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PART F

CHANCELLOR'S PAPERS ON HEALTH AND SOCIAL SECURITY SERVICES

PO -CH /NL/0223 PART F

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SECRET

FROM: R B SAUNDERS

DATE: 18 November 1988

CHIEF SECRETARY

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

NHS REVIEW: FUNDING

I attach a revise of this paper, agreed with DOH officials, reflecting the discussion at your meeting with Mr Clarke last night. It homes in on the option discussed there: instead of bringing everybody to 100 (as measured by RAWP or whatever other capitation formula), we go for

- 102 for the Thames regions

- 99 for other regions.

2. The justification for this is set out in paragraph 13. The effects are shown in the Annex. In brief, it is redistributive, but by less than RAWP. In theory, the Thames regions would be happy, because they stand to lose less than under RAWP, while the others would be happy because they still stand to gain. The most difficult case is West Midlands, who move from being RAWP gainers of £15m to losers of £16m under this system. Some special provision may be needed for them, but we have not in the time available been able to produce a scheme.

3. There is a marked difference in treatment between the North Thames regions (who are still quite big losers) and the South Thames regions (who actually gain money). There may therefore be a case for further splitting the Thames formula - say 101 for

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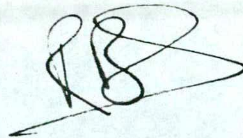
South Thames and 103 for North Thames. The justification for this would be that the North Thames regions have a greater proportion of London districts (and hence London Weighting pay costs, etc) than the South Thames regions. This is perhaps something for your meeting with Mr Clarke on Monday morning.



R B SAUNDERS

SECRET

DRAFT

HC 58

FUNDING THE HOSPITAL SERVICE

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

This paper considers the mechanisms by which:

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

b. regions allocate funds to district health authorities, and

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

Introduction

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

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

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

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

5. The problems posed by moving to such a system are quite different at the regional and district levels. We look first at the regions.

The regional transition

6. We have agreed that allocations to regions would be based on population, weighted according to age structure, with some adjustment for, eg, London weighting pay costs. There already exist generally accepted methods for age adjustments, based on the average cost to the NHS of people in different age groups. The overall health of the region's population (as expressed by morbidity) would also figure in the weightings. Further work is in hand on what would be the best and most acceptable measure.

7. We need to decide how best to move to a new system of allocations. It will be essential to remove the present arrangements under which cross-boundary flows are reflected only in complicated, obscure and belated modifications to population weightings. Using the most recent data for numbers and up-to-date costings of different types of treatment, all regions would be required during 1989-90 to agree how much cross-boundary flows are costing. The sums so identified could be physically paid between regions. Ultimately, as the transition at district level proceeds, the need for such regional cross-boundary adjustments would fall away. This would mean that the main financial allocations to regions would in future be for the services used by their resident populations.

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

a. move to a weighted capitation system as soon as possible, without any regions losing. This would mean injecting additional funds to bring every region up to the level of the highest

b. bring all regions to a weighted capitation distribution, over a period of, say, three years with those currently funded above the average (in effect the Thames regions) losing resources to those below it

c. move over three years to weighted capitation funding, but at a higher level for the Thames regions than for the rest.

The practical consequences of each option are set out in the Annex. Both the second and third options are illustrated on a self-financing basis. For comparison, the effects of the present RAWP system are also shown .

9. The full "levelling up" implied by the first option, without imposing cuts or freezes elsewhere, would cost at least £800m a year. This is out of the question and we do not consider it further.

10. The approach underlying option (b) is that which the Group has indicated it prefers in principle. As the Annex shows, however, in this form it would involve significant shifts away from present levels of funding. The losing regions would, in the new system, be able to compete to attract patients from elsewhere. But they might not be able to attract enough to make up for a loss of funds on this scale.

11. Option (c) would give an explicitly higher level of funding to the Thames regions. This would be in recognition of a number of factors: the higher costs of the South East generally (not just pay costs); the less comprehensive primary care services in London; and the historically higher rate at which residents of inner city areas in London make use of hospitals, even after allowing for measurable factors like age and morbidity. This last factor has a number of causes, including the simple behavioural fact that people living near to large hospitals will tend to make more use of them.

12. We recommend this third option. [We think the proposed 3 per cent differential between the Thames regions and the rest is defensible for the reasons given. The Thames regions would still lose resources to the rest, but less than they stand to lose under RAWP. And most of the other regions would still gain as compared with the present distribution.]

The transition for districts

13. At present districts are funded by regions, but on varying bases. Some use formulae akin to RAWP, but most fund their districts according to where hospitals happen to be located. Under the new system, we would propose, as with regions, to move to weighted capitation allocations, with direct payment between districts for cross-boundary flows.

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

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

- differences between current levels of funding and those implied by a weighted capitation system are much larger than at regional level. An immediate switch would involve substantial shifts in resources.

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

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

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

16. A start depends on improved information at hospital and district level about population, movement of patients and costs of different types of treatment. Once that is available, and it should come naturally from the improved information systems we are proposing more generally, cross-boundary flows could be explicitly costed and paid for.

- First, districts would identify and cost the services which were being provided for the residents of other districts, which would then be paid for. District allocations would thus be based on the cost of services that were being provided for their residents, rather than the cost of the hospitals they contained.

- Self-governing hospitals would be paid direct by districts. Otherwise districts would initially pay one another, the necessary legislation having been enacted. As more hospitals become self-governing and more directly-managed hospitals become capable of handling contracts, so payments to districts would give way to payments direct to hospitals. Districts would be free to look to hospitals elsewhere and hospitals to compete for the business of other districts.

17. To sum up, the transition at district level will take longer than at regional level. The general principles - the objective of weighted capitation funding and transparent cross-boundary charging - are however the same as for regions. Once "contractual" funding is in place, the regional role in making cross boundary adjustments can be phased out. The internal market will predominate.

Performance funding of hospitals

18. Once the new system is fully operational, there will be automatic performance incentives, since districts will be seeking the most cost-effective deals from hospitals. But during the transitional period, a system of top-sliced performance funding, along the lines set out in HC27 and HC49, is necessary. This addresses the common complaint that hospitals which increase their efficiency cannot make commensurate improvements in the numbers of

patients they treat without some additional funding to cover the variable cost element of treating those extra patients. The scheme would also include incentives for some hospitals to concentrate on waiting list cases and to draw in patients from elsewhere so as to have the maximum impact on waiting lists; and provision for establishing additional consultant posts along the lines set out in HC49. The amount of money to be set aside for the scheme within the agreed total provision for health expenditure should be the subject of annual discussion between us in the public expenditure survey.

Self-governing hospitals

19. Self-governing hospitals will accelerate the pace of change at district level. It is of their essence that they will be funded by contracts with districts. We need to ensure that districts are ready to negotiate these contracts before they are set to move into "contract funding" more generally. Self-governing hospitals will need contracts to supply both "core" and "contract" services on behalf of local districts. Further work by the Department of Health is in hand on the form that these contracts will take, and on the costings that will underpin them.

20. One effect of hospitals switching to self-governing status may be to denude some districts of substantial functions. This may encourage amalgamations with neighbouring districts, a process which might be consistent with merger with the - in terms of area, often larger - FPCs.

GP practice budgets

21. The Treasury have reservations about the practicability of a full-blown scheme for GP practice budgets. This is to be addressed separately. Assuming for the moment, however, that these problems are resolved, GP practice budgets would substitute for part of districts' spending on acute hospital services. The money for paying hospitals would therefore need to come out of the hospital and community health services budget, not the FPS.

22. The proposal is an extension of those for funding districts as "buyers" of services. It would make sense therefore to give regions the responsibility for allocating funds to practices, since it is they who would also be responsible for funding districts. This would be consistent with lines of accountability irrespective of whether FPCs and DHAs are merged.

Capital

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

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

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

Timetable and summary

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

April 1989 - Regions required to agree cost of cross-boundary flows.

- Districts begin work on improved information.

- First candidates for self-governing hospitals identified.

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

- Development of schemes for contractual funding of hospitals.

- New top-sliced performance funding scheme.

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

- First wave of self-governing hospitals set up, funded by contracts with purchasing districts.

April 1992 - Extend contract funding to more hospitals.

- Transition to weighted capitation at regional level complete.

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

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ANNEX

	(1) Existing Alloc Excl the effect of cross-boundary flows	(2) Gain(+) or loss(-) under Option(A)	(3) Gain(+) or loss(-) under Option(B)	(4) Gain(+) or loss(-) under Option(C)	(5) Gain(+) or loss(-) of moving to RAWP targets
	£m	£m	£m	£m	£m
Northern	731	+ 64	+10	+ 3	+12
Yorkshire	834	+ 79	+17	+10	+11
Trent	1034	+103	+26	+17	+28
East Anglia	426	+ 47	+15	+11	+18
N W Thames	850	+ 13	-45	-29	-34
N E Thames	1002	0	-68	-49	-68
S E Thames	915	+ 67	+ 1	+19	-15
S W Thames	716	+ 50	- 2	+13	- 7
Wessex	625	+ 77	+29	+23	+11
Oxford	494	+ 34	- 2	- 6	+13
S Western	721	+ 82	+28	+21	+10
W Midlands	1174	+ 80	- 6	-16	+15
Mersey	583	+ 32	-10	-15	- 9
N Western	972	+ 77	+ 6	- 2	+14
Total RHAs	11076	+807	0	0	0

All figures relate to 1988-89 initial allocations (excluding Review Body additions)

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SECRET

FROM: R B SAUNDERS

DATE: 18 November 1988

CHANCELLOR

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

Ch/ This string all new pps. Others in folder are just for background.

MPW.

NHS REVIEW: MEETING ON 22 NOVEMBER 1988

There will again be a long agenda for this meeting, and little chance of dealing with all the papers. This note does not seek to give full briefing on all of them, but reminds you of the main points, and may serve as an agenda for your briefing meeting on Monday evening.

Funding

2. The joint paper by the Chief Secretary and Mr Clarke will be the first item on the agenda. At the time of writing, we are inching towards an agreed paper. Cabinet Office and No 10 have agreed that we can delay circulation until Monday, but under some protest as the Prime Minister will be concentrating on Monday and Tuesday on a major speech.

FPS Management

3. There was a brief discussion of this paper last time. I attach my earlier brief. There are one or two points to add:

- The draft letter attached to my minute of 16 November (now sent) points out the problems for GP practice budgets posed by the relationship with the private sector. Mr Clarke may

try to shrug these off, but he should not be allowed to get away with this. There is a serious risk, as the proposals now stand, that large numbers of patients in middle-class areas will be able to use public money to help pay for private treatment they would otherwise have been quite prepared to finance themselves.

- Merger of districts and FPCs is likely to be discussed again. Quite apart from the prospect of improved financial control over the FPS that it offers, merger is also logical in relation to other proposals in the Review. In particular, if "contract funding" between districts and hospitals is going to work, there needs to be close co-operation between the districts, who manage the budget, and the GPs who take the referral decisions which determine how it is spent. Also, as more hospitals become self-governing, districts will have less of a direct management role, and will probably therefore need to merge with each other if they are to remain viable; merging them with the (in terms of area, larger) FPCs would be a logical accompaniment to this process. This point will be made in our funding paper and Mr Clarke has not objected to its inclusion.

- The Prime Minister raised the question of GPs remuneration at the last meeting, suggesting that the direct reimbursement of accommodation and staff expenses should cease. Mr Clarke will, I understand, be ready to respond to these points. In general, we should approach this with some caution. At present, direct reimbursement is of only 70 per cent of expenses, so new staff and accommodation do not represent a free good to doctors. Moreover, we will be cash limiting direct expenses from 1990. So anything which tends to shift remuneration from direct expenses to indirect expenses (which are not cash limited), particularly if reimbursed in full, would be a retrograde step.

Decisions so far

4. This paper by the Cabinet Office was commissioned at the last meeting. It is intended to set out the areas on which the group has agreed, and to identify where further work is required. Among the more obvious gaps are the following:

- the precise arrangements by which "contract funding" will work, so that GP freedom of referral can be reconciled with budgetary control by districts

- a large number of detailed issues about the arrangements under which self-governing hospitals will operate: what end-year and other flexibilities they might have, whether they will have power to hold reserves and borrow, and from whom, (and more generally what their banking arrangements will be), how accountability will be exercised, and so on - these are problems analogous to those we are tackling on Next Steps agencies

- pay arrangements, both in self-governing hospitals and more generally; Mr Griffiths' minute of today reports that we will not be able to produce an agreed paper in time for this meeting

- how consultants' contracts will be better managed (on which we are promised a letter from Mr Clarke)

- how the consultants' distinction award system is going to be reformed

- what action is to be taken in respect of FPS expenditure on drugs if the system is not to be cash-limited

- how GP practice budgets will work.

5. The paper is silent on the question of tax relief, which it was agreed should not formally be minuted. You will wish to judge whether this is an appropriate opportunity to raise the points in Mr Culpin's minute of 14 October.

A better service to patients

6. See the draft attached to my minute of 16 November. Also Mr Call's minute of 4 November (copy attached).

Capital

7. The position remains as set out in HC56. The next stage on private finance is for we and Department of Health to agree a series of examples which would show how the present rules operate and how DOH would like them altered. The Department are still working on their shopping list, and have promised us a sight of it next week. I attach again the defensive briefing prepared last time.

The public and private sectors

8. See the draft attached to my minute of 16 November.

Professional and employment practices

9. "The idea of an independent inquiry looks a very bad one."

Patsy Tong

pp R B SAUNDERS

MANAGING THE FPS (HC51)

Main points from paper

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

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

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

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

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

6. Change FPC composition to reduce professional input.

7. Make FPCs accountable to regions.

Main points to make

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

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

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

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

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

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

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

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CONFIDENTIAL

FROM: MARK CALL
DATE: 18 NOVEMBER 1988

CHANCELLOR

cc Chief Secretary
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Ramsden
Mrs Chaplin
Mr Tyrie

PENSIONERS - RATIONALE FOR ACTION

We will have to be careful to be consistent in stating the rationale for the pensioners package. Up to now we have referred to the need to do something for poorer pensioners.

2. In the defensive briefing attached to Paul McIntyre's minute to the Chief Secretary of 18 November, he says the 'aim is to provide special help for older pensioners, who tend to be more frail, and disabled pensioners. Poorer pensioners in 60-74 age group will still be helped by Income Support, and Housing Benefit'.

3. In his note to you of 18 November, Andrew Tyrie suggests that we can use grounds of affordability to justify why the schemed will not cover those in the 70-74 age group who had no chance to benefit from SERPS.

4. In presenting the measures we will need to be clear and coherent about who we are targetting (although we may choose not to use the word) and why. I don't think affordability arguments will get us very far at all.

MC

MARK CALL

CONFIDENTIAL AND PERSONAL

FROM: J P MCINTYRE
DATE: 18 NOVEMBER 1988

CHIEF SECRETARY

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

POORER PENSIONERS

I attach draft briefing on poorer pensioners which could be used for your appearance before the TCSC next Wednesday and for other purposes. It assumes that Mr Moore will already have spoken in the Queen's Speech debate earlier that afternoon (or, in the event of the Opposition choosing the economy rather than social security for the first day's debate, that Mr Moore will have made a statement before the debate begins). If this assumption proves wrong and we learn on Monday that nothing will have been said about poorer pensioners before TCSC, we can let you have alternative briefing on that issue.

2. This briefing is intended to supplement the briefing already prepared for the Autumn Statement on social security and NICs (briefs EE17 and D1). It has not yet been cleared by DSS.

Transitional Protection

3. There is one particular issue to which I would draw your attention. As things stand, DSS are taking the line (and this is reflected in the briefing) that those on Income Support transitional protection will see their TPs reduced by the £2.50/£3.50 increases. That is, they will be no better off next October (except for those with TP of less than £2.50/£3.50 who will still gain something but not the full increase.) They will of course be better off in due course, because they will be floated off TP earlier than they would otherwise have been. But this may not seem of much comfort to those affected, and it is a point which

(would)

might be picked up by the Opposition in an attempt to spoil the overall effect of the increases.

4. I have asked DSS how far the increases will erode TP expenditure. They estimate £5 million, but they say that, assuming erosion, the first year cost would be about £90 million. In other words, if TP payments were not to be affected, we would not be pushing the overall expenditure estimate over £100 million for the first year. As a result of the erosion, 15,000 would gain nothing from the October increases and a further 85,000 would have their gains reduced by an average of £1. 5,000 of the first group are disabled; 20,000 of the second group.

5. As the £5 million is within the £100 million costing for 1989-90, you may want to consider not eroding TP. The argument would be that the increases are special, and that TP will continue to be eroded by the normal April upratings.

6. There are two possible drawbacks. First, primary legislation may be needed: DSS are checking. Second, ~~is~~ it would be less easy to rebut the point that we were simply putting back the savings on pensioners' benefits made by the April reforms. But that may be a price worth paying for being able to say that all pensioners over 75 on income support will get the full benefit of the increases next October.

7. Incidentally, DSS do not propose to erode housing benefit TP with the October increases. Their argument is that those in the transitional HB scheme will already have suffered a £2 cut in April and that a further cut in October would be hard to defend.

8. There is, in any case, a fundamental difference between the TP arrangements for IS and for HB. In IS, there is a defined cash benefit entitlement for each client group which is gradually, with each uprating, moving up towards the levels at which benefits for those on TP were frozen in April 1988. In HB, the TPs are essentially the difference between 1987-88 and 1988-89 entitlements. This is not automatically eroded by annual upratings. We have to decide each year by how much to reduce the

TPs - next April, they will be cut by £2. However, this distinction between IS and HB is complicated and may not be easy to get over - perhaps another reason for not offsetting the October increases against the income support TPs.

Conclusions

9. It would be helpful to know whether you and the Chancellor are broadly content with the briefing and if there are any further questions you want covered. It would also be helpful to have your views on the TP issue. Are you interested in the possibility of changing the current DSS line and avoiding erosion of income support (as well as HB) TPs?

J P MCINTYRE

Pensioners

FACTUAL

(i) Changes will increase Income Support paid to pensioners aged 75 and above (and disabled pensioners over 60) by £2.50 a week for single pensioners and £3.50 for couples, over and above the new Income Support rates already announced for 1989-90. Increases to take effect in October next year. Increases in rates will be around 5 per cent on top of those already announced for 1989-90.

(ii) Income Support levels for pensioners after implementation of next October's increases:

£ per week

Age:	60-74		75-79		80+ (and disabled)	
	SINGLE	COUPLE	SINGLE	COUPLE	SINGLE	COUPLE
	46.10	71.85	48.60	75.35	51.10	77.80

(iii) **Number of gainers** 2 million single pensioners and pensioner couples:

900,000 on Income Support
1,000,000 on Housing Benefit
60,000 newly eligible for Income Support
40,000 newly eligible for Housing Benefit

Number of individual pensioners gaining: about 2½ million .

(iv) **Cost:** £195 million in extra benefit expenditure in full year. Less than £100 million in 1989-90 because of October implementation. Cost will be additional to existing DSS plans. Will be met from Reserves, within planning totals.

(v) Total number of single pensioners and pensioner couples now on:

Income Support and Housing Benefit: [1.75] million
Housing Benefit only: [1.75] million

(vi) Total number of single pensioners and pensioner couples: [7] million.

(vii) Total number of pensioners (individuals): 9.8 million.

(viii) **Basic pension rates for 1989-90**

Single: £43.60. Couple: £49.80.

(ix) **Take-up of means-tested benefits (latest evidence):**

	Proportion of recipients entitled ~~entitled~~	Proportion of expenditure if all those entitled were to claim
INCOME SUPPORT[1]:	[65] per cent	[80] per cent
HOUSING BENEFIT[1]:	[70] per cent	[90] per cent
FAMILY CREDIT[2]:	[40] per cent	[60] per cent

(1) Based on 1983 FES data. May well have increased since then.

(2) Based on data up to end-October 1988.

(ix) **Pledged Benefits (accounting for [50] per cent of programme)**

Retirement Pension
Widows Benefit
Industrial Disablement Benefit
War Pension
Invalid Care Allowance
Attendance Allowance
Income Support for Pensioners
Invalidity Pension
Severe Disablement Allowance
Guardian Allowance

POSITIVE

(i) Average real incomes of pensioners rose 23 per cent between 1979 and 1986 (3 per cent between 1974 and 1979).

(ii) On average, pensioners total incomes have risen twice as fast as those of population as a whole (1979 to 1986).

(iii) Proportion of pensioners in lowest 2 deciles of income distribution has fallen from 38 per cent in 1979 to 24 per cent in 1985.

(iv) Benefit expenditure on elderly has risen 27 per cent in real terms since 1979. Main reasons: 1 million extra pensioners and increase in SERPS expenditure (nearly 2 million SERPS recipients now; average SERP of someone retiring now is £25 per week versus £1 in 1979).

(v) Pensioners have shared in growing prosperity including those on low incomes eg 99 per cent own TV; 81 per cent a washing machine; 96 per cent a fridge.

DEFENSIVE

(i) **Why not help pensioners aged 60-74?**

Aim is to provide special help for older poorer pensioners, who tend to be more frail, and disabled pensioners. Poorer pensioners in 60-74 age group will still be helped by income support and housing benefit.

(ii) **Why not implement now or in April 1989?**

Not practical. Local Authorities will first need to be consulted about changes to housing benefit. Then secondary legislation. Too late after that to include in April 1989 uprating which is already in preparation. But pensioners won't have to wait until next general uprating in April 1990 - extra amounts to be paid from next October.

(iii) **Changes are simple: Why not announced in uprating statement on 27 October?** Need something like: Decision in principle. Had to consider all options. Now we have concluded simplest best.

No decisions had been taken at that point.

(iv) **Many poor pensioners will not claim**

Evidence is that most do claim. And DSS will take additional steps to publicise income support and housing benefit next year.

(v) **What does £195 million costing assume about take-up?**

Assumes existing case-load ie no increase in take-up above current levels is assumed.

[but must assume something about these floated on?]

(vi) **2½ million pensioners gain: tiny minority?**

A minority. There are 9.8 million pensioners in all.

(vii) **Increases will add 100,000 to numbers on means-tested benefits: is this reducing dependency culture?**

Inevitable result of extra help for those most in need. Other government measures, such as encouragement of personal pensions and cuts in personal taxation, are aimed at reducing dependence on State. Over time, increasing amounts from SERPS, occupational schemes and personal pensions will reduce pensioners' dependence on benefits.

(viii) **Why not increase the basic pension to help all pensioners, especially those just above benefit levels who won't gain from these changes?**

Would help many pensioners who don't need it and therefore poor use of extra resources. £195 million spent in this way would permit an increase of only £[ ] in basic pension, spread among 9.8 million pensioners.

(ix) **Increases simply pay back money saved on pensioners in April 1988 reforms.**

No. Great majority of pensioners on income-related benefits ([ ] per cent) gained in cash terms from reforms, and transitional protection has been paid to avoid any cash losers. Government now using reformed structure of benefits to target additional help where most needed.

(x) **Position of pensioners getting transitional protection as a result of IS and HB changes in April 1988.**

Income Support transitional payments will be reduced by the amount of these increases. But only [ ] per cent of pensioners getting the increases will be affected in this way. Housing Benefit transitional payments will not be reduced.

(xii) **Will pensioners' benefits be means-tested? eg Christmas Bonus, Attendance Allowance, Mobility Allowance**

No plans to introduce means testing of other benefits.

(xiii) **What provision in Autumn Statement for future upratings?**

Plans assume full upratings of all benefits in April 1990 and April 1991.

(xiv) **Pensioners' exemption from prescription charges**

No plans to change existing exemption.

(xv) **Any changes to other NHS charges?**

Cannot anticipate outcome of Health Review.

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

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

CH/EXCHEQUER
REC. 18 NOV 1988
ACTION Mr. P. McIntyre
COPIES TO CST

CONFIDENTIAL

A C S Allan Esq
Principal Private Secretary to
The Chancellor of the Exchequer
Treasury Chambers
Parliament Street
LONDON
SW1P 3AG

18 November 1988

Ch
Are you ready to accept these?
AA

Yes, subject to one addition. ✓
[cleared with DSS]

Dear Alex

POORER PENSIONERS

Thank you for your letter of earlier today. My Secretary of State is content with the draft minute subject to some minor amendments marked in manuscript on the attached. Please let me know if these cause you any difficulties.

Yours sincerely

Rod Clark

ROD CLARK
Private Secretary

CONFIDENTIAL.

CST cc Mr McIntyre

POORER PENSIONERS

Is the attached, incorporating the Chancellor's amendment OK?

AA

[note. PMac's only comment was "new" for "existing"]

chex.ul/docs/mcintyre

CONFIDENTIAL

DRAFT

PRIME MINISTER

POORER PENSIONERS

The Chief Secretary and I have now agreed with John Moore how best to take forward our plans to provide additional help for poorer pensioners.

As you know, this was discussed both before and during the public expenditure round this year. John Moore and Nick Scott put forward a scheme which would have provided additional income support for the over-80s and also for disabled pensioners. After discussion, it was agreed that further work should be done on the options available to us.

We have now reached the conclusion that income support is undoubtedly the most effective way of targetting additional resources on poorer pensioners. We also agree that the coverage of the new measure should be wider than the over-80s and the disabled.

The scheme we have agreed would increase the income support level for single pensioners aged 75 and over by £2.50 a week and for couples by £3.50. The over-80s, and all disabled pensioners aged 60 and over on income support, who at present get a higher premium than other pensioners, would receive the same increases; their special position would therefore be maintained. The increases would be around 5 per cent over and above the rates already announced for 1989-90.

CONFIDENTIAL

About 900,000 pensioners (single people and couples) already on income support would gain. And nearly 1 million, with incomes above income support levels, would also gain; their entitlements to housing benefit would increase because of the alignment of income support and housing benefit under the April 1988 reforms. In addition, an extra 60,000 would become eligible for income support and an extra 40,000 for housing benefit. This would help to address directly the concern expressed by some of our supporters about the "Nearly Poor" with incomes currently just above benefit levels.

The full year cost would be £195 million. But implementation would not be possible at the beginning of 1989-90. We believe that October next year would be the right time to introduce the increases. On this basis, the additional benefit expenditure in 1989-90 would be some £98 million. This would not of course increase our public expenditure totals but be met from the Reserve.

Now that we have agreed on the best way forward, I think there is every reason to announce our plans as soon as possible. The longer we delay, the greater the risk of a leak and a consequent bidding up of the figures. And until we announce our plans, it is certain we will continue to be harried on the subject. Some delay might have been justified if we had preferred a more complex option, such as a new benefit, which would have clearly needed a great deal of working up. But now that we have decided to go for the relatively simple means of adapting the existing system there is no case for delay on these grounds.

I would therefore be grateful for your agreement to the changes set out above and that John Moore should announce them during the debate on the Queen's Speech.

NIGEL LAWSON

I am copying this minute to John Moore.

He tells the story of Bertrand Russell. Russell described how in 1903-4 he was trying to solve the contradictions mentioned above. 'Every morning I would sit down before a blank sheet of paper. Throughout the day, with a brief interval for lunch, I would stare at the blank sheet. Often when evening came it was still empty . . . it seemed quite likely that the whole of the rest of my life might be consumed in looking at that blank sheet of paper.'

The Universities Funding Council would surely consider such behaviour inefficient since nothing was produced for two whole years, argues Dr Blackburn. Yet it led to 'Principia Mathematica' and the transformation of logic and arithmetic.

In a utilitarian age, philosophers have to work hard to convince people of their right to sit and think. Dr Blackburn says the subject is fundamental because nobody can escape from ideas. The philosopher's job is to place ideas in context, to understand the rationale behind them and to look for alternatives.

Such things can be done outside a university department because everybody is moderately reflective, says Dr Blackburn, but the aim of philosophy is to do them as rigorously and well as possible. It is much easier to think well with the help of earlier philosophers. 'You can pitch in to think about reason without knowing Hume or Kant, but you have to be a unique genius to get as far as they got,' says Dr Blackburn.

Philosophers have laid the framework for some remarkable developments. Frege and Russell, for instance, created the whole system of ideas which made it possible to see how computation by machine could take place. Their work led directly to the computer and the computer program.

A philosophically trained mind also has direct and practical uses in the world of work. An analysis of the standardised test scores of college graduates for 1964 to 1982 by the American National Institute of Education shows that philosophy majors perform considerably better than average across the whole variety of tests surveyed.

No other group had such a consistent pattern of success. In the Graduate Management Admission Test, designed to select future lawyers, managers and businessmen, the philosophers scored 11 per cent above the average, doing better than anyone except the mathematicians and much better than the business studies majors.

Yet some employers remain to be convinced. A report produced by the Royal Institute of Philosophy and the University of Warwick speaks of the need to prepare graduates for the 'hostility and ignorance displayed by some potential employers'.

One philosophy graduate who found a job as an organiser for the Citizens' Advice Bureau said: 'Employers seem to believe philosophers to be people who sit about for much of the day doing nothing in particular, and are adherents to strange cults.'

Another said: 'Many educated people have no idea what philosophy is. Worse still, some of them have misconceptions and think it is something to do with mysticism or meditation or some other woolly activity.'

Perhaps the name of the subject should be changed, suggests Dr Blackburn, to 'Clear, Deep Thinking'.

Not all is gloom, however. In London, a new centre for philosophical studies has just been set up at King's College to draw together the different departments involved in philosophy.

Dr Mark Sainsbury, one of the philosophers at the centre, aims to go out to employers and to show them that philosophy graduates have just the skills they are seeking. He says: 'It looked at one point as though philosophy might not survive into the twenty-first century. Now I am more optimistic. With the help of public education I think we can ensure that is does.'

