Po-CH/NL/0223

PART II

Chex
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PART H

SECRET

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PART H

CHANCELLOR'S PAPERS ON
HEALTH AND SOCIAL
SECURITY SERVICES

Begins: 7/12/88

Ends: 14/12/88 (CONTINUED)

DD: 25 years

15/9/95

PO -CH /NL/0223
PART H

st.ln/min/1.6.12

CONFIDENTIAL

FROM: MISS M E PEIRSON
DATE: 7 DECEMBER 1988

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Mr Phillips
Mr McIntyre
Mr Potter
Mr Saunders
Mr D Rayner

GRIFFITHS REPORT ON COMMUNITY CARE

1. You asked for a brief note of the present arrangements for community care, the problems caused by them, and the Griffiths proposal.

Summary

2. The clients are mainly elderly people on income support requiring some degree of care. The problem is the enormously accelerating burden of social security payments for residential care for them, from £10 million in 1979 to nearly £1 billion in 1988-89 and (if present trends continue) £1½ billion in 1991-92. The solution (though it would only restrain that growth, not eliminate it) is to give one authority the full financial responsibility for all forms of care for such people, and the powers to assess their needs. Griffiths recommended that the relevant authority should be the local authorities; other possibilities are the health authorities or FPS but they are ruled out by the health review changes; that leaves a new central government authority (a community care authority). If all these solutions are unacceptable, a fall-back is to give the social security local offices the power and the duty to assess need (as well as means) before granting income support for the full costs of residential care.

Present arrangements

3. Community care is currently the responsibility of no single agency. The principal groups involved - the elderly, mentally ill, mentally handicapped and physically disabled - generally need mixed packages of health and non-health services. The **health services** required by these groups include community health services (eg district nursing) and general medical services, and are the responsibility of Health Authorities and the Family Practitioner Services. **Non-health services**, which are the subject of the Griffiths report and are generally provided by local authority social services and housing departments, include:

- **residential care** mainly for the elderly, ranging from intensive personal care to short term respite care. Around 45% of places are directly provided and managed by local authorities, which also sponsor people in private and voluntary residential homes;

- **day care services**, including adult training centres for the mentally handicapped and day centres mainly for the elderly. These services are virtually 100% directly provided and managed by local authorities;

- **domiciliary services**, mainly for the elderly - eg home helps and meals on wheels - also almost exclusively provided and run by local authorities;

- **housing services**, mainly sheltered housing units for the elderly and the physically handicapped, two thirds of which are directly provided and managed by local authorities. Housing is not discussed by Griffiths, nor further in this note.

4. A summary of the costs in 1985-86 in England of the publicly-funded services, excluding housing and general medical services, is shown in table 1 attached. Activity levels in 1986 for both private and public sectors are shown in table 2. The private and voluntary sector contribution to non-health care includes over

half of residential care places, and about a third of sheltered housing places, but very little day or domiciliary care. Table 2 shows also that the large numbers in residential care are the elderly: the mentally ill, whom Mr Clarke wishes to treat differently, are fairly few.

The problem

5. During the 1980s, supplementary benefit became available to help meet fees in independent care homes, thus making this form of care seem artificially cheap to clients and statutory providers. People may enter private or voluntarily-provided residential care at will and, if they qualify for income support, DSS foot the entire bill (board, lodging and care). In other words, DSS operate a means test but not a care test.

6. As a result, expenditure on social security payments for residential care has risen dramatically, from £10 million in 1979 to around £980 million by 1988-89, and if present trends continue will reach £1½ billion by 1991-92. Half of those in private sector homes now have their expenses met from benefit, compared with only 10 per cent in 1981. Residents in local authority homes do not qualify for such support, and so the growth of local authority homes has virtually halted.

The solution

7. The essential method of removing that perverse financial incentive, and introducing some restraint on the growth in social security payments for residential care, is as follows. One public sector authority must be given total financial responsibility for all forms of non-health care, and the powers to decide what form a client requires. That is, that authority would assess the need of the client, whether for domiciliary services, day care services, or residential care. That authority would then finance the care required. (All of this applies only to clients who qualify for income support. That is, DSS could continue to operate the means test, whatever authority were given the responsibility for community care.)

8. The authority given this overall responsibility for non-health care need not provide the services. It could buy them. Private sector provision of domiciliary care might take some time to develop, especially in rural areas, but the management of the present local authority services could be contracted out.

9. The new authority would be given a budget initially comprising the present costs of local authorities and the present social security expenditure on people in residential care, minus an allowance for ordinary income support and housing benefit for their clients. That is, in future anyone eligible for income support - including those in LA homes - would get it from DSS in the normal way (plus normal housing benefit), but the new authority would pay for all "care" on top of that.

Choice of responsible authority

10. The various reports which have studied the problem (the Firth Report, the Griffiths Report, and the recent Interdepartmental - Halliday - Report have all concluded that the local authorities should be the responsible authority. Local authorities have statutory responsibilities for looking after their residents in various ways; they provide many of the services required; the assessment of need could most easily be done by their existing social workers. And the Halliday Report in particular made various suggestions to ensure that the local authorities did not abuse their new powers: a statutory requirement on LAs to introduce free competition for the provision of residential care, and to offer choice to consumers; the same regulations to apply to both LAs and the private sector; and a requirement on local authorities to produce satisfactory management plans, to be approved and monitored by DH, before their budgets were increased. At the meeting on 29 November, Mr Ridley added the idea of using the Social Services Inspectorate to monitor the quality of assessment and the provision of care.

11. But other authorities could be given the job. The ideas for giving it to an existing health care agency (the health

authorities or the family practitioners service) now seem ruled out, since such agencies will have enough to cope with following the health review. That leaves a new community care authority, ie a new central government structure or quango.

12. A new community care authority might be organised rather like the health authorities. It would take over from the local authorities the financial responsibility for their services, and would need to set up its own staff for assessing need. It would however be initially expensive and disruptive, and could cause problems over the conflict between its responsibility and the remaining statutory responsibilities of the local authorities.

Half solution

13. If none of the above solutions is acceptable, there is the half-solution of asking DSS local offices to assess need. It is not really feasible to think of the DSS taking over full responsibility for buying and financing all the care services required. If we headed down that road, we would end up with the new community care authority, which has really nothing to do with social security. But it would be better than nothing to give the social security offices a requirement to assess need for residential care, as well as to apply the means test. Since they would have no powers or responsibilities as regards the provision of alternative services, this is very much a second best solution: the local authorities could simply refuse or fail to supply the necessary domiciliary or day care services, and the social security officers might feel forced to accept the need for residential care. Any restraint on the growth of the social security payments would therefore be less than might be expected under any of the other solutions discussed above.

Specific grant

14. One point to watch is that if LAs should be given the job, Mr Clarke wants to give them large and continuing specific grant for the purpose. I have opposed DH's views on this, arguing that LAs should get only a transitional specific grant, limited to the

initial care costs of existing residents in private sector homes (less the income support etc to be given to existing residents of LA homes), and phased out as they die. Mr Ridley will support you in preferring block grant.

Conclusion

15. I recommend that preferably the local authorities or alternatively a new community care authority be given full financial responsibility for all forms of non-health care of the elderly on income support. Failing that, however, social security officers should be given the power and duty to assess need for residential care as well as means.

MEP

MISS M E PEIRSON

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COMMUNITY CARE: PUBLIC EXPENDITURE IN ENGLAND (1985-86)

TABLE 1

£ million

DOMICILIARY SERVICES		DAY CARE SERVICES		RESIDENTIAL CARE	
LOCAL AUTHORITY DOMICILIARY SERVICES		**LOCAL AUTHORITY DAY CARE PROVISION**		**LOCAL AUTHORITY RESIDENTIAL CARE PROVISION**	
HOME HELPS	327	ELDERLY	60	ELDERLY	655
MEALS ON WHEELS	56	YOUNG PHYSICALLY DISABLED	26	YOUNG DISABLED	47
AIDS AND ADAPTATIONS	37	ADULT TRAINING CENTRES FOR MENTALLY HANDICAPPED	117	MENTAL HANDICAP: CHILDREN	39
				: ADULTS	105
		MENTALLY ILL	19	MENTAL ILLNESS	21
TOTAL	420	TOTAL	222	TOTAL	867
COMMUNITY HEALTH SERVICES				**SOCIAL SECURITY**	
DISTRICT NURSING	205			INCOME SUPPORT FOR RESIDENTIAL AND NURSING CARE	353*
HEALTH VISITING	12				
CHIROPODY	31				
TOTAL	248				
TOTAL DOMICILIARY SERVICES	668	TOTAL DAY CARE SERVICES	222	TOTAL RESIDENTIAL CARE	1220

* England only, like rest of table. GB equivalent is over £400 million, rising to an estimated £980 million in 1988-89.

COMMUNITY CARE: ACTIVITY STATISTICS (1986)

TABLE 2

DOMICILIARY CARE

LOCAL AUTHORITY
DOMICILIARY SERVICES

HOME HELPS: NUMBER OF CLIENTS	586,000
: NUMBER OF HOME HELPS	54,000
NUMBER OF MEALS PROVIDED	44,112,000
CASES OF ASSISTANCE PROVIDED (AIDS-ADAPTATIONS)	655,000

COMMUNITY HEALTH SERVICES

DISTRICT NURSING: FIRST VISITS TO PERSONS 65+ (46% OF ALL FIRST VISITS)	1,584,000
HEALTH VISITING: VISITS TO PERSONS 65+ (8% OF ALL VISITS)	1,133,000
CHIROPODY: NUMBER OF PERSONS 65+ TREATED (90% OF ALL PERSONS TREATED)	1,644,000

DAY CARE

LOCAL AUTHORITY
DAY CARE (NUMBER OF PLACES)

DAY CENTRES FOR THE ELDERLY	32,000
DAY CENTRES FOR YOUNG PHYSICALLY DISABLED	13,000
ADULT TRAINING CENTRES FOR MENTALLY HANDICAPPED	50,000
DAY CENTRES FOR THE MENTALLY ILL	8,000
TOTAL	**103,000**

RESIDENTIAL CARE

LOCAL AUTHORITY PROVISION (NUMBER OF PLACES)

ELDERLY AND YOUNG PHYSICALLY DISABLED	115,600
MENTAL HANDICAP	15,800
MENTAL ILLNESS	4,500
TOTAL	**135,900**

VOLUNTARY SECTOR (PLACES)

ELDERLY AND YOUNG PHYSICALLY DISABLED	36,000
MENTAL ILLNESS	2,200
MENTAL HANDICAP	4,700
TOTAL	**42,900**

PRIVATE SECTOR (PLACES)

ELDERLY AND YOUNG PHYSICALLY DISABLED	92,600
MENTAL ILLNESS	1,700
MENTAL HANDICAP	3,900
TOTAL	**98,200**

PRIVATE AND VOLUNTARY NURSING HOMES (NUMBER OF BEDS)

ELDERLY	41,600
MENTAL ILLNESS	1,900
MENTAL HANDICAP	900
TOTAL	**44,400**

Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Switsfwrdd)
01-270 (Llinell Union)
Oddi wrth yr Is-Ysgrifennydd Seneddol

CONFIDENTIAL

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Switchboard)
01-270 (Direct Line)
From The Parliamentary Under-Secretary

8 December 1988

CHIEF SECRETARY
REC. - 9 DEC 1988
Miss Peirson
COPIES TO Ex. Sir P Middleton
Mr Anson, Sir T Burns
Mr Phillips, Mr Beastall
Mr Porter, Mr Saunders, Mr Call.

Dear Alison

AUDIT OF THE NATIONAL HEALTH SERVICE

Thank you for copying to me your letter of 8 December to Roger Bright about the draft minute the Lord President wishes to send to the Prime Minister following the meeting with Ministers on 6 December. I can confirm my Minister is content.

I am copying this letter to Roger Bright, Geoffrey Podger and Carys Evans.

Yours
Jan Dominguez

MISS J M DOMINGUEZ
Private Secretary

Ms Alison Smith
Private Secretary to
The Rt Hon John Wakeham MP
Lord President of the Council
Privy Council Office
Whitehall
LONDON

st.ln/min/4.8.12

CONFIDENTIAL

FROM: MISS M E PEIRSON
DATE: 8 DECEMBER 1988

CHIEF SECRETARY

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

NHS AUDIT

1. The Lord President's office has circulated a draft minute to the Prime Minister, reporting the conclusions of the meeting you attended on Tuesday. He wants clearance before close tomorrow.

2. You will know whether the draft is an accurate record of the meeting. However, you may like to consider the following points. I attach a draft letter for your private secretary to send, covering the second and third points below.

3. First, the Lord President is cautious in his presentation. But that seems right for the business manager, and he has not overstated the difficulties.

4. Secondly, the first part of the second paragraph is not strictly accurate, even if that was what was said at the meeting. There does have to be some provision in the Bill at introduction. But it would not be impossible for a simple paving provision to be subsequently expanded (in committee stage) to take in the full legislation for the transfer of the whole of the NHS audit to the Audit Commission. There are strong arguments against attempting such a feat, namely the shortage of time in which to get right every aspect of some fairly complicated provisions (at most about 6 months), the additional lengthening of the Bill, and the greater risk of opening up debate both on the health review front and on the NAO/PAC front. However, since the Prime Minister may

otherwise ask about the possibility, you might like to suggest an amendment (see draft letter attached).

5. Third, the last substantive paragraph mentions Mr Ridley's suggestion that he make a speech in early January, praising the Audit Commission and announcing the intention of extending their role into the NHS, in order to play down the provision in his Bill as an essentially technical issue.

6. However, DH say that Mr Clarke has since had second thoughts about the wisdom of this idea, and may wish to suggest its removal from the minute to the Prime Minister. He was talking to Mr Howard Davies immediately after the meeting with the Lord President, and Mr Davies said that, since the aim of the change in responsibility for the NHS audit was to heighten its profile, a speech by Mr Ridley (which would not be noticed by the health community) was not the right way to go about things.

7. I do not think much of Mr Davies' argument in this instance. The health review white paper will itself announce the change to the NHS audit, and get as much publicity as need be, and I have no doubt about Mr Davies' ability to heighten the profile of the NHS audit.

