PO-CH/NL/0102

PART 5

Part. 5.

SECRET

(Circulate under cover and notify REGISTRY of movement)

Begins: 16/1/89.
Ends: 27/1/89.

PO -CH /NL/0102
PART S

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Directions: 25 Years

14/8/95.

PO -CH /NL/0102
PART S

cst.ps/17ce16.1/lets

COVERING SECRET

000038

Treasury Chambers, Parliament Street, SW1P 3AG

Paul Gray Esq
Private Secretary
10 Downing Street
London
SW1

16 January 1989

Dear Paul

NHS REVIEW: EXPENDITURE IMPLICATIONS

... I attach a joint note by the Chief Secretary and the Secretary of State recording the outcome of their discussions on the expenditure implications of the Review.

One point which remains to be resolved is whether the amount, £43 million, provided in the Survey for expected Review costs in 1989-90 should be spelt out in the paragraph on public expenditure implications in the White Paper. The Secretary of State for Health feels that it should, on the grounds that it is a substanial sum indicating that the Government means business, and it is in any event certain that people will ask how much money has been provided. The Chief Secretary feels that the sum should not be mentioned in the White Paper. He feels that it may be seen as inadequate in relation to expectations raised by the reforms, and that to include the sum in the public expenditure paragraph will sit oddly with the rest of the White Paper which does not include any costings in relation to individual measures. He is content for the £43 million figure to be used in response to questions.

I am copying this to the Private Secretaries to the Chancellor, the Secretaries of State for Health, Scotland, Wales and Northern Ireland, the Minister for Health, Sir Roy Griffiths, and Sir Robin Butler and Ian Whitehead (Policy Unit).

Yours
Cathy

MISS C EVANS
Private Secretary

SECRET

PUBLIC EXPENDITURE IMPLICATIONS OF THE NHS REVIEW

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

At the last meeting of the Ministerial Group we were asked to discuss bilaterally the line to be taken in the White Paper on the public expenditure implications of the NHS Review measures.

2 We have reached agreement on a suitable paragraph on public expenditure for the White Paper. The text we propose is shown in Annex A. We have also agreed the line to take in response to specific questions about the adequacy of provision for the costs of the Review reforms in 1989-90. This is outlined in Annex B.

3 We have agreed that we should handle the position in 1989-90 as follows. The progress in implementing the reforms will determine whether or not any extra costs in that year will exceed the provision made in the Survey for Review measures or associated expenditure. Offsetting factors to be taken into account include the scope for increased efficiency and other savings within the health budget - reflecting, for example, revised priorities; any replacement by Review-related work of other items already provided for; together with any underspending on services which may emerge during the course of the year. If in the light of these factors, a bid on the Reserve is sustained, the Chief Secretary will be prepared to consider it, but on the basis that any essential additional net provision will not be financed at the expense of patient services.

4 The Department of Health's preliminary assessment of the costs of implementing the Review measures is that there will be a rising scale of expenditure up to some £½ billion in gross terms by 1992-93. Some further items of expenditure may be identified and, as yet, there are no estimates of the offsetting savings from the improved efficiency which will result from the reforms. We have agreed that the question of the provision of any additional

resources cannot be addressed until more detailed proposals have been put forward and scrutinised, with a full cost benefit analysis, and the extent of the resulting efficiency savings and the scope for offsetting savings from elsewhere within the health programme have been examined. This will be essential information for the 1989 Survey in the context of which decisions will be reached.

16 January 1989

ANNEX A

DRAFT PARAGRAPH FOR NHS REVIEW WHITE PAPER

Public expenditure

The reforms in this White Paper will enable a higher quality of patient care to be obtained from the resources which the nation is able to devote to the NHS. The provision for spending on health in the coming financial year, 1989-90, announced in the Autumn Statement, included the likely costs of preparing for the reforms and for the legislation which will give effect to them. Any extra costs should over time be offset by the improved efficiency which will stem from them. The total provision for spending on health will take account of the progress made in implementing the reforms - including the increased efficiency savings. Costs in future years will be considered in the annual public expenditure surveys.

cst.ps/16jm16.1

SECRET

ANNEX B

LINE TO TAKE ON PROVISION FOR COSTS OF REVIEW MEASURES IN 1989-90

1. NHS expenditure plans for 1989-90 announced in Autumn Statement anticipated the likely costs of the NHS Review reforms. [Figure of £43 million can be used if pressed.]

2. Impossible to foresee precise costs, which will depend on speed of implementation. Total level of spending will take account of progress made in implementing the reforms, including resulting savings from improved efficiency.

[If pressed]

3. If - which we do not expect at this stage - actual costs in 1989-90 turn out to be greater than anticipated, the necessary funding will be made available without detriment to patient services.

16.1.89.2

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 16 January 1989

CHANCELLOR

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

NHS REFORM WHITE PAPER

Following your meeting this morning, I attach a revised list of the main drafting points. I will send the minor ones to Department of Health at official level. I have sent a copy of this list to Mr Wilson (Cabinet Office), saying that, while it is based on discussion with you, you have not had a chance yet to see the detailed drafting.

Ch/ These amendments marked up in manuscript on your copy.

DIS

R B SAUNDERS

Ch

Also note agreed paper by CST & Clarke on PX costs, below.

16.1.89.1

CONFIDENTIAL

NHS REFORM WHITE PAPER - SIGNIFICANT DRAFTING POINTS

Para 1.2 - final sentence to read "The health service will continue to be mostly free at the point of delivery ...".

Para 1.7 - second indent, replace second sentence by:

> "This will enable them, while remaining in the NHS, to take fuller responsibility for their own affairs, harnessing the skills and enthusiasm of their staff."

Add at end:

> "Within annual financing limits, they will be free to borrow money. And they will be able to set the rates of pay of their own staff."

New "key change", to follow practice budgets, as follows:

> "Fifth, steps will be taken to improve value for money. The Audit Commission will assume responsibility for auditing the accounts of health authorities and other NHS bodies, and will undertake wide-ranging value for money studies. Complementary to this, arrangements for medical audit will be extended throughout the health service, thus helping to ensure that the best quality of clinical care is given to patients."

Another "key change", covering health authority membership, and related organisational issues, might come at the end, as follows:

> "Seventh, health authorities will be streamlined, with functions delegated from regions to districts and from districts to hospitals where appropriate. Their membership will be reduced to make them more management-oriented bodies. Local authorities will no longer have the right to appoint members. Family practitioner committees will in future report through regional health authorities to the NHS Management Board."

CONFIDENTIAL

Para 1.10 - first sentence, delete "To achieve this" at the beginning of the first sentence, and substitute "believes" for "intends".

Para 1.11 - delete second sentence, and start third sentence "These improvements will bring greater appreciation ...". [Alternatively, delete altogether the third sentence which is pretty platitudinous.]

Para 1.12 - the heading should read "An efficient health service".

Para 1.13 - fifth sentence to read "The Government believes that most decisions are better taken at local level."

Para 1.16 - final sentence, delete "who have to face much higher premiums"; add "income" before "tax relief"; delete "those" substitute "private medical insurance".

Para 2.23 - first sentence to conclude "... income and large capital sums from property which is surplus to requirements". Third sentence to read "In order to assist them in this, the NHS ... a central group of professionals ...".

Para 3.15 - first sentence to read:

> "Hospital trusts will be subject to annual financing limits, within which they will be free to borrow, either from the Government or from the private sector."

Para 5.22 - this is the subject of Mr Clarke's letter of 13 January. We do not object to the inclusion of a target increase in number of posts, so long as the timing is realistic, but we do not want any costs included at this stage. So delete "at a cost of [£50m] including all support costs".

CONFIDENTIAL

Para 6.13 - final two sentences to read:

"The Government intends that they should be free to spend up to 50% of any such savings on improving their practices and offering better services to their patients. The balance of any savings would be surrendered to the RHA. In auditing the accounts of practice budgets, the Audit Commission will certify that any underspends have been applied only to such purposes."

Para 7.21 - replace with two new paragraphs as follows:

"7.21. It is the Government's responsibility to ensure that there is adequate access to primary care services across the country, and that opportunities exist for good doctors to enter general practice. But the Government also has a responsibility to the taxpayer to ensure that the total cost of the service does not rise beyond acceptable bounds. The present system by which fees and allowances are set so as to deliver a target average net income for GPs, irrespective of changes in the average numbers of patients on their lists, is a matter for concern.

7.22. The Government proposes therefore to take two further steps to enable it better to control the total cost of the service while ensuring that sufficient opportunities remain in general practice for the best young doctors. First, it will seek reserve powers ... Health and Medicines Act 1988. [as in present draft]"

Para 7.23 - second indent, add at end "serving in a personal rather than a representative capacity".

Para 9.11 - delete "without capital funding from the health authority" in the second sentence. (This is incorrect in relation to Bromley, and unnecessarily restrictive more generally - even if privately financed schemes are to go ahead, the possibility of joint funding with the health authority should not be ruled out.) Delete the following sentence, since the reference to "bridging finance" is obscure. Final sentence to begin "The objective would be a hospital ...".

16/1 PWP

CHANCELLOR OF THE EXCHEQUER'S OFFICE: MEETING

SUBJECT	NHS Review Briefing Meeting
DATE	Monday 16th January
TIME	12.00 am
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 H. Phillips Mr Anson Mr Saunders Mr MacAuslan Mr Culpin [redacted] Mr Parsonage Mr Call

cc. Miss Wallace
Mr Griffiths.

SUBJECT : NHS Review Briefing Meeting 1hr.

LOCATION : HMT.

CAST LIST.	PHONE NO.	DATE + TIME. 12.00 16/1. ✓	IF NO GIVE REASON	✓	IF NO GIVE REASON	✓	IF NO GIVE REASON	✓	IF NO GIVE REASON
CST.		✓							
PEM		✓	With Brig Back						
TB	5201 ~~XXXXXX~~	✓							
Phillips	4390	✓							
Anson	4370	✓							
Saunders	4800	✓							
MacAuslan	4780	✓							
Cullpin	4419.	✓							
Griffiths.	5216	X	IN HOSPITAL.						
Parsonage	4740	✓							
Call.	5106	✓							

PAPERS :

CONFIDENTIAL

2 MARSHAM STREET
LONDON SW1P 3EB
01-276 3000

My ref:

Your ref:

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

CHIEF SECRETARY	
REC.	17 JAN 1989
ACTION	Miss Peirson
COPIES TO	Cx, Sir P Middleton, Mr Anson, Sir T Burns, Mr Phillips, Mr Beastall, Mr Potter, Mr Saunders, Mr Call

16 January 1989

Dear Ken

AUDIT OF THE HEALTH SERVICE

As agreed, I went to the Audit Commission on 12 January to tell them in confidence about the new role you are planning for them in the audit of the Health Service. You may like to have the attached copy of what I said to them.

Without exception all the members present welcomed this new challenge and saw great positive potential in the task, though none of them are under any illusions about the complexities of getting into the health area both at the technical and at the political level. I was very heartened by their attitude and by the fact that several of the members clearly already know a good deal about the Health Service and will "hit the floor running".

Once you have published your White Paper it will be entirely for you and your Department to take matters forward with the Commission. I made it clear to the Commission that I should not expect to be involved with them at all in Health Service matters and the work they do for you, apart from my small involvement in carrying through the paving provision in the Local Government and Housing Bill this session. I think they would very much welcome it therefore if you were able to meet them all at an early meeting to start up the dialogue about how they will operate in Health Service matters.

There will no doubt be one or two matters on which we shall need to consult one another from time to time such as appointments, the top management structure, and the constitutional position and independence of the Commission. Our officials are already in touch about these, and will no doubt ensure that the appropriate degree of liaison on these matters is maintained.

I am copying this letter to Peter Walker, John Major, John Wakeham and Sir Robin Butler.

Yours ever

NICHOLAS RIDLEY

GOVERNMENT PROPOSALS TO EXTEND THE ROLE OF THE AUDIT COMMISSION TO THE NHS : SPEAKING NOTES

When I came to your last meeting in December I said how important I felt it to be that you had established such a widespread reputation for independence both of local government and of Ministers. Yet I am here again today. I do apologise. I assure you I have no wish to compromise your reputation. The Chairman invited me to come in order to clarify matters in view of the recent press speculation there has been concerning the Government's proposals for audit of the National Health Service.

As you may know my colleagues have been conducting a wide ranging review of the operation of the National Health Service and the Secretary of State for Health will be announcing the conclusions of that review shortly. One conclusion of the review is that there is a need to strengthen the audit of Health Authorities and to give increased emphasis to value for money in the Health Service. You are aware that we have been very impressed by the Commission's excellent work on audit and value for money work for local government over the last six years. We have therefore decided to ask the Commission to extend their role and to assume statutory responsibility for the audit of the National Health Service in England and Wales. This is at present an internal function of the Department of Health and the Welsh Office. To give some idea of the scale of this, NHS audit is currently 35-40 per cent in expenditure terms of local government audit but with increased emphasis on value for money this might rise to 50 per cent or more.

There are clearly someareas of overlap between local government and the Health Service but this will essentially be a new and greater challenge for you and for the Commission's top management. I recognise that this will impose a greater burden upon all of you but I very much hope that you will feel able to accept the increased commitment which this implies.

The change we are proposing is a major one and the details will take time to work out in consultation between yourselves, Department of Health, the Welsh Office and others. It would be our intention to enact the proposals in a Health Bill in the next session of Parliament so that they would not come fully into operation until the late summer or autumn of 1990. In the meanwhile, in order to prepare the ground for this transfer and to enable the Commission to make an early start in the health field, particularly in the training of staff and on value for money studies , I am proposing to include a preliminary provision in the Local Government and Housing Bill which I shall be publishing shortly. This will enable the Commission to undertake some preliminary work in the health field under contract to the Secretaries of State for Health and for Wales.

When we come to the full proposals it would be our intention to make some increase in the size of the Commission so that we might appoint some additional members with Health Service experience and so as to limit the additional commitment upon you. I have had some informal discussions with your Chairman and Controller and I know they have some preliminary ideas on how the Commission's business might be managed which build on the panel structure which you have evolved to meet the varied demands of local government work.

As to staff, there will be a cadre of staff from the NHS audit service, most of whom, will have to be assimilated into the Commission. It will be for you to decide how this existing experience will need to be supplemented with new staff, upgraded training and more contracting out. You will also clearly want to look again at your own top management structure.

DRAFT 17 JANUARY 1989

The Government is proposing 7 key measures to achieve these objectives. They are:

First: to maximise the NHS's ability to respond to the needs of patients as much power and responsibility will be delegated to local level. These include the delegation of functions from regions to districts and from districts to hospitals. The detailed proposals are set out in the next chapter. They include power to settle the details of pay and conditions of staff and financial incentives to make the best use of their assets.

Second: to stimulate a better service to the patient, major hospitals will be able to apply for a new self-governing status as NHS Hospital Trusts. This means that, while remaining within the NHS, they will be free to offer their services to other parts of the NHS and to the private sector. They will have an incentive to attract patients so they will make sure that the service they offer is what their patients want. And in turn they will stimulate other NHS hospitals to respond to local requirements. NHS Hospital Trusts will also be able to set the rates of pay for their own staff and, within annual financing limits, to borrow money to help them respond to patient demand.

Third: to enable hospitals which best meet the needs and wishes of patients to benefit financially from doing so. The old barriers to money required to treat a patient crossing administrative area boundaries will be scrapped. All NHS hospitals, whether run by health authorities or self-governing, will be free to offer their services to different health authorities or to the private sector. Consequently, a health authority will be able to discharge its duty to use its available funds to secure a comprehensive service, including emergency services, by obtaining the best service it can whether from its own hospitals, another authority's hospitals, from self-governing hospitals or from the private sector.

Fourth: to reduce waiting times, help give individual patients appointment times they can rely on and cut the long hours worked by some junior doctors, X new consultant posts will be created over the next Y years. These new posts will be over and above the Z already being created under the Government's "Achieving a Balance" initiative in July 1986.

Fifth: to help the family doctor (or general practitioner, (GP)) improve his service to patients initially large GP practices will be able to secure their own budgets to buy a defined range of services direct from hospitals. Again, in the interests of a better service to the patient, GPs will be encouraged to compete for patients by offering better services. And patients will be totally free to choose (and change) their own GP as they wish.

Sixth: to streamline and sharpen up the efficiency and accountability of NHS management regional, district, hospital and general practitioner management bodies will be ~~sharply~~ reduced in size and reformed on business lines, with executive and non executive directors. The Government believes that in the interests of patients and staff the era in which the £24billion NHS has been run by neither truly representative nor proper management bodies must be ended. The confusion of roles will be replaced by a clear remit and accountability.

Seventh: to ensure that all concerned with delivering services to the patient have the basic information to assess and improve their performance a system of auditing and monitoring the use of resources is to be steadily applied throughout the NHS. To secure self-governing status a hospital will for example have to have a medical audit in place. Similarly, as with the hospital service, the Government intends to work with the medical profession to establish a system of medical audit in general practice.

The Government will publish in the near future X technical papers elaborating in detail on how these key proposals are to be implemented.

SECRET

We need to deal with this important presentational point if we are to give the document the fairest wind. I believe we can do so fairly readily if we:

i) recognise this is an action document, take credit for it and reflect this in the presentational approach;

ii) pay particular attention to Chapters 1 and 13;

iii) and pay especially close attention to Paras 1.4-1.6 in Chapter 1 and the title and introduction to Chapter 13.

The key passage which will set the tone is Paras 1.4-1.6 under the heading "The Need for Change". I suggest this passage should be re-written to present the outcome of the review - an action programme - as a logical consequence of the Government's experience over the last 10 years. The Government needs to demonstrate that it has not conjured this White Paper out of thin air but that its programme is deeply rooted in its long experience of trying to improve health care for the British people over a decade. As we discussed, it can also legitimately call in aid the views and opinions of a wide variety of organisations and people who have written to Departments.

Consequently I suggest Paras 1.4-1.6 should follow this construction:

"Throughout the 1980s the Government has thus presided over a massive expansion of the NHS. It has ensured that the quality of care provided and the response to emergencies remain among the best in the world.

"But increasingly the country as well as the Government have recognised that more needs to be done because of rising demand and an ever-widening range of treatments resulting from advances in medical technology. It has increasingly been recognised that the injection of more and more money per se is not the answer.

"It is clear that the organisation of the NHS - the way it delivers health care to the individual patient - also needs to be reformed.

"The Government has been tackling these organisational problems. It has taken a series of measures to improve the way the NHS is managed. The main one was the introduction of general management in 198-. This has been particularly successful and has also demonstrated the way ahead.

SECRET

"The new management information systems have provided clear evidence of a wide variation in performance up and down the country. [Take in rest of Para 1.5]

"The Government wants to raise the performance of all hospitals and GP practices to that of the best and the main question which this review has addressed is how to achieve that.

"It is convinced that this can be done only by two related measures:

i) devolving responsibility down the Service as close as possible to the delivery of health care to the patient - predominantly to the GP and the local hospital; and

ii) developing clear accountability for the use of the resources involved in dealing with patients.

[Take in rest of Para 1.6, omitting last sentence]

"This White Paper presents a programme of action, summarised in Para 13, to secure two objectives:-

i) to give patients wherever they live in the UK, better health care and greater choice of the services available; and

ii) greater satisfaction and rewards of those working in the NHS who successfully respond to the opportunity to meet local needs and performances."

So far as Chapter 13 is concerned I do not like the heading "The new NHS takes shape". Surely we should describe this Chapter as "The action programme". We also need to introduce it properly rather than go bald into the commitment to early legislation..

cst.ps/1ce18.1/mins

pwp

FROM: MISS C EVANS
DATE: 17 January 1989

MR SAUNDERS

pwp

cc: PS/Chancellor
Miss Peirson
Mr H Phillips

NHS REVIEW

The Chief Secretary has reported that during the extended meeting today it was not possible to make the Treasury points on paragraphs:

2.23
2.28
3.15
7.21
7.22

of the White Paper. He would like to write to Mr Clakre tomorrow making these points, and would appreciate a draft.

2. Following my conversation with Mr Phillips, I reported to the Chief Secretary that you have been scrutinising the technical papers which DH propose to issue giving more details of the Review proposals. The Chief Secretary would be grateful to see these in draft, with advice on how it is proposed to handle them.

PS/CST TO SAUNDERS 17/1

MISS C EVANS

Private Secretary

0559A

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

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

CONFIDENTIAL

CH/EXCHEQUER
REC. 18 JAN1989
ACTION MR SAUNDERS
COPIES TO CST
SIR P MIDDLETON
SIR T BURNS
MR ANSON, MR PHILLIPS
MR CULPIN, MRS LOMAX
MR KELLY, MISS PEIRSON
MR PARSONAGE, MR GRIFFITHS
MR CALL.

PWP

Paul Gray Esq
No 10 Downing Street
LONDON SW1

18 January 1989

Dear Paul

NHS REVIEW: DATE OF PUBLICATION OF WHITE PAPER

The Ministerial Group have been aiming towards publishing the White paper on 31 January and the Department has been making preparations to launch the White Paper on that day. These include a very substantial exercise to communicate the content of the White Paper as soon as possible to about 2,000 NHS chairmen, managers and clinicians who will be important opinion formers within the service. The plans include a teleconference on the day and roadshows led by Ministers over the following three days. We have now reached the stage where if the White Paper is to be published on 31 January we need to send invitations this week to those attending the teleconference and roadshows. My Secretary of State would also like to tell Parliament, via letters to the Chairman of the Social Services Committee and Robin Cook, of the expected date in advance of it becoming widely known throughout the service.

Once the letters and invitations have been sent it will be extremely difficult to alter the date but we must advise people sufficiently in advance if the launch is to be a success.

I would be grateful for clearance to issue the letters and invitations for publication on 31 January. The Lord President is content with the Parliamentary arrangements.

I am sending a copy of this letter to Alison Smith (Lord President's Office) to the Private Secretaries of members of the Ministerial Group and to Richard Wilson.

Yours

Andy

A J McKEON
Principal Private Secretary

KH/0694t

18/1/95.

CH/EXCHEQUER	
REC.	19 JAN 1989
ACTION	MR SAUNDERS
COPIES TO	CST SIR P MIDDLETON SIR T BURNS, MR ANSON MR PHILLIPS, MR CULPIN MRS LOMAX, MR KELLY, MISS PEIRSON, MR PARSONAGE MR GRIFFITHS MR CALL.