OBSERVER SUNDAY 20 NOVEMBER 1988

Sunday People

★ STUDENT loans instead of grants as proposed by Chancellor Lawson will surely discourage the children from poorer families from going on to higher education. Surely the Government should see grants as a necessary investment in the future success of our country.
— Janet Fells,

Letters

Chelsea Bridge House, Queenstown Road, London SW8 4NN. 01-627 0700

OBSERVER

Lawson's smokescreen

SIR — Has it occurred to no one that Nigel Lawson's 'Pensiongate' has achieved exactly what he wanted to achieve, although perhaps more clumsily than he intended?

Lawson was using the lobby system to distract attention from a painful crisis in the Lords over opticians' charges. The Government is a past-master at this ploy, inflating a demon to scare the masses, to hustle us into accepting a smaller devil instead.

In this case, the charges revolt disappeared entirely from the front and middle pages. Although Lawson was forced to become more visible than he wished, the fracas only helped the distraction. His career will hardly have been rocked by the mini-storm, though the lobby system has not been exactly strengthened.

What amazes me is the gullibility with which Press and TV accept these tiddlers, rushing after each new bait without a thought.

Charles Harris,
London NW3.

■ One particular passage in Robert Harris's article last week seems to confirm something which we thought, but could hardly believe, we heard Lawson say in his interview with Robin Day.

It seems he said that increasing child benefit would be no help to the poorest because any increase would only be deducted from the children's allowances portion of income support and from family credit.

It is true that child benefit is taken fully into account in calculating income support, though the obvious solution would have been to reduce the children's allowances by £7.25 and then ignore child benefit in calculating income support. This would ensure that any restoration of the proper level of child benefit gave real benefit to those families receiving income support.

It is not true that an increase in child benefit would be deducted from family credit. Child benefit is ignored in calculating family credit — see regulation 24 (2) and para 15 of schedule 2 of the Family Credit (General) Regulations 1987.

The interesting question is whether Mr Lawson was trying to mislead, or whether he did not know the family credit rules. If the latter, it seems staggering that decisions can be made by a Government when it seems that its principal economic Minister does not know what he is talking about.

P. D. Foley,
Derby.

Moira
Is X true?
[illegible]

X

4a

gets Pens
+CB +4½p

make no diff

MP

000554

CHIEF SECRETARY
REC. 21 NOV 1988
CX

CABINET OFFICE

70 Whitehall London SW1A 2AS Telephone 01-270

SECRET

P 03279

Paul Gray Esq
No. 10 Downing Street

21 November 1988

Dear Paul,

REVIEW OF THE NHS: FUNDING THE HOSPITAL SERVICE

I have been asked to circulate the enclosed note on Funding the Hospital Service (HC 58) by the Secretary of State for Health and the Chief Secretary to the Treasury, for discussion at the next meeting of the Ministerial Group on 23 November.

I would be grateful if recipients would ensure that the paper is seen only by those with a strict operational need to see it.

I am copying this letter and the paper to the private secretaries to the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister of State (Department of Health), and Sir Roy Griffiths and to Sir Robin Butler and Ian Whitehead.

Yours sincerely,

Richard

R T J WILSON

SECRET

HC 58

FUNDING THE HOSPITAL SERVICE

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

This paper considers the mechanisms by which:

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

b. regions allocate funds to district health authorities, and

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

Introduction

2. As a Group we are agreed that RAWP, the present system for allocating funds to regions, should be transformed into a simpler system along the lines of the model set out in paper HC35. Under the new system, regions would be funded by the Department on the basis of "weighted capitation" (total population adjusted for age structure and morbidity). There would be no published "targets". Regions would fund districts broadly on the same basis, and hospital funding would be based much more than now on performance and success in attracting additional patients. Cross-boundary flows (of patients across health authority borders) would be handled by way of cash payments from the district in which the patient resided to that where he or she was treated.

3. We are also agreed that health authorities should continue to be responsible for securing those "core" services which have to be available locally: casualty, urgent medical treatment, paediatric services, maternity and ante-natal care, some types of long stay care, and so on. Hospitals must be funded in order to make these

available on demand, as now. They would also compete for contracts to supply other types of service, mainly elective surgery, to districts, who would be acting on behalf of their local populations.

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

5. The problems posed by moving to such a system are quite different at the regional and district levels. We look first at the regions.

<u>The regional transition</u>

6. We have agreed that allocations to regions would be based on population, weighted according to age structure, with some adjustment for, eg, London weighting pay costs. There already exist generally accepted methods for age adjustments, based on the average cost to the NHS of people in different age groups. The overall health of the region's population (as expressed by morbidity) would also figure in the weightings. Further work is in hand to finalise the details of the best and most acceptable measure of morbidity weighting.

7. We need to decide how best to move to a new system of allocations. It will be essential to remove the present arrangements under which cross-boundary flows are reflected only in complicated, obscure and belated modifications to population weightings. Using the most recent data for numbers and up-to-date costings of different types of treatment, all regions would be required during 1989-90 to agree how much cross-boundary flows are

costing. The sums so identified could be physically paid between regions. Ultimately, as the transition at district level proceeds, the need for such regional cross-boundary adjustments would fall away. This would mean that the main financial allocations to regions would in future be for the services used by their resident populations.

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

a. move to a weighted capitation system as soon as possible, without any regions losing. This would mean injecting additional funds to bring every region up to the level of the highest

b. bring all regions to a weighted capitation distribution, over a period of, say, three years with those currently funded above the average (in effect the Thames regions) losing resources to those below it

c. move over three years to weighted capitation funding, but at a higher level for the Thames regions than for the rest. The justification for this differential would be the particular problems faced in the capital.

The practical consequences of each option are set out in the Annex. Both the second and third options are illustrated on a self-financing basis. For comparison, the effects of the present RAWP system are also shown .

9. The full "levelling up" implied by the first option, without imposing cuts or freezes elsewhere, would cost at least £800m a year. This is out of the question and we do not consider it further.

10. The approach underlying option (b) is that which the Group has indicated it prefers in principle. As the Annex shows, however, in this form it would involve significant shifts away from present levels of funding. The losing regions would, in the

- Self-governing hospitals would be paid direct by districts. Otherwise districts would initially pay one another, the necessary legislation having been enacted. As more hospitals become self-governing and more directly-managed hospitals become capable of handling contracts, so payments to districts would give way to payments direct to hospitals. Districts would be free to look to hospitals elsewhere and hospitals to compete for the business of other districts.

17. To sum up, the transition at district level will take longer than at regional level. The general principles - the objective of weighted capitation funding and transparent cross-boundary charging - are however the same as for regions. Once "contractual" funding is in place, the regional role in making cross boundary adjustments can be phased out. The internal market will predominate.

__Performance funding of hospitals__

18. Once the new system is fully operational, there will be automatic performance incentives, since districts will be seeking the most cost-effective deals from hospitals. But during the transitional period, a system of top-sliced performance funding, along the lines set out in HC27 and HC49, is necessary. This addresses the common complaint that hospitals which increase their efficiency cannot make commensurate improvements in the numbers of patients they treat without some additional funding to cover the variable cost element of treating those extra patients. The scheme would also include incentives for some hospitals to concentrate on waiting list cases and to draw in patients from elsewhere so as to have the maximum impact on waiting lists; and provision for establishing additional consultant posts along the lines set out in HC49. The amount of money to be set aside for the scheme within the agreed total provision for health expenditure should be the subject of annual discussion between us in the public expenditure survey.

Self-governing hospitals

19. Self-governing hospitals will accelerate the pace of change at district level. It is of their essence that they will be funded by contracts with districts. We need to ensure that districts are ready to negotiate these contracts before they are set to move into "contract funding" more generally. Self-governing hospitals will need contracts to supply both "core" and "contract" services on behalf of local districts. Further work by the Department of Health is in hand on the form that these contracts will take, and on the costings that will underpin them.

20. One effect of hospitals switching to self-governing status may be to denude some districts of substantial functions. This may encourage amalgamations with neighbouring districts, a process which might be consistent with merger with the - in terms of area, often larger - FPCs.

GP practice budgets

21. The Treasury have reservations about the practicability of a full-blown scheme for GP practice budgets. This is to be addressed separately. Assuming for the moment, however, that these problems are resolved, GP practice budgets would substitute for part of districts' spending on acute hospital services. The money for paying hospitals would therefore need to come out of the hospital and community health services budget, not the FPS.

22. The proposal is an extension of those for funding districts as "buyers" of services. It would make sense therefore to give regions the responsibility for allocating funds to practices, since it is they who would also be responsible for funding districts. This would be consistent with lines of accountability irrespective of whether FPCs and DHAs are merged.

Capital

23. Capital allocations would be based on capitation weighted by age and morbidity. Land sales would continue to be retained for developments within regions. Other capital issues are being addressed separately.

Timetable and summary

24. The proposals in this paper may be summarised in the following schematic timetable.

April 1989 - Regions required to agree cost of cross-boundary flows.

- Districts begin work on improved information about population, movements of patients, and costs of different forms of treatment.
- First candidates for self-governing hospitals identified.

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

- Explicit cash payments introduced for cross-boundary flows between regions.
- Development of schemes for contractual funding of hospitals.
- New top-sliced performance funding scheme.

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

- First wave of self-governing hospitals set up, funded by contracts with purchasing districts.

April 1992 - Extend contract funding to more hospitals.

- Transition to weighted capitation at regional level complete.

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

SECRET

ANNEX

	(1) Existing Alloc Excl the effect of cross-boundary flows	(2) Gain(+) or loss(-) under Option(A)	(3) Gain(+) or loss(-) under Option(B)	(4) Gain(+) or loss(-) under Option(C)	(5) Gain(+) or loss(-) of moving to RAWP targets
	£m	£m	£m	£m	£m
Northern	731	+ 64	+10	+ 3	+12
Yorkshire	834	+ 79	+17	+10	+11
Trent	1034	+103	+26	+17	+28
East Anglia	426	+ 47	+15	+11	+18
N W Thames	850	+ 13	-45	-29	-34
N E Thames	1002	0	-68	-49	-68
S E Thames	915	+ 67	+ 1	+19	-15
S W Thames	716	+ 50	- 2	+13	- 7
Wessex	625	+ 77	+29	+23	+11
Oxford	494	+ 34	- 2	- 6	+13
S Western	721	+ 82	+28	+21	+10
W Midlands	1174	+ 80	- 6	-16	+15
Mersey	583	+ 32	-10	-15	- 9
N Western	972	+ 77	+ 6	- 2	+14
Total RHAs	11076	+807	0	0	0

All figures relate to 1988-89 initial allocations (excluding Review Body additions). There are two points to note about the figures in Column 4. They are the cumulative effect of changes in three years and they would in any event alter dramatically as a result of inter year changes.

Copy No: 2

HC 51

NHS Review

MANAGING THE FAMILY PRACTITIONER SERVICES

Note by the Secretary of State for Health

1. This paper addresses three related issues arising from the Group's discussion of budgets for general practice (HC 47):

* the management of contracts with GPs.
* the number of GPs.
* the role and constitution of FPCs.

I am working separately to develop our proposals on GP practice budgets in the light of our discussion.

2. In brief, my proposals are that

i. on prescribing costs, we should

a. pilot an incentive scheme for FPCs on drug spending.

b. enable FPCs to buy in the medical manpower they need to follow up their monitoring.

c. take powers for FPCs to impose financial penalties on GPs who persistently over-prescribe .

ii. we should give a high priority to improving the information available to GPs and FPCs about referral rates and costs, and give FPCs the capacity and powers they need to follow up their monitoring of referral rates.

iii. subject to an assessment of the overall impact of the review on the medical profession, we should take powers to control GP numbers; and should in due course reduce the retirement age from 70 to 65.

iv. we should keep FPCs separate from DHAs, but

a. strengthen their non-executive leadership by changing their composition.

b. introduce a tougher, and better resourced, executive management.

c. make FPCs accountable to Regions.

Medical audit in general practice is dealt with in paper HC 50.

I MANAGEMENT OF CONTRACTS WITH GPs

Context

3. Leaving aside the number of GPs, we have identified two main respects in which further action may be needed to secure greater cost-effectiveness in general medical practice: prescribing habits; and referrals to hospitals. GP practices which opt to have their own budgets will have a strong incentive to act cost-effectively. We must therefore address the position of GPs who are not covered by the practice budget scheme. In my view the right way forward is to build on our existing policy of tightening the GP contracts and giving FPCs the powers and capacity they need to manage the contract effectively.

4. The terms of service of GPs are set out in Regulations. These Regulations, along with the current fees and allowances, constitute the basis of each GP's contract with his or her FPC. The main obligations which the terms of service place on GPs, and the main controls and sanctions which are available to FPCs, are summarised in Appendix A, along with examples of the action we have in hand to extend these obligations and controls following the Primary Care White Paper. The following paragraphs set out how these contractual arrangements can - and should - be used to secure cost-effective prescribing and referrals, and how they will need to be reinforced to make them effective for this purpose.

Prescribing costs

5. We have already discussed the possibility of trying to control prescribing costs through cash limits or "indicative" drug budgets. As I have argued in previous papers, I believe that an approach along these lines would be fraught with political difficulty. There would be potential for 30,000 GPs to protest - and encourage their patients to protest - at the perceived inadequacies of their budgets. We would be bombarded with stories of individual patients deprived of necessary medication by the effects of "cash limits".

6. Some FPCs are already monitoring and advising on prescribing habits, but this function has hitherto been carried out primarily by doctors from the Department's Regional Medical Service (RMS). This approach is relatively limited in scale: the RMS visits practices whose prescribing costs exceed the local average by 25%. But these visits -

which are educational, not punitive - are effective enough to save on average around £10,000 per practice in the first year. We are doubling this RMS activity from 1989-90.

7. We are already intending to ensure that FPCs themselves take a more active role from now on. We should not underestimate the potential impact of this. In particular:

i. the experience of some FPCs which are already active in this field suggests that the essential first step is to educate GPs, for example in the use of practice formularies (short lists of drugs selected on the basis of economy and efficiency); the scope for generic prescribing; or systems for helping GPs to for control and reduce repeat prescriptions. We shall be ensuring that in future all FPCs give a strong local lead in educating GPs, so that no doctor can claim to be ignorant of what can be done to control prescribing costs.

ii. we shall also inform - both GPs themselves, so that they can audit their own prescribing, and FPCs, so that they can monitor the performance of their GPs. And I shall be arranging for the publication of "league tables" of FPC prescribing costs. A description of the new "PACT" information system, appended to HC47, is attached again as Appendix B. Despite strong opposition from the profession, we shall be making this information available to FPCs from next year, and all FPCs will be covered by the system from 1990-91. In anticipation of the impact of this information, and of the related FPC and RMS activity, my PES bid offered savings of £15 million and £20 million in 1989-90 and 1990-91 respectively.

8. As I suggested in HC 47, I believe we should explore the scope for reinforcing these initiatives with some incentives. The scheme I set out in that paper was one in which an FPC could be set a target level of spending on drugs, with a proportion of any savings being returned to them to finance primary care initiatives in their area. Involving the GPs themselves would help to secure their commitment to the scheme. I hope colleagues will agree that I should pilot this proposal with the help of a willing FPC.

9. Effective though I believe they will be, our current plans would still leave FPCs with two important handicaps: a shortage of resources with which to follow up their monitoring; and, since a requirement to prescribe economically does not figure in the contract, a lack of effective sanctions. I propose to overcome these handicaps as follows:

i. for most GPs the most effective response to evidence of over-prescribing will be pressure and advice from their peers. We should therefore give FPCs the medical manpower with which to follow up their monitoring, and not only when costs are 25% or more above the local

average (which is all the RMS is resourced to do). The most practical approach, at least initially, would be to expand the RMS and charge FPCs for the use of RMS doctors. I am confident that the resulting savings would outweigh the manpower costs by a wide margin.

ii. we must enable FPCs to impose financial penalties where GPs persist in over-prescribing. Current Regulations provide only for Local Medical Committees (LMCs), which represent the GPs themselves, to investigate excessive prescribing, at the request of the Secretary of State. This provision is ineffective, and has fallen into disuse. I suggest we seek to amend the Regulations to enable an FPC to investigate on its own initiative and to fine GPs who persistently refuse to curb excessive prescribing. This power would be subject to the normal right of appeal to the Secretary of State. GPs' terms of service would also be amended to require doctors to answer questions from their FPC about their prescribing patterns.

10. I have considered further colleagues' suggestion that we should publish comparative information about the prescribing costs of different GP practices. Aside from the certain opposition of the profession there is a fundamental problem: the evidence - from FPC performance reviews, for example - suggests that at least in some areas patients tend to prefer doctors who are more ready to write a prescription. If this is so, publicity could have precisely the reverse effect of the one we intend. It might be more profitable to experiment with publicity campaigns to educate patients not to put pressure on their doctors to prescribe indiscriminately, although I understand that experience of a campaign of this kind in Northern Ireland is not encouraging.

Referral rates

11. We are less well prepared to tackle referral rates. We lack both information and experience in this field. Medically, inefficient referral patterns are more difficult to spot than excessive prescribing. We need to curb over-referral, but we must also guard against the under-referral of patients who need specialist attention.

12. The essential first step is to improve the information available to both GPs and FPCs. There are a number of useful local initiatives, including examples of GPs keeping records of their own referral rates. But the most important development is a project in East Anglia, based at the RHA and part-funded by the Department. This project is tackling three problems, with extensive co-operation from the Region's GPs:

i. developing an information system to identify the decisions being made. The first phase of the project has shown that it is possible to trace the patient and the

referring doctor using existing data, although some difficulties remain to be resolved. (For example, the GPs referring the patient may or may not be the GP with whom the patient is registered, and it is the latter who tends to be recorded.) The next phase, now in hand, is to develop and program a regional computer system.

ii. developing techniques for linking costs to these decisions. Information about the cost of out-patient work is currently poor. It will be important to develop a system which takes account of case mix, as do diagnosis related groups (DRGs) for in-patient costs. We are planning soon to test through the project the use of an adapted version of "ambulatory visit groups" (AVGs), an out-patient equivalent of DRGs being developed in the USA. Linked systems will be needed to cover in-patient and diagnostic costs, and we shall need to ensure compatibility with the resource management initiative. All this work will also be an essential input to the development of GP practice budgets.

iii. learning more about what constitutes a "good" referral decisions in terms of cost effectiveness. The Region have initiated useful work here, too, for example in encouraging GPs and consultants jointly to draw up "protocols" covering particular conditions such as diabetes. But this approach can be fully effective only when adequate information is in place to support it.

13. Our current estimate is that it will take about two years to reach the point at which the information systems at (i) and (ii) will be fully in place in East Anglia and ready for adoption by other Regions. It might be possible to accelerate this programme given additional resources.

14. In the meantime, as for prescribing costs, we must ensure that FPCs will have the capacity and powers to make effective use of referral information when they get it. To this end:

i. FPCs are to contract with independent medical advisers - drawing on academic medicine, the RMS and other sources - to encourage good practice in the referral of patients to hospital. This capacity will be built up steadily over time. Among the other effects of this work should be a reduction in waiting times.

ii. although the approach must be primarily educational, I suggest that FPCs are given powers to impose financial penalties in cases of persistent over- or under-referral, as for over-prescribing. But it will be some time before FPCs have adequately robust criteria against which to use this power.

Relationship to practice budgets

15. I am confident that the measures outlined in paragraphs 7-14 will be not only effective in themselves but also more than sufficient to avoid giving large GP practices a disincentive to opt for their own budgets. Without going into detailed aspects of practice budgets, which I have been asked to work up separately, it may be helpful to make three further points:

i. the main incentives for a practice to take its own budget are that it

- enables them to back their choices with money, and
- opens up the possibility of generating funds for their practice through virement.

In both respects it offers the potential for attracting more patients. All these incentives apply whether or not other practices are brought under effective pressure to curb prescribing and referral costs.

ii. if practice budgets are calculated in the way I proposed in HC 47 only practices which beat the average, or believe they can do so, will have an incentive to opt into the scheme. This in turn means that practices which would like to join the scheme will have an incentive to beat the average first.

iii. colleagues have questioned my proposal in HC 47 that practices opting for a hospital service budget should have the option of having a drug budget too. The logic of this proposal is that, if drug budgets were a compulsory element of the scheme, practices which would like a hospital service budget but do not (at least yet) beat the prescribing costs average would be deterred altogether. I believe this logic holds good, and that we should proceed accordingly. I would rather they at least began with a hospital services budget to get them into the scheme. They would then have a strong incentive to bring down their prescribing costs so that they could safely opt for a drugs budget and thereby increase their scope for virement. (They might choose to vire into drug spending, of course, where they judged this more cost-effective than using hospital services.)

II CONTROLLING GP NUMBERS

16. Recruitment into general practice is buoyant. The number of GPs in Great Britain has increased by nearly 20% over the past decade, to nearly 30,000. The increase in the year to October 1987 was 1.8%. In 1987 the average GP had less than 2,000 patients on his list, compared with nearly 2,300 in

MB

1977. There is a strong demand to fill practice vacancies even in traditionally unattractive areas. Excluding the cost of drugs and hospital referrals, but including practice expenses, the average GP costs the Exchequer £56,000.

17. Aside from the normal immigration controls, the Government has no power to restrict the entry of suitably qualified doctors to general practice. The only "de facto" control is that exercised by the statutory Medical Practices Committee (MPC), which regulates the geographical distribution of GPs. Under present arrangements a doctor who wishes to set up in practice in an area with an average list size of 2,100 patients or less must apply to the MPC for admission to the relevant FPC's "Medical List". The power to change this criterion to a different average list size rests with the MPC itself. The MPC is empowered to refuse an application from a suitably qualified doctor only where the number of doctors in the area is "already adequate".

18. Controlling the total number of GPs would require primary legislation. I continue to see some difficulties in this. Limiting the number of independent practitioners (small businesses, in effect) is arguably inconsistent with our general approach to freeing trade restrictions (although we have done it for pharmacists); and public reaction to limiting the number of GPs might well be unfavourable. It would be opposed by the profession, whose declared aim is an average list size of 1,700 (although in private many would see controlling the numbers as helping to maintain their incomes). Abolishing the MPC, or substantially constraining its role, would also be strongly contested by the profession.

19. For these reasons I suggest we defer a final decision until we are in a position to assess the reaction of the profession to the review package as a whole. Subject to that, I agree in principle that we should legislate to take the necessary powers.

20. I shall give further thought to how these controls should work and to the nature of the powers we shall need, so that we are ready with detailed proposals when the White Paper is published. I see two basic approaches, each operating within a ceiling - set by Government - for the total number of GPs in any one year:

i. we could empower the Secretary of State to direct the MPC - or a successor body - as to the manner in which, and criteria on which, it exercises its existing functions.

ii. allocations within the ceiling could be made to FPCs, either directly by the Department or, preferably, by Regions. The MPC would be abolished.

21. The main advantage of option (i) is that it distances Government from potentially contentious allocation decisions. It could work well if we changed the composition of the MPC, or replaced it altogether, to remove its current domination by the profession. On the other hand option (ii) arguably makes more management sense because it enables allocations to Regions and FPCs to be directly related to other priorities and resource allocation decisions. I should like to give a little more thought to this.

22. As we discussed at our last meeting it will be important to ensure that we do not deter good, young doctors from entering general practice. I shall need to give further thought to this, too. The best approach might be

i. to reduce from 70 to 65 the retirement age for GPs which we are introducing through the Health and Medicines Bill, this reduction to take effect when the new manpower controls are established.

ii. to ensure that, when filling single-handed practice vacancies, FPCs give priority to younger doctors who are keen to work as members of primary health care teams.

I am looking at ways in which FPCs could have more influence over the filling of vacancies in partnerships.

III THE ROLE AND CONSTITUTION OF FPCs

Need for change

23. There is a clear need to strengthen the management of the FPS. In particular, we must

* complete the substantial body of changes set out in the White Paper, including the implementation of legislation.

* secure much more effective local management of contracts with independent practitioners. Appendix A outlines some of what is involved for GPs (and GPs with their own budgets will, of course, remain in contract with FPCs and subject to the same basic terms of service).

* implement effectively the measures proposed in parts I and II of this paper.

24. The key management changes we need are

i. a strong, non-executive leadership devoted specifically to the management of the FPS locally.

ii. tougher, and better resourced, executive management of the FPS.

iii. firmer monitoring and accountability of local FPS management.

My proposals under these three heads are set out more fully in paragraphs 27-32 below.

Merger with DHAs

25. The changes in paragraph 24 will be needed whether or not FPCs are merged with DHAs. DHAs could not simply absorb either these new management tasks or the existing administrative functions of FPCs, and they would lack the experience which FPCs have been building up since 1985.

26. I remain of the view, therefore, that we should not merge FPCs with DHAs, for the reasons I gave in HC 41. In short:

i. I believe we can inject competition into the NHS more effectively by keeping "customers" and "suppliers" separate and by ensuring that the interests of hospitals do not dominate those of primary care. This is still more true if we are to develop GP practice budgets.

ii. merger could easily be portrayed as indicative of a Government which does not know its mind. FPS and hospital administration were merged from 1974 until 1985, following the 1974 reorganisation. It was this Government which detached them again, not least because we judged that health authorities did not have a good track record in their administration of the FPS. Since 1985 there has been real progress towards more effective management.

iii. if the introduction of general management into the hospital and community health services is included in the reckoning, merging FPCs with DHAs would be the fourth administrative upheaval within a decade. Of 90 FPCs, 56 relate to more than one District and 17 cover part or all of at least four Districts. Further reorganisation would tend to divert effort away from more important objectives.

iv. there would be significant costs - in additional computers, in reorganising FPC registers and in additional staff - but only minimal financial savings because the bulk of the work undertaken by FPCs would continue as before.

Composition of FPCs

27. FPCs currently consist of 15 members from the professions and 15 lay members. All the members are appointed by the Secretary of State. The professional members are drawn from Local Representative Committee (LRC) nominees. Four of the

lay members are drawn from DHA nominees, and a further four from local authority nominees. The Chairman may or may not be lay - we have been steadily reducing the proportion of chairmen drawn from the contractor professions - but the professional members tend to dominate the proceedings.

28. Not surprisingly, some Committees regard the support of the contractors as more important than service to the customers. There is a general tendency to shrink from proper enforcement of the contracts, and I see changing the constitution of FPCs as essential to strengthening the management of the FPS. There will be strong opposition from the contractor professions, particularly the doctors, but I believe we should face this.

29. I propose that the composition of FPCs should in future be as follows:

i. there should be no more than, say, 12 members in total.

ii. there should be a lay chairman, appointed by the Secretary of State.

iii. there should be a clear minority of professional members - one from each of the four contractor professions. The professional members could be nominated by anyone but would be appointed by the RHA.

iv. the chief executive (paragraph 31 below) should always be a member of the committee. (There are no equivalents of the other executive members I propose for DHAs - see HC52.)

v. the remaining members - all lay - would be appointed by the RHA and chosen for their experience and personal qualities. No places would be reserved for DHA or local authority nominees.

vi. the currently extensive sub-committee structure should be radically slimmed down, and many decisions currently taken by sub-committees devolved to officers. The reduced size of the membership should then suffice.

Executive management

30. The typical FPC has about 50 staff, most of whom are engaged in the routine work of paying practitioners and maintaining records. Computerisation has enabled staff savings to be made and released resources for strengthening middle management. But this is not enough.

31. I believe we must now appoint new chief executives to all FPCs, by open competition. The salaries offered will need to be good enough to attract quality managers from both inside

B:DC4.2/36

and outside the NHS. Essentially the same level of administrative support should remain, with the chief executive supplying the drive and managing the many changes that will be needed. I estimate the costs at around £3 million a year.

Accountability

32. Since April 1985 the 90 English FPCs have reported direct to the Department. Although a good deal has been achieved by way of setting objectives for the Committees and giving them a sense of direction, it is impossible to monitor all FPCs as closely as we would like. As they take on new responsibilities it will be necessary to assess their performance more regularly. I therefore believe that FPCs should be made managerially accountable to RHAs, who would carry out much more frequent performance reviews than the four-yearly formal reviews carried out by the Department now. This relatively modest addition to the functions of Regions will be more than offset by the overall slimming down I propose in HC52.

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APPENDIX A

GENERAL PRACTITIONERS' CONTRACTS

The contract with the FPC

1. GPs are independent contractors. Their contract with the FPC is governed by Regulations which include their terms of service. The main obligations placed on the GP are:

- to render to his patients all necessary and appropriate personal medical service.
- to do so in suitable surgery premises or at the patient's home.
- to refer the patient to other parts of the NHS if necessary.
- to prescribe whatever medicines are necessary.
- to provide 24-hour cover either personally or through a deputising service.
- to provide (if he so contracts) maternity services, contraceptive services, cervical cytology and vaccination and immunisation.

Controls and disciplinary procedures

2. FPCs have the following powers

- to refer a complaint about unsatisfactory treatment to a Service Committee. This is set up by the FPC under lay chairmanship with, additionally, three GPs and three other lay people.
- to receive and act on recommendations from the Service Committee as to whether or not there has been a breach of the GP's terms of service.
- to fine the GP if he is in breach, subject to the Secretary of State's agreement. Fines of £500-£1000 are not uncommon. There is a procedure for the GP to appeal to the Secretary of State.
- to refer more serious cases (eg repeated breaches) to the NHS Tribunal, which is a statutory body with an independent chairman appointed by the Lord Chancellor; and to remove a GP from the FPC's list if so instructed by the Secretary of State in the light of the NHS Tribunal's decision. This is also subject to an appeals procedure.

