fiscal concessions for all-employee share schemes. That said, the Chancellor is prepared to proceed as you suggest in paragraph 12 of your minute, holding our fire until we first see the draft White Paper, and arguing then that the tax proposals had been overtaken. He comments that this will have to be done on the first occasion the Review group discusses the draft White Paper.

MOIRA WALLACE

week.26.9/m.3

SECRET

BF 2819

FROM: H PHILLIPS
DATE: 27 September 1988

PS/CHIEF SECRETARY

Ch/ I understand the outcome of this was that meeting will be arranged in due course, and MrC's office will stop any unilateral action. mpw

cc PS/Chancellor
Sir P Middleton
Mr Anson
Miss Peirson
Mr Saunders
Mr Parsonage

NHS REVIEW: CAPITAL

There has been a running confusion with DoH about whether or not the Chief Secretary and Mr Clarke had agreed to talk about new arrangements for NHS capital. This surfaced again yesterday in the Official Group, when DoH officials said that because there had not been a meeting, Mr Clarke would put a paper into the Review. I said that this would be an unfriendly act; it was a matter on which the Ministerial Group had expected a bilateral exchange, if not bilateral agreement.

2. We should sort this out. Has there been a formal request from Mr Clarke's office? I said that if there had been it was not surprising, given the Chief Secretary's programme, that it has been refused. I also said that if the prospect of a meeting was slim the Chief Secretary would expect a letter from Mr Clarke setting out what he wanted and allowing time for reply before he acted unilaterally.

HP.

HAYDEN PHILLIPS

PHILLIPS TO PS/CST 27 SEPT

week.26.9/m.4

SECRET

Moira Wallace PERSONAL.
for info only.

FROM: H PHILLIPS

DATE: 27 September 1988

MR SAUNDERS

cc Sir P Middleton
Sir T Burns
Mr Anson
Miss Peirson
Mr Parsonage
Mr Sussex
Mr Griffiths

NHS REVIEW

As you know there are two official group Review meetings this week and because of the bilateral programme I attended the meeting yesterday, and you will attend tomorrow's discussion. This note sets out the main lines of argument I developed on the draft papers before us, and offers some other comments.

2. The present plans are for the meeting on 4 October to take 5 papers namely

(i) a paper on the merging of DHAs and FPCs, with cash limits;

(ii) a paper on how the opting out of groups of GPs could be made to work;

(iii) one on independent hospitals;

(iv) a summary of the White Paper;

(v) a note on outstanding issues and how they should be taken forward (this will include a couple of paragraphs of where we have got to on NHS Audit).

PHILIPS TO SAUNDERS 27 SEPT

3. Yesterday's long discussion concentrated on the first two of these papers.

Merger of DHAs and FPCs with cash limits

4. As you know the draft of this paper, following Mr Clarke's views, rejects merger on the grounds principally that it would be an organisational distraction and a political mistake, while it welcomes cash limiting in principle but says it should only be approached for the long term and should certainly not be announced as part of the Review. Mr Clarke's policy is to make FPCs accountable to regions and to make existing controls over FPCs, including the drugs bill, more effective. Both Mr Wilson (Cabinet Office), Mr Whitehead (No.10) and I tended to argue in similar terms against the paper. I said that I did not think that the Chancellor would, in the light of the arguments presented, change his view about the desirability of merger though the fact that they were detached as recently as 1985 (I presume by Mr Clarke when Minister of State) was a telling point and we had also to note that the Labour Party had announced that they were in favour of merger. I said that we neither understood, nor believed to be true, the argument that during the merger period of 1974-85 primary care had lost out in the face of the interests of higher spending hospitals. On cash limiting I argued, as we had agreed, that the emphasis given by the DoH to existing controls was misplaced; that on the whole these were not controls exercised by the Department (it is the DDRB that controls the remuneration of GPs); and that it was at least as persuasive to suggest that the imposition of cash limits would be the best way to develop lower-tier controls rather than the other way round. Essentially the DoH argue against cash limits on political grounds namely that such a major change would swamp the rest of the package of reforms and outrage the medical profession. I acknowledged that this was a political judgement that Ministers would have to make.

Robin Cook argued on Today this morning that the GPs would benefit from merger

5. I said I was uncertain about the proposed new role for the regions simply on the grounds that it looked to me as though this would boost their role and importance out of all proportion to the stance which Ministers had already taken about slimming down the role of regions.

GP practice budgets

6. I said that our initial reading of the paper we had been given led us to the view that the proposals in it were "bonkers". For rather different reasons the No.10 Policy Unit and the Cabinet Office shared this view.

7. I said that the paper itself seemed to be an uneasy compromise between the proposal which Ministers had already rejected, namely GP budgets for acute elective surgery, and the proposal which the Prime Minister had asked to be studied, namely arrangements for groups of GPs to opt out of an FPC. The key purpose of the paper, as I understood it, was to attempt to answer the practical questions which the Chancellor had posed at the last meeting. This it signally failed to do.

8. Among the key points which were discussed were the following;

(a) the DoH were arguing that GP practices would have recourse to any back pocket reserve held by DHAs or FPCs if a practice reached its budget limit before the end of the year. Most of us at the meeting pointed out that this was opting in rather than opting out and was the opposite of what the Prime Minister had asked to be studied;

(b) it was not clear that a GP with a practice budget could or could not jump the queue if he had funds nor what happened to his patient if he ran out of funds, clinical need being equal;

(c) the general proposition tended in our view to continue to founder on the fact that the real decision making power in relation to most patients referred to hospital would continue to rest with consultants and not GPs.

9. The No.10 Policy Unit tend to agree with all of these points but believe that the opportunity for large group practices to opt out is the way in which that part of the health care market can be 'deregulated'; and will bring a new dynamic into relations with

hospitals, eliciting a more efficient response in the area of acute elective surgery. I argued that if this was the policy Ministers wished to pursue then it seemed to me there was considerable advantage of going for our earlier proposals of merging FPCs and DHAs, within a cash limit, because this would give both a measure of greater control and an incentive for those GPs who felt able to produce a better deal for their patients to opt out. Certainly, and here I agreed with Mr Whitehead, there was nothing in Mr Clarke's present proposals to offer GPs any incentive to indulge in these experiments or pilot schemes.

10. It was also argued in the meeting, and the DoH took note, that Ministers could not be expected to endorse pilot schemes for GP practices opting out unless it was clearly specified what types of expenditure they would be given control of themselves nor in what areas of elective surgery they would contract direct with hospitals.

11. As a result of this battery DoH officials asked if it was possible for the paper to be withdrawn and not submitted for the October 4 meeting. Mr Wilson took the view, which I believe is right, that Ministers expect a paper to be presented and it should be redrafted and brought forward.

The White Paper

12. We did not get on to the draft White Paper in any detail but I made the point that the Introduction as presented in these papers gave the firm impression that there had never been any need for a Health Review and that the NHS was in fine shape. I pointed out that a good deal of work had been done in August on a previous draft; that a number of our suggestions and comments were available to the group (and I mentioned that the Chancellor had formed a view about the way in which the introduction should be shaped); and that the two key things which needed to be brought to the front of the White Paper were how were the Government going to go about tackling waiting lists and improving service to the public in other ways. You will need to pursue the detailed points on the draft White Paper in tomorrow's discussion.

13. Finally there was an irritating exchange about capital which I have recorded separately in a note to the Chief Secretary's office.

HP.

HAYDEN PHILLIPS

RG 0416t

CONFIDENTIAL

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

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

CLARKE TO CST 27 SEPT

CHIEF SECRETARY

REC. 28 SEP 1988

ACTION Mr Saunders

COPIES TO Cx, Sir P Middleton, Mr Anson, Mr Phillips, Mr Luce, Miss Pearson, Mr Tomblin, Mr MacAuslan, Mr Bull, Mr White, Mr Griffiths, Mr Grosse, Miss Walker, Mr Rayner, Mr Call

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

27 September 1988

Dear John,

Thank you for your letter of 21 September. Our recollection of the agreed work programme accords pretty much with yours. An agreed note of the Bilateral will of course be a great help, but there are a few points in your latter on which I should comment.

I have noted the observations in your second paragraph but the point remains that the cost of carrying through into the Survey the consequences of our decision last April on full funding of The Review Body awards is a very large element of my bid figures. Indeed as I warned you an additional bid is likely to be needed despite the very determined action we are taking to keep the cost down. I also made it clear that I thought from a political viewpoint that last year's settlement was too low. I do not therefore find the comparison drawn particularly relevant.

So far as the action programme is concerned my comments are (your lettering):

a. As I recall, I asked in the bilateral about your reservations, and my officials were able to assure you that the work which concerned you had in fact already been done in agreement with your officials. I am entirely happy to explore the scope for improved efficiency and I am satisfied that the model will be of great assistance to us both. I would <u>not</u> be disposed to ignore it because the figures looked unpalatable.

d. I note that you are prepared to offer 562/582/599 for the Review Body costs, and my officials are looking at these figures. As indicated, my bid is likely to need to be revised.

g. We both, I know, attach considerable importance to the successful wider implementation of the Resource Management Initiative, and I shall myself be examining closely how it is proposed to manage this process.

i. I understand that our officials are already in touch. I would prefer the question of DRC cover in 1989-90 to be resolved between officials, but if necessary you and I will have to look at it again.

E.R.

So far as cash limiting the FPS is concerned, a paper has been prepared by my officials in the context of the NHS Review which addresses the concerns set out in your letter.

I am copying this letter to Michael Forsyth and to Peter Walker.

KENNETH CLARKE

cs.ps/ce326.9/min

SECRET

COPY NO 2 OF 12 COPIES.

000343

EVANS TO GRIFFITHS 26 SEPT

FROM: MISS C EVANS
DATE: 26 September 1988

MR GRIFFITHS

cc: Chancellor
Sir Peter Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Saunders
Mr MacAuslan
Mr Call

PES 1988:HPSS

The Chief Secretary was grateful for your minute of 23 September. This is to be discussed at the meeting arranged for 4.30pm this afternoon.

2 The Chief Secretary's instinct is to offer sufficient carrot to keep Mr Clarke flexible. He prefers the opening offer of 1000/1250/1785 (subject to 3 below) with real HCHS current increases of a credible size. Mr Clarke would know the lower offer was a ploy but he would not be so certain about the higher.

3 The Chief Secretary thinks it would be helpful to set a structured agenda for the discussion with Mr Clarke on Friday. This should aim to reach decisions/clear ground on:

- how to deal with pay (Review Bodies and Whitley);
- whether/how to ring-fence the NHS capital review etc;
- assumptions on service maintenance/development;
- AIDS (full costs or excess);

- superannuation;

CIPS savings etc.

He would be grateful if you could give some thought to this before the meeting this afternoon.

Cathy Evans

MISS C EVANS
Private Secretary

22.9.3

SECRET

I agree (subject to the point marked on para 7). Whether to go for an opening offer of 900 or 1000 is a matter of judgement. But 900 is certainly respectable.

RPR 23/9

1. MR SAUNDERS
2. CHIEF SECRETARY

FROM: D P GRIFFITHS
DATE: 23 September 1988

cc Chancellor
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr Call

GRIFFITHS TO CST 23 SEPT

PES 1988: HPSS

We have been giving some thought to the opening offer you might wish to make to Mr Clarke in due course. There is clearly more work to be done in examining bids and options for reductions and we will want to see what revisions Mr Clarke decides to make following the first bilateral. But you might like to consider the following two alternative packages.

Options

2. The first option would be an offer of 900/1100/1560. This compares with net bids of 1998/2757/3690 and a forecast outcome of 1363/1629/2162 (we have increased the forecast outcome by £100m in each year to reflect the inevitability of further bids in relation to nurses' pay). The offer would produce HCSS Current real increases (excluding cips) of 2.0%/1.3%/0.8% - higher in years one and two than last year's settlement (1.7%/1.1%/0.9%). The offer is made up as follows, although it would not be necessary nor desirable to reveal its composition:

A1a	review body consequentials	562	582	599
A1b	underlying overcommitment*	100	100	100
A1c	service growth	200	400	700
A1d	pay	85	180	295
A3	AIDS	25	34	37
A4	Management/information (Project 2000 bid only)	10	15	20
A8	Cyclotron	3	3	-
A10	FPS Estimating	185	226	474
A11	IT for GPs	3	8	8
A12	FPS service improvements	2	2	2
B1	Efficiency savings	-175	-350	-575
B2	land sales receipts	-100	-100	-100

* contingent on satisfactory settlement on HCHS Capital (see below)

The main differences between the offer and our forecast outcome are lower provision for the underlying commitment and service growth; DoH's receiving nothing on their main HCHS Capital bids (the forecast outcome assumes we give them 140/100/100); and nothing for CFS or PSS.

3. We recommend that you do not offer anything on the CFS bids until Mr Clarke has committed himself to deliver a reasonable level of savings on the Welfare Food programme. On HCHS Capital, you could offer to drop your option for reduction and meet the underlying over-commitment bid in part provided that Mr Clarke dropped his bids.

4. We consider the offer is large enough to be credible without restricting our subsequent room for manoeuvre. However, if you think a more generous opening offer is required, we would suggest as an alternative: 1000/1250/1785. This would give HCHS Current real increases of 2.8%/1.6%/1.4%. The composition differs from the first option in two respects: we offer 150/150/150 for the underlying over-commitment bid (+50/+50/+50) and 250/500/875 for service growth bid (+50/+100/+175).

Timing of offer

5. You will probably not want to make an offer at the second bilateral itself. This might look like our giving ground too soon and encourage Mr Clarke to take a tougher line. It might also be to our advantage if Mr Clarke felt there was a real prospect that the programme might go to the Star Chamber. And there could also be developments at the next NHS Review Ministerial Group which strengthened our hand. We would therefore recommend you make an offer immediately after the second bilateral (subject to seeing how the bilateral goes). This would allow time for a third bilateral to be held before the Party Conference at which Mr Clarke could respond to the offer (our guess is that he will not move significantly from his opening position until you have made an offer). You could then follow this up as appropriate with a private meeting at the Conference itself.