8. But I also do not think that Mr Ridley's idea would work. It could not detract from the impact of the health review white paper, so the risk that the clause in Mr Ridley's Bill would open up the debate on the health review would be unaffected.

9. To include Mr Ridley's proposal might therefore raise false hopes of avoiding difficulties, and you may like to suggest deletion. I have included that suggestion in the draft attached, though you may prefer to leave the matter to Mr Ridley and Mr Clarke.

MEP

MISS M E PEIRSON

st.ln/dra/1.8.12

CONFIDENTIAL

DRAFT LETTER FROM PS/CHIEF SECRETARY TO PS/LORD PRESIDENT

NHS AUDIT

1. Thank you for your letter of 8 December. The Chief Secretary is content with the draft minute to the Prime Minister, subject to the following points.

2. First, the second paragraph does not discuss the possibility that the paving provision mentioned in the last sentence could, in principle, be expanded at committee stage to encompass the full legislation required for the transfer of the NHS audit to the Audit Commission. The Prime Minister will no doubt wish to know the arguments against that possibility. The Chief Secretary accordingly suggests the following amendments:-

i) In line 3, delete "this" and insert "it entirely".

ii) In lines 4-5, delete "Any provisions that were agreed" and insert "some minimum provision".

iii) At the end of the paragraph, insert: "(In principle, it would be possible for such a paving provision to be expanded at committee stage to embrace the full legislation required for the transfer of the NHS audit to the Audit Commission, but the problems that even a paving provision could create, as discussed below, would be greatly magnified by such a move and we concluded that it was not practicable.)"

3. Secondly, the Chief Secretary has been reflecting since the meeting on the helpful suggestion by the Secretary of State for the Environment, recorded in the last substantive paragraph of the draft. He has some doubts about whether a speech along the lines suggested would have the effect intended, and wonders whether it would be better not to raise false hopes that some of the difficulties could be overcome in this way. The Chief Secretary's point is that, after the suggested speech, the health review white paper would be published, and would include the proposal to transfer the NHS audit to the Audit Commission. Therefore the provision in the Local Government Bill is likely to be seen in that light, no matter what the Secretary of State for the Environment had said before the White Paper had issued.

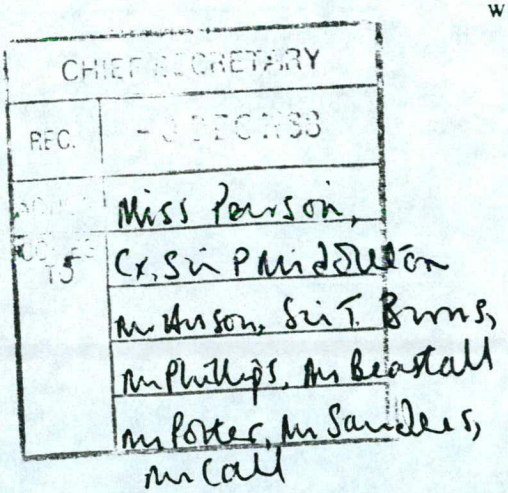
4. I am copying this letter to the recipients of yours.

CONFIDENTIAL

PRIVY COUNCIL OFFICE

WHITEHALL. LONDON SW1A 2AT

8 December 1988



Dear Roger,

AUDIT OF THE NATIONAL HEALTH SERVICE

On Tuesday, the Lord President held a meeting with your Secretary of State, the Secretary of State for Health, the Chief Secretary and Mr Grist to discuss your Secretary of State's letter of 28 November and the Chief Secretary's letter of 5 December.

The meeting agreed that the Lord President should report their conclusions to the Prime Minister and, subject to the agreement of your Secretary of State and the other Ministers present, the Lord President would now like to write in the terms of the attached draft. The Lord President would be very grateful if this could be cleared before close on Friday so that it could go to the Prime Minister for the weekend.

I am sending copies of this letter and enclosure, with a similar request for clearance, the Private Secretaries of the other Ministers present at the meeting on Tuesday.

Yours,

Alison

ALISON SMITH
Private Secretary

Roger Bright Esq
Private Secretary to
the Secretary of State for the Environment
Department of the Environment
2 Marsham Street
LONDON
SW1P 3EB

CONFIDENTIAL

D R A F T

PRIME MINISTER

AUDIT OF THE NATIONAL HEALTH SERVICE

In a recent meeting of your Ministerial group on the review of the National Health Service (NHS) you asked Kenneth Clarke for a note on the possibilities for using this session's Housing and Local Government Bill to provide for the Audit Commission to take over the external audit of the NHS. In the event, it proved most convenient for me to take a meeting last Tuesday on this issue with Kenneth Clarke, Nicholas Ridley, John Major and Ian Grist. This minute, which I have agreed with them, reports the conclusions that we reached.

First, we agreed that if any provisions on NHS audit were to be included in Nicholas Ridley's Bill, it would not be practicable to do this by way of Government amendment during the Bill's passage. Any provisions that were agreed would therefore have to be ready for the Bill's introduction at the end of January, ie shortly after the likely publication of the NHS White Paper. It would not be possible to prepare a fully worked-up set of NHS audit provisions on that timetable, but we were also clear that there were considerable objections to the idea of promoting a general power that would simply enable the Audit Commission's role within the public sector to be expanded. We therefore

concluded that the only practical compromise would be a paving provision authorising the Audit Commission to undertake some audit and value for money work in the NHS field, so as to enable them to build up experience and prepare to assume the full role that they would be given when the main NHS review legislation came forward in a later session.

A paving provision of this kind should be fairly short, and Nicholas Ridley is prepared for it to be included in his Bill. Given the lead-time the Audit Commission would need to build up its role, and the importance of the topic in your review group's thinking, Kenneth Clarke and John Major would ideally have wanted the Audit Commission to be given the full powers in the present session. Failing that possibility, they view the paving provision as the bare minimum that should be done on the issue in 1988-89.

The inclusion of a paving provision of this kind would require a reference to the NHS in the Bill's long title and it would clearly enlarge the scope of the Bill in a way that made it vulnerable to some amendment on NHS issues. It is impossible to predict quite how far that vulnerability might extend beyond the immediate areas of efficiency audit and value for money, as a great deal would depend on the ingenuity and determination of the Opposition. If, for example, the NHS review were to link funding with performance and efficiency, and the

Opposition were determined to debate those issues on Nicholas Ridley's Bill, then they could probably find a way to do so. There is, therefore, an unavoidable risk that Nicholas's Bill could be seized as the first vehicle for debating the NHS review in a way that might be difficult to contain. Kenneth Clarke and John Major both feel that this is unlikely to happen. They see the extension of the Audit Commission's remit as an essentially technical matter that is unlikely to attract a great deal of attention, especially if it is tucked away towards the end of a very long Bill on local government matters.

So far as the carriage of Nicholas's Bill itself is concerned, it is clearly unwelcome to have to contemplate a completely new kind of extension of a major Bill that is already starting very late. In my own view, it would be too optimistic to assume that the Opposition would entirely refrain from exploiting the inclusion of NHS material, and I believe that expanding the Bill in this way would be bound to add to the difficulties of managing it. The fact that the Bill is almost certain to be guillotined is not the end of the story. I know that Nicholas is anxious that the inclusion of NHS material should not be allowed to have much impact on the Bill's timetable, but I am afraid that I cannot guarantee that. Nevertheless, if it is decided to include this material, then I am confident that we can bring the Bill to Royal Assent, albeit at the possible

cost of limiting our room for manoeuvre in other parts of the programme.

I think it follows from this that, although I see the business management aspects as quite important, they are not the decisive factor. The essential thing is the assessment of the threat that a paving provision in Nicholas's Bill might present to the overall presentation of the NHS review proposals during the first half of next year. The majority of the colleagues at my meeting this week were confident about this, and I hope that this minute will provide you with a basis for reaching a decision on the point.

Finally, if it is decided to include this provision in the Bill, Nicholas Ridley wondered whether the most effective way of playing it down as an essentially technical issue might be for him to make a speech on audit issues in early January, praising the Audit Commission's performance and announcing the intention of extending their role into the NHS as a pragmatic and sensible next step. I know that Nicholas would welcome your views on this suggestion if you decide in favour of taking the paving power in his Bill.

I am sending copies of this minute to Nicholas Ridley, Kenneth Clarke, John Major, Ian Grist, and to Sir Robin Butler.

FINANCIAL ARRANGEMENTS FOR SELF-GOVERNING HOSPITALS

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

Introduction

1. Self-governing hospitals will offer better value for money, higher efficiency, increased choice for patients and closer links with their local community, providing a spur for the improvement of standards in the rest of the hospital service. To achieve these objectives they will need the maximum freedom and flexibility in managing their financial affairs consistent with maintaining public expenditure control and accounting propriety. This paper considers what financial arrangements will be required.

2. Self-governing hospitals will be statutory bodies managed by boards appointed by and accountable to the Secretary of State for Health. We envisage a financial framework for these bodies which would lead to their being treated as public corporations for public expenditure control purposes. They will be financed mostly by payments from District Health Authorities (and certain General Practitioners) for services supplied. Most of these services will be supplied under contracts: there will be bulk contracts to enable the necessary 'core' services such as accident and emergency services to be maintained and omnibus contracts for the provision of a specified quantity of other services. (It is envisaged that initially the contracts will simply reflect the hospital's existing pattern of service and sources of patients.) The hospitals will be able to negotiate contracts on a fee for service basis. They will also be able to generate income by selling their services to the private sector - eg by treating private patients, franchising space in hospitals etc.

3. Self-governing hospitals will not therefore receive any specific revenue allocations from the Department of Health. Their funding will depend on their success in obtaining business from public and, to a much lesser extent, private sector purchasers of health care. They will be competing for business with other self-governing hospitals, health authority-managed hospitals and private sector hospitals. It will be for them to determine in

negotiation with the purchasers of their services the prices they charge and their success in attracting contracts will depend on their price-competitiveness.

Freedoms of self-governing hospitals

i) Ownership and use of assets

4. Self-governing hospitals will have considerable assets in the form of land, buildings and equipment. Ownership would be vested in the board of the self-governing hospital, in keeping with the overall objective of giving them the maximum possible freedom to run their own affairs. They should also have the freedom to make use of their assets to provide the pattern of their service they think best. This should include the freedom to dispose of assets subject only to a duty to inform the Secretary of State who would have a reserve power to intervene if the disposal was against the public interest.

5. To impose the necessary commercial discipline, the hospitals should not be given these assets as a free good. We propose that - like Trading Funds - the hospitals should be given an interest bearing originating debt, equal to the value of their initial assets at vesting, repayable on terms set out in the enabling legislation. They would therefore not need to be subject to the capital charging system. The interest self-governing hospitals should pay on their inherited assets, the method of valuation and accounting for depreciation will need to be considered further in tandem with the details of the capital charging scheme: the different arrangements should not result in self-governing hospitals being placed at a competitive advantage or disadvantage to the rest of the hospital sector.

6. like other public enterprises, self-governing hospitals should be set financial targets in the form of a real rate of return on capital employed which they would be required to achieve.

ii) Retention of Surpluses and Reserves

7. Self-governing hospitals will, if successful, make surpluses on their activities. They should be allowed to retain these surpluses

and build up reserves to improve their services and help finance capital investment. More importantly, it will give the hospitals an additional incentive to maximise their efficiency and keep their costs down. (The legislation will need to specify the form in which these reserves can be held.) Self-governing hospitals will therefore be free from the normal requirement that surplus balances need to be surrendered at the end of each financial year.

iii) Deficits

8. We cannot be certain that self-governing hospitals will invariably be able to balance their budgets every year. A hospital may end a particular year with a deficit despite being in a sound underlying financial position. A requirement that hospitals could not run end-year deficits would be an artificial and unnecessary constraint on their activities. However, a self-governing hospital should not be entitled to run a continued deficit: this would undermine its viability and build up potential liabilities for the Exchequer. This would clearly be undesirable but could be avoided by setting a requirement that they should break even taking one year with another.

iv) Working Capital and Capital Investment

9. Self-governing hospitals' costs will not be directly funded and their income and expenditure cash flows are unlikely to match each other at all times throughout the year. They will therefore need access to working capital through loans/overdraft facilities. Indeed they will need to have a loan at their foundation to give them the necessary working funds until the income from their contracts starts to flow. More significantly, they will also need access to funds for capital investment so that they can maintain and expand their facilities to meet demand and provide the required standard of service. They are unlikely to be able to finance their capital investment solely from sales of assets and/or the reserves they have built up. They should therefore be able also to meet their capital requirements through loans, which they would have to service from their income in the same way as hospitals in the rest of the NHS will be charged for their capital.

10. The funds used to finance the expenditure of self-governing hospitals will almost all be public money for which the Department of Health will be accountable. While the hospitals remain statutory public sector bodies all their borrowing, or the expenditure it finances, will be public expenditure.

[To maintain public expenditure control there will therefore need to be limits to the amount the self-governing hospitals can borrow. The aggregate of these would be settled in the Public Expenditure Survey. The Department of Health would then decide how much each individual hospital could borrow. A hospital could either be given its own borrowing limit for the financial year or submit bids to the Department for its capital expenditure as required during the year.]

or

[Self-governing hospitals should not be constrained by any specific financing limit but should, within certain boundaries, have the discretion to borrow etc as they saw fit. This would, however, mean a very significant relaxation of public expenditure control.]

11. Self-governing hospitals could be allowed to borrow from the private sector or the Government. However, the commercial banks would not offer such fine terms - even if the loans were covered by Government guarantees - and their loans would therefore be more expensive. More of a self-governing hospital's resources would be required to service its debt rather than being available for the provision of health care and this could also be reflected in the prices it needed to charge its customers. Borrowing from the Government would therefore be preferable on value for money grounds. This would also be more transparent to Parliament. Depending upon the precise legal status of the hospitals, there are two options for the source of Government loans: the National Loans Fund; or voted funds. The latter could be more appropriate as it would emphasise that the Department of Health would have the responsibility for satisfying itself that the loan would be serviced, and repaid, in full. Provision of Government loans at preferential rates would entail the hospitals' being required to invest their surplus cash in the public sector (otherwise they

would have straight arbitrage opportunities which would expose the Accounting Officer to criticism).