✓ 19/1

SECRET

PRIME MINISTER

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

We have now revised the paragraphs of the draft White Paper that deal with the central management of the NHS in the light of yesterday's discussion. I attach the new version.

2. You said yesterday, and I entirely agree, that while the text of the White Paper does not need to go into detail, we ourselves must be clear about the details before the White Paper is published and the issues are debated publicly. This is the object of my minute.

3. We did not resolve yesterday whether we should have a Management Board or Committee. For convenience, I use the term "Board" in this minute. I still prefer it because to my mind "Board" underlines the importance we attach to its role. A change to "Committee" would mistakenly be taken to signal a reduction in its functions and status.

4. There are four main points to settle:

first, the relationship of the Secretary of State and the Policy Board to the Chief Executive and the Management Board.

second, the constitutional position of the Management Board and its relationship to the Department.

third, the relationship between the Management Board and Regional Health Authorities.

fourth, accountability to Parliament.

5. On the first point, we are agreed that the Secretary of State is responsible for strategy and policy on the NHS and, as part of the exercise of this responsibility, will chair the Policy Board. The Policy Board's remit will be to determine the strategy, objectives and finances of the NHS and to set objectives for the Management Board and monitor whether they are satisfactorily achieved.

6. All operational and managerial issues will be the responsibility of the Chief Executive and the Management Board which he will chair. The Management Board will be accountable to the Policy Board for the delivery of the objectives set by the Policy Board. This is an important and new separation of their respective responsibilities.

7. On the second point, the Management Board will have a separate line of accountability from that of the Department, clearly marked by the fact that the Chief Executive will report directly to the Secretary of State on all operational and management matters. The Chief Executive will also be accounting officer for all expenditure on the hospital and community health services.

8. For administrative purposes the Management Board will be located within the Department of Health. I fully accept that the work of the Management Board will be separate from the work of officials whose responsibility is to advise me.

9. It will take time and require careful political handling to establish the Management Board with the separate and accepted identity of its own that I certainly intend it to have. To take a particularly difficult but very important example, it is a long standing practice for the British Medical Association to have direct access to the Secretary of State. I have long felt that it is a nonsense that the employment and management of doctors has become part of the political process, and not simply part of the management of the Service. The BMA feel equally strongly that this is a part of the understanding on which the NHS rests. We need to move to a position where they accept it is normal practice to meet and deal with the Chief Executive on operational matters such as the management of consultants' contracts. I intend to move towards that as quickly as possible.

10. On the third point, I will continue to maintain contact with and to consult Regional Chairmen, who are appointed by the Secretary of State and regard themselves as charged with the delivery of Government policy in their Regions. In future, however, the General Managers of the Regional Health Authorities will be accountable to the Chief Executive who will set objectives for them.

11. The overall effect of these changes will be to introduce for the first time a clear and effective chain of command running from Districts through Regions to the Chief Executive and from there to the Secretary of State.

12. On the fourth point, the normal Accounting Officer rules will apply to the Chief Executive. I shall expect him to take a prominent role in dealing with Select Committees and the like.

13. So far as Ministerial responsibility to Parliament is concerned, we shall follow the line set out in para 2.4 of the draft White Paper. This will require us all to take a robust stance. Realistically we must expect considerable pressure from backbenchers on both sides for Health Ministers to continue to answer on any operational issues which are in the public eye or which are seen as major constituency concerns. This will be so whether or not such issues have been delegated to the Management Board. It is very important that we maintain a common line on this in Scotland, Wales and Northern Ireland.

14. I intend to operate the Department on the basis that I have set out in this minute. It is an important part of the way in which I expect to see our reforms implemented. I trust that the form of words attached for the White Paper backed up by this minute clearly express our new approach.

15. I am copying this to the Chancellor of the Exchequer, the Secretaries of State for Wales, Scotland and Northern Ireland, the Chief Secretary, the Minister for Health, Sir Robin Butler, Mr Brian Griffiths and Mr Richard Wilson.

AJM

18/1 K C

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

DELEGATING RESPONSIBILITY

Central Management of the NHS

2.4 The NHS will continue to be funded by the Government mainly from tax revenues. Ministers must be accountable to Parliament and to the public for the spending of these huge sums of money. But Ministers cannot, and in future will not, be directly involved in the decisions taken locally by operational units. On the contrary, the oversight of those decisions ought to be the responsibility of the Chief Executive of the NHS Management Board. Ministers must however remain responsible for policy and strategy.

2.5 The central management of the NHS must reflect this division of responsibilities. The Government proposes that responsibility for strategy will be for a Policy Board chaired by the Secretary of State for Health. Responsibility for all operational matters will be for a Management Board chaired by a Chief Executive. The Management Board will be accountable to the Policy Board for the management of the NHS within the strategy and objectives set by the Policy Board.

2.6 The specific proposals are:

* a new Policy Board, chaired and appointed by the Secreatary of State, will consider all strategic issues for the NHS in the light of Government policy. It will replace the former Health Service Supervisory Board and will include non-executive members drawn from inside and outside the NHS;

* the Management Board will be chaired by the Chief Executive and appointed by the Secretary of State in consultation with the Chief Executive. It will deal with all operational matters within the strategy and objectives set by the Policy Board;

* responsibility for the management of family practitioner services will be brought under the Management Board. The better integration of primary care and hospital services is an important objective.

2.7 The overall effect of these changes will be to introduce for the first time a clear and effective chain of management command running from Districts through Regions to the Chief Executive and from there to the Secretary of State.

The role of regions

2.8 The Management Board could not directly exercise effective authority over the current 190 District Health Authorities (DHAs) which have a total expenditure of nearly £14 billion (nearly £19 billion with family practitioner services). Regional Health Authorities (RHAs) will therefore continue to ensure that Government policies are properly carried out within their regions. To be effective they will need to concentrate their efforts on their essential tasks. These include monitoring the performance of the health service, evaluating its effectiveness and keeping the state of health of the people of the region under review. They will have a key role to play in managing the wider programme of changes that are set out in the White Paper.

2.9 In addition, RHAs have traditionally provided a range of operational and management services. These include distribution centres, ambulance and blood transfusion services which could not be provided economically in every District. They also include legal, information and management services to Districts themselves. Following the introduction of general management and the re-organisation of regional headquarters, many RHAs have reviewed the provision of these services. As a result, some services have already been

streamlined, delegated to Districts or contracted out to the private sector.

2.10 There remains, however, a wide variation in the size of each Region's operations. The Government believes that there is still considerable scope for reductions in the number of staff directly employed by RHAs on these operations. The Management Board will therefore review the provision of all regionally managed services. It will only approve the retention of services at the regional level if it is cost-effective to do so. As part of this exercise, Districts will be asked whether they can provide more of these services themselves or purchase them from the private sector.

The role of districts and hospitals

2.11 The Government also believes that there is further scope for delegating decision-making from DHAs to hospitals and their associated management units. Many large hospitals already have a significant degree of self-determination. RHAs should now satisfy themselves that, whenever possible, all DHAs delegate operational functions to their hospitals, taking account of the availability of staff in key disciplines and the need to ensure that, overall, the management of services remains cost-effective.

2.12 The Government's objective is to create an organisation in which those who are actually providing the services are also responsible for day-to-day decisions about operational matters. Like RHAs, DHAs can then concentrate on ensuring that the health needs of the population for which they are responsible are met; that there are effective services for the prevention and control of diseases and the promotion of health; that their population has access to a comprehensive range of high quality, value for money services; and on setting targets for and monitoring the performance of those

management units for which they continue to have responsibility.

Ch

PWP

You were going to raise this.

19/1/88.

PAC: **FORTY-SIXTH REPORT: MANAGEMENT OF THE FAMILY PRACTITIONER SERVICES (FPS)**

Line to take: agree. MWard.

X Called for planning of the FPS to be integrated with that of the hospital and community health services. A unified management structure with the health authorities should also be considered. Noted the lack of an information strategy for FPS and inadequate use of performance indicators. Essential for Family Practitioner Committees (FPCs) to monitor the use of GPs' deputising services, provide appropriate health care for the homeless and rootless, and target expenditure on GPs' premises which are below standard.

REPLY

DH has issued guidance to FPCs to strengthen planning and accountability. The Corporate Management Programme for the NHS in Wales points to full integration of the FPCs in planning. DH will devise an information strategy for the FPS this year. DH and WO will consider action for homeless and rootless people in the light of two pilot schemes in London, and will require FPCs to target money on practice premises where the need is greatest.

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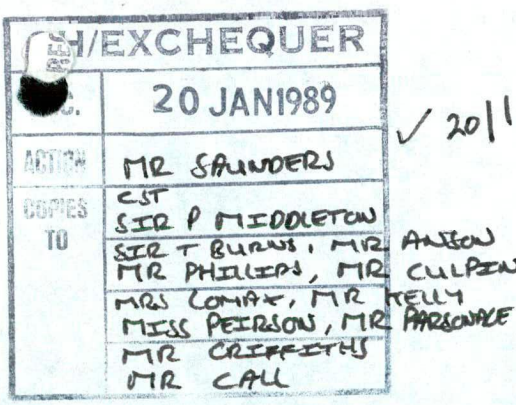

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

19 January 1989

Dear Andy,

NHS REVIEW: DATE OF PUBLICATION OF WHITE PAPER

Thank you for your letter of 18 November which the Prime Minister has seen. She is content for the arrangments you describe to be put in hand for the publication of the White Paper on 31 January.

I am sending a copy of this paper to Alison Smith (Lord President's Office), to the Private Secretaries of members of the Ministerial Group and to Richard Wilson (Cabinet Office).

Yours,
Paul

(PAUL GRAY)

Andy McKeon, Esq.,
Department of Health.

CONFIDENTIAL

SECRETARY OF STATE FOR SCOTLAND

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

CH/EXCHEQUER

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ACTION	MR SAUNDERS ✓ 1911
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SECRET

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

19 January 1989

Dear John,

NHS REVIEW

As I mentioned at our discussion on 17 January I have decided that I want to make a firm announcement of my intention to appoint a Chief Executive of the NHS for Scotland. For that purpose I want to amend paragraph 17 in Chapter 10 to read:

> "The responsibility for health service policy will continue to rest with the Scottish Home and Health Department, reporting to the Minister for Education and Health and the Secretary of State. However, it is desirable that the management of the Health Service should be strengthened and the Government has decided to appoint a Chief Executive for the NHS in Scotland. The Chief Executive will be responsible for the efficiency and performance of the Health Service and for the overall supervision of the execution of policy. He will have responsibility for the establishment of appropriate and adequate information and data systems required to ensure the effective delivery of patient services."

This would be a new post for which the appropriate nominal level would appear to be Grade 3 and I would propose to retain the existing two Health Grade 3 posts, at least for the period of active implementation of our proposals, and to review the situation in 1990.

I hope you are content with this wording and the proposal. My people will write to yours about the details.

I am copying this letter to the Prime Minister, Nigel Lawson, Peter Walker, Tom King, David Mellor, Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No 10 Policy Unit and to Sir Robin Butler and Mr Wilson in the Cabinet Office.

Yours ever,
Malcolm

MALCOLM RIFKIND

RIFKIND TO CST 19JAN

HMP018M5.016

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FROM THE PRIVATE SECRETARY
TO THE SECRETARY OF STATE
FOR WALES

COVERING CONFIDENTIAL

19 January 1989

Dear Paul,

NHS WHITE PAPER: WELSH CHAPTER

My Secretary of State has asked me to circulate the attached further draft of the Welsh Chapter which has been revised in the light of discussion at Tuesday's meeting.

As you know, my Secretary of State will unfortunately be unable to attend the E (EA) next Tuesday because of long-standing engagements in Wales. If there are comments on the Welsh Chapter, I would therefore be grateful to receive them by the end of this week, if at all possible, so that they can be considered here before the E(EA) meeting.

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

Yours sincerely,
Stephen

S R WILLIAMS

Paul Grey Esq
Private Secretary
10 Downing Street
LONDON
SW1

CONFIDENTIAL

3RD DRAFT 18.1.89

DRAFT OF WELSH CHAPTER OF NHS REVIEW WHITE PAPER

1. The people of Wales will benefit fully from the improvements which will flow from the Review, and which will make the NHS more responsive to the needs of patients. There are distinctive health care needs and circumstances in Wales. This Chapter describes these and the distinctive programme of action for the Principality.

2. These improvements will build on the remarkable record of achievement of the NHS in Wales over the last decade. NHS expenditure per household in Wales each year has risen from £568 in 1978/79 to the record level of £1,854 planned for 1989/90, a rise of over 44% in real terms. This has made possible the highest ever number of front line staff. By 1987 there were 327 more hospital, medical and dental staff than in 1979 - an increase of nearly 18% - and 4,733 more nursing and midwifery staff - a real increase of 13% (ie after allowing for the reduction in the standard working hours for nurses). Over £600million (at 1988/89 prices) has been spent since 1978/79 on new and improved hospitals and other health service facilities. Most important of all, record numbers of patients are receiving the treatment they need: comparing 1987 with 1979, over 99,000 more in-patients were treated (up over 28%); over 88,000 more new out-patients (up over 20%); and over 45,000 more day cases (up nearly 150%). Additional and recurrent Welsh Office investment (£13.75million in 1988/89) has made possible an unprecedented expansion of community services for those with mental handicaps, at the same time as improvements in the hospitals. Mental illness services are receiving similar recurrent additional investment (over £10million in 1988/89).

3. There is no regional health authority in Wales. Some of the functions of the regional health authorities in England - such as the holding of medical consultants' contracts - are the responsibility of district health authorities in the Principality. Others are carried out on authorities' behalf by the Welsh Health Common Services Authority (WHCSA), and there is the special remit of the Health Promotion Authority for Wales, which works in co-operation with the DHAs and other interests, to prevent ill health and promote better health.

4. Other regional functions, such as determining the capacity, location and funding of regional services (such as renal dialysis) resource allocation, regional manpower planning, and strategic investment in information systems and technologies are the direct responsibility of the NHS Directorate in the Welsh Office. The NHS in Wales works under the strategic direction of the Health Policy Board, which is chaired by the Secretary of State. An Executive Committee of the Board is led by the Director of the NHS in Wales and is responsible for carrying into

effect the decisions of the Board. The Director is also the Chairman of WHCSA. These arrangements, which were introduced following the NHS management inquiry of 1983, have proved their worth and will continue. They will be focused to ensure the delivery of the programme of action described in this chapter.

PUTTING THE PATIENT FIRST: THE PROGRAMME FOR ACTION

Increased autonomy for hospitals

5. The introduction of general management at all levels of the NHS in Wales has already brought a significantly improved focus on quality of care and cost effectiveness. Unit general managers have been appointed to run hospital and community services at local level and given clear responsibility, working in co-operation with medical, nursing and professional staffs, for budgets and results. Wales is in the vanguard of the UK-wide drive to introduce the information systems and technologies which are needed to show what individual medical treatments cost.

6. The managerial autonomy of hospitals will be further enhanced and hospital management and clinical staff will be given direct responsibility for the services they provide. They will move as quickly as possible to a position where they are, in effect, contracted to provide a given level, range and quality of service.

7. It will be possible by the early 1990s for a major acute hospital that so desires to become self-governing, provided that it shows clearly that it will have the capacity to provide efficiently and effectively an adequate range and depth of services to the population it serves. The Secretary of State will determine that range and depth of services. During the 1990s a wider range of Welsh hospitals might be regarded as potential candidates for self-government providing the Secretary of State is satisfied that they can carry out the functions required of them.

Widening the choice of health care

8. These changes in the management of hospitals will take place against a general background of widening choice of health care.

9. Private sector hospital care is relatively poorly developed in Wales, with just 215 in-patient beds. And there are just 54 pay beds in NHS hospitals. These facilities will need to expand to increase patient choice.

10. Health authorities in Wales have begun to purchase private sector care where this represents the best deal for patients. These initiatives will be built on to lead a sustained drive to reduce waiting times. Special consideration will be given to the establishment of treatment centres to ensure the rapid turn-round

of cases, with direct referrals by GPs for key disabling conditions where waiting times are too long, such as hip and knee replacements, cataracts, varicose veins and hernias.

11. The drive to widen choice in health care for the benefit of patients will be supported and encouraged by changes in the way in which resources are allocated. Money must move with the patient so that hospitals which are efficient and effective, and attract more work, get the resources they need. Detailed proposals will be the subject of consultation.

Assuring quality of care

12. The Welsh Office will work jointly with the other UK Health Departments and the professions to introduce as rapidly as possible a comprehensive system of medical audit. There will be close working with the professions and the representative bodies in Wales to build on the work which has already been done. The NHS in Wales will embark upon a programme to improve the quality of acute care and other services, commencing with proposals in 1989 for better ways to inform patients about services and to take account of patients' views in the development of services.

Additional Consultants

13. Between 1982 and 1987 there was an increase of 121, or 18.5%, in the whole-time equivalent number of medical consultants in Wales. Proposals for additional permanent posts will be announced shortly.

Closer involvement of doctors in management

14. Wales is well advanced in developing the role of clinicians in management, in particular through the pilot resource management project and the development of costings for individual treatments. This work will be accelerated, so that information systems to enable doctors to work with general managers and ensure the most cost-effective use of resources are in place throughout Wales by 1992.

Developing the role of the GP

15. The NHS in Wales has taken the lead in encouraging the closer involvement of GPs in the planning and development of hospital services, through an experiment under which the decisions of GPs about where patients receive hospital treatment will be reflected in the DHA's planning and budgeting. The experience gained will be used to develop the role of GPs in service planning across Wales.

16. There is already a sustained drive to equip GPs with the management systems and technologies they need to make effective

referrals to hospital services. The central elements are information about waiting lists, waiting times and the costs of treatment. This programme will be accelerated so that by 1992 all GPs in Wales will have up-to-date information on which to base their decisions.

17. As these initiatives take effect, and as GPs are able to demonstrate their management capacity in these new ways, the programme to enable GPs to hold budgets for their expenditure, and those of key areas of hospital services, will be extended to Wales. At first, practices with lists of at least 11,000 will be eligible to apply to hold budgets; this represents about 30 practices in Wales. Details of the scheme will be set out in the detailed document which the Secretary of State will publish following the Review. Subject to suitable arrangements being worked out with the appropriate health authorities, the Government would like to see a number of GP budgets in operation by the early 1990s.

Promoting better health

18. There is far too much avoidable illness and premature death in Wales. Levels of coronary heart disease, strokes and most forms of cancer are significantly higher in Wales than on average in the United Kingdom. A sustained drive to tackle these problems is central to the future of a prosperous Wales. The Secretary of State has set up the Health Promotion Authority for Wales to lead this drive, building on the success of Heartbeat Wales. Detailed proposals for action will be published later this year.

The health authorities

19. Health authority memberships will be reconstructed with the creation of new style boards on which the non-executive members, including the Chairman, will be appointed by the Secretary of State. There will be a strong emphasis in these appointments on leadership and top level management qualities. The Secretary of State will continue to appoint at least one member to each authority in Wales from the University of Wales College of Medicine. The executive directors of the board will include the district general manager and the medical, nursing and finance directors. The non-executive directors will form a majority.

20. The new boards will sharpen the focus on the delivery of cost effective services and the quality of care, through the development of the DHAs' role as enablers and purchasers of services, rather than simply as direct providers.

The Family Practitioner Committees

21. The Family Practitioner Committees have major leadership and management tasks, which are taken further by the proposals in this Review. They too will therefore have newly structured memberships, along the lines set out in Chapter 7. Each FPC in Wales will have a Chief Executive, selected by the Committee following open competition, who will be a member of the Committee.

The consumer voice

22. There are 22 community health councils (CHCs) in Wales. Their memberships come from the voluntary sector, the local authorities, and by direct appointment by the Secretary of State. In the light of the new style boards of DHAs, there is a strong case for there being one CHC for each DHA area, to represent the consumer voice in a clear and more focused way. The Secretary of State will publish proposals along these lines for consultation.

Value for money

23. All of these proposals are aimed to secure better patient care and to see that the maximum benefit is obtained from the large resources that will be available. To help authorities achieve targets for cost improvement programmes and the generation of income, a value for money unit will be set up in the NHS Directorate. There will be increased emphasis on independent value for money studies. To help secure this the external audit of the NHS in Wales will become the responsibility of the Audit Commission.

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SECRET

Prime Minister

NHS REVIEW: DRAFT WHITE PAPER

1. At the end of the Ministerial Group meeting on Tuesday, I undertook to circulate revised versions of parts of the draft White Paper in advance of Cabinet circulation tomorrow.

2. I attach for your agreement, and that of other members of the Group, revised drafts of chapters 1 and 13. The former in particular draws heavily on Bernard Ingham's helpful suggestions. I should be grateful for any comments by early tomorrow.

3. I am also attaching a revised draft of the section on GP numbers in Chapter 7. This is based closely on the Chancellor's draft, but I have not included his suggested references to the GP remuneration system. I do not entirely agree with them, they are not relevant to our proposals, and they would provoke a quite needless row.

4. We must settle a title. I have confirmed that "Fit for the Future" has been used before (Report of the Committee on Child Health Services, 1976). The same applies to "Patients First", which is among the suggestions made by Bernard Ingham yesterday. I am not opposed to "Better Health", although it is rather dull and sounds rather like a health promotion or keep fit brochure. I have thought about Bernard's other suggestions, but would myself prefer "The NHS: A Healthy Future". I should be grateful for your and colleagues' agreement. We do not have time to wait any longer for real inspiration. Failure to settle a title by tomorrow morning could jeopardise the printing timetable for a laminated cover.

CLARKE TO PM 19 JAN (CHS 1,7,13)

5. I am copying this minute to the other members of the Ministerial Group, to Professor Griffiths and Mr Whitehead in the No 10 Policy Unit and to Mr Wilson in the Cabinet Office.

19 January 1989

KC

Draft (19.1.89)

CHAPTER 1: A BETTER HEALTH SERVICE FOR PATIENTS

Introduction

The achievements of the NHS

1.1 The United Kingdom enjoys high standards of health care. The Health Service has contributed to longer life expectancy, fewer stillbirths and lower rates of perinatal and infant mortality. There have been dramatic increases in the number of people treated in hospital. Transplant surgery is now commonplace. Doctors can carry out successful hip operations on people in their seventies and eighties. People are not only living longer but are enjoying a better quality of life.