Additionally, an FPC can refer a case to the General Medical Council, which can remove a GP from the Medical Register and therefore from the right to practise altogether.

3. An FPC can also

- check that premises are up to standard and, if not, withhold reimbursement of rent and rates.
- withhold fees or allowances if the specified conditions are not satisfied.
- approve consultation hours.
- approve and oversee use of deputising services.

Current plans to tackle weaknesses

4. The weaknesses of these arrangements are

- poor leadership in some FPCs.
- domination of FPCs by the professions.
- limited FPC resources to take necessary follow up action.
- lack of specific requirements in the terms of service (eg. no reference to health promotion).
- patients ill informed of rights and service availability; patients' expectation are low.
- inadequate flow of information about GPs' activities.
- the complaints procedure is cumbersome and insufficiently consumer friendly.
- quality of care is not monitored.

5. Following the Primary Care White Paper, the Government intends to:

- make the remuneration system performance related.
- increase competition and consumer power through better information about local services and greater emphasis on capitation fees.
- cash limit and target expenditure on premises improvements and practice team staff on those premises and practice teams where the need is greatest.
- retire elderly doctors.

- enhance the role of FPCs and their management.
- make GPs' terms of service more specific.
- streamline the complaints procedure.

6. In addition, FPCs will be required to:

- submit service development plans for improving services where most needed.
- set targets for GPs in receipt of vaccination and immunisation and cervical cytology fees.
- monitor performance of GPs using outcome measures, performance indicators and consumer surveys.
- exercise leadership in improving the cost effectiveness of prescribing.
- in due course apply similar arrangements to hospital referrals.
- exercise more vigorously their powers to inspect records.
- use existing Service Committee and Tribunal powers to raise and maintain standards.

APPENDIX B

GP PRESCRIBING - INFORMATION PROVIDED TO PRACTICES

The Prescription Pricing Authority has developed a 3-level reporting system based on data taken from prescriptions dispensed by community pharmacists (shortly to be extended to dispensing doctors):

* Level 1 reports are sent quarterly to each GP practice and within 3 months of the period measured. Each report compares the practice prescribing costs (calculated at list price) with the FPC average and the national average. It also compares the prescribing pattern with the FPC average in each of the 6 highest-cost drug categories (e.g. cardiovascular). The report gives information on the prescribing of individual GPs within the practice and about generic prescribing habits.

* Level 2 reports are sent automatically within a week of the level 1 report to practices whose costs exceed their FPC average by 25% or more and to those whose costs in any of the 6 major cost categories exceed the FPC average by 75%. Level 2 reports are sufficiently detailed to identify areas of high cost down to individual drugs. Tables show how individual GPs stand in relation to the practice as a whole, and how practices stand in relation to the FPC overall, in terms of

    - numbers of items prescribed

    - total cost (at list prices)

    - average cost per item

* Level 3 reports are available on request for those wishing to carry out a detailed audit. It provides a full catalogue of items prescribed. Analyses of prescribing can be provided in terms of

- overall pattern
- 6 major cost groups
- all other drug groups
- appliance and dressings
- other preparations

2. The system is under continuing review. A leaflet explaining its methods and purposes has been sent by the Department to all GPs and group practices.

Copy No: 2

HC 53

NHS Review

A BETTER SERVICE TO PATIENTS

Note by the Secretary of State for Health

Introduction

1. We are agreed that, in presenting the outcome of the review to the public, we shall need to be ready with a convincing package of expected benefits to patients and to the public generally consistent with the impact on doctors and managers.

2. I propose to deal with this in three ways:

first, by presenting our proposals throughout in the White Paper in a way which brings out the patient's perspective and underlines the improvements being made for the benefit of patients. I will also emphasise that while much of our work has concentrated on financial and managerial issues, underlying this is our objective of securing a better service by giving patients and their GPs a greater say in where they will be treated and by encouraging greater competition in the provision of services.

second, by a package of measures to improve both service to patients and the quality of clinical care.

third, by a number of initiatives to emphasise our aim of improving health as well as the treatment of those who need care.

3. In summary, my key proposals on the second and third points are:

i. a national initiative to put better service to patients at the top of the agenda. The key to this will be a quality assurance programme in every District.

ii. specific proposals for making the service more personal, including proposals on waiting times for outpatients' departments and for diagnosis and treatment.

iii. much better information provided by hospitals, e.g. leaflets, better telephone service, periodic reporting to the public.

iv. more emphasis on the quality of clinical care through better information about clinical outcomes, medical audit and monitoring of health outcomes.

The first and most obvious issue for me would be to ensure that a self-governing hospital continued to provide an adequate range of services for the people in its district, and that it did not abuse its monopoly or near-monopoly position as a provider of acute hospital services.

One of the key tests of whether or not self-governing has any meaning would be the ability of hospitals to employ whatever staff they judge necessary (with the exception of junior doctors, but including consultants) and to settle the pay and conditions of those staff. At the same time, I would have to ensure that the exercise of this freedom did not compromise the ability of other areas in Wales to recruit and retain staff. We are already struggling in parts of Wales (particularly in the valleys and the rural areas) to fill key medical and other posts. I could not allow this situation to deteriorate further. I confess that I see no answer which would square this circle, short of ensuring that the NHS could pay the going rate to get the staff it needs.

I should also have to ensure that the education and training of staff, and particularly doctors, was not adversely affected. That would mean that a full range of quality services must continue to be provided in each area, not least in the 3 hospitals in Cardiff which provide the clinical base for our only College of Medicine and the bulk of our regional services.

All this would be tricky enough if I were confident about the standards of management and financial control in the major hospitals. I am afraid that quite the contrary is the case, and I should expect to have to carry out a sustained programme of action to improve this state of affairs before I could allow any existing hospital in Wales to become self-governing. As things stand, there would be the strong likelihood of dominant medical personalities seeking to increase their individual independence from management at a time when most of them are just beginning to develop understanding about what it means to take responsibility for budgets and to account for their performance. I would expect this to be particularly true in the isolated acute hospitals in our rural and valleys areas.

If we were to proceed immediately towards a programme of encouraging hospitals to become self-governing in Wales, I would see no alternative (whatever the statutory basis for the establishment of self-governing hospitals as legal entities in their own right) but for me to be able not only to determine whether or not a hospital may become self-governing, but also:-

£34,000, plus an annual enhancement of up to 4% in performance-related pay (PRP). This is for handling a revenue budget in excess of £150 million. By way of comparison the Financial Director of a private sector company with only a £100m turnover would expect to earn over £50,000 plus related benefits.

I feel strongly that we have gone down the wrong road in seeking simply to adjust pre-existing pay arrangements. As a result we have achieved only a modest leavening of outsiders. I believe that we need a much more radical approach, under which we would pay-off humanely those who are simply not up to operating with the entrepreneurial flair and energy which is needed, and recruit top class managers, particularly financial managers, from the private sector who could bring a dynamic approach to the management of property, to the generation of income, and to the operation of a substantially more open market in health care, where health authorities and hospitals will be competing directly with the private sector. We would ensure that this flexibility was not abused by exercising control over appointments at regional level.

In my minute to you of 13 October I leant my support to Kenneth Clarke's proposals for opening up the use of private capital and suggested an initiative, to be launched as part of the outcome of the review, to use the private sector to reduce waiting times to our targets. I set out in an annex to this memorandum a list of the key areas where I feel we should be tapping private sector funding. The key will be to relax the self-defeating Treasury rules which force comparisons on the basis of the relative cost of the Government borrowing money as opposed to the private sector. This will always point to Government funding for all but the shortest life projects. But this is a meaningless conclusion when we all know that the extent of public capital investment will be strictly limited. The need is for investment in health care services now - in renovated and new buildings, in information technology and systems, in medical equipment and so on - and there is every reason to believe that the private sector is able and willing to make this investment.

ANNEX

POTENTIAL AREAS FOR USE OF PRIVATE SECTOR FINANCE IN THE NHS

1. Hospitals
Two new district general hospitals are planned in South Wales over the next few years. The timetable for their construction would be greatly accelerated if the private sector were invited to design, build and, possibly, run them. The DHAs involved would either lease the buildings on completion or, if they were run by the private sector, contract with them for the services to be provided.

2. Management Information and Information Technology
The Welsh Office has an Information and Information Technology strategy to equip the NHS to be managed effectively and efficiently through improved clinical budgeting, manpower planning, patient administration, integrated telecommunications and coherently managed community health services. The total investment needed is in excess of £40 million. At current possible levels of direct Government investment the systems will not be available throughout Wales for about 10 years. The private sector could design, install and maintain them on contract within one or two years, subject to DHAs being able to fund leasing and contractual arrangements from revenue expenditure. The rapidly developing field of information systems points to leasing as likely to be the most cost-effective use of public resources.

3. Medical Equipment
It makes little sense for the same reasons for the NHS to invest heavily in high-risk short-life technologies - and the pace of technological change is increasing all the time. Again, leasing from the private sector is likely to offer the most cost-effective solution.

4. Energy Savings
There are significant savings to be made which would be available for use on patient care, if private finance could be used to accelerate the capital investment necessary to finance energy savings. Also contract energy management schemes using private sector funding should be developed.

5. Specific Services
Four subsidiary renal dialysis units are already contracted out to the private sector in Wales. In addition, heart surgery for people in North Wales is purchased from AMI's hospital in Manchester. Other areas where the private sector might most cost-effectively carry out treatments include hip and knee replacement operations. cataracts, hernias, varicose veins, and

gynaecological operations. More radically, it might be possible to set up with private finance (and possibly run by the private sector) a "factory" style central treatment centre or centres in Wales to ensure rapid turn-round of cases, with direct referral by GPs to ensure that local consultants do not decline to refer for fear of the implications for their private practice.

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MR CALL

CABINET OFFICE

70 Whitehall London SW1A 2AS Telephone 01-270

SECRET

P 03279

Paul Gray Esq
No. 10 Downing Street

21 November 1988

Dear Paul,

REVIEW OF THE NHS: FUNDING THE HOSPITAL SERVICE

I have been asked to circulate the enclosed note on Funding the Hospital Service (HC 58) by the Secretary of State for Health and the Chief Secretary to the Treasury, for discussion at the next meeting of the Ministerial Group on 23 November.

I would be grateful if recipients would ensure that the paper is seen only by those with a strict operational need to see it.

I am copying this letter and the paper to the private secretaries to the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister of State (Department of Health), and Sir Roy Griffiths and to Sir Robin Butler and Ian Whitehead.

Yours sincerely,

Richard

R T J WILSON

SECRET

HC 58

FUNDING THE HOSPITAL SERVICE

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

This paper considers the mechanisms by which:

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

b. regions allocate funds to district health authorities, and

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

Introduction

2. As a Group we are agreed that RAWP, the present system for allocating funds to regions, should be transformed into a simpler system along the lines of the model set out in paper HC35. Under the new system, regions would be funded by the Department on the basis of "weighted capitation" (total population adjusted for age structure and morbidity). There would be no published "targets". Regions would fund districts broadly on the same basis, and hospital funding would be based much more than now on performance and success in attracting additional patients. Cross-boundary flows (of patients across health authority borders) would be handled by way of cash payments from the district in which the patient resided to that where he or she was treated.

3. We are also agreed that health authorities should continue to be responsible for securing those "core" services which have to be available locally: casualty, urgent medical treatment, paediatric services, maternity and ante-natal care, some types of long stay care, and so on. Hospitals must be funded in order to make these

available on demand, as now. They would also compete for contracts to supply other types of service, mainly elective surgery, to districts, who would be acting on behalf of their local populations.

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

5. The problems posed by moving to such a system are quite different at the regional and district levels. We look first at the regions.

<u>The regional transition</u>

6. We have agreed that allocations to regions would be based on population, weighted according to age structure, with some adjustment for, eg, London weighting pay costs. There already exist generally accepted methods for age adjustments, based on the average cost to the NHS of people in different age groups. The overall health of the region's population (as expressed by morbidity) would also figure in the weightings. Further work is in hand to finalise the details of the best and most acceptable measure of morbidity weighting.

7. We need to decide how best to move to a new system of allocations. It will be essential to remove the present arrangements under which cross-boundary flows are reflected only in complicated, obscure and belated modifications to population weightings. Using the most recent data for numbers and up-to-date costings of different types of treatment, all regions would be required during 1989-90 to agree how much cross-boundary flows are

costing. The sums so identified could be physically paid between regions. Ultimately, as the transition at district level proceeds, the need for such regional cross-boundary adjustments would fall away. This would mean that the main financial allocations to regions would in future be for the services used by their resident populations.

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

a. move to a weighted capitation system as soon as possible, without any regions losing. This would mean injecting additional funds to bring every region up to the level of the highest

b. bring all regions to a weighted capitation distribution, over a period of, say, three years with those currently funded above the average (in effect the Thames regions) losing resources to those below it

c. move over three years to weighted capitation funding, but at a higher level for the Thames regions than for the rest. The justification for this differential would be the particular problems faced in the capital.

The practical consequences of each option are set out in the Annex. Both the second and third options are illustrated on a self-financing basis. For comparison, the effects of the present RAWP system are also shown .

9. The full "levelling up" implied by the first option, without imposing cuts or freezes elsewhere, would cost at least £800m a year. This is out of the question and we do not consider it further.

10. The approach underlying option (b) is that which the Group has indicated it prefers in principle. As the Annex shows, however, in this form it would involve significant shifts away from present levels of funding. The losing regions would, in the

new system, be able to compete to attract patients from elsewhere. But they might not in the short term be able to attract enough to make up for a loss of funds on this scale. This would be particularly true in London.

11. Option (c) would give an explicitly higher level of funding to the Thames regions. This would be in recognition of a number of factors: the higher costs of the South East generally (not just pay costs); the less comprehensive primary care services in London; and the historically higher rate at which residents of inner city areas in London make use of hospitals, even after allowing for measurable factors like age and morbidity. This last factor has a number of causes, including the simple behavioural fact that people living near to large hospitals will tend to make more use of them.

12. We recommend this third option. We think the proposed 3 per cent differential between the Thames regions and the rest is defensible for the reasons given. On the nil cost basis illustrated, the Thames regions would still lose resources to the rest, but their position would be noticeably better than under RAWP. And most other regions would still gain as compared with the present distribution.

The transition for districts

13. At present districts are funded by regions, but on varying bases. Some use formulae akin to RAWP, but most fund their districts according to where hospitals happen to be located. Under the new system, we would propose, as with regions, to move to weighted capitation allocations, with direct payment between districts for cross-boundary flows.

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

- the change will have to run alongside the move to contractual funding for hospital services. It will take time to develop a system for districts to enter into

contracts with hospitals which make sense in terms of financial management without unacceptably limiting the ability to refer patients to where they can be treated quickest or most cost-effectively;

- differences between current levels of funding and those implied by a weighted capitation system are much larger than at regional level. An immediate switch would involve substantial shifts in resources.

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

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

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

16. A start depends on improved information at hospital and district level about population, movement of patients and costs of different types of treatment. Once that is available, and it should come naturally from the improved information systems we are proposing more generally, cross-boundary flows could be explicitly costed and paid for.

- First, districts would identify and cost the services which were being provided for the residents of other districts, which would then be paid for. District allocations would thus be based on the cost of services that were being provided for their residents, rather than the cost of the hospitals they contained.

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

- the change will have to run alongside the move to contractual funding for hospital services. It will take time to develop a system for districts to enter into

contracts with hospitals which make sense in terms of financial management without unacceptably limiting the ability to refer patients to where they can be treated quickest or most cost-effectively;

- differences between current levels of funding and those implied by a weighted capitation system are much larger than at regional level. An immediate switch would involve substantial shifts in resources.

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

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

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

16. A start depends on improved information at hospital and district level about population, movement of patients and costs of different types of treatment. Once that is available, and it should come naturally from the improved information systems we are proposing more generally, cross-boundary flows could be explicitly costed and paid for.

- First, districts would identify and cost the services which were being provided for the residents of other districts, which would then be paid for. District allocations would thus be based on the cost of services that were being provided for their residents, rather than the cost of the hospitals they contained.

- Self-governing hospitals would be paid direct by districts. Otherwise districts would initially pay one another, the necessary legislation having been enacted. As more hospitals become self-governing and more directly-managed hospitals become capable of handling contracts, so payments to districts would give way to payments direct to hospitals. Districts would be free to look to hospitals elsewhere and hospitals to compete for the business of other districts.

17. To sum up, the transition at district level will take longer than at regional level. The general principles - the objective of weighted capitation funding and transparent cross-boundary charging - are however the same as for regions. Once "contractual" funding is in place, the regional role in making cross boundary adjustments can be phased out. The internal market will predominate.

Performance funding of hospitals

18. Once the new system is fully operational, there will be automatic performance incentives, since districts will be seeking the most cost-effective deals from hospitals. But during the transitional period, a system of top-sliced performance funding, along the lines set out in HC27 and HC49, is necessary. This addresses the common complaint that hospitals which increase their efficiency cannot make commensurate improvements in the numbers of patients they treat without some additional funding to cover the variable cost element of treating those extra patients. The scheme would also include incentives for some hospitals to concentrate on waiting list cases and to draw in patients from elsewhere so as to have the maximum impact on waiting lists; and provision for establishing additional consultant posts along the lines set out in HC49. The amount of money to be set aside for the scheme within the agreed total provision for health expenditure should be the subject of annual discussion between us in the public expenditure survey.

<u>Self-governing hospitals</u>

19. Self-governing hospitals will accelerate the pace of change at district level. It is of their essence that they will be funded by contracts with districts. We need to ensure that districts are ready to negotiate these contracts before they are set to move into "contract funding" more generally. Self-governing hospitals will need contracts to supply both "core" and "contract" services on behalf of local districts. Further work by the Department of Health is in hand on the form that these contracts will take, and on the costings that will underpin them.

20. One effect of hospitals switching to self-governing status may be to denude some districts of substantial functions. This may encourage amalgamations with neighbouring districts, a process which might be consistent with merger with the - in terms of area, often larger - FPCs.

<u>GP practice budgets</u>

21. The Treasury have reservations about the practicability of a full-blown scheme for GP practice budgets. This is to be addressed separately. Assuming for the moment, however, that these problems are resolved, GP practice budgets would substitute for part of districts' spending on acute hospital services. The money for paying hospitals would therefore need to come out of the hospital and community health services budget, not the FPS.

22. The proposal is an extension of those for funding districts as "buyers" of services. It would make sense therefore to give regions the responsibility for allocating funds to practices, since it is they who would also be responsible for funding districts. This would be consistent with lines of accountability irrespective of whether FPCs and DHAs are merged.

Capital

23. Capital allocations would be based on capitation weighted by age and morbidity. Land sales would continue to be retained for developments within regions. Other capital issues are being addressed separately.

Timetable and summary

24. The proposals in this paper may be summarised in the following schematic timetable.

April 1989 - Regions required to agree cost of cross-boundary flows.

- Districts begin work on improved information about population, movements of patients, and costs of different forms of treatment.

- First candidates for self-governing hospitals identified.

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

- Explicit cash payments introduced for cross-boundary flows between regions.

- Development of schemes for contractual funding of hospitals.

- New top-sliced performance funding scheme.

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

- First wave of self-governing hospitals set up, funded by contracts with purchasing districts.

April 1992 - Extend contract funding to more hospitals.

- Transition to weighted capitation at regional level complete.

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

SECRET

ANNEX

	(1) Existing Alloc Excl the effect of cross-boundary flows	(2) Gain(+) or loss(-) under Option(A)	(3) Gain(+) or loss(-) under Option(B)	(4) Gain(+) or loss(-) under Option(C)	(5) Gain(+) or loss(-) of moving to RAWP targets
	£m	£m	£m	£m	£m
Northern	731	+ 64	+10	+ 3	+12
Yorkshire	834	+ 79	+17	+10	+11
Trent	1034	+103	+26	+17	+28
East Anglia	426	+ 47	+15	+11	+18
N W Thames	850	+ 13	-45	-29	-34
N E Thames	1002	0	-68	-49	-68
S E Thames	915	+ 67	+ 1	+19	-15
S W Thames	716	+ 50	- 2	+13	- 7
Wessex	625	+ 77	+29	+23	+11
Oxford	494	+ 34	- 2	- 6	+13
S Western	721	+ 82	+28	+21	+10
W Midlands	1174	+ 80	- 6	-16	+15
Mersey	583	+ 32	-10	-15	- 9
N Western	972	+ 77	+ 6	- 2	+14
Total RHAs	11076	+807	0	0	0

All figures relate to 1988-89 initial allocations (excluding Review Body additions). There are two points to note about the figures in Column 4. They are the cumulative effect of changes in three years and they would in any event alter dramatically as a result of inter year changes.

chex.rm/mw/64 **SECRET AND PERSONAL**

FROM: MISS M P WALLACE
DATE: 21 November 1988

MR TYRIE

cc **Chief Secretary**
Mr Phillips
Mr McIntyre
Mr Gieve
Mrs Chaplin
Mr Call

POORER PENSIONERS: SURVEY DISCUSSIONS

The Chancellor was most grateful for your note of 18 November. He comments that it is clearly essential that there are no leaks.

MPW.

MOIRA WALLACE

MS0098A

SECRET

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

Copy No 1

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

CH/EXCHEQUER
REC. 21 NOV 1988
ACTION MR SAUNDERS ✓21/11
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SIR P MIDDLETON
SIR T BURNS
MR ANSON
MR PHILLIPS
MR MACAUSLAN
MR PARSONAGE
MR GRIFFITHS
MR CALL

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

21 November 1988

Dear Nigel,

NHS REVIEW: CONSULTANTS' CONTRACTS

At the last Ministerial Group meeting on the NHS Review you asked how the better management of consultant contracts was to be achieved in practice. I thought it might be helpful to write setting out the approach I propose, along the lines which the Group have already agreed.

We have recognised that it is not the job of managers to tell consultants how to treat patients. As John Moore argued in an earlier paper, we must preserve both the freedom of consultants to take clinical decisions within the boundaries of accepted professional standards, and their 24-hour responsibility for their patients. At the same time, it is unacceptable for local management to have little authority or influence over those who are responsible for committing most of the service's resources. The decisions which the Group has now taken offer a comprehensive and practical basis for the exercise of that authority and influence, consistent with a consultant's accountability to his patients for his clinical decisions. I see management leverage applying at six key points which are set out below.

First, appointment: at present, consultant appointments are recommended by essentially professional Advisory Appointment Committees, whose primary consideration is the professional suitability of the candidate. We have decided to amend the Appointment of Consultants Regulations to enable the District General Manager to take part directly in the selection process. Professional suitability will and should remain a major criterion, but the general manager will be able to ensure that the chosen candidate is willing and able to meet the managerial as well as professional requirements of the post in question.

Secondly, each consultant - including those already in post - will have a detailed job description. This will equip District (or hospital) management to:

E.R.

* ensure that the consultant's job covers, for example, responsibility and accountability for the use of resources;

* establish a set of clear, measurable benchmarks - such as the number and timing of outpatient clinics - against which they can monitor whether the consultant is fulfilling his contractual obligations.

Job descriptions, which will be subject to annual review, will be an essential tool for managing all consultants' contracts. They will be especially important to managing maximum part-time contracts. You will recall that "maximum part-time" consultants - 32 per cent of the total - are expected, like whole-time consultants, to devote "substantially the whole" of their professional time to their NHS duties; but that they are free within this constraint to undertake unlimited private practice and are paid only 10/11th of a whole-time salary. Detailed job descriptions will enable local management to spell out a work commitment commensurate with the contractual obligation. If this commitment is not then discharged management will be able to do one of three things: specify what the consultant must do in future to earn his salary, and hold him to it; agree a revised contract for x (ie up to 9) sessions a week, at x/11ths of the whole-time salary; or ask the employing authority (whether Region or teaching District) to take disciplinary action which might lead to dismissal.

Thirdly, doctors will be increasingly engaged in the process of resource management. This will enable hospital management increasingly to ensure that consultants are working within established budgets for which the consultants themselves are responsible.

Fourthly, local management will be able to ensure that the quality and cost-effectiveness of medical work is reviewed and improved through medical audit. We discussed this in detail at our last meeting.

Fifthly, general managers will have much greater influence over incentives to better performance through the changes we propose to the distinction awards system. Managers' influence will be increased by our decision to widen the criteria for future awards and to inject a much stronger managerial voice into the distinction awards process. The incentive effects of the awards themselves will be strengthened by making new and increased awards reviewable after five years and subject to completion of at least three years further service.

Sixthly, managers will be able to make much more effective and efficient use of disciplinary procedures than is possible at present. The new procedures will be more flexible, for example by introducing new local procedures for dealing with circumstances which warrant disciplinary action short of dismissal. Most importantly, we shall be speeding up the appeals procedure so that no consultant will be paid for more than nine months following dismissal. This will remove the present incentive for consultants dismissed by their authorities to spin out their appeals to the Secretary of State, sometimes for several years, in order to

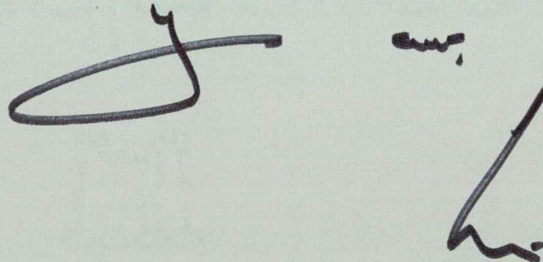
E.R.

continue in receipt of their NHS salaries. These cases, though relatively few in number, have rightly attracted considerable public censure and have deterred managers from embarking on a dismissal in the first place.

Taken together, the proposals I have summarised in this letter represent a major step forward in increasing proper management discipline for consultants. We must expect that some of these measures will be strongly criticised and opposed in negotiation by the consultants' representatives, and we shall need to deploy our case in public with great care and vigour. Equally, we have to recognise that progress on, for example, the resource management initiative and medical audit cannot simply be imposed from above but depend on the active co-operation and enthusiasm of consultants themselves - as the Guy's example well illustrates; and the central theme of involving consultants in management will not hold water if we are seen to question their general competence or reliability. In my view we have now established a balanced package of measures in this area which offer the best prospect of real progress. To go further would be counter-productive to our wider objectives in the review.

(Yes, but how was process started at Guy's?)

I am copying this letter to the Prime Minister, Peter Walker, Tom King, Malcolm Rifkind and John Major, to Professor Griffiths and Ian Whitehead in the No 10 Policy Unit, to David Mellor and Roy Griffiths in my own Department and to Mr Wilson in the Cabinet Office.



KENNETH CLARKE

CONFIDENTIAL

NOTE OF A MEETING TO DISCUSS THE AUDIT OF THE NATIONAL HEALTH SERVICE: 18 NOVEMBER 1988

Present:

HM Treasury	**Department of the Environment**	
Mr Anson (Chairman)	Sir T Heiser	
Mr Phillips	Mr Osborn	
Mr Beastall		
Miss Peirson		
Mr Griffiths		
Department of Health	**Welsh Office**	**NAO**
Mr France	Mr Wyn Owen	C&AG: Mr Bourn
	Mr Pavelin	Deputy: Mr Myland

1. Opening the meeting Mr Anson said that, although the NHS Review was still continuing and there would be no announcement of its conclusions for a little time yet, officials had been authorised to give the NAO advance information of the decision Ministers had taken on NHS audit so that the necessary preparatory work could be progressed. Ministers were concerned to achieve better value for money in the NHS, and therefore to improve the statutory external audit of the NHS. The choice lay between establishing a new tailor-made NHS audit organisation or using an existing body. It had been decided that it would be best to use the existing expertise of the Audit Commission. However, in the case of the NHS the auditors would have to be responsible to the Secretary of State for Health (or Wales). The constitutional context would therefore be different from that of the Commission's local authority work and the legislation would need to reflect that.

2. Mr Anson acknowledged that, as Mr Bourn had stated in his letter, there had been a proposal in 1983 that the Comptroller and Auditor General should take over the statutory audit of the NHS. However, that proposal had been excluded from the National Audit Act as enacted, with the support of the Bill's original sponsor, Mr St John Stevas. It should also be noted that a previous Comptroller and Auditor General had expressed the view that it would not be appropriate for his Office to undertake this task. As regards the other points Mr Bourn had raised in his letter, they would certainly require careful consideration. But for

example, it could be inappropriate for the Audit Commission in its NHS work to have powers equivalent to those in section 27 of the Local Government Finance Act.

3. Mr France added that it was necessary that the organisation carrying out the audit of the NHS should be responsible to Ministers as the NHS itself was accountable to Ministers. It would not be feasible to have separate lines of accountability.

4. Mr Bourn said that it was entirely comprehensible that Ministers might wish to improve NHS audit arrangements and to use the Audit Commission or another body as their instrument for doing so. However, by choosing the Audit Commission (assuming its reports were to be published), they could be creating a situation of potential tension with the Secretary of State for Health. Mr France acknowledged that this might be the case but said that Ministers were prepared to accept this. There was no alternative to having the Commission's reports published. The Secretary of State would be in a position to take action on the reports. Mr Anson said that publication of the reports was desirable, in order to stimulate local pressure for improvement. Mr Phillips added that the proposal was in line with the thrust for greater devolution and value for money which was a major theme of the NHS Review.