Preventing abuses of self-government

12. Self-governing hospitals should have the maximum freedom consistent with normal Accounting Officer principles. As they remain public bodies, the Secretary of State will need some controls over their exercise of their powers. He will, of course, be able to dismiss the board of a hospital and remove its self-governing status. However, these are draconian sanctions for use in extremis if it is clear that a hospital is no longer fit to run its own affairs. It will also be necessary for the Secretary of State to have the power to intervene if abuses of self-governing status are occurring. Since self-governing hospitals will not be subject to the general direction of the Secretary of State in the manner of the rest of the NHS, he will need some limited specific powers, for example, regarding the sale and purchase of assets and size and use of reserves. These powers would only be for use where there was a serious risk that a hospital was abusing its freedoms or getting itself into difficulties.

13. Further controls may need to be provided to prevent any hospital with a local monopoly of health care provision unfairly exploiting its position by, for example, charging high prices for its services. The system of capitation funding for health authorities will provide some protection. An authority will have a fixed sum to purchase services for its population which will constrain what it can pay the self-governing hospital. Its contracts with a self-governing hospital may not by themselves provide all the funding the latter requires. The hospital may need to compete for business from outside its home district and this will affect the prices it can charge. However, it will be necessary to consider whether this needs to be reinforced by specific powers. (for whom?)

Other Issues

(i) Corporate Plans

14. Like any commercial enterprise self-governing hospitals will need to prepare financial and business plans. They should discuss

and agree corporate plans with the Department of Health covering matters such as major capital investment and disposal plans or changes in the provision of services, and performance and efficiency targets.

(ii) Tax

15. The tax treatment of the surpluses made by self-governing hospitals needs to be considered. (As the law currently stands, the view of the Inland Revenue is that health authorities are probably liable to tax on their profits from treating private patients and other income generation activities.) The VAT treatment of contracts let by health authorities to these hospitals is another issue to be considered.

(iii) Accounts

16. Self-governing hospitals would be required to maintain their own accounts. These should include provision for depreciation. The hospitals will not need to be subject to the capital charging regime since, as noted above, they will pay interest on any loans they take out. Their situation will therefore be analogous to that of the rest of the hospital service which, from 1991 onwards, will also be paying interest on their capital assets.

(iv) Accountability

17. Parliament will expect the Secretary of State for Health to be accountable for the hospitals' role within the NHS. The operations of self-governing hospitals must therefore be subject to audit by the Audit Commission which we have agreed should be the agents of the Secretary of State in his management of the NHS.

18. As our intention is that these hospitals should be as autonomous as possible, they will not be under the same direct control of the Department as the rest of the NHS. The Department's Accounting Officer should therefore not be accountable for each individual hospital but he will have an overall stewardship responsibility for their use of public funds. (As now he will will remain accountable for payments, including loans, made from his votes to the hospitals and, in his capacity of Accounting

Officer for the NHS, for payments to health authorities.) To protect the position of the Accounting Officer it will therefore be necessary to ensure that there are adequate monitoring arrangements.

19. The NAO will remain responsible for auditing the consolidated accounts of the NHS and will also scrutinise the Departmental Vote under which loans are made to the self-governing hospitals. It is for consideration whether the NAO should be permitted to carry out value for money studies of these hospitals (as they will continue to do in the rest of the NHS). It is conceivable that there would be some Parliamentary pressure to subject the affairs of the self-governing hospitals to scrutiny by the NAO and PAC. However, if the hospitals are classified as public corporations, we should oppose this. It is Government policy not to allow the NAO access to the public corporations and we would clearly not want to set an unwelcome precedent with self-governing hospitals.

(iv) Privatisation

20. The financial arrangements proposed for self-governing hospitals go as far as possible in giving them autonomy consistent with their remaining in the public sector. To go any further would entail their having to be privatised.

Conclusion

21. The above proposals would offer self-governing hospitals:-

(i) ownership of their assets and the freedom to use them as they think best subject only to certain reserve powers of the Secretary of State;

(ii) freedom to retain surpluses and to build up reserves,

(iii) freedom to manage any temporary deficits;

(iv) the power to borrow up to prescribed limits to finance their working capital and capital investment.

We consider that the financial regime outlined above can be created by the legislation establishing self-governing hospitals.

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ACCESS TO PRIVATE CAPITAL - NOTE BY DH AND TREASURY OFFICIALS

1. Our paper HC 56 said that we would report back to the Group when we had completed further work on this question.

2. We have examined a range of projects which have come to the Department's notice as ventures which individual health authorities would like to undertake. In many cases, we have been able to establish that they would be entirely consistent with the principles governing privately financed projects, and that there is every reason to encourage them. Examples of these include:-

- Joint developments between NHS hospitals and private health care providers, under which facilities are financed by each party in proportion to the use they plan to make of them.

- Leasing NHS land, buildings or other facilities for use by private sector health care providers or other ventures. Such leases may involve conventional fixed repayments, or be linked in some way to the profits generated by the lessee.

- Schemes under which housing associations take over the provision of residential accommodation for nurses and other NHS staff, again using land leased from the health authority.

3. The general principles we have applied in addressing these cases are that value for money must be secured on behalf of the tax payer, and that, where the costs of a project ultimately devolve onto the tax payer, there is a presumption that it should not be additional to the agreed public expenditure programme. For the most part, the application of these principles to particular cases is clear, and creates no special difficulty.

4. But we have identified some areas where we need to do further work on the precise ground rules to be applied. One such is contracting out. The overriding criterion here must be value for money, but there is a further and separate question whether control total adjustments are needed. If, for example, a district were to contract out all its hospital services, it would not need any capital provision, although it would incur more revenue expenditure to cover the capital element in the fees it paid. At the other end of the spectrum, however, no question of adjustments has been raised in the contracting out of catering, cleaning, and laundry services.

5. We have identified one area where there is a clear difference of view. This is the financing of cost-saving projects of the sort now proposed for Bromley district health authority. The issues are discussed more fully in paragraph 7-9 below.

Value for Money

6. There is agreement that the value for money criterion is met where any higher interest costs of private finance are offset by better management or superior services. The question raised by the DH examples

(Examples 1 and 2 in the Annex) is whether, in certain cost-saving circumstances, private financing should also be allowable where public finance is perceived by health authorities to be unavailable.

7. The fundamental problem is that certain projects involving cost saving or the release of surplus land, but no significant service development tend not to go ahead because they are given insufficient priority by regions. The reason is not that these are "marginal" projects but that health authorities have no objective basis for comparing projects that meet service objectives with those that offer revenue cost savings. Without such a yardstick public opinion and medical pressures will almost always ensure that priority is given to projects offering service improvements directly (whereas cost savings schemes lead to service improvements indirectly).

8. DH argue that practical choice facing health authorities in this situation is frequently between mounting the cost saving project now using private finance or mounting it considerably later using public finance. In the circumstances, even the most rigorous investment appraisal may suggest that the cost effective option is to use private finance. In the absence of a specific fund for cost-saving projects, the Department believes there may be some scope for tolerance of projects which promise exceptional benefits in cash, service or political terms, through making use of particular financing opportunities provided by the private sector.

9. The Treasury consider that best value for money must always be the aim for the health service. In their view it is possible to accommodate such projects within the agreed capital programme, even if regions do not now give them high priority. This could be done by keeping back part of the caital programme for allocation centrally to such projects. A similar idea was proposed by the department in the course of this year's public expenditure survey.

Public Expenditure Control

10. Treasury and DH also differ over the situations in which the introduction of private finance should not involve a change in the public expenditure control totals.

11. There is agreement that there should be no adjustment where the private sector finance manage and own of the project and there is no substitution for NHS provision. For example the private financing and management of shops or private hospital facilities on NHS land (Example 5). The same would be true for a jointly funded new hospital complex provided each partner financed, owned and managed its own defined part (Example 3).

12. There is also agreement that there should be no adjustments when the NHS contracts-out services involving limited capital expenditure. Catering, domestic services and laundries are examples that have already been agreed. Privatisation of accommodation for nurses (Example 7 in the Annex) is also accepted as requiring no change to control totals.

13. However, there are other areas where the effect of the private finance principles on contracting-out need to be given further attention. For example DH argue that there are good demonstration grounds for allowing the contracting out of continuing care for the elderly to be exempt from additionality rules (Example 4). Treasury are willing to consider the demonstration case on its merits and has been agreed that detailed guidelines should be drawn up across the contracting-out field.

Enterprise and Risk

14. There is agreement that it is acceptable for the NHS to enter into co-operative or joint venture arrangements that involve limited risks of revenue loss. (Examples 5 and 6). Arrangements for the leasing of NHS land or buildings that include a profit or income sharing element are acceptable provided that the health authority acts with due prudence, by identifying and assessing the risks of revenue or capital loss, and ensuring that it has the appropriate management capability to monitor and control such risks. Its auditors will need to take a particular interest in such arrangements. The Treasury expect DH to establish mandatory guidance on the kinds of activities that could be entered into on this basis and safeguards to be applied, but does not regard the assumption of risk itself as raising a major point of principle.

15. We understand health authorities currently do not have the power to establish or participate in formal joint venture companies ie involving health authorities contributing capital to limited liability companies.

Self-Governing Hospitals

16. Questions relating to access to private capital for self-governing hospitals have not yet been discussed in detail by officials. Treasury officials would take the view that the conditions governing access to private capital should be the same for self-governing hospitals as for public enterprises. DH officials believe that self-governing hospitals offer a unique opportunity to encourage entrepreneurial behaviour in the health service and that they should not be constrained by the conditions governing other public enterprises.

Conclusions

17. Treasury and DH officials are agreed that:

i. The current opportunities for co-operation between the NHS and private capital should be publicised more widely. The new guidelines for the NHS on access to private capital should highlight the possibilities, drawing as necessary on the examples attached to this note;

ii. An illustration of these opportunities is the wide range of circumstances in which use of or co-operation with the private sector (including finance) need not involve changes in the public expenditure capital control totals, either because there is no substitution for NHS provision or because contracting-out involves limited capital expenditure. However, there is a need to clarify the circumstances in which contracting-out can be allowed without requiring adjustments to planning totals.

iii. Special measures may be required to encourage health authorities to fully exploit cost-saving opportunities. Treasury officials believe that these should take the form of the Department or Regions earmarking funds for cost-saving projects. The earmarked funds could be financed from existing or additional public expenditure provision. DH officials recognise the transparency of such solutions but believe that until additional funds can be made available Ministers may attach such priority to the NHS being seen to co-operate with private finance in situations such as Bromley that they would favour special dispensations. The dispensations could be confined to a limited and carefully defined set of circumstances where there was a very high payoff and/or confined within a cash limited sum.

18. The position of self-governing hospitals has not yet been discussed in detail.

EXAMPLE [1] : NEW DGH FUNDED BY LAND SALE PROCEEDS (BROMLEY)

1. An old, out-dated DGH is located in a town centre, where land values are high. If short-term bridging funding could be made available it would be possible to build a completely new DGH on a cheaper greenfield site peripheral to the town and to cover the entire cost from the proceeds of the subsequent sale of the released town-centre site(s). The DGH would enable the same level of service to be provided in a much higher - quality environment and with useful revenue savings as well. The region has many pressing priorities and does not feel able to provide the necessary bridging finance.

2. Such a development could be funded in several ways. For example:

a. By the health authority borrowing against the security of the land which will be released when the development is completed.

b. By forward selling the land to be released.

c. By accepting a proposal from a commercial contractor who is willing to fund the new development on the basis of a single contract embracing both the building of the new hospital and the purchase by the contractor of the site(s) to be released.

The preferred option would be that which was best in terms of the balance between overall cost and risk.

3. In any of these cases it is likely that the authority would want to adopt a fast-track design and build procurement process to minimise the period for which bridging finance at commercial rates is needed.

Analysis

4. The proposal involves unconventional finance because short-term private sector bridging finance is being used to fund the building of the new DGH.

5. The proposal offends in two ways. First, the use of private sector funding implies a second-best in terms of VFM, because bridging finance provided from public funds must inevitably be cheaper. Secondly, the provision of bridging finance would be inconsistent with public expenditure controls, unless there were a control total adjustment. But in that event, the proposal would fall because the region would have no incentive to fund it privately.

6. The problem arises because the strategic planning system, combined with local political and other pressures, tends to give service development priority over cost-saving or capital-releasing investment in regional capital programmes. This is in part because there is no objective method for

comparing "rates of return" from service development with those from cost saving projects. If there is to be more cost-saving investment, and if regions will not make room for it within their capital programmes, some other means of financing it has to be found. Treasury believe the logical way would be to acknowledge that such investment is of a rather different nature to service development, and to provide a top-sliced allocation within the capital programme specifically for the purpose. Regional programmes would then be explicitly for service development. A proposal for a capital loan fund on these lines, but involving additional expenditure, was advanced by Department of Health in the 1988 Public Expenditure Survey.

7. If nevertheless such schemes were to go ahead on a privately financed basis, the position of the Accounting Officer would need to be considered. On the face of it, he would be exposed to criticism by the PAC for allowing a project to go ahead on a basis which was shown on investment appraisal not to be the most cost-effective. This aspect needs to be addressed in each such project which is proposed, and is being considered in the present case of Bromley DHA.

8. DH acknowledge the logic of a separate capital fund for cost-saving investments. However, existing capital allocations are fully committed making service improvements. Until an addition to public expenditure is agreed DH believe that private sector finance represents the only way to exploit cost-saving opportunities. Moreover, DH note that in these bridging cases short-term borrowing from the private sector does no more than facilitate or expedite the release of the value inherent in the land. The quantum of public sector activity/investment is therefore being determined not by the private sector borrowing, but by the value of the underlying publicly owned asset (the land) which is being brought into play. This is arguably within the spirit of the rules, and additionally should achieve maximum VFM from assets given into their charge. And health authorities will certainly regard the ruling out of second best options as incomprehensible when the consequence is that very worthwhile benefits are foregone.