1.2 The proposals in this White Paper aim to build on these achievements by providing an even better service for patients. The Government will keep all that is best in the NHS. It supports and will not change the principles of the Service. The service provided by the NHS is, and will continue to be, open to all, regardless of income, and financed mainly out of general taxation.

1.3 The NHS is growing at a truly remarkable pace. The number of hospital doctors and dentists has increased from 42,000 in 1978 to over 48,000 in 1987, and the number of nurses and midwives from 444,000 to 514,000. Total gross expenditure will increase from £8 billion in 1978-79 to £26 billion in 1989-90, an increase of 40 per cent after allowing for general inflation. Expenditure by the NHS will then be equivalent to around £35 for an average family of four, as compared with about £11 in 1978-79. This and improved

productivity mean, for example, that NHS hospital staff now treat over one and a half million more in-patients a year than in 1978.

The need for change

1.4 Throughout the 1980s the Government has thus presided over a massive expansion of the NHS. It has ensured that the quality of care provided and the response to emergencies remain among the best in the world. But increasingly the country as well as the Government has recognised that more needs to be done because of rising demand and an ever-widening range of treatments resulting from advances in medical technology. It has increasingly been recognised that the injection of more and more money is not, of itself, the answer.

1.5 It is clear that the organisation of the NHS - the way it delivers health care to the individual patient - also needs to be reformed. The Government has been tackling these organisational problems. It has taken a series of measures to improve the way the NHS is managed. The main one was the introduction of general management from 1984. This has been particularly successful and has also demonstrated the way ahead.

1.6 The new management information systems have provided clear evidence of a wide variation in performance up and down the country. In 1986/87, the average cost of treating acute hospital in-patients varied by as much as 50 per cent between different health authorities, even after allowing for the complexity and mix of cases treated. Similarly, a patient who waits several years for an operation in one District may get that same operation within a few weeks in another. There are wide variations in the drug prescribing habits of GPs, and in some places drug costs are nearly twice as high per head of

population as in others. And at the extremes there is a twenty-fold variation in the rate at which GPs refer patients to hospital.

1.7 The Government wants to raise the performance of all hospitals and GP practices to that of the best. The main question it has addressed in its review of the NHS has been how to achieve that. It is convinced that it can be done only by delegating responsibility as close as possible to where health care is delivered to the patient - predominantly to the GP and the local hospital. Experience in both the public service and the private sector has shown that the best run services are those in which local staff are given responsibility for responding to local needs and are held to account for doing so.

1.8 This White Paper presents a programme of action, summarised in chapter 13, to secure two objectives:

* to give patients, wherever they live in the UK, better health care and greater choice of the services available; and

* greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences.

The Government's proposals

Key changes

1.9 The Government is proposing seven key measures to achieve these objectives:

First: **to maximise the Health Service's ability to respond to the needs of patients, as much power and**

responsibility as possible will be delegated to local level. This includes the delegation of functions from Regions to Districts, and from Districts to hospitals. The detailed proposals are set out in the next chapter. They include greater flexibility in setting the pay and conditions of staff, and financial incentives to make the best use of a hospital's assets.

Second: **to stimulate a better service to the patient, major hospitals will be able to apply for a new self-governing status as NHS Hospital Trusts.** This means that, while remaining within the NHS, they will take fuller responsibility for their own affairs, harnessing the skills and enthusiasm of their staff. NHS Hospital Trusts will be free to offer their services to other parts of the NHS and to the private sector. They will have an incentive to attract patients, so they will make sure that the service they offer is what their patients want. And in turn they will stimulate other NHS hospitals to respond to local requirements. NHS Hospital Trusts will also be able to set the rates of pay of their own staff and, within annual financing limits, to borrow money to help them respond to patient demand.

Third: **to enable hospitals which best meet the needs and wishes of patients to get the money to do so.** The money required to treat patients will be able to cross administrative boundaries. All NHS hospitals, whether run by health authorities or self-governing, will be free to offer their services to different health authorities or to the private sector. Consequently, a health authority will be better able to discharge its duty to use its available funds to secure a comprehensive service, including emergency services, by obtaining the

best service it can whether from its own hospitals, from another authority's hospitals, from self-governing hospitals or from the private sector.

Fourth: **to reduce waiting times and improve the quality of service, to help give individual patients appointment times they can rely on, and to help cut the long hours worked by some junior doctors, 100 new consultant posts will be created over the next 3 years.** These posts will be additional to the two per cent annual expansion of consultant numbers already planned.

Fifth: **to help the family doctor improve his service to patients, large GP practices will be able to apply for their own budgets to buy a defined range of services direct from hospitals.** Again, in the interests of a better service to the patient, GPs will be encouraged to compete for patients by offering better services. And it will be easier for patients to choose (and change) their own GP as they wish.

Sixth: **to sharpen up the efficiency and accountability of NHS management, regional, district, hospital and general practitioner management bodies will be reduced in size and reformed on business lines, with executive and non executive directors.** The Government believes that, in the interests of patients and staff, the era in which the £24 billion NHS has been run by authorities which are neither truly representative nor fully management bodies must be ended. The confusion of roles will be replaced by a clear remit and accountability.

Seventh: **to ensure that all concerned with delivering services to the patient make the best use of the resources available to them, quality of service and value for money will be more rigorously audited.** Arrangements

for what doctors call "medical audit" will be extended throughout the Health Service, helping to ensure that the best quality of clinical care is given to patients. The Audit Commission will assume responsibility for auditing the accounts of health authorities and other NHS bodies, and will undertake wide-ranging value for money studies.

1.10 The Secretary of State for Health will publish shortly eight working papers explaining in detail how major aspects of the Government's proposals are to be implemented in England. [Similar papers will be published as necessary by the Secretaries of State for Scotland, Wales and Northern Ireland.]

Putting patients first

1.11 People sometimes have to wait too long for treatment, and may have little if any choice over the time or place at which treatment is given. The Government has already done much to tackle this problem. Over the past two years, £60 million has been spent on a new initiative to reduce waiting lists and waiting times, allowing over 220,000 additional patients to be treated. As a result, half of all waiting list patients are now admitted from the list within five weeks or less. In 1989/90, another £40 million will be spent on this initiative.

1.12 The changes proposed in this White paper are intended further to improve the quality of the service that the NHS is able to offer to its patients. This applies not only to waiting times for treatment. The service provided on admission to hospital is sometimes too impersonal and inflexible. This is not what either the Government or those working in the Health Service want to see. The best NHS

hospitals provide more than clinical excellence. They provide a service which considers patients as people. The Government is determined that this is what all the NHS should provide.

1.13 The Government believes that each hospital should offer:

* appointments systems which give people individual appointment times that they can rely on. Waits of two to three hours in out-patient clinics are unacceptable.

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

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

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

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

* rapid notification of the results of diagnostic tests.

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

1.14 In short, every hospital in the NHS should offer what the best offer now. These improvements will bring greater appreciation and recognition from patients and their families for all the care that the Health Service provides.

The best use of resources

1.15 If the NHS is to provide the best service it can for its patients, it must make the best use of the resources available to it. The quest for value for money must be an essential element in its work. This becomes even more important as the demands on the Health Service continue to grow.

1.16 Those who take decisions which involve spending money must be accountable for that spending. Equally, those who are responsible for managing the service must be able to influence the way its resources are used. The Government believes that most decisions are better taken at local level. Parts Two and Three of this White Paper include a range of important proposals for strengthening local management and improving value for money in addition to those referred to in paragraph [1.9]. They build on the introduction of general management and on the proposals for the better management of the family practitioner service (FPS) set out in "Promoting Better Health" (Cm 249).

1.17 Among the most important aims behind these changes are:

* effecting a clearer distinction at national level between the policy responsibilities of Ministers and the operational responsibilities of top management;

* improving the information available to local managers, enabling them in turn to make their

budgeting and monitoring more accurate, sensitive and timely;

* ensuring that hospital consultants - whose decisions effectively commit substantial sums of money - are involved in the management of hospitals; are given responsibility for the use of resources; and are encouraged to use those resources more effectively;

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

* ensuring that drug prescribing costs are kept within reasonable limits.

Public and private sectors working together

1.18 The NHS and the independent health sectors should be able to learn from each other, to support each other and to provide services for each other. Anyone needing treatment can only benefit from such a development. People who choose to buy health care outside the Health Service benefit the community by taking pressure off the Service and add to the diversity of provision and choice. The Government expects to see further increases in the number of people wishing to make private provision for health care, but at the moment many people who do so during their working life find the cost of higher premiums difficult to meet in retirement. The Government therefore proposes to make it easier for people in retirement by allowing tax relief on private medical insurance premiums paid by them or, for example, by their families on their behalf.

Scope of proposals

1.19 Everyone is entitled to better health services with higher quality and more choice, regardless of where they live. The White Paper's proposals therefore apply throughout the UK. The way in which they are implemented in England, Scotland, Wales and Northern Ireland will need to reflect the different organisational structures that have grown up in each country, in the light of their own distinctive health care needs and circumstances. Chapters 2-9 are written in terms which apply primarily to England. Those aspects which are particular to the other three countries are dealt with in chapters 10-12.

Draft (19.1.89)

Revised Paragraph on GP Numbers

7.21 It is the Government's responsibility to ensure that there is adequate access to primary care services across the country; that opportunities exist for good doctors to enter general practice; and that there is a sensible, overall balance between the numbers of doctors in hospitals on the one hand and in general practice on the other. The Government proposes to take two further steps to enable it better to control the total cost of the service while ensuring that sufficient opportunities remain in general practice. First, it will seek reserve powers to control, if necessary, the number of GPs entering into contract with the NHS. Secondly, it will seek in due course to reduce from 70 to 65 the retirement age for GPs which has been introduced through the Health and Medicines Act 1988.

Draft (19.1.89)

CHAPTER 13: PROGRAMME FOR REFORM

13.1 The proposals in this White Paper offer a new and exciting challenge to all those who work in the NHS. They add up to the most significant review of the NHS in its 40-year history. They represent a wide-ranging opportunity to put the interests and wishes of the patient at the forefront of decision-making at all levels. They amount to a substantial body of change, which must be implemented with determination and commitment.

13.2 The Government is planning a programme of reform in three main phases:

* **Phase 1: 1989**

The Secretary of State for Health will establish a new NHS Policy Board and reconstitute the NHS Management Board.

The Health Departments, and RHAs in England, will identify the first hospitals to become self-governing as NHS Hospital Trusts, and plan for their new status; will devolve further operational responsibility to Districts and hospitals; and will begin preparing the ground for GP practice budgets.

The Government will introduce Regulations to make it easier for patients to change their GPs.

The first additional consultant posts will be created; Districts will begin agreeing job descriptions with

their consultants; and a new framework for medical audit will begin to be implemented.

The resource management initiative will be extended to more major acute hospitals.

Preparations for indicative drug budgets for GPs will begin.

The Audit Commission will begin its work in the NHS.

* **Phase 2: 1990**

The changes begun in phase 1 will gather momentum. Devolving operational responsibility, changing the management of consultants' contracts and extending medical audit throughout the hospital service will near completion.

"Shadow" boards of the first group of NHS Hospital Trusts will start to develop their plans for the future.

RHAs, DHAs and FPCs will be reconstituted, and FPCs will become accountable to RHAs. Regions will begin paying directly for work they do for each other.

* **Phase 3: 1991**

The first NHS Hospital Trusts will be established.

The first GP practice budget-holders will begin buying services for their patients.

The indicative drug budget scheme will be implemented.

DHAs will begin paying directly for work they do for each other.

13.3 The reforms in this White Paper will enable a higher quality of patient care to be obtained from the resources which the nation is able to devote to the NHS. The provision for spending on health in the coming financial year, 1989/90, announced in the Autumn Statement, included the likely costs of preparing for the reforms and for the legislation which will give effect to them. Over time, any extra costs should be offset by the improved efficiency which will stem from them. The total provision for spending on health will take account of the progress made in implementing the reforms - including the increased efficiency savings. The costs of implementing the reforms in future years will be considered in the annual public expenditure surveys.

13.4 A number of the changes proposed will require legislation, which will be introduced at the earliest opportunity.

13.5 Throughout this programme, the Government will hold to its central aims: to extend patient choice, and to delegate responsibility to those who are best placed to respond to patients' needs and wishes. The result will be a better deal for the public, both as patients and as taxpayers. The Government will build further on the strengths of the NHS, but will not flinch from tackling its weaknesses. This is the way to give the NHS a healthy future.

week.16.1/m.17

SECRET

FROM: H PHILLIPS
DATE: 19 January 1989

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Miss Peirson
Mrs Lomax
Mr Saunders

NHS REVIEW: FINAL DRAFTS OF THE WHITE PAPER

You will wish to consider whether you should comment on the final redrafts of the White Paper which Mr Clarke has circulated today.

Central Management of the NHS

2. Mr Clarke's minute to the Prime Minister of 18 January circulates revised White Paper paragraphs on the central management of the NHS. These now represent, as you know, a very significant shift in the planned relationships between the Management Board and the DoH; the Secretary of State, and Regional Chairmen; and Ministers and Parliament.

3. In general terms Treasury interests appear to be safeguarded. Ministerial accountability for expenditure on the NHS is clearly stated and we have been keen to see the Chief Executive play a much higher public profile on management issues - a concern which quickened during the nurses' regrading exercise. But the Accounting Officer responsibilities of the Chief Executive are not wholly clear - the covering note (paragraph 7) does not mention how the Management Board's new responsibility for oversight of the FPS (referred to in paragraph 2.6 of the White Paper) is to be discharged. At present Sir Christopher France is the Accounting Officer for the FPS. We shall also need to tease out more fully what the relationship will be between the DoH and the Management Board and its staff as its costs are borne on the Department's vote, and the Chief Executive, as Accounting Officer is supported

by, the Department's PFO. These points I think we can follow through at official level.

4. You may like, also, to bear in mind the following additional comments.

5. First, paragraph 10 of Mr Clarke's cover note, on Regional Chairmen, masks the confusion which arises if they maintain their direct line to the Secretary of State while "their" General Managers are accountable not to them but to the Chief Executive. The logic of the policy under discussion is effectively that Regions will become arms of the Management Board. I fail to see how a Regional General Manager is not accountable to his Regional authority which is after all a management body. I imagine that Mr Clarke's view is that if the Regional authority 'in toto' reported to the Chief Executive some chairmen and possibly some of the best, would simply resign. This might happen but what is proposed looks unworkable and will not deliver the management arrangement it purports to achieve.

6. Second, the suggestion in paragraph 12 of the covering note that the Chief Executive will take a prominent role with Select Committees and the like (whatever that means) as well as the PAC is the logical consequence of the proposal to give the Management Board clear responsibility for operational matters. Presumably it will still be for Ministers to handle policy issues before the Select Committee, although the Committee will no doubt adopt the broadest interpretation of policy that they can. Assuming that a workable distinction is found for this purpose between policy and management it is worth noting that in practice these Select Committee appearances take up an enormous amount of time in briefing, preparation, and follow-up. I do wonder whether the weight of Parliamentary business and other representational work that might fall on the Chief Executive will get in the way of his actually managing the NHS.

7. Third, there is the question of Ministers and Parliament. The policy amounts to saying that Ministers will not deal with MP's constituency business - letters, PQs etc - as they have in the past on local operational matters but have them dealt with in the accountability chain ending with the Chief Executive. As you know, in some other areas of central Government responsibility, such as social security, and immigration, there is increasing, and

increasingly accepted, contact between MP's and local managers to resolve individual cases. And this will happen to an increasing extent with some Next Steps agencies. Nonetheless the line proposed will be very controversial and difficult to hold, and may not help the passage of the necessary health legislation to implement the Review if it is pushed rather than eased into place.

Draft White Paper

8. Mr Clarke's minute of 19 January covers fresh drafts of chapters 1 and 13, and of the paragraph on GP numbers. The new Chapter 1, which is an amalgam of his earlier draft, your comments and Bernard Ingham's passage, now looks acceptable. So does Chapter 13, which includes the public expenditure paragraph as 13.3. There has been one change to the final sentence which now reads as follows (the underlined words have been added to the earlier draft):

> "The costs of implementing the reforms in future years will be considered in the annual public expenditure surveys."

This does not change the meaning from what was intended, and I think we can regard it as a clarification which improves the draft.

9. While the new paragraph 7.21 draws on some of your proposed wording, it omits the central point that the insensitivity of the remuneration system to the average workload of GPs is a matter of concern. Mr Clarke's covering minute explains that he does not accept that this is so, and that to say so would, in his view, provoke a needless row. You will wish to consider whether you want to press this point. (Whatever his view on these points, he is wrong to say that your draft was "not relevant to our proposals": it is precisely this which leads to the reserve power to control GP numbers.)

(your draft separately below)

10. His covering minute proposes a title, "The NHS: A Healthy Future". While the pun makes one cringe a little, we see no need to dissent.

Date of publication of White Paper

11. Mr Clarke's Private Secretary's letter of 18 January seeks authority to start making arrangement for publication on 31 January. This is obviously right.

Conclusion

12. You may conclude that at this stage you do not wish to press any points but, if you do, I would suggest you picked up

(a) the accountability relationship between Regions, the Management Board, and the Secretary of State (paragraph 5 above):

(b) the problem of defining what the different roles of the Chief Executive and Ministers should be before the Select Committee (paragraph 6); and

(c) the unsatisfactory response to your proposal for stating clearly the need for concern over GPs' remuneration in relation to numbers.

Mr Saunders is ready to offer you a draft tomorrow in the light of your views.

HP.

HAYDEN PHILLIPS

cst.ps/3jm18.1/drfts

CONFIDENTIAL

CC- CX, Mr Phillips
Mr Saunders.
Miss Peirson.

PWP

Treasury Chambers, Parliament Street, SW1P 3AG

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

19 January 1989

Dear Secretary of State,

NHS REVIEW: DRAFT WHITE PAPER

CST to CLARKE 19/1

At Tuesday's meeting I said that I would write to you about some further points which the Chancellor and I have on the draft.

The present draft of paragraph 2.23 gives the misleading impression that health authorities will become major property developers in their own right. This is not the case: property development is an activity which is properly for the private sector, and health authorities do not in any case have the expertise to control the considerable risks that would be involved. In the first sentence, therefore, delete "imaginative use of property assets" and substitute "property which is surplus to requirements". In the fourth sentence, delete "encourage more imaginative property development", substitute "assist them in this", and insert "central" before "group of professionals". The present text invites a replay of the Crown Agents' scandal.

The third sentence of paragraph 2.28 mistakenly implies that the Audit Commission will be responsible for auditing the consolidated accounts of the NHS, which is and will continue to be the responsibility of the NAO. This sentence should instead read "... the external audit of health authorities and other NHS bodies at present audited by the department. In this capacity, it would report to the Secretary of State."

In the fourth indent of paragraph 3.14, the requirement on hospital trusts will be rather more than simply to break even taking one year with another. Like other public sector bodies, hospital trusts will need to earn a rate of return on their capital, which will be reflected in their annual financing limits. The sentence should read "... temporary deficits, but will be set overall financial targets designed to yield an appropriate rate of return on the capital employed."

CONFIDENTIAL

The first sentence of paragraph 3.15 has got a little garbled. I suggest it should read:

> "Hospital trusts will be subject to annual financing limits, within which they will be free to borrow, either from the Government or from the private sector."

The third indent of paragraph 6.9 suggests that the drugs element of practice budgets should be higher than if the GP was not in the scheme and hence had only an indicative drugs budget. This is not a proposal we have previously discussed, and it seems to me to have no merit at all. There is no reason why holders of real budgets should be more likely to overspend than those with indicative budgets: if anything the reverse will be the case. Moreover, the agreed 5% flexibility will give GPs adequate scope to manage fluctuations in their drugs expenditure. This extra margin seems unnecessary and wasteful. The words "but with a small premium because it will be a component of a real budget" should therefore be deleted.

As the Chancellor said at the meeting, the present paragraph 7.21 does not include the point agreed at our 5 January meeting about the failing in the present system that the remuneration of GPs in aggregate does not take account of falling list sizes. We suggest replacing it with the following two paragraphs:

> "7.21. It is the Government's responsibility to ensure that there is adequate access to primary care services across the country, and that opportunities exist for good doctors to enter general practice. But the Government also has a responsibility to the taxpayer to ensure that the total cost of the service does not rise beyond acceptable bounds. The present system by which fees and allowances are set so as to deliver a target average net income for GPs, irrespective of changes in the average numbers of patients on their lists, is a matter for concern. It means that the costs of the system increase in direct proportion to the numbers of practitioners.
>
> 7.22. The Government proposes therefore to take two further steps to enable it better to control the total cost of the service while ensuring that sufficient opportunities remain in general practice for the best young doctors. First, it will seek reserve powers ... Health and Medicines Act 1988. [as in present draft]"

I am copying this letter to the Prime Minister, the Chancellor, Secretaries of State for Scotland, Wales and Northern Ireland, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson (Cabinet Office), and Mr Whitehead (Policy Unit).

Yours sincerely,

P. Warless

pp JOHN MAJOR

[Approved by the Chief Secretary and signed in his absence.]

18.1.89.2

CONFIDENTIAL

PWP

FROM: R B SAUNDERS

DATE: 18 January 1989

CHIEF SECRETARY

cc Chancellor
Mr Phillips
Miss Peirson
Mr Burns

NHS REVIEW: OUTSTANDING POINTS ON DRAFT WHITE PAPER

Following Miss Evans' minute of last night, I attach a draft letter to Mr Clarke recording these outstanding points. I have also added two others: on 3.14 and 6.9. Both have been fed in at official level, but on reflection I think would be worth reinforcing in a letter from you. The second in particular is a bit naughty on DoH's part - the proposal has not been discussed by Ministers previously, and we have only just spotted that they have slipped it into the draft White Paper. The idea that budgets should be set at a higher level because they are real rather than indicative seems a very bad one.

2. I will let you have a note about the detailed technical papers later today.

SAUNDERS TO CST 18/1

*

CH/ Are you content? The amendments in paras 4 and 6 are new.

R B SAUNDERS

@15

OK with additions (marked).

M.

Relevant chapters attached.

18.1.89.3

CONFIDENTIAL

DRAFT LETTER FROM CHIEF SECRETARY TO

Secretary of State for Health

NHS REVIEW: DRAFT WHITE PAPER

At yesterday's meeting I said that I would write to you about some further points which the Chancellor and I have on the draft.