5. Mr Bourn asked what sort of published studies the Audit Commission would produce. For example, would it provide a league table of the high and low spending health authorities together with general reports about aspects of NHS operations such as laundry services and concomitant good practice manuals? Mr Anson agreed and added that the Audit Commission would probably also conduct studies of particular areas of operations and then use its findings to inform its local audits. Mr France noted that, although it was intended that the use of the Audit Commission should enhance the value for money work carried out in the NHS, the regularity audit had also to be continued. Mr Owen said that it was important for the NHS management to be able to identify areas where specific investigations should be carried out. He was uncertain if this could be done if the NAO were used.

6. Mr Bourn considered the NAO could carry out both regularity and value for money audit. However, he recognised that the NAO could not be the servant of the Secretary of State. He accepted that Ministers wanted the Audit Commission, and that they recognised the problems that would bring. He thought it would be possible for the NAO to reach a modus vivendi with the Audit Commission. The Audit Commission would carry out regularity and certification work, with the papers being available to the NAO for their audit. The NAO would also have access to the Audit Commission's value for money work. Provided that the Commission confined its published reports to matters of general practice and did not venture into detailed criticisms of individual health authorities' performance, it would not encroach on the role of the NAO. However, if the Commission conducted a set of value for money studies going into detail about particular authorities, that would be very much akin to the work of the NAO and the PAC might wish to take up the Commission's report with the Accounting Officer.

7. Sir T Heiser observed that the Audit Commission's most powerful studies in respect of local authorities had been of a general character. Mr Anson said that the NHS was a sufficiently large organisation for two bodies to examine. If the NAO wished to pursue an issue which the Audit Commission had studied, the NAO would still produce a report, as now, since it was the NAO's findings which the PAC would want to examine.

8. Mr Myland said that the Audit Commission would be well-equipped to take on the examination of the achievement of value for money at local level (which had not been done very well to date). However, it should be recognised that the Commission would only be the auditor, in a position to encourage, not dictate. He thought it would confuse the issue of accountability if there were two bodies in the same field carrying out general value for money studies. Sir T Heiser said that, as far as local government was concerned, the Audit Commission investigated the local authorities, while the NAO examined the Department. He agreed that there might be problems in NHS audit if the respective roles

of the NAO and Audit Commission were not clearly defined. Mr Anson said that to make the new arrangements work there would need to be co-operation between the NAO, the Audit Commission and the Department of Health. But reaching an understanding might turn out to be easier in practice than it looked in theory.

9. Mr Myland said that independent audit of health authorities and promoting better value for money had been rolled together in the statutory audit with the value for money work being the poor relation. He asked whether it would be possible to take the opportunity to clarify these functions. Mr France noted that Ministers wished to see the value for money work given higher profile, but that would not affect the integrated nature of the system, in which both management and audit reported to the Secretary of State.

10. Mr Bourn suggested that the Audit Commission's reports could be published under the authority of the Secretary of State. That would produce a clear distinction between the AC's work and that of the NAO. Mr Anson agreed. Mr France added that the NAO could then ask the Accounting Officer what action had been taken following the AC reports.

11. Mr Bourn said that, if the work of the Audit Commission were seen to be under the control of the Secretary of State and its reports published by him, the Commission's work would be seen as part of the Secretary of State's discharge of his functions. (He added that the Secretary of State could however decide that in general the AC reports would be published, without any intervention from him.) In these circumstances he would be able to tell the PAC and Parliament that the position of the NAO was unaffected; and that it could continue to carry out its work, have access to papers and prepare its reports in the same way as now. The NAO would naturally talk to the Audit Commission about the NAO's and the AC's work plans. Mr Anson agreed. There would be no restriction of the NAO's powers; and the NAO would surely welcome improved statutory audit. The AC would be playing the same constitutional role as the DH auditors played at present. And its published reports could assist the NAO.

12. Mr Myland said that the NAO was the auditor of the consolidated health authority accounts. It would continue to need access to the regularity audit reports on individual authorities. Mr Anson said there would be no change in that respect. The Audit Commission would have to undertake regularity audit. The NAO's relationship to the Audit Commission would be the same as with any other "internal" auditor.

13. Mr Osborn said that it had been decided not to veto the publication of Audit Commission reports on local authority matters. That gave the reports more authority and the Commission itself more weight, which outweighed any embarrassment. He assumed that approach would be adopted in respect of the NHS. Mr Anson said that the constitutional position would be that the Audit Commission had to report to the Secretary of State and that publication would be under his authority. But in practice the Secretary of State could still tell Parliament that he intended to publish the Commission's reports. Mr Anson noted that the Government were increasingly prepared to publish material which could be critical. Mr France said that there would need to be more dialogue between the Government and the Audit Commission regarding its NHS reports than was the case with its local government work. Mr Phillips said that further thought was necessary on the distinction between the NHS and the Department of Health, and on the role of the Secretary of State in relation to each; and also on the effects of the eventual outcome of the health review.

14. In conclusion Mr Bourn said he thought that the PAC would be able to understand the rationale behind the Government's proposals provided that there was a clear distinction between the roles of the NAO and Audit Commission with the former's role unaffected. He hoped that the work of the two bodies would be complementary rather than duplicatory. He would want to know when he could talk to the PAC. He asked how the Governmental discussion of the issues involved would be carried forward. Mr Anson said that the health review timing was indeterminate, but it would not end

before Christmas. An interdepartmental working group had been established to discuss the issues; and when there were aspects affecting relations with the NAO, the NAO would be invited to attend.

HM Treasury
30 November 1988

Distribution

Treasury officials present
Principal Private Secretary
PS/Chief Secretary
Sir P Middleton
Sir T Burns
Mr Saunders

Sir T Heiser	DOE
Sir R Lloyd-Jones	Welsh Office
Mr France	DH
Mr Hillhouse	Scottish Office
Mr Osborn	DOE
Mr Wyn Owen	Welsh Office
Mr Pavelin	Welsh Office

There is no reason why an accreditation agency should not be accountable direct to health Ministers - and every reason given our statutory responsibilities under the NHS Act why this should be the case.

5. The sort of agency Kenneth proposes would, in my view, act as a very powerful engine for increased expenditure, not necessarily in accordance with any objective appraisal of priorities, nor in accordance with our policy objectives. By definition, its activities and reports would focus on the need for improvements and it would be naive to think that these would be solely concerned with improved economy and efficiency within current levels of resources. This has certainly been true of the NHS Health Advisory Service, both in the period before its reports were publicly available and since. Arguably, an accreditation agency appointed by and accountable to health Ministers would have a more precise remit related to the achievement of minimum standards - standards which the Government could set in consultation with the professions.

6. I am content with the proposals in paper HC54 for developing competitive tendering of pathology and radiology through the fostering of local initiatives. As Kenneth says, this is a sensitive and difficult area, involving legitimate professional concerns. We would come badly unstuck if we were to try to force through a central programme of action. I would expect us to be able to achieve all that sensibly can be achieved by developing competitive tendering in these fields in an evolutionary way.

7. I support the proposal in paper HC55 to set up a directed inquiry to produce recommendations aimed at the reduction of rigidities caused by professional boundaries. Given the importance of this issue and its implications for the Health Departments generally, I would like to see the members of the inquiry team appointed by and accountable to health Ministers collectively. The team would be able to build on the work in the primary care field which has been done by the Welsh review group on community nursing.

8. I agree too with the importance of increasing local flexibility in respect of employment practices. I would, however, like to consider the detailed recommendations of the seconded NHS personnel specialist who is reporting to Kenneth by the end of the year, before agreeing the details of how this is to be taken forward.

9. I too see the efficient and effective deployment of nursing staff as one of the central issues. My Department has put a lot of work into leading action on this in Wales and I should want my officials to play a part in shaping the proposals for inclusion in the White Paper.

10. Finally, I am glad to see from paper HC56 that Kenneth Clarke and John Major have agreed that there should be real charging for the use of capital assets within the NHS and that officials are to work up specific proposals to open up access to private sector capital. I have minuted you and colleagues separately with my strong views on the importance of this latter issue. I would be grateful if my officials could join Department of Health and Treasury officials in working up the detailed proposals.

11. I am copying this minute to Nigel Lawson, Kenneth Clarke, Tom King, Malcolm Rifkind, John Major and David Mellor; to Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No 10 Policy Unit; and to Mr Wilson in the Cabinet Office.

Keith Davies

21 November 1988

PW

Approved by the Secretary of State and signed in his absence

SECRET Copy 1 of 20

CH/EXCHEQUER
REC. 22 NOV 1988
ACTION MR SAUNDERS
COPIES TO CST
SIR P MIDDLETON
SIR T BURNS
MR ANSON
MR PHILLIPS
MR MacAUSLAN
MR PARSONAGE
MR GRIFFITHS
MR CALL

PRIME MINISTER

NHS REVIEW

I enclose a note providing observations upon a number of the major features of the NHS Review.

These are views from a Welsh standpoint. In Wales the function of a Regional Health Authority is largely performed by my Department. My NHS Directorate, headed by a Director recruited from the private medical sector, is achieving some considerable economies and improvements in efficiency.

I give in the attached memorandum my observations on self-governing hospitals, GP budgets, improvements in the quality of managerial and financial staff and the use of more private capital.

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

Keith Davies

21 November 1988 P W

Approved by the Secretary of State
and signed in his absence

SECRET

Copy 1 of 17

EXCHEQUER
22 NOV 1988
MR SAUNDERS
CST
SIR P MIDDLETON
SIR T BURNS
MR ANSON
MR PHILLIPS
MR MACAUSLAN
MR PARSONAGE
MR GRIFFITHS, MR C

PRIME MINISTER

NHS REVIEW

1. Kenneth Clarke's office has circulated 4 papers - HC53, HC54, HC55 and HC56 - and invited comments.

2. I support the thrust of Kenneth's proposals in paper HC53. I argued in my minute to you of 13 October that we need to show clear and convincing outcomes for patients if our reforms are to have any credibility with the general public. I hope, therefore, that we can link to Kenneth's proposals my ideas for mounting a special initiative with the private sector to reduce waiting times to our targets. As I said in my earlier minute, the costs would be modest: only some £11 million in 1989/90 for Wales.

3. Kenneth's proposals for the development of a programme of quality assurance in clinical care and in the delivery of health care generally in each district, embodies objectives I am already pursuing through our Corporate Management Programme for the NHS in Wales. I agree that we will need additional resources if DHAs are to be able to produce plans next year for implementation in 1990/91. Similarly, we are building on the pioneering work of Heartbeat Wales in the field of health promotion and the prevention of ill-health, through the establishment of the Welsh Health Promotion Authority. I expect to receive its strategic programme shortly. This will include clear targets for improvements in health outcomes, within which district health authorities and other agencies will frame their activities and local targets. The development of a full corporate strategy for the NHS in Wales by 1991/92 will place all these developments in a coherent framework for sustained development.

4. I agree, too, with Kenneth that we need independent means to assess the quality of care in acute sector hospitals. This seems to me an essential precondition, not only for effective quality assurance at all levels and in all spheres of the NHS, but also for the creation of a more open market in health care involving an expanded role for the private sector. We need to be able to assure the public of the bona fides of all agencies offering health care. There is at present no licensing of private health care, nor any inspectorate, save for a few specific activities such as abortions. I am not convinced, however, that these objectives would be best met by the kind of agency which Kenneth proposes. In my view, they would be better served by a formal system of hospital accreditation.

MEMORANDUM BY THE SECRETARY OF STATE FOR WALES

Self Governing Hospitals

In his paper HC46 on self-governing hospitals, Kenneth Clarke proposed that the opportunity to become self-governing should be open to all major acute hospitals in England. He defined these as hospitals with in excess of 250 beds and showed (in the appendix to HC46) that no less than 141 of the 260 such hospitals are located within 5 miles of another such, thus providing good preconditions for competition between them, at least for elective surgery.

In Wales there are 17 major acute hospitals with more than 250 beds. Of these only 3 are within 5 miles of each other. As it happens, these 3 are in Cardiff and, although in separate management units, they work in co-operation in providing the clinical base for Wales' only teaching hospital. The other major acute hospitals are widely dispersed. Gwynedd and Pembrokeshire each have only one; Powys none at all, relying on acute provision in neighbouring districts in Wales and in England. In large parts of Wales, therefore, there would be little or no effective competition between hospitals for elective surgery. The private hospital sector in Wales is tiny, with just 215 beds. The two main private units are based on the north Wales coast and in Cardiff, leaving our valleys and rural areas entirely reliant on the DHA-run acute hospitals.

I am already pursuing key objectives we have identified in the review: the devolution of management responsibility to hospital level (the introduction of unit general management has been completed successfully); the strengthening of hospital management; and the close involvement of clinicians in management, budgeting and accounting for their use of resources. Our resource management project is in the vanguard of the national drive to create effective clinical budgets and to price treatments - the essential pre-condition to move to a more open market in health care. We have been leaders in contracting our services to the private sector where that provides the most cost-effective option, for instance in developing more accessible renal dialysis of a high standard.

These achievements provide good foundations for pursuing our objectives in the review. In carrying these forward, however, I must be able to carry out my statutory responsibilities for the NHS by ensuring that an adequate range and quality of care is provided to all regardless of means.

i. to define the minimum services it will need to provide;

ii. to approve proposals for significant capital investment and to consent to the disposal of assets. (I agree with Kenneth Clarke that these hospitals - and the NHS more generally - should have more open access to private sector capital, but the bulk of funding would continue to come from central Government); and

iii. to be able to withdraw the right to self-government if a hospital failed to fulfil these requirements, or in any other sense acted in a manner which abused its position of monopoly or near-monopoly supplier.

Given these circumstances and the current management weaknesses I have described, these requirements would necessarily involve strengthening my Department to lead and assist the programme and to monitor closely any hospitals which were to become self-governing, to ensure that they were performing adequately and not abusing their freedoms. It would be a grave mistake in my view to dissipate in this way our concerted drive to secure improvements and create a more effective and efficient hospital service in the longer-term.

GP Budgets

I see GPs in Wales developing a much more direct role in the shaping of hospital services, and I believe strongly in what we are doing throughout the UK to provide incentives to GPs to carry out more work and so to prevent unnecessary referrals to hospital.

We are establishing a pilot project to involve GPs directly in the development of hospital services. Before the NHS review, proposals were developed for an experiment in the Powys District Health Authority area (which, as noted above, does not have a major acute hospital), to test, on the basis of notional GP budgets for hospital services, the effect on patterns of resource distribution of linking GPs into the planning and budgeting arrangements for hospital referrals. Subject to the results of a pre-feasibility study, to secure the co-operation of GPs and establish the notional budgets, I expect the project to begin next Spring.

I have to say, however, that the quality of our GPs and practices in Wales is often poor, especially in some of the South Wales Valleys. Kenneth Clarke has proposed that practices with list sizes in excess of 11,000 might initially be eligible for independent budgets. In Wales I estimate that only some 30 practices (out of a total of 589) would be eligible on this

basis, and only a minority of these would be capable of handling competently GP budgets in the foreseeable future.

Moreover, I still have major worries about the proposals for independent budgets for GPs. The proposals we have discussed would, it has been suggested, provide GPs with a significant incentive to refer to hospitals less indiscriminately and to undertake more work themselves. This would be achieved, it is said, by allowing them to retain a proportion of any underspending on their budgets provided that this is reinvested in their practices. But what would that in fact mean? One obvious course for the GP would be to buy bigger and better practice premises. In due course he would be able to dispose of a valuable capital asset. And how are we to control what is and is not regarded as a legitimate investment of the underspend? Would cars for practice use be included? In a sense, these things would be tolerable (even if presentationally extremely difficult for us) were it not for the fact that they might well be achieved at the expense of patients who did not receive referral to hospital when they needed it or who were denied drugs and other treatments they need directly from the GP.

In addition, the FPCs in Wales are managerially weak and their memberships are unimpressive. They would not, in my view, be able to handle effectively the support for GPs generally which our proposals would require. Indeed, our decision as part of the review to remove professional members from the FPCs would make our position even worse in this respect, since most of our more effective chairmen and members are contractors. For this reason - and to secure the more effective long-term development of the role of GPs in the planning and delivery of health services in the round - I would wish to merge the DHAs and the FPCs in Wales and to secure more vigorous enforcement of the revised contract for GPs by DHAs operating with a far stronger managerial ethos and competence.

Ingredients for success

The key thrusts of our objectives for the NHS require that members, managers and practitioners should operate with more flair, imagination and drive. They will need the right management skills to be able to do this and the right management context.

I see little point in our embarking on a purportedly radical programme of action if we do not ensure that the NHS has skilled people to tackle the job. I have seen more than enough in Wales of poor standards of financial management which would simply not be tolerated in any commercial organisation with a similar level of cash flow. The best paid Welsh DHA Treasurer earns some

v. an action plan on quality assurance programmes.

vi. a major training initiative to back up these plans.

vii. a new acute sector advisory service to monitor the quality of service in acute hospitals.

viii. a focus on better health, through more public awareness, monitoring health, measuring the outcome of health services and a new initiative to encourage health promotion and disease prevention.

?? – NO!

ix. one element of this focus would be the development of a portfolio of health indicators.

A national initiative

4. There is already a lot of good work going on in the field. A number of Regions, notably Trent and Wessex, have set up comprehensive programmes aimed at improving the quality of service to patients. We now need a national initiative to ensure that every health authority puts the issue at the top of the agenda.

5. The key to change is to get a quality assurance programme up and running in every District. The objectives of each programme will be:

i. to treat people as people by giving a more personal service and offering them a wider choice of amenities,

ii. to inform and consult people so that they are less daunted by hospitals and feel they can have a say about the way services are delivered to them,

iii. to maintain and improve the quality of clinical treatment that patients receive by encouraging professionals to review systematically their procedures and the clinical outcomes.

6. The review offers us the ideal opportunity to launch such an initiative. But we should not overplay the role of central Government. We need above all to change the attitudes and commmitment of the people working in the NHS, and the experience of large private corporations has shown that this takes time and resources in education and training. Any national initiative must also be flexible enough to accommodate a potentially enormous range of local initiatives. I therefore envisage the programme being driven by local management with the full involvement of the professions.

Information

11. I also want to see a much better flow of information between hospitals and their customers. Again, there are a number of basic rules which I would expect all health authorities to follow, such as:

i. sending all prospective hospital patients a leaflet telling them what they need to know about coming into hospital - how to get there, what to bring, and other relevant information. Brighton have produced some very attractive and informative booklets,

ii. making sure that telephone calls are answered promptly by the hospital switchboard. This is a good example of a basic improvement where targets can be set and progress monitored.

12. Further, I expect all health authorities to keep their customers informed about past performance and future plans through periodic reports, annual meetings open to the public and regular publicity in the local media.

Improving the quality of clinical care

13. Quality assurance programmes are not just about improving hotel and support services. These are important - and highly visible to patients - but all health authorities should be satisfying themselves that they have adequate mechanisms in place for monitoring and improving the quality of clinical care. In the past, this has been inhibited by the absence of a reliable information base and the technology which enables the complex range of clinical and personal data to be processed quickly at ward level. We are now well on the way to overcoming these problems and have more "computer literate" doctors and nurses wanting to develop this aspect of care.

14. My separate paper on medical audit (HC 50) suggests how we can ensure that every doctor is involved in securing high-quality cost-effective clinical care. The same principles apply to all the professional groups. Nurses, for example, are leading a number of initiatives for improving standards of care. The acceleration of the Resource Management Initiative will provide an added stimulus and context for the developing quality assurance on a national scale.

15. Health authorities must also be able to focus on areas of particular concern. Monitoring the health of the local population will continue to be a key role of all DHAs. Health authorities will need to satisfy themselves that what they are buying offers not only value for money but also a high quality service which is effective in improving the health of its resident population. In this regard, the work currently under way to devise better measures of health outcomes (para 27-28

Making the service more personal

7. The most visible impact of a district programme on the public will be in making services more personal. Some health authorities are already alive to the need to change both their image and their practices, but this attitude should be the norm and not the exception.

8. I have considered whether we should set specific targets from the centre for improving customer service, but it would not be easy to monitor and risks crowding out other worthwhile, local initiatives. In the White Paper we can however give examples of the kind of improvements we expect to see health authorities introducing. I have in mind:

i. ensuring that all the patients are properly welcomed to the clinic or ward,

ii. providing facilities for patients, or their relatives who are distressed, to recover or be counselled in private,

iii. ensuring that a full range of optional extras are available for patients who are willing to pay an extra charge. These could include more elaborate meals, colour TVs, hairdressing services and so on.

9. Considerable irritation and inconvenience is also caused when, having arrived for an appointment in a clinic or an outpatients' department, a patient is kept waiting to see the doctor for long periods without any explanation or apology. A more personal service would tackle this, too. I would expect all health authorities to review their appointments procedures, to make sure that every patient is given a specific appointment time and, as far as possible, is seen within a reasonable period of that time; in Peterborough, for example, all patients are expected to have been seen within 20 minutes of their appointment time. Where there are unavoidable delays, patients should be given an apology and told what has gone wrong.

Waiting times

10. The White Paper will also need to deal with the more intractable problem of long waiting times for diagnosis and treatment. We shall also need to draw out the ways in which our proposals for greater competition and moving money with the patient will serve the objective of reducing waiting times. Our current national waiting list initiative, our proposals for rolling it forward in 1989/90 - for which resources have already been earmarked - and my proposals on "performance funding" (HC 49), can be presented as interim solutions until the full effects of our proposals work through.

below) will be particularly valuable. Health authorities must also learn to listen to their customers, and surveys must be an integral part of the district's monitoring role.

Implementing quality assurance programmes

16. We cannot rely solely on exhortation to ensure that all health authorities introduce a quality assurance programme. Following the publication of the White Paper, I suggest that all health authorities should be required to draw up plans in 1989/90 for implementation from 1990/91. Progress on preparation and delivery will be monitored through the performance review process. I propose to consolidate this by including improvements to quality of service and clinical care as one of the criteria against which general managers' performance will be assessed. I also believe that the increased competition that will result from our other proposals will act as a spur to a systematic improvement in quality.

Costs

17. Quality assurance programmes themselves need not cost a great deal to introduce. In Wessex, for example, the initial work is costing about £0.75m a year, excluding training costs. But a major training initiative is also vital. British Airways, for example, invested £25 million over 3 years to retrain their 40,000 staff. Given the size of the NHS, even a basic training programme would cost at least £10m a year in the first two years that the programme was launched. We are therefore talking of £20 million a year over 2 years to launch a comprehensive quality assurance initiative.

An acute sector advisory service

18. I have also given some thought to whether we should establish a national body to monitor the quality of services in acute hospitals. A number of the organisations who have made submissions to the review have advocated some form of hospital inspectorate, and the Social Services Committee endorsed the idea in their report on the future of the NHS. We shall therefore need to be ready to give our views when the White Paper is published, even if we do not make specific proposals ourselves.

19. A monitoring body could take various forms. I am not proposing an organisation that is independent of Government and could develop into yet another lobby for more resources. For this reason, I have rejected the models adopted in the United States and Canada under which an independent body formally accredits hospitals against a set of national quality standards. I am however attracted to the idea of an advisory body that is ultimately answerable to Ministers but whose main function is to offer a source of independent advice to local management on a consultancy basis.

20. The model I have in mind is akin to the existing NHS Health Advisory Service (HAS). The HAS was established in 1970. It is professionally led and monitors, on my behalf, the provision of services for the mentally ill and the elderly. An acute sector advisory service might similarly consist of a small, central group of staff with perhaps a doctor as its director. For each visit it would appoint a multi-disciplinary team drawing on a group of practising professionals who could command the respect of colleagues. The membership of the team would of course need to reflect the nature of the service being reviewed. The inspectorate would be self-financed mainly through fees from health authorities and hospitals being visited.

21. I have considered the option of extending the remit of the existing HAS into the acute hospital sector, but I have concluded that acute hospital services are sufficiently different to merit a separate body. More importantly, unlike the HAS which sets its own programmes, I see the acute sector advisory service as essentially a tool of local management, with the bulk of its work programme being determined in the early stages by Regions and later by Districts. It would also be available to - but would not be imposed upon - self-governing hospitals. There may however be occasions where difficulties arise of sufficient importance for Ministers to ask the service to investigate a particular area of work or a particular hospital. As with HAS reports, the new advisory service's reports should be published. Not to do so risks charges of excessive secrecy.

22. The concern of the advisory body would be mainly the quality of clinical services. It would in some circumstances be an imposed peer review. Thus when a local manager, unhappy at the quality or performance of a particular specialty, called in the advisory body, the key part of their visit would be the review of local professional work by other doctors in that specialty. In this way, it would complement the other work being undertaken in the hospital either in the context of value for money initiatives or as part of a medical audit programme. The multi-disciplinary composition of the team and its independent status would however enable it to take a wider view of service provision, including the targets and priorities that a hospital had set itself and to act as an outside stimulus to change.

23. The follow up to an advisory report would in the first instance be the responsibility of local management, who would need to have regard to the wider resource and policy implications. But an adverse report would also be picked up by the RHA as part of the performance review process. Failure to take action on a report would be one of the criteria against which the general manager's performance was assessed. At national level, advisory reports would be one of the sources of information against which regional performance was assessed.

24. I believe that an initiative of this kind would be widely welcomed. The UK is one of the few countries not to have some

form of national body that is capable of assessing the quality of acute hospital services. My proposals do not go as far as some have argued, not least because we must avoid a heavy-handed, bureaucratic approach. But they would help to reassure the public and the professions that the review is not simply about value for money, and, in my judgement, are the minimum we can put forward in the White Paper.

Better Health

25. I have dealt so far with the scope for improving services for patients who need treatment. We must also do more to reduce the numbers who do need treatment. I propose to focus on four developments in the White Paper:

> First, building on our successful efforts to convince people that by taking sensible measures e.g. on diet, exercise, smoking and alcohol they can help to improve their own health.
>
> Second, improving our ability to monitor health and to identify areas of concern e.g. adverse changes in the patterns of disease so that we can respond to them effectively and in good time.
>
> Third, measuring the outcome of health services.
>
> Fourth, developing new initiatives to prevent illness and to promote health.

26. Public awareness Our emphasis here should be on providing better information so that people can make their own choices. This will be consistent with our emphasis elsewhere on the importance of choice.

27. Monitoring health Following discussions between my predecessor and the Chancellor, my officials have agreed with Treasury officials the basis for developing a portfolio of health indicators, which will be published regularly. The indicators will enable us to chart improvements in health and to identify potential areas of concern. We would also, if we so wished, be able to quantify what we wanted to achieve e.g. a reduction in alcohol misuse.

28. Measuring outcome of health services The health indicators will also enable us to provide data for the first time on the benefits to quality of life by treatment in the NHS. In so doing, we shall be able to set out much more clearly the beneficial impact of our NHS funding. This will enable us for example to put into proper perspective the issue of those waiting for treatment as compared to those already successfully cured.

29. Health promotion and disease prevention. I propose to take a major new initiative with Regional Health Authorities to encourage the development of new ideas in this field. The aim

will be to build on local enthusiasm, as has been successfully done with the Welsh campaign "Heartbeat Wales" and the English campaign "Look After Your Heart". There are two main elements:

First, and more important, incentives for developing new initiatives in disease prevention and health promotion, e.g. the detection of congenital deafness and treatment of undisclosed high blood pressure as well as new health education programmes. These would be funded from regional allocations by agreement with Regional Chairmen.

Second, prizes for those who have already run successful disease prevention or health promotion campaigns. The prizes would be funded privately by charitable foundations (I already have one potential backer) or leading local firms.

We would be able to link this initiative to the development of new health outcome indicators, since these would help us to identify areas where incentives were most needed. The amount of money involved, particularly in the prizes would be small. But it should provide very good value. It will also help us to respond to public concern that we do not pay as much attention to the prevention of disease as to its cure.

SECRET

CH/EXCHEQUER
REC. 22 NOV 1988
ACTION MR SAUNDERS
COPIES TO CST
SIR P MIDDLETON
SIR T BURNS
MR ANSON
MR PHILLIPS
MR MacAUSLAN
MR PARSONAGE
MR GRIFFITHS
MR CALL

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

22 November 1988

Dear Andy,

NHS REVIEW GROUP

It may be helpful to record that I think the Prime Minister is likely to take the papers for tomorrow morning's meeting in the following order:

(i) Decisions So Far (HC57): note by the Cabinet Office.

(ii) Funding the Hospital Service (HC58): note by the Secretary of State for Health and the Chief Secretary.

(iii) Managing the Family Practitioner Services (HC51): note by the Secretary of State for Health (discussed in part at the last meeting).

(iv) Better Service to Patients (HC53): note by the Secretary of State for Health.

(v) Management of Capital (HC56): note by the Secretary of State for Health and the Chief Secretary.

In addition, the two other papers which your Secretary of State circulated for the last meeting may also be relevant: namely The Public and Private Sectors (HC54) and Professional and Employment Practices (HC55).

If there is time at the end of the meeting the Prime Minister thinks it would be helpful to spend a few minutes on the timetable for the remaining stages of the Review, including the date of publication of the White Paper and its implementation thereafter.

I am copying this letter to the Private Secretaries to other members of the group and to Trevor Woolley (Cabinet Office), Richard Wilson (Cabinet Office) and Ian Whitehead (Policy Unit).

Yours,
Paul

PAUL GRAY

PS: if time, at end, they'll want you to stay to discuss Peach successor

Andy McKeon, Esq.,
Department of Health.

chex.ps/mw/8 CONFIDENTIAL AND PERSONAL

MP

FROM: MISS M P WALLACE
DATE: 22 November 1988

MR CALL

cc PS/Chief Secretary
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Ramsden
Mrs Chaplin
Mr Tyrie

PENSIONERS - RATIONALE FOR ACTION

The Chancellor was grateful for your minute of 18 November.