SECRET

PES AND THE NHS REVIEW

6. My minute of 16 September proposed that the funds needed for NHS Review measures might be provided by ring-fencing and holding back an appropriate part of the PES Settlement with the option of announcing this Review money at the same time as the reduction in NHS employer superannuation contributions. I suggested a possible package of measures costing some £200m in 1989/90. The Chancellor asked what the corresponding figures for years 2 and 3 would be. The package would look as follows:

	89/90	90/91	91/92
i) Top-sliced funds for efficient hospitals to tackle waiting lists (found from within service growth provision - A1c)	100*	200*	350*
ii) Improving physical surroundings in hospitals - brightening up waiting rooms etc. (Found from HCHS capital investment money - A6)	50*	50*	50*
iii) Extension of RMI (A4a and A6a)	50	[180]*	[200]*
iv) IT for GPs (A11)	5	8	8
TOTAL	**205**	**438**	**608**

* Marker estimates. Precise amounts to be discussed further

This would give a total Review package of £1¼ bn. However, I would emphasise that this is only an illustrative package. The amounts to be allocated to the efficiency and 'waiting room' funds have yet to be considered and could be adjusted as appropriate to ensure that there was both a defensible overall PES Settlement to announce in the Autumn Statement and a presentable cash outcome to the Review.

7. There is also a problem over longer-term funding for the RMI. We are recommending that you only provide additional funds for the

RMI on a one year basis until we are confident that DoH have come forward with properly worked up proposals. Our forecast outcome reflects this. The settlement would not therefore contain any provision for the RMI for 1990/91 and 1991/92. If we are to announce extra RMI funds for these years in the Review, it would have to be on the basis that they were agreed bids for the 1989 Survey. The sums to held back in the 1988 settlement for Review measures would therefore only amount to 205/258/408.

I think it better not to do this; it is too soon to commit sums of this order RB

8. If we hold back the above sums from the settlement announced in the Autumn Statement and assuming we achieve our forecast outcome, the additions to the HPSS baselines in the Autumn will be 1158/1371/1754. For the HCHS Current programme this will produce real increases (excluding cips) of 2.5%/1.3%/0.2%. (Including cips the increases are 3.6%/2.3%1.6%.) This is a generous first year Settlement but not so good in the later years. The picture in these years could be improved by reducing somewhat the sums held back for years 2 and 3 from the main service growth provision.

9. If, in addition to holding back the Review money, the savings from the reduced NHS superannuation contribution were scored in the Autumn Statement rather than waiting until later, the additions to the HPSS baselines would be 846/1048/1422. This would have the apparent effect of reducing the HCHS Current real increases to 0.5%/1.3%/0% (excluding cips), but in presenting the autumn statement increases every effort would be made to emphasise the gross increases, which would be the same as in paragraph 8 above.

10. For the sake of completeness, I have also calculated the effect of scoring the NHS superannuation savings but not holding back any money for NHS Review measures. This reduces our forecast outcome on the HPSS programme to 1051/1306/1830. The HCHS Current real term increases are 1.4%/1.9%/1.2%, but again we would try to emphasise the gross increases.

11. You may wish to discuss these issues before next Friday's bilateral.

D P GRIFFITHS

cst.ps/9ce23.9/min CONFIDENTIAL

FROM: MISS C EVANS
DATE; 23 September 1988

MR SAUNDERS

cc: Chancellor
Sir Peter Middleton
Mr Anson
Mr H Phillips
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr Griffiths
Mr Cropper
Mr Tyrie
Mr Call

EVANS TO SAUNDERS 23 SEPT

NHS REVIEW AND THE SURVEY

As I said on the phone the Chief Secretary has been thinking further about the options for handling additional resources linked to the NHS Review as discussed in Mr Griffiths submission of 16 September. His preference would be to agree in the Survey a figure for review related expenditure, ring-fence it, and take it out of the figures to be announced in the Autumn Statement. Mr Clarke's press release would then explain that the NHS Review was likely to entail certain in-year commitments for which extra funding would be made available. This would have the advantage of improving on the Health PES announcement by suggesting that yet more money was to be available, but it would also enable us to express this in a way which pitched expectations at a realistic level. You kindly agreed to reflect this view in the advice Mr Griffiths is submitting on tactics for the Health programme.

Cathy Evans

MISS C EVANS
Private Secretary

PES

cst.ps/1jm27.9

CONFIDENTIAL

CST TO C X 27 SEPT

CHANCELLOR

FROM: CHIEF SECRETARY
DATE: 27 September 1988

HEALTH

We might have a word on Thursday about one aspect of the health PES settlement.

2 As you know the Government Actuary has recommended a cut in NHS employers' contributions which will reduce health authorities' pay bills by £300 million a year. The interaction with the Survey needs careful handling. I see two options.

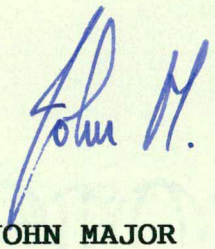
3 First we could announce the change at the time of the Autumn Statement. But this would mean reducing Ken Clarke's headline total - the net increase in health provision - by £300 million. Health authorities' spending power would be increased by this £300 million over and above the net increase in provision, but to get the credit for that we would have to base our case on an adjusted figure, with obvious risks of being misrepresented. Arguments about this could detract from the presentation.

4 The alternative, which I prefer, would be to announce the change at the time of the Pay Review Body announcements in January, thus enabling authorities to use the £300 million to meet the extra pay bill costs. (If we keep the provision for pay in the settlement to the GDP deflator there is a good chance that the extra cost of the RB awards will come out close to £300 million. We shall have to decide how to handle the balance - plus or minus - and whether to earmark some of any surplus for the Whitley settlement.) This approach carries a risk that we will be accused of cutting health authorities' budgets to fund the pay award but in my view this claim would be easy to rubbish. Health authorities will have budgetted to meet the £300 million as part of their pay bills. As a result of the GAD report this cost would disappear and the Government would allow authorities to divert

these resources to meet the Review Body bill. There would be absolutely no effect on authorities' plans. This seems to me an eminently defensible position.

5 A linked issue is the NHS review. Here my view is that we shall have to hold back a credible amount of Review linked money agreed in the Survey, for announcement when we publish the White Paper. Since this will depress the health Survey totals this strengthens the case for the preferred option for handling the superannuation savings.

6 I am discussing this with Ken Clarke on Friday morning. The final decision must be his since he will have to present the case but it would be helpful to have your views before I see him.



JOHN MAJOR

29.9.1

SECRET

FROM: R B SAUNDERS

DATE: 29 September 1988

MR PHILLIPS

cc Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Parsonage
Mr Griffiths
Mr Sussex
Miss Evans (personal)
Miss Wallace (personal)

NHS REVIEW

I attended Richard Wilson's meeting yesterday afternoon. The intention is that the 4 October Ministerial meeting will take the five papers listed in your note of 27 September, plus Mr Clarke's paper on Capital (which was said to be on its way to the Chief Secretary).

2. We discussed two papers. The first was the outline White Paper. Department of Health said that the opening chapters (which, as you will recall, consist largely of a ringing defence of the NHS in its present form; and a statement that the Government has rejected radical reform in favour of an evolutionary approach to solving some unclearly-specified problems) reflected their understanding of what Mr Clarke wanted to say. Apparently, however, he had said that these thoughts might be more appropriate to his party conference speech (about which he is beginning to think) than to the White Paper. That sounds more like it.

3. There were however some interesting points:

- Richard Wilson said that one objective of the next Ministerial meeting would be to get some guidance as to the sort of White Paper that Ministers wanted: an old-fashioned brisk summary of the Government's conclusions; a worthy but discursive longer piece; or something designed to take the initiative in the political debate.

SAUNDERS TO PHILLIPS 29 SEPT

- Mr Hunter (NIO) said the White Paper should make clear early on that it was primarily about how to organise the delivery of health care, rather than about health as such. This would be important to forestall criticism that it says nothing about services for the mentally ill, mentally handicapped, etc.

- Ian Whitehead said it should begin with a statement on strategy, including the objectives of providing better services to patients and tackling waiting lists.

- Richard Wilson pointed out that it highlighted the very large number of important issues which had yet to be discussed by Ministers.

There was a discussion of this last point, which identified the following: the future of the NHS Management Board; the implications of reconstituting health authorities (eg do they continue to meet in public?); how do we beef up community health councils; how do we set about "slimming down" regions when every policy paper produced by the Department appears to give them another new task? I said that we would want to know what they propose on capital, on pay/manpower flexibility, and on further restructuring on nurses.

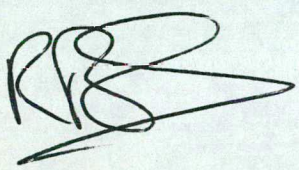
4. Department of Health concluded by saying they would get Mr Clarke to put a cover note on the outline White Paper addressing some of these issues.

5. We then moved on to self-governing hospitals, on which the Department produced the attached paper. They are now approaching this slightly differently. The line is that there should first be lots more delegation and flexibility across the board (as in paragraph 3 of the paper), and only when that had been achieved would some hospitals take up the further option of self-governing status. This led to an interesting discussion on the theme of "what is a self-governing hospital?". I asked what incentive a hospital would have to go for this status. Would they be offered a sweetener of some sort? I was assured that no sweeteners were in

mind. The conclusion of a slightly incoherent answer to the other question appeared to be that the main benefit was that they would employ their own staff, rather than having them employed by the health authority. It was acknowledged, however, that this had not been a source of friction up to now.

6. Richard Wilson then asked if the Department would be seeking to encourage hospitals to go for self-governing status. Would there, for example, be targets - say 20 self-governing hospitals after 2 years? The answer came that there was a completely open mind on this question; they should have the option, but the Department would neither encourage nor discourage them. Most of us expressed doubts about whether this was politically credible.

7. Ian Whitehead then went on to develop an idea for more full-blooded self-governing status. He wondered whether it might be possible to reconstitute hospitals as limited companies, with the Secretary of State as sole shareholder. Department of Health replied that this would be regarded as a first step to privatisation. I said I was worried about a possible Crown Agents effect - if the companies went bust, the Government would have to pick up the tab. Moreover, I did not see how the company model could work, since they would not be trading in the normally understood sense of the term. Mr Wilson countered that there were several new forms of accountability being explored at the moment - like Next Steps Agencies. He saw the problems with the idea, but thought it might be worth exploring further. It is one which might be raised by the Policy Unit again.



R B SAUNDERS

CONFIDENTIAL

NHS REVIEW

DEVELOPING HOSPITALS FOR SELF GOVERNMENT

Introduction

1. Paper HC28 set out a path towards self governing hospitals. Paper HC35 set out a new approach to funding the hospital service. This paper draws upon the main ideas from these two papers to outline a practical way forward for hospitals in both the short and longer terms.

Developing hospitals within the present system

2. Our main objectives may be summarised as follows:

- devolution of management responsibility to unit level
- correspondingly stronger local management, and better tools available for them
- switch from "formula" funding to a funding system which follows performance to agreed standards
- more varied, flexible and competitive interrelationships between DHAs, GPs, hospitals and the private sector.

3. All of these objectives can be achieved within the present framework of the NHS, which is, I believe, important if we are to follow an evolutionary path to change, and avoid disruptive organisational restructuring. Achieving these objectives would give us effective self government for hospitals, and much can be done without legislation. The key developments are:

i. The Resource Management Initiative which will give clinicians, as the main users of NHS resources, responsibility and accountability for the way resources are used, and information to help them in this.

ii. Greater flexibility over the manpower and capital resources used to provide services.

iii. A "contractual" style of management making explicit the responsibilities of hospital and DHA, and the quanity, quality and cost of services to be delivered.

iv. Contract-funding for cross-boundary flows where DHAs would buy services within an internal market, mainly in elective treatments, according to the best available deal. This development would need legislation.

4. We need to secure these developments for all hospitals, although it will take longer for some than for others. Once a hospital has reached the degree of self government represented by (i) to (iii) in paragraph 3, it could be free to opt for statutorily independent status in its own right.

The next step

5. With this status, the hospital would take on formalised legal contracts under 3 (iii) and (iv), and would become the employer of staff under (ii). This is where we need major statutory change. One of the issues we must decide is to what extent to signal this step in the White Paper, and at what stage to make the legislative changes necessary to enable such a step to be taken.

6. In my judgement, we should put forward this approach as a possible endgame in the White Paper, and include powers to enable flexible experiments toward that end in legislation. But I do not think we should at this stage be prescriptive about the way in which the main objectives set out in paragraph 2 above should be followed up in the longer term. I believe it is those objectives which should be the focus of our presentation of self government for hospitals.

7. I have set out in annex 1 the main criteria and processes by which those hospitals that wish to do so might seek to cut the umbilical cord to the DHA in that latter stage of the development we envisage. In summary these are:

- Hospitals would be required to meet certain centrally determined criteria

- The hospital management team, preferably supported by the DHA and the local community would put forward proposals for running their services on their own;

- Regions, under delegated powers, would approve these proposals, and set in train the creation of a management board for the hospital.

8. The main features of the status which hospitals would then adopt, and an outline of the funding and contractual arrangements which would apply, are set out in annex 2. These are:

- Each hospital would have a statutory management board comprising the management team and external "non-executive directors";

- Hospitals would be accountable to the authorities, via their contracts, for service delivery;

- Hospitals would be responsible to Regions for their stewardship of publicly owned assets;

- Hospitals would receive funding according to the contracts they won.

9. I see an important role for the slimmed down Regions, on behalf of the NHS Management Board, in overseeing the process by which some hospitals may become free of health authority control. This is for the following reasons:

- it will be important to ensure fair competition within the NHS, and a proper spread of resources and services

- there is no stable constituency of patients (as there is of parents in the schools context) so the consumers' interest will require special care which even the closer involvement of GPs will not wholly guarantee

- DHAs - and hospital managements - may have mixed motives for seeking the change; it will be important that neither "side" seeks to take advantage of the other

- Regions will have a continuing part to play in the stewardship of publicly owned assets (the management of which is discussed in a separate paper).

Conclusion

10. I invite colleagues to agree that our approach should be to pursue the goal of self government for hospitals through the objectives set out in paragraph 2. Colleagues might also agree to the suggested approach to allowing hospitals to become free of health authority control set out in paragraph 5 and the annexes.

STEPS TOWARDS SELF GOVERNMENT

1. This annex suggests the steps by which hospitals might become free of health authority control, in terms of the criteria and procedures which might be applied.

2. The number of hospitals which might achieve ultimate self governing status would depend on the criteria and controls applied. On one hand, too restrictive a regime would be self-defeating; on the other, laisser faire might cause chaos. Few would be likely to meet the criteria at first, and it is unlikely that all hospitals would both choose and be suitable for this status, even in the long run. Health authorities would therefore remain as significant service providers in their own right. At the same time authorities would make contracts with self governing hospitals for some services. It would therefore be important that the spread of self government took place in such a way as to maximise the benefits of competition and of clear specification by contract, and to minimise the natural tendency of health authorities to favour "their" units over self governing ones.