9. As examples of similar schemes would be rare there need be no undesirable replications of a concession here. The need for further concessions could be ended by agreement on a new capital programme in the next PES round. Failing such an agreement, if permission is limited to cases where the cost of the development is fully (or within an agreed %) covered by the value of the asset being redeployed, instances will remain rare. As an additional protection for public expenditure totals it would be possible to agree a maximum aggregate figure below which offsets would be waived.

10. The Treasury believe it would be very difficult indeed to defend a more expensive privately-financed option on the grounds that room cannot be found for the project within a gross HCHS capital programme of £1.2bn. This is to argue that hospital capital spending should be at a level higher than that agreed by Ministers in the Public Expenditure Survey. It is not relevant that there are offsetting land sales receipts later: activity by the public sector is still increased, even if it is not financed directly by the taxpayer. If the rate of return on the project is so good, room should be found for it within the capital programme; if not, it should not take precedence over others. The ranking of a project should be determined by its rate of return, not by method of financing.

11. DH's proposals go well beyond the freedom given to Local Authorities to undertake Bromley type schemes. Local Authorities are not allocated funds to finance expenditure to be undertaken in anticipation of receipts to be realised from an asset sale in a later year.

EXAMPLE [2] : CONTRACT ENERGY MANAGEMENT AND WASTE INCINERATION

Opportunities for cost saving by contracting out ancillary services

(a) Contract Energy Management

1. A district has a hospital with an old, outdated boiler and heating plant. A modern, state of the art installation, which might cost in the region of £500,000, would yield immediate major revenue savings as a result of (a) increased efficiency of conversion of fuel into heat, coupled with (b) better utilisation as a result of "intelligent" electronic sensors and controls. The potential revenue savings are so large that the capital investment could be recouped within 2-3 years.

2. For the reason set out in example 1 - HA preference for service improvements over cost-saving investments - there are cases where the capital for this clearly highly desirable cost-saving investment is in fact not forthcoming. Firms specialising in contract energy management (CEM) will install and manage new equipment in return for an annual charge, by means of which the firm recoups its annual running costs and recovers its initial capital investment. At the end of the contract period - say 7 years - the ownership of the equipment would revert to the health authority.

3. Option appraisal shows that although the conventionally funded option is best VFM, the private sector (CEM) option is only marginally more expensive. (This is possible (a) because the specialist CEM firm has more expertise and achieves greater efficiency in the use of the new plant, and (b) because the initial capital investment is small in comparison to the ongoing revenue costs). Both options are far more beneficial than the "do-nothing" option in providing a return on the investment that handsomely exceeds the test discount rate. Locally managers, who have tried and failed to win public funds for upgrading heating systems, cannot understand why they may not enter into CEM contracts which will yield major and immediate revenue savings at nil cost to the health authority. The option may be marginally second-best, but it is highly advantageous and second-best only to what is perceived as a non-available option.

(b) Waste Incineration

4. Cost saving opportunities (together with greater certainty in meeting an externally imposed regulatory requirement) are likely to arise from contracting out waste incineration. During 1989 strict new statutory controls on emissions will be introduced by DOE. To comply with these new controls, almost all existing NHS incineration plant will have to be upgraded or replaced (at an estimated total cost of about £50 million, although the impact of this expenditure will be mitigated by the provision of a transitional period for compliance).

5. An obvious alternative to installing new equipment would be to contract-out the clinical and other waste incineration function to the private sector, wherever option appraisal indicated this to be preferable to installing new NHS equipment. Contracting-out has the further advantage that there is likely to be a progressive tightening of controls on emissions in

years to come: incineration looks set to become a complex tightly-regulated high-technology industrial process, best left to specialists to handle.

Analysis

6. A joint note by H M Treasury and the Department of Energy (issued in May 1987) gives specific guidance on the procedures for assessing CEM schemes. This requires that CEM schemes offer first-best VFM in every case. The existing guidance presumes that control total adjustments will be made where CEM schemes involve large capital investments (over £1 million) or where the cost of financing the capital installed is greater than half the annual costs paid to the CEM contractor; although de minimis adjustments of less than £250,000 to annual control totals in respect of all CEM schemes in a year would not normally be made. There is no specific guidance on waste incineration but it may be assumed that the same principles will apply.

7. DH believe that the CEM requirements are too restrictive and that their effect is simply to delay the achievement of significant revenue savings. They argue that a second best (in cost-benefit terms) option should be allowable in cases where the ideal option is not readily available and the default is "do-nothing", especially given the opportunity not only for substantial savings but also to "roll back the frontiers of the state". This latter opportunity applies also to waste incineration where if contracting-out is not arranged the additional statutory requirements will have to be met within the public sector. In this respect the schemes differ significantly from other lease/purchase equipment replacement/upgrading proposals. Because of health authorities practical inability to compare service improvement and cost-saving projects DH also believe that a higher de minimis threshold is required. For waste incineration schemes if the new statutory requirements are to be met increased PE provision (or reduced service developments) will be necessary unless a relatively high control total adjustment threshold is set. DH propose that the threshold should be set at £1 million for individual CEM and waste incineration schemes.

8. The Treasury welcomes the contracting-out of services such as contract energy management and waste incineration wherever this can be shown to be more cost-effective than in-house provision. In the case of CEM the conditions made under which these schemes will be approved and their implications for expenditure control are already the subject of detailed guidance, agreed as recently as May 1987 with the Department of Energy, and the Treasury would be content for similar guidelines to apply waste incineration. In the Treasury's view these guidelines strike the right balance between encouraging the injection of private sector expertise and maintaining public expenditure priorities; no case has been established for saying that they are no longer applicable to the NHS.

EXAMPLE [3] A JOINT VENTURE: SHARING OF ON-COSTS

A cost saving opportunity

1. The private sector and the NHS could share the construction of a new hospital on a greenfield site owned by the NHS. Each sector would own and manage a defined part of the new hospital complex.

2. The two sectors would share an appropriate part of the cost of clearing the site, sinking foundations, and bringing in services thereby substantially reducing the cost to each.

3. There would be opportunities for trading between the private and NHS 'sides' of the hospital. The NHS might generate income by selling diagnostic services, heating, etc to the private company. Because the NHS owned the land it would receive rent.

Analysis

4. Such a venture offers significant opportunities for the fruits of capital and revenue economies of scale to accrue to the NHS (and the private sector). However, there may be some risk to the NHS if the private company went out of business causing a temporary loss of income.

5. Treasury agree that offsets to NHS capital expenditure would not be required if the construction costs were shared proportionately between the private company and the NHS.

EXAMPLE [4]: CONTRACTING OUT CONTINUING CARE OF THE ELDERLY

A Contracting Out Opportunity

1. A District Health Authority has an old, outdated geriatric hospital housing [x] dependent elderly people. The building has reached the end of its useful life.

2. A private nursing home organisation offers to replace the existing NHS hospital with a larger private nursing home, the construction to be financed by the private sector, and to provide [x] contracted beds to the DHA. The price of the long-term contract will undercut the present running costs to the health authority. Thus it has a better NPV than if the DHA were to build the replacement. The major reason for the lower cost is that the private sector is proposing to provide care in an innovative institutional form that is not yet widely accepted in the NHS. It is believed that satisfactory guarantees of quality of care can be secured in the contract, partly by ensuring continuing cover by geriatricians.

Analysis

3. This proposal will certainly pass the value for money test, (given the satisfactory guarantees on quality of care). But it would equally certainly substitute for NHS provision. The necessary capital expenditure on the existing building, or a new one, must form part of the district's capital expenditure plans. In principle, therefore, the correct course would be to reduce the regional capital allocation while increasing the district's current expenditure allocation to cover the capital financing element of the fees paid to the contractor. This realignment of provision would allow the health authority to retain the current expenditure savings.

4. The Department of Health believe, however, that the district would be unlikely to pursue the opportunity in the near future if an offset to capital expenditure is required. In practice a project of this kind that is too innovative or controversial in the NHS will not receive priority in the capital programme unless the requirement for an offset is waived. In their view the demonstration value of the project is such that Ministers should decide to allow it to proceed as an addition to the programme.

5. The Treasury will be considering the specific case with the Department of Health. In their view, however, this is a good illustration of the case for a capital loan fund (example 1), which would enable the Department to fund projects over and above regional service priorities.

EXAMPLE [5]: A JOINT VENTURE PRIVATE PATIENTS FACILITY

An Income Generation Opportunity

1. A District Health Authority may decide that it could optimise the use of its assets by making some provision for private patients and that this would be best provided by a new facility (eg a private wing) on the surplus land of a District General Hospital. There are several options for the building of a new facility.

(a) Leasing

2. Part of the land could be leased to a private company who would then build the facility. It would be owned and managed by the private company. The income generated for the DHA would come from creation of the leasehold and sale of services (eg diagnostics) to the private company.

Analysis

3. The risks to the DHA are very low and would arise only if the private company went out of business causing a delay before this site could be leased again or sold.

4. Treasury see this example as presenting no problem.

(b) Joint Venture

5. The facility could be built by a private company and, as part of a joint venture by the DHA, the land would be provided on a lease that could provide for a share in the profits from the venture. The income generated for the DHA would come from a share in the profits generated by the facility and sale of services (eg diagnostics) and to a lesser extent from creation of the leasehold. In other respects the scheme would be the same as (a).

Analysis

6. The risks to the DHA are low and would arise primarily if the private company went out of business causing a delay before this property could be leased again. But there would also be a risk of forgoing the lower, but more certain, income involved in a leasehold-only arrangement. The expected income to the NHS is greater under this option than under option (a) and would grow through time as demand for private care grew. DH believes the low risks are acceptable in areas in which health authorities can claim good product and market knowledge. Thorough financial appraisal of schemes would be needed and it would be prudent to include in any contract a getout or renegotiation clause.

7. Treasury see this example as presenting no problem provided health authorities act with due prudence, by identifying and assessing the risks of revenue or capital loss and ensuring that they have the appropriate management capability to monitor and

control the risks. The authories' auditors will need to take particular interest in such arrangements.

(c) Joint Venture Health Resource Centre

8. As an alternative to (b) a prevention-oriented facility called, say, a community health resource centre could be built by a private company and, as part of a joint venture by the DHA, the land would be provided at a below-market lease. The facility would provide screening, investigation, fitness assessment, sports medicine, health education, and occupational health services. The income generated for the DHA would come from a share in the profits generated by the facility and sale of services and to a lesser extent from creation of the leasehold.

Analysis

9. The risks to the DHA are reasonably low and would arise primarily if the private company went out of business causing a delay before this property could be leased again. But there would also be a risk of forgoing the lower, but more certain, income involved in a leasehold-only arrangement. The expected income to the NHS is increased under this option through the sharing of profits and would grow through time as demand for private health promotion grew. DH believes the risks are acceptable in areas in which health authorities can claim good product and market knowledge. Thorough financial appraisal of schemes would be needed and it would be prudent to include in any contract a getout or renegotiation clause.

10. Treasury see this example as presenting no problem provided health authorities act with due prudence, by identifying and assessing the risks of revenue or capital loss and ensuring that they have the appropriate management capability to monitor and control the risks. The authories' auditors will need to take particular interest in such arrangements.

EXAMPLE [6]: A JOINT VENTURE INVOLVING A NON-HEALTH FACILITY

An Income Generation Opportunity

1. The NHS might lease surplus land to a private company for a non-health activity such as a hotel or retailing. The private company would bear the full development cost and would pay a guaranteed basic rent plus a percentage of the income from the development throughout the period of the lease. Assessment of the market potential and the conveyance of the lease would be based on professional advice. The NHS would need to monitor the lease and would have the option to dispose of it on the commercial market if it were considered appropriate to do so.

Analysis

2. Such an arrangement would, in some circumstances, produce a higher return than selling the land or making it available for rent to an enterprise concerned with health care. The straightforward sale of a freehold may not always provide the best return - particularly where the full development potential is still to be established. Mandatory guidance will be issued on the conditions under which health authorities can involve themselves in non-health activities.

3~~10~~. Treasury see this example as presenting no problem provided health authorities act with due prudence, by identifying and assessing the risks of revenue or capital loss and ensuring that they have the appropriate management capability to monitor and control the risks. The authories' auditors will need to take particular interest in such arrangements.

EXAMPLE [7]: A COOPERATIVE VENTURE WITH A HOUSING ASSOCIATION

A Privatisation Opportunity

1. In some areas NHS staff have difficulty in finding accommodation at rates they can afford. A District Health Authority may find that to recruit and retain sufficient staff it must provide good quality residential accommodation and in doing so that better value for money could be achieved by closer cooperation with a housing association. It is not suggested that there should be any change in existing policies on the scale of provision of accommodation for NHS staff. The scheme might be undertaken in more than one way.

(a) Site Leasing

2. Part of a hospital site could be leased to a housing association who would then build the accommodation. It would be owned and managed by the housing association. There would be income generated for the DHA from creation of the leasehold.

Analysis

3. This would cost the DHA less than if it were to provide the accommodation itself. The risks to the DHA are very low and would arise only if the housing association went out of business causing a delay before this site could be leased again.

4. Treasury agree that offsets to NHS capital expenditure would not be required.

(b) Joint Venture

5. The accommodation could be built by a housing association and, as part of a joint venture by the DHA, the land would be provided at a below-market lease. Such a subsidy, in this example, would be necessary to induce the housing association to take over the provision of accommodation. There might be income generated for the DHA from a share in any profits and to a lesser extent than under (a) from creation of the leasehold. In other respects the scheme would be the same as (a).

Analysis

6. The cost to the NHS under this option would be no greater than if the NHS were to provide the accommodation itself. The risks to the DHA are low and would arise only if the housing association went out of business causing a delay before this property could be leased again. DH believes the low risks are acceptable.

7. Treasury agree that offsets to NHS capital expenditure would not be required.

(c) Higher Quality Provision

8. Existing accommodation could be leased to a housing association who would then refurbish it and improve its quality. As part of a joint venture by the DHA, the property would be provided at a below-market lease. Such a subsidy, in this example. would be necessary to induce the housing association to take over the provision of accommodation. The costs of refurbishment and improvement incurred by the housing association would be recovered in the rent charged to the residents. The DHA would not feel able to commit its own resources to this purpose.

Analysis

9. There is no cost to the DHA under this option and there is the benefit that staff enjoy better accommodation. The risks to the DHA are very low and would arise only if the private company went out of business causing a delay before this property could be leased again.