2. He comments that the target of the package would be "poorer, older". A line has to be drawn somewhere: we are proposing to redraw the existing line in a more generous way. Whenever you do something like this, you will always be asked: "Why didn't you do more?". We simply brush that aside, by seeking a welcome for what we are doing, and so "poorer, older" will do.

MPW

MOIRA WALLACE

st.ln/dra/1.21.11

CONFIDENTIAL

FROM: MISS M E PEIRSON
DATE: 22 NOVEMBER 1988

1. MR ANSON
2. CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Phillips
Mr Beastall
Mr Saunders
Mr Call

Sarah for folder

NHS REVIEW: NHS AUDIT

1. I understand that NHS audit may be raised at tomorrow's NHS review meeting. You should therefore be aware of the outcome of Mr Anson's meeting with Mr Bourn on 18 November. The purpose of the meeting was to discuss both the Government's decision to give the statutory external audit of health authorities and FPCs to the Audit Commission, and Mr Bourn's counter proposal that the NAO should instead take on the job. DH, DOE and WO were represented, and Mr Anson has informed the SO of the outcome, so their Ministers will probably know by tomorrow.

2. As a result of the discussion, Mr Bourn withdrew his proposal. He said that he could defend to the PAC the Government's decision, on the basis that for this purpose the Audit Commission would be reporting to the Secretary of State, and their reports would be published by him. That is, the Secretary of State for Health would be providing himself with the necessary instrument to assure himself of the use to which the funds he had authorised were being put. That would be sufficient to differentiate the role of the Audit Commission from the role of the NAO. The two organisations could talk to each other about their programmes of value for money work, to avoid overlap.

3. That is satisfactory, subject to some care about the publication of Audit Commission reports. As you know, the Treasury do not want the Department of Health to have so much control over the Audit Commission reports that they can prevent publication, or can insist on so much watering-down that the reports become useless as an instrument to provoke public interest

and pressure for action by health authorities. However, in fact the Audit Commission's value for money reports generally draw attention to good practice rather than bad (though their league tables highlight both good and bad practice). And Mr Bourn volunteered that, whilst the Secretary of State might formally be in control of publication, the Secretary of State could decide that in general Audit Commission reports should be published, and that he would not exercise a veto.

4. The publication point does however require further consideration within Government. It will be considered in the discussions now proceeding in the group of officials, and recommendations will be made to Ministers.

5. We are preparing a draft reply to Mr Bourn, which we will show you before it is sent. If the subject is not fully covered tomorrow, we could also let you have a draft letter from you to your colleagues, informing them of our approach to the NAO and the outcome.

MEP

MISS M E PEIRSON

CONFIDENTIAL

MP

AUDIT COMMISSION AND THE NATIONAL HEALTH SERVICE

DRAFT NOTE TO MINISTERS ON THE LEGISLATIVE OPTIONS

1. Ministers have agreed in principle that the Audit Commission should take over the statutory audit of the National Health Service including regularity and propriety audit and value for money studies.

2. There is no health legislation proposed for the 1988/89 session which would be a suitable vehicle for implementing this proposal. Early legislation would enable the Audit Commission to become effective in the NHS at least a year sooner than waiting for main health legislation. Officials were therefore asked to explore whether it would be possible to include suitable provisions in the Local Government and Housing Bill in the 1988/89 session.

Options

3. Officials have identified three options for early action in the Local Government and Housing Bill in the 1988/89 session:

(i) Full implementation of the whole proposal, giving full statutory responsibility for the audit of the Health Service to the Audit Commission, and resolving all questions about its relationship to the Secretaries of State for Health and for Wales and to the National Audit Office and the PAC.

(ii) A paving provision enabling the Audit Commission to undertake some audit and value for money work in the Health Service field under contract to the Secretaries of State for Health and for Wales; so as to enable them to begin to build up experience in the Health Service field and make an early impact on vfm issues before full implementation in later legislation.

(iii) A more general enabling power for the Audit Commission to undertake audit work and/or value for money studies within some defined non local government areas at the request or with the approval of the relevant Secretary of State.

Option 1

4. A note of some of the issues that will need to be considered and resolved in implementing the full proposal is attached at Annex A. On many of these issues it will probably be sufficient to replicate the Audit Commission's present statutory regime - which is set out in 28 sections in the Local Government Finance Act 1982 - with suitable modifications to apply it to the Health Service. Officials estimate that this could require 10 or more clauses in a Bill. (Alternatively, this could be done in subordinate legislation which would reduce the number of clauses in the Bill to those required to empower the Secretary of State for Health to make regulations, to bring about any structural changes which might be required to the Commission and to amend the powers for payment of money to the Commission.) But there are a few

issues which will be difficult, which will require very careful analysis and consideration by Ministers and which may result in a need for further clauses. The most important are:

(i) The relationship between the Secretaries of State for Health and for Wales (and their Accounting Officers) and the Audit Commission with particular regard to the quantity and quality of regularity audit and the commissioning of special studies;

(ii) The degree of independence to be allowed to the Audit Commission in choosing subjects for value for money studies and in publishing its findings, coupled with the degree of influence to be retained for the Secretaries of State for Health and for Wales over these matters;

(iii) The relationship between the Audit Commission and the NAO, and the arrangements for ensuring that they work effectively together without unnecessary overlap or conflict; and beyond that the arrangements for Parliamentary and PAC oversight of audit work in the Health Service field.

5. Timing issues would be difficult under this option. There is a good deal of work to resolve all the issues at Annex A during the next few weeks. It would also impose additional burdens on Parliamentary Counsel's drafting resources which are already heavily stretched for the Local Government and Housing Bill.

6. Presentationally it would be difficult to include provisions in the Local Government and Housing Bill if that has to be published before the Health Service Review is completed, unless Ministers were willing to announce the proposals for the audit of the Health Service in advance of the rest of the Health Service Review conclusions. That however would run the risk of opening up debate on the NHS review more generally before Ministers were ready. Inclusion of the whole package in the Local Government and Housing Bill could also therefore delay progress on the Bill in Parliament which is already tightly time-tabled because of its late introduction.

Option 2

7. At present the Audit Commission is only allowed to do audit and value for money work in relation to local government. It has no powers to undertake work in any other field. It could not therefore do anything to prepare for Health Service audit until it receive the appropriate powers and the ability to charge for work done. Apart from the organisational adjustments and training, it will need time to prepare the ground particularly on the value for money side where national studies are normally undertaken in the year preceding local value for money audits. The second option identified by officials would therefore be a paving provision to enable the Audit Commission to undertake some preliminary training, audit and value for money work for the Health Service under contract to the Secretaries of State for Health and for Wales.

8. This would be a simple provision, not requiring more than one clause, and would enable the Audit Commission to build up early experience in Health Service matters, without making any other change to the present statutory arrangements for the audit of the Health Service. Under such a provision as this the Audit Commission and its auditors would be on a similar footing to the private sector auditors or consultants whom the Secretary of State for Health already uses for parts

of statutory audit work for the Health Service. This would thus be essentially a temporary arrangement pending full Health Service legislation in a later session.

9. There would be no timing difficulties about legislating in this way. And the proposal could be defended in Parliament on the basis that it would in any case be useful for the Secretary of State of Health to be able to employ the Audit Commission from time to time on audit and value for money work, whatever longer term arrangements are made about the full statutory audit. But such a presentation might seem disingenuous if followed within a couple of months by an announcement that the Audit Commission were to take over the statutory responsibility. Alternatively, therefore Ministers may wish to announce at this stage their long-term intentions and explain to Parliament that this enabling power precedes further substantive legislation. 'Health' would appear in the long title of the Bill so that the Secretaries of State for Health and for Wales could answer any wider debate which may arise on matters concerning the control of and accountability for Health Service expenditure. The option would remain open of introducing the full provisions later on amendment if that seemed feasible and desirable once the Health Service Review is published.

This option would also run the risk of premature debate of the NHS review. Parliamentary Counsel's preliminary view is that with appropriate references to amendment of the 1982 Act in the long title (the Bill may include another unrelated amendment to that Act) it might be possible to introduce this provision by amendment during the Bill's passage but this is uncertain and could well run into difficulties with scope with in the Commons.

Option 3

10. This option is for a more general power to enable the Audit Commission to undertake audit or value for money work within some more widely defined area of operations by agreement with the appropriate Secretary of State on a contractual basis and perhaps only after consultation with the C and A G. This would again be a simple provision of a single clause. Various other areas have already been suggested from time to time as possibilities for useful Audit Commission work (e.g. the Housing Association field, DTp's highway agency arrangements, Local Government Boundary Commission). And arrangements on these lines have already been enacted in Section 220 of the Education Reform Act 1988 to enable the Audit Commission to be appointed on a competitive tender basis to do work for the polytechnics and for contracted-out schools.

11. A general power to operate on a wider basis in this way if requested by the relevant Secretary of State could be useful in itself, and would enable preliminary work to be done in the Health Service field without giving undue prominence to the full Health Service proposals if these are not yet fully developed or announced. However, by the same token it would not open the way for any fuller Health participation in the Parliamentary debate which might well arise once the NHS review was published and it became clear what a main use of this provision would be. Also, it would give the Audit Commission a potentially very wide scope which could over-stretch it if it was too widely used. To guard against this the Secretary of State might make clear that in general he would only approve such work by the Audit Commission in limited areas of the public sector where they might be able to contribute particular expertise. Once the Health Service Review is published he might indicate that some preliminary studies by the Commission in the Health Service field could be a possible use of the power.

CONFIDENTIAL

AUDIT COMMISSION AND THE NATIONAL HEALTH SERVICE

POINTS FOR LEGISLATION

1. Name of Commission

Under existing statute, the Local Government Finance Act 1982 (the 1982 Act), the long title of the Audit Commission is the 'Audit Commission for Local Authorities in England and Wales'. The long title of the expanded Commission might be the 'Audit Commission for Local Authorities and the National Health Service in England and Wales'.

2. Number of members of Commission

The 1982 Act provides that there shall be not less than 13 nor more than 17 members of the Commission. The maximum number of members might be increased to 20: comprising very roughly 8 with local government interests, 6 generalists and 6 with health service interests, though in some cases those appointed may have overlapping experience.

3. Appointment procedures for members, chairman and deputy chairman

The 1982 Act provides for the Secretary of State to make these appointments after consultation with interested organisations. There would be no difficulty in the Secretaries of State for Health and for Wales appointing the health service members in the same way as the Secretary of State for Wales currently appoints Welsh members. The Secretary of State for the Environment would continue to take the lead in appointing the chairman. Further thought would need to be given to the consultation provisions on appointments.

4. **Sub-structure of Commission**

The Commission is currently required to appoint a chief executive and such other officers as it considers necessary. Questions of how the extended Commission structures its operations might be best left to the Commission to determine. If a sub-structure were set out in legislation this might prove an unwelcome restriction on the Commission's management freedom and also give the appearance of an intention to create separate bodies dealing with health and local government.

5. **Duties of Commission in relation to the Health Service**

Further detailed consideration is being given in the Working Group to the duties of the Commission in relation to the NHS. These are likely to duplicate most of the Commission's existing duties under the 1982 Act and to include:

appointing auditors;
carrying out or promoting value for money studies;
certification of grant and other claims;
providing advice/carrying out other studies;
prescribing a scale of audit fees;
preparing a code of audit practice;
directing a special investigation.

6. **Duties of auditors**

The Working Group is also giving further detailed consideration to the duties to be required of auditors. Under the 1982 Act these include:

certifying accounts in relation to regularity and propriety;
conducting value for money audits;
reporting on matters of concern;
taking action in respect of fraud and corruption;
revealing unlawful expenditure and loss;
taking preemptive action to prevent unlawful expenditure and loss by issuing 'stop' orders or seeking judicial review.

7. Bodies subject to audit

Under the 1982 Act those bodies specified in the Act are required to have their accounts audited by an auditor appointed by the Commission. Other bodies who appear to the Secretary of State to be concerned with local government may by agreement with the Commission and with his approval have their accounts audited by the Commission's auditors. A similar arrangement might be applied to the Health Service with health authorities and FPCs subject to statutory Commission audit and other related bodies audited by agreement.

8. Reporting procedures

Audit reports would go to the health authority copied to the Secretary of State and the Commission. National value for money studies would go to the Secretary of State. The detailed procedures for reporting, clearance and publication could be dealt with in the audit code of practice.

9. Fees and payment

Under the 1982 Act the Commission is required to meet its expenditure from income. It sets a scale of audit fees (subject to Ministerial veto) sufficient to cover both the costs of its audit and central value for money work and charges audited bodies directly. Similar arrangements could be applied in the Health Service.

10. Functions and powers of the Secretary of State for Health

The 1982 Act gives the Secretary of State a number of functions in relation to the Commission (see attachment). The Working Group is considering what, if any, further powers or functions might be needed in relation to health service audit.

1[illegible] Answerability of the Commission and its auditors in respect of their powers and duties

The 1982 Act provides that the C&AG examines the Commission's annual statement of accounts and reports to Parliament on it; and the Commission and the auditors it appoints are answerable to the courts in respect of their statutory duties and powers. The Commission would continue to produce a single annual report and statement of accounts for Parliament but the financial statement would need to identify local government and health separately.

12. Relationship with NAO

The Working Group is giving further consideration to the relationship between the Commission and the NAO, the arrangements for ensuring they work effectively together and for Parliamentary and PAC oversight of audit work in the Health Service.

13. Employment of NHS audit staff

DoH and the Welsh Office are discussing with the Commission possible arrangements for the transfer of audit staff and whether statutory provisions are needed.

MP

TREASURY MINUTE ON ESTATE MANAGEMENT IN THE NHS (to be published on Wednesday 30 November)

Line to Take

1. General
The PAC report has some important messages for anyone who has a responsibility for managing property. But, by its nature, it leans towards criticism and fails to give credit for the very positive and constructive attitudes of the Government and health authorities.

2. Investment in the Estate
Capital allocation in excess of £1350m gross will be made available for the NHS estate in 1988-89. This represents an increase of nearly 40% in real terms over the last 10 years. We have the largest ever programme of new building in the NHS with over 500 schemes at various stages of planning, design and construction. The building programme is worth £4 billion.

3. Rationalisation of the Estate
We are energetically rationalising the NHS estate (land sales receipts for 1987-88 were £200m and should reach £300m in the current year). Theese receipts are retained within the NHS - to deliver health care by means of an estate which is well maintained and fully utilised.

4. Safety Standards
The management policies and procedures of the NHS take account of statutory standards relevant to the health and safety of patients and staff. Where Crown immunity does not apply (in the case of the Health and Safety at Work Act 1974) the National Health Service is liable to the same inspection and enforcement procedures as other bodies. Elsewhere, not withstanding Crown immunity, the NHS is required to comply with relevant legislation. The NHS Management Board will monitor compliance with safety standards rigorously - through their review processes.

APS/FST - for information cc APS/Chancellor

The above is a line to take from Dept of Health for No.10. The PAC report mentioned is one which the Treasury are replying to at 3.30pm today in the form of a Command paper laid in the name of the FST.

[signature] 29/11

SECRET

FROM: R B SAUNDERS
DATE: 22 November 1988

CHIEF SECRETARY

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

NHS REVIEW: FUNDING THE HOSPITAL SERVICES

I attach the briefing which the Department of Health have given Mr Clarke for tomorrow's meeting. It was discussed with me in draft. It also reflects the points which we understand have been included in the Prime Minister's briefing.

2. The table attached to the briefing has been given by Department of Health to Cabinet Office, and will be in the Prime Minister's briefing. It demonstrates - the difference between columns 3 and 4 - just how much difference the inclusion of morbidity makes to some regions. It increases the allocations of Northern, Yorkshire, Mersey and North Western considerably. But it reduces the relative share for East Anglia, the Thames regions, Wessex, Oxford and South Western. In some cases (eg Yorkshire, NW Thames, SW Thames, South Western and Mersey) it largely offsets the effect of the age weighting. But in Oxford both the age weighting and the morbidity weighting go in the same direction. What this table demonstrates, I think, is the importance including both age and morbidity in the calculation. Leaving out either or both would make enormous differences to some regions, leading to a wasteful maldistribution of resources across the country.

3. Richard Wilson will also be giving the Prime Minister the table I produced at an earlier stage showing how regions have moved closer to RAWP targets since 1979-80. I attach a copy of this also.

Capital

4. Ian Whitehead at the Policy Unit has told me that he is concerned that the proposals in the papers (the very short paragraph 23 in the Funding paper, and the brief report on capital in HC56) are too skimpy. He may therefore make this point in his brief to the Prime Minister. He has been working up some ideas under which hospitals would pay a percentage of "earnings" to regions as a return on their investment, as an alternative the capital charging proposal. Regions would thus be encouraged to invest capital where it get the best rate of return, as measured in this way.

5. I confess I really do not understand how this will work, since the "earnings" would be largely the result of revenue allocations placed by the regions themselves, nor how the proposition can be reconciled with a system based on annual Parliamentary supply. However, we cannot judge this sensibly unless and until we have seen the proposals set out with more clarity. If the point is raised, therefore, I suggest that Mr Whitehead be invited to put his proposals on paper and discuss them with Department of Health and Treasury officials.

6. At yesterday's meeting with Mr Clarke, you asked what are the arrangements for allocating capital to "opted out" schools. At present, maintained schools fall under the arrangements for local authority capital spending, while there is a separate pool of central government capital money for voluntary schools. A school which opts out would move from the first system to the second. It would have to bid against the capital budget for voluntary and opted-out schools. (In theory, there will be an adjustment between the voluntary/opted-out budget and local authority capital expenditure.) Capital receipts by opted-out schools can go to finance capital expenditure, but excess receipts would be

surrendered to the local authority. All significant plans for expansion or contraction by schools (opted-out as well as maintained) require departmental approval.

7. This looks no less restrictive than the capital regime we are proposing for self-governing hospitals. Indeed, we are being more liberal in some ways, eg the ability to make minor disposals of assets without prior approval.

R B SAUNDERS

SECRET

FUNDING THE HOSPITAL SERVICES (HC58)

1. The joint paper with the Chief Secretary responds to the Prime Minister's request for a paper following discussion of HC49.

2. Discussion is likely to concentrate on the replacement of RAWP but may touch upon the role for regions, timetable for the transition (particularly at district level) and performance funding. The briefing below on replacement of RAWP reflects the views of Treasury officials; they will brief the Chief Secretary similarly.

POINTS TO WATCH

Replacement of RAWP

Allocations to Regions (paras.6-12)

(a) Why a morbidity weighting?

3. Cabinet Office will include the table at flag A, on alternative approaches to capitation funding, in the Prime Minister's brief. They will also include the table at flag B which shows differences from existing RAWP targets now and in 1979-80.

4. A morbidity weighting is needed to take account of well-known differences in the amount of illness requiring hospital care in different parts of the country. This difference is not picked up by age weighting. It affects younger age groups as well. Not to include a weighting for morbidity differences would be open to severe and unanswerable criticism. It is even more important to reflect these differences in the new system by which health authorities buy services on behalf of their resident population.

5. Excluding morbidity would also represent poor value for money because it would pump substantial sums of money towards the healthier populations of Wessex, Oxford, South Western and East Anglia, where the money is not needed, and away from Northern, North Western, Mersey and others on a scale impossible to justify. Nor would it be possible to counter the effects by patients being treated elsewhere. The morbidity differences are most pronounced in conditions such as bronchitis, heart disease and various cancers which need treatment locally (and would form part of "core" services).

6. Minutes of the last meeting record agreement that allocations should reflect both age and morbidity.

7. [If pressed: if the Group wished to further protect the Thames Regions' position, this could not be done without a row. But the issue would be better tackled head on by giving the Thames Regions even higher per capita allocations than the rest of the country. Leaving out morbidity from the formula would simply give other Regions (and their MPs) a more objective basis for complaint.]

8. The paper says (para 6) that further work is being done on the details of the morbidity measure. If pressed Secretary of State could simply indicate that DoH's own analysts are taking a more detailed look at the best weighting to use in a simpler capitation approach. (Introduction of a "deprivation" factor as proposed in the RAWP Review is also possible, but very controversial.)

(b) Why not simply stop now? Why take more money away from Thames Regions?

9. For simplicity, the table shows the North Thames Regions "losing" money. But the changes would be phased over 3 years, and growth money will swamp them. So in practice our proposals would simply mean that the Thames Regions would get less growth than other Regions, not that we'd be taking money away from London.

10. To freeze funding for all Regions at its present level would cause problems in parts of the country with growing populations such as East Anglia and Oxford. These Regions - and others who had been expecting higher than average growth - would soon find that they didn't have enough cash to open hospitals that are already being built.

(c) How does this proposal differ from Secretary of State's previous proposal?

11. The new proposals are simpler. Key differences are:

- Previous proposals explicitly attempted to "buy out RAWP", hence open to objection that - by implication - they continued Government support for RAWP formula and for idea that some Regions are "under-funded".

- No "targets" in future - so not creating feeling that some are losing.

- New proposals accept that equal capitation funding across the whole country not feasible - except perhaps in the very long term. But they propose levelling up to an affordable extent without disrupting services, rather than attempting to buy out RAWP.

[Note: One common feature of new and old proposals is that both mean accepting different levels of capitation funding in Thames compared with rest of country.]

SECRET

12. NOTE: Secretary of State will wish to avoid committing himself for or against any particular form of public presentation of these proposals. He may still wish to leave open the possibility of some sort of "special fund" approach during the transitional period.

(d) Differences from existing RAWP formula

13. The capitation funding approach proposed is much simpler than the existing RAWP formula. Key differences are:

- New approach funds Regions on basis of their "own" population. They can then provide services themselves or buy them from other Regions; or can sell their services to other Regions. So no need for complicated cross-boundary flow adjustments to formula.

- Spending by age group reflects total spending on HCHS services by broad age group. RAWP formula uses more complex approach, estimating expenditure by age for each service separately.

- Proposed morbidity measure (relative mortality rates - SMRs) given less weight overall (see (a) above); but applied to all expenditure.

- Existing RAWP takes account of death rates for different causes. New approach drops this complication. [RAWP Review found it difficult to justify, and not necessary as long as appropriate weight given to overall SMRs.]

- Existing formula uses death rates over all ages. New approach uses deaths for people aged under 75.

(e) Why not separate arrangements for North and South Thames Regions? Could we not simply ring-fence London?

14. In principle it would be possible to treat North and South Thames Regions differently. But it would be an added complication. Any special treatment for the Thames Regions will in practice be difficult to justify. Once we admitted the principle of different treatment for pairs of Regions, every Region's MPs would start arguing the case for special treatment for their Region - West Midlands for example. So there are advantages in keeping things simple.

15. Separate arrangements simply for London are just not practical. They would amount to taking central decisions on District funding - without the local knowledge that Regions have. They would greatly add to the complication of the formula.

SECRET

Allocations to Districts (paras.13-17)

(a) <u>The Group may consider the funding arrangements complex or too slow (paras. 14 and 16).</u>

16. New proposals are not more complicated. First step is simply to identify how much each District is being spent on services for the population of each District. This becomes the starting point for new contract funding arrangements. Starting in this way minimises disruption to existing services.

17. An immediate move to equal weighted capitation funding district by district would create vast upheaval for mythical benefits (see para 22 below). Our approach is to:

1. Identify how much is being spent for the population of each District at present.

2. Make that the initial District allocation.

3. Change relative allocations to Districts over time on a planned basis.

4. Thus at the outset no-one will suffer a loss of access to health care, but we can target additions more accurately in future.

18. Apparent complexity simply comes from the new contract arrangements which the Group agree are needed to ensure that "money follows patient". This is logical consequence of funding authorities as buyers and introducing market disciplines to the provision of services.

(b) <u>Role of Regions</u>

19. Para.14 of the paper lists the reasons why change must be carefully managed to avoid turbulence. We need a smooth and orderly transition to the new system; Regions have the local knowledge which will be needed to make this possible.

(c) <u>Timetable (para.25)</u>

(i) contract funding

20. <u>Colleagues may comment on the time required to complete the introduction of contract funding of hospitals (April 1994).</u>

21. Implementation depends crucially on the ability of local finance and other staff to negotiate, monitor and control contracts. This in part depends on better cost and activity information - which we are addressing through the Resource Management Initiative - but even more on attracting staff with the appropriate skills into the service. Circumstances will differ markedly between Districts and even more between

hospitals. Timetable makes plain that we would expect some Districts to start work quickly (April 1990), other Districts drawing on experience gained. To try to rush individual hospitals ahead before they have developed the necessary enhanced management capacity risks undermining the credibility of the whole exercise.

(ii) Equal capitation funding for all districts

22. The eventual aim must be to produce more equal capitation in districts but it must be a long process and will move at a different pace in different regions. The shifts in funding would be great. Even if they got paid for cross-boundary flows from other Districts, some Districts would get 20 per cent less cash from weighted capitation funding than at present. Others would get 20 per cent more. Losers would include many central London Districts. Reasons for this include:

- people living near hospitals tend to use them more (eg instead of going to their GPs)

- worse primary care in inner cities

- available morbidity measures may not identify all local factors affecting calls on hospital care (eg local environmental factors - everything from coal mines to heavy traffic and higher accident rates). This will matter more at District level-variations more likely to average out within Regions.

It might be argued that until we have equal capitation funding, Districts will not be able to compete fairly with each other - there won't be a "level playing field". But the districts at present experiencing the highest utilisation rates are likely to be those experiencing most demand from their residents. To that extent the "playing field is level" because they need to purchase more services to meet this demand.

SECRET

EXPLANATORY NOTES

(a) Morbidity measures

1. The morbidity measure used means, broadly, that an area with a 10 per cent higher than average standardised mortality rate (SMR) for people aged under 75 gets 5 per cent more cash per head than average. The RAWP Review found evidence that giving around this weight to relative mortality rates was the best way to reflect the known geographical variations in the use of (acute) hospital services. (This variation is over and above the greater use which tends to be made of hospitals by people living nearest to them.)

2. This method has a less extreme effect on Thames Regions than would simply adopting - in suitably simplified form - the approach used in the existing RAWP formula, which would give 10 per cent more cash to Regions with 10 per cent higher SMRs. This weighting given to SMRs in the existing RAWP formula was not based on hard evidence; at that time (1976) there was none. So taking account in this way of the Review of the RAWP formula would make sense.

[Note: the SMR is a measure of death rates relative to the national average, taking account of differences in the age structure of the population. High SMRs tend to be found in parts of the country where morbidity is also higher.]

(b) Basis of proposals

3. The 3 options given in the paper are derived as follows:

Option A:

(i) calculate age and morbidity weighted population shares by Region of present cash total, and adjust Thames Regions' figures for higher pay costs in same way as present RAWP formula

(ii) calculate extent to which present allocation for N E Thames (the Region "furthest adrift" from (i)) exceeds figure derived as at (i)

(iii) scale up every Region's allocation on an age and morbidity weighted capitation basis (ie the figure at (i)) to the N E Thames level (ie by the figure at (ii)).

Option B:

Simple age and morbidity weighted population shares, adjusted for higher pay costs in London and the South East as for Option A.

Option C:

Figures at Option B increased by 2 per cent for Thames Regions and decreased by one per cent for other Regions - this leaves the totals unchanged.

4. In each case, there would be separate "protected" funding arrangements for teaching and for high-tech services - developed from the present arrangements.

Copy no. 8

FLAG A

Region	(1) Existing allocation excluding the effect of cross-boundary flows	(2) Simple capitation	(3) Capitation with age	(4) Capitation with age and morbidity
	£ million	£ million	£ million	£ million
NORTHERN	731	716	686	741
YORKSHIRE	834	841	819	851
TRENT	1,034	1,086	1,042	1,060
EAST ANGLIAN	426	471	471	441
NORTH WEST THAMES	850	819	839	805
NORTH EAST THAMES	1,002	881	947	934
SOUTH EAST THAMES	915	851	942	916
SOUTH WEST THAMES	716	697	761	714
WESSEX	625	682	697	654
OXFORD	494	584	523	492
SOUTH WESTERN	721	747	788	749
WEST MIDLANDS	1,174	1,213	1,133	1,168
MERSEY	583	561	535	573
NORTH WESTERN	972	929	901	978
TOTAL RHAs	11,076	11,076	11,076	11,076

Explanatory Notes

1. Capitation: population of the Region.

2. Age weighting reflects our knowledge of the relative use of health services by different age groups.

3. The morbidity measure reflects geographical variations in hospital use.

4. Columns (1), (3) and (4) include adjustments to take account of higher pay costs in London and the South East.

5. Figures relate to initial allocations for 1988/89 before Review Body additions.

SECRET

ANNEX A

REGIONAL ALLOCATIONS AS COMPARED WITH WEIGHTED CAPITATION

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

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

PERSONAL AND CONFIDENTIAL

FROM: J P MCINTYRE
DATE: 22 November 1988

CHIEF SECRETARY

cc Chancellor
Mr Anson
Mr Phillips
Mr Turnbull
Miss Peirson
Mr Gieve
Mr Ramsden o.r.
Mrs Chaplin
Mr Tyrie
Mr Call

POORER PENSIONERS

I attach a revised version of the draft briefing I sent you on 18 November, which reflects comments from DSS. Please let me know if you think there are any further points which need to be covered.

2. The line taken on transitional protection (defensive (x)) assumes that Income Support transitional payments will be reduced by the £2.50/£3.50, which is our formal position with the Department. However, as discussed in my minute to you of 18 November, there is a case for not eroding these transitional payments. We will obviously need to resolve this question before the announcement on Thursday (if there is one).