3. The most likely hospitals to opt out at first would be the major teaching hospitals or other "centres of excellence" which do at present see themselves as picking up other districts' or regions' "hard cases" for insufficient compensation. The rules for implementing self governing status would need to guard against the risk that such hospitals could corner the market in certain specialties to the disadvantage of health provision generally.

Criteria for freedom from DHA control

4. A number of criteria could be applied to hospitals which wished to become free of DHA control. These fall into four main categories:

- Service related
- Management related
- Market related
- Political

Possible considerations in each of these categories are outlined below.

5. A formal system of accreditation or inspection is likely to be needed in any case to assure quality standards across the public and private sectors. This would go wider than simply the question of whether a hospital should become self governing, though in the longer term, this might be be a practical method of

deciding that question. It would also be necessary to ensure that the standards required for becoming self governing were maintained, and loss of self governing status would need to be considered where a hospital fell short. At the outset, however, decisions on self government will need to be made in the absence of a well developed accreditation system, hence the evolutionary approach described in the introduction.

Service related

6. Target service quality levels could be required of a unit if it were to achieve self governing status. These might cover easily measurable factors such as waiting lists, OPD booking arrangements and readmission rates (though it would be less easy to measure avoidable readmissions). They could also cover measures such as health outcomes, staff attitudes, environmental and other "hygiene factors". In general, any attempt to base judgements on subjective measures would probably be more trouble than they were worth.

Management related

7. The hospital should have a firm place in the regional strategy for the health service; there would be no point in making self governing a hospital destined for closure. A financial clean bill of health would be required. At the least this would involve adequate budgetary control, and a sound income and expenditure position. But this might extend further into the availability and use of management information more generally, including its effective use by clinicians, in line with the objectives of the Resource Management Initiative.

8. The management team should be able to demonstrate sustained performance in their assumption of delegated responsibilities. Systematic medical audit involving appropriate external referees would be a basic requirement.

9. Specific efficiency measures could be required, either on some absolute scale, or showing a history of steady improvement in efficiency and a healthy cost improvement programme.

Market related

10. Self government might be approved (first) in situations where there was potential for a competitive market, with neighbouring units broadly in the same catchment area, and offering the same services. The implications for neighbouring non-self governing hospitals would need to be considered.

11. It could be required that a candidate unit should already be accepting a significant number of cases from those buyers which have a choice of provider, indicating that its services were attractive in the marketplace.

12. Homogeneous units might be preferred, in service terms. Those units that provide a tidy self-contained package of services might find it most easy to "go it alone". Groupings of hospitals, or of hospitals and community services, might equally meet this criterion.

Political

13. Some element of grass roots support might be looked for, such as local community interest in the work and future of the unit, or even a nascent management board. The local Community Health Council might indicate its support. However reliance on such indicators could just as easily invite opposition to self governing status.

Initiating the move

14. There are two main players: the RHA and the hospital. As the current "owner" of the hospital, the DHA may have mixed motives in the matter. In some cases there might be a desire to get rid of the responsibility for an ailing hospital; in others an unwillingness to lose its main operational raison d'etre.

Role of the RHA

15. The RHA's role would be to oversee the progressive devolution of responsibility to units, as outlined in the introduction. Correspondingly, each RHA would need to ensure that haphazard growth of self government should not be allowed to put at risk the effective working of the remainder of the NHS. Change needs to be introduced in line with strategic principles and objectives. Thus the primary choice of candidates for self government should therefore rest with RHAs, within centrally developed guidance.

Role of the hospital

16. While the RHA will need a measure of control over the implementation of self government, it need not be forced upon a hospital willy-nilly. Indeed, the formal initiative could lie with the hospital, which would seek to "opt out" and become self governing, subject only to the broad central guidance referred to above. As noted above, a hospital is not a formal legal entity capable of "opting". However the initiative in this matter could be taken by any one of the following, with the others in support:

- The hospital management team - a procedure could be defined whereby a petition by the general manager, and the senior medical and nursing staff, would start the process.

- The local community - more relevant in rural or suburban areas where there is a close identification with "our" hospital; in large cities, this might be less meaningful. But this is not a clearly defined body, and would be likely to be a self-selected group of "do-gooders". The CHC (which covers a whole District, rather than one hospital) could provide an input.

- The DHA - although for the reasons noted above, its role might be ambiguous.

17. Further work would be needed to define the procedure for moving towards this new status. The best approach might be for the initiative to come in the first instance from the hospital management team (prompted and encouraged if need be by the RHA or DHA). The team would work up a "proposal" which would be required to set out certain key points in a plan for self government. Subject to the plan meeting centrally determined criteria, the RHA would be required to put in hand the creation of the self governing hospital.

FINANCIAL AND CONSTITUTIONAL FRAMEWORK

1. A fully self governing hospital would be run by an independent board of management. It would be free to develop and offer packages of services that the board considered most effective, and to buy in or sub-contract out any part of its operation. Self governing hospitals would take on contracts with one or more District Health Authorities for the provision of agreed services, and would be answerable solely to the DHAs for performance according to those contracts.

2. This annex describes the funding, constitution, accountability and management of the self governing hospital which is fully free of DHA management control.

Revenue funding

3. Self governing hospitals, as autonomous legal entities, would provide services under contract to one or more DHAs - and the private sector - and receive funds accordingly. The main types of contract and corresponding funding arrangements are as follows:

"Core" services - essential local services which cannot effectively be provided elsewhere. In some areas there may be competition for the provision of these services. In general, DHAs will lay down tight performance specifications in terms of overall volume, availability and quality, which hospitals will be required to meet. It might be necessary to provide certain statutory obligations on self governing hospitals, or else arrangements for settling disputes over the scale and cost of core services in non-competitive situations. Payments to hospitals would flow steadily through the year, regardless of the actual patient throughput.

"Contract services" - primarily elective services which can be obtained further afield if need be, and at a chosen time. Hospitals would contract with DHAs and GPs participating in the GP budgets arrangements (and with the private sector) for a set level of provision at an agreed unit price, with a number of different buyers, including the private sector. They would be competing against other hospitals to win contracts. Payment would flow according to the patients treated.

Training - hospitals would be separately funded under contracts with RHAs for the provision of training overheads for nurses and doctors.

Constitution

4. Self governing hospitals would be constituted as distinct legal entities, enabling them to make contracts, own assets, employ staff, etc. Various models are available: special health authority, trust, or limited company (by shares or guarantee). The most appropriate model, however, is a new form of statutory body established under new legislation. This body would be the Board of Management of the hospital.

Membership of boards of management

5. The management board should be designed to provide firm but accountable management on a businesslike basis. They should not follow the present DHA model of representative or political appointments. Separate mechanisms for securing an effective consumer voice are described below.

6. There are four key roles to be filled:

Chairman

Chief Executive (General Manager, in traditional NHS terms)

Executive Directors (senior clinical staff)

Non-executive Directors (eg outside businessmen)

7. These roles can be combined in various ways, and not all roles need to be filled by formal members of the board of management. For example, the Chief Executive could be a servant of the board, not a member, as is the current health authority practice. Or the Chairman and Chief Executive roles could be combined.

8. A key requirement is that the board should not become a self-perpetuating oligarchy. Appointments to management boards could therefore be made by, or on behalf of, the Secretary of State. It would be possible, however, to allow boards some powers of co-option, perhaps subject to ratification. Although the number of boards which would exist cannot be predicted at this stage, it is likely the number of appointments would be greater than could sensibly be handled by the Secretary of State. It seems most practical, therefore, for the power of appointment to be exercised by the RHAs.

9. Further work needs to be done to identify the preferred model for boards of management, and indeed, whether a single model needs to be prescribed. Other factors such as payment for non-executive directors, and the likely availability of sufficient candidates, will also need consideration.

Accountability

10. Self governing hospitals, or rather, their boards of management, would be accountable to DHAs and to GPs (or FPCs) through the terms of their contracts for services. This would in practice be the most significant day-to-day discipline on the hospital management team. Boards would also be accountable for their stewardship of assets; this is discussed further below. Further work would be necessary to devise arrangements for handling, for example, failure to deliver service according to contract, or legal action against a hospital by a patient.

11. The Secretary of State would remain accountable to Parliament for securing an adequate health service. This responsibility would be discharged primarily through the DHAs, for it would be they who would determine the amount and quality of service procured through their contracts with self governing (and private) hospitals, and through any remaining directly managed units.

12. The general public and consumer interest could be represented by successors to the Community Health Councils. CHCs could continue to have a statutory role in relation to the DHAs, and by this means they could influence the priorities and corresponding contractual arrangements of the DHAs. CHCs could also have a statutory role in relation to self governing hospitals, although since the aim is to disengage such hospitals from statutory restrictions, this might be inadvisable. Alternatively, boards of management could be encouraged, if not required, to make their own arrangements for involving the local community in the affairs of the hospital.

Management of capital assets

13. The main aims for the management of the key resources of capital and manpower (for which see below) are:

- to delegate responsibility to the greatest degree possible;
- to ensure that managers receive appropriate economic signals in their use of resources;
- to ensure that public assets are used most effectively in support of the health service as a whole.

14. It would be possible to vest ownership of all assets in the management boards. This would achieve the fullest delegation of responsibility, but it would limit the scope for gradually changing the distribution of assets to reflect wider service needs. Furthermore, since a self governing hospital could in principle cease trading (at least with the NHS) its assets should not be alienated.

15. Vesting ownership of all health service assets (except perhaps minor assets or gifts) in the Secretary of State would secure flexibility in the longer term allocation of assets, while still enabling substantial delegation of responsibility for their day-to-day management, including their acquisition and disposal. This could be coupled with a system of charges for the use of capital which would reflect the cost of using assets, and provide corresponding incentives to use them cost-effectively.

16. For routine management of capital investment and accountability for the stewardship of assets - including payment of capital charges - hospitals would look to RHAs, acting on behalf of the Secretary of State. The scope for self governing hospitals to raise finance for capital projects from the private sector is under consideration.

Manpower

17. Self-governing hospitals also need to have maximum delegated responsibility for the management of the other key resource, manpower. In particular, this means that management boards must be free to hire and fire staff. In principle this should embrace all staff, but the position of consultants is under consideration elsewhere.

18. Self governing hospitals could also have greater freedom to determine pay levels and working practices in ways which meet the needs of the hospital in meeting its contractual obligations and market opportunities. This freedom of management to control staffing and staff costs should not be constrained by rigid central determination of national pay and conditions as at present. However a free-for-all in the public sector would be likely to inflate staff costs unnecessarily. A national pay bargaining system would need to be established under the auspices of the Department of Health, but with considerable latitude for regional or local variation.

19. Long-term manpower planning, and medical and other professional training could not be left to individual hospital boards. National and regional oversight of future needs for skilled manpower, and of the corresponding professional training needed to meet them, would continue to be necessary as at present, and individual hospitals and other units would continue to provide training. Funding specifically for training would be channelled through the RHAs, and would, in effect, be subject to contracts similar to those for service provision.

Ch/ [illegible] MP

This is most irritating (x)
I am not sure if CST's office
have been able to fee off this
further return to the charge

I trust so. (x) is an [illegible] paper prepared for [illegible].

Do not inform Mr C's MP — office [illegible] from [illegible]: clarify this

KH/6956

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

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

Rt Hon John Major MP
Chief Secretary
HM Treasury
Parliament Street
London
SW1P 3AD

CHIEF SECRETARY
REC. 29 SEP 1988
ACTION Mr Saunders.
COPIES TO Cx. Sir P Middleton
Mr Anson, Mr Phillips
Mr Tornbull, Miss Penson
Mr Griffiths, Mr Call.

29 September 1988

Dear John.

NHS REVIEW: CAPITAL

As you know, I was asked at our last Ministerial Group meeting to circulate a paper which brought together the issues on which we have yet to settle our approach.

One of these issues is the management and investment of capital. But I did not think this could be usefully encompassed in a paragraph or two in a paper covering a variety of issues as it is such an important element of our review and there are a number of difficult points we have to address.

Officials have already done some preliminary ground clearing. But before we ask them to do more I thought it would be much better for the Ministerial Group to have a 'second reading' debate, as we have done on other major topics. That will enable us to set the overall strategic framework round which officials can work up final proposals for us to consider.

With this in mind, I asked for the attached paper to be prepared for next week's meeting. I should add that I have asked for the annexes to be slimmed down. If you were able to have a word about the paper before I circulate it on Friday, I should welcome the opportunity to go over the issues with you. But I appreciate how tied up you are by public expenditure discussions.

Yours ever.

KENNETH CLARKE

CONFIDENTIAL

NHS REVIEW HC[ ]

MANAGEMENT OF CAPITAL ASSETS AND INVESTMENT

Note by the Secretary of State for Social Services

Introduction

1. My first paper to the Group (HC37) set out four key aims for the management of capital:

i. clear, devolved, responsibilities for decisions on the opening and closing of hospitals;

ii. maximum devolution of responsibility for management of capital programmes;

iii. some form of charging for the use of capital assets;

iv. access to private capital.

2. The first of these I propose to deal with in the context of other work on organisation and the functions of Regions and Districts. This paper outlines my proposals in the remaining three areas. They are framed against the background of our previous agreement that delivery of health care should be based much more on explicit agreement on the timing, quality and cost of services to patients, and that the NHS should move towards a contractual way of working.

Devolution of responsibility for capital programmes

3. There is already scope for virement by health authorities between their revenue and capital accounts, and a recent change allows a useful carry-forward from one year to the next. Regions can also "broker" large capital expenditures between authorities and between years, while keeping within the overall annual cash limits. Below certain limits, new investment in buildings etc may be made on the sole decision of the Region.

4. To increase this flexibility, officials have also recently agreed increases in the capital expenditure limits above which projects have to be referred up to the Department or the Treasury for approval. Schemes with a capital cost of over £15m (previously £10m) have to be referred to Treasury for approval. Schemes costing over £10m (previously £5m) have to be referred to my Department. This will be welcomed by the health authorities.

5. I therefore propose that officials should look further at the use of existing flexibility for virement and carry-forward, and identify where further help can be given. Although the increases in delegated limits would be welcomed if we implemented them straight away, they should be announced and implemented in coordination with the wider outcomes of the Review.