2. The present draft of paragraph 2.23 gives the misleading impression that health authorities will become major property developers in their own right. This is not the case: property development is an activity which is properly for the private sector, and health authorities do not in any case have the expertise to control the considerable risks that would be involved. In the first sentence, therefore, delete "imaginative use of property assets" and substitute "property which is surplus to requirements". In the fourth sentence, delete "encourage more imaginative property development", substitute "assist them in this", and insert "central" before "group of professionals". The present text smiths a replay of the Crown Agents' scandal.

3. The third sentence of paragraph 2.28 mistakenly implies that the Audit Commission will be responsible for auditing the consolidated accounts of the NHS, which is and will continue to be the responsibility of the NAO. This sentence should instead read "... the external audit of health authorities and other NHS bodies at present audited by the department. In this capacity, it would report to the Secretary of State."

4. In the fourth indent of paragraph 3.14, the requirement on hospital trusts will be rather more than simply to break even taking one year with another. Like other public sector bodies, hospital trusts will need to earn a rate of return on their capital, which will be reflected in their annual financing limits. The sentence should read "... temporary deficits, but will be set overall financial targets designed to yield an appropriate rate of return on the capital employed."

5. The first sentence of paragraph 3.15 has got a little garbled. I suggest it should read:

> "Hospital trusts will be subject to annual financing limits, within which they will be free to borrow, either from the Government or from the private sector."

6. The third indent of paragraph 6.9 suggests that the drugs element of practice budgets should be higher than if the GP was not in the scheme and hence had only an indicative drugs budget. This is not a proposal we have previously discussed, and it seems to me to have no merit at all. There is no reason why holders of real budgets should be more likely to overspend than those with indicative budgets: if anything the reverse will be the case. Moreover, the agreed 5% flexibility will give GPs adequate scope to manage fluctuations in their drugs expenditure. This extra margin seems unnecessary and wasteful. The words "but with a small premium because it will be a component of a real budget" should therefore be deleted.

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7. As the Chancellor said at the meeting, the present paragraph 7.21 does not include the point agreed at our 5 January meeting about the failing in the present system that the remuneration of GPs in aggregate does not take account of falling list sizes. We suggest replacing it with the following two paragraphs:

> "7.21. It is the Government's responsibility to ensure that there is adequate access to primary care services across the country, and that opportunities exist for good doctors to enter general practice. But the Government also has a responsibility to the taxpayer to ensure that the total cost of the service does not rise beyond acceptable bounds. The present system by which fees and allowances are set so as to deliver a target average net income for GPs, irrespective of changes in the average numbers of patients on their lists, is a matter for concern. It means that the costs of the system increase in direct proportion to the numbers of practitioners.
>
> 7.22. The Government proposes therefore to take two further steps to enable it better to control the total cost of the service while ensuring that sufficient opportunities remain in general practice for the best young doctors. First, it will seek reserve powers ... Health and Medicines Act 1988. [as in present draft]"

8. I am copying this letter to the Prime Minister, the Chancellor, Secretaries of State for Scotland, Wales and Northern Ireland, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson (Cabinet Office), and Mr Whitehead (Policy Unit).

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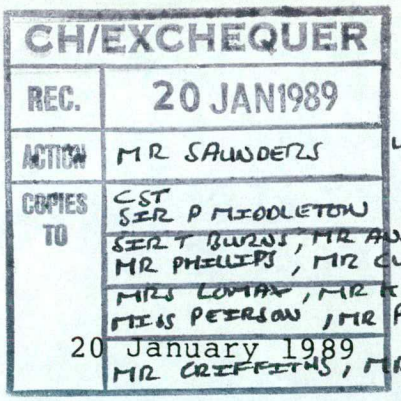

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

20 January 1989

PWP

Dear Stephen,

NHS WHITE PAPER: WELSH CHAPTER

Thank you for your letter of 19 January enclosing a revised draft of the Welsh Chapter.

The Prime Minister is generally content with this. She had two detailed comments:

(i) it might be helpful in the second sentence of paragraph 2 to quote the figures for expenditure per household per week rather than per year;

(ii) the second sentence of paragraph 7 might best be deleted.

The Prime Minister welcomed the emphasis, for example in paragraph 11, on money moving with patients, and hopes this will come out as clearly in the English Chapter.

The Prime Minister has noted that your Secretary of State will be unable to attend the meeting of E(A) next Tuesday.

I am copying this letter to Alex Allan (HM Treasury), Andy McKeon (Department of Health), David Crawley (Scottish Office), Stephen Leach (Northern Ireland Office), Carys Evans (Chief Secretary's Office), Alan Davey (Minister for Health's Office), Sir Roy Griffiths (Department of Health), Richard Wilson (Cabinet Office), and Brian Griffiths and Ian Whitehead (Policy Unit).

Yours,
Paul

(PAUL GRAY)

Stephen Williams, Esq.,
Welsh Office.

CONFIDENTIAL

cst.ps/6pw20.1/lets

SECRET

000057

cc- CX
Sir P Middleton
Mr Anson
Mr Phillips
Miss Person
Mr Saunders
Mr Call
Mrs Lomax
Mr Griffiths
Mr MacAuslan

Treasury Chambers, Parliament Street, SW1P 3AG

pwp

Andy McKeon Esq
Private Secretary to the
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1

20 January 1989

Dear Andy,

NHS REVIEW: FINAL DRAFTS OF THE WHITE PAPER

We spoke earlier today and I explained that the Chief Secretary was content with the draft of Chapter 13 circulated on 19 January subject to one small amendment.

This is simply to confirm that the Chief Secretary would like the final sentence of paragraph 13.3 to be amended to read:

> "The costs of implementing the reforms in future years will be considered as part of the annual public expenditure surveys."

Yours,

Peter

PETER WANLESS
Assistant Private Secretary

chex.md/ds/12 SECRET

FROM: D I SPARKES
DATE: 20 January 1989

pwp

MR H PHILLIPS

cc PS/Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Miss Peirson
Mrs Lomax
Mr Saunders

PS/IR

DIS TO PHILLIPS FINAL DRAFTS 20/1

NHS REVIEW: FINAL DRAFTS OF THE WHITE PAPER

The Chancellor was grateful for your minute of 19 January concerning the final redrafts of the White Paper which Mr Clarke circulated yesterday. He has commented that there is much that remains unsatisfactory about the White Paper but he is not disposed to press any further points. He would, however, like to make absolutely sure that the paragraph which referred to 'imaginative property development' has been amended in the manner we agreed. He also feels that the present wording of the tax paragraph in chapter 9 is not crystal clear; as drafted, it implies that there will be tax relief on premiums paid by 60 year olds on behalf of young people. Mr Saunders has clarified the ambiguity and I have passed the attached drafting amendment to Mr Clarke's office.

DS.

DUNCAN SPARKES

Amendent to White Paper
Chs 1 and 9

within reasonable limits.

Public and private sectors working together

1.18 The NHS and the independent health sectors should be able to learn from each other, to support each other and to provide services for each other. Anyone needing treatment can only benefit from such a development. People who choose to buy health care outside the Health Service benefit the community by taking pressure off the Service and add to the diversity of provision and choice. The Government expects to see further increases in the number of people wishing to make private provision for health care, but at the moment many people who do so during their working life find the cost of higher premiums difficult to meet in retirement. The Government therefore proposes to make it easier for people in retirement by allowing tax relief on private medical insurance their premiums paid by them or, for example, by their families on their behalf.

whether

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10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

20 January 1989

GRAY TO McKEON 20/1

Dear Andy,

NHS REVIEW

The Prime Minister was grateful for your Secretary of State's minute of 18 January on the Central Management of the NHS and his minute of 19 January providing revised drafts of Chapters 1 and 13 and part of Chapter 7.

Central Management

The Prime Minister has considered further whether the Body reporting to the Policy Board should be termed the Management Board or Management Committee. She continues to feel that to have two Boards would be highly confusing. But rather than calling it the Management Committee, she suggests the title should be the Management Executive.

The Prime Minister also has some drafting comments on the existing text of paras 2.4 to 2.12. For convenience these are annexed to this letter.

But the Prime Minister continues to be seriously concerned about exactly how the new central management structure will operate. She would be grateful if your Secretary of State would now prepare a detailed paper on this subject, for consideration by the NHS review group following the meeting of E(A) on Tuesday 24 January.

This paper needs to spell out in detail the existing arrangements for the involvement of Department of Health officials in the operation of the NHS (including the numbers involved) and the links between the centre, the regions and districts. It should then go on to specify in detail the proposed new arrangements, spelling out the nature of the support structure for the Policy Board/Management Executive, the way in which policy advice and operational responsibilities at the centre will be separated and the links between the centre, regions and districts. The line of responsibility and chain of command at each point should be specified.

The Prime Minister assumes that alternative options have been developed covering some or all of these points. She thinks it would be helpful for these alternatives to be set out, as well as your Secretary of State's recommended

SECRET

approach. Her own view is that it is essential for there to be maximum delegation of operational responsibility to the health authorities, with the minimum necessary manpower engaged at the centre on operational matters and a clear distinction at the centre between policy and operational responsibilities. She also thinks it essential that the new arrangements for accountability to Parliament and the way in which they will match the new management structure in the NHS and the Department should be spelled out.

The Prime Minister would be grateful if your Secretary of State would arrange for the Treasury and the Cabinet Office to be associated with the preparation of the paper, which should be circulated on Monday 23 January.

White Paper Title

The Prime Minister has considered your Secretary of State's proposal that the title should be "The NHS - A Healthy Future". She continues to feel however that it is important to include the word "Patient" in the title. She suggested that "Patients First" might be used in the title. But when we spoke about this this morning you explained that this had been used in an earlier publication. You said that the latest proposal from the Department was "Working for the Patient". I will report to the Prime Minister when she returns to the office later today that this is the title you are now planning.

Other Draft Comments

I attach at Annex B the Prime Minister's detailed drafting comments on Chapters 1 and 13.

I am copying this letter to the Private Secretaries to the Chancellor, the Secretaries of State for Wales, Scotland, Northern Ireland, the Chief Secretary, Minister for Health, Sir Robin Butler, and to Richard Wilson (Cabinet Office) and Ian Whitehead (Policy Unit).

Yours,
Paul

(PAUL GRAY)

Andy McKeon, Esq.,
Department of Health.

Paragraph 2.4: It would be impracticable for the Chief Executive to oversee the day-to-day decisions taken locally by operational units, and any attempt to do so could lead to excessive bureaucracy. Redraft to read:

> "...Such accountability does not mean that Ministers should be involved in operational decisions. On the contrary, these decisions must be taken locally by operational units and oversight of the operational units will be the responsibility of the Chief Executive of the NHS Management Committee. Ministers will be responsible for policy and strategy".

Paragraph 2.6: There needs to be a clearer definition of the role of the Policy Board, as follows:

> "A new Policy Board, chaired and appointed by the Secretary of State, will determine the strategy, objectives and finances of the NHS in the light of Government policy, and will set objectives for the Management Committee and monitor whether they are satisfactorily achieved. It will replace..."

Paragraph 2.8: Delete "and keeping the state of health of the people of the region under review" in the penultimate sentence.

SRWBTV

ANNEX B

Chapter 1

Paragraph 1.3

The reference to "around £35 for an average family of 4" should make clear that this relates to a week.

Paragraph 1.5

Amend the last sentence to read "This is now showing results and has pointed the way ahead".

Paragraph 1.17

It would be better to start each of the indents with the infinitive and in the first indent to start with "To secure" rather than "To effect".

Chapter 13

Paragraph 13.1

This would read better as:

"The proposals in this White Paper put the interests and wishes of the patient first. They offer a new, exciting and potentially rewarding challenge to all the work in the NHS. They add up to the most significant review of the NHS in its 40 year history. And they amount to a formidable programme of reform which will require energy and commitment to carry it through".

Paragraph 13.2

Amend the opening phrase to: "The Government is planning to implement the programme in three main Phases". And add to the first indent under Phase 1 "as a Management Executive".

Paragraph 13.5

Add to the end of the first sentence "and to secure the best value for money".

Comments passed to APS/CST
DJS. 23/1

I agree with the amendments already marked by Dick. In addition, the pop version should have something like para 16 of the NHS staff version, while

CHANCELLOR OF THE EXCHEQUER

Chy/

Here are the two summaries of the NHS White Paper.

Dick Saunders' comments are marked.

DH would greatly appreciate it – in view of the tight timetable – if we could restrict our comments to matters of substance!

X on the staff version must also mention the other 1/2 of the consultants' package: performance of

DJS

NB I notice that the "popular" version makes no mention of tax relief – is this right?

their contracts & new approach to merit awards.

N

0601A

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

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

MCKEON TO EVANS 20 JAN WHITE PAPER SUMMARIES

cc Duncan as discussed Carys

COVERING SECRET

000060

Ms Carys Evans
Private Secretary to the
Chief Secretary to the Treasury
HM Treasury
LONDON SW1

CHIEF SECRETARY
REC. 20 JAN 1989
ACTION Mr Saunders
COPIES TO CX Mr Anson
Mr H Phillips
Miss Peirson
Mr Griffiths Mr Call

20 January 1989

Dear Carys

NHS REVIEW: WHITE PAPER SUMMARIES

As promised, I enclose a copy of the two summaries of the White Paper - a popular version for the public which would be in leaflet form and a version for NHS staff. The drafts will need to be updated to ensure consistency with the White Paper as editorial changes are made there (today's summary versions are based on yesterday's White Paper draft!).

We would be grateful if the Chief Secretary could consider the drafts in relation to his wider role concerning Government publicity. We could also be glad to know if you think the drafts include any errors or depart from the substance of the White Paper.

As requested, I am also sending a copy of this letter and enclosures to Paul Gray (No 10) and Richard Wilson (Cabinet Office).

? Nothing on consultants' contracts and distinction awards - should be in NHS staff version.

Yours

Andy

A J McKEON
Principal Private Secretary

0526A

DRAFT - 20/1/89

DRAFT PoP VERSION OF WHITE PAPER

The Health Service today

All in all, Britain's Health Service is the best system of its kind anywhere in the world. It has a highly skilled and dedicated staff, backed by huge and growing resources. There are well over 6,000 more doctors and dentists and 70,000 more nurses and midwives than in 1978. Spending has shot up - from £8 billion in 1978 to £26 billion in 1989 (£154 million each week in 1978 compared with £500 million each week in 1989). And, to take just one example, the NHS now cares for $1^{1}/2$ million more in-patients each year.

There is a lot to be proud of. Today, the Health Service is helping people in Britain to live longer and enjoy a better quality of life. But despite those successes, the performance of the NHS still varies greatly from place to place:

- people have to wait for operations much longer in some places than in others. A patient who has to wait several years in one District could have the same operation within a few weeks in another;

- drug costs in some places are nearly twice as high per head of population as in others.

- some GPs refer twenty times more patients to hospitals than others.

- the average cost of treating someone in hospital varies by as much as 50% between different health authorities.

Of course, the NHS is not a business run for profit, but it can certainly become more business-like. What the Government now wants to do is to take all that is best in the NHS, and raise the rest of it to that very high standard. An NHS that is run better will be an NHS that can care better.

The Way Ahead

Over the last year, the Government has been looking at ways of strengthening the Health Service. That review is now over, and its conclusions have just been announced. Some of them will need the approval of Parliament. They all have a simple aim - a service that puts patients first. But while some of them will require major reforms in the way the NHS is run, the basic principles that have guided it over the last 40 years will continue to guide it into the next century. As now, the Health Service will continue to be available to everyone, regardless of income, and paid for mainly out of general taxation.

The proposals are all designed to enable those who work in the NHS to give you even better care. In future:

* as much power and responsibility as possible will be taken from central and regional administration and given to those working to provide care at a local level;

* resources will go more directly to those hospitals which offer the best service - popular hospitals which attract more patients will attract more money. Rewarding the best will increase the quality of patient care, and encourage all hospitals to improve their standards;

0526A/3

* there will be more rigorous audit of quality of service and value for money. Arrangements for medical audit will be extended throughout the NHS. And the Audit Commission will take over the audit of health authorities and other NHS bodies.

* major hospitals will be able to choose to run their own affairs. Known as "NHS Hospital Trusts", those self-governing hospitals will still be part of the NHS, but will have much more freedom to take their own decisions. In order to earn income, they will have to provide the kind of service that patients want. They will of course continue to provide emergency treatment to anyone who needs it;

* large GP practices will be able to buy a range of services direct from hospitals. They will be able to "shop around" to get the best possible care for their patients. This means that they will, for example, be able to send patients to hospitals where waiting times are shortest. All GPs will also be encouraged to offer a better service, because their pay will be increasingly related to the number of patients they attract. It will be easier for patients to choose (and change) their GP;

* there will be 100 new consultants over the next three years. This will help keep up the attack on waiting times and on the long hours worked by some junior doctors.

Putting Patients First

All these reforms will improve the quality of the service that the NHS provides. Some of them will however take time to work through. So there will be other initiatives to tackle the areas of greatest public concern more immediately:

i. the Waiting List Initiative will be continued. Over the last two years, a special £60 million fund has allowed an extra 220,000 people to be treated. Half of all waiting list patients are now admitted from the list within 5 weeks or less. Another £40 million will be spent on this initiative next year.

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- individual and reliable appointment times;
- more attractive waiting areas, with proper facilities for parents with children;
- counselling for family and friends;
- clear and sensitive explanations of what is happening when someone is in hospital;
- rapid notification of the results of diagnostic tests.

iii. In addition, so that patients can feel more at home and exercise more choice, they will in future be able to pay for a number of optional extras such as a choice of meals, a single room, a telephone or a television.

Timetable for Change

Taken together the Government's proposals will bring major change for the NHS. They are too important to rush into, so 1989 will be a year of preparation. By 1990, the new NHS will be taking shape, and the new method of funding hospitals will start. By 1991 (and subject to the approval of Parliament) the first NHS Hospital Trusts will be up and running, and some GPs will be buying hospital services for their patients. In the nineteen-nineties the new NHS will provide the country with a more modern and effective service, working for patients even better than before.

The best use of resources

These reforms will also improve the value that people get for the £35 a week the average family pays for the NHS. Managers will be freed to get on with the job of managing. And doctors will be made more accountable for the resources they use.

YA/0613t

[3rd DRAFT - 20/1/89]

SUMMARY OF NHS REVIEW WHITE PAPER - FOR NHS STAFF

INTRODUCTION

1. The Government has published a White Paper: ["Working For Patients"] (Cm 555) setting out its plans to reform and strengthen the National Health Service.

2. Underlying every proposal in the White Paper is a simple aim - a service that puts patients first. The achievements of the NHS - in helping increasingly large numbers of people to enjoy a better quality of life and to live longer - will be the foundation from which an even better service can be built. All that is best in the NHS will be retained. The Government supports and will not change the principles on which it was founded - it will continue to be open to all, regardless of income, and financed mainly out of general taxation.

THE ACHIEVEMENTS OF THE NHS

3. The NHS is growing at a truly remarkable pace. There are over 6,000 more hospital doctors and dentists and 70,000 more nurses and midwives than in 1978. Spending has increased massively - up from £8 billion in 1978/79 to £26 billion in 1989/90, an increase of 40 per cent after allowing for general inflation. All this, coupled with improved productivity, means that - to give one example - NHS hospital staff now treat over $1\frac{1}{2}$ million more in-patients a year than in 1978.

THE NEED FOR CHANGE

4. So the NHS has expanded enormously since 1978. The quality of its medical care and its ability to respond to emergencies remain among the best in the world. But increasingly people recognise that rising demand and an ever-greater range of treatments mean that more needs to be done. And that the injection of more and more money is not, of itself, the answer.

5. The organisation of the NHS - the way it delivers care to individuals - needs reform. The Government has already taken a series of measures to improve the way the Service is managed, notably the introduction of general management. Their success points the way ahead.

6. The performance of all hospitals and GP practices needs to be raised to the level of the best. How to do so has been the main question for the Government's review. There is clear evidence of wide variations at present. For instance, in 1986-87, the average cost of treating acute hospital in-patients varied by as much as 50 per cent, even after allowing for the complexity and mix of cases. In the same way, waiting times for operations vary sharply and there are great differences in the referral rates and prescribing habits of GPs.

7. To achieve its aims the Government intends to provide a framework in which the talent and enterprise of all those working in the NHS can flourish. It wants much more delegation of power and responsibility to those who deliver care to patients - mainly the GP and the local hospital. The best run services are those where local staff are given as much responsibility as possible for responding to local needs and are held to account for doing so.

8. The White Paper proposals are a programme of action designed to secure two objectives:

* to give patients, wherever they live, better health care and greater choice of the services available; and

* to produce greater satisfaction and rewards for NHS staff who successfully respond to local needs and preferences.

THE KEY PROPOSALS

9. The White Paper contains seven key measures:

* More delegation of responsibility to local level

To maximise responsiveness to patients' needs, functions will be delegated from Regions to Districts and from Districts to hospitals. All hospitals will be given much more responsibility for running their own affairs, enabling local commitment, energy and initiative to flourish.

* Self-governing hospitals

To stimulate a better service to patients, major hospitals will be able to apply for a new self-governing status within the NHS as NHS Hospital Trusts. These Trusts will be given more freedom to take the decisions which most affect them, such as offering their services to the NHS and private sector, determining the pay of their own staff and (within limits) borrowing capital.

* New funding arrangements

To enable hospitals which best meet patients' needs to get the money to do so, the money required to treat patients will be able to cross administrative boundaries. In future, all NHS hospitals - whether run by health authorities or self-governing - will be free to offer their services to different health authorities or to the private sector. In this way money will go more directly to where the work is done and health authorities will be better able to use their funds to secure a comprehensive range of services.

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To reduce waiting times and improve the quality of service, 100 new consultant posts will be created over the next three years. These will be over and above the already agreed rate of expansion and will also help reduce the long hours worked by some junior doctors.

* GP practice budgets

To help the family doctor improve his service to patients, large GP practices will be able to apply for their own budgets to buy a defined range of services direct from hospitals. GPs will be encouraged to compete for patients by offering better services and it will be easier for patients to choose (and change) their GP.

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To sharpen the efficiency and accountability of NHS management, regional, district, hospital and family practitioner management bodies will be reduced in size and reformed on business lines. They will have executive and non-executive directors. Community Health Councils will continue to act as a channel for consumer views.