3. As for TCSC tomorrow, you may like to note the figures for take-up of means-tested benefits in factual (ix) and (x) of this briefing, which DSS agree could be used publicly. More generally, you have a copy of the briefing note I circulated yesterday on poorer pensioners, which covers the position pre-announcement.

J P MCINTYRE

Pensioners

FACTUAL

(i) Changes will increase Income Support paid to pensioners aged 75 and above (and disabled pensioners over 60) by £2.50 a week for single pensioners and £3.50 for couples, over and above the new Income Support rates already announced for 1989-90. Increases to take effect in October next year. Increases in rates will be around 5 per cent on top of those already announced for 1989-90.

(ii) Income Support levels for pensioners after implementation of next October's increases:

£ per week

Age:	60-74		75-79		80+ (and disabled)	
	SINGLE	COUPLE	SINGLE	COUPLE	SINGLE	COUPLE
	46.10	71.85	48.60	75.35	51.10	77.80

(iii) **Number of gainers** nearly 2 million single pensioners and couples:

880,000	on Income Support and Housing Benefit
990,000*	on Housing Benefit alone
60,000	newly eligible for Income Support
40,000*	newly eligible for Housing Benefit
1,970,000	

* No. of gainers in 1990-91 (Community Charge will increase nos entitled to HB.)

Number of individual pensioners gaining: about 2½ million.

(iv) **Cost:** £195 million in extra benefit expenditure in full year. Less than £100 million in 1989-90 because of October implementation. Cost will be additional to existing DSS plans. Will be met from Reserves, within planning totals.

(v) Total number of individuals above state retirement pension age now on:

Income Support and Housing Benefit: 1.75 million
Housing Benefit only: 1.75 million

A further 0.2 million, mainly men aged 60-64, qualify for pensioner premium in income support.

(vi) Total number of single pensioners and pensioner couples drawing state retirement pension: 7 million.

(vii) Total number of pensioners (individuals) getting state retirement pension: 9¾ million.

(viii) Basic pension rates for 1989-90

Single: £43.60. Couple: £69.80.

(ix) Take-up of means-tested benefits (latest evidence):

	Proportion of recipients entitled	Proportion of expenditure if all those entitled were to claim
INCOME SUPPORT[1]:	76 per cent	89 per cent
HOUSING BENEFIT[1]:	77 per cent	88 per cent
FAMILY CREDIT[2]:	40 per cent	60 per cent

[1] Based on 1984 FES data. May well have increased since then.

[2] Based on data up to end-October 1988, and assuming FIS take-up in 1987-88 of 50 per cent for caseload and 70 per cent for expenditure. (Estimates of total number entitled to FC were based on estimates for FIS in 1987-88. They are therefore highly uncertain.)

(x) Take-up of means-tested benefits BY PENSIONERS (latest evidence):

	Proportion of recipients entitled	Proportion of expenditure if all those entitled were to claim
INCOME SUPPORT[1]	67 per cent	79 per cent
HOUSING BENEFIT[1]	81 per cent	91 per cent

[1] Based on 1984 FES data

(xi) Pledged Benefits (accounting for 60 per cent of programme)

Retirement Pension
Widows Benefit
Industrial Disablement Benefit
War Pension
Invalid Care Allowance
Attendance Allowance
Income Support for Pensioners
Invalidity Pension
Severe Disablement Allowance
Guardian Allowance

In addition, there is a statutory requirement to uprate unemployment benefit, sickness benefit, and maternity allowance though these are not pledged.

POSITIVE

(i) Average real incomes of pensioners rose 23 per cent between 1979 and 1986 (3 per cent between 1974 and 1979).

(ii) On average, pensioners total incomes have risen twice as fast as those of population as a whole (1979 to 1986).

(iii) Proportion of pensioners in lowest 20 per cent of income distribution has fallen from 38 per cent in 1979 to 24 per cent in 1985.

(iv) Benefit expenditure on elderly has risen 27 per cent in real terms since 1979. Main reasons: 1 million extra pensioners and increase in SERPS expenditure (nearly 2 million SERPS recipients now; average SERP of someone retiring now is £25 per week versus £1 in 1979).

(v) Pensioners have shared in growing prosperity: eg 99 per cent own TV; 81 per cent a washing machine; 96 per cent a fridge.

DEFENSIVE

(i) **Why not help pensioners aged 60-74?**

Aim is to provide special help for older, poorer pensioners, who tend to be more frail, and disabled pensioners. Poorer pensioners in 60-74 age group will still be helped by income support and housing benefit.

(ii) **Why not implement now or in April 1989?**

Not practical. Local Authorities will first need to be consulted about changes to housing benefit. Then secondary legislation. Too late after that to include in April 1989 uprating which is already underway. But pensioners won't have to wait until next general uprating in April 1990 - extra amounts to be paid from next October.

(iii) **Changes are simple: Why not announced in uprating statement on 27 October?**

No decisions had been taken at that point.

(iv) **Many poor pensioners will not claim**

Evidence is that most do claim. Many who don't claim have small entitlements. In any case, those already receiving income support and housing benefit will get the increases automatically; they will not need to make fresh claims. And DSS will take additional steps to publicise these benefits next year, to bring them to attention of those who do not now claim.

(v) **What does £195 million costing assume about take-up?**

Assumes existing case-load ie no increase in take-up above current levels is assumed.

(vi) **2 million gainers: tiny minority?**

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

(vii) **Increases will add 100,000 to numbers on means-tested benefits: is this reducing dependency culture?**

Inevitable result of extra help for those most in need. Other government measures, such as encouragement of personal pensions and cuts in personal taxation, are aimed at reducing dependence on State. Over time, increasing amounts from SERPS, occupational schemes and personal pensions will reduce pensioners' dependence on means-tested benefits.

(viii) **Why not increase the basic pension to help all pensioners, especially those just above benefit levels who won't gain from these changes?**

Would help many pensioners who don't need it and therefore poor use of extra resources. £195 million spent in this way would permit an increase of only 40p a week in basic pension, spread among 9¾ million pensioners.

(ix) **Increases simply pay back money saved on pensioners in April 1988 reforms.**

No. Great majority of pensioners on income-related benefits (85 per cent) either gained from reforms or were unaffected in cash terms. Transitional protection has been paid to the poorest, on Income Support, to avoid cash losers. Government now using reformed structure of benefits to target additional help where most needed.

(x) **Position of pensioners getting transitional protection as a result of IS and HB changes in April 1988.**

Income Support transitional payments will be reduced by the amount of these increases. But only 4 per cent of pensioners getting the increases will be affected in this way. Housing Benefit transitional payments will not be reduced.

(xii) **Will pensioners' benefits be means-tested? eg Christmas Bonus, Attendance Allowance, Mobility Allowance**

No plans to introduce means testing of any of these benefits.

(xiii) **What provision in Autumn Statement for future upratings?**

Plans assume full upratings of all benefits in April 1990 and April 1991. But, apart from pledged benefits, no decisions taken.

(xiv) Pensioners' exemption from prescription charges

No plans to change existing exemption.

(xv) Any changes to other NHS charges?

Cannot anticipate outcome of Health Review.

I agree with CST

Ch/ Incredible....

DSS now came back to tell us that 18% is right.

The variables are a and b.

Including (a) total no. of pensioners is 10 million.

Including (b) pensioners on IS total 1.95 million.

The sums are therefore:

	%
1.75 ÷ 9.75	= 17.94
1.75 ÷ 10	= 17.5
1.95 ÷ 9.75	= 20
1.95 ÷ 10	= 19.5

PS What is yr view on transitional protection point in McIntyre minute of 18/11? CST, I gather, feels we should

be generous on this pt.
Judith Chaplin agrees – her
note also behind.

NL

CONFIDENTIAL

FROM: J P MCINTYRE
DATE: 22 November 1988

CHANCELLOR

cc Chief Secretary
Mr Anson
Mr Phillips
Miss Peirson
Mr Ramsden
Mrs Chaplin

POORER PENSIONERS

You asked for a note clarifying the various estimates of the number of pensioners, those on income support, etc. This has been agreed with DSS.

2. The total number of pensioners (ie individuals) in Great Britain getting a state retirement pension is 9¾ million. This excludes about ¼ million people above pension age who do not receive the basic pension. It includes married women pensioners aged 60 and above getting a pension on the basis of their husband's national insurance record. The number of "pensioner units" (ie single pensioners and pensioner couples) is 7 million.

a

3. The number of individuals above the state retirement pension age who are dependent on both income support and housing benefit is about 1¾ million. This is made up of about 1¼ million single pensioners and ½ million in pensioner couples. (These figures underlay the PM's remark in the House that 18 per cent of pensioners claimed income support.) There is, in addition, a further 0.2 million (mainly men aged 60-64) who do not receive a basic pension but qualify for the pensioner premium in income support.

b

4. The number of individual pensioners claiming housing benefit only is also roughly 1¾ million, made up of some 1.3 million single people and 0.4 million pensioners in couples.

5. So, in total, out of 9¾ million individuals getting a state retirement pension, about 3½ million (over one third) receive one or both of the income-related benefits.

6. The alternative way of looking at the numbers is to consider "pensioner units" ie single pensioners and pensioner couples. The total is 7 million. Of these 1½ million are on income support (21 per cent) and a further 1½ million are on housing benefit only. So, in total, some 3 million pensioner units or 43 per cent get one or both of the income-related benefits.

The over-75s

7. There are 3¾ million individual pensioners aged 75 and over. However, in assessing the impact of the increased premia, it is better to focus on "pensioner units". This is because there are some people below 75 who will gain because they are married to someone aged 75 or above.

8. There are 3 million "pensioner units" (ie single pensioners and pensioners in couples) aged 75 and over. This includes couples where one partner may be under 75.

9. Of these about 750,000 claim income support and a further 860,000 claim housing benefit. (In 1990-91, the housing benefit figure will rise to 990,000 because of the impact of the community charge.) So, overall, about 1¾ million single pensioners and pensioner couples out of 3 million get either or both of the means-tested benefits (58 per cent of the age group) in 1990-91.

The Disabled

10. There are about 130,000 single pensioners and pensioner couples getting the higher premium in income support because of their disability.

Gainers from new proposals (over 75s and disabled)

11. These will be:

Existing IS and HB claimants:	880,000 (x + y)
New IS and HB claimants:	60,000
Existing HB claimants only:*	990,000
New HB claimants only:*	40,000
Total gainers	1,970,000

* 1990-91

J P MCINTYRE

chex.ps/mw/8 CONFIDENTIAL AND PERSONAL

FROM: MISS M P WALLACE
DATE: 22 November 1988

MR CALL

cc PS/Chief Secretary
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Ramsden
Mrs Chaplin
Mr Tyrie

Pat this came back to me with some other stuff. I take it amendment had not been done

PENSIONERS - RATIONALE FOR ACTION

The Chancellor was grateful for your minute of 18 November.

2. He comments that the target of the package would be "poorer, older". A line has to be drawn somewhere: we are proposing to redraw the existing line in a more generous way. Whenever you do something like this, you will always be asked: "Why didn't you do more?". We simply brush that aside, by seeking a welcome for what we are doing, and so "poorer, older" will do.

MOIRA WALLACE

[I would be nervous if we had lost a copy of this]

Right. Psr & I must have an urgent talk. This is a poor do.

Ch/

x in factual iii prompted me to check with Paul McIntyre where he got to in checking out the 18% "tiny minority" figure. I'm afraid its bad news - numerator was benefit cases, denominator was individuals* This is a bloody nuisance and we shall have to find some way of getting ourselves out of it.

It does also mean we have to decide whether to present whole thing in terms of individuals or cases if we want to avoid further confusion.

On which basis? And what are the other bases?

mpw

* right figure is apparently 23%

CONFIDENTIAL

FROM: JUDITH CHAPLIN
DATE: 22 November 1988

CHANCELLOR

Cc: CST
Mr McIntyre
Mr Tyrie
Mr Call

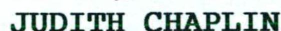
POORER PENSIONS

I think there is a genuine presentational problem over the additional help for poorer pensioners which we need to consider carefully before the Debate or indeed the announcement of the scheme.

2. Those pensioners who lost under the social security reforms were given transitional relief. If I were a Labour Party spokesman, I would say that you had now recognised that the changes were unfair to pensioners and the transitional relief was being made permanent so as to place these pensioners in the situation which they were before the reforms.

3. Although many pensioners gained under the social security reform and they will gain still further from the additional money, certainly some of those who will come back on to income support and housing benefit because of the new scheme must by definition be those who were pushed off it by the reform. I think, therefore, we need to have a clear line of argument on this particular point.

4. I think too it does suggest that the additional payment should be on top of transitional payments for both housing benefit and income support so that it can be seen as being totally separate from considerations relating to the original changes.



JUDITH CHAPLIN

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CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 22 November 1988

CHANCELLOR

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

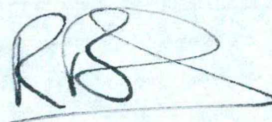
NHS REVIEW: GP PRATICE BUDGETS

At yesterday's briefing meeting, you asked me to estimate the potential cost of expenditure from GP budgets substituting for health care that would otherwise be paid for privately. I attach some figuring which suggests, very roughly:

- initial costs could be around £50m

- long term, after allowing for behavioural effects, the cost could rise to £150m.

2. These are however conservative estimates. They are based on the DOH estimates of the size of budgets that GPs would need, ie some £30 per patient for elective surgery. This looks on the low side compared with the average private health insurance premium of £100-150. So the attached arithmetic assumes that GPs use their budgets to pay private medical costs in part rather than in whole. To the extent that they pay more on behalf of private patients, and succeed in getting the budgets increased, the costs could rise considerably. Well over £500m worth of private treatment could potentially be subsidised in this way.



R B SAUNDERS

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CONFIDENTIAL

GP PRACTICE BUDGETS: COST OF PRIVATE PATIENTS

DOH estimate
- 800 practices eligible (ie 11,000 or more patients)
- covering 20% of population
- average budget (including elective surgery, outpatient referrals, diagnostic tests and practice premises and staff) £½m

Assume
- all eligible practices opt for budget
- proportion of private patients is 20%, ie double the national average
- 80% of budget covers, eg outpatient referrals and surgery, where use of private sector possible

Then potential cost = £400,000 x 20% x 800
= £64m

This is the cost if 4% of the population is both privately insured and within the scheme. If more private patients move to GPs with practice budgets, and practices merge so as to enable themselves to hold budgets, a higher proportion of the 10% who are privately insured would come within the arrangements. Ultimately this could be as much as

£64m x 10/4 = £160m

JM 22/11.

FROM: M A BOLTON
DATE: 22 NOVEMBER 1988

1. MR MCINTYRE
2. CHANCELLOR

cc Chief Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Mr Turnbull
Miss Peirson
Mr Ramsden or
Mr Speedy
Mrs Chaplin
Mr Tyrie
Mr Call

EFFECT OF CHILD BENEFIT FREEZE ON FAMILY CREDIT AND INCOME SUPPORT

You asked for a short note on how payments of Family Credit and Income Support adjust to offset any change in Child Benefit.

2. The attached tables were compiled before the final PES settlement, so some of the figures may not be exactly those agreed on for April 1989. However, they show the key point, that net income is the same whether or not CB is uprated. The ways in which changes in CB are offset are different for IS and FC, so it is necessary to consider them separately.

3. Child Benefit is deducted in full from the child allowances in Income Support. The mother receives CB, and an equivalent sum is deducted from the IS received by the family. Thus, from one year to the next, the family's total income rises in line with IS, which is uprated by Rossi, and is unaffected by changes in CB, which is uprated by the RPI.

4. Child Benefit is not taken into account when calculating Family Credit entitlement. However, in the event of a CB freeze, the amount by which CB would have risen (ie RPI increase) is added to the child rates for FC. Thus FC families always gain compared with those on IS: they receive FC child rates uprated by Rossi and an effective CB uprating in line with the RPI, whether or not CB is actually uprated.

Michael Bolton

M A BOLTON

FAMILY ON IS:

(a) 1 child under 11

Benefits	1988-89 £	1989-90 if CB uprated £	1989-90 if CB frozen £
Allowance for couple	51.45	53.80	53.80
Family premium	6.15	6.45	6.45
Child Benefit	7.25	7.70	7.25
IS Child Allowance*	3.50	3.55	4.00
Total	68.35	71.50	71.50

(b) 1 child under 11, 1 child 11-15

Benefits	1988-89 £	1989-90 if CB uprated £	1989-90 if CB frozen £
Allowance for couple	51.45	53.80	53.80
Family premium	6.15	6.45	6.45
Child Benefit	14.50	15.40	14.50
IS Child Allowance* < 11	3.50	3.55	4.00
11-15	8.85	9.20	9.65
Total	84.45	88.40	88.40

*IS Child allowance figures less CB, which is deducted in full from the income-related benefit.

FC - Family earning £100 per month (net income)

(a) 1 child under 11

	1988-89 £	1989-90 if CB uprated £	1989-90 if CB frozen £
Max allowance	38.15	39.90	40.35
Actual entitlement	4.15	7.55	8.00
Child Benefit	7.25	7.70	7.25
Total Income**	111.40	115.25	115.25

(b) 1 child under 11, 1 child 11-15

	1988-89 £	1989-90 if CB uprated £	1989-90 if CB frozen £
Max allowance	49.55	51.80	52.70
Actual entitlement	15.55	19.45	20.35
Child Benefit	14.50	15.40	14.50
Total Income**	130.05	134.85	134.85

** For the sake of simplicity, earnings assumed constant at £100 per week in both years.

FROM: MOIRA WALLACE
DATE: 23 NOVEMBER 1988

CHANCELLOR

cc: PS/CST

EFFECT OF CHILD BENEFIT FREEZE ON FAMILY CREDIT AND INCOME SUPPORT

I think that when you spoke to the Chief Secretary on the phone earlier this evening Alex mentioned that I had been looking into the family credit point made in the Observer letter. We have a note from ST, behind, which explains what happens, but I'm not quite sure we have reached a user-friendly explanation of why it happens.

The what is fairly straightforward, as para 4 of Mr Bolton's minute sets out. This year, although we froze CB, we added on to FC the 45p by which CB would have increased if it had been uprated in line with the RPI. So in that sense it is literally true to say that increasing CB would have made no difference to those on FC. But only literally. What you said on Panorama was what we took this to mean - ie that CB was offset against FC as it it is against IS.

The question of why the system works this way is trickier. As I understand it, when the relativities between the child premia in IS and FC were first established the rationale was (broadly) **Family Credit = Income Support + cash amount for free school meals - CB.** The addition for free school meals reflected the fact that FC people were no longer going to be entitled to them, unlike those on IS. The deduction for CB was because it was deemed to be subsumed in the IS children's rates, but FC people were going to carry on getting it separately. If CB is subsumed in benefit for those on IS, then like the rest of IS it gets uprated by Rossi. If you then didn't make sure FC recipients' CB was uprated by something then gradually the original IS/FC differential would be progressively narrowed.

Panorama is clearly spilt milk. What I think we have to do now is figure out:

(i) the most user-friendly way of answering the Observer point. It would be helpful if this "uprating practice" is enshrined in the legislation, more awkward if it is just one of our (internal) "ground rules". (Paul McIntyre is checking this point).

(ii) an answer to the point that is just a little odd that the 45p we have added on to FC represents RPI uprating when the rest of FC is rossi-uprated. It sounds a bit as if we think that really CB "ought" to be RPI uprated. (On CB, Rossi would have produced 35p rather than 45.)

MOIRA WALLACE

st2.ar/docs/23.11.2

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 23 November 1988

CHIEF SECRETARY

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

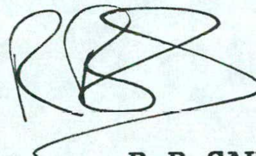
NHS REVIEW: PRIVATE FINANCE

Mr Phillips and I spoke to you briefly this morning about our fear that the resumed discussion after Cabinet tomorrow may get into the substantive issues on private finance. I attach as discussed a short aide-memoire of our position on the subject.

2. On more specific points, see also:

a. the defensive briefing on HC56, attached to my minute of 18 November, which deals with Mr Clarke's pet points;

b. paragraphs 4 and 5 of my minute of 22 November, which deal with some ideas which the Policy Unit are hatching, but about which we have only heard sketchy details.



R B SAUNDERS

CONFIDENTIAL

PRIVATE FINANCE: MAIN POINTS

1. Privately-financed NHS schemes have to be paid for by the taxpayer. When private financing increases costs the rest of the NHS suffers.

2. Similarly, private finance does not offer a painless way of increasing expenditure on the NHS. The taxpayer always pays sooner or later.

3. Not an argument against bringing in private sector management and expertise. Want to do that where it saves money.

4. In exactly the same way, we favour private finance when it is more cost-effective (Government Data Network a good example).

5. But pointless to argue generalities: best value for money essential. We therefore need to look at specific things which health authorities want to do. See first at how they can be done without unnecessarily increasing costs to taxpayer or damaging public expenditure control. Where that is unsatisfactory, will try to identify what specific exceptions or relaxations can be considered.

6. DOH working up a list of such examples. Not yet shown to Treasury. Ball in their court.

M

WT Speech

Ch/ not too bad. One or two funnies marked. At the back is the embryonic backbenchers' brief. Judith C is planning to have a go at this tomorrow.

CST + Paul M^c I will be meeting at 9.00 to go through Moore speech so the sooner we can have any comments from you, the better.

MPW..

PS/CST

cc PS/C.Ex.
Mr Anson
Mr Phillips
Miss Peirson
Mrs Chaplin

SECRET

POORER PENSIONERS

Extract from Mr Moore's draft speech. JP 23/11.

31. But of course we have always recognised that some pensioners do not fit this picture of rising prosperity which has transformed the lives of many others. I am sure the House will be aware of the group to which I am referring. They are [those] the generation who retired before they could benefit from SERPS or from a good occupational pension. Many will have had their working lives disrupted by war and their savings battered by the rampant inflation of the '70s.

32. The present income support scheme already provides extra help for pensioners. It does so through the pensioner and higher pensioner premiums which are currently worth £10.65 and £13.05 a week respectively for single pensioners.

33. But even so we have been looking at additional ways of helping this particular group of pensioners. I am delighted to tell the House that, as a result of this work, we have decided to channel significant extra resources to this group. I am very pleased to be able to tell the House today that, subject to the necessary consultative procedures, we intend to introduce into the income support scheme a new and enhanced structure of pensioner premiums, £s m

34. This new pattern of premiums will result in almost £200 million extra being directed to pensioners who are less well-off. It will be carefully focussed on three groups:

- first, pensioners over 75 on income support;

- second, disabled pensioners over 60 on income support; and

- third, poorer pensioners in these groups whose income is at present just above the qualifying level for income support and who will get extra help through housing benefit.

35. Let me take each of these groups in turn. Before I do can I make a general point. I recognise the complexity of what I am about to say but there will be ample time to discuss these matters further when the necessary Regulations are brought before this House.

SECRET

36. First, in order to help the over 75s, I shall be introducing a completely new premium for those aged between 75 and 79. This will be set above the rates of pensioner premium announced for next April and will be worth an extra £2.50 for a single pensioner and an extra £3.50 for a couple. This will raise the income support premium available to those aged between 75 and 79 to £13.70 a week for single people and £20.55 for couples.

37. In addition there will be an improved premium for the over 80s, which will subsume and enhance the existing higher pensioner premium which currently goes to some 550,000 pensioners. As with that for the over 75s, the over 80s premium will be increased by £2.50 a week for a single person, £3.50 for a pensioner couple. This means that pensioners over 80 on income support will receive a premium of £16.20 if single, rising to £23 for a married couple.

38. Secondly, I propose to enhance the disabled pensioner's premium for those over 60. The House will know that at the moment all disabled pensioners over 60 receive the higher pensioner premium. I propose that this should be carried through into the new scheme and that these people should receive the highest rate of premium. Thus at 1989/90 rates a single disabled pensioner will receive a premium of £16.20 and a couple £23 a week.

39. I estimate that in a full year these first two changes will result in around 900,000 pensioners on income support receiving increases of £2.50 or £3.50 a week. What is more those increases will be on top of the increases in income support which I recently announced with effect from next April. Taken together, all these changes will give most of these pensioners an increase of around 10 per cent in their benefit and in some cases even more.

40. But these proposals will not only benefit the poorest pensioners. They will also help those whose incomes currently place them just above the qualifying level for income support. They will do this by raising the income level at which pensioners can obtain help with their housing costs. Indeed as a result of the new structure of premiums a further 1,030,000 poorer pensioners will, in a full year, receive additional help through housing benefit.

41. In all, some 2 1/2 million pensioners will receive significant increases at a total additional cost of some £200 million in a full year. This is all new money. The public expenditure element will be found from the Reserve and will be an addition to my total programme.

TIMING

42. As I have said, these changes are in addition to those already announced in my uprating statement. Work on the uprating is already well in hand. I propose, subject to consultation with the local authorities and to the passage of the necessary Regulations, to introduce these changes in October 1989. This will enable my benefit offices and the local authorities to give pensioners this extra help before the onset of winter. Thus elderly and disabled pensioners can look forward to two upratings next year. One in the spring and a second in the autumn.

PUBLICITY

43. For most of those involved, the increase will be automatic. They will not need to make any new claim or fill in any form. I know some of my hon Friends will be concerned about whether pensioners will claim the benefits to which they are entitled. I propose therefore to mount a publicity campaign at the appropriate time to tell pensioners about the new arrangements which will come in next October. As part of that campaign we shall be writing to all pensioners over 75 whose address we hold in order to explain the changes.

44. I want the campaign to try and help not only those who will become eligible for help for the first time but also those who are already entitled to claim but do not.

45. I am also anxious to assist the Members of this House. With permission therefore, Mr Speaker, I will arrange for the details of the measures I have just announced to be printed in the Official Report.

CONCLUSION

46. Mr Speaker, the package of measures which I have just announced will bring extra help to nearly 2 1/2 million of our least well-off pensioners. It will do so by directing almost £200 million of taxpayers' money to those who genuinely need it. I am confident it will be warmly welcomed by the House and by the people of this country.

47. These new measures must, however, be seen against the background of the steady increases in the living standards of pensioners as a whole. As I said earlier a gap in that overall pattern does exist and this scheme will, I believe, fill that gap. What these new measures will do is ~~tackle something which I thought was a tenet of the party opposite - they will~~ give most help to those who need it most. This is one of our key objectives for social security. We intend to see it through.

EXTRA HELP FOR PENSIONERS - THE GOVERNMENT'S PROPOSALS

It is proposed that income support paid to pensioners will be restructured from October 1989. ~~There will be new premiums for~~ [Income support for] pensioners 75 and over, 80 and over and disabled pensioners. ~~These~~ will [provide] [be increased by] ~~an extra~~ **£2.50** a week for single pensioners and an extra **£3.50** a week for couples. This will be over and above the increases already announced for the April uprating. The [same increase will apply to the] housing benefit [rates] so that pensioners slightly above income support levels will also benefit through extra help with rent and rates or community charge.

[changes will be carried through to]

	New Structure of Income support Premiums from October 1989			Announced Rates from April 1989	
	Single £	Couple* £		Single £	Couple* £
60-74 (not disabled)	**11.20**	**17.05**	)	11.20	17.05
75-79	**13.70**	**20.55**	)		
80 plus	**16.20**	**23.00**		13.70	19.50
Disabled 60 and over	**16.20**	**23.00**		13.70	19.50

* The couples rate applies if either member is over 75 or 80, or is disabled

Resulting Income Support Levels for Pensioners

£ per week

	Age 60-74		Age 75-79		Age 80 plus or Disabled	
	Single	Couple	Single	Couple	Single	Couple
Current	44.05	67.70	44.05	67.70	46.45	70.05
Apr. 1989	46.10	71.85	46.10	71.85	48.60	74.30
Oct. 1989	**46.10**	**71.85**	**48.60**	**75.35**	**51.10**	**77.80**

Number who benefit in a full year

2 million pensioners and couples (2.6 million individuals) gain in a full year:

880,000 on income support
990,000 on housing benefit
60,000 new recipients of income support
40,000 new recipients of housing benefit

Cost

£95 million in 1989-90
£195 million in 1990-91

(Fact Sheet for backbenchers, press.)

chex.md/mw/125 **CONFIDENTIAL**

FROM: MISS M P WALLACE
DATE: 23 November 1988

MR MCINTYRE

cc PS/Chief Secretary
Mr Phillips

POORER PENSIONERS

The Chancellor was grateful for your minute of 22 November.

MOIRA WALLACE

chex.md/mw/127 **CONFIDENTIAL**

FROM: MISS M P WALLACE
DATE: 23 November 1988

MP

MRS CHAPLIN

cc PS/Chief Secretary
Mr McIntyre
Mr Tyrie
Mr Call

POORER PENSIONERS

The Chancellor was grateful for your minute of 22 November.

MOIRA WALLACE

chex.md/mw/128 CONFIDENTIAL AND PERSONAL

FROM: MISS M P WALLACE
DATE: 23 November 1988

PS/CHIEF SECRETARY

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

POORER PENSIONERS

The Chancellor has seen Mr McIntyre's minute of 18 November. This is to confirm that he agrees with the Chief Secretary's view that the new increases should not be allowed to erode transitional protection for either housing benefit or income support.

MOIRA WALLACE

PERSONAL AND CONFIDENTIAL

MP

FROM: J P MCINTYRE
DATE: 23 November 1988

CHIEF SECRETARY

cc Chancellor
Mr Anson
Mr Phillips
Miss Peirson
Mr Gieve
Mr Ramsden o.r.
Mrs Chaplin

Ch/ The latest version includes more on lobby, the tape etc.
MP

POORER PENSIONERS

I understand that DSS will be sending over this evening a draft of Mr Moore's speech for tomorrow. I now attach a further revise of the Q&A briefing.