Charges for capital

6. In proposing the introduction of charges for capital I have in mind six basic principles that I think we need to secure:

a. There should be a system of capital accounting in the NHS which requires appropriate valuation of the capital assets employed.

b. Health authorities should be required explicitly to take account of the cost of capital in costing the services they provide.

c. There should be a level playing field between health providers in the public and private sectors.

d. Government should retain effective control over the total level of capital expenditure in the NHS.

e. Whatever arrangements are introduced should be consistent with the achievement of value for money.

f. These arrangements need to be capable of adaptation to self governing hospitals.

7. I do not think we are likely to have difficulty in agreeing these principles, but it has become clear that officials have not as yet been able to agree how best they can be secured. I am concerned lest we find ourselves unable to say in our White Paper how we propose to implement what I believe will be seen as a key element of the more competitive NHS environment we are seeking to create. I think therefore that we need to agree among ourselves how best to go forward.

8. My proposals are set out in Annex 1. The crux of the problem is whether our objectives can be secured by a system of notional management accounts, as the Treasury believe, or whether actual charging mechanisms are required, as I believe. There are subsidiary questions about valuation, distribution of resources and disposal of assets, but I think that if we can settle the main question these others are likely to fall into place. A good deal of work has already been done, both in my Department and in the NHS, in developing valuation and asset accounting systems.

9. My reason for preferring real to notional charges is that these would provide most sharply the necessary discipline in the highly devolved and "trading" environment contemplated in the Review. Real charges would be essential anyway for transactions with the private sector, and to ensure the level playing field referred to in paragraph 6(c). Managers may not see the necessity for translating figures from management accounts into the actual prices they charge. And even if they were scrupulous in doing so, their revenue accounts would then be boosted by income for which there was no corresponding outgoing, unless the charging regime applied all the way up the line.

10. I therefore propose that we should agree that all health authorities (and in due course, self governing hospitals) should be required to pay real charges for the use of their capital assets. Officials should work up a practical scheme for implementing such a system.

Access to private capital

11. It seems to me integral to the new environment we are seeking to create in the NHS that we should, where this can be done without jeopardising the principles I set out in paragraph 6, enable the NHS to cooperate closely with the private health sector and compete directly with it. I believe that this means allowing the NHS, and in time self governing hospitals, a greater measure of freedom in relation to private funding than is presently the case.

12. My proposals are set out in Annex 2. They are deliberately limited to the NHS, and designed to be capable of being controlled from the centre. They also, in my judgement, represent a minimum package, given the interest both in and beyond the NHS that has become apparent over the last year or two.

13. In short I propose that, where health authorities can earn a good return on investment through income generation and other schemes, no compensating reductions should be made in public allocations; and the criterion to be applied should simply be "good" value for money. Furthermore, in situations where health authorities seek to contract out services, or to make land development arrangements requiring initial finance which a private developer is prepared to provide, financing from private sector sources should be allowed up to a limit. This limit should be set at, say, £100 - £200 million nationally (as compared with some £800 million capital grants, and £200 - £300 million from land sales) and be administered centrally. Authorities would bid for the use of this limit to cover their access to private funds.

14. Another proposal, which I have put forward for the current PES round, is for a central capital loan fund which would provide repayable short term finance. For example, an authority might wish to reorganise its estate to obtain overall savings and release redundant land, but might need capital funding in advance to make this possible. The loan fund would meet this need.

ANNEX 1

CONFIDENTIAL

ACCOUNTING AND CHARGING FOR CAPITAL

Introduction

1. In the long term prices need to reflect the full economic cost of resources in both the public and private sectors, and there should be incentives for local managers to make optimal decisions on the use of the capital stock and on investment and disinvestment. There should be a level playing field for all participants in the competitive health services market. Integral to this is the way that the NHS accounts for the use of capital stock.

2. Since the NHS is likely to remain part of the public sector for the foreseeable future, any new developments in accounting for, or charging for capital, should be consistent with cash limits and with other control and management devices - such as option appraisal - that have proved their worth over the years.

Existing arrangements

3. Health authorities receive capital grants for new investment. These constitute about 8% of the national budget for hospital services. Proceeds from land sales adds another 25% to the capital programme. The current practice in the NHS is that investments are written off once they are made. Except in a few special circumstances there is no subsequent accounting for the cost of capital. Existing assets appear as a 'free good' to managers unless, of course, they have alternative uses within the NHS or can be sold off (Health Authorities are allowed to keep the proceeds of sales). There are no charges in respect of depreciation of, and interest on, the capital stock. This means

that services provided with Authorities' own assets appear cheaper than they should be and there is a cash incentive to retain such services in house, at least during the life of the assets concerned.

Capital accounts

4. A necessary requirement for handling capital more satisfactorily, is for health authorities to set up a system of capital accounts which would value all assets at their "current" or "replacement" cost to the NHS, depreciating them appropriately, according to their age. Such accounts would include appropriate charges for the assets used, based upon these valuations.

5. Valuation of Regional hospital stocks has been carried out in the past and experiments are under way in a number of Districts to build asset registers and capital accounts from the bottom up. But further work would be required to develop robust and convincing NHS capital accounts.

6. Capital charges would consist of annual depreciation plus interest on the current value of the capital stock. They would usually rise with new investment and fall with disinvestment. Differential land and building costs between RHAs would need to be addressed in setting any capital charges, in order to preserve the level nature of the playing field as between the public and private sectors, region by region.

7. Once such accounts were in place it would become easier to make comparisons of unit costs internally and externally and to set prices, with appropriate apportionment of capital costs. Such accounts will also provide clear information to authorities about the presence and notional cost of surplus and underused assets.

Management accounts versus full cost charging systems

8. The NHS Review is working towards a mix of three main different forms of financing for the NHS in future:

i. the familiar form of block budgeting for health authorities in a management line relationship;

ii. internal trading, at arm's length, between different health authorities and between health authorities and self-governing hospitals;

iii. more external buying and selling services with the private sector.

9. Existing Treasury guidance on fees and charges and on contracting out already recommends full cost charging for trading and comparisons between government bodies and the private sector. It also recommends full cost charging for trading between government bodies themselves. This would apply to self-governing hospitals, and to inter-authority payments for patients treated under contract in the "internal market".

10. Under the proposed funding arrangements, Health authorities and self governing hospitals would need to include in their contract prices the full cost of capital used in providing services as described in para 8(ii) and (iii) above. It follows that they would pay the income received in respect of capital charges to the higher authority supplying capital. Correspondingly, purchasing authorities would need to be provided with larger budgets to cover these capital charges on services purchased from providing authorities or self governing hospitals - as happens now, in principle, with contracting out. To this extent, therefore, a system of real charges for capital is inevitable.

11. The question remaining therefore, is what, if anything, should be done about accounting for, or charging for, capital under the continuing arrangements involving the type of financing described in para 8(i) above - the familiar block budgeting in a management line relationship. The present public sector practice where capital is, in effect, written off as soon as it is invested, is unacceptable. It must be replaced either by a system of notional management accounts, or actual charges as would apply in "trading" situations.

12. A system of management accounts could be set up resembling those used by some private companies to control their subsidiaries. They would entail notional budgeting and "repayment" arrangements to reflect capital charges together with performance targets such as making an agreed return on capital and preserving the net worth of assets.

The basic discipline would be enforced by the line management relationship, and managers would need to take account of the capital costs shown in their management accounts when dealing with "trading" situations, but not otherwise.

13. Instead of relying on management accounts, and indirect performance indicators based upon them, it would be possible to move to a system of full cash budgeting for, and repayment of, capital charges within and between NHS management tiers. Most of the management processes would be the same, but there would be a number of differences:

i. a cash system would provide stronger and more consistent incentives for authorities than a system of management accounts, because they would apply automatically, across the board;

ii. If interest was repaid to the Exchequer there would be an increase in gross spending but there would be no increase in net public expenditure.

iii. there would no longer be any need for adjustments to revenue budgets for the scale of contracting out, or for the scale of the internal market, because all NHS expenditure would appropriately reflect capital charges;

iv. there could be greater incentives to efficiency savings because authorities could retain capital charge allocations (instead of the proceeds of asset sales) after disposing of assets. They could then use the released capital charge element for other purposes. (However, it would be necessary to guard against any running down of assets to enhance short term performance);

v. there would be auditing and transaction costs in handling real cash transactions between authorities.

Conclusion

14. It is necessary in any case to improve capital accounting in the NHS so as to determine full costs and charges for internal and external transactions and comparisons. It will also be necessary to set up a complementary system of budgeting for and repayment of capital charges for the purposes of trading between health authorities and self-governing hospitals and the private sector. As to the choice between cash transfers and management accounts for directly managed services, cash accounts would put all internal budgetary transfers between tiers of the NHS on the same footing as the external and internal market transactions of the NHS. This would have merit both in fully levelling the playing field and in obviating the need for continual adjustments to

revenue budgets for changes in the scale of contracting out and the internal market. The resulting increase in gross spending would have mainly presentational disadvantages. While there would be costs associated with the extra cash flows which would have to be set up, these should in the longer term be outweighed by the greatly increase efficiency and effectiveness of capital management.

15. These arguments favour a system of cash transfers across the board, rather than a mixed system of notional management accounts, and cash transfers. Early announcement of an intention to introduce a cash transfer system would be a clear signal of the Government's commitment to a more competitive health market.

Annex 2

CONFIDENTIAL

Draft

NHS Review

THE USE OF PRIVATE FINANCE IN THE NHS

1. This note suggests some modifications of the rules on unconventional finance (in particular the use of private capital) to encourage private provision and to give the NHS more scope to take advantage of commercial opportunities.

Schemes to be encouraged

2. It is established policy to encourage the following types of schemes:

* private provision in NHS hospitals (paybeds) - new powers in the Health and Medicines Bill will allow authorities to make a profit.

* partnership with the private sector in joint schemes - breaking down the barriers between NHS provision and private provision.

* income generation schemes - the provision of a wide range of services and facilities for profit (shopping malls etc).

3. In addition health authorities are being pressed to take advantage of commercial opportunities in respect of:

* contracting out NHS provision to the private sector.

* the use of existing (high value) NHS land for commercial development and the provision of alternative NHS facilities elsewhere - perhaps with reduced running costs.

The rules on unconventional finance

4. Two basic principles underlie the rules on unconventional finance

(i) any proposal must offer best value for money in Exchequer terms (in practice this means comparing the proposal with the publicly financed equivalent - whether or not such public finance is in fact available).

(ii) where private finance is used it is expected that there will be a compensating reduction in the (public) capital allocation unless Ministers decide otherwise.

5. As means of ensuring respectively value for money and effective control over the size of the public sector these rules are eminently sensible. But they significantly inhibit some schemes we otherwise want to encourage. These schemes will almost inevitably include a cost of servicing the private capital (and therefore fail to meet the first criterion) even though they might represent good value for money and an appropriate return on that capital; while the requirement for compensating reductions in other schemes is a continuing source of difficulty since usually in service terms they have higher priority. Indeed the very purpose of a compensating reduction is to prevent an expansion in services and it is likely to be applied even where such expansion could lead to more health care and increased income.

"Trading" schemes

6. The schemes described in paragraph 2 involve the NHS operating on a trading basis. That distinguishing characteristic applies to certain privately financed Department of Transport schemes (the Dartford crossing where tolls are to be imposed) for which no compensating reductions are to be made. Consideration of similar NHS schemes, case by case, hardly seems appropriate however in view of the relatively small sums involved for individual schemes. A way round this would be to remove restrictions on access to private capital (without a compensating reduction) for those three categories - private provision in the NHS, joint public/private schemes and

income generation initiatives. There would need to be auditable criteria to ensure that the removal of restrictions was limited to those categories of scheme.

7. Clearly it would still be necessary for a health authority to demonstrate good value for money and an appropriate return on the investment. But, for these three categories, it is proposed that the investment decision should be determined locally on normal commercial criteria. Modification of the two general principles of unconventional finance in the way described should lead to an expansion in private health care provision and a closer mix of public/private care.

Contracting out and commercial opportunities

8. As for the two categories of scheme in paragraph 3 - contracting out to the private sector and land development opportunities - there is a growing commercial interest in joining with authorities in such schemes; and contracting out, whether it be geriatric care or elective surgery, is often seen as a very attractive option.

9. So far as contracting out is concerned the present rule of thumb is that the use of private provision (especially surplus capacity) by an authority in an ad hoc way may be disregarded, but that long term contracting out represents substitute provision and falls for consideration under the unconventional finance rules (best value for money and compensating reductions).

10. As to land development, typically developers are offering, perhaps on a full design and construct contract, to provide a new hospital in advance of the release of high value land occupied by the existing facilities. Clearly however in this context the rules prevent private finance being used simply as a way round cash limits and avoid high financing costs.

11. Such schemes may however represent the only realistic way of achieving higher efficiency and/or an improvement in patient services. One approach to reflect the special needs of the NHS, would be to modify the rules on

unconventional finance by allowing access to private finance for these two categories within an agreed limit (say £100m-£200m nationally) within which compensating reductions would not be made, for use only on schemes where the financing costs were at least partially offset by reduced running costs.

Conclusion

12. It is a feature of the Review that we should encourage private health care provision. One approach to this would be to give health authorities complete freedom to use private finance for private facilities, and for joint provision. We should also reinforce the income generation initiative. The current rules on unconventional finance inhibit the use of private finance to enhance public provision and they should therefore be modified - whilst preserving essential safeguards. We therefore propose that:

* for NHs private provision, joint private/public provision and income generation schemes there should be no compensating reductions in public allocations, and a requirement only to demonstrate good value for money and an appropriate return on the investment.

* for other schemes compensating reductions would be applied only above £100m-£200m a year nationally where financing costs were at least partially offset by a reduction in running costs.

NHS AUDIT

CONFIDENTIAL

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From The Secretary of State for Wales

CHANCELLOR/EXCHEQUER
REC. 29 SEP 1988
ACTION MR H PHILLIPS
COPIES TO CST, PMG, SIR P MIDDLETON, SIR T BURNS, MR ANSON, MR TURNBULL, MISS PEIRSON, MR CULPIN, MR AJC EDWARDS, MR J SHORE, MR SAUNDERS, MR CALL, PS/IR, MR LEWIS - I.R, MR KLUCZYS - IR

Rt Hon Peter Walker MBE MP

CT/6965/88

29 September 1988

Dear Secretary of State

NHS AUDIT

Thank you for sending me a copy of your letter of 5 September to Nicholas Ridley about the external audit of the NHS.

It is common ground between all of us that we need to take steps to improve the external audit of the NHS. The obvious route would be to establish a new, independent body, but it would of course take time to get it up and running and for it to make any impact.