10. Treasury agree that offsets to NHS capital expenditure would not be required.

CONFIDENTIAL

2 MARSHAM STREET
LONDON SW1P 3EB
01-276 3000

My ref:

Your ref:

Alison Smith
Private Secretary to
The Rt Hon John Wakeham MP
Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1A 2AT

CHIEF SECRETARY
REC. - 9 DEC 1988
COPY TO
Miss Peirson,
cx, Sir P Middleton
Mr Anson, Mrs T Burns
Mr Phillips, Mr Beastall
Mr Potter, Mr Saunders, Mr Call

9 December 1988

Dear Alison

AUDIT OF THE NATIONAL HEALTH SERVICE

Thank you for your letter of 8 December attaching a draft of the minute which the Lord President proposes to send to the Prime Minister reporting the conclusions of the meeting on Tuesday.

My Secretary of State feels that the draft rather labours the difficulties of including the proposed paving provision in his Bill. He hopes that it will not prove that difficult and that his suggestion for a speech will help set the measure in the context of making fuller use of a body which has proved its effectiveness. He believes that the minute should invite the Prime Minister to give her views on whether this measure should be in the Bill at Introduction so that there is no ambiguity thereafter about drafting authority.

I am copying this letter to the recipients of yours.

Yours
Roger

R BRIGHT
Private Secretary

(contrary to what they fear) the private finance rules do not prohibit. The approach of the second draft therefore is to emphasise the wide measure of agreement and to identify and isolate the points of difference. This is clearly the right approach to take with the Prime Minister.

3. On substance, it will be important to keep to the main issues. Mr Clarke may well want to talk about borrowing by self governing hospitals from the private sector. But you should insist that that is taken in the context of the paper about self governing hospitals, and not here. He may also argue that the powers of health authorities to enter into joint ventures with property companies are insufficient. Again, that is an interesting policy issue, but it has nothing to do with private finance. It raises completely different issues about, for example, whether property development is really an appropriate activity for the public sector to be undertaking.

4. One DOH objective is to allow Bromley (example 1) and Bolton (example 4) to go ahead. But the existing regime allows Ministers to decide that they should, if they think fit.

5. The DOH paper implies that he would like two further changes. Paragraphs 4 and 7 appear to argue that any project which can pass the rate of return test should be allowed to go ahead with private finance. But that is completely unacceptable. All will have to be paid for eventually by the taxpayer, and the effect is simply to drive a coach and horses through public expenditure controls. You should press Mr Clarke very hard on this.

6. Paragraph 5 of the paper argues for complete exemption of all contracting out. We would argue that this is unrealistic. If - taken to the extreme - all hospital services are contracted out, then no NHS capital expenditure is needed. So control total adjustments must be needed in some circumstances. It is one thing to argue that specific trail-blazing projects should be additional, but Mr Clarke does not seem to have thought it through further.

chex.md/mw/15 UNCLASSIFIED

FROM: MISS M P WALLACE
DATE: 9 December 1988

ANNEX C

MR SAUNDERS

cc PS/Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Culpin
Mr Parsonage
Mr Griffiths
Mr Call

SPEECH BY BOB GRAHAM - CHIEF EXECUTIVE, BUPA

The Chancellor thought you and others might be interested to read ... the attached speech sent to him by Mr Bob Graham, Chief Executive of BUPA.

MOIRA WALLACE

vj2.9.12

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 9 DECEMBER 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 Richardson
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: ACCESS TO PRIVATE CAPITAL

You will be discussing this issue with Mr Clarke on Monday morning. The main paper will be the note by Treasury and DOH officials attached to Mr Phillips' minute of 7 December. I attach however two more notes:

(a) a draft note by you and Mr Clarke, which would cover an agreed note by officials, along the lines of the earlier paper. This has been prepared by DOH officials, and has not been cleared by Mr Clarke;

(b) a longer draft paper which would subsume the note by officials. This is my draft. It has not been shown to DOH, although they are aware of its existence.

2. On handling, the main issue is which type of paper to put into the meeting of the Prime Minister's group later in the week. We should argue strongly for a paper along the lines of my draft. The DOH approach sets up the issues in a much too combative way. It slides over the fact there is a wide range of schemes which health authorities want to do and which

7. There are two possible areas of compromise (other than simply conceding the Bromley and Bolton cases on pragmatic grounds within the present rules):

(a) the Chancellor's suggestion that we should take a more relaxed view of value for money so far as self governing hospitals are concerned, so that, for example, a Bromley-type scheme could go ahead. This has attractions in principle, but it would mean applying a more liberal regime to these hospitals than to other parts of the public sector, including nationalised industries and local authorities;

(b) conceding some additional public money (say £50-100m) for a capital loan fund to finance schemes like those at Bromley or Bolton.

Chmm... not quite your wording — we "relax" only because they are self governing and it is ∴ their lookout!

8. Our version of the draft paper offers neither at the moment. But we might discuss at our pre-meeting whether we should do so in discussion.

R B SAUNDERS

NHS REVIEW

CAPITAL

Joint paper by the Secretary of State for Health and the Chief Secretary to the Treasury

Introduction

1. We were asked to give further consideration to the scope for freeing up access to private capital by NHS hospitals. Colleagues were keen that self governing hospitals in particular should have as much freedom in this respect as possible. The arrangements for capital financing of self governing hospitals are discussed in a separate paper. Officials have examined the present rules on "unconventional finance" as they affect directly managed NHS hospitals. The results of their work are attached at Annex A. This paper sets out the views of the Secretary of State for Health and the Chief Secretary on the issues they wish to put before the Ministerial Group.

Private capital for directly managed hospitals

2. The current rules on DHAs' freedom to use private capital require that any project must show best value for money, and the capital so used must normally be set against allocations of public expenditure.

3. Our officials have studied a range of examples of such projects which illustrate the way in which the present rules bite, and the way in which they constrain the achievement of other objectives of the Review, such as greater involvement of the private sector and income generation. Annex 1, the paper by officials, sets out the existing scope within existing rules for allowing greater flexibility for management.

4. The Secretary of State believes that this does not go far enough. In general, competent NHS management, acting on sound financial advice, and with the longstop of effective audit, should have the freedom to identify their own capital needs, and fulfil them by whatever means makes sense in the particular circumstances.

5. The Secretary of State welcomes the recognition that "contracting out" projects should be assessed under a more relaxed approach (paragraph 13 of the officials' paper). Contracting out is an key element of Government policy and it will be important to encourage its adoption by means of "demonstration projects". However he believes that this approach should be applied across the board, and not on a case-by-case basis, which will only hamper health authorities' in pursuing valuable opportunities. The responsibility for allowing such projects to proceed should be for higher tiers of management whether at Region or the Management Board.

6. He also welcomes the interpretation of the rules in relation to the risk of profit-sharing ventures (paragraph 14 of the officials' paper). This interpretation is not widely understood by NHS Managers, who will be able to bring forward effective projects. This is an example of the scope that should be permitted to prudential managers.

7. However the Secretary of State considers that an important point of principle needs to be established, which so far this examination of the Treasury rules has not addressed. Where any scheme in the NHS will yield a net cost saving to the public purse, and cannot be financed from current allocations of public funds, a health authority should be permitted to use private capital, where this is available, provided the scheme yields good (not necessarily "best") value for money. In addition, in these circumstances, there should not be a corresponding offset in the allocation of public capital funds, (which will normally already be allocated elsewhere in the capital programme).

8. Against this, the Chief Secretary [For Treasury draft - points out that the rules are intended to achieve value for money in the use of public funds, and to contain public expenditure within limits set by Ministers. In that light, he considers that it would not only be unnecessary to go further towards freeing access to private finance, but also contrary to proper management of the economy.]

9. Colleagues are invited to:

- endorse the limited scope for more liberal interpretation of the present rules, as set out in the officials' paper

- consider whether there is scope for giving greater freedom for NHS managers in this field, along the lines set out by the Secretary of State, in the more highly devolved and competitive environment which we seek to create.

CONFIDENTIAL

DRAFT

ACCESS TO PRIVATE CAPITAL

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

Our paper HC56 said that we would report back to the Group when we completed our further work on this question.

2. We have examined a range of projects which individual health authorities would like to undertake. In so doing, we have applied two general principles: that value for money must be secured on behalf of the taxpayer; and that, where the capital costs of a project ultimately devolve onto the taxpayer, there is a presumption that it should not be additional to the agreed public expenditure programme.

3. For the most part, the application of these principles to particular cases is clear, and we have found no reason why they should impede the projects from going ahead. The following are among the examples we have considered, and which we see every reason to encourage:

(a) a joint venture between the NHS and the private sector, who share the construction of hospital facilities, with costs apportioned according to the use they plan to make of them. There would be opportunities for trading between the two sectors, with the private sector selling capacity to the NHS and the NHS selling diagnostic services, etc to the private sector. The NHS would receive rent from the private health care provider in respect of the land;

(b) leasing NHS land, buildings or other facilities to private sector health care providers. The private sector would run facilities on an NHS hospital site. The lease might be on conventional repayment terms, or might enable the NHS as landlord to share some of the profits generated by the lessee;

(c) as (b), but with the lessee providing a non-health facility. This might be a hotel, shops, or a sports centre. It could sell its services to the hospital, to patients and to visitors. Again, the lease could either be conventional or involve an element of profit-sharing. This would be an alternative to the sale of the freehold, if the health authority considered that it offered a better deal;

(d) leasing part of a hospital site to a housing association which would provide low-cost accommodation for NHS staff. The NHS might subsidise the lease, and possibly share in the profits. The housing association could either build afresh or refurbish existing accommodation.

4. In all these cases, there are no complications resulting from the private finance principles. The health authority needs to assess the commercial risks it faces from the venture (eg if its partner went out of business) and to ensure that it has the right management capacity and skills to deal with this as appropriate.

Contracting out

5. Contracting out is an issue, however, which raises slightly more difficult questions. In principle, if a service is contracted out to the private sector, the need for capital in the NHS is reduced. But since the contractor's fees will involve an element for the cost of financing its capital expenditure, the health authority should receive a higher current allocation. In principle, therefore, health authority capital spending should be reduced, and current spending increased. Where services have been contracted out so far, however - mainly, catering, cleaning and laundry services - the capital element in the contractor's fee has been so small as not to warrant any ajustment. But, at the other end of the spectrum, there are cases where adjustments between capital and current allocations are clearly appropriate - for example, in the hypothetical case of a health authority which decided to contract out all its hospital services.

6. There is a grey area in the middle. It has already been explored for contract energy management schemes, under which a contractor takes over the energy management of a hospital, including perhaps the installation of a new boiler incorporating modern technology, with the aim of substantially reducing energy costs. Guidelines for taking account of the contractor's capital expenditure have been agreed across government. Rather similar issues will be raised by the need to upgrade or replace NHS incineration plant to comply with new statutory controls on emissions. Again, this is an area where the expertise resides in the private sector, and where significant capital expenditure by the contractor may be involved. Another case is that of a health authority which is seeking to contract out the care of some geriatric patients, rather than to replace itself an outdated and crumbling hospital.

7. Our two Departments are in touch bilaterally on these issues. We propose that officials should continue their work to clarify the ground rules in such cases.

Private bridging finance

8. There is however one particular case where we have identified a clear difference of view between us. This is the financing of cost-saving projects of the sort now proposed for Bromley District Health Authority. Outdated town centre facilities would be moved to a greenfield site just outside the town, thus bringing about expenditure savings as well as largely financing the cost of the new hospital from the proceeds of selling the present sites. There is however a timing problem in that the land sales receipts are not available until after the new hospital has been constructed and the patients moved into it. A developer has proposed that he should bear the costs of the construction himself, receiving in return the vacant land now occupied by the District General Hospital. In effect, he provides bridging finance.

9. Such bridging finance is likely to be more expensive to the government than financing the project in the usual way through public expenditure. This therefore increases the cost of the project to the taxpayer. The Secretary of State argues that the alternative is the project not going ahead at all; the Region's capital programme is fully committed for several years ahead, and health authorities have no objective basis for comparing cost-saving projects of this sort with those that meet service objectives. In the Secretary of State's view, the practical choice facing health authorities in this situation is between mounting the cost saving project now using private finance or mounting it considerably later using public finance. In these circumstances, the Secretary of State believes that the extra costs would be outweighed by the benefit of bringing the project forward.

10. The Chief Secretary does not accept however that such projects must inevitably be delayed. When projects promise such a good return, they should be accommodated within the level of capital expenditure agreed for the NHS, even if regions do not give them high priority. This could be ensured by keeping back part of the capital programme, which is at present all distributed to regions, for allocation centrally by the department to such projects. A similar idea was proposed by the Department in the course of this year's Public Expenditure Survey. The Secretary of State's proposal would mean giving greater freedom to health authorities, than to local authorities, where we have recently been tightening up.

11. The position of the Accounting Officer also needs to be considered. If the privately financed route were taken, an option would be adopted which investment appraisal had shown not to be the most cost-effective. In such circumstances, the Accounting Officer would be exposed to criticism by the PAC. This issue is being addressed at present in the Bromley case, and will need also to be considered in any other such projects which are put forward.

Self governing hospitals

12. The principles set out in paragraph 2 - that the taxpayer must get value for money, and that we must adhere to agreed public expenditure programmes - apply throughout the public sector. Approval of capital projects in nationalised industries and other public enterprises is subject to these considerations. And we have recently taken action to ensure that local authorities take proper account of them. So in principle, therefore, they must apply to self governing hospitals. The approval procedures will however be different. Although they will still be expected to abide by the general principle that public capital projects must deliver value for money, they will in practice be subject to less detailed scrutiny and control than the rest of the NHS.

Conclusions

13. In conclusion, we invite colleagues:

(a) to note that private finance considerations are fully compatible with a wide range of co-operative adventures which health authorities wish to enter with the private sector;

(b) to agree that our two Departments should do further work on the detailed application of the general principles to the different types of contracting out which are possible;

(c) to consider the issues raised by projects of the sort discussed in paragraphs 8-11, including the idea of a publicly financed capital loan fund;

(d) to agree that self governing hospitals should be guided by the same principles, although they will not be subject to detailed control in the way that health authority managed hospitals are.