* More rigorous audit arrangements

To ensure that all who deliver patient services make the best use of resources, quality of service and value for money will be more rigorously audited. Arrangements for "medical audit" will be extended throughout the NHS. And the Audit Commission will audit the accounts of health authorities and other NHS bodies and undertake wide-ranging value for money studies. It will report to Ministers and its reports will be published.

(Some of these proposals will require the approval of Parliament.

10. The Secretary of State for Health will shortly publish a number of working papers explaining in detail how major aspects of these proposals are to be implemented in England.

[TO BE IN A SEPARATE BOX]

SELF-GOVERNING HOSPITALS

The Government wants to create a number of "self-governing" hospitals within the NHS in order to:

* make the most of the energy, commitment and ability of hospital staff, by setting them free from many of the current constraints.

* encourage a stronger sense of local pride in hospitals, many of which are substantial organisations spending £10-50 million a year.

* enable them to offer their services throughout the NHS and to the private sector, which should lead to more patient choice, greater efficiency and encourage other hospitals to do even better. As a result patients should receive better services.

The powers and responsibilities of each self-governing hospital will be vested in a new body, known as an NHS Hospital Trust. They will be run by small Boards of Management operating like a commercial Board of Directors, with executive and non-executive members and a General Manager.

Self-governing hospitals will get their money from selling their services, mainly to health authorities. A hospital which is good at its job and attracts increasing numbers of patients will see its income rise.

A simple procedure will apply for establishing an NHS Hospital Trust. A variety of groups will be able to start the ball rolling, such as the hospital management team or the senior medical staff, with the Secretary of State for Health taking the final decision. Initially, major acute hospitals will be the most suitable candidates but in due course other hospitals may come within the scope of the proposals.

Self-governing hospitals will be free to determine the pay and conditions of their own staff. And they will have ~~greater~~ freedom (within limits) to borrow ~~capital.~~ money

The first self-governing hospitals should be established from April 1991, subject to the necessary legislation.

[TO BE IN A SEPARATE BOX]

NEW FUNDING ARRANGEMENTS

At present, NHS funds are allocated from central Government to individual hospitals (via Regions and Districts) through a complicated and remote process. Regions get their money through the RAWP formula. RAWP has largely achieved its purpose of equalising the resources available to each Region. But it has disadvantages. It's highly complex and slow to compensate those Regions which take many patients from elsewhere. District funding too is slow to reflect these flows of patients across administrative boundaries. This means funding and workload may be out of step. As for hospitals, they are at present subject to the perverse effects of a system which can penalise success.

The Government wants to change all this. So it proposes to:

* change the method of funding Regions and Districts to a simpler one based on population numbers and weighted for the health and age of that population. The cost of treating patients from other Regions and Districts will be reflected in budgets much more quickly than now. The Thames Regions will get slightly higher funding per head - some three per cent - to reflect their populations' higher use of services. The transition to the new system should be complete by April 1992 for Regions and [April 1994] for Districts.

* place the funding of hospitals on a new footing. The objective is a system where the money goes more directly to where the work is done and done best.

At the hospital level there is a clear distinction to be drawn between services where guaranteed immediate access is necessary, such as Accident and Emergency, and those where the patient and his GP have some choice about when and where to be treated. Some immediate access (or "core") services will be funded through a management budget by which the DHA sets clear performance targets for its own hospitals. DHAs will also be able to buy such services from other Districts or from self-governing hospitals.

Where there is some choice over the time and place of treatment, services will be obtained through a contract, specifying the cost and amount of treatment. DHAs will be able to place contracts with their own, directly managed, hospitals, or with self-governing, private or other DHAs' hospitals. [GPs will still be able to refer a patient to whichever hospital or consultant they think best.]

[TO BE IN A SEPARATE BOX]

GP PRACTICE BUDGETS

The GP service is one of the great strengths of the NHS. The GP is the patient's key adviser about the best hospitals and specialists. But it can take a long time for good and popular hospitals - which treat more patients - to receive more money. So GPs have little incentive to offer patients a choice of hospitals.

The Government wants GPs in large practices to hold their own budgets with which they can buy hospital services for their patients. These budgets will cover:

* out-patient services;
* a defined group of in-patient and day case treatments, such as hip replacements and cataract removals;
* diagnostic tests, such as X-rays and pathology tests.

And budgets will be bigger and more flexible (at least £600,000-700,000) by also including:

* the 70% of the cost of employing staff which the Government already reimburses;
* money for improving premises; and
* the costs of prescribing drugs.

At first only practices with lists of at least 11,000 patients (twice the national average) will be eligible to join this voluntary scheme. Over 1,000 UK practices could join, covering about 25% of the population. The details of each practice budget will be settled by the RHA with the practice, within national guidelines to ensure consistency and fairness. Savings will be available to finance further improvements in the care delivered. And a fee will be provided to cover the costs of participation. The scheme should start from April 1991.

SCOPE OF THE PROPOSALS

11. Everyone is entitled to better health services with higher quality and more choice, regardless of where they live. So the White Paper proposals apply throughout the UK. The way they are implemented in each country will need to reflect each one's particular organisation of health care, as well as its distinctive needs and circumstances.

PUTTING PATIENTS FIRST

12. People sometimes have to wait too long for treatment and may have little, if any, choice over the time or place of treatment. The Government has already done much to tackle this problem. Over the past two years, £60 million has been spent on a new initiative to reduce waiting lists and times, allowing over 230,000 additional patients to be treated. As a result, half of all waiting list patients are now admitted from the list within five weeks or less. In 1989/90, another £40 million will be spent on this initiative.

13. The changes in the White Paper seek to improve further the quality of services offered by the NHS. At present the service provided on admission to hospital is sometimes too impersonal and inflexible. The Government intends to improve matters by ensuring that, like the best hospitals now, every hospital provides a service which considers patients as people, by offering:

* appointment systems which give people individual and reliable appointment times.

* quiet and pleasant waiting and other public areas.

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

* once someone is in hospital, clear and sensitive explanations of what is happening.

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

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities, such as single rooms, televisions and choice of meals, for those prepared to pay for them.

THE BEST USE OF RESOURCES

14. A quality Service - which provides not only clinical excellence but also makes patients feel valued - requires a quality management and organisation. To provide the best possible service from its resources, particularly as demands continue to grow, the NHS must always seek to make the best use of the resources available.

15. [There will be no wholesale administrative reorganisation of the NHS.] But local managers must have more freedom to manage. And those whose decisions affect the use of resources must be more accountable for that expenditure. For some time the Government has been concentrating on giving more responsibility for taking decisions to those actually working in hospitals. The White Paper aims to take this process much further by:

* effecting a clearer distinction at national level between Ministers' policy responsibilities and the operational duties of top management.

* continuing the drive towards better information systems for local managers, enabling them to improve their budgeting and monitoring.

* ensuring that hospital consultants - whose decisions about treatment commit substantial sums of money - are more directly involved in hospital management; accept responsibility for their use of resources and are encouraged to use those resources more effectively. Proposals here include agreeing up-to-date job descriptions and modifying the distinction awards scheme.

* ensuring that GPs too take greater responsibility for their use of resources. Additional resources will be made available for developing computer systems for general practice.

* obtaining further improvements in the cost information available to managers, doctors and other professionals by extending the Resource Management Initiative - to up to 50 more acute hospitals in 1989/90, with the aim of covering all 260 major acute units by the end of 1991/92.

* introducing a system of accounting for capital which encourages managers to balance the need for new investment against the maintenance of older stock. Limits on the size of new projects needing central approval will be raised and joint ventures with the private sector encouraged.

* ensuring that drug prescribing costs are kept within reasonable limits.

* ensuring that services are carried out as cost-effectively as possible by contracting out more functions.

* re-examining the work of nurses and other professional staff so as to secure the most cost-effective use of their skills.

*

* making the reconstituted FPCs accountable to Regional Health Authorities.

PUBLIC AND PRIVATE SECTORS WORKING TOGETHER

16. The NHS and the independent health sector should be able to support each other and provide services for each other, to the benefit of patients. Those who choose to buy health care outside the Health Service take pressure off the NHS and add to the diversity of provision and choice. The Government expects to see further increaes in the number of people wishing to make private provision. But many who do so during their working life find the cost of higher premiums difficult to meet in retirement. The Government therefore proposes to allow tax relief on private medical insurance premuims ~~paid by retired people~~ or, for example, by their families on their behalf.

for retired people, whether paid by them

MANAGING THE FAMILY PRACTITIONER SERVICES

17. Primary care provided by GPs and the work of hospitals are closely intertwined. The Government intends to build on the proposals in its White Paper on primary care services, "Promoting Better Health", by:

* encouraging GPs to take greater responsibility for their use of resources. One objective is to introduce a national framework for medical audit whereby GPs would systematically review their work, supported by a special committee in each FPC.

* pressing ahead with plans to let consumers have more information about GP services and to make it easier to change doctor.

* increasing competition between GPs by raising the proportion of their pay derived from the number of patients on their lists from 46% to at least 60% as soon as possible.

* taking steps to control the total cost of the GP service whilst ensuring that sufficient opportunities remain in general practice. So the Government will seek reserve powers to control, if necessary, the number of GPs in contract with the NHS. It will also seek to reduce the retirement age of GPs from 70 to 65.

* reducing the rate of increase in spending on drugs through a new budgeting scheme whereby RHAs will give FPCs budgets for drug spending and GP practices will receive indicative budgets for their prescribing costs. There will be special arrangements to deal with over- and under-spends at both the practice and FPC level. People will still be able to get the medicines they need.

PROGRAMME FOR REFORM

18. The White Paper proposals will enable a higher quality of patient care to be obtained from the resources devoted to the NHS. They represent a wide-ranging opportunity to put the interests and wishes of patients at the forefront of decision-making at all levels.

19. They also offer a new and exciting challenge to all those who work in the NHS. The proposals amount to a substantial body of change, which must be implemented with determination and commitment.

20. The provision for health in the coming financial year, 1989/90, includes the likely costs of preparing for the reforms. Over time, any extra costs should be offset by the improved efficiency which will stem from the changes. The total provision for health will take account of progress in implementing the reforms, including the increased efficiency savings. The costs of implementation in future years will be considered in the annual public expenditure surveys.

21. Throughout the programme of reform the Government will hold to its central aims:

to extend patient choice; and

to delegate responsibility to those best placed to respond to patients' needs and wishes.

The result will be a better deal for the public, both as patients and taxpayers. The Government will build further on the strengths of the NHS, but will not flinch from tackling its weaknesses. This is the way to ensure that the NHS continues working for patients.

[TO BE IN A SEPARATE BOX]

A TIMETABLE FOR CHANGE

Legislation will be introduced at the earliest opportunity to give effect to the proposals. The programme of reform will have three main phases:

PHASE 1: 1989

* The Secretary of State for Health will establish a new NHS Policy Board and reconstitute the NHS Management Board.

* The Health Departments, and RHAs in England, will identify the first hospitals to become self-governing as NHS Hospital Trusts, and plan for their new status; will devolve further operational responsibility to Districts and hospitals; and will begin preparing the ground for GP practice budgets.

* The Government will introduce regulations to make it easier for patients to change their GP.

* The first additional consultant posts will be created; Districts will begin agreeing job descriptions with their consultants; and a new framework for medical audit will begin to be implemented.

* The resource management initiative will be extended to more major acute hospitals.

* Preparations for indicative drug budgets for GPs will begin.

* The Audit Commission will begin its work in the NHS.

PHASE 2: 1990

* The changes begun in Phase 1 will gather momentum. Devolving operational responsibility, changing the management of consultants' contracts and extending medical audit throughout the hospital service will near completion.

* "Shadow" Boards of the first group of NHS Hospital Trusts will start to develop their plans for the future.

* RHAs, DHAs and FPCs will be reconstituted, and FPCs will become accountable to RHAs. Regions will begin paying directly for work they do for each other.

PHASE 3: 1991

* The first NHS Hospital Trusts will be established.

* The first GP practice budget-holders will begin buying services for their patients.

* The indicative drug budget scheme will be implemented.

* District Health Authorities will begin paying directly for work they do for each other.

10 DOWNING STREET

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SEE INSTRUCTIONS IN LETTER

0601A

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

COVERING SECRET 000060

Ms Carys Evans
Private Secretary to the
Chief Secretary to the Treasury
HM Treasury
LONDON SW1

CHIEF SECRETARY
REC 20 JAN 1989
ACTION Mr Saunders
COPIES TO CX Mr Anson
Mr H Phillips
Miss Pearson
Mr Griffiths Mr Call

20 January 1989

Dear Carys

NHS REVIEW: WHITE PAPER SUMMARIES

As promised, I enclose a copy of the two summaries of the White Paper - a popular version for the public which would be in leaflet form and a version for NHS staff. The drafts will need to be updated to ensure consistency with the White Paper as editorial changes are made there (today's summary versions are based on yesterday's White Paper draft!).

We would be grateful if the Chief Secretary could consider the drafts in relation to his wider role concerning Government publicity. We could also be glad to know if you think the drafts include any errors or depart from the substance of the White Paper.

As requested, I am also sending a copy of this letter and enclosures to Paul Gray (No 10) and Richard Wilson (Cabinet Office).

Yours

Andy

A J McKEON
Principal Private
Secretary

0526A

DRAFT - 20/1/89

DRAFT PoP VERSION OF WHITE PAPER

The Health Service today

All in all, Britain's Health Service is the best system of its kind anywhere in the world. It has a highly skilled and dedicated staff, backed by huge and growing resources. There are well over 6,000 more doctors and dentists and 70,000 more nurses and midwives than in 1978. Spending has shot up - from £8 billion in 1978 to £26 billion in 1989 (£154 million each week in 1978 compared with £500 million each week in 1989). And, to take just one example, the NHS now cares for $1\frac{1}{2}$ million more in-patients each year.

There is a lot to be proud of. Today, the Health Service is helping people in Britain to live longer and enjoy a better quality of life. But despite those successes, the performance of the NHS still varies greatly from place to place:

- people have to wait for operations much longer in some places than in others. A patient who has to wait several years in one District could have the same operation within a few weeks in another;

- drug costs in some places are nearly twice as high per head of population as in others.

- some GPs refer twenty times more patients to hospitals than others.

- the average cost of treating someone in hospital varies by as much as 50% between different health authorities.

Of course, the NHS is not a business run for profit, but it can certainly become more business-like. What the Government now wants to do is to take all that is best in the NHS, and raise the rest of it to that very high standard. An NHS that is run better will be an NHS that can care better.

The Way Ahead

Over the last year, the Government has been looking at ways of strengthening the Health Service. That review is now over, and its conclusions have just been announced. Some of them will need the approval of Parliament. They all have a simple aim - a service that puts patients first. But while some of them will require major reforms in the way the NHS is run, the basic principles that have guided it over the last 40 years will continue to guide it into the next century. As now, the Health Service will continue to be available to everyone, regardless of income, and paid for mainly out of general taxation.

The proposals are all designed to enable those who work in the NHS to give you even better care. In future:

* as much power and responsibility as possible will be taken from central and regional administration and given to those working to provide care at a local level;

* resources will go more directly to those hospitals which offer the best service - popular hospitals which attract more patients will attract more money. Rewarding the best will increase the quality of patient care, and encourage all hospitals to improve their standards;

* major hospitals will be able to choose to run their own affairs. Known as "NHS Hospital Trusts", those self-governing hospitals will still be part of the NHS, but will have much more freedom to take their own decisions. In order to earn income, they will have to provide the kind of service that patients want. They will of course continue to provide emergency treatment to anyone who needs it;

* large GP practices will be able to buy a range of services direct from hospitals. They will be able to "shop around" to get the best possible care for their patients. This means that they will, for example, be able to send patients to hospitals where waiting times are shortest. All GPs will also be encouraged to offer a better service, because their pay will be increasingly related to the number of patients they attract. It will be easier for patients to choose (and change) their GP;

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All these reforms will improve the quality of the service that the NHS provides. Some of them will however take time to work through. So there will be other initiatives to tackle the areas of greatest public concern more immediately:

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- individual and reliable appointment times;
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5. The organisation of the NHS - the way it delivers care to individuals - needs reform. The Government has already taken a series of measures to improve the way the Service is managed, notably the introduction of general management. Their success points the way ahead.

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* More rigorous audit arrangements

To ensure that all who deliver patient services make the best use of resources, quality of service and value for money will be more rigorously audited. Arrangements for "medical audit" will be extended throughout the NHS. And the Audit Commission will audit the accounts of health authorities and other NHS bodies and undertake wide-ranging value for money studies. It will report to Ministers and its reports will be published.

10. The Secretary of State for Health will shortly publish a number of working papers explaining in detail how major aspects of these proposals are to be implemented in England.

CONFIDENTIAL

[TO BE IN A SEPARATE BOX]

[redacted]SELF-GOVERNING HOSPITALS

The Government wants to create a number of "self-governing" hospitals within the NHS in order to:

* make the most of the energy, commitment and ability of hospital staff, by setting them free from many of the current constraints.

* encourage a stronger sense of local pride in hospitals, many of which are substantial organisations spending £10-50 million a year.

* enable them to offer their services throughout the NHS and to the private sector, which should lead to more patient choice, greater efficiency and encourage other hospitals to do even better. As a result patients should receive better services.

The powers and responsibilities of each self-governing hospital will be vested in a new body, known as an NHS Hospital Trust. They will be run by small Boards of Management operating like a commercial Board of Directors, with executive and non-executive members and a General Manager.

Self-governing hospitals will get their money from selling their services, mainly to health authorities. A hospital which is good at its job and attracts increasing numbers of patients will see its income rise.

A simple procedure will apply for establishing an NHS Hospital Trust. A variety of groups will be able to start the ball rolling, such as the hospital management team or the senior medical staff, with the Secretary of State for Health taking the final decision. Initially, major acute hospitals will be the most suitable candidates but in due course other hospitals may come within the scope of the proposals.

Self-governing hospitals will be free to determine the pay and conditions of their own staff. And they will have greater freedom (within limits) to borrow capital.

The first self-governing hospitals should be established from April 1991, subject to the necessary legislation.

CONFIDENTIAL

[TO BE IN A SEPARATE BOX]

NEW FUNDING ARRANGEMENTS

At present, NHS funds are allocated from central Government to individual hospitals (via Regions and Districts) through a complicated and remote process. Regions get their money through the RAWP formula. RAWP has largely achieved its purpose of equalising the resources available to each Region. But it has disadvantages. It's highly complex and slow to compensate those Regions which take many patients from elsewhere. District funding too is slow to reflect these flows of patients across administrative boundaries. This means funding and workload may be out of step. As for hospitals, they are at present subject to the perverse effects of a system which can penalise success.

The Government wants to change all this. So it proposes to:

* change the method of funding Regions and Districts to a simpler one based on population numbers and weighted for the health and age of that population. The cost of treating patients from other Regions and Districts will be reflected in budgets much more quickly than now. The Thames Regions will get slightly higher funding per head - some three per cent - to reflect their populations' higher use of services. The transition to the new system should be complete by April 1992 for Regions and [April 1994] for Districts.

* place the funding of hospitals on a new footing. The objective is a system where the money goes more directly to where the work is done and done best.

At the hospital level there is a clear distinction to be drawn between services where guaranteed immediate access is necessary, such as Accident and Emergency, and those where the patient and his GP have some choice about when and where to be treated. Some immediate access (or "core") services will be funded through a management budget by which the DHA sets clear performance targets for its own hospitals. DHAs will also be able to buy such services from other Districts or from self-governing hospitals.

Where there is some choice over the time and place of treatment, [redacted] services will be obtained through a contract, specifying the cost and amount of treatment. DHAs will be able to place contracts with their own, directly managed, hospitals, or with self-governing, private or other DHAs' hospitals. [GPs will still be able to refer a patient to whichever hospital or consultant they think best.]

[TO BE IN A SEPARATE BOX]

GP PRACTICE BUDGETS

The GP service is one of the great strengths of the NHS. The GP is the patient's key adviser about the best hospitals and specialists. But it can take a long time for good and popular hospitals - which treat more patients - to receive more money. So GPs have little incentive to offer patients a choice of hospitals.

The Government wants GPs in large practices to hold their own budgets with which they can buy hospital services for their patients. These budgets will cover:

* out-patient services;

* a defined group of in-patient and day case treatments, such as hip replacements and cataract removals;

* diagnostic tests, such as X-rays and pathology tests.

And budgets will be bigger and more flexible (at least £600,000-700,000) by also including:

* the 70% of the cost of employing staff which the Government already reimburses;

* money for improving premises; and

* the costs of prescribing drugs.

At first only practices with lists of at least 11,000 patients (twice the national average) will be eligible to join this voluntary scheme. Over 1,000 UK practices could join, covering about 25% of the population. The details of each practice budget will be settled by the RHA with the practice, within national guidelines to ensure consistency and fairness. Savings will be available to finance further improvements in the care delivered. And a fee will be provided to cover the costs of participation. The scheme should start from April 1991.

SCOPE OF THE PROPOSALS

11. Everyone is entitled to better health services with higher quality and more choice, regardless of where they live. So the White Paper proposals apply throughout the UK. The way they are implemented in each country will need to reflect each one's particular organisation of health care, as well as its distinctive needs and circumstances.

PUTTING PATIENTS FIRST

12. People sometimes have to wait too long for treatment and may have little, if any, choice over the time or place of treatment. The Government has already done much to tackle this problem. Over the past two years, £60 million has been spent on a new initiative to reduce waiting lists and times, allowing over 230,000 additional patients to be treated. As a result, half of all waiting list patients are now admitted from the list within five weeks or less. In 1989/90, another £40 million will be spent on this initiative.

13. The changes in the White Paper seek to improve further the quality of services offered by the NHS. At present the service provided on admission to hospital is sometimes too impersonal and inflexible. The Government intends to improve matters by ensuring that, like the best hospitals now, every hospital provides a service which considers patients as people, by offering:

* appointment systems which give people individual and reliable appointment times.

* quiet and pleasant waiting and other public areas.

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

* once someone is in hospital, clear and sensitive explanations of what is happening.

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

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities, such as single rooms, televisions and choice of meals, for those prepared to pay for them.

THE BEST USE OF RESOURCES

14. A quality Service - which provides not only clinical excellence but also makes patients feel valued - requires a quality management and organisation. To provide the best possible service from its resources, particularly as demands continue to grow, the NHS must always seek to make the best use of the resources available.