The idea of using the Audit Commission is therefore interesting and attractive. It would not be without its dangers and you have pointed up some of these in your letter. At the heart of it would be the relationship between the Audit Commission on the one hand and Ministers and Accounting Officers on the other. And the publication of reports is an area which needs particularly careful attention.

I see no objection in principle to using the Audit Commission in the way you propose. I agree therefore that the work you outlined in paragraph 9 of your letter and the further consideration of the details of the proposed relationship between Departments and Commission should proceed. In view of my responsibilities for the NHS in Wales I will, of course, want my officials to be fully involved in this.

I am sending a copy of this letter to Nigel Lawson, Nicholas Ridley and John Major.

Yours sincerely

Kick Davies

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

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

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
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Telephone 01-210 3000

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

COVERING CONFIDENTIAL

Rt Hon Nigel Lawson MP
Chancellor of the Exchequer
HM Treasury
Parliament Street
LONDON SW1

5 September 1988

Ch/ written more or less as drafted - bar the strong plug for the AC we had wanted. MPW.

Dear Nigel.

NHS AUDIT

Thank you for your letter of 19 August on this issue.

I have today written to Nicholas Ridley in terms which have been agreed generally between our officials and I attach a copy of my letter.

KENNETH CLARKE

CH/EXCHEQUER
REC. 07 SEP 1988
ACTION MR H PHILLIPS
COPIES TO CST, PMG
SIR P. MIDDLETON, SIR T BURNS,
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719

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

CONFIDENTIAL

Rt. Hon. Nicholas Ridley AMICE MP
Secretary of State for the Environment
2 Marsham Street
LONDON SW1P 3EB

5 September 1988

Dear Nick,

NHS AUDIT

One issue which has arisen in the health review is the external audit of the NHS (the health authorities and Family Practitioner Committees). At present, this is done in England by a mix of Department of Health staff and private sector firms, but the Prime Minister's group has agreed that we should aim to replace the Departmental audit directorate by a body which, whilst appointed by and reporting to myself as Secretary of State for Health, is otherwise independent of the Department and NHS, and whose reports would be published.

2. The attached note by officials sets out the current arrangements for NHS audit, the basic criteria which the independent body would be required to meet and the arguments, as understood by the Department and the Treasury, for and against appointing the Audit Commission to take on the job.

3. My reason for writing to you now is to ask for your views on the latter proposition. If you saw no objection we could jointly explore with the Audit Commission, in confidence, whether they feel that they could meet the basic criteria and whether they would wish to have the chance of taking on the job. I should be most grateful to have your views since I wish to report back to the Prime Minister as soon as possible.

4. Clearly, if the Audit Commission were to take this on, their relationship with me would have to be significantly different from their existing relationship with you and Peter Walker, since unlike the local authorities the health authorities and FPCs are not separately elected bodies but appointed by Ministers and directly funded by central Government. The legislation would need to make the different relationship clear, but I should welcome your view in principle on the Audit Commission's taking on such a new role. The alternative is to establish a new audit body from scratch.

CLARKE → RIDLEY 5/9

E.R.

5. If of course either you or Peter Walker, or the Audit Commission themselves did see overriding difficulty in their taking on a new and different role, then we should have to turn to the alternative of establishing a new audit body from scratch.

6. Any independent audit body which is to examine the NHS should satisfy certain criteria. It should:-

(i) be so empowered under statute; primary legislation would be needed;

(ii) be appointed by, and report to, the Secretary of State for Health (who would of course be separately advised by his own officials on the product of the audit body);

(iii) provide technical and regularity audit support to the Accounting Officers.

(iv) agree in advance with the Secretary of State its annual programme of work, covering:-

(a) regularity audits of the 350 individual health authorities and FPCs including certification of their accounts;

(b) value for money audit of the individual health authorities and FPCs, either self-standing or following upon and based on the studies at (c) below;

(c) special VFM studies of particular aspects of health authority and FPC work, including both clinical and support services;

(v) establish a data base for its work (agreed with NHS Management);

(vi) establish a mechanism for avoiding errors of fact: clearance with the authorities upon which it is reporting would seem the simplest and most appropriate mechanism;

(vii) publish its reports (see below);

(viii) produce an annual report on its activities, to be presented to Parliament by the Secretary of State.

7. There is no question but that the new audit body would publish reports on its work at paragraph 6(iv) above. But further consideration needs to be given to the extent to which I, as the Secretary of State (advised by my Department, including for this purpose the Accounting Officers and the NHS Management Board) should have control over publication. That point is discussed further in the note by officials; but it does not need to be settled straightaway.

8. It is a matter for judgment - both ours and theirs - whether the role outlined above could be suitably filled by the Audit Commission. As I have already said, the Commission's relationship with me would be different from their relationship with you and Peter Walker on their local authority work, and it is possible that the two sets of audit requirements laid on the Commission would not sit easily side by side. On the other hand, the Commission has experience and expertise in subjects related to the work of the NHS, and might therefore be up and running more quickly than an audit body created from scratch.

E.R.

9. The next step, whether we decide the Audit Commission might fill the role or not, would be to consult the C&AG, to ensure smooth relations between the new audit body, the NAO and the PAC, and to explore the implications of any possible duplication of the NAO's own value for money studies of particular aspects of health authority work. But that must wait until we know whether we are going for the Audit Commission or a new body.

10. I am copying this letter to Nigel Lawson, John Major and Peter Walker.

ANNEX D

NHS AUDIT

Note by Officials

Current arrangements for NHS audit

1. There are currently three layers of audit function in the NHS:

(a) internal audit within health authorities and Family Practitioner Committees (FPCs);

(b) the Department of Health's statutory external audit of health authorities and FPCs, which reports to the Secretary of State; and

(c) audit by the National Audit Office (NAO).

(a) Internal audit

2. The NAO reported on internal audit in the NHS in April 1987, concluding that, whilst considerable progress had been made since their 1981 study, shortcomings remained in audit planning and execution and coverage of FPCs and computer systems.

(b) Statutory external audit

3. The Department's Audit Directorate audits 221 health authorities, 90 FPCs and 40 other bodies. Some 15% of these audits are performed by private sector firms. Of the Directorate's staff of about 210, 59 are qualified accountants/auditors and a further 104 are engaged in external training for qualifications. The Directorate's regularity audit provides, inter alia, the basis for the NAO audit of the NHS consolidated accounts. Some 10% (and increasing) of the Directorate's audit effort is devoted to VFM audit. It is currently engaged in a number of VFM studies; for example of health authorities' cost improvement programmes, medical and nursing staff levels, and hospital pharmacies. These studies are reported in the Director of Audit's annual report to the Secretary of State who makes it available to Parliament and to the NHS. All of the Directorate's audit reports are used as appropriate by NHS management to help increase internal pressure for management improvements.

(c) NAO audit

4. The National Audit Act, 1983, provides statutory authority for the C&AG to carry out VFM audit examinations. The NAO audit the NHS consolidated accounts, not the accounts of the individual health authorities. They devote some 60% of their work to VFM performance in the NHS. Over the last 18 months they have published reports on the employment of professional and technical staff; competitive tendering in the NHS; usage of operating theatres; care in the community; estate management; and FPC management. Current studies include the quality of care in NHS hospitals; heart disease; oversight of hospital building in England; and financial control in the NHS.

Criteria for new statutory external audit arrangements

5. Any new independent audit body to replace the Department of Health's Audit Directorate's work on the statutory external audit of the NHS should:-

(i) be so empowered under statute; primary legislation would be needed;

(ii) be appointed by, and report to, the Secretary of State for Health (who would of course be separately advised by his own officials on the product of the audit body);

(iii) provide technical and regularity audit support to the Accounting Officers.

(iv) agree in advance with the Secretary of State its annual programme of work, covering:-

(a) regularity audits of the 350 individual health authorities and FPCs mentioned above, including certification of their accounts;

(b) value for money audit of the individual health authorities and FPCs, either self-standing or following upon and based on the studies at (c) below;

(c) special VFM studies of particular aspects of health authority and FPS work, including both clinical and support services;

(v) establish a data base for its work (agreed with NHS Management);

(vi) establish a mechanism for avoiding errors of fact: clearance with the authorities upon which it is reporting would seem the simplest and most appropriate mechanism;

(vii) publish its reports (see below);

(viii) produce an annual report on its activities, to be presented to Parliament by the Secretary of State.

6. The reports at (iv)(b) and (c) above would include recommendations for VFM improvements in individual health authorities and would, as required by the Secretary of State or on the audit body's own initiative, report on a wide range of VFM issues in the NHS. The reports would also have to take into account the fact that value for money in the NHS is not a function solely of costs but of achieving the highest quality of health care at the most cost-effective price. When examining clinical areas the body would have to work in multi-disciplinary teams or have access to qualified medical advice in order to judge the quality of medical care. In addition the body would be required to produce rigorous and systematic comparisons of aspects of efficiency and effectiveness between different health authorities in order to encourage the less efficient to match the performance of the best.

7. These criteria need of course to be geared to the structures and funding of the NHS emerging from the health review: the criteria may need to be adapted. But for as long as the NHS continues to be funded mainly from

taxation, and its management continues to be devolved in part to some structure of health authorities, the above criteria should serve in broad terms.

Publication of reports

8. The audit reports produced by the new body would simultaneously be submitted:-

- to each health authority for consideration by the authority;

- to the Secretary of State for Health for any management action required by the Department.

9. To be independent of the Department and the NHS, the new audit body would have to report direct to the Secretary of State. In the process of producing its reports, and before submitting them to the Secretary of State and publishing them, it would have to check facts with the health authorities concerned, and reveal to them the deductions it wished to make from the facts and the options it wished to express. Further consideration needs to be given to how far it should clear its reports with the Department before publication: there is a case for saying that the reports under 5(iv)(a) and (b) above should be published by the audit body without the need for the Secretary of State's approval, but that the studies under 5(iv)(c) should be published by the Secretary of State, with any response which he felt he wished to give. On the other hand, since the NHS is virtually 100% vote funded and accountable to the Secretary of State, it is arguable that he should retain a degree of

control of the publication of all audit reports and of the way in which the audit findings are expressed. The formal position of the Accounting Officers would also have to be safeguarded.

Relations with the NAO

10. As with the present Departmental Directorate, the new audit body would also need to act as secondary auditors for the NAO. And to allow the NAO to test the effectiveness of the audit process it would as now be necessary for the NAO to retain the right to all audit files relating to Departmental votes and to examine audit processes and systems.

Current role of the Audit Commission

11. The Audit Commission is responsible for the audit of local authorities in England and Wales and reports to them. Some 30% of local authority audits are contracted out to private sector firms. The Commission devotes some 40% of its audit effort to VFM work. It instructs its auditors in the course of their audit to gather figures for specific activities. It then assembles and compares these figures and produces models of best practice.

12. We understand that the Audit Commission produces broadly three types of reports:-

(a) Annual audits of individual local authorities, including certification of their accounts. When the auditor wishes to raise matters of concern he writes a private management letter to the members of the local authority. When the auditor discovers matters of wider concern he may make a public interest report to the authority; there is a

requirement for the local authority to consider it as a publicly available document. Such reports are sent to all members and they generally receive local publicity.

(b) Reports which look at particular services across local authorities. The study team analyse the way the activity is tackled in a number of local authorities thereby identifying the elements of good management practice. The names of authorities taking part may remain confidential, and commonly do when the findings are critical.

(c) Reports on the impact of central government on value for money in particular areas of local government work. The Commission can point out conflicts between different central government policies as they bear on local authorities.

13. The Commission operates as a statutory independent body; it often consults Departments at draft stages of the reports and endeavours to agree facts, but may not always be amenable to changes suggested by Departments to its reports, which are of course not concerned with Departments' direct expenditure but with that of the local authorities to whom the Audit Commission reports.

14. The audit regime which the Audit Commission provides to local authorities would not be appropriate to the case of the health authorities and the FPCs, which are not separately elected bodies but part of central government and accountable to the Secretary of State. The statutory external audit of the NHS must also recognise that the Accounting Officers are accountable to Parliament for the financial propriety and regularity as well as for the prudence, economy and value for money of voted expenditure.

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(b) Reports which look at particular services across local authorities. The study team analyse the way the activity is tackled in a number of local authorities thereby identifying the elements of good management practice. The names of authorities taking part may remain confidential, and commonly do when the findings are critical.

(c) Reports on the impact of central government on value for money in particular areas of local government work. The Commission can point out conflicts between different central government policies as they bear on local authorities.

13. The Commission operates as a statutory independent body; it often consults Departments at draft stages of the reports and endeavours to agree facts, but may not always be amenable to changes suggested by Departments to its reports, which are of course not concerned with Departments' direct expenditure but with that of the local authorities to whom the Audit Commission reports.

14. The audit regime which the Audit Commission provides to local authorities would not be appropriate to the case of the health authorities and the FPCs, which are not separately elected bodies but part of central government and accountable to the Secretary of State. The statutory external audit of the NHS must also recognise that the Accounting Officers are accountable to Parliament for the financial propriety and regularity as well as for the prudence, economy and value for money of voted expenditure.

15. It is possible that the Secretary of State's and the Accounting Officers' audit requirements could be met by the Audit Commission but the two separate sets of audit requirements laid on the Audit Commission might not sit easily side by side. (See, for example, current pressure by the Audit Commission on the local authorities for increased expenditure on highway maintenance).

16. On the other hand, the Audit Commission has considerable experience and expertise in areas of work closely related to that of the health authorities. In particular, it is accustomed to working in multi-disciplinary teams with professionals looking at professional services. It might therefore start work, and make an impact, on the NHS audit requirements set out above, more quickly than a new audit body created from scratch. A new body could however subcontract some work to the Audit Commission.

29.9.3

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 29 September 1988

CHIEF SECRETARY

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

NHS REVIEW: CAPITAL

With his letter of 29 September, Mr Clarke tries to bounce you into agreeing the circulation of a paper for Tuesday's meeting of the Prime Minister's group. Unless you speak to him about it at tomorrow's bilateral, we can assume that he will circulate it in the course of the day.

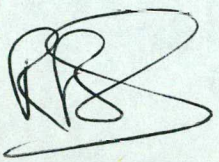
2. You should make it clear in the margins of the bilateral that you are not prepared to be bounced in this way. It was agreed at the last meeting of the Prime Minister's group that there should be a bilateral discussion of this issue between you and Mr Clarke before it went back to the main group. He cannot expect this to be on the basis of a completely new and lengthy paper which none of us have had a chance to read. You should tell him that you think we should stick to the earlier plan: a bilateral discussion, with an agreed paper going to the group.