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

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

CH/EXCHEQUER

REC.	-9 DEC 1988
ACTION	MR SAUNDERS
COPIES TO	CST SIR P MIDDLETON SIR T BURNS MR ANSON MR PHILLIPS, MR CULPIN MR TURNBULL, MISS PEIRSON MR PARSONAGE, MR GRIFFITHS, MR CALL.

✓ 12/12

COVERING SECRET

Paul Gray Esq
10 Downing Street
LONDON
SW1

9 December 1988

Dear Paul

NHS REVIEW

I attach the following papers for discussion at next Friday's meeting of the Ministerial Group:

HC62 NHS Review: Draft White Paper

HC63 Managing the FPS: Outstanding Issues

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

Yours

A J McKEON

B:D8.43/4

3.9.12 C O N F I D E N T I A L

FROM: C W KELLY

DATE: 9 December 1988

CHIEF SECRETARY

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

NHS REVIEW : PAY

I had a useful meeting with DH officials this morning as a result of which we have produced the attached revised version of the paper on pay. The bulk of the text is now agreed between us (ad referendum on both sides) and the two main points of dissension flagged up for discussion between you and Mr Clarke on Monday. These are:

i. Is it politically feasible to take doctors, nurses and PAMs in self-governing hospitals outside the scope of the Review Bodies, if that is what the hospitals want?

ii. Should self-governing hospitals be able to take advantage of their new freedoms over pay at a pace and time of their own choosing without any further reference to the centre, or should they first have to satisfy the centre that certain conditions are satisfied?

3. You objective on Monday as far as this paper is concerned will be to focus discussion on these two questions, if possible to reconcile the two positions, if not to agree how they should be handled in the paper, and to avoid any back sliding on the agreement which has now been reached on the rest of the text.

4. The judgement about the Review Bodies is essentially a political one. In principle it makes just as much sense to give self-governing hospitals discretion over the pay of eg nurses as it does over the rest of their staff.

5. The difference between us about the extent to which the process of change should be managed now appears to be rather less than it was, subject to one proviso. The Department of Health are now saying that, like us, they would not expect self-governing hospitals to depart very far from current pay regimes very quickly. But they would like them to feel that they could, if they wanted, without having any further bureaucratic hoops through which to jump. They argue that such hospitals should not have to prove again the depth of their management expertise since they will have had to do that when achieving self-governing status in the first place; and they are not prepared to accept that delegation should depend upon the reality of competitive pressures being first demonstrated.

6. The proviso is an important one. His officials think that Mr Clarke has given up the idea of legislating so that all staff in self-governing hospitals have new contracts of employment immediately. But they are not entirely sure. It would be as well to tease this out at your meeting. If he does favour the legislative route that would raise a different set of issues which would have to be dealt with in the papers.

7. The revised paper is going simultaneously to Mr Clarke tonight. I have sidelined the changes compared with the last version which you saw. I do not think that any of the detailed points should cause you any difficulty.

C W KELLY

enc

NHS REVIEW

PAY AND CONDITIONS OF NHS STAFF

Joint paper by the Secretary of State for Health and the Chief Secretary to the Treasury

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

Background

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

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

Flexible pay systems

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

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

Flexibility in the main-stream of the NHS

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

- performance-related pay for about 2,000 top managers together with some discretion to vary basic rates according to job weight. These arrangements are being extended to cover a further 7,000 staff with provision for market flexibility elements for hard to fill posts.

- regional variations for IT staff.

- bonus schemes for manual staff and

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

7. Health authorities also have responsibility for grading staff within centrally agreed grading structures, which affords some flexibility of a kind which varies between different groups of staff. There is some evidence that some authorities, particularly in London and the South East, have been exceeding the proper limits of this flexibility in order to overcome recruitment and retention difficulties.

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

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

10. A radical internal review by DH of conditions of service is also nearing completion. Greater devolution is a key objective, giving managers greater freedom to devise employment packages more suited to local needs. The review has highlighted a number of central controls which could readily be abolished - for example where at present an authority wishes to appoint an officer above the starting point on the relevant pay scale, perhaps because of special skills, individual approval and a "variation order" must be sought from the DH. Local management currently has few responsibilities in any of these areas. But it ought to be possible to give them progressively greater freedom as they gain experience and develop the expertise to run a more highly devolved system.

Self-governing hospitals

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

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

13. First, however desirable in principle, there is a question as to whether in the immediate future at least it is politically feasible to take doctors and nurses working in self-governing hospitals out of the remit of Review Bodies. [Drafting to be amended in light of discussion].

14. Second, self-governing hospitals will not be starting from scratch. They will be taking on their existing staff who, even in the non-review body groups, will have existing contracts of employment which explicitly or implicitly relate to pay and conditions determined under the existing mechanisms. Attempts unilaterally to vary the method of pay determination could be held to be a breach of contract which could lead to unfair dismissal claims, and redundancy payments. It might be possible to deal with this to some extent by legislation. But that would involve taking away existing public and common law rights and for that reason would be likely to be controversial. The alternative would be negotiation by each hospital of new contracts of employment with particular groups or individual members of their staff, which will take time to produce results.

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

16. In principle, genuine competition for the provision of services ought to be an effective constraint on hospital management against letting pay get out of control. They would

simply lose business if they did. But in some parts of the country, and in some specialities, the competition would be limited, particularly in the immediate future. It would therefore be necessary to rely upon some combination of:

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

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

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

Conclusion

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

19. If they are to achieve their full potential, and because this is consistent with their underlying philosophy, there is a strong argument for giving self-governing hospitals much greater flexibility in the pay and personnel management area, not excluding complete freedom for determining their own pay and conditions, [at least for the non-review body groups]. But going

down this road does depend upon having sufficient confidence both in the ability of the managements concerned to manage pay negotiations with trade unions and in the effectiveness of competition and other mechanisms to prevent it leading to pay leap-frogging and increases in the NHS salary bill which it would in practice be difficult not to fund.

20. [Reference to position of Review Body Groups].

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

22. Against this background there are three broad options for self-governing hospitals:

Option 1: remove from self-governing hospitals any obligation to observe centrally determined pay and conditions, leaving them free to follow central arrangements, introduce entirely different arrangements, or adopt some intermediate position. Satisfying the Secretary of State that the hospital had the managerial and personnel capacity to handle this degree of freedom would be one of the conditions of self-governing status.

Option 2: keep self-governing hospitals within the general system but give them much greater freedom within it. For example, under the A&C arrangements described in Annex 2 they could be required to use the new national (and very flexible) grading structure and to operate within the 20-30 per cent limits, but would be subject to no other direct constraints or controls.

Option 3: enable self-governing hospitals individually to propose to the Secretary of State what new arrangements they wished to adopt, from withdrawal from the general arrangements to specific changes going beyond those available to main-stream hospitals.

23. [The Secretary of State for Health prefers Option 1, the Chief Secretary Option 3].

24. Colleagues are invited:

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

ii. To endorse the conclusion that no attempt should be made in the immediate future to exclude from the scope of the Review Bodies staff currently within their remit, [whether in self-governing hospitals or more generally in the main-stream of the NHS/but allowing self-governing hospitals to do so if they wished].

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

iv. To agree that the appropriate way of doing this is ....

9 December 1988

ANNEX 1

DETERMINATION OF PAY AND CONDITIONS OF SERVICE FOR REVIEW BODY GROUPS

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

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

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

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

PROPOSALS FOR INTRODUCTION OF GREATER LOCAL FLEXIBILITY

The problem

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

Senior managers

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

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

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

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

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

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

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

Administrative and clerical staff

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

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

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

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

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

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

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

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

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

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

Nursing and midwifery staff

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

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

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

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

Other staff groups

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

dg9.12.3 SECRET

FROM: D P GRIFFITHS
DATE: 9 December 1988

1 MR SAUNDERS

2 CHIEF SECRETARY

cc Chancellor
Paymaster General
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Richardson
Mr L Watts
Mrs Butler
Mr Parsonage
Mr MacAuslan
Mr Sussex
Mr Call

NHS REVIEW: SELF-GOVERNING HOSPITALS

I attach a further draft of the paper on the financial arrangements for these hospitals which has been sent to Mr Clarke and will form the basis for discussion on Monday. The paper has been shortened, with the proposals outlined at the start, and makes clear our view that the public corporation model is the best available.

Handling of the paper

2. We consider that it would be desirable to submit a paper along these lines to the Ministerial Group meeting on 16 December unless we can reach agreement with Mr Clarke on the financial regime for these hospitals. (In which case it would only be necessary to submit a short note or even simply reflect the agreement in general terms in the draft White Paper chapter on self-governing hospitals.) However, we regard this as rather unlikely, given the reports we have of Mr Clarke's thinking. But we should aim for a joint paper if at all possible.

Public Expenditure

3. Another issue has come to light since yesterday's discussion. This is that public expenditure - as measured by the planning total and GGE - could increase as a rewsult of changing the status of hospitals to public corporations and requiring them to pay interest charges on originating debt. This is because payments by health authorities will have to cover the hospital's loan charges, but hospitals' payments of interest to the government will be

revenue (not negative expenditure) . While the effect on PSDR is neutral, the planning total and GGe are higher than they otherwise would be. In view of the likely net value of the hospitals' initial assets, the size of the annual interest charge is likely to be substantial.

Points of Contention

4. We have not had a full report of Mr Clarke's views but he is likely to press for even greater freedoms for self-governing hospitals than we have proposed. In particular, he may argue that there should be no restriction on the hospitals' borrowing powers. His line may be that if the hospitals' loans are not guaranteed by the Government, there is no reason why they should score as public expenditure and hence no need to control their borrowing. He is likely to quote the example of universities. Although the great bulk of their running costs comes from public funds, they are free to borrow as they see fit.

5. This is a false analogy. Universities are private sector bodies. While a body is in the public sector its borrowing inevitably scores as public expenditure and there clearly must be some control over the amount it can borrow. Even leaving aside the question of whether it is the intention of the Ministerial Group that self-governing hospital should be private sector bodies, it is very doubtful whether, on the basis of current proposals, they would be eligible for this status. A majority (though not all) of the board of a self-governing hospital will be appointed by the public sector (either the Secretary of State or the RHA). This will mean that the hospital is deemed on control grounds to be in the public sector. Similarly the reserve powers of the Secretary of State and particularly his right to withdraw self-governing status would probably be construed as giving him control over the hospital hence leading it to be classified as a public body.

6. We are also clear that while self-governing hospitals remain in the public sector the Department will retain a general stewardship responsibility for their use of public funds, besides any specific accountability for loans from their votes to the hospitals. Nor can the hospitals escape from the scrutiny of the NAO.

[redacted]. An issue which may exercise DH officials more than Mr Clarke is the source of any government loans to these hospitals. They may want the loans to come from the NLF rather than voted funds. We should resist this. DH are accountable for the loans and voted funds are therefore the proper source. As the Treasury would be accountable for loans for the NLF there would be a dual accountability which would not be a satisfactory arrangement.

D P GRIFFITHS

FINANCIAL ARRANGEMENTS FOR SELF-GOVERNING HOSPITALS

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

Introduction

1. Self-governing hospitals will offer better value for money, higher efficiency, increased choice for patients and closer links with their local community, providing a spur for the improvement of standards in the rest of the hospital service. To achieve these objectives they will need the maximum freedom and flexibility in managing their financial affairs consistent with maintaining public expenditure control and accounting propriety. This paper considers what financial arrangements will be required.

2. We consider that the best available model for the financial framework for these bodies is that of the public corporation. Thus self-governing hospitals would have:

(i) ownership of their assets and the freedom to use them as they think best subject only to certain reserve powers of the Secretary of State;

And, subject to an annual financing limit:

(ii) freedom to retain surpluses and to build up reserves;

(iii) freedom to manage any temporary deficits;

(iv) freedom to borrow to finance their working capital and capital investment.

Freedoms of self-governing hospitals

i) Ownership and use of assets

3. The assets of self-governing hospitals would be vested in their boards, in keeping with the overall objective of giving them the maximum possible freedom to run their own affairs. They should also have the freedom to make use of their assets to provide the pattern of service they think best. This should include the

freedom to dispose of assets subject only to a reserve power for the Secretary of State to intervene if the disposal was against the public interest.

4. To impose the necessary commercial discipline, the hospitals should not be given these assets as a free good. We propose that - like Trading Funds - the hospitals should be given an interest bearing originating debt, equal to the value of their initial assets at vesting. This would have the same financial management advantages as but be outside the capital charging system to be introduced into the rest of the hospital system from 1991 onwards.

5. Like other public enterprises, self-governing hospitals should be set financial targets in the form of a real rate of return on capital employed which they would be required to achieve.

ii) Retention of Surpluses and Reserves

6. To give self-governing hospitals end-year flexibility on their operating surpluses, they should be allowed to retain these surpluses. They should also have the freedom to build up reserves to improve their services and help finance capital investment. This will give them an additional incentive to maximise their efficiency and keep their costs down. (The legislation will need to specify the form in which these reserves can be held.)

iii) Deficits

7. We cannot be certain that self-governing hospitals will invariably be able to balance their budgets every year. A hospital may end a particular year with a deficit despite being in a sound underlying financial position. A requirement that hospitals could not run end-year deficits would be an artificial and unnecessary constraint on their activities. However, a self-governing hospital should not be entitled to run a continued deficit: this would undermine its viability and build up potential liabilities for the Exchequer. This would be avoided by setting a requirement that they should break even taking one year with another.

iv) Working Capital and Capital Investment

8. Self-governing hospitals' income and expenditure cash flows are unlikely to match each other at all times throughout the year. They will therefore need access to working capital through loans/ overdraft facilities. (They will need a loan at their foundation to give them the necessary working funds until the income from their contracts starts to flow.) More significantly, they will also need access to funds for capital investment so that they can maintain and expand their facilities to meet demand and provide the required standard of service. They are unlikely to be able to finance their capital investment solely from sales of assets and/ or the reserves they have built up. They should therefore be able to meet their capital requirements through loans, which they would have to service from their income in the same way as hospitals in the rest of the NHS will be charged for capital.