15. [There will be no wholesale administrative reorganisation of the NHS.] But local managers must have more freedom to manage. And those whose decisions affect the use of resources must be more accountable for that expenditure. For some time the Government has been concentrating on giving more responsibility for taking decisions to those actually working in hospitals. The White Paper aims to take this process much further by:

* effecting a clearer distinction at national level between Ministers' policy responsibilities and the operational duties of top management.

* continuing the drive towards better information systems for local managers, enabling them to improve their budgeting and monitoring.

* ensuring that hospital consultants - whose decisions about treatment commit substantial sums of money - are more directly involved in hospital management; accept responsibility for their use of resources and are encouraged to use those resources more effectively. Proposals here include agreeing up-to-date job descriptions and modifying the distinction awards scheme.

* ensuring that GPs too take greater responsibility for their use of resources. Additional resources will be made available for developing computer systems for general practice.

* obtaining further improvements in the cost information available to managers, doctors and other professionals by extending the Resource Management Initiative - to up to 50 more acute hospitals in 1989/90, with the aim of covering all 260 major acute units by the end of 1991/92.

* introducing a system of accounting for capital which encourages managers to balance the need for new investment against the maintenance of older stock. Limits on the size of new projects needing central approval will be raised and joint ventures with the private sector encouraged.

* ensuring that drug prescribing costs are kept within reasonable limits.

* ensuring that services are carried out as cost-effectively as possible by contracting out more functions.

* re-examining the work of nurses and other professional staff so as to secure the most cost-effective use of their skills.

* making the reconstituted FPCs accountable to Regional Health Authorities.

PUBLIC AND PRIVATE SECTORS WORKING TOGETHER

16. The NHS and the independent health sector should be able to support each other and provide services for each other, to the benefit of patients. Those who choose to buy health care outside the Health Service take pressure off the NHS and add to the diversity of provision and choice. The Government expects to see further increaes in the number of people wishing to make private provision. But many who do so during their working life find the cost of higher premiums difficult to meet in retirement. The Government therefore proposes to allow tax relief on private medical insurance premuims paid by retired people or, for example, by their families on their behalf.

MANAGING THE FAMILY PRACTITIONER SERVICES

17. Primary care provided by GPs and the work of hospitals are closely intertwined. The Government intends to build on the proposals in its White Paper on primary care services, "Promoting Better Health", by:

* encouraging GPs to take greater responsibility for their use of resources. One objective is to introduce a national framework for medical audit whereby GPs would systematically review their work, supported by a special committee in each FPC.

* pressing ahead with plans to let consumers have more information about GP services and to make it easier to change doctor.

* increasing competition between GPs by raising the proportion of their pay derived from the number of patients on their lists from 46% to at least 60% as soon as possible.

* taking steps to control the total cost of the GP service whilst ensuring that sufficient opportunities remain in general practice. So the Government will seek reserve powers to control, if necessary, the number of GPs in contract with the NHS. It will also seek to reduce the retirement age of GPs from 70 to 65.

* reducing the rate of increase in spending on drugs through a new budgeting scheme whereby RHAs will give FPCs budgets for drug spending and GP practices will receive indicative budgets for their prescribing costs. There will be special arrangements to deal with over- and under-spends at both the practice and FPC level. People will still be able to get the medicines they need.

PROGRAMME FOR REFORM

18. The White Paper proposals will enable a higher quality of patient care to be obtained from the resources devoted to the NHS. They represent a wide-ranging opportunity to put the interests and wishes of patients at the forefront of decision-making at all levels.

19. They also offer a new and exciting challenge to all those who work in the NHS. The proposals amount to a substantial body of change, which must be implemented with determination and commitment.

20. The provision for health in the coming financial year, 1989/90, includes the likely costs of preparing for the reforms. Over time, any extra costs should be offset by the improved efficiency which will stem from the changes. The total provision for health will take account of progress in implementing the reforms, including the increased efficiency savings. The costs of implementation in future years will be considered in the annual public expenditure surveys.

21. Throughout the programme of reform the Government will hold to its central aims:

to extend patient choice; and

to delegate responsibility to those best placed to respond to patients' needs and wishes.

The result will be a better deal for the public, both as patients and taxpayers. The Government will build further on the strengths of the NHS, but will not flinch from tackling its weaknesses. This is the way to ensure that the NHS continues working for patients.

[TO BE IN A SEPARATE BOX]

A TIMETABLE FOR CHANGE

Legislation will be introduced at the earliest opportunity to give effect to the proposals. The programme of reform will have three main phases:

PHASE 1: 1989

* The Secretary of State for Health will establish a new NHS Policy Board and reconstitute the NHS Management Board.

* The Health Departments, and RHAs in England, will identify the first hospitals to become self-governing as NHS Hospital Trusts, and plan for their new status; will devolve further operational responsibility to Districts and hospitals; and will begin preparing the ground for GP practice budgets.

* The Government will introduce regulations to make it easier for patients to change their GP.

* The first additional consultant posts will be created; Districts will begin agreeing job descriptions with their consultants; and a new framework for medical audit will begin to be implemented.

* The resource management initiative will be extended to more major acute hospitals.

* Preparations for indicative drug budgets for GPs will begin.

* The Audit Commission will begin its work in the NHS.

PHASE 2: 1990

* The changes begun in Phase 1 will gather momentum. Devolving operational responsibility, changing the management of consultants' contracts and extending medical audit throughout the hospital service will near completion.

* "Shadow" Boards of the first group of NHS Hospital Trusts will start to develop their plans for the future.

* RHAs, DHAs and FPCs will be reconstituted, and FPCs will become accountable to RHAs. Regions will begin paying directly for work they do for each other.

PHASE 3: 1991

* The first NHS Hospital Trusts will be established.

* The first GP practice budget-holders will begin buying services for their patients.

* The indicative drug budget scheme will be implemented.

* District Health Authorities will begin paying directly for work they do for each other.

23/1

000966

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

22 January 1989

GRAY TO M'KEON 22/1

NHS REVIEW: WHITE PAPER SUMMARIES

The Prime Minister was grateful for a sight of the two proposed summaries of the White Paper, enclosed with your letter of 20 January to Carys Evans.

Popular Version

The Prime Minister has the following comments:

- in the first line delete "the best system of its kind" and substitute "unsurpassed";
- add to the end of the last sentence of the first paragraph "bringing the total to X millions a year";
- on the first line of page 3 delete "major";
- the Prime Minister thinks it is essential for the popular version to include a reference to tax relief for the elderly.

Draft Paper for NHS Staff

The Prime Minister has the following comments:

- paragraph 9, second indent, line one, delete "major";
- section on Self-Governing Hospitals, paragraph 4, delete the last sentence (beginning "Initially, major acute hospitals....")
- in the New Funding Arrangements section, delete the last sentence;
- in the GP Practice Budgets section, third paragraph, amend "at least £600,000-£700,000" to "at least £500,000";
- paragraph 15, first sentence should be deleted.

I am copying this letter to Carys Evans (Chief Secretary's Office and Richard Wilson (Cabinet Office).

PAUL GRAY

Andy McKeon, Esq.,
Department of Health.

SECRET (3)

PRIME MINISTER

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

I attach the detailed paper on the central management of the NHS for which you asked.

2. You will see from the paper that I am well content with the title of Management Executive that you suggested.

3. I make only one general point. It is that whatever we decide on central management and accountability should be consistent for the United Kingdom as a whole.

4. I am copying this minute and the paper to the Chancellor, the Secretaries of State for Wales, Scotland, Northern Ireland, the Chief Secretary, the Minister for Health, Sir Robin Butler, Mr Wilson (Cabinet Office) and Mr Whitehead (Policy Unit)

23 January 1989

K C

SECRET

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

Note by the Secretary of State for Health

I attach summary notes setting out:

- the functions, structure and management of the Department of Health (DH) (Annex 1)

- staff numbers in DH (Annex 2)

- the management of the NHS by the Management Board (Annex 3)

2. We have three broad objectives:

first, to put in place an effective chain of command to implement and carry forward our proposed reforms.

second to make clear the distinction between policy advice and operational responsibilities at the centre and the relationship between the managerial chain of command and the Department.

third, to ensure that the Government are only answerable in Parliament for those matters for which they can sensibly be held to account.

Future arrangements for central management of NHS

3. There is a range of options. They begin with the present arrangements then move progressively further from that. In order they are:

1. Management Board (MB), as now

   The MB has a distinct role within the Department, but is essentially part of it. We are agreed we must move beyond this.

2. Management Executive (ME), with a separate and defined status under the Secretary of State for Health

   This would put the ME on a quite different basis from the MB and, for the reasons set out below, is my preferred option.

3. English Health Authority (EHA), a body with separate legal status.

   A new body, between the Secretary of State and the NHS with a Chairman as well as a Chief Executive. Unlike now, Regional Health Authorities (RHAs) would be statutorily responsible to the EHA, rather than the Secretary of State. The simplest model would be a health authority model.

4. Health Service Corporation (HSC), a public corporation with separate legal status.

   The HSC would operate like a nationalised industry,

with direct management control. It could be a unitary model or a devolved model. With a unitary model, the NHS would become a single unified organisation with central, regional and local boards. But the regional and local boards would have no separate legal identity as health authorities have now. With a devolved model, regional and local boards could become more independent bodies. So the Northern Region for example could develop its own character, rather like the NHS has developed its own character in Scotland, Wales and Northern Ireland.

4. Starting with the far end of the spectrum, a Health Service Corporation as in Option 4 would provide a clear separation of the Government from the management of the NHS. The unitary model would provide a streamlined, direct chain of command. The devolved model would provide a visible buffer between the centre and local management, enabling the latter to get on with its job.

5. But I am not aware of any precedent for a public corporation running a public service funded almost entirely (97%) from taxation (81%) and National Insurance contributions (16%) and with virtually no independent income of its own. Even those nationalised industries that have been grant aided have had profit and loss accounts to which they have taken their income from charges or trading. Detailed accountability to Parliament would certainly be much less than now - but to an extent which we would not find easy to defend. We would also have to deal with allegations that the public corporation was a first step to privatisation. And, most important of all, an independent public corporation with a high profile Chairman and funded through taxation would become a powerful, and very visible, lobby for extra resources.

6. Unlike the public corporation model, the English Health Authority envisaged by option 3 would be recognisably in the NHS mould by building on the existing NHS structure. It would provide a separation between the Government and the management of the NHS, though not as sharply as option 4. It would provide an extra link in the chain of command between the centre and regions which matched that between regions and districts.

7. This option still presents us with two of the significant obstacles which apply to option 4, a public corporation. First the EHA would not be part of central government. The Accounting Officer would have to be in DH, as he would be if we went for option 4. And inevitably, the temptation for the EHA would always be to attribute failings to the lack of resources or other constraints imposed by Government. Of course, we would maintain some disciplines through contractual obligations and direct lines of accountability to me from the EHA and its senior management. But the EHA would come under permanent pressure from many of the health authorities below it to become a powerful and visible lobby for more resources. That indeed would be seen as its only quality by people in the NHS who would otherwise look on it as another layer of bureaucracy between them and Ministers. Second, if we are to adopt this option, or option 4, we should have to look again at the arrangements in Scotland, Wales and Northern Ireland.

8. Having reexamined the case for options 3 and 4, I have concluded that option 2, a Management Executive, is to be preferred. Annex 1 explains how the Management Board operates within the Department of Health. As my minute of 18 January made clear, I fully recognise both the enhanced role we see for the new ME which will replace the Management Board and the need for us to mark out its new status clearly. I

propose a number of important steps to achieve this:

First, all central operational and management work on the NHS would come under the ME.

Second, staff working for the ME would have a clearly defined responsibility to the ME. If necessary, this could be incorporated in letters of appointment. I also expect that in future a greater proportion of ME staff will be seconded from the NHS.

Third, all operational and management work on the family practitioner services, including negotiations with the contractor professions, will in future be the responsibility of the ME. The Chief Executive will become Accounting Officer for this block of work too. My officials are discussing with the Treasury the implications of this for the present Vote structure.

Fourth, as I said in my minute of 18 January, the Chief Executive will report to me direct on all NHS operational and management matters.

Fifth, the Chief Executive will have his own budget for the operation of the ME. The precise accounting arrangements, which could draw on the Next Steps Agency model, would need to be worked out.

Sixth, as I have also already said, the Chief Executive will take a prominent role in dealing with Select Committees.

Finally, I envisage that the ME will operate on the basis of policy and resource directives issued by the Policy Board which I chair.

9. Taken together, these steps will both underline and underpin the new and separate status of the ME. They will not however - nor should they - lead to a situation where policy and strategy on the one hand and operations and management on the other become artificially separated. The ME will not be excluded from offering me policy advice; and of course the Chief Executive will be on the Policy Board. Similarly, I will not expect the Department to frame its policy advice without taking account of operational and management factors. And some senior officials will need to offer me advice on both fronts. The crucial point is that it will be clear where the advice comes from, the Department or the ME. It will be like advice on fiscal matters to the Chancellor, some of which comes from the Treasury's Fiscal Policy Division and some from the Inland Revenue

The Secretary of State, the ME and the RHAs

10. There are two lines of communication now between the centre and regions. One is between the Secretary of State and the Chairman, who are appointed by him. The other is between the Chief Executive and the Regional General Managers. This is less messy and more practical than it sounds. The line to Chairman from me is essentially political; the management line is from the Chief Executive to the Regional General Managers. The same arrangement applies between Regions and Districts. If a Regional General Manager spots any different emphasis between the messages he is getting from the Chief Executive and his Chairman it is quickly sorted out in practice.

11. In future the management line will be reinforced by my intention (mentioned in my minute of 18 January) that Regional General Managers will be accountable to the Chief Executive who will set objectives for them. I intend that the Chief Executive will be responsible for monitoring the

performance of Regional General Managers against objectives set for Regions by the ME.

12. It is important, however, that we retain the separate links to Chairmen who, as I have said, regard themselves as charged with the delivery of Government policy in their Regions. This will help us considerably in carrying through our reforms. But it may be even more important in achieving our aims on accountability. Regional Chairmen, as Chairmen of public authorities, have a personal position and standing of their own. This enables them to act as political firebreaks, in resolving or halting issues so that they do not automatically reach Ministers and Parliament.

Accountability

13. My approach to the Management Executive will enable us to establish a new basis for Ministerial accountability to Parliament. Operational and management matters will be for NHS Management rather than Ministers. National management issues will be for the ME to handle and more detailed issues for Regions, Districts and local management to handle as appropriate. I envisage that, when our legislation is implemented, we should normally refer Members who write or ask Questions to the relevant level of the NHS.

14. I do not expect us to get to our final goal overnight. We must move towards it steadily, as part of the implementation of our reforms. It would not be helpful in carrying through our proposed legislation if we were to appear to present Parliament with a fait accompli which meant an immediate and major shift in the present conventions on accountability. In any event I would not want health authorities as at present constituted before our legislative changes to be given this opportunity to attack the Government when pressed on their local problems.

15. I should reiterate the point that we can only change Parliamentary expectations on accountability if we maintain a common line in all four countries. Otherwise my position, and that of the Prime Minister, would not be tenable.

DH 23 January 1989

THE DEPARTMENT OF HEALTH

Functions

The Department has two main functions:-

a. to inform, advise and serve the Secretary of State and other Ministers across the whole range of their responsibilities for health and personal social services, including:

i. supporting Ministers in their, and the Department's duty of informing and accounting to Parliament.

ii. developing policy in response to the requirements of the Secretary of State and of Parliament, consulting the relevant statutory authorities and others as appropriate.

iii. co-ordination and close collaboration with the Cabinet Office, Treasury and other Government departments in carrying forward the business of the Government as a whole.

b. to support the Secretary of State in the implementation of the legislation for which he is responsible, including the efficient and effective delivery of services costing £23 billion in 1989/90 and employing directly and indirectly over a million people.

Services

2. The services in England for which the Secretary of State is responsible can be grouped broadly as follows:-

a. Hospital and Community Health Services, delivered through the agency of 14 Regional Health Authorities, 191 District Health Authorities and 10 Special Health Authorities governing the London post-graduate teaching hospitals, the Health Education Authority and the Disablement Services Authority and managed by the NHS Management Board.

b. Family Practitioner Services: Services are provided on the Secretary of State's behalf by 62,000 independent contractors. Their contracts are negotiated centrally by the Department with representatives of the professions concerned; and are administered locally by 90 Family Practitioner Committees which were established in 1985 as separate bodies directly accountable to the Secretary of State.

c. Personal Social Services: the Social Services departments of local authorities are required by statute to act under the general guidance of the Secretary of State who, in addition, possesses certain specific powers (eg of formal

inquiry, inspection and action in default) and responsibilities (eg in relation to social work training) but not the same measure of resource allocation and performance monitoring as for the health services

d. an extensive range of wider health and social responsibilities some of which derive from specific statutes and others from his general statutory duty to safeguard public health. They include direct executive responsibilities for Special Hospitals, public and environmental health measures, public health laboratories, health education and preventive health measures, relations with the private health sector, licensing medicines, evaluating health care equipment, sponsoring the pharmaceutical and medical equipment industries, grants to voluntary bodies, sponsoring research, monitoring the professions' self regulation and international work.

Structure and Management

3. Support to the Secretary of State for the two main functions is provided at Headquarters. Management developments have been based on the following specific guidelines:-

i. No work should be done in the Department that could be done more cost-effectively outside it.

ii. Work should be delegated to the lowest competent level, subject to monitoring by higher management;

iii. There should be clear lines of accountability at all levels; and

iv. Managers at all levels should be held accountable for performance against agreed objectives.

Where the Department has responsibility for the implementation of policy, directly or indirectly, management bodies dedicated to the particular service have been established some with external advice. By contrast, the Department maintains responsibility of the integrated formulation of policy over the whole field of the Secretary of State's responsibility for health and personal social services, in liaison with the relevant statutory authorities. The Department is developing new management information systems to reflect the varying communications needs of the main businesses.

4. Most recently possible candidates as Next Steps Agencies have been identified with a view to improving the efficiency and effectiveness of delivery of services to customers when it has seemed inappropriate to delegate responsibility for delivery outside the Department.

5. The analysis of DH Headquarters staff numbers at Annex [2] illustrates this trend: Medicines Division (227 staff) is about to become a self-financing Agency within the Department; the Special Hospitals (3,220 in the hospitals themselves) are due to become a Special Health Authority within the NHS this year; NHS Statutory Audit (220) will be transferred to the Audit Commission; the Disablement Services Authority (1,080) is already a Special Health Authority, though for the moment mainly staffed by DH officials; the Dental Reference Service (62) is being transferred to a Special Health Authority and NHS Superannuation (800), Youth Treatment Centres (190) and the Social Services Inspectorate (192) are possible candidates for Next Steps Agencies. Thus the size of the DH is in the process of being more than halved; and a further 1,400 staff are already being transferred or are being examined for transfer into different forms of Agency.

DEPARTMENT OF HEALTH

Approximate Staff Numbers, January 1989

A. HEADQUARTERS (London based)

			Total
(i)	NHSMB support		
	(a) Information, Performance Indicators, Planning, IT	64	
	(b) Health Authority Finance, Financial Management, Management Services, Income Generation	82	
	(c) Regional Liaison	87	
	(d) Health Building	103	
	(e) Procurement	157	
	(f) Personnel	115	
	(g) Estate and Property Management	25	
		633	633
(ii)	Family Practitioner Services		166
(iii)	Health & Personal Social Services Policy		353
(iv)	Medicines Division (Licensing & regulation of pharmaceuticals) (NOTE 1)		227
(v)	Professional Groups (including administrative support)		
	(a) Medical	234	
	(b) Dentists	10	
	(c) Nurses	65	
	(d) Social Services Inspectorate HQ (NOTE 2)	66	
	(e) Analytical and statistical	266	
	(f) Legal	28	
		669	669
(vi)	Finance and internal audit		139
(vii)	Personnel Management and Central Account		203
(viii)	Private Offices and Information Division		83
(ix)	Office Services (typing, messengers, security etc)		420
	Total		2893

NOTE 1: About to become a self-financing Agency within the Department with externally recruited director.

NOTE 2: These are HQ numbers; see B5(a) for the field force.

B. DEPARTMENT OF HEALTH SERVICES

			Total
(i)	Special Hospitals	(NOTE 3) 3220	
(ii)	NHS Superannuation	(NOTE 4) 800	
(iii)	Youth Treatment Centres	(NOTE 4) 190	
(iv)	NHS Statutory Audit	(NOTE 5) 220	
(v)	Miscellaneous services (outside London)		
	(a) Social Services Inspectorate (NOTE 4)	126	
	(b) Dental Reference Service (NOTE 6)	62	
	(c) Regional Medical Service	219	
	(d) Mental Health Act Commission and Review Tribunals	47	
		4884	4884

C. DISABLEMENT SERVICES AUTHORITY (NOTE 7) 1080

GRAND TOTAL	A. Headquarters	2893	
	B. DH Services	4884	
	C. DSA	1080	
		8857	8857

NOTE 3: Planned to become a Special Health Authority within the NHS during 1989

NOTE 4: Possible candidates for Next Steps Agencies

NOTE 5: To be transferred to the Audit Commission on 1.4.91

NOTE 6: To be transferred to the Dental Estimates Board (an SHA) on 1.9.89.

NOTE 7: Became a Special Health Authority in July 1987 tasked with arranging full transfer to the NHS by 1.4.91. Included in the Department only because the Authority is, for the present, staffed mainly by DH officials.

ANNEX 3

THE MANAGEMENT OF THE NHS BY THE MANAGEMENT BOARD

The NHS Management Board (MB) currently manages the NHS through a series of formal systems and informal relationships. Ministers are heavily involved in many of these systems and relationships. The following notes describe the main elements.

2. The MB's Director of Finance leads the Department's work on establishing the financial needs of the NHS in PES. Once Ministers have agreed the outcome, the Finance Director advises Ministers on the allocations to individual Regions and other health authorities, and is responsible for the release of funds to individual authorities, for monitoring expenditure against cash limits and for ensuring delivery of the cash limit by the NHS as a whole. The MB's Director of Financial Management monitors the income and expenditure position of RHAs and their Districts in order to ensure that the NHS spends at a level which can be afforded.

3. Health authorities are required to draw up short term programmes (ie annual operating plans) before every financial year. These show what services they intend to provide (including new developments), what manpower will be employed and how they will be funded. The STPs must be framed to respond to policy guide-lines from the Department eg as to the development of particular services. The STPs must also contain proposals for

cost improvement and income generation. These STPs are vetted for ambition, coherence and soundness by the revelant MB Directors (Planning, Financial Management, Operations and Personnel), before approval. Implementation is monitored by the MB.