3. The paper concentrates on two issues, capital charging and private finance. On the first, we have heard nothing from Department of Health since the letter I sent them on 1 September (attached to my minute of 6 September) commenting on an earlier version of their paper. There has been complete radio silence from there ever since. Mr Clarke's paper suggests that there is some great argument of principle between Treasury and the Department. There is not - we are simply trying to get them to tease out the issues, which we believe they have not properly thought through yet.

CAPITAL
SAUNDERS
29/9

4. On private finance, Mr Clarke proposes some "modifications" of the present rules as they apply to health authorities. We have not had a chance to digest these proposals, but at first sight, rather than modifying them, they seem to remove all semblance of control. For example, it is suggested that "contracting out" (whatever that means in this context) should be exempt from the rules. But any private finance proposal can be dressed up us contracting out; the distinction between the two is most unclear. If Mr Clarke suggests that everybody knows what we mean by "contracting out", we should ask for a clear definition - it may turn out that we and Department of Health have very different ideas. Also, a mistaken analogy is drawn with the Dartford Bridge. This conveniently ignores the fact that privately financed NHS development will still have to be paid for by the taxpayer so long as the NHS is tax-funded.

5. There is a lot of work yet to do on this paper. Mr Clarke should give us the opportunity to do it.



R B SAUNDERS

30.9.2

SECRET

FROM: R B SAUNDERS

DATE: 30 September 1988

CHANCELLOR

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

NHS REVIEW: MEETING ON 4 OCTOBER

Mr Clarke has circulated 6 papers for this meeting:

a. Merging FPCs and DHAs
b. GP practice budgets
c. NHS audit
d. Self-governing hospitals
e. An outline White Paper
f. Outstanding issues

2. In addition, he may place his paper on capital (attached to his letter of 29 September) on the table, but not for discussion. This is not yet resolved as I dictate this minute. (my note at front - n)

Merging FPCs and DHAs

3. This paper argues against merger, but instead trying to improve the operation of FPCs by making them independent of the professions and taking certain (unspecified) steps to manage their contracts better. Regions are to be made "agents of change", but it appears that this does not involve FPCs reporting to the Department through regions.

4. The second part of the paper discusses the possible cash limits of the FPS. It proposes cash-limits as a long term objective, but only after certain preparatory steps have been taken. In the meantime, this long term aim should remain undeclared publicly.

SAUNDERS TO CX BRIEF 30 SEPT

5.This is all pretty unsatisfactory. While Mr Clarke's main argument against merger - that yet another NHS reorganisation is the last thing we want to come out of the Review - is not to be set aside lightly, we have always seen merger as the only sensible way of extending cash limits to the FPS.

6. We accept that significant elements of the programme - the drugs bill and spectacle vouchers, for example - are very difficult to control in-year. The best approach is to bring them within a combined NHS budget. No alternative proposals are offered for controlling the expenditure, other than a suggestion that we should take powers "at the right time" to control the number of GPs and to develop the existing levers for controlling drugs expenditure. On this last, however, he quotes last November's Primary Care White Paper, which said the Government had no plans at present to extend the selected list or introduce compulsive generic prescribing. A scheme has recently been introduced for informing GPs about their prescribing habits compared with the norm. But otherwise, the paper holds out no prospect of significant reform.

7. I suggest the following points to make.

- Do not understand the proposals in relation to FPCs (Paras 3 and 4). How precisely will the hand of FPCs be strengthened? How can regions act as "agents of change" if they have no direct responsibility for FPCs?

- Understand argument that do not want unnecessary reorganisation. But potential gains of merger in terms of financial control outweigh this.

- See no reason to be wary of reversing 1985 de-merger (para 7). Clearly the 1985 decision was wrong.

(!)

- We need to control the number of GPs. But proposals in para 21 hopelessly woolly.

- Since the Primary Care White Paper closed off the most effective measures for containing the growth of the drugs bill, what positive measures does Mr Clarke have instead?

GP practice budgets

8. This is Mr Clarke's response to the proposal (which originally emanated from the Policy Unit) that GP practices should be able to "opt out" of the system. Contrary to the remit in the minutes of the last meeting, it has not been considered jointly with the Treasury, but is instead a pure DoH effort.

9. In essence, this builds on Mr Clarke's earlier proposal for GP budgets, with the main differences that it is optional and available only to the larger practices. In general, the paper is rather clearer than the earlier effort. Opted-out practices will agree "bulk" contracts with individual hospitals - presumably, in most cases, their local district general hospital - and the arrangement would be confined to out-patient services and elective surgery. The annexes identify some of the many practical problems which remain to be resolved, such as how to define what sorts of treatment should be within the system and which not, what happens if the money runs out before the end of the year (less of a problem here than under the earlier proposal, since GPs would have made a positive choice to opt out and should reasonably be expected to live with the consequences), and how exactly the contracts between practices and hospitals should be specified. These would be explored in experimental pilot projects initially.

10. This all looks better and more workable than the earlier proposal. My main worry is what these changes will actually achieve. It is not clear how, in the majority of cases, anything much will change, particularly from the point of view of the patient. In principle at least, neither patient choice nor GP freedom of referral will be enhanced, although in practice GPs may find it easier to refer patients "out-of-district" if some money from their budget accompanies them. But this may be unduly pessimistic, and I certainly would not advise you to stand in the way of experiments of this sort going ahead.

NHS audit

11. Miss Peirson has submitted a separate note on this paper.

Self-governing hospitals

12. This paper seeks to develop this idea further. It starts by arguing that the objectives (set out in paragraph 2) can be achieved without structural change, by greater flexibility in managing the system and in the financing mechanisms. Mr Clarke proposes to develop these for all hospitals. The idea is that hospitals would then have the further option of self-governing status. This would give some further freedoms, like management by their own board rather than by the district; employment of staff by the hospital rather than the district or region; and the ability to seek contracts from districts other than those to whom they were formerly responsible.

13. In general, I think you can again endorse these proposals, with two reservations. The first is that, like those for GP practice budgets, they are not terribly exciting and, because of their complexity, may not be easy to present publicly. Secondly, and more specifically, you should not sign up to paragraph 3(ii) (greater flexibility over manpower and capital) without a detailed look at what is proposed.

Outline White Paper

14. The Department of Health draft is pretty tentative at this stage, and Mr Clarke's covering note looks for a general steer from the group as to what sort of document it should be. These are very much questions on which you will want to exercise your political judgement, but, for what it is worth, my views on the questions in paragraph 11 of the paper are as follows:

- On the type of document (paragraph 3) I would go for something short and crisp which seeks to take the initiative in public debate.

- On the main thrust (paragraph 8), it is clearly right that the White Paper should seek to emphasise that the exercise is about improving the service that patients get, rather than one of management theory. It therefore seems right to keep hammering this theme throughout the document, and not just in the chapter about service to patients.

- I would on the whole see little point in a chapter about wider health issues (paragraph 9). It seems a perfectly defensible proposition that the White Paper is about the way the service is delivered, rather than the Government's overall health strategy. The two are really quite separate issues.

- I think Mr Clarke is right to suggest picking up specific Scottish, Welsh or Northern Irish points where they come up. But I think he is also right that there could be a separate chapter about the territories if the relevant Ministers so preferred.

15. There will probably not be time for a detailed discussion of the draft. But you may wish to take the opportunity to raise the question of fiscal incentives, on which Mr Culpin is supplying a separate note. (Chapter 7 contains a reference to this.) Otherwise, there are several points about which we need to know more before we could sign up to them, like more delegation of pay and conditions questions (chapter 4).

Outstanding issues

16. This details a formidable list of important points where decisions have yet to be taken. We have not seen this paper in draft. My instant comments, based on a quick read, are as follows:

Consultants contracts - the proposals for better management of contracts look on the right lines, but are worryingly vague at one or two points (for example, what does "give districts more involvement in the appointment of consultants" actually mean?). The proposal for replacing the lowest grade C distinction award by a performance related pay system, run by both senior doctors and general managers, looks promising. But the higher awards are to remain the province largely of the medical profession. Why the ? should the higher awards be treated any differently from the first level one?

Charging for inessential treatment - he proposes not pursuing this further. I think this is right - there is little evidence of genuinely inessential treatment (purely cosmetic nose jobs, etc) in NHS hospitals. There is certainly evidence of ineffective treatment, but that is another matter, to be pursued through the mechanism of medical audit.

Improved treatment of patients - he says he is working on ideas here. These must come forward soon. This is a very important part of the White Paper.

Restrictive practices - this is vague in the extreme. Does Mr Clarke actually have anything specific in mind in, for example, "breaking down rigidities caused by professional boundaries"?

NHS Management Board - again, proposals must be forthcoming as soon as possible.

Competitive tendering - Mr Clarke offers to foster local initiatives in competitive tendering for pathology and radiology. This seems a reasonable approach, so long as there are results to show for it.

IT and the RMI - this is the subject of a Survey bid. Up to now, we have been very unhappy with the way Department of Health have set about the resource management initiative. Extending it across all health authorities is an enormous project - on a par with computerisation of PAYE or of social security offices. The Department seem not to have grasped this and only now, after much prodding from us, do they seem to be about to set up proper arrangements to drive the project from the centre. Only when those are in place will we be able to look at their Survey bid seriously.

Medical audit - these proposals go in the right direction, but depend critically on co-operation from the medical profession. This should not be a problem, since the

Royal Colleges have been making the right noises about this form of self-regulation. If we can proceed in that way, all well and good. But Mr Clarke should be prepared to take mandatory action - for example by acting on consultants' contracts - if need be. Will he be prepared to do this?

Capital

17. We hope this will not be discussed. If it is, see my minute of 29 September. The earlier agreement was that there would be bilateral discussions between Mr Clarke and the Chief Secretary before the Prime Minister's Group considers these issues. We should stick to that.

R B SAUNDERS

st.ln/min/3.30.9

CONFIDENTIAL

FROM: MISS M E PEIRSON
DATE: 30 September 1988

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Sir A Wilson
Mr Phillips (o/r)
Mr Beastall
Mr Turnbull
Mr Saunders
Mr Potter
Mr Call

HEALTH REVIEW: NHS AUDIT

One of the papers for Tuesday's meeting is a note by Mr Clarke on NHS Audit. The attached note by officials you have all seen before.

2. Mr Clarke's note sets out the position now reached, namely that the Audit Commission have now persuaded all concerned that they can do the job; and invites agreement that

i. the external audit should "in principle" be transferred to the Audit Commission, and

ii. officials should now discuss the change with the NAO.

3. Mr Walker has already written (29 September) to agree to the Audit Commission, and though Mr Ridley has not yet done so there is every expectation that he will agree on Tuesday. Mr Rifkind is not directly involved, but his officials have advised him that the Scottish equivalent to the Audit Commission is not of such a high standard, and that therefore the Scottish audit should stay where it is, which is within the Scottish Finance Department (not within the Scottish Health Department).

PEIRSON TO C X NHS AUDIT 30 SEPT

Recommendation

4. You will want to urge agreement to both of Mr Clarke's conclusions. I suggest you also make the following points:-

i. That the decision "in principle" should be "in practice", and that the change should be announced in Mr Clarke's statement on the health review. We should have been able to square the NAO by then (we suggest that Treasury officials should lead the discussions, since TOA have close relations with NAO); and we do not want the Department of Health to engineer further delay - other than that created by the need for legislation.

ii. Officials should be invited, outside the Health Review, to consider and prepare proposals on the legislation and other mechanics of the change, and in particular the two points of policy outstanding:-

a. the Audit Commission's relationship with the Secretaries of State for Health and Wales; and

b. the degree of independence the Audit Commission should have in publishing its reports (see paragraph 9 of the note by officials).

iii. Mr Rifkind might like to think harder about the desirability of an independent external audit body, either strengthening the Scottish equivalent of the Audit Commission by the infusion of new talent or setting up a new body. (The principal advantage we have always seen in an independent audit body is the publication of comparative reports, which at present is done no more in Scotland than by the DH.)

MISS M E PEIRSON

GJFPa

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

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

CH/EXCHEQUER
REC. 30 SEP 1988
ACTION Mr SAUNDERS
COPIES TO CST, Sir P. MIDDLETON, Sir T. BURNS, Mr ANSON, Mr H. PHILLIPS, Mr CULPIN, Mr TURNBULL, MISS PEIRSON, Mr PARSONAGE, Mr GRIFFITHS, PS/IR, Mr LEWIS-IR, Mr KUCZYS-IR.

30/9

COVERING SECRET

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

30 September 1988

Dear Paul

NHS REVIEW: PAPERS FOR MINISTERIAL GROUP ON 4 OCTOBER 1988

I enclose the following papers for discussion at the meeting of the Ministerial group on the NHS review to be held on 4 October:

HC39	Self-governing hospitals
HC40	GP practice budgets
HC41	Merging FPCs and DHAs
HC42	NHS audit
HC43	Outstanding issues
HC44	Outline White Paper

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

yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

SECRET

FROM: N I MACPHERSON
DATE: 30 SEPTEMBER 1988

1. MR CULPIN

2. CHANCELLOR

we can discuss this on Monday KC 30/9

cc. Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Scholar
Mr Saunders

TAX BRIEF

NHS REVIEW: TAX MEASURES

Chapter 7 asks whether the draft White Paper will "include fiscal incentives, or will these be dealt with separately by the Chancellor?" I attach some speaking notes.

N. I. Macpherson

N I MACPHERSON

SECRET

SPEAKING NOTES

Draft asks whether Chapter 7 will include fiscal incentives.

Better not. White Paper about supply: come a long way over the last few months.

Tax proposals about demand; would not sit well with rest of White Paper. Would prefer to deal with them separately.

Suggest better not to announce when White Paper published. Would only distract attention. [hmmm...]

Suggest wait for reaction to White Paper. See whether genuine pressure for fiscal incentives builds up. If so, do tax relief for the elderly in Budget.

Budget is where people will be expecting any tax measures to be announced, so no problem with presentation.

Have to say more I think about it, more I am against a benefits-in-kind exemption. Lets favoured few employees buy health insurance out of untaxed income. How could we expect our self employed supporters to pay for private medical insurance out of taxed income? Of all groups they can surely least afford to get stuck in NHS queues. Prefer to drop this.

plus the question you asked before — do we think demand boost (a) needed (any new stats?) (b) can be coped with without simply driving up prices.

Q. Given success in increasing supply, what's wrong with a small injection of demand?

A. Fiscal incentives likely to increase demand overnight. In contrast to supply side measures, whose impact will build up slowly. At a time when demand for private health care is expanding rapidly, danger that boost in demand will only result in increased pay for medical professionals.