9. The funds used to finance the current expenditure of self-governing hospitals will almost all be public money for which the Department of Health will be accountable. As public corporations, all their borrowing from whatever source and their other external finance would also be public expenditure. To maintain public expenditure control there will therefore need to be limits to the amount the self-governing hospitals can borrow. The overall limit for the self-governing hospital sector would be set in the Public Expenditure Survey. This would then be disaggregated by the Department of Health into annual financing limits for the individual hospitals, taking into account their capital investment/disposal plans and internally generated resources. (The hospitals will anyway need to produce corporate plans.)

10. Self-governing hospitals could be allowed to borrow from the private sector or the Government. However, the commercial banks would not offer such fine terms - even if the loans were covered by Government guarantees - and their loans would therefore be more expensive. Borrowing from the Government would therefore be preferable on value for money grounds and it is expected that in practice the hospitals would use the Government for their capital borrrowings. (This would also be more transparent to Parliament.)

11. Loans from voted funds, rather than the National Loans Fund, would be the appropriate source of borrowing from the Government. This would reflect the Department of Health's responsibility for the NHS and for self-governing hospitals in particular. It would be for the Departmental Accounting Officer to satisfy himself that the loan would be serviced, and repaid, in full. Otherwise, if borrowing was from the NLF, the Treasury would share this responsibility, which would unacceptably muddle accountability to Parliament for the hospitals.

12. There would need to be arrangements to ensure that funds borrowed from the Government could not be put on deposit at higher rates of interest since the Accounting Officer would be open to criticism if loans were used for this purpose.

Preventing abuses of self-government

13. Self-governing hospitals should have the maximum freedom consistent with normal Accounting Officer principles. As they remain public bodies, the Secretary of State will need some controls over their exercise of their powers. He will, of course, be able to dismiss the board of a hospital and remove its self-governing status. However, these are draconian sanctions for use in extremis if it is clear that a hospital is no longer fit to run its own affairs. It will also be necessary for him to have the power to intervene if abuses of self-governing status are occurring. Since self-governing hospitals will not be subject to the general direction of the Secretary of State in the manner of the rest of the NHS, he will need some limited specific powers, for example, regarding the sale and purchase of assets and size and use of reserves. These powers would only be for use where there was a serious risk that a hospital was abusing its freedoms or getting itself into difficulties.

14. Further controls may need to be provided to prevent any hospital with a local monopoly of health care provision unfairly exploiting its position by, for example, charging high prices for its services. The system of capitation funding for health authorities will provide some protection. An authority will have a fixed sum to purchase services for its population which will constrain what it can pay the self-governing hospital. Its

contracts with a self-governing hospital may not by themselves provide all the funding the latter requires. The hospital may need to compete for business from outside its home district and this will affect the prices it can charge. However, it will be necessary to consider whether this needs to be reinforced by specific powers.

Other issues to be settled

(i) Tax

15. The tax treatment of the surpluses made by self-governing hospitals needs to be considered. (As the law currently stands, the view of the Inland Revenue is that health authorities are probably liable to tax on their profits from treating private patients and other income generation activities.) The VAT treatment of contracts let by health authorities to these hospitals is another issue to be considered.

(ii) Accounting for Capital

16. Self-governing hospitals would be required to maintain their own accounts. These should include provision for depreciation. The interest self-governing hospitals should pay on their inherited assets, the method of valuation and accounting for depreciation will need to be considered further in tandem with the details of the capital charging scheme: the different arrangements should not result in self-governing hospitals being placed at a competitive advantage or disadvantage to the rest of the hospital sector.

(iii) Accountability

17. The operations of self-governing hospitals will be subject to audit by the Audit Commission like the rest of the NHS. As our intention is that these hospitals should be as autonomous as possible, they will not be under the same direct control of the Department as the rest of the NHS. The Department's Accounting Officer will not be accountable for each individual hospital but he will have an overall stewardship responsibility for their use of public funds. (As now, he will will remain accountable for payments, including loans, made from his votes to the hospitals

and, in his capacity of Accounting Officer for the HCHS, for payments to health authorities.) To protect the position of the Accounting Officer it will therefore be necessary to ensure that there are adequate monitoring arrangements.

18. The NAO will remain responsible for auditing the consolidated accounts of the NHS and for scrutinising the Departmental Vote under which loans are made to the self-governing hospitals. They will have right of access to papers relating to the accounts and audit of self-governing hospitals and will also be able to include self-governing hospitals in their value for money studies of the NHS. in each self-governing hospital there will therefore need to be a single person with overall financial and accounting responsibility.

Conclusion

19. We consider that the financial regime outlined above can be created by the legislation establishing self-governing hospitals.

cst.ps/7ce12.12/lets

CONFIDENTIAL

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

Treasury Chambers, Parliament Street, SW1P 3AG

Ms Alison Smith
Private Secretary
to the Lord President
Privy Council Office
Whitehall
London
SW1A 2AT

12 December 1988

Dear Alison,

NATIONAL HEALTH SERVICE AUDIT

Thank you for your letter of 8 December. The Chief Secretary is content with the draft minute to the Prime Minister, subject to the following points.

First, the second paragraph does not discuss the possibility that the paving provision mentioned in the last sentence could, in principle, be expanded at committee stage to encompass the full legislation required for the transfer of the NHS audit to the Audit Commission. The Prime Minister will no doubt wish to know the arguments against that possibility. The Chief Secretary accordingly suggests the following amendments:-

i) In line 3, delete "this" and insert "it entirely".

ii) lines 4-5, delete "Any provisions that were agreed" and insert "some minimum provision".

iii) At the end of the paragraph, insert: "(In principle, it would be possible for such a paving provision to be expanded at committee stage to embrace the full legislation required for the transfer of the NHS audit to the Audit Commission, but the problems that even a paving provision could create, as discussed below, would be greatly magnified by such a move and we concluded that it was not practicable.)"

Secondly, the Chief Secretary has been reflecting since the meeting on the helpful suggestion by the Secretary of State for the Environment, recorded in the last substantive paragraph of the draft. He is fairly neutral about this although he does have some doubts about whether a speech along the lines suggested would have the effect intended, and wonders whether it would be better not to raise false hopes that some of the difficulties could be overcome in this way. The Chief Secretary's point is that, after the suggested speech, the health review white paper would be published, and would include the proposal to transfer the NHS audit to the Audit Commission. Therefore the provision in the Local Government Bill is likely to be seen in that light, no matter what the Secretary of State for the Environment had said before the White Paper had issues.

I am copying this letter to Roger Bright (Environment), Andy McKeon (Health) and Jan Dominguez (Welsh Office)

Yours,

Pete Wales

pp **MISS C EVANS**
Private Secretary

SECRET

SCOTTISH OFFICE
WHITEHALL LONDON SW1A 2AU

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

CH/EXCHEQUER

REC.	14 DEC 1988
ACTION	MR SAUNDERS
COPIES TO	CST SIR P MIDDLETON SIR T BURNS, MR ANSON MR PHILLIPS, MR CULPIN, MR TURNBULL, MISS PEIRSON MR PARSONAGE MR GRIFFITHS MR CALL

12 December 1988

✓ 14/12

NHS REVIEW: WHITE PAPER

Thank you for the copy of your letter of 7 December to Peter Walker about the way in which the territorial departments' interests are to be handled in the White Paper.

I will be unable to be present at the Group's meeting on 16 December because I shall be fulfilling engagements in the Western Isles which I had to cancel at short notice earlier in the year and cannot cancel a second time. My view, however, is that the main part of the White Paper should be drafted with the minimum of complicated cross references to the territorial interests; and that given the differences between Scotland, Wales and Northern Ireland, the three countries should each have a short chapter devoted to them.

My officials have already circulated a brief outline of what the Scottish chapter will contain. I shall aim to circulate an expanded version of that outline for the meeting on the 22 December; but clearly it will require further work to take account of the shape of your main text on which work will have been proceeding in parallel.

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

MALCOLM RIFKIND

EML344G7

SECRET

0294A

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

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

CONFIDENTIAL

Ch/ This is the promised note which arrived after our mtg. Proposal at X is Do it at their mtg Sensitive! (Dich will incorporate in his 1 page briefing note)

MPW.

14/12

Paul Gray Esq
10 Downing Street
LONDON
SW1

12 December 1988

Dear Paul

NHS REVIEW - GP BUDGETS AND PRIVATE PRACTICE

At the Prime Minister's meeting on 23 November the Secretary of State agreed to circulate a note about the effects of rates of private insurance on GP budgets.

The two points raised in discussion were:

firstly, that if patients knew that the GP would refer them to a private hospital as NHS treatment this would act as a disincentive to taking out private insurance; and

secondly, that a simple capitation approach to budget setting would lead to overfunding practices with existing high rates of usage of the private sector.

On the first, the Secretary of State believes that in practice the incentives will be quite the other way. Any NHS patients referred to the private sector will be a charge on the practice budget in just the same way as patients referred to NHS hospitals. The GP will wish to protect his budget and this may well provide the GP with an incentive to be more assiduous in enquiring whether the patient has private insurance cover before making his referral. This could lead to greater usage of private sector facilities, though not at NHS expense, than previously. This incentive to make sure that existing insurance cover is fully used will be particularly effective where the budget already takes account of the propensity of patients to use the private sector.

X that will go down well!

E.R.

This in turn suggests that the budgets should not be based on an unvarying capitation system. Rather budgets need to take account not just of expected levels of referrals but also actual or historical levels. When the RHA agrees with the GP practice the level of the budget it needs to have information about referral practices, at least to NHS hospitals, in the previous year. Where the "expected" referral level - based on weighted capitation - is higher than actual rates, the RHA would rely mainly on the latter. They would have no interest in unnecessarily overfunding a practice at the expense of other participating practices or DHAs. The GP practices need to be able to feel that they can "beat the budget" - that after all is their incentive to participate - but that should arise from more careful referral practices rather than overfunding. This use of both expected and actual referral rates in setting the budget, in the Secretary of State's view, meets the second point above.

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

Yours

Andy

A J McKEON
Private Secretary

SOMMET·**TORONTO**·SUMMIT

* to go communication only to me — no circulation

Alex

This is what John Moore gave me, in strict confidence.

I have got to be interested in any virus* from MSC/RPC (whoever is less pressured @ the present time).

As you know, I do not see this as a Budget for NICs — rather, I am relieved not to return to NICs until we can afford to abolish the stages altogether. But, whilst I am not attracted to linking the abolition of LEL to earnings, I am [illegible] the UEL is unlinking, so as to somehow create an extra [illegible] [illegible]

over

 PERSONAL AND CONFIDENTIAL

BF 20/12

FROM: A C S ALLAN
DATE: 12 DECEMBER 1988

MR CULPIN

NICs

When Mr Moore came to see the Chancellor on Friday he gave the Chancellor, in strict confidence, the attached papers. The Chancellor would be interested in any views you have, copied to him only at this stage.

2. As you know, the Chancellor does not see this as a Budget for NICs - indeed, he is inclined not to return to NICs until we can afford to abolish the steps altogether. But, while he is not attracted to linking the LEL to earnings, he is interested in unlocking the UEL somehow, so as to create an extra option.

3. Meanwhile, it is clear that we ought to use Mr Moore's forthcoming Social Security Bill as a means of enabling us, without further primary legislation, to divert more NIC contribution money to the NHS, thus avoiding an embarrassing build-up on the NI Fund.

ACSA

A C S ALLAN

ENC

NICs - OPTIONS FOR CHANGE

1. Smoothing

pro - removes cliff edges

cons - presentationally complex
- involves higher standard NIC rate
(query: open up debate on this issue in the future?)

2. Abolition of UEL substantial increase to UEL

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

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

3. Reducing all rates

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

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

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

KEY ELEMENTS OF PREFERRED (AFFORDABLE) PROPOSALS

1. LEL/UEL linked to earnings

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

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

2. Reduce lower rates % down and bands increased

pro - "tax" cuts aimed at low paid

con - increasing height of cliff edge to higher rate

3. Money

(a) Surplus

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

(b) Balance

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

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

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

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

OPTION

a Lower and Upper Earnings limits linked to Earnings

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

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

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

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

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

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

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

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

++ Negligible

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

3. NUMBER OF CONTRIBUTORS AFFECTED (MILLION)

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

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

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

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

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

Losers

Estimated numbers of losers

i Above the current UEL

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

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

Total offset (GAD estimate): £30 million.

ii contracted -out losers below the UEL

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

Earning £130 to £325 : 6 to 6.5 million

4. TYPES OF PEOPLE AFFECTED

The characteristics of the gainers is as follows:

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

Further analysis of Gainers and Losers Option 1(a)