2. The Q&A is based on the material I sent you yesterday. Some further points have been added, especially on the events of 4-6 November.

3. I have discussed the transitional protection issue with DSS, following your and the Chancellor's agreement that income support transitional payments should not be eroded by the October increases. The Department is considering whether this is feasible in administrative terms.

JM

J P MCINTYRE

Pensioners

FACTUAL

(i) Changes will increase Income Support paid to pensioners aged 75 and above (and disabled pensioners over 60) by £2.50 a week for single pensioners and £3.50 for couples, over and above the new Income Support rates already announced for 1989-90. Increases to take effect in October next year. Increases in rates will be around 5 per cent on top of those already announced for 1989-90.

(ii) Income Support levels for pensioners after implementation of next October's increases:

£ per week

Age:	60-74		75-79		80+ (and disabled)	
	SINGLE	COUPLE	SINGLE	COUPLE	SINGLE	COUPLE
	46.10	71.85	48.60	75.35	51.10	77.80

(iii) **Number of gainers** nearly 2 million single pensioners and couples:

880,000	on Income Support and Housing Benefit
990,000*	on Housing Benefit alone
60,000	newly eligible for Income Support
40,000*	newly eligible for Housing Benefit
1,970,000	

* No. of gainers in 1990-91 (Community Charge will increase nos entitled to HB.)

Number of individual pensioners gaining: about 2½ million.

(iv) **Cost:** £195 million in extra benefit expenditure in full year. Less than £100 million in 1989-90 because of October implementation. Cost will be additional to existing DSS plans. Will be met from Reserves, within planning totals. Will not therefore add to total public expenditure.

(v) Total number of individuals above state retirement pension age now on:

Income Support and Housing Benefit:	1.75 million
Housing Benefit only:	1.75 million

A further 0.2 million, mainly men aged 60-64, qualify for pensioner premium in income support.

(vi) Total number of single pensioners and pensioner couples drawing state retirement pension: 7 million.

(vii) Total number of pensioners (individuals) getting state retirement pension: 9¾ million.

(viii) Basic pension rates for 1989-90

Single: £43.60. Couple: £69.80.

(ix) **Take-up of means-tested benefits (latest evidence):**

	Proportion of recipients entitled	Proportion of expenditure if all those entitled were to claim
INCOME SUPPORT[1]:	76 per cent	89 per cent
HOUSING BENEFIT[1]:	77 per cent	88 per cent
FAMILY CREDIT[2]:	40 per cent	60 per cent

[1] Estimate of total number entitled based on 1984 FES data. Take-up may well have increased since then.

[2] Based on FC caseload data up to end-October 1988, and assuming FIS take-up in 1987-88 of 50 per cent for caseload and 70 per cent for expenditure. (Estimates of total number entitled to FC were based on estimates for FIS in 1987-88. They are therefore highly uncertain.)

(x) **Take-up of means-tested benefits BY PENSIONERS (latest evidence):**

	Proportion of recipients entitled	Proportion of expenditure if all those entitled were to claim
INCOME SUPPORT[1]	67 per cent	79 per cent
HOUSING BENEFIT[1]	81 per cent	91 per cent

[1] Estimate of total number entitled based on 1984 FES data

(xi) **Pledged Benefits (accounting for 60 per cent of programme)**

Retirement Pension
Widows Benefit
Industrial Disablement Benefit
War Pension
Invalid Care Allowance
Attendance Allowance
Income Support for Pensioners
Invalidity Pension
Severe Disablement Allowance
Guardian Allowance

In addition, there is a statutory requirement to uprate unemployment benefit, sickness benefit, and maternity allowance though these are not pledged.

POSITIVE

(i) Average real incomes of pensioners rose 23 per cent between 1979 and 1986 (3 per cent between 1974 and 1979).

(ii) On average, pensioners' total incomes have risen twice as fast as those of population as a whole (1979 to 1986).

(iii) Proportion of pensioners in lowest 20 per cent of income distribution has fallen from 38 per cent in 1979 to 24 per cent in 1985.

(iv) Benefit expenditure on elderly has risen 27 per cent in real terms since 1979. Main reasons: 1 million extra pensioners and increase in SERPS expenditure (nearly 2 million SERPS recipients now; average SERP of someone retiring now is £25 per week versus £1 in 1979).

(v) Pensioners have shared in growing prosperity: eg 99 per cent own TV; 81 per cent a washing machine; 96 per cent a fridge.

DEFENSIVE

(i) **Why not help pensioners aged 60-74?**

Aim is to provide special help for older, poorer pensioners, who tend to be more frail, and disabled pensioners. Poorer pensioners in 60-74 age group will still be helped by income support and housing benefit.

(ii) **Why not implement now or in April 1989?**

Not practical. Local Authorities will first need to be consulted about changes to housing benefit. Then secondary legislation. Too late after that to include in April 1989 uprating which is already underway. But pensioners won't have to wait until next general uprating in April 1990 - extra amounts to be paid from next October.

(iii) **Changes are simple: Why not announced in uprating statement on 27 October?**

No decisions had been taken at that point.

(iv) **Panic response to Chancellor's briefing**

No. Announced now because decision has been taken. As Chancellor made clear, we have been considering for some time how best to provide additional help for older, poorer pensioners. Today's announcement is result of that process.

(v) **Has scheme been brought forward? Was it not planned for next year's Autumn Statement (ie for introduction in 1990)?**

We had discussed in Public Expenditure Survey provision of more help for poorer pensioners but agreed that further work was needed on options. We had not decided when to go ahead. We certainly brought forward announcement of our intentions (Chancellor on 7 November) and completed work on options in order to reassure many pensioners alarmed by misleading stories in press.

(vi) **Extra money only provided because of reaction to Chancellor's briefing**

No. Additional help for poorer pensioners discussed in Public Expenditure Survey, well before Chancellor's briefing. Agreed in Survey that further work was necessary on how best to achieve this.

(vii) **Chancellor's briefing revealed hidden agenda for means-testing**

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

(viii) **Agree that only "tiny minority" of pensioners have difficulty making ends meet?**

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

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

No. This is simply false.

(x) **Why did government leave it until Monday 7 November to deny the Sunday stories?**

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

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

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

(xii) **What about the tape recorder?**

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

(xiii) **Many poor pensioners will not claim**

Evidence is that most do claim. Many who don't claim have small entitlements. In any case, those already receiving income support and housing benefit will get the increases automatically; they will not need to make fresh claims. And DSS will take additional steps to publicise these benefits next year, to bring them to attention of those who do not now claim.

(xiv) **What does £195 million costing assume about take-up?**

Assumes existing case-load ie no increase in take-up above current levels is assumed.

(xv) **2 million gainers: tiny minority?**

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

(xvi) **Increases will add 100,000 to numbers on means-tested benefits: is this reducing dependency culture?**

Inevitable result of extra help for those most in need. Other government measures, such as encouragement of personal pensions and cuts in personal taxation, are aimed at reducing dependence on State. Over time, increasing amounts from SERPS, occupational schemes and personal pensions will reduce pensioners' dependence on means-tested benefits.

(xvii) **Why not increase the basic pension to help all pensioners, especially those just above benefit levels who won't gain from these changes?**

Would help many pensioners who don't need it and therefore poor use of extra resources. £195 million spent in this way would permit an increase of only 40p a week in basic pension, spread among 9¾ million pensioners.

(xviii) **Increases simply pay back money saved on pensioners in April 1988 reforms.**

No. Great majority of pensioners on income-related benefits (85 per cent) either gained from reforms or were unaffected in cash terms. Transitional protection has been paid to the poorest, on Income Support, to avoid cash losers. Government now using reformed structure of benefits to target additional help where most needed.

(xix) **Position of pensioners getting transitional protection as a result of IS and HB changes in April 1988.**

[Neither Income Support nor Housing Benefit transitional payments will be reduced by the amount of these increases. Transitional payments will be eroded at time of the normal upratings in April each year but not as result of these special increases next October.]

(xx) **Will pensioners' benefits be means-tested? eg Christmas Bonus, Attendance Allowance, Mobility Allowance**

No plans to introduce means testing of any of these benefits.

(xxi) **What provision in Autumn Statement for future upratings?**

Plans assume full upratings of all benefits in April 1990 and April 1991. But, apart from pledged benefits, no decisions taken.

(xxii) **Pensioners' exemption from prescription charges**

No plans to change existing exemption.

(xxiii) **Any changes to other NHS charges?**

Cannot anticipate outcome of Health Review.

st.ln/min/1.25.11

SECRET

FROM: MISS M E PEIRSON

DATE: 25 NOVEMBER 1988

CHIEF SECRETARY

cc Chancellor
Sir Peter Middleton
Mr Anson
Mr Phillips
Mr Saunders

NHS AUDIT: OPTIONS FOR LEGISLATION

1. Parliamentary Counsel's views have now been obtained (see below), and Mr Ridley is about to circulate the attached note by officials on the 3 options for early action in the Housing and Local Government Bill. His covering letter will express considerable doubts about two of them (see below).

2. It now looks as though the matter will be discussed initially at the meeting between Mr Clarke and Mr Ridley (and Mr Moore) on Tuesday on the Griffiths report (see my separate submission), and Mr Clarke or Mr Ridley may then minute the Prime Minister.

3. There has been one significant development which could invalidate some of the argument in the attached note. It now looks likely that the health review statement will precede the publication of the DOE Bill. If so, there should be no difficulty about putting health into the long title of the Bill.

4. However, Mr Ridley's letter will express his considerable worry about including in his Bill clauses which will bring in health review and health funding matters, and probably difficulties with the PAC. He might well therefore refuse anything but option (iii), the general enabling clause, which the Treasury do not like (see below).

5. Parliamentary Counsel's view, which related to the possibility of introducing clauses into the DOE Bill after publication, is as follows. The long title to the Bill will probably need anyway to refer to the Local Government Finance Act 1982, and that might be sufficient to allow the clauses proposed

under either option (ii) or option (iii) of the attached note to be introduced into the Bill at a later stage, subject to some doubt whether they would be "within scope in the Commons". But option (i), and possibly option (ii), would bring the whole of health funding into the Bill, which would appear (Parliamentary Counsel thought) to rule them out. It seemed to him that the only realistic options were option (iii), without any reference to the NHS, or separate legislation.

6. The suggestion that anything specific about the NHS audit would "bring the whole of NHS funding into the Bill" would seem to me to cast doubt also on the desirability of using the Finance Bill, which as I mentioned in my earlier submission might be considered as an option for early legislation.

7. My conclusion is that the options now are:-

a) Option (iii) of the attached note, ie a general enabling power. But it would not be possible to expand such a clause later during the Bill's passage; and Treasury officials would recommend against it, because we consider that the private sector rather than the Audit Commission should be given the audit of some of the other sorts of public sector bodies which DOE have in mind.

X

b) Wait for health legislation.

8. Therefore, desirable though it would have been to have enabled the Audit Commission to start work early, it seems best, at least from the Treasury's point of view, to wait for the health legislation. As I have said before, DH do not consider that that rules out all Audit Commission involvement in the interim: DH say they are anxious to start secondments of staff between the Audit Commission and themselves, both to enable the Audit Commission to gain experience and to facilitate the rundown of DH staff.

MEP

MISS M E PEIRSON

cst.rj/docs/25.11.5

RESTRICTED

FROM: A G TYRIE

DATE: 25 November 1988

CHANCELLOR

cc: Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Mr McIntyre
Mr Turnbull
Mr Forman MP
Mrs Chaplin
Mr Call

LABOUR PLEDGES ON PENSIONS

As I expect you noted, Robin Cook committed Labour to restore the earnings link. He also, more or less, committed Labour to increase it by £11 for single pensioners and £18 for married pensioners - the 1979 equivalents. Are you happy with that assumption for costing purposes, Hansard attached?

2. Paul McIntyre has very kindly agreed to check the accuracy of Mr Cook's own costing, of £5 billion.

3. I think our backbenchers' next question to Brown and co can be:

> "Does the RHG for Livingston's pledge to restore the pensions link with earnings at 1979 levels mean that Labour have dropped their manifesto pledge to raise pensions to half average earnings for single people and third average earnings for married couples?"

No! ? see below

RJ

pp A G TYRIE

No. The next backbench question must be to elucidate whether the pledge to restore the earnings link is prospective or retrospective. Then we can cost it on a firm basis. At present the pledge is unclear — a matter which will be a matter of dispute [illegible] the Lab front bench.

very first acts of this Government was to smash the link between the pension and the rise in earnings. If that link had been maintained single pensioners would now be £11 a week better off and married pensioners would be £18 a week better off. Compare and contrast that with the £2·50 that has just been announced for special categories of old-age pensioners. Compare also the £200 million that the Secretary of State has just announced with the £5,000 million that the Government saved by smashing the link with earnings. The Government have taken £5,000 million away and now invite us to thank them for giving back £200 million.

Mr. David Shaw: Is the hon. Gentleman saying that it would be Labour party policy at the next election to restore the link, or, as happened in 1976, will the link be restored only when it can be done in such a way that eight months' inflation can be taken out of the calculation?

Mr. Cook: The Government have uprated the pension in precisely the same way as the Labour Government did when they introduced the link in 1977. The hon. Gentleman's question was fair. It is not something that I or any of my hon. Friends have tried to conceal. It appears that we have failied, but we have tried to get it across to every pensioner in the land that we would restore the link with earnings. That will be one of our major planks at the next election, and it is a plank with which we shall beat the Secretary of State about both ears.

Several Hon. Members *rose*——

Mr. Cook: I should like to make progress with my speech, so I shall not give way.

One of the reasons why we believe that it is not possible to end poverty in old age by means testing alone is that, inevitably with such means testing comes a stigma. Universal benefits go to everybody as citizens, and they can be worn as a badge of citizenship. Means-tested benefits go only to the poor, so they are a label of poverty. Sometimes the Department of Social Security appears to go out of its way to rub in and stigmatise that poverty.

I have a copy of form AG1, which pensioners and others who wish help with prescriptions on grounds of low income have to complete. It runs to 15 pages and has 18 separate parts. The most interesting feature about the document is that the income test for free prescriptions is the same as that for assistance to visit a relative in prison. The Department of Social Security, presumably to consolidate prices and the cost of the document, has provided a common form for applications for help with free prescriptions or with travel to visit a relative in prison. If one wishes to apply for help, one of the first things that one finds on page 1 is the advice:

> "Claim now if you think you or your partner will need things like NHS prescriptions . . . or are going to visit someone in prison."

Confronted with that, thousands of pensioners in Britain will close up the form then and there and refuse to apply rather than submit to such a stigmatised test. That is why this is so important. If we are to end the poverty of those in old age, while allowing them to retain their dignity, it is vital, in addition to looking at means-tested benefits, to provide a decent universal flat-rate state pension.

We approach the Government's commitment to means-tested benefits with a certain degree of jaundice because we have had an opportunity over the past year to observe what happens to means-tested benefits under this Administration. We notice that they have a tendency to become even meaner. This debate comes at the start of a new parliamentary year, but half-way through the social security year. It is a convenient point at which to take stock of the changes that we have seen—particularly those in April. This debate is doubly convenient because the reply will be given by the architect of those changes.

The then Secretary of State for Social Services, the right hon. Member for Sutton Coldfield (Mr. Fowler), will recall his constant promise that his reform of the social security system was the biggest for 40 years and that it had to stand the test of the next 40 years. Over the past couple of months I have often wondered what thoughts are passing through the right hon. Gentleman's mind as he notes the observations of his right hon. and hon. Friends, who appear to consider that his reforms have not stood the test of the first year.

The Chancellor, in expansive form, suggests that the social security system needs major restructuring—so major that it will require a programme of re-education of Government Back Benchers. The Secretary of State for Social Security and his hon. Friend the Minister told the House that he did not make any secret of his belief that child benefit is not an effective way of helping the poor. That is perfectly true. I accept that the right hon. Gentleman has never made any secret of his distaste for child benefit. I am happy to assure him that I for one never believed the stories that he was fighting hard to uprate child benefit.

The difficulty is that the Secretary of State never shared his little secret before polling day. The author of the Conservative manifesto's comment on child benefit was not the Secretary of State for Social Security but his right hon. Friend the Member for Sutton Coldfield. His manifesto commitment was:

> "Child benefit will continue to be paid as now, and direct to the mother."

The comma is important. We have it on the Chancellor of the Exchequer's authority that he is not able to go back on the manifesto because of the comma. When asked who was responsible for inserting the comma, the Chancellor replied:

> "I don't know—not me."

Today, we have the author of the comma. The Secretary of State for Employment must be rueful that his most enduring legacy to his successor is a comma, without which his colleagues would not wait another 40 hours, never mind 40 years, before attacking the structure of child benefit.

The unfortunate feature of all this is that child benefit is the one thing that the right hon. Member for Sutton Coldfield got right. In his White Paper before the reforms, he presented the view:

> "Child benefit is . . . simple, straightforward, well understood and preferred as it is. The case for changing it has not been made out."

The question that I ask at this early point, so that the right hon. Gentleman may have an opportunity to reflect on it before replying, is whether he stands by that quotation; or has he, too, been the subject of a re-education programme and does he now accept the case made by his right hon. Friend the Secretary of State for Social Security that child benefit should be frozen until death?

I turn from the assurance of the right hon. Member for Sutton Coldfield to that of his successor, which has proved to be equally flexible. I remind the Secretary of State for Social Security that when the changes were debated in

HOUSE OF COMMONS
LONDON SW1A 0AA

Rt Hon Nigel Lawson
The Chancellor
11 Downing Street
London

? 7 Nov

Dear Chancellor

This afternoon you were asked a number of very specific questions that you failed to answer. I would now be grateful if , in dealing with the unanswered questions, you would confirm:

First, that prescriptions for the elderly will remain free of charge and there are no plans whatsoever to introduce means testing

Second, that there will be no new health service charges

Third, that Attendance Allowance , paid to 695,000 disabled families , will be uprated and its value maintained and that it will not be means tested

Fourth,that Mobility Allowance paid to 600,000 disabled persons will be uprated in line with inflation and that it will not be means tested

I would be grateful if you would also confirm that your statement that only"a tiny minority"of pensioners have genuine difficulty in making ends meet is in fact wholly inaccurate and that your own official figures confirm that millions of pensioners are on low incomes and in poverty.

Finally I would be grateful to know why your new scheme for poor pensioners , outlined today ,was entirely absent from the briefing you gave the Sunday press on Friday. In particular it would be helpful to know the cost, the detail the time scale and the numbers who are to benefit ,and , indeed, whether any pensioner will benefit from these proposals this winter or next .I think you are aware that the very people you are now promising to help are the very people who suffered most as a result of the Housing Benefit changes and the imposition of the 20% rates requirement, and the loss of heating allowances and the replacement under the Social Fund of grants by loans .I hope you will agree that a Chancellor who wished to help the poorest pensioners would now withdraw these changes that have made large numbers of pensioners many pounds a week worse off

Yours faithfully,

Gordon Brown

Gordon Brown
Labour Treasury spokesman

6.1

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FROM: J P MCINTYRE
DATE: 25 November 1988

CHANCELLOR

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

CHILD BENEFIT/FAMILY CREDIT/INCOME SUPPORT

You asked for a further note on how family credit and income support are adjusted in relation to decisions on the level of child benefit.

Family Credit

2. I should perhaps first explain how family credit is made up. It comprises an adult credit (one per family) of £32.10 (1988-89 rate) and a series of child credits varying according to the ages of the children. Thus, for example, the maximum entitlement of a family with one child under 11 would be:

	£ per week (1988-89)
Adult credit	32.10
Child credit	6.05

	38.15

If the family earns more than £51.45 (the threshold for all three income-related benefits), each extra £1 of income results in a reduction of 70p in the maximum entitlement (the 70 per cent taper).

3. It is the child credit element in family credit which interacts with child benefit. For example, the under 11 credit for this year was determined as follows:

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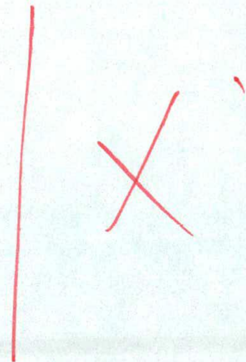
	£ per week
Income support rate for child under 11:	10.75
Deduct child benefit:	- 7.25
Add compensation for loss of free school meals:	2.55
∴ child credit	6.05



4. Thus child benefit is deducted from the child credits in family credit. However, in exchange, child benefit is not counted as income in determining family credit entitlements (it is so counted in income support).

5. There are therefore 3 elements in next April's uprating of the child credits in family credit.

i. a prices uprating by the ROSSI (RPI - housing) index. This is not required by statute, nor is there a pledge to do it. But in view of the government's commitment to family credit as a means of improving work incentives, it would be difficult to defend not uprating it.

ii. An increase of 45p to compensate for the non-uprating of child benefit. Because child benefit is not included in the calculation of the child credits, family credit families would not be compensated for a child benefit freeze by merely uprating the child credits themselves. So the "45p" has to be added on separately. This is not, DSS advise us, a statutory requirement. We have discretion, subject to the proposed rates being approved in the annual uprating orders. But the addition is necessary to enable us to say that low income families are unaffected by a child benefit freeze.

iii. An increase of 50p over and above the prices uprating and the 45p compensation for the child benefit freeze. This is of course also discretionary and will be achieved through the uprating order.

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6. Thus the new child credit rate for children under 11 next year will be:

	£ per week
Existing rate:	6.05
ROSSI uprating (4.7%):	0.30
CB compensation:	0.45
Additional 50p:	0.50

	7.30

Comparison with income support

7. Family credit families are treated slightly differently from income support families. Child benefit is uprated by the RPI, and family credit families get this increase either directly, if child benefit itself is uprated, or through extra family credit. Either way, they get the value of the RPI uprating of child benefit.

8. The position of income support families is more complex. As with family credit, it makes no difference to them whether or not child benefit is uprated. If it is uprated, then the uprating is simply docked off their income support. If it is not uprated, their income support is uprated in full by ROSSI, with no additional amount docked off. Either way, they end up with the same amount of income support and child benefit combined.

9. It could be argued (though no one has apparently raised this with DSS) that income support families are inadequately compensated for a child benefit freeze because ROSSI tends to go up by less than the RPI. The answers to this are:

i. the child allowances in income support are larger than child benefit eg the smallest allowance, for under 11s, is £10.75 this year. A ROSSI uprating of this is 50p, compared with the 45p which would have resulted from a child benefit uprating. So income support families do not lose out.

some might argue that they shd have got both ie 95p, as FC recipients seem to "get both"

ii. ROSSI is the right index for uprating income support, because housing costs are dealt with through housing benefit.

iii. In some years, ROSSI may go up faster than the RPI.

Conclusions

10. Although income support and family credit work in different ways, it is the case for both that it makes no difference to recipients whether or not child benefit is uprated. In the event of a child benefit freeze, there is full, direct compensation for family credit families (though we have discretion not to compensate). In income support, the compensation is more complex. But because the child allowances in income support are significantly larger than child benefit itself, a ROSSI uprating should normally be enough to give them at least the equivalent of a child benefit uprating by the RPI.

Y |||

JM

J P MCINTYRE

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[Ch - This cd make the Review look pretty silly if not handled correctly - MPW]

FROM: MISS M E PEIRSON

DATE: 25 NOVEMBER 1988

CHIEF SECRETARY

cc Chancellor
Mr Anson
Mr Phillips
Mr McIntyre
Mr Saunders
Mr D Rayner

GRIFFITHS REPORT ON COMMUNITY CARE

1. Mr Clarke, Mr Ridley and Mr Moore are meeting on Tuesday to discuss. You have been invited, but may not be able to go. That is a pity, because you would doubtless wish to listen to the arguments and to influence them; but you will have a chance to intervene when Mr Clarke puts proposals to the Prime Minister. The purpose of this note is to bring you up to date on what the ideas canvassed at Tuesday's meeting seem likely to be.

2. The Prime Minister, I understand, suggested yesterday that the Griffiths solution of giving full responsibility to the local authorities should be ruled out. You and Mr Clarke were already initially opposed to that solution, but Mr Clarke's officials hope to persuade him that, with sufficient controls, it is the best idea. Mr Ridley favours the local authority solution, though his officials are not sure how strongly. Mr Moore is not thought to feel strongly. There remains a chance, therefore, that Mr Clarke will, depending on the outcome of Tuesday's meeting, wish to persuade the Prime Minister that a local authority solution should be adopted, though with more controls than in the Grffiths proposals.

3. Those controls are discussed briefly below. But first, the main alternatives to local authorities would be:-

i) Health authorities: scarcely a runner, since they will have to cope with all the Health Review changes.

ii) Primary care authorities (based on FPCs): initially favoured by Mr Clarke, but now probably ruled out (his officals think) by the decision in the health review to merge DHAs and FPCs in the medium term.

iii) Community care authorities (new central government organisations, like the NHS): Mr Clarke's second choice, but very disruptive and expensive to set up, damaging to the rest of social services, and likely to become strong pressure groups for increased funding.

iv) No (or little) change: damaging politically, and offering no prospect of restraint on the astronomical growth of social security payments to people living in private sector residential care homes. Unless assessment of need is combined under one authority with financial responsibility for all forms of care, we achieve no real improvement on the present situation.

4. The sorts of controls which DH envisage imposing on local authorities are: legislative provision to oblige them to have free competition (between themselves and the private sector) for the

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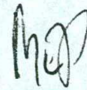
provision of residential care, with the same regulations applying to all; and a requirement of satisfactory management plans, to be approved and monitored by DH, before LAs are given any more money than the initial amount of social security already being spent on people in their areas.



MISS M E PEIRSON

MP

community care

Ch/

Prompted by your comment on Margaret's minute behind, I have found out a little more about the arithmetic of benefit for people in residential care. It turns out that they don't actually get "full" income support on top of the cost of their board and lodging. Instead they get an allowance of £9.25 (a 1987 figure, which must be a little higher now) for personal expenses ie pocket money .

The real scandal, of course, is the money the individuals never see, which goes straight to the owners of the homes. It is subject to statutory limits, but they're pretty high (see uprating statement behind). And of course, every time the limits are raised the homes just increase their prices.