Q. If self employed the problem, why not give them a special relief as well?

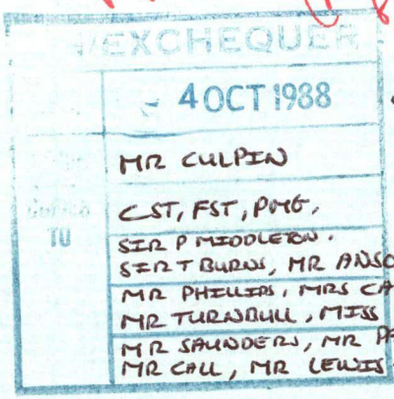
A. Fear that if we go ahead with benefits in kind exemption, however limited in scope, and relief for self employed we would face irresistible pressure for a general tax relief. All the arguments in Kenneth Baker's recent letter would then come into play. Why not a tax relief for education where at least genuine contracting out of state system is possible?

CONFIDENTIAL

SS28SL1

ELIZABETH HOUSE
YORK ROAD
LONDON SE1 7PH
01-934 9000

The Rt Hon Nigel Lawson MP
Chancellor of the Exchequer
The Treasury
Parliament Street
LONDON
SW1P 3AG



30th September 1988

In my letter of 6th September I raised with you what could be the repercussive effects of extending tax allowances to private health care and the consequent effects to education.

Our friends in the Institute of Economic Affairs have brought out a booklet by Professor Anthony Flew advocating tax credits for education. It is a rather strange scheme which involves a half-way move to vouchers but would in the first stage, in effect, introduce tax allowances for people who choose to send their children to private schools. The clear object is to increase the number of private schools by giving these tax advantages to parents.

I think this is just a taste of the different ideas that will be promoted if we were to extend tax relief. It may be that you will decide to do this for health service reasons. However, if we do, we must be very clear how it can be ring-fenced. I am still of the opinion that a very strong campaign will develop amongst our own supporters for tax relief on private education.

I am copying this letter only to the Prime Minister and to Kenneth Clarke.

CONFIDENTIAL

FINANCIAL TIMES

Right-wing body suggests tax credits for education

By David Thomas, Education Correspondent

THE GOVERNMENT should introduce education tax credits to encourage people from poorer backgrounds to go to independent schools, according to a pamphlet published today by the Institute of Economic Affairs, the right-wing think tank.

The institute sees the proposal as a halfway house to the introduction of the full educational voucher scheme it has championed.

Under the institute's proposals, education tax credits would be given to parents whose children were at independent schools.

The credit would reduce parents' tax liability. In cases where the parents' income was too low to make them liable for tax, the credit would be paid direct to the parents.

The pamphlet suggests the credit might initially be restricted to parents with low incomes. The point of that is to spread the social base of independent schools and avoid the charge that the credit would disproportionately benefit the wealthy.

The pamphlet does not give any indication of how much the scheme might cost.

However, Professor Antony Flew, the pamphlet's author, suggested that the credit might be set initially at up to 75 per cent of school fees. Annual fees in public schools range up to about £7,050 and in preparatory schools up to about £5,400.

Prof Flew argued that the cost to the exchequer would be minimised by reductions in state school spending. He acknowledged that the proposals went against the Government's belief in cutting tax allowances.

Education Tax Credits. IEA, 2 Lord North Street, London SW1P 3LB. £2.50 incl. p&p.

DAILY EXPRESS Tuesday Septem

Tax lure call in move to boost private schools

By WILL STEWART
Education Correspondent

CHANCELLOR Nigel Lawson was urged yesterday to allow parents huge tax "credits" towards school fees.

Parents could claim up to £1,750-a-year on getting top-grade independent schooling.

The radical plan to open up private schools to thousands more pupils was called for by the right-wing Institute of Economic Affairs.

The aim is to give greater choice to parents and encourage more private schools to open —so raising standards.

Professor Antony Flew of Reading University, who proposes the scheme in a new booklet Education Tax Credits, claims it would not be a major burden on the Treasury.

It would simply mean switching cash from the State sector to the private sector for those parents who chose the tax credit option, says the professor.

Voucher

Parents earning over a certain amount, perhaps £30,000, would not qualify.

The Chancellor would be able to fix the exact amount of tax credit, which would be paid in the form of a voucher but Prof Flew said it should be between 50-75 per cent of average private school day fees.

"It must be enough to encourage a worthwhile number of people to think: 'I can now go private'," he added.

Eventually, Professor Flew wants to see State schools competing in the market place, with parents choosing to "spend" fees either in comprehensive or the independent sector.

Parents would be able to top-up the basic level of their voucher.

The scheme would run alongside the present Assisted Places Scheme, allowing pupils from less well-off families to win places at top private schools.

Tuesday, September 27, 1988

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000
From the Secretary of State for ~~Social Services~~ Health

SECRET

Paul Gray, Esq.,
Private Secretary
10 Downing Street,
London, SW1.

30 September 1988

CH/EXCHEQUER
REC. 30SEP1988
ACTION Mr SAUNDERS
COPIES TO CST, Sir P. MIDDLETON, Sir T. BURNS, Mr ANSON, Mr H. PHILLIPS, Mr CULPIN, Mr TURNBULL, MISS PEIRSON, Mr PARSONAGE, Mr GRIFFITHS, PS/IR, Mr LEWIS-IR, Mr KUCZYS-IR
30/9

Dear Paul,

NHS REVIEW

My Secretary of State has asked me to circulate the enclosed paper, prepared for the NHS Review, on the management of capital assets and capital investment. Unfortunately it has not yet been possible to discuss this issue with the Chief Secretary and it is not proposed that the Paper should be placed on the agenda on 4 October. The Paper is therefore circulated, as we agreed, for information at this stage.

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

Yours sincerely,

Geoffrey Podger

G.J.F. Podger,
Private Secretary

HC45

SECRET

copy no. 2

NHS REVIEW HC 45

MANAGEMENT OF CAPITAL ASSETS AND INVESTMENT

Note by the Secretary of State for Health [pity]

1. My first paper to the Group (HC37) set out four key aims for the management of capital:

- clear, devolved, responsibilities for decisions on the opening and closing of hospitals;
- maximum devolution of responsibility for management of capital programmes;
- some form of charging for the use of capital assets;
- access to private capital.

2. The first of these I propose to deal with in the context of other work on organisation and the functions of Regions and Districts. This paper outlines my proposals in the remaining three areas. These proposals are framed against the background of our previous agreement that delivery of health care should be based much more on explicit agreement on the timing, quality and cost of services to patients, and that the NHS should move towards a contractual way of working.

Devolution of responsibility for capital programmes

3. There is already scope for virement by health authorities between their revenue and capital accounts, and a recent change allows a useful carry-forward from one year to the next. Regions can also "broker" large capital expenditures between authorities and between years, while keeping within the overall annual cash limits. Below certain limits, new investment in buildings etc may be made on the sole decision of the Region.

4. To increase this flexibility, officials have recently agreed increases in the capital expenditure limits above which projects have to be referred up to the Department or the Treasury for approval. Schemes with a capital cost of over £15m (previously £10m) have to be referred to Treasury for approval. Schemes costing over £10m (previously £5m) have to be referred to my Department. This will be welcomed by the health authorities.

5. I propose that officials should look further at the use of existing flexibility for virement and carry-forward, and identify where further help can be given.

B:D5.20/1

SECRET

Charges for capital

6. In proposing the introduction of charges for capital I have in mind six basic principles that I think we need to secure:

a. There should be a system of capital accounting in the NHS which requires appropriate valuation of the capital assets employed.

b. Health authorities should be required explicitly to take account of the cost of capital in costing the services they provide.

c. There should be a level playing field between health providers in the public sector and between the public and private sectors.

d. Government should retain effective control over the total level of capital expenditure in the NHS.

e. Whatever arrangements are introduced should be consistent with the achievement of value for money.

f. These arrangements need to be capable of adaptation to self governing hospitals.

7. I do not think we are likely to have difficulty in agreeing these principles, but it has become clear that officials have not as yet been able to agree how best they can be secured. I am concerned lest we find ourselves unable to say in our White Paper how we propose to implement what I believe will be seen as a key element of the more competitive NHS environment we are seeking to create. I think therefore that we need to agree among ourselves how best to go forward.

8. My proposals are set out in Annex 1. The crux of the problem is whether our objectives can be secured by a system of notional management accounts, as the Treasury believe, or whether actual charging mechanisms are required, as I believe. There are subsidiary questions about valuation, distribution of resources and disposal of assets, but I think that if we can settle the main question these others are likely to fall into place. A good deal of work has already been done, both in my Department and in the NHS, in developing valuation and asset accounting systems.

9. My reason for preferring real to notional charges is that these would provide more sharply the necessary discipline in the highly devolved and "trading" environment contemplated in the Review. Real charges would be essential anyway for transactions with the private sector, and to ensure the level playing field referred to in paragraph 6(c). Managers may not see the necessity for translating figures from management accounts into the actual prices they charge. And even if they were scrupulous in doing so, their revenue accounts would then be boosted by

income for which there was no corresponding outgoing, unless a charging regime applied all the way up the line.

10. I therefore propose that we should agree that all health authorities (and in due course, self governing hospitals) should be required to pay real charges for the use of their capital assets. Officials should work up a practical scheme for implementing such a system.

Access to private capital

11. It seems to me integral to the new environment we are seeking to create in the NHS that, where we can do so without jeopardising the principles I set out in paragraph 6, we should enable the NHS to cooperate closely with the private health sector and to compete directly with it. I believe that this means allowing the NHS, and in time self governing hospitals, a greater measure of freedom in relation to private funding than is presently the case.

12. My proposals are set out in Annex 2. They are deliberately limited to the NHS, and designed to be capable of being controlled from the centre. They also, in my judgement, represent a minimum package, given the interest both in and beyond the NHS that has become apparent over the last year or two.

13. In short I propose that, where health authorities can earn a good return on investment through income generation and other schemes, no compensating reductions should be made in public allocations; and the criterion to be applied should simply be "good" value for money. Furthermore, in situations where health authorities seek to contract out services, or to make land development arrangements requiring initial finance which a private developer is prepared to provide, financing from private sector sources should be allowed up to a limit. This limit should be set at, say, £100 - £200 million nationally (as compared with some £800 million capital grants, and £200 - £300 million from land sales) and be administered centrally. Authorities would bid for the use of this limit to cover their access to private funds.

14. Another proposal, which I have put forward for the current PES round, is for a central capital loan fund which would provide repayable short term finance. For example, an authority might wish to reorganise its estate to obtain overall savings and release redundant land, but might need capital funding in advance to make this possible. The loan fund would meet this need.

September 1988

ANNEX 1

ACCOUNTING AND CHARGING FOR CAPITAL

Introduction

1. In the long term prices need to reflect the full economic cost of resources in both the public and private sectors, and there should be incentives for local managers to make optimal decisions on the use of the capital stock and on investment and disinvestment. There should be a level playing field for all participants in the competitive health services market. Integral to this is the way that the NHS accounts for the use of capital stock.

2. Since the NHS is likely to remain part of the public sector for the foreseeable future, any new developments in accounting for, or charging for capital, should be consistent with cash limits and with other control and management devices - such as option appraisal - that have proved their worth over the years.

Existing arrangements

3. Health authorities receive capital grants for new investment. These constitute about 8% of the national budget for hospital services. Proceeds from land sales adds another 25% to the capital programme. The current practice in the NHS is that investments are written off once they are made. Except in a few special circumstances there is no subsequent accounting for the cost of capital. Existing assets appear as a 'free good' to managers unless, of course, they have alternative uses within the NHS or can be sold off (health authorities are allowed to keep the proceeds of sales). There are no charges in respect of depreciation of, and interest on, the capital stock. This means that services provided with authorities' own assets appear cheaper than they should be and there is a cash incentive to retain such services in house, at least during the life of the assets concerned.

Capital accounts

4. A necessary requirement for handling capital more satisfactorily, is for health authorities to set up a system of capital accounts which would value all assets at their "current" or "replacement" cost to the NHS, depreciating them appropriately, according to their age. Such accounts would include appropriate charges for the assets used, based upon these valuations.

5. Valuation of Regional hospital stocks has been carried out in the past and experiments are under way in a number of Districts to build asset registers and capital accounts from the bottom up. But further work would be required to develop robust and convincing NHS capital accounts.

6. Capital charges would consist of annual depreciation plus interest on the current value of the capital stock. They would usually rise with new investment and fall with disinvestment. Differential land and building costs between RHAs would need to be addressed in setting any capital charges, in order to preserve the level nature of the playing field as between the public and private sectors, region by region.

7. Once such accounts were in place it would become easier to make comparisons of unit costs internally and externally and to set prices, with appropriate apportionment of capital costs. Such accounts will also provide clear information to authorities about the presence and notional cost of surplus and underused assets.

Management accounts versus full cost charging systems

8. The NHS Review is working towards a mix of three main different forms of financing for the NHS in future:

i. the familiar form of block budgeting for health authorities in a management line relationship;

ii. internal trading, at arm's length, between different health authorities and between health authorities and self-governing hospitals;

iii. more external buying and selling services with the private sector.

9. Existing Treasury guidance on fees and charges and on contracting out already recommends full cost charging for trading and comparisons between government bodies and the private sector. It also recommends full cost charging for trading between government bodies themselves. This would apply to self-governing hospitals, and to inter-authority payments for patients treated under contract in the "internal market".

10. Under the proposed funding arrangements, health authorities and self governing hospitals would need to include in their contract prices the full cost of capital used in providing services as described in para 8(ii) and (iii) above. It follows that they would pay the income received in respect of capital charges to the higher authority supplying capital. Correspondingly, purchasing authorities would need to be provided with larger budgets to cover these capital charges on services purchased from providing authorities or self governing hospitals - as happens now, in principle, with contracting out. To this extent, therefore, a system of real charges for capital is inevitable.

11. The question remaining therefore, is what, if anything, should be done about accounting for, or charging for, capital under the continuing arrangements involving the type of financing

described in para 8(i) above - the familiar block budgeting in a management line relationship. The present public sector practice where capital is, in effect, written off as soon as it is invested, is unacceptable. It must be replaced either by a system of notional management accounts, or actual charges as would apply in "trading" situations.