4. The performance of each RHA is thoroughly reviewed every year. The MB examines, inter alia, the execution of a series of special tasks agreed with the RHA at the previous year's review (the Action Plan); the RHA's financial position; and its achievement of a range of policy or other objectives eg the improvement of vaccination rates, the implementation of energy conservation measures,the better use of beds the reduction of waiting times. Having carried out their review, the MB Directors then support a Minister to who carries out Ministerial Review, at which the key issues are thrased out with the RHA Chairman.

5. Capital investment in the NHS is controlled through the requirement on RHAs to submit major building schemes for approval - schemes of over £10m have to go to the Treasury, - and through the monitoring of RHA performance on schemes (eg time and cost over-run).

6. RHAs are obliged to submit disputed hospital closures for Ministerial decision. Such closures often cause political

difficulties and considerable work for the health authorities, Ministers and officials.

7. The pay and conditions of NHS staff are tightly controlled through their central determination by Ministers, whether on the advice of Review Bodies or Whitley Councils.

8. RHAs, and DHA Chairmen, are appointed by Ministers. Ministers now enjoy very close relations with Regional Chairmen. Ministers meet them regularly; frequently consult them on policy and management issues; and expect (and receive) considerable personal loyalty in carrying out Ministers' policies.

9. The MB Chief Executive and his fellow Directors enjoy good relations with Chairmen and very close relations with Regional General Managers. The Chief Executive has established himself as "professional" head of general managers in the NHS, and spends much time and effort encouraging the development of management skills and raising management standards in the NHS. Through hundreds of visits and speaking engagements he has become highly visible to the NHS managers. The MB's functional directors (eg Financial Management, Personnel) also act as professional heads of their functions in the NHS.

10. Paragraph 2-7 above describe some of the formal, regular systems by which Ministers and the MB manage the NHS. In addition, of course, the MB is in frequent touch with Regions and Districts over particular problems or issues. The requirement to answer in Parliament for what happens in the NHS inevitably pulls up, to Departmental level, many issues which would not otherwise require our involvement.

SECRET

PS/Chancellor
PS/CST
Sir Peter Middleton
cc Mr Anson
Mr Beastall
Mrs Lomax
Mr Peirson
Mr Saunders

WILSON (CAB. OFFICE) TO HEPPELL (HEALTH) 23/1

CABINET OFFICE

P 03343

70 Whitehall London SW1A 2AS Telephone 01-270

S T Heppell Esq
DEPARTMENT OF HEALTH
Richmond House
Whitehall
LONDON SW1

HP. 23/1.

23 January 1989

Dear Strachan,

NHS REVIEW: ACCOUNTABILITY

Following the decision in the Ministerial Group that it should be made clear that Ministers are not to be answerable in Parliament for day-to-day operations of the NHS, we have been considering with the Machinery of Government Division of the Cabinet Office what this might mean in practice. The following thoughts may be helpful in drawing up the new arrangements referred to in Paul Gray's letter of 20 January.

i. The Secretary of State will continue to be answerable to Parliament, not only for the huge sums of money spent on the NHS as indicated in paragraph 2.4, but also for the matters dealt with by the Policy Board and for the functions dealt with by his Department which lie outside the NHS (eg public health).

ii. If the Secretary of State is asked by a Member of Parliament about an operational matter, his normal course will be to refer it to the Chief Executive or, in appropriate cases, the relevant Regional or District Health Authority for a reply. The Chief Executive will be available to appear before Select Committees or to meet MPs on operational issues, where necessary. In the last resort, if the MP is still not satisfied, particularly on a major issue such as a hospital closure, it will still be open to the Secretary of State to reply; but this will not be the normal routine.

iii. In exceptional cases, where for instance an operational issue may be symptomatic of a more general national problem, the Secretary of State may respond to pressure in Parliament by asking for a report from the Chief Executive, discussing it with him and publishing the report together with an account of the action being taken to deal with the problem.

I am copying to Hayden Phillips.

Yours,

R T J WILSON Richard

15
230

cst.ps/4pw23.1/lets

SECRET

000067

cc- CX. Mr Anson
Mr H Phillips,
Miss Peirson
Mr Griffiths
Mr Saunders
Mr Gall

Treasury Chambers, Parliament Street, SW1P 3AG

PWP

Andy McKeon Esq
Principal Private Secretary
to the Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1

23 January 1989

Dear Andy,

NHS REVIEW:WHITE PAPER SUMMARIES

We spoke earlier today about the two NHS review summaries enclosed with your letter of 20 January and I relayed the Chief Secretary's comments to you. For the record these are detailed below.

DRAFT POP VERSION OF WHITE PAPER

First paragraph, line 6: delete 'compared with' and insert 'has now risen to'.

Under "The Way Ahead" second indent, redraft first sentence to read '..popular hospitals which treat more patients will receive more money'.

Amend fifth indent, first sentence to read. ' ... over the next three years over and above the increase previously planned'.

The Chief Secretary also suggests inserting a new final indent which reads as follows:

'There will be more rigorous audit of quality of treatment and value for money. Arrangements for medical audit will be extended throughout the NHS. And the Audit Commission will take over the audit of health authorities and other NHS bodies'.

Under the heading "Timetable for Change", the Chief Secretary would like to amend the fourth sentence to read:

'By 1991, and subject to the approval of Parliament, the first NHS Hospital Trusts will be up and running ..."

The Chief Secretary would like to include a final paragraph entitled 'The best use of resources". This would read as follows.

'These reforms will also improve the value that people get for the £35 a week the average family pays for the NHS. Managers will be freed to get on with the job of managing. And doctors will be made more accountable for the resources they use.'

Finally the Chief Secretary thinks that the 'pop' version should include a paragraph along the lines of paragraph 16 in the staff version.

SUMMARY OF NHS REVIEW WHITE PAPER - FOR NHS STAFF

In paragraph 3 the Chief Secretary suggests adding a new fourth sentence. 'It now totals £35 per family, per week.'

The Chief Secretary is firmly of the view that the fourth indent of paragraph 9 should mention the other half of the consultants package; namely enforcement of contracts and the new approach to merit awards

Paragraph 9 should end with the sentence 'Some of these proposals will require the approval of Parliament.'

In the penultimate paragraph on self governing hospitals, the Chief Secretary would like to redraft the second sentence to read:

'And they will have freedom (within limits) to borrow money'.

Finally, the Chief Secretary thinks that the last sentence of paragraph 16 should be revised to read:

"The Government therefore proposes to allow tax relief on private medical insurance premiums for retired people, whether paid by them or, for example, by their families on their behalf.

I am copying this letter to Paul Gray (No.10) and Richard Wilson (Cabinet Office)

Yours,

Pete

PETER WANLESS
Assistant Private Secretary

23.1.89.1

SECRET

FROM: R B SAUNDERS
DATE: 23 January 1989

CHANCELLOR

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

Mail 1 Late

NHS REVIEW

The draft White Paper is to be taken in E(A) on Tuesday morning, which will be followed by a meeting of the Prime Minister's Group to discuss the central management of the NHS, on which Mr Clarke has been asked to circulate a further note.

Draft White Paper

2. With one exception, all significant Treasury points on the previous draft have been taken. The exception is that paragraph 3.13 still contains no reference to the need for self-governing hospitals to earn a rate of return on their assets. Mr Clarke does not question the policy, but thinks that to include the point in the White Paper might raise suspicions about privatisation. I do not think you need press the point, so long as it is made clear in the Working Paper on self-governing hospitals that their external financing limits will be set in the light of financial targets based on an appropriate return on assets. We will be offering appropriate amendments.

Central management of the NHS

at very end of folder

3. At the time of writing, I have seen Mr Clarke's paper only in draft. But Mr Phillips and I attended a meeting at Cabinet Office on Friday at which the issues were discussed.

SECRET

4. Mr Clarke continues to favour his existing option:

- a new Management Executive, under the Policy Board and the Secretary of State. This would be set up with clearer duties and responsibilities than the existing Management Board, and would be separated from the department

- a chain of command running from the chief executive of the Management Executive to regional general managers to district general managers

- general managers would also report to the chairman of their health authority

- the Secretary of State would maintain a separate line of communication with regional chairmen, and regional chairmen with district chairmen.

5. The problem with this structure, of course, is that regional general managers would serve two masters: the chief executive of the Management Executive and his health authority chairman. But both are appointed by, and answerable to, the Secretary of State. The difference is that the chief executive/RGM/DGM line is an "official" one, while the Secretary of State/RHA chairmen/RGM line is a "political" one (although by no means all regional chairmen are party political appointments, eg Sir Peter Baldwin). Department of Health argue that this split reporting line effectively works now, and can be made to work more formally in the future, because the Secretary of State bestrides both hierarchies, and the same message should be transmitted down both. It is argued that both the Management Executive and the regional chairmen have a role to play as buffers between the Secretary of State and detailed operational problems and issues. The regional chairmen can deal with local problems, while the Management Executive can tackle technical and management problems which may span more than one region.

6. This is partially, but not totally, convincing. It is not so clear from the paper what the Management Executive will actually do. It will act as a conduit between the Secretary of State and regions on operational and financial issues. The chief executive will have a representational function, for example with his annual report to Parliament. But this is not managing the NHS. Moreover, the separation from the department, while stated clearly in paragraph 7, is promptly blurred in paragraph 8 (my copy of the draft says "some senior officials need to offer me advice on both fronts [ME and departmental]").

7. The Management Executive may be the best model available, but the alternatives need to be considered. Since the problem with the proposed structure is that regional and district general managers are potentially torn two ways, the alternatives involve diminishing the role of one or other hierarchy. In other words, a reduced role for regional and district chairmen, or a reduced role for the Management Executive.

8. The Review's general approach is to slim down health authorities, turning them into more executive bodies. It would be consistent with this to do away with the quasi-political nature of their chairmen, so they became entirely executive bodies, chaired by the general manager. This is described in Mr Clarke's paper as the "Health Service Commission". The extreme "unitary" version would constitute the NHS as a single executive body, effectively a sort of departmental agency, reporting through the Management Executive to the Secretary of State. The problem is that a structure of this sort would tend to become very centralised, with a top down approach to management and large volumes of instructions emanating from the centre. Formally separating it from the department in an attempt to make Ministers no longer accountable in Parliament for individual cases would, as Mr Clarke rightly says, encourage it to act as a pressure group for higher expenditure.

9. A variant of this type of approach, which is less "unitary" but still downgrades the role of regional chairmen in relation to the Secretary of State, is his "English Health Authority" model. But this still creates a new public expenditure pressure. It would also create political difficulties with regional chairmen who would not take kindly to reporting to the Management Executive.

10. Alternatively one might beef up the regions, in particular their chairmen, as those primarily accountable for the performance of the NHS. This is a bit like Mr Clarke's "devolved Health Service Commission". The Management Executive would have a reduced role, primarily financing the regions, negotiating pay and issuing central guidance on major policy issues. This too has its problems. While the chief executive would continue to be Accounting Officer, his responsibilities would end with the allocation of money to regions. Regional general managers would presumably have to appear with him before the PAC on specific issues. And the Secretary of State is more likely to get drawn in on issues covering more than one region.

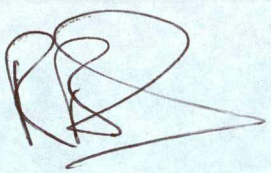
11. Treasury interests are to ensure that strong and effective lines of accountability (including to the PAC) exist, and that the organisation is not such as to generate pressures for higher spending. These considerations do not point decisively in favour of any one option. Options without the quasi-political buffer of the regional chairmen are likely to be less good at containing expenditure pressures, while distancing the Secretary of State from detailed answerability in Parliament. Mr Clarke's preferred model is on paper something of a muddle, but his judgement is that it can be made to work. On balance, we think it is best to accept his view.

Publicity for the White Paper

12. Mr Clarke is, as you are probably aware, planning an intensive campaign to get the White Paper across to people in the NHS. This will involve a live video conference, a "road show", and the production of short versions of the White Paper - a leaflet for the general public, and a longer version for NHS staff - copies of which you saw in draft over the weekend. The total cost of the exercise is £1.2m, and this received some press attention on Saturday.

13. If the point is raised, you should be aware that Cabinet Office are satisfied about the propriety of this. It is essentially a management communication exercise. The one exception is the "pop" leaflet, but its terms have been carefully

scrutinised by us and Cabinet Office and we are satisfied that they do not breach the conventions in these matters. We have also scrutinised the proposed expenditure, and have concluded that the costs are reasonable. The benefits of ensuring that those who work in the NHS receive details of the proposal from the Government and from their employers, rather than just reading about it in the newspapers, are worth the investment. The costs are being found within the existing NHS information budget, and from savings elsewhere.



R B SAUNDERS

0606A

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

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

CONFIDENTIAL

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

23 January 1989

CLARKE
EST
23/1

Dear John,

NHS REVIEW: DRAFT WHITE PAPER

Thank you for your letter of 19 January.

Taking your suggested amendments in turn:

- paragraph 2.23: accepted; ie "imaginative property schemes"
- paragraph 2.28: accepted;
- paragraph 3.14: I am unhappy with this suggestion, which raises a wholly new proposition going beyond the terms of HC65. I am of course prepared to discuss the basis on which self-governing hospitals should manage their finances, although I do not believe they should be placed under constraints, or set targets, which do not apply to NHS hospitals generally. On the understanding that this is the underlying intention, I have amended the preceding indent to clarify this point. The words you suggest would also tend to signal that self-governing hospitals might not, after all, remain within the NHS;
- paragraph 3.15: accepted (although I have turned the wording round to make it sound more positive);
- paragraph 6.9: I accept that this proposal has not previously been discused, and I have deleted it. But I have also removed the implication that the prescribing costs element of a practice budget would necessarily be the same as an indicative budget under the general drug budget scheme. I should like to give further thought to this. We may need to discuss further as the detail is developed;

E.R.

- paragraph 7.21: I have dealt with this in my minute of 19 January to the Prime Minister.

I am copying this letter to the recipients of yours.

KENNETH CLARKE

st.ln/min/1.23.1

SECRET

FROM: MISS M E PEIRSON
DATE: 23 JANUARY 1989

CHIEF SECRETARY

PWP

cc Chancellor
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Kelly
Mrs Lomax M. Luca
Mr Saunders Mr AM White
Mr Griffiths
Mr Call

NHS REVIEW: SCOTTISH CHIEF EXECUTIVE

1. Mr Rifkind's letter of 19 January to you proposes that he should announce in the White Paper his decision to appoint a Chief Executive for the NHS in Scotland. He proposes that the new post should be at grade 3, and that he should retain the existing two health grade 3 posts, at least until 1990.

2. I recommend that:-

i) you agree to the proposed amendment to the White Paper;

ii) you agree that the appropriate grade for the new post is grade 3; but

iii) you say that your agreement is without prejudice to your further consideration of the proposal to retain in addition the two existing health grade 3 posts.

3. As regards (ii), we have heard that Mr Forsyth is urging Mr Rifkind to make the new Chief Executive a grade 2 post. That would be quite unacceptable for such a comparatively small health service, though we might well agree to extra pay if needed to attract a suitable outside candidate.

4. As regards (iii), we shall study the details when they are sent by Scottish officials. But it would appear that the new Chief Executive will be taking over virtually all of the work of one of the existing grade 3 posts, and one of the grade 5 divisions of the other. Although there will undoubtedly be extra work flowing from the health review changes, much of it will have to be done by the new Chief Executive. It seems on the face of it unlikely that a third grade 3 post could be justified for more than a very short handover period. We shall give more considered advice when we have seen the detailed case, but meanwhile we recommend you reserve your position.

5. I attach a draft reply.

MISS M E PEIRSON

st.ln/dra/1.23.1

SECRET

DRAFT LETTER FROM THE CHIEF SECRETARY TO MR RIFKIND

NHS REVIEW: CHIEF EXECUTIVE OF THE NHS FOR SCOTLAND

1. Thank you for your letter of 19 January. I am content with your proposed amendment to paragraph 17 of your chapter of the draft white paper. I also agree that the new post should be at grade 3.

2. However, my agreement is without prejudice to my consideration of your proposal to retain in addition the existing two health grade 3 posts. I shall respond to that when my officials have seen the details.

3. I am copying this letter to the recipients of yours.

Mr. AM White cc Mr Luce
Mr Saunders
Is SHHD already adequately SCOTTISH OFFICE
over-provided with senior WHITEHALL LONDON SW1A 2AU
grade starched posts, or can
we let it go on the basis
at X ? The
next Scottish
SoS Review
is April 1990.

	19 JAN1989
	MR SAUNDERS
TO	CST SIR P MIDDLETON SIR T BURNS, MR ANSON MR PHILLIPS, MR CULPIN MRS LOMAX, MR KELLY, MISS PEIRSON, MR PARSONS MR GRIFFITHS MR CALL

SECRET

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

19 January 1989

Dear John,

NHS REVIEW

As I mentioned at our discussion on 17 January I have decided that I want to make a firm announcement of my intention to appoint a Chief Executive of the NHS for Scotland. For that purpose I want to amend paragraph 17 in Chapter 10 to read:

> "The responsibility for health service policy will continue to rest with the Scottish Home and Health Department, reporting to the Minister for Education and Health and the Secretary of State. However, it is desirable that the management of the Health Service should be strengthened and the Government has decided to appoint a Chief Executive for the NHS in Scotland. The Chief Executive will be responsible for the efficiency and performance of the Health Service and for the overall supervision of the execution of policy. He will have responsibility for the establishment of appropriate and adequate information and data systems required to ensure the effective delivery of patient services."

This would be a new post for which the appropriate nominal level would appear to be Grade 3 and I would propose to retain the existing two Health Grade 3 posts, at least for the period of active implementation of our proposals, and to review the situation in 1990.

I hope you are content with this wording and the proposal. My people will write to yours about the details.

I am copying this letter to the Prime Minister, Nigel Lawson, Peter Walker, Tom King, David Mellor, Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No 10 Policy Unit and to Sir Robin Butler and Mr Wilson in the Cabinet Office.

MALCOLM RIFKIND

HMP018M5.016

36/19/1

031/2761

CONFIDENTIAL

FROM: MISS C EVANS
DATE: 24 January 1989

MR R B SAUNDERS

pwp

cc:
Chancellor
Paymaster General
Sir Peter Middleton
Mr Anson
Sir T Burns
Mr H Phillips
Mrs Lomax
Miss Peirson
Mr Gieve
Mr MacAuslan
Mr Parsonage
Mr Sussex
Mr Burns
Mr Call

NHS REVIEW: DETAILED DISCUSSION PAPERS

The Chief Secretary was grateful for your minute of 18 January.

2 The Chief Secretary notes that we must avoid being bounced in these papers and he is most grateful to you for scrutinising them in detail. He fears that this is a very heavy workload but one he regards as essential. He asks that you involve him if this proves necessary.

CEvans

MISS C EVANS
Private Secretary

cst.ps5jm24.1/lets

SECRET

000074

PWP

cc:
Chancellor
Sir Peter Middleton
Mr Anson
Sir T Burns
Mr H Phillips
Miss Peirson
Mr Kelly
Mrs Lomax
Mr Luce
Mr A M White
Mr Saunders
Mr Griffiths
Mr Call

Treasury Chambers, Parliament Street, SW1P

The Rt Hon Malcolm Rifkind QC MP
Secretary of State for Scotland
Scottish Office
Dover House
Whitehall
London
SW1A 2AU

24th January 1989

Dear Malcolm,

NHS REVIEW: CHIEF EXECUTIVE OF THE NHS FOR SCOTLAND

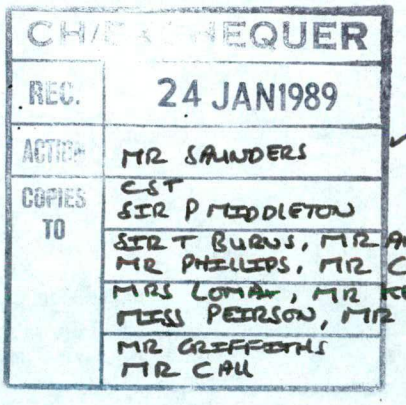
Thank you for your letter of 19 January. I am content with your proposed amendment to paragraph 17 of your chapter of the draft white paper. I also agree that the new post should be at grade 3.

However, my agreement is without prejudice to my consideration of your proposals to retain in addition the existing two health grade 3 posts. I shall respond to that when my officials have seen the details.

I am copying this letter to the Prime Minister, the Chancellor, Peter Walker, Tom King, David Mellor, Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No. 10 Policy Unit and to Sir Robin Butler and Mr Wilson in the Cabinet Office.

Yours Ever,
John

JOHN MAJOR



CONFIDENTIAL

PRIME MINISTER

pwp

NHS WHITE PAPER

I have seen your Private Secretary's letter of 20 January and am quite content with the two amendments you suggest to the Welsh Chapter.

I have also seen Kenneth Clarke's memorandum to you of 23 January about the central management of the NHS. The management of the NHS in Wales is of course described in paragraph 4 of the Welsh Chapter, where we say that the management arrangements have 'proved their worth and will continue'. I assume that nothing in Kenneth's paper will mean that these arrangements in Wales will now need to be reviewed.

I am copying this minute to the Chancellor of the Exchequer, Secretary of State for Health, Secretary of State for Scotland, Secretary of State for Northern Ireland, Chief Secretary, Minister of State for Health, Sir Roy Griffiths, Professor Griffiths, Mr Whitehead and Mr Wilson.

Keith Dawes

PW
Dictated by the
Secretary of State and
Signed in his absence.

25.1.89.3

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 25 January 1989

PS/CHIEF SECRETARY

cc Chancellor
Mr Phillips
Miss Peirson
Mr Parsonage
Mr Griffiths
Mr Call

Ch/CST wld much appreciate your views on whether he shld write to Mr Clarke. He doesn't wish to stir up the pot unnecessarily – but is disposed to accept Dick's advice.

WT spoke

SAUNDERS → CST 25/1

NHS REVIEW WHITE PAPER: FPS

We spoke. I have only just spotted, I am afraid, that chapter 7 of the White Paper omits some of the proposals included in the paper HC 68, which was endorsed by the Ministerial Group. I attach a copy of the paper for ease of reference. The missing points are as follows.

a. No explicit reference to drug budgets being cash limited at RHA level.

b. No reference to the increased capitation element of GP remuneration being at the expense of basic practice allowance.

c. No reference to geographical variation of basic practice allowance.