MP

[illegible]AIN BENEFIT RATES — APRIL 1989

(Weekly rates unless shown)	Old £	New £
Attendance Allowance		
Higher	32.95	34.90
Lower	22.00	23.30
Child Benefit — each child	7.25	7.25
Child's Special Allowance	8.40	8.95
Guardian's Allowance — each child	8.40	8.95
Industrial Death Benefit—widow's pension		
Higher rate	41.15	43.60
Lower rate	12.35	13.08
Industrial Disablement Pension (18 and over)		
100%	67.20	71.20
20%	13.44	14.24
Invalid Care Allowance	24.75	26.20
Invalidity Benefit		
Invalidity pension	41.15	43.60
Invalidity allowance		
Higher	8.65	9.20
Middle	5.50	5.80
Lower	2.75	2.90
Maternity Allowance	31.30	33.20
Mobility Allowance	23.05	24.40
One Parent Benefit	4.90	5.20
Retirement Pension		
Full rate	41.15	43.60
Husband's insurance	24.75	26.20
Married couple	65.80	69.80
Contributions before 1948/over 80s	24.75	26.20
Additional pension, guaranteed minimum pension and graduated retirement benefit	increased by 5.9%	
Increments to basic and additional pension, guaranteed minimum pension and graduated retirement benefit	increased by 5.9%	
Graduated retirement benefit (unit) (pence)	5.39	5.71
Prescribed maximum amount of additional pension (also applies to widow's and invalidity benefits) (from 6 April)	34.75	41.71
Addition at age 80	.25	.25
Severe Disablement Allowance	24.75	26.20
Sickness Benefit		
Over pension age	39.45	41.80
Under pension age	31.30	33.20
Statutory Maternity Pay		
Earnings threshold	41.00	43.00
Lower rate	34.25	36.25
Statutory Sick Pay		
Earnings threshold	41.00	43.00
Standard rate threshold	79.50	84.00
Lower rate	34.25	36.25
Standard rate	49.20	52.10
Unemployment Benefit		
Over pension age	41.15	43.60
Under pension age	32.75	34.70
Occupational pension abatement	35.00	35.00
Widow's Benefit		
Widow's payment (lump sum)	1000.00	1000.00
Widowed mother's allowance	41.15	43.60
Widow's pension — standard rate	41.15	43.60

INCOME SUPPORT

Maximum amounts for accommodation and meals in Residential Care Homes	Old £	New £
old age	130.00	140.00
very dependent elderly	155.00	155.00
physical disablement		
(under pension age)	190.00	200.00
(over pension age)	130.00	140.00
Nursing Homes		
terminal illness	230.00	235.00
physical disablement		
(under pension age)	230.00	235.00
(over pension age)	185.00	190.00
Family Credit		
Adult Credit	32.10	33.60
Child Credit		
under 11	6.05	7.30
11-15	11.40	12.90
16-17	14.70	16.35
18	21.35	23.30

EARNING RULES

Retirement pension, invalid care allowance, unemployment benefit - all unchanged.	Old £	New £
Industrial injuries unemployability, permitted earnings (p.a.)	1404.00	1482.00
War pensioners' unemployability supplement permitted earnings level (annual amount)	1404.00	1482.00

WA[illegible] Friday October 28 1988

Disablement pension (100% rates)	Old £	New £
private or equivalent (p.w.)	67.20	71.20
officer (p.a.)	3504.00	3712.00
Age allowances		
40%-50%	4.70	5.00
over 50%	7.30	7.75
over 70%	10.45	11.10
over 90%	14.60	15.50
Unemployability allowance		
personal	43.70	46.30
adult dependency increase	24.75	26.20
increase for each child	8.40	8.95
Invalidity allowance		
higher	8.65	9.20
middle	5.50	5.80
lower	2.75	2.90
Constant attendance allowance		
exceptional	53.80	57.00
intermediate	40.35	42.75
normal maximum	26.90	28.50
part-time	13.45	14.25
Comforts allowance		
higher	11.60	12.30
lower	5.80	6.15
Mobility supplement	25.60	27.10
Exceptionally severe disablement allowance	26.90	28.50
Clothing allowance (£ p.a.)		
higher	92.00	97.00
lower	58.00	61.00
Education allowance (£ p.a.) (max)	120.00	120.00
War widow's pension (private)		
widow	53.50	56.65
childless widow under 40	12.35	13.08
Age allowance		
(a) age 65 to 69	5.79	6.10
(b) age 70 to 79	11.50	12.20
(c) age 80 and over	12.00	12.60
Child addition	12.00	12.60
Orphan's pension	13.15	13.80
Unmarried dependant living as spouse (max)	51.45	54.60
Rent allowance (max)	20.35	21.55
Adult orphan's pension (max)	41.15	43.60
Widower's pension (max)	53.50	56.65

INCOME-RELATED BENEFITS

Income Support and Housing Benefit (Common Provisions Rates)	Old £	New £
Personal allowance rates		
Single, 25 or over	33.40	34.90
Lone parent, 18 or over	33.40	34.90
Couple (at least one age 18)	51.45	54.80
Dependant children		
under 11	10.75	11.75
11-15	16.10	17.35
16-17	19.40	20.80
18	26.05	27.40
Premiums		
Family	6.15	6.50
Lone parent: Income Support	3.70	3.90
Housing benefit	8.60	8.60
Pensioners		
single	10.65	11.20
couple	16.25	17.05
Pensioners (higher)		
single	13.05	13.70
couple	18.60	19.50
Disability		
single	13.05	13.70
couple	18.60	19.50
Severe disability		
single	24.75	26.20
couple (one disabled)	24.75	26.20
couple (both disabled)	49.50	52.40

3/36

[passed on to CST]

FROM: M A BOLTON
DATE: 25 NOVEMBER 1988

1. MR MCINTYRE JM 25/11

2. CHIEF SECRETARY

cc Chancellor
Financial Secretary
Economic Secretary
Paymaster General
MCU
Mr Anson
Mr Phillips
Miss Peirson
Mr Gieve
Mr Saunders
Mr Ramsden
Mrs Chaplin
Mr Tyrie
Mr Call

Ch/ On x, I suppose organisations like Age Concern + any other biggies might merit a CST reply? MPW.

only the real biggies -

CORRESPONDENCE ON PENSIONERS

We have received 94 letters from MPs about benefits for pensioners. These can mostly be answered on standard lines. Before submitting separate replies to all these letters, it would be helpful to know if you are content with the attached 'core' draft. I will of course cover any non-standard points raised by individual MPs or their constituents as necessary.

2. We have also received roughly 300 letters from members of the public and a few letters from organisations representing pensioners. I understand that you are now content for officials to reply to the former, since Mr Moore has made his announcement. X Would you also wish officials to reply to the organisations which have written? And are you content for the replies to follow the terms of the reply to MPs?

Michael Bolton
M A BOLTON

✓

* I have made a number of changes to the draft. The CST may want to make more!

DRAFT REPLY TO CORRESPONDENCE ON PENSIONERS

I should first emphasise that the Government is fully committed to maintaining the value of the state retirement pension on its present contributory basis. The basic retirement pension has been, and will be, uprated each year in line with the increase in prices.

I can also confirm that there is no foundation in suggestions that the Government is planning to ~~change the existing rule exempting~~ [means-test] pensioners ~~from~~ [for] prescription charges. Nor are there plans to means-test the payment of the Christmas bonus. Indeed, the Government has ensured payment of the bonus automatically each year by making it a legal requirement.

However, one of the main aims in our social security policy is to bring additional help to those who need it most. As you know, in line with this policy, John Moore has announced on 24 November extra help to poorer pensioners who are aged 75 or above or are disabled. Altogether 2½ million pensioners will gain from this extra help. Single pensioners in these groups will receive an extra £2.50 per week in Income Support, and couples an extra £3.50, with effect from October 1989. These changes will benefit not only the poorest pensioners on Income Support, but those whose incomes are just over the qualifying level for Income Support, because they will also raise the income level at which pensioners can obtain help through Housing Benefit. This extra help will cost approximately £195 million in a full year. The increases will be in addition to those already announced for next April.

Finally, I think it is right to put these changes in the context of what has been happening to pensioners' incomes generally. Pensioners have greatly benefited from the success of the Government's economic policies. In particular, their savings have been protected by the control of inflation, and the amounts being paid out in SERPS and occupational pensions have been rising. As a

[Handwritten annotations: "spell out" (SERPS); "the number of pensioners with significant entitlements to"; "has"; "And the number of pensioners with additional sources of income over and above the state pension has also been rising."]

result, pensioners' average net incomes rose by 23 per cent in real terms between 1979 and 1986, a far greater increase than in the preceding period of very high inflation. John Moore's initiative recognises that, while many pensioners have been doing better, some older and disabled pensioners with little or no income apart from their basic state pension, deserve more help.

JOHN MAJOR

CONFIDENTIAL

2 MARSHAM STREET
LONDON SW1P 3EB
01-276 3000

My ref:

Your ref:

The Rt Hon John Wakeham MP
Lord President of the Council
Privy Council Office
68 Whitehall
LONDON
SW1

CH/EXCHEQUER
REC. 28 NOV 1988
ACTION CST
COPIES TO

28/11

28 November 1988

Dear John

AUDIT OF THE NATIONAL HEALTH SERVICE

We are to meet shortly with colleagues to discuss the possibility of incorporating into the Local Government and Housing Bill provisions to extend the role of the Audit Commission to cover the Health Service. I enclose a paper prepared by the Steering Group of officials which examines the options for early legislation in my Bill and which we can perhaps consider at our meeting.

As you know I had originally preferred proceeding with the full implementation of the whole proposal in one go rather than a two stage process. It is beginning to look as though that is not viable in the time. I am not, as I have said, very attracted to options in the paper for furthering paving or enabling provisions in my Bill since I fear they may embroil me in Parliament on a whole range of constitutional and PAC concerns*. I am however willing to go along with colleagues' views on these if it is felt that there is a compelling case for taking some provisions in this area in advance of full legislation on the Health Service Review.

Whatever course of action we decide upon we clearly ought to take a decision in the near future so that Parliamentary Counsel can be properly instructed. I hope it will be possible for us to get together within the next two weeks.

I am copying this letter to Kenneth Clarke, Peter Walker and Nigel Lawson.

* We could open up the whole debate about the Audit of the Nationalized Industries which we had a few years ago!

Yours ever

NICHOLAS RIDLEY

Nicholas

CONFIDENTIAL

AUDIT COMMISSION AND THE NATIONAL HEALTH SERVICE

DRAFT NOTE TO MINISTERS ON THE LEGISLATIVE OPTIONS

1. Ministers have agreed in principle that the Audit Commission should take over the statutory audit of the National Health Service including regularity and propriety audit and value for money studies.

2. There is no health legislation proposed for the 1988/89 session which would be a suitable vehicle for implementing this proposal. Early legislation would enable the Audit Commission to become effective in the NHS at least a year sooner than waiting for main health legislation. Officials were therefore asked to explore whether it would be possible to include suitable provisions in the Local Government and Housing Bill in the 1988/89 session.

Options

3. Officials have identified three options for early action in the Local Government and Housing Bill in the 1988/89 session:

(i) Full implementation of the whole proposal, giving full statutory responsibility for the audit of the Health Service to the Audit Commission, and resolving all questions about its relationship to the Secretaries of State for Health and for Wales and to the National Audit Office and the PAC.

(ii) A paving provision enabling the Audit Commission to undertake some audit and value for money work in the Health Service field under contract to the Secretaries of State for Health and for Wales; so as to enable them to begin to build up experience in the Health Service field and make an early impact on vfm issues before full implementation in later legislation.

(iii) A more general enabling power for the Audit Commission to undertake audit work and/or value for money studies within some defined non local government areas at the request or with the approval of the relevant Secretary of State.

Option 1

4. A note of some of the issues that will need to be considered and resolved in implementing the full proposal is attached at Annex A. On many of these issues it will probably be sufficient to replicate the Audit Commission's present statutory regime - which is set out in 28 sections in the Local Government Finance Act 1982 - with suitable modifications to apply it to the Health Service. Officials estimate that this could require 10 or more clauses in a Bill. (Alternatively, this could be done in subordinate legislation which would reduce the number of clauses in the Bill to those required to empower the Secretary of State for Health to make regulations, to bring about any structural changes which might be required to the Commission and to amend the powers for payment of money to the Commission.) But there are a few

issues which will be difficult, which will require very careful analysis and consideration by Ministers and which may result in a need for further clauses. The most important are:

(i) The relationship between the Secretaries of State for Health and for Wales (and their Accounting Officers) and the Audit Commission with particular regard to the quantity and quality of regularity audit and the commissioning of special studies;

(ii) The degree of independence to be allowed to the Audit Commission in choosing subjects for value for money studies and in publishing its findings, coupled with the degree of influence to be retained for the Secretaries of State for Health and for Wales over these matters;

(iii) The relationship between the Audit Commission and the NAO, and the arrangements for ensuring that they work effectively together without unnecessary overlap or conflict; and beyond that the arrangements for Parliamentary and PAC oversight of audit work in the Health Service field.

5. Timing issues would be difficult under this option. There is a good deal of work to resolve all the issues at Annex A during the next few weeks. It would also impose additional burdens on Parliamentary Counsel's drafting resources which are already heavily stretched for the Local Government and Housing Bill.

6. Presentationally it would be difficult to include provisions in the Local Government and Housing Bill if that has to be published before the Health Service Review is completed, unless Ministers were willing to announce the proposals for the audit of the Health Service in advance of the rest of the Health Service Review conclusions. That however would run the risk of opening up debate on the NHS review more generally before Ministers were ready. Inclusion of the whole package in the Local Government and Housing Bill could also therefore delay progress on the Bill in Parliament which is already tightly time-tabled because of its late introduction.

Option 2

7. At present the Audit Commission is only allowed to do audit and value for money work in relation to local government. It has no powers to undertake work in any other field. It could not therefore do anything to prepare for Health Service audit until it receive the appropriate powers and the ability to charge for work done. Apart from the organisational adjustments and training, it will need time to prepare the ground particularly on the value for money side where national studies are normally undertaken in the year preceding local value for money audits. The second option identified by officials would therefore be a paving provision to enable the Audit Commission to undertake some preliminary training, audit and value for money work for the Health Service under contract to the Secretaries of State for Health and for Wales.

8. This would be a simple provision, not requiring more than one clause, and would enable the Audit Commission to build up early experience in Health Service matters, without making any other change to the present statutory arrangements for the audit of the Health Service. Under such a provision as this the Audit Commission and its auditors would be on a similar footing to the private sector auditors or consultants whom the Secretary of State for Health already uses for parts

of statutory audit work for the Health Service. This would thus be essentially a temporary arrangement pending full Health Service legislation in a later session.

9. There would be no timing difficulties about legislating in this way. And the proposal could be defended in Parliament on the basis that it would in any case be useful for the Secretary of State of Health to be able to employ the Audit Commission from time to time on audit and value for money work, whatever longer term arrangements are made about the full statutory audit. But such a presentation might seem disingenuous if followed within a couple of months by an announcement that the Audit Commission were to take over the statutory responsibility. Alternatively, therefore Ministers may wish to announce at this stage their long-term intentions and explain to Parliament that this enabling power precedes further substantive legislation. 'Health' would appear in the long title of the Bill so that the Secretaries of State for Health and for Wales could answer any wider debate which may arise on matters concerning the control of and accountability for Health Service expenditure. The option would remain open of introducing the full provisions later on amendment if that seemed feasible and desirable once the Health Service Review is published.

This option would also run the risk of premature debate of the NHS review. Parliamentary Counsel's preliminary view is that with appropriate references to amendment of the 1982 Act in the long title (the Bill may include another unrelated amendment to that Act) it might be possible to introduce this provision by amendment during the Bill's passage but this is uncertain and could well run into difficulties with scope with in the Commons.

Option 3

10. This option is for a more general power to enable the Audit Commission to undertake audit or value for money work within some more widely defined area of operations by agreement with the appropriate Secretary of State on a contractual basis and perhaps only after consultation with the C and A G. This would again be a simple provision of a single clause. Various other areas have already been suggested from time to time as possibilities for useful Audit Commission work (e.g. the Housing Association field, DTp's highway agency arrangements, Local Government Boundary Commission). And arrangements on these lines have already been enacted in Section 220 of the Education Reform Act 1988 to enable the Audit Commission to be appointed on a competitive tender basis to do work for the polytechnics and for contracted-out schools.

11. A general power to operate on a wider basis in this way if requested by the relevant Secretary of State could be useful in itself, and would enable preliminary work to be done in the Health Service field without giving undue prominence to the full Health Service proposals if these are not yet fully developed or announced. However, by the same token it would not open the way for any fuller Health participation in the Parliamentary debate which might well arise once the NHS review was published and it became clear what a main use of this provision would be. Also, it would give the Audit Commission a potentially very wide scope which could over-stretch it if it was too widely used. To guard against this the Secretary of State might make clear that in general he would only approve such work by the Audit Commission in limited areas of the public sector where they might be able to contribute particular expertise. Once the Health Service Review is published he might indicate that some preliminary studies by the Commission in the Health Service field could be a possible use of the power.

CONFIDENTIAL

AUDIT COMMISSION AND THE NATIONAL HEALTH SERVICE

POINTS FOR LEGISLATION

1. Name of Commission

Under existing statute, the Local Government Finance Act 1982 (the 1982 Act), the long title of the Audit Commission is the 'Audit Commission for Local Authorities in England and Wales'. The long title of the expanded Commission might be the 'Audit Commission for Local Authorities and the National Health Service in England and Wales'.

2. Number of members of Commission

The 1982 Act provides that there shall be not less than 13 nor more than 17 members of the Commission. The maximum number of members might be increased to 20: comprising very roughly 8 with local government interests, 6 generalists and 6 with health service interests, though in some cases those appointed may have overlapping experience.

3. Appointment procedures for members, chairman and deputy chairman

The 1982 Act provides for the Secretary of State to make these appointments after consultation with interested organisations. There would be no difficulty in the Secretaries of State for Health and for Wales appointing the health service members in the same way as the Secretary of State for Wales currently appoints Welsh members. The Secretary of State for the Environment would continue to take the lead in appointing the chairman. Further thought would need to be given to the consultation provisions on appointments.

4. Sub-structure of Commission

The Commission is currently required to appoint a chief executive and such other officers as it considers necessary. Questions of how the extended Commission structures its operations might be best left to the Commission to determine. If a sub-structure were set out in legislation this might prove an unwelcome restriction on the Commission's management freedom and also give the appearance of an intention to create separate bodies dealing with health and local government.

5. Duties of Commission in relation to the Health Service

Further detailed consideration is being given in the Working Group to the duties of the Commission in relation to the NHS. These are likely to duplicate most of the Commission's existing duties under the 1982 Act and to include:

- appointing auditors;
- carrying out or promoting value for money studies;
- certification of grant and other claims;
- providing advice/carrying out other studies;
- prescribing a scale of audit fees;
- preparing a code of audit practice;
- directing a special investigation.

6. Duties of auditors

The Working Group is also giving further detailed consideration to the duties to be required of auditors. Under the 1982 Act these include:

- certifying accounts in relation to regularity and propriety;
- conducting value for money audits;
- reporting on matters of concern;
- taking action in respect of fraud and corruption;
- revealing unlawful expenditure and loss;
- taking preemptive action to prevent unlawful expenditure and loss by issuing 'stop' orders or seeking judicial review.

7. Bodies subject to audit

Under the 1982 Act those bodies specified in the Act are required to have their accounts audited by an auditor appointed by the Commission. Other bodies who appear to the Secretary of State to be concerned with local government may by agreement with the Commission and with his approval have their accounts audited by the Commission's auditors. A similar arrangement might be applied to the Health Service with health authorities and FPCs subject to statutory Commission audit and other related bodies audited by agreement.

8. Reporting procedures

Audit reports would go to the health authority copied to the Secretary of State and the Commission. National value for money studies would go to the Secretary of State. The detailed procedures for reporting, clearance and publication could be dealt with in the audit code of practice.

9. Fees and payment

Under the 1982 Act the Commission is required to meet its expenditure from income. It sets a scale of audit fees (subject to Ministerial veto) sufficient to cover both the costs of its audit and central value for money work and charges audited bodies directly. Similar arrangements could be applied in the Health Service.

10. Functions and powers of the Secretary of State for Health

The 1982 Act gives the Secretary of State a number of functions in relation to the Commission (see attachment). The Working Group is considering what, if any, further powers or functions might be needed in relation to health service audit.

11. Answerability of the Commission and its auditors in respect of their powers and duties

The 1982 Act provides that the C&AG examines the Commission's annual statement of accounts and reports to Parliament on it; and the Commission and the auditors it appoints are answerable to the courts in respect of their statutory duties and powers. The Commission would continue to produce a single annual report and statement of accounts for Parliament but the financial statement would need to identify local government and health separately.

12. Relationship with NAO

The Working Group is giving further consideration to the relationship between the Commission and the NAO, the arrangements for ensuring they work effectively together and for Parliamentary and PAC oversight of audit work in the Health Service.

13. Employment of NHS audit staff

DoH and the Welsh Office are discussing with the Commission possible arrangements for the transfer of audit staff and whether statutory provisions are needed.

CONFIDENTIAL

FROM: J P MCINTYRE
DATE: 28 November 1988

Thanks. 2. I agree with X: hence my suggestion to Mr Tyrie.

CHANCELLOR

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

POORER PENSIONERS

One of the main points made by Mr Cook, in his speech following Mr Moore's announcement on Thursday of last week, was that the additional £200 million now being provided for pensioners had to be compared with £5 billion of savings which the government has made from uprating the basic pension by prices rather than earnings. It is possible that the Opposition may repeat this line in the economic debate and elsewhere.

2. DSS Ministers will be giving more details on all this when they write in response to a written PQ from Nicholas Brown left over from the last session. Their answer will show that if the basic pension had been uprated in line with earnings since 1979:

- the April 1988 rate of basic pension would have been £7.95 higher for a single pensioner (£12.75 for a couple).

- the cumulative increase, in 1988 prices, would have been £1,404 pa for a single pensioner (£2,246 for a couple).

- public expenditure would be £3.73 billion higher in 1988-89.

- the cumulative increase in public expenditure would have been £12.97 billion in 1988 prices.

3. These figures do not match Mr Cook's. He said the weekly pension would be £11 higher (£18 for couples) and put the Government's saving from uprating by prices at £5 billion. It is not clear how his figures were compiled. They may be based on the 1989 pension rate, which would account for some of the discrepancy.

4. In winding up Thursday's debate, Mr Fowler did not address Mr Cook's point. But DSS officials agree that one way of responding would be to point to the average increase in pensioners' total income (other than the basic pension) since 1979. Figures are only available for 1979-86: they show that income from sources other that social security benefits rose by £9.70p per week, ie more than the discrepancy of £7.95 if pensions had gone up in line with earnings (and the margin will of course have widened since 1986). Some care is needed in putting together figures from different sources covering different periods. But I have added this point to our Q&A briefing (attached).

5. Apropos Mr Tyrie's minute of 25 November (not copied to all), I must say that I think Mr Cooke's statement during the debate ("we would restore the link with earnings") is at least ambiguous and more likely to mean that Labour would undertake to uprate the basic pension in line with earnings once they had returned to office, not that they would immediately increase the basic pension by £11 (£18 for couples) to bring the level up to what it would have been with earnings upratings since 1979.

pp J P MCINTYRE

Pensioners

FACTUAL

(i) Changes will increase Income Support paid to pensioners aged 75 and above (and disabled pensioners over 60) by £2.50 a week for single pensioners and £3.50 for couples, over and above the new Income Support rates already announced for 1989-90. Increases to take effect in October next year. Increases in rates will be around 5 per cent on top of those already announced for 1989-90.

(ii) Income Support levels for pensioners after implementation of next October's increases:

£ per week

Age:	60-74		75-79		80+ (and disabled)	
	SINGLE	COUPLE	SINGLE	COUPLE	SINGLE	COUPLE
	46.10	71.85	48.60	75.35	51.10	77.80

(iii) Number of gainers nearly 2 million single pensioners and couples:

880,000	on Income Support and Housing Benefit
990,000*	on Housing Benefit alone
60,000	newly eligible for Income Support
40,000*	newly eligible for Housing Benefit
1,970,000	

* No. of gainers in 1990-91 (Community Charge will increase nos entitled to HB.)

Number of individual pensioners gaining: about 2½ million.

(iv) Cost: £195 million in extra benefit expenditure in full year. Less than £100 million in 1989-90 because of October implementation. Cost will be additional to existing DSS plans. Will be met from Reserves, within planning totals. Will not therefore add to total public expenditure.

(v) Total number of individuals above state retirement pension age now on:

Income Support and Housing Benefit: 1.75 million
Housing Benefit only: 1.75 million

A further 0.2 million, mainly men aged 60-64, qualify for pensioner premium in income support.

(vi) Total number of single pensioners and pensioner couples drawing state retirement pension: 7 million.

(vii) Total number of pensioners (individuals) getting state retirement pension: 9¾ million.

(viii) Basic pension rates for 1989-90

Single: £43.60. Couple: £69.80.

(ix) Take-up of means-tested benefits (latest evidence):

	Proportion of recipients entitled	Proportion of expenditure if all those entitled were to claim
INCOME SUPPORT[1]:	76 per cent	89 per cent
HOUSING BENEFIT[1]:	77 per cent	88 per cent
FAMILY CREDIT[2]:	40 per cent	60 per cent

[1] Estimate of total number entitled based on 1984 FES data. Take-up may well have increased since then.

[2] Based on FC caseload data up to end-October 1988, and assuming FIS take-up in 1987-88 of 50 per cent for caseload and 70 per cent for expenditure. (Estimates of total number entitled to FC were based on estimates for FIS in 1987-88. They are therefore highly uncertain.)

(x) Take-up of means-tested benefits BY PENSIONERS (latest evidence):

	Proportion of recipients entitled	Proportion of expenditure if all those entitled were to claim
INCOME SUPPORT[1]	67 per cent	79 per cent
HOUSING BENEFIT[1]	81 per cent	91 per cent

[1] Estimate of total number entitled based on 1984 FES data

(xi) Pledged Benefits (accounting for 60 per cent of programme)

Retirement Pension
Widows Benefit
Industrial Disablement Benefit
War Pension
Invalid Care Allowance
Attendance Allowance
Income Support for Pensioners
Invalidity Pension
Severe Disablement Allowance
Guardian Allowance

In addition, there is a statutory requirement to uprate unemployment benefit, sickness benefit, and maternity allowance though these are not pledged.

POSITIVE

(i) Average real incomes of pensioners rose 23 per cent between 1979 and 1986 (3 per cent between 1974 and 1979).

(ii) On average, pensioners' total incomes have risen twice as fast as those of population as a whole (1979 to 1986).

(iii) Proportion of pensioners in lowest 20 per cent of income distribution has fallen from 38 per cent in 1979 to 24 per cent in 1985.

(iv) Benefit expenditure on elderly has risen 27 per cent in real terms since 1979. Main reasons: 1 million extra pensioners and increase in SERPS expenditure (nearly 2 million SERPS recipients now; average SERP of someone retiring now is £25 per week versus £1 in 1979).

(v) Pensioners have shared in growing prosperity: eg 99 per cent own TV; 81 per cent a washing machine; 96 per cent a fridge.

DEFENSIVE

(i) **Why not help pensioners aged 60-74?**

Aim is to provide special help for older, poorer pensioners, who tend to be more frail, and disabled pensioners. Poorer pensioners in 60-74 age group will still be helped by income support and housing benefit.

(ii) **Why not implement now or in April 1989?**

Not practical. Local Authorities will first need to be consulted about changes to housing benefit. Then secondary legislation. Too late after that to include in April 1989 uprating which is already underway. But pensioners won't have to wait until next general uprating in April 1990 - extra amounts to be paid from next October.

(iii) **Changes are simple: Why not announced in uprating statement on 27 October?**

No decisions had been taken at that point.

(iv) **Panic response to Chancellor's briefing**

No. Announced now because decision has been taken. As Chancellor made clear, we have been considering for some time how best to provide additional help for older, poorer pensioners. Today's announcement is result of that process.

(v) **Has scheme been brought forward? Was it not planned for next year's Autumn Statement (ie for introduction in 1990)?**

We had discussed in Public Expenditure Survey provision of more help for poorer pensioners but agreed that further work was needed on options. We had not decided when to go ahead. We certainly brought forward announcement of our intentions (Chancellor on 7 November) and completed work on options in order to reassure many pensioners alarmed by misleading stories in press.

(vi) **Extra money only provided because of reaction to Chancellor's briefing**

No. Additional help for poorer pensioners discussed both before and during Public Expenditure Survey, well before Chancellor's briefing. Agreed in Survey that further work was necessary on how best to achieve this, although principle of extra help was firmly agreed.

(vii) **Chancellor's briefing revealed hidden agenda for means-testing**

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

(viii) **Agree that only "tiny minority" of pensioners have difficulty making ends meet?**

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

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

No. This is simply false.

(x) **Why did government leave it until Monday 7 November to deny the Sunday stories?**

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

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

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

(xii) **What about the tape recorder?**

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

(xiii) **Many poor pensioners will not claim**

Evidence is that most do claim. Many who don't claim have small entitlements. In any case, those already receiving income support and housing benefit will get the increases automatically; they will not need to make fresh claims. And DSS will take additional steps to publicise these benefits next year, to bring them to attention of those who do not now claim.

(xiv) **What does £195 million costing assume about take-up?**

Assumes existing case-load ie no increase in take-up above current levels is assumed.

(xv) **2 million gainers: tiny minority?**

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

(xvi) **Increases will add 100,000 to numbers on means-tested benefits: is this reducing dependency culture?**

Inevitable result of extra help for those most in need. Other government measures, such as encouragement of personal pensions and cuts in personal taxation, are aimed at reducing dependence on State. Over time, increasing amounts from SERPS, occupational schemes and personal pensions will reduce pensioners' dependence on means-tested benefits.

(xvii) **Why not increase the basic pension to help all pensioners, especially those just above benefit levels who won't gain from these changes?**

Would help many pensioners who don't need it and therefore poor use of extra resources. £195 million spent in this way would permit an increase of only 40p a week in basic pension, spread among 9¾ million pensioners.

(xviii) **Increases simply pay back money saved on pensioners in April 1988 reforms.**

No. Great majority of pensioners on income-related benefits (85 per cent) either gained from reforms or were unaffected in cash terms. Transitional protection has been paid to the poorest, on Income Support, to avoid cash losers. Government now using reformed structure of benefits to target additional help where most needed.

(xix) <u>**Position of pensioners getting transitional protection as a result of IS and HB changes in April 1988.**</u>

Neither Income Support for Housing Benefit transitional payments will be reduced by the amount of these increases. Transitional payments will be eroded at time of the normal upratings in April each year but not as result of these special increases next October.

(xx) <u>**Will pensioners' benefits be means-tested? eg Christmas Bonus, Attendance Allowance, Mobility Allowance**</u>

No plans to introduce means testing of any of these benefits.

(xxi) <u>**What provision in Autumn Statement for future upratings?**</u>

Plans assume full upratings of all benefits in April 1990 and April 1991. But, apart from pledged benefits, no decisions taken.

(xxii) <u>**Pensioners' exemption from prescription charges**</u>

No plans to change existing exemption.

(xxiii) <u>**Any changes to other NHS charges?**</u>

Cannot anticipate outcome of Health Review.

(xxiv) <u>**Basic pension would be £11 higher (£18 for couples) if gov't had uprated by earnings rather than prices since 1979. Now saving £5 billion a year by prices upratings**</u>

- Wrong to look at basic pension alone.

- pensioners' incomes from sources <u>other</u> than social security benefits increased, on average, by almost £10 per week between 1979-1986 (in 1985 prices).Overall result is that pensioners average net incomes rose 23% in real terms. (3% per year) during this period.

- (if necessary) Labour's record shows that real increases in basic pensions do not necessarily leave pensioners better off: income from <u>savings</u> actually fell under Labour and total incomes only rose by 0.6% per year.

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FROM: A C S ALLAN
DATE: 28 November 1988

MR TYRIE

cc PS/Chief Secretary
PS/Financial Secretary
PS/Paymaster General
PS/Economic Secretary
Mr McIntyre
Mr Turnbull
Mr N Forman MP
Mrs Chaplin
Mr Call

LABOUR PLEDGES ON PENSIONS

The Chancellor was grateful for your minute of 25 November. But he thinks the next backbench question must be to elucidate whether the pledge to restore the earnings link is prospective or retrospective. Then, we can cost it on a firm basis. At present the pledge is unclear - and may well be a matter of dispute within the Labour Front Bench.

ACSA

A C S ALLAN