12. A system of management accounts could be set up resembling those used by some private companies to control their subsidiaries. They would entail notional budgeting and "repayment" arrangements to reflect capital charges together with performance targets such as making an agreed return on capital and preserving the net worth of assets. The basic discipline would be enforced by the line management relationship, and managers would need to take account of the capital costs shown in their management accounts when dealing with "trading" situations, but not otherwise.

13. Instead of relying on management accounts, and indirect performance indicators based upon them, it would be possible to move to a system of full cash budgeting for, and repayment of, capital charges within and between NHS management tiers. Most of the management processes would be the same, but there would be a number of differences:

i. a cash system would provide stronger and more consistent incentives for authorities than a system of management accounts, because they would apply automatically, across the board;

ii. If interest was repaid to the Exchequer there would be an increase in gross spending but there would be no increase in net public expenditure.

iii. there would no longer be any need for adjustments to revenue budgets for the scale of contracting out, or for the scale of the internal market, because all NHS expenditure would appropriately reflect capital charges;

iv. there could be greater incentives to efficiency savings because authorities could retain capital charge allocations (instead of the proceeds of asset sales) after disposing of assets. They could then use the released capital charge element for other purposes. (However, it would be necessary to guard against any running down of assets to enhance short term performance);

v. there would be auditing and transaction costs in handling real cash transactions between authorities.

Conclusion

14. It is necessary in any case to improve capital accounting in the NHS so as to determine full costs and charges for internal and external transactions and comparisons. It will also be necessary to set up a complementary system of budgeting for and repayment of capital charges for the purposes of trading between health authorities and self-governing hospitals and the private sector. As to the choice between cash transfers and management accounts for directly managed services, cash accounts would put all internal budgetary transfers between tiers of the NHS on the same footing as the external and internal market transactions of the NHS. This would have merit both in fully levelling the playing field and in obviating the need for continual adjustments to revenue budgets for changes in the scale of contracting out and the internal market. The resulting increase in gross spending would have mainly presentational disadvantages. While there would be costs associated with the extra cash flows which would have to be set up, these should in the longer term be outweighed by the greatly increase efficiency and effectiveness of capital management.

15. These arguments favour a system of cash transfers across the board, rather than a mixed system of notional management accounts, and cash transfers. Early announcement of an intention to introduce a cash transfer system would be a clear signal of the Government's commitment to a more competitive health market.

ANNEX 2

THE USE OF PRIVATE FINANCE IN THE NHS

1. This note suggests some modifications of the rules on unconventional finance (in particular the use of private capital) to encourage private provision and to give the NHS more scope to take advantage of commercial opportunities.

Schemes to be encouraged

2. It is established policy to encourage the following types of schemes:

* private provision in NHS hospitals (paybeds) - new powers in the Health and Medicines Bill will allow authorities to make a profit.

* partnership with the private sector in joint schemes - breaking down the barriers between NHS provision and private provision.

* income generation schemes - the provision of a wide range of services and facilities for profit (shopping malls etc).

3. In addition health authorities are being pressed to take advantage of commercial opportunities in respect of:

* contracting out NHS provision to the private sector.

* the use of existing (high value) NHS land for commercial development and the provision of alternative NHS facilities elsewhere - perhaps with reduced running costs.

The rules on unconventional finance

4. Two basic principles underlie the rules on unconventional finance

(i) any proposal must offer best value for money in Exchequer terms (in practice this means comparing the proposal with the publicly financed equivalent - whether or not such public finance is in fact available).

(ii) where private finance is used it is expected that there will be a compensating reduction in the (public) capital allocation unless Ministers decide otherwise.

B:D5.20/1

5. As means of ensuring respectively value for money and effective control over the size of the public sector these rules are eminently sensible. But they significantly inhibit some schemes we otherwise want to encourage. These schemes will almost inevitably include a cost of servicing the private capital (and therefore fail to meet the first criterion) even though they might represent good value for money and an appropriate return on that capital; while the requirement for compensating reductions in other schemes is a continuing source of difficulty since usually in service terms they have higher priority. Indeed the very purpose of a compensating reduction is to prevent an expansion in services and it is likely to be applied even where such expansion could lead to more health care and increased income.

"Trading" schemes

6. The schemes described in paragraph 2 involve the NHS operating on a trading basis. That distinguishing characteristic applies to certain privately financed Department of Transport schemes (the Dartford crossing where tolls are to be imposed) for which no compensating reductions are to be made. Consideration of similar NHS schemes, case by case, hardly seems appropriate however in view of the relatively small sums involved for individual schemes. A way round this would be to remove restrictions on access to private capital (without a compensating reduction) for those three categories - private provision in the NHS, joint public/private schemes and income generation initiatives. There would need to be auditable criteria to ensure that the removal of restrictions was limited to those categories of scheme.

7. Clearly it would still be necessary for a health authority to demonstrate good value for money and an appropriate return on the investment. But, for these three categories, it is proposed that the investment decision should be determined locally on normal commercial criteria. Modification of the two general principles of unconventional finance in the way described should lead to an expansion in private health care provision and a closer mix of public/private care.

Contracting out and commercial opportunities

8. As for the two categories of scheme in paragraph 3 - contracting out to the private sector and land development opportunities - there is a growing commercial interest in joining with authorities in such schemes; and contracting out, whether it be geriatric care or elective surgery, is often seen as a very attractive option.

9. So far as contracting out is concerned the present rule of thumb is that the use of private provision (especially surplus capacity) by an authority is an ad hoc way may be disregarded, but that long term contracting out represents substitute

provision and falls for consideration under the unconventional finance rules (best value for money and compensating reductions).

10. As to land development, typically developers are offering, perhaps on a full design and construct contract, to provide a new hospital in advance of the release of high value land occupied by the existing facilities. Clearly however in this context the rules prevent private finance being used simply as a way round cash limits and avoid high financing costs.

11. Such schemes may however represent the only realistic way of achieving higher efficiency and/or an improvement in patient services. One approach to reflect the special needs of the NHS, would be to modify the rules on unconventional finance by allowing access to private finance for these two categories within an agreed limit (say £100m-£200m nationally) within which compensating reductions would not be made, for use only on schemes where the financing costs were at least partially offset by reduced running costs.

Conclusion

12. A major aim of the Review is to encourage private health care provision and to reinforce the income generation initiative. One approach to this would be to give health authorities complete freedom to use private finance for private facilities, and for joint provision. The current rules on unconventional finance inhibit the use of private finance to enhance public provision and they should therefore be modified - whilst preserving essential safeguards. It is therefore proposed that:

* for NHS private provision, joint private/public provision and income generation schemes there should be no compensating reductions in public allocations, and a requirement only to demonstrate good value for money and an appropriate return on the investment.

* for other schemes compensating reductions would be applied only above £100m-£200m a year nationally where financing costs were at least partially offset by a reduction in running costs.

Maria

NO10 have fixed further meetings on the NHS for 9.30 am on 14 Sept - 2.30pm on 4 October.

Shall we fix the briefing meetings, for the day before each one, now before Hayden has a chance to go anywhere? Usual cast?

Julie
21/7.

Yes pl - but Thurlow will be less optional and Lax people more optional ~~the~~ in fact only in the Culpin m

3/0

CHANCELLOR OF THE EXCHEQUER'S OFFICE: MEETING

SUBJECT	NHS BRIEFING
DATE	MONDAY 3 OCTOBER
TIME	4.00 PM
VENUE	Chancellor's Room, Treasury/~~No. 11/Conference Room/House of Commons~~
PAPERS	TO BE CIRCULATED BY No 10.
THOSE ATTENDING	CST Sir P. Middleton Sir T. Burns Mr Anson Mr Phillips Mr Culpin Mr MacAuslon Mr Saunders Miss Peirson Mr Personage Mr D. Griffiths Mr Call cc Miss Wallace

Tony

Please can someone ring everyone on this list & move the meeting to 4.00pm HMT Monday 3 Oct.

No 10 have taken our slot we have no choice

Thanks.

Julie'
20/9.

3/10

CHANCELLOR OF THE EXCHEQUER'S OFFICE: MEETING

SUBJECT	NHS Briefing.
DATE	Monday 3 October.
TIME	2.45 pm.
VENUE	Chancellor's Room, Treasury/~~No.11/Conference Room/House of Commons~~
PAPERS	To be circulated by No10.
THOSE ATTENDING	CST. cc Miss Wallace -or. Sir P Middleton Sir T Burns. Mr Anson Mr Phillips. Mr Culpin Mr Turnbull. Mr Saunders. Miss Pearson Mr Parsonage Mr D Griffiths. Mr Call.

SUBJECT: NHS Briefing. BF 3/10

LOCATION: HMTT.

✓ tick

CAST LIST.	PHONE NO.	4.00pm 3/10 DATE + TIME. pl'ning rehearsal time of Sept. meeting from	IF NO GIVE REASON	~~4.00pm 13 Sept to 5.30pm~~	IF NO GIVE REASON	+ confirm Monday 3 Oct 2.45pm	IF NO GIVE REASON	+ 5 Sept 4.00pm.	IF NO GIVE REASON.
~~PEM~~ CST		✓		✓		✓		✓	
PEM.		✓		✓		✓		✓	
TB	5202	✓		✓		✓		✓	
Anson.	5643	✓		✓		✓		✓	
Phillips	5261.	✓		✓		✓		✓	
Culpin	5264.	✓		✓		✓		✓	
~~Turnbull~~ MacAuslan.	5516.	✓		✓		✓		✓	
Saunders	5033.	✓		✓		✓		✓	
Parsonage	5498	✓		✓		✓		✓	
Call	Back on Friday.	✓		✓		✓		✓	
Pearson'	5031.	✓		✓		✓		✓	
D. Griffiths.	5216.	✓							
↓ Back on Monday									

PAPERS:

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UNCLASSIFIED

1979

BF 13/9.

FROM: MRS JULIE THORPE
DATE: 21 July 1988

PS/CHIEF SECRETARY

cc Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Culpin
Mr Turnbull
Mr Saunders
Mr Parsonage
Miss Peirson
Mr D Griffiths
Mr Call

NHS

No.10 have fixed up two more meetings to discuss the NHS, for Wednesday 14 September, at 9.30am and Tuesday 4 October at 2.30pm.

2. I would like to suggest that we hold the usual Briefing Meetings at 4.00pm on Tuesday 13 September and at 2.45pm on Monday 3 October, both meetings in the Treasury.

3. All copy recipients are invited to attend. If anyone is unable to attend please can they let me know.

CER PK

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

The Rt Hon Kenneth Clarke QC MP
Secretary of State for Health
Alexander Fleming House
Elephant & Castle
LONDON
SE1 6BY

CHIEF SECRETARY	
REC.	- 3 OCT 1988
ACTION	Mr Saunders/Mr Tomlinson
COPIES TO	Cx, Mr Pendlebury, Mr Anson, Mr Phillips, Miss Pearson, Mr Turnbull, Mr Griffiths, Mr Sussex, Miss Wiseman, Mr Call.

with attachments

October 1988

Dear Secretary of State,

For some time the Scottish Home and Health Department has been working on a corporate strategy for the Health Service in Scotland with a view to a publication similar to the strategies already published in Wales and in Northern Ireland. This work was overtaken to an extent by Sir Roy Griffiths' report on community care arrangements and, more importantly, by the review of the NHS. I therefore decided instead to publish a stocktaking review of the Health Service in Scotland which will mark its 40th Anniversary and give particular emphasis to what has been achieved since 1979. It will set out priorities for service development and will briefly sketch the challenges for the future on which the Government's position will be made known following the NHS review and Griffiths, but it will not anticipate the conclusions of either of these.

The booklet will be given wide circulation, free, through Health Boards, to Health Board members and all groups of staff, members of the family practitioner services, local health councils and the public. It will be in colour and fully illustrated and it is designed to have wide popular appeal. I propose to publish the booklet on 5 or 6 October. I think it will be helpful for us also to have our strategy set out for the public in this way before our decisions on the Health Service Review are announced. I enclose the text of the booklet with the associated press release.

I am sending copies of this letter and its enclosures to Peter Walker and Tom King and also, in view of the timing of this publication in relation to the NHS review, to the Prime Minister, to the Chief Secretary to the Treasury, to Sir Robin Butler, to Mr Wilson in Cabinet Office and to Mr Whitehead in the Policy Unit, to keep them similarly informed.

Lynn Shankland
pp **MALCOLM RIFKIND**
(approved by the Secretary of State and signed in his absence).

EML277G5

3.10.5

covering **SECRET**

FROM: R B SAUNDERS

DATE: 3 October 1988

CHANCELLOR

cc Chief Secretary
Mr Phillips
Miss Peirson
Mr Parsonage
Mr Griffiths
Mr Call

NHS REVIEW: MEETING ON 4 OCTOBER

I attach an aide-memoire of the main points made at today's briefing meeting.

R B SAUNDERS

Proposals in para 3(i) go against earlier line that doctors should be more closely involved in management (as in resource management initiative, and also chapter 5 of draft White Paper). Taking professions off FPCs will create just as big a row as merger.

As to other ideas in paper, need to see clear timetable for proposals on controlling GP numbers (para 21), and something more definite on controlling the drugs bill than "I am considering how to make progress in this field" (para 29).

Audit

Good progress. Need now to agree to make Audit Commission responsible, and that officials should try to square the NAO.

Outstanding issues

See Mr Saunders' minute of 30 September, para 16.

Draft White Paper

Go for crisp and well-written, but nonetheless substantial, document.

Bring economic arguments (Chancellor's minutes of 28 June and 6 July) to fore.

Reopen question of fiscal incentives.

Capital (if raised)

To be discussed and agreed first by Chief Secretary and Mr Clarke.

3.10.6

SECRET

NHS REVIEW MEETING 4 OCTOBER 1988: POINTS TO MAKE

Self-governing hospitals

OK to go ahead with pilot experiments. But:

- who decides on behalf of a hospital to go for changed status? (There is no governing body or similar at the moment.)

- what precise manpower flexibilities are in mind?

GP practice budgets

Can see there are modest attractions. But officials need to work up details. For instance:

- what incentives do GPs have to opt out?

- what does happen when budgets run out (para 8)? If budget does not bite on out-patient referrals, what is the point of including them in the system?

- does status of GP (opted-out or opted-in) or of hospital (self-governing or DHA) affect, in theory or in practice, how the patient is dealt with and how long he or she has to wait?

Merging FPCs and DHAs

What are the problems with the workings of the FPS which Mr Clarke seeks to address in paras 3 and 4? What does "more effective management" (para 3) mean?

- If problems are with drugs bill and with prescribing habits, would it not not be better to deal with them by merging and cash-limiting?