Arguably, the final sentence of 7.3 gives b. and c. by implication. But it is buried very deep, and certainly does not imply abolition of BPA for some GPs. Moreover, since the Department is currently negotiating these and related matters with the GMSC following the Primary Care White Paper, a clear statement of the Government's intentions is essential.

2. I have discussed this with Mr Phillips and with Richard Wilson. Both agree that it would be appropriate for the Chief Secretary to write to Mr Clarke this afternoon asking for these points to be inserted in the draft. It would obviously be better not to raise the matter at Cabinet tomorrow. We could perhaps live with the point on drug budgets appearing only in the working paper

CONFIDENTIAL

on this subject. But, on basic practice allowance, there is no working paper. And a change as fundamental as this must be included in the White Paper, not buried in supporting documentation.

3. I attach a draft letter.

R B SAUNDERS

25.1.89.4

FROM THE CHIEF SECRETARY TO

The Secretary of State for Health

NHS REVIEW: DRAFT WHITE PAPER

On re-reading the complete draft of the White Paper, we have only just noticed that the proposals you and I agreed in relation to the FPS, described in HC 68 and subsequently endorsed by the Ministerial Group, are not fully reflected in the draft. I am sorry to raise a point of substance at such a late stage, but as you will appreciate it is a matter of some importance.

2. Chapter 7 of the White Paper does not make clear that drug budgets will be cash limited at regional level. Nor does it make clear that the increased capitation element of GPs' remuneration will be at the expense of basic practice allowance, which will become subject to geographical variation, including abolition in some areas. I realise that the final sentence of 7.3 could be taken to imply this, at least partially. But it is a very oblique reference and certainly does not imply abolition of BPA for some GPs. Since these matters are currently being discussed between your department and the GMSC, it is surely essential to have a clear statement of the Government's intentions so that those concerned know precisely where they stand. Otherwise, there are bound to be accusations of bad faith when you do introduce the proposal.

3. In order to remedy these deficiencies, the following changes need to be made.

Para 7.3 - insert a new sentence at the end:

"Basic practice allowance will form a reduced proportion of remuneration, and its level will vary according to the location of the practice; in some cases, it will be reduced to zero."

Para 7.16 - first sentence to start as follows:

"Each year the provision made for FPS drug costs will be divided into separate cash-limited allocations for the 14 health regions, and RHAs will set ...".

4. I am sending copies of this letter to the Prime Minister, the Secretaries of State for Scotland, Wales and Northern Ireland, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson (Cabinet Office) and Mr Whitehead (Policy Unit).

NHS REVIEW: FPS - HEADS OF AGREEMENT

Drug budgets

1. Cash limits to be set for RHAs to be passed on to FPCs, who will set indicative budgets for GPs.

2. Excess expenditure in one year to be recovered by reduction in RHA's cash limit the next (except where specifically agreed).

3. Scheme to be set up on basis of existing information base. Study needed of factors causing legitimate differences in prescribing costs at practitioner level to put in place adequate information systems and control mechanisms.

4. Sanctions against excessive prescribers available in the form of peer review and Service Committee proceedings, but would not in practice be used until improved information base fully operational in 2-3 years time. (Target date for RHAs to become responsible for FPCs is April 1991, following necessary legislation.) In meantime existing pressure for more economical prescribing, through dissemination of information and FPC monitoring, will continue.

Control of GP numbers

1. Legislation to be introduced to obtain powers, to be held in reserve, to control numbers of GPs.

2. Continue to negotiate with GMSC to increase capitation element of remuneration, at expense of Basic Practice Allowance.

3. Geographical variation of Basic Practice Allowance, including abolition in some areas.

cst.ps/7jm25.1/drfts

CONFIDENTIAL

cc:
Chancellor
Mr H Phillips
Miss Peirson
Mr Parsonage
Mr Saunders
Mr Griffiths
Mr Call

CST → CLARKE 25/1

Treasury Chambers, Parliament Street, SW1P 3AG

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

25th January 1989

Dear Ken,

NHS REVIEW: DRAFT WHITE PAPER

On re-reading the complete draft of the White Paper, we have noticed that the proposals you and I agreed in relation to the FPS, described in HC 68 and subsequently endorsed by the Ministerial Group, are not fully reflected in the draft. I am sorry to raise a point of substance at such a late stage, but as you will appreciate it is a matter of some importance.

Chapter 7 of the White Paper does not make clear that drug budgets will be cash limited at regional level. This is clearly important. Nor does it make clear that the increased capitation element of GPs' remuneration will be at the expense of basic practice allowance, which will become subject to geographical variation, including abolition in some areas. I realise that the final sentence of 7.3 could be taken to imply this, at least partially. But it is a very oblique reference and certainly does not imply abolition of BPA for some GPs. Since these matters are currently being discussed between your department and the GMSC, it is surely essential to have a clear statement of the Government's intentions so that those concerned know precisely where they stand. Otherwise, there are bound to be accusations of bad faith when you do introduce the proposal.

In order to remedy these deficiencies, the following changes need to be made.

Para 7.3 - insert a new sentence at the end:

"Basic practice allowance will form a reduced proportion of remuneration, and its level will vary according to the location of the practice; in some cases, it will be reduced to zero."

Para 7.16 - first sentence to start as follows:

"Each year the provision made for FPS drug costs will be divided into separate cash-limited allocations for the 14 health regions, and RHAs will set ...".

I am sending copies of this letter to the Prime Minister, Malcolm Rifkind, Peter Walker, Tom King, David Mellor, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson (Cabinet Office) and Mr Whitehead (Policy Unit).

Yours Ever, John

JOHN MAJOR

26.1.89.1

CHANCELLOR

FROM: R B SAUNDERS

DATE: 26 January 1989

cc Chief Secretary
Mr Phillips
Miss Peirson
Mr Griffiths

THE OUTCOME OF THE HEALTH REVIEW: CENTRE FOR POLICY STUDIES CONFERENCE

David Willetts has invited Mr Griffiths and me to this half day conference on Thursday 2 February. I attach the proposed programme.

2. I think it will be interesting to hear initial reactions to the White Paper from some people in the NHS, and that it would be useful for us to attend. But it is of course very close on the heels of the White Paper and slap in the middle of the period when Mr Clarke will be taking his roadshow around the country. We do not know what, if anything, the press will be saying about the Treasury's role in the Review. I should be grateful therefore if you could say if you see any problem with our attending.

Ch/ OK?

R B SAUNDERS

CENTRE FOR POLICY STUDIES
8 Wilfred Street, London SW1E 6 PL. Tel: 01-828 1176

THE OUTCOME OF THE HEALTH REVIEW
WHITEHALL SUITE, ROYAL HORSEGUARDS HOTEL, WHITEHALL COURT
LONDON, S W 1

9.00	Coffee
9.30	Introduction
9.40	Ken Jarrold - the internal market (District Manager, Gloucestershire Health Authority)
9.50	Dr Michael Goldsmith - a mixed economy in health care (CPS Research Fellow)
10.00	Dr Donald Irvine - GP budget holders (GP, former President of Royal College of General Practitioners)
10.10	Dr Clive Froggatt - GP budget holders (GP)
10.20	Dr Gillian Todd - self governing hospitals (Unit Manager, Ransom Hospital, Notts)
10.30	Professor Ian McColl - self governing hospitals (Professor of Surgery. Guy's Hospital)
10.40	Conclusion
11.00	Coffee
11.15	Questions and discussion
12.30	Close and drinks

chex.ps/ds.59 UNCLASSIFIED

FROM: D I SPARKES
DATE: 27 January 1989

MR R B SAUNDERS

cc PS/Chief Secretary
Mr Phillips
Miss Peirson
Mr Griffiths

THE OUTCOME OF THE HEALTH REVIEW:
CENTRE FOR POLICY STUDIES CONFERENCE

The Chancellor was grateful for your minute of 26 January and has no objections to you and Mr Griffiths attending this Conference in a listening role.

D.I.S.

DUNCAN SPARKES

cst.pas/mc/4.27.1

SECRET

FROM: MARK CALL
DATE: 27 JANUARY 1989

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Culpin
Miss Peirson
Mr Saunders
Mr Gieve

NHS REVIEW PRESENTATION

I discussed with Jonathan Hill (Ken Clarke's Special Adviser) the presentation of the Review. In particular I asked how Mr Clarke would respond to questions on the things we expect hospitals to provide (paragraph 1.13 in the White Paper, an earlier draft of which is attached at Annex 1). Such as what is going to cause these to happen? And, why haven't they happened before? Some media commentators might be unkind enough to point out that some years back there was a White Paper called something like "Putting Patients First", and ask whatever happened to that? I wish the answers were more convincing.

2. I'm sure the key is to present the Review proposals as a system and not simply a list of desirable changes. Thus it should focus on the new mechanisms such as the internal market, independent hospitals, and patient feedback. In a system which has limited choice and lacks price signals, feedback from patients is vital. It is thus most important that when patients feel they are not getting the service they deserve (ie points A. and B. on Annex 1), or have suggestions for improvement, they can feed these into the system. And it must be credible. In other words, the information should feed into the management system and perhaps the Review process, and something should happen as a result.

SECRET

3. I stressed the VFM points, and was interested to see that the Gallup survey of attitudes among hospital managers, consultants and GPs (commissioned, I believe, by CCO and given to me by Jonathan Hill) shows that many of those working in the NHS see the need for improved cost-effectiveness (see Annexes 2 and 3).

4. The survey's results on independent hospitals, co-operation between the public and private sectors, and cross-border patient flows, are also encouraging (Annex 4).

5. You may be interested to know that Jonathan Hill is leaving next week; his replacement as Special Adviser at Health is Tessa Keswick (wife of Henry K of Jardine).

MC

MARK CALL

1.10 To achieve this, the Government intends that each hospital should offer:

Annex 1

* appointments systems which give people individual appointment times that they can rely on. Waits of two to three hours in out-patient clinics are unacceptable;

* quiet and pleasant waiting and other public areas, with proper facilities for parents with children and for counselling worried parents and relatives;

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

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

C

B

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

A

* rapid notification of the results of diagnostic tests;

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

1.11 In short, every hospital in the NHS should offer what only the best offer now. The Government is sure that, given a clear lead, all those working in the hospital service will welcome the achievement of these higher standards. Achieving them will in turn bring greater appreciation and recognition from patients and their families for all the care that the Health Service provides.

Annex 2

GALLUP

SUMMARY

* Four out of five general managers believe that the quality of care in the NHS, has improved over the last decade but only one in three consultants and GPs hold this view.

* All three groups agree that in real terms the level of funding of the NHS has declined over the last decade.

* Apart from insufficient government funding all three groups recognise that increased demand for health services, developments in the medical field, the ageing population, and higher public expectations were factors influencing the shortage of financial resources in the NHS.

* For all three groups, only one in three believe that more money is the solution to the problems of the NHS. A majority recognise that reorganisation and more efficient resources is needed, as well as an increase in funding.

* Apart from increased taxation as a method of increasing funding, there was substantial support of a national lottery and patients paying for "extras" such as a better room and a choice of food. There was some support for tax relief for private health schemes, but there was strong opposition to health voucher schemes, charging for out patient attendance and routine treatments.

* Two out of three general managers believe the Health Service to be efficient. Consultants and GPs are fairly evenly divided on their views and are concerned about waste and administration costs.

* Whereas more than two out of three general managers believe that the NHS is as efficient as the private sector, only a minority of consultants and GPs believe this.

* There was considerable support for generating more funds for the NHS through increased cooperation between the public and private sectors.

* The selling of laundry, pharmacy and pathological services, as well as providing screening and xray facilities to the private sector, were strongly supported as methods of increasing resources for the NHS.

* There was also considerable support for leasing spaces in hospital shopping malls, offering franchises, and selling catering and laundry services. A majority of general managers and consultants approved of private beds and amenity beds.

* A majority of all three groups thought the NHS should be administered at the district level, but one in four consultants favoured regional administration and one in five consultants and GPs favoured hospital level administration.

* More than two out of three of all those surveyed supported the notion of a much greater degree of self government to be given to individual hospitals and two out of three consultants favoured taking responsibility for their own budgets.

* Nine in ten general managers said that competitive tendering was a worthwhile way to reduce costs in the NHS, but only half of the consultants shared this view. Saving money and greater efficiency were seen to be benefits of competitive tendering, but the drawbacks were a lowering of standards and morale.

* More than two out of three respondents supported the publication of waiting lists for each type of operation as a way to increase efficiency in the NHS. The provision of data bases on waiting lists for all GPs was also strongly supported. Just over half the sample of general managers and GPs believe in encouraging the public to go to a pharmacist for minor ills, but just one in three consultants share this view. Consultants are not generally in favour of GPs performing minor surgical operations, but four out of five managers supports this, as do two out of three GPs.

* Two out of three managers and GPs thought that incentives should be given to GPs to take greater responsibility for their patients as a way of increasing efficiency, but less than half of consultants shared this view.

* One in three general managers think that consultants' contracts should be short term, but less than one in five consultants agree with this. Long- term contracts for consultants are supported by four out of five consultants, but less than one in three managers.

* Nine in ten general managers would like to have consultants' contracts held at district level, but only one in five consultants hold this view. Two in three consultants prefer regional level contracts.

* When it comes to clinical audit, there is overall majority support for it to be carried out by the medical profession.

* Administrative and clerical staff was mentioned most often by managers and consultants as the staff level most difficult to recruit, followed by paramedics and general nurses.

* The main reasons for recruitment problems, mentioned by three out of four general managers, was low wages. The high cost of housing and "too much pressure" were the other main reasons for recruitment problems for both general managers and consultants.

* Hip replacements were cited by over half of managers and over two thirds of GPs as the operation most affected by unacceptably long waiting lists. ENT operations also posed the problem of long waiting lists for the majority of managers and GPs.

* Just over half of consultants said that they did not have unacceptably long waiting lists for operations.

* The appointment of more consultants with supporting staff was perceived to be the best method of shortening waiting lists for all three groups.

* Over half of the entire sample supported the maintenance and encouragement of cross-boundary district patient flow as a way to improve patient care in the NHS. The availability of more resources was the reason given most often for this support. Specialist care and shortened waiting lists were also seen to be benefits of cross-boundary district patient flow.

* Half of the general managers and consultants favoured budget transfers for cross-boundary district patient flow, but less than two out of five GPs agreed with this.

* For all three groups, the most important priority area in the NHS was to provide better services for patients, when and if the Government injected extra money into the NHS. Other priorities were modernisation of hospitals, pay increases for administrative and clerical staff, equipment and research.

Annex 3

GALLUP

TABLE 5

Some people say that the National Health Service needs more money. Others say that more money is not necessary, just a reorganisation and more efficient use of resources. Which of these two views comes closest to your own?
(RING ONE ONLY)

	General Managers %	Consulants %	GPs %
More money is needed	30	35	33
Reorganisation and more efficient use of resources is needed	3	11	12
A combination of these	66	53	53
Don't know	1	1	2

5.0 METHODS OF INCREASING FUNDING FOR THE NATIONAL HEALTH SERVICE

All three professions were shown a list of seventeen different ways of increasing funding for the National Health Service and they were asked how much they agreed or disagreed with each proposal. The results are shown overleaf.

General managers, consultants and GPs were agreed on the following proposals, stressing their support for fiscal measures as being the prime way of funding the Health Service. For the following six methods of funding, there were more respondents in favour than against

Methods of Funding with majority support

Proposal	Percentage Agreeing (Agree strongly and agree)		
	General Managers %	Consultants %	GPs %
Increase in tax on alcohol and tobacco	83	72	71
Increasing the basic rate of taxation	70	55	54
More realistic contributions from car insurance companies	75	47	53
A national lottery	41	54	53
Compulsory national insurance scheme	44	46	46
Patients are able to pay for "extras" such as a better room and choice of food	62	46	45

For the following two proposals all three professions were fairly evenly divided.

Tax relief payable to the contributor for private health care for the elderly	37	42	37
Encouraging private health by offering tax relief to individuals and companies	27	46	40

For the following proposals all three professions were more in disagreement than agreement.

Proposal	Percentage Disagreeing (Disagree strongly and disagree)		
	General Managers %	Consultants %	GPs %
Charges for 'hotel' services	57	47	41
Limited medical cover insurance schemes which enable people to pay for "top-ups" if admitted to hospital	31	50	46
Medical insurance which enables people who choose to go private to pay at a reduced rate	54	49	49
Transferable Medical Insurance allowing people who choose to go private to opt out	74	58	42
Charging patients for a choice of admission for minor operations	70	63	54
Patients are encouraged to be treated privately by paying difference between NHS and private treatment	53	56	53
Charges for some routine treatments	63	66	56
Health Voucher Scheme	61	54	57
Charge of out-patient attendance	82	78	77

Clearly any charges for out-patient attendance would meet with graet opposition from all three professional groups and more generally they are against any charges for what they see as **"traditional"** national health services.

Annex 4

TABLE 9

It has been proposed that further money could be generated or saved through more co-operation between the private and public sectors. Do you agree or disagree with this proposal?

	General Managers %	Consultants %
Agree strongly	19	12
Agree	58	46
Neither agree nor disagree	9	18
Disagree	11	15
Disagree strongly	0	6
Don't Know	3	3

TABLE 13

It has been suggested that one way to give hospital management greater control over the running of their own hospitals would be to give individual hospitals a much greater degree of government. How much, if at all, would you favour such a policy?

	General Managers %	Consultants %	GPs %
Favour strongly	19	32	27
Favour somewhat	46	37	45
Neither favour nor oppose	4	9	11
Oppose somewhat	22	12	9
Oppose strongly	8	7	3
Don't know	1	4	5

TABLE 24

It has been suggested that one way to improve patient care in the NHS is to maintain and encourage cross-boundry district patient flow. Do you support this approach in principle or not?

	General Managers %	Consultants %	GPs %
Support strongly	18	19	22
Support somewhat	50	33	39
Neither support nor oppose	15	17	16
Oppose somewhat	14	17	12
Oppose strongly	2	11	8
Don't know	1	3	2

The reason given most often in support of cross-boundary district flow was the availability of more resources. This comment was made by 21 per cent of managers, 22 per cent of consultants and 15 per cent of GPs. Managers (21 per cent) and GPs (12 per cent) also said that it would be better for patients. Only 9 per cent of consultants shared this view.

The opportunity to provide **"specific specialist care"** was also a benefit according to 16 per cent of consultants, 12 per cent of managers and 8 per cent of GPs. GPs (12 per cent) also thought that cross-boundary district flow would **"help reduce waiting lists,"** although only 8 per cent of consultants and 6 per cent of managers shared this view.

Those who opposed the maintenance and encouragement of cross boundary district patient flow did so for fairly specific reasons. The reason most often given by managers (38 per cent), consultants, (28 per cent) and GPs (41 per cent) was that it would be **"inconvenient for the patient"**. It would also be **"difficult to control"** according to 20 per cent of consultants, 19 per cent of managers, and 11 per cent of GPs.

There also was the sentiment that **"the locals would suffer,"** according to 31 per cent of managers, 16 per cent of consultants, and 6 per cent of GPs. The fact that the **"system could be abused"** was commented on by 13 per cent of consultants, eleven per cent of GPs and 6 per cent of managers.

We then asked all respondents how they thought cross-boundary district patient flow should be financed. Views on this subject were not clear-cut, because by and large managers (59 per cent) and consultants (49 per cent) favoured **"budget transfers with patients,"** while 47 per cent of GPs favoured **"central financing."** Indeed, 8 per cent of managers favoured a combination of central funds and budget transfers.

Central financing was favoured generally because it was an **"easier solution"** involving less administration, as recorded by 61 per cent of managers, 28 per cent of consultants and 21 per cent of GPs. The other consideration was that central financing was perceived as a way to **"ensure no detriment to home districts"**. Twenty-two per cent of managers said this, as did 10 per cent of consultants and 9 per cent of GPs. Forty per cent of GPs and 26 per cent of consultants said that they did not know why they preferred central financing of cross-boundary district patient flow.

Those who favoured budget transfers did so mainly because they believed that this method would **"encourage greater efficiency"** and would be **"cost effective"**. Twenty two per cent of managers, 16 per cent of consultants and 18 per cent of GPs said this. The other main reason was that budget transfers would be **"more equitable"** and would make districts **"financially accountable"**, according to 18 per cent of both GPs and consultants and 12 per cent of managers.

There was also the feeling, shared by 14 per cent of managers, 12 per cent of consultants and 9 per cent of GPs, that budget transfers made more sense because of better local provision of these services.

In the end, however, 36 per cent of GPs, 32 per cent of consultants and 24 per cent of managers did not know why they preferred budget transfers for the funding of cross-boundary district patient flow.

TABLE 25

Regardless of whether or not you support this proposal, how do you think that cross-boundary district patient flow should be financed? (RING ONE ONLY)

	General Managers %	Consultants %	GPs %
Financed centrally, without detriment to home district	18	39	47
Budget transfers with patients	59	39	41
Combination of central funds and budget transfers	8	1	1
Don't know	5	8	12
Other	10	2	1

18.0 PRIORITIES IN THE NHS FOR ADDITIONAL GOVERNMENT FUNDS

All three groups were presented with a list of areas that could be given priority when, and if, the Government injects extra money into the NHS. Respondents were first asked which area should be given most priority. Far and away the most important area for all three groups was **"better services for patients"**

Thirty-nine per cent of managers said this, as did 26 per cent of GPs and 18 per cent of consultants. Community health care was a priority for 18 per cent of GPs for 15 per cent of managers and six per cent of consultants. Sixteen per cent of both consultants and GPs said that pay rises for all nurses should be a priority, but no general managers shared this view.

When asked which other areas should be given priority, modernisation and/or improvement of hospitals ranked highest overall, with 55 per cent of managers, 45 per cent of GPs and 44 per cent of consultants saying this. Pay rises for administration and clerical staff was given priority by 55 per cent of managers 52 per cent of consultants and 35 per cent of GPs. Equipment was also considered an area of priority for more funds.

Community health care emerged once again as a priority, especially amongst managers (52 per cent) and GPs (44 per cent). Consultants were not as convinced that community health care should be a priority, with only 22 per cent claiming this. Better services for patients featured in the list of priorities again, with 33 per cent of consultants, 37 per cent of GPs and 35 per cent of managers saying this.