Option 1a. Range of gains by earnings level

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

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

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

CHART 1

NATIONAL INSURANCE CONTRIBUTIONS

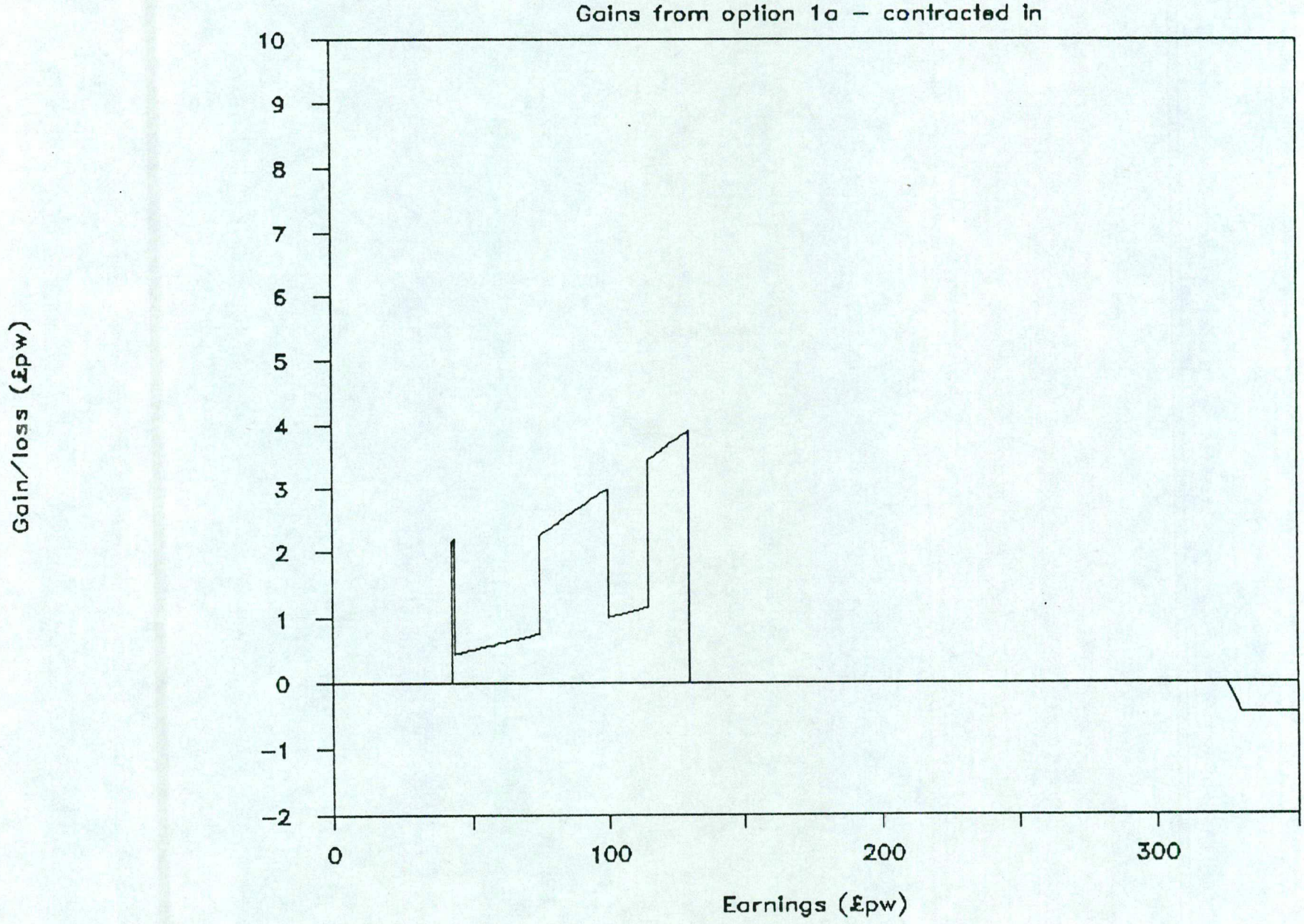
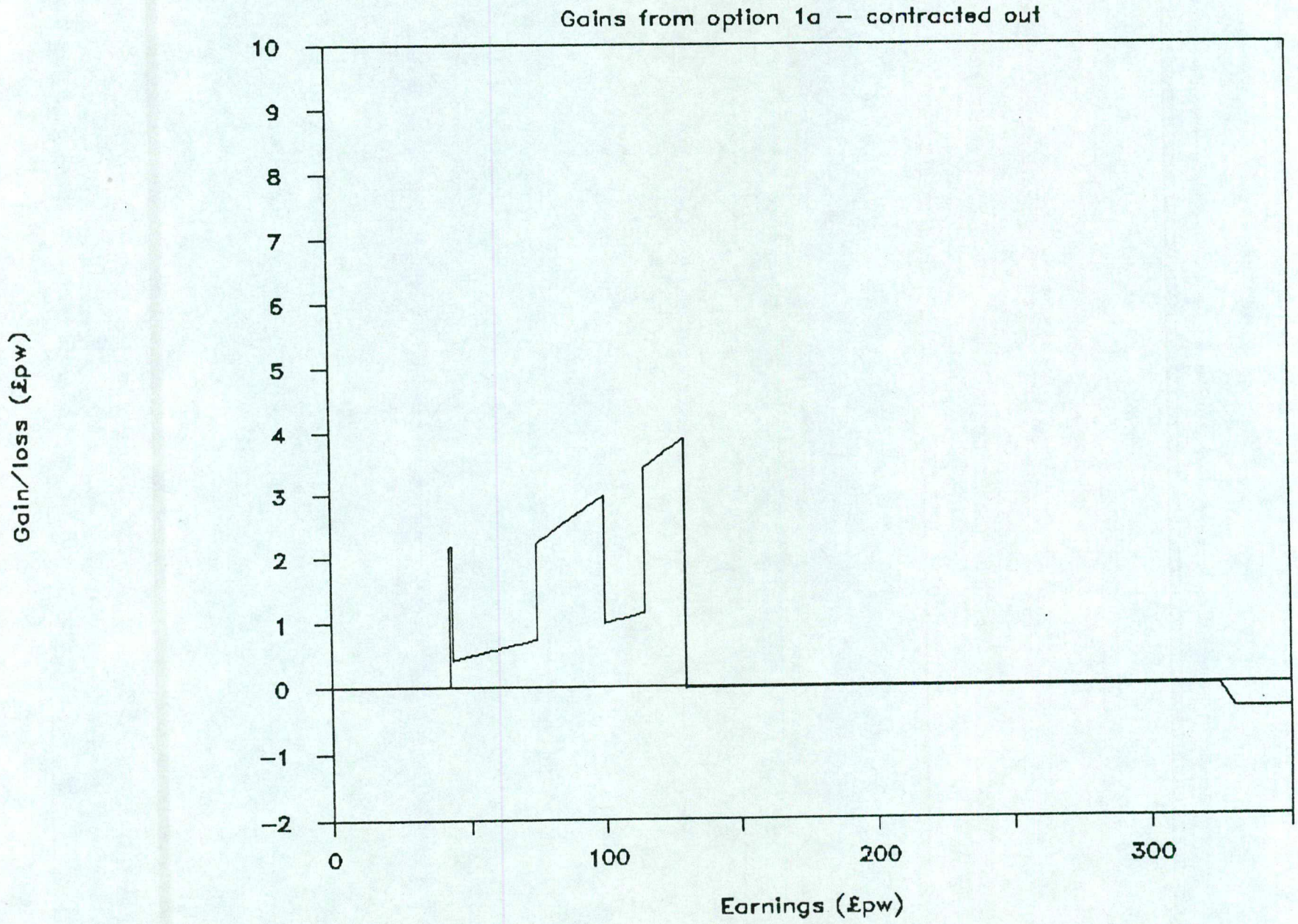


CHART 2

NATIONAL INSURANCE CONTRIBUTIONS



5. BENEFIT IMPLICATIONS

Family Credit

Numbers floated off benefit: 2500

Reduction of expenditure: £10 million

(Assuming current take up of Family Credit.)

Housing Benefit

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

Short-term contributory benefits

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

6. EFFECT ON INCENTIVES

The effects of the option can be summarised as follows:

a. Unemployment Trap

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

b. Poverty Trap

Combined deduction rate reduced at around £125 a week:

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

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

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

decst1.12

I have asked your office to ensure we see the revised Q+A as soon as it is available.

1. MR MCINTYRE JM 13/12.

2. CHIEF SECRETARY

[Note urged PMP to press for amendment]

FROM: P FRANCIS
DATE: 13 December 1988

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

Ah/X in DoSS answer simply isn't true, (yet).
Y below is clearly preferable.
mpow.

CHILD BENEFIT/FAMILY CREDIT: PQ BY THE COUNTESS OF MAR

I attach a PQ for Oral Answer put by the Countess of Mar to DSS Ministers on the increase in family credit and the freezing of child benefit. The attached reply has been agreed by Lord Skelmersdale this morning (though we do not yet know whether Mr Moore and Mr Scott are content).

2. Our view is that, although the draft reply says nothing we could strongly object to, it is laborious and not very clear. We have suggested a simpler alternative to DSS on the following lines, but it has not found favour:

RPT

> "Yes. An uprating of child benefit would have [~~given those on family credit~~] meant an extra 45p per child. Instead, we are increasing family credit by an extra 95p per child, over and above the uprating for prices"

Y

3. Notes for supplementaries are also attached, though DSS are still revising these. The main change will be to ensure that the response to any supplementary on take-up levels will point out that expenditure on family credit (at just over £400 million this year) is running at or above the level initially expected. DSS Ministers are however reluctant to use the 60 per cent figure for take-up in expenditure terms, which contrasts with the 30-40 per cent estimate for take-up in terms of caseload. This is because they want to switch the focus of debate away from the take-up percentages.

(odd, if we have better nos than those opposition will quote!)

K Taylor

4. I would be grateful to know if you are content with the DSS draft reply or whether you wish to press for amendments, for example in the lines suggested in paragraph 2. Lord Skelmersdale will be answering the Question on Thursday, so we need to go back to DSS tomorrow (Wednesday).

P FRANCIS

The Countess of Mar

To ask Her Majesty's Government whether they consider that the increase in family credit announced in the Autumn Statement will adequately compensate families on low pay for the lack of an increase in child benefit.

Draft Reply approved by Lord Skelmersdale

Yes, the increase in Family Credit announced in the annual uprating statement will more than compensate lower paid families. The procedure for uprating Family Credit ensures that any shortage from freezing Child Benefit is added to the uprating and, over and above that, we have included an extra 50p per child.

ID7636nJAN

1. Mr Allsop
2. Parliamentary Clerk

From: I Williams B2A
Date: 8 December 1988

Copies: Mr Taylor B
Mr Brereton ~~FC1A~~ D2
Mrs Thorp B2B
Mr Miller B2C
Mr Brown FC1A

PQ73: THE COUNTESS OF MAR

1. A suggested reply and briefing is attached.

I. Williams.

I WILLIAMS
Room 537
New Court
Ext 2515

7621n

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Thursday 15 December 1988
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The Countess of Mar

To ask Her Majesty's Government whether they consider that the increase in family credit announced in the Autumn Statement will adequately compensate families on low pay for the lack of an increase in child benefit.

Suggested Reply

Yes. Child Benefit and child credit rates must be added together for the true picture. Thus the increase for all Family Credit children's rates will be significantly higher than the rate of inflation. The biggest group - those under 11 - will get 9.3 per cent.

NOTES FOR SUPPLEMENTARIES

Uprating Child Benefit best way of targetting help on families with children?

Next April's uprating targets extra help on the neediest. The majority of any Child Benefit uprating would go to families who are better-off - including wealthiest. Amongst families who stand to gain from an increase in Child Benefit, seventy per cent of Child Benefit goes to those with incomes above average earnings.

Uprating: more money in Family Credit is no substitute for increase in Child Benefit, owing to poor take up, etc

Boosting Family Credit gives more to those who are already claiming. Also, it will encourage those who have been undecided, so far, whether to claim. We have to ensure that these, and the ones newly brought into Family Credit eligibility, do make a claim.

Amounts payable

Amounts payable by way of Family Credit are considerably more generous than FIS. For example:

- a couple with 2 children aged 11 and 14, with the father earning about £135 a week gross, would qualify for about £14.70 a week at present, [they would get about £20.70 from next April after the proposed uprating.]

- a lone parent with one child aged 5, and gross earnings of £75 a week would get about £25 now, [over £30 after the uprating].

Families on higher levels of earnings are eligible for Family Credit. For example:

- at present, a family with 2 children aged 11 and 14 will usually be eligible if their gross earnings are less than about £166: from April 1989 this will become £179;

- for a lone parent, one child aged 5, the upper limit is now £130, and becomes £139 gross;

- for a couple with 2 children, aged 4 and 6, it goes up from £143 to £155 gross;

- for a couple with 3 children, aged 3, 8 and 11, it goes up from £150 to £183 gross.

Uprating: Existing recipients only get the increase from the next renewal after the uprating: child benefit would have gone up straightaway

Awards of Family Credit are made for 6 months at a time and are not then changed - either for any changes in family's circumstances or for upratings. This often works in the claimant's favour - eg, increases in earnings are not taken into account until the next renewal claim. This carries forward what happened in Family Income Supplement but it is better in Family Credit because the award period is shorter (6 months instead of 12): therefore people don't have to wait as long to get the uprating.

Family Credit take-up is much lower than Government estimates

It is true that the caseload is not yet approaching the estimate of 450,000. But it is growing steadily. Apart from the months affected by the postal dispute, the caseload has grown each month. With the number of claims still in the pipeline, the underlying caseload is now approaching 300,000.

[IF PRESSED ABOUT WHEN TARGET OF 450,000 WILL BE REACHED: As I have said, the number of recipients is growing steadily. We are taking steps to get the message over to all who are eligible but I cannot speculate how quickly the number of recipients will grow.]

Family Credit take-up is only about 35 per cent

One cannot jump to this conclusion. Earnings and, therefore, incomes have increased more rapidly than we expected when the original estimates were made in October last year. Higher incomes mean fewer people may now be eligible than we thought originally. We will not know the true take-up rate until we have analysed the Family Expenditure Survey for this year and subsequent years. That will be in several years time.

[IF PRESSED: But even on the basis on which the Noble Lord, and others, have arrived at their figure of [35] per cent, this is almost certainly too low. We believe that the underlying caseload is now approaching 300,000 which would indicate a take-up rate, based on last year's estimates, nearer 40 per cent than 35 per cent.]

Total amount being spent on Family Credit

Indications are that Family Credit expenditure is running at or slightly above the level expected for the full 450,000 caseload estimate. This suggests that those entitled to high amounts have already claimed and that those who have not yet claimed are generally entitled to lower amounts.

Measures to increase take-up

A major exercise began at the end of last month and will run until Christmas. Everyone who collects their child benefit from the Post Office will receive a leaflet about Family Credit. This gives more information, particularly on points where there is evidence of misunderstanding, and invites people to make a claim. We are also advertising on local radio and taking other local initiatives.

For the future, we plan to have a further major advertising campaign, including television. We shall continue to publicise Family Credit and, especially, to make clear the levels of income at which it can be paid.

Delays in dealing with Family Credit claims

There were some problems in the early weeks of the new scheme, but average clearance times have now reduced to about 23 working days. The target is 18 days and as staff become more experienced I am confident that we shall soon hit that target.

Size of the Family Credit claim form (FC1) - 16 pages

I accept that it is long and looks complicated, but it has been designed to be simple to complete. There are full explanations about what is required and most claimants can skip whole sections which do not apply to them. Nevertheless, we are looking at ways of shortening the form and simplifying it still further.

Uprating: No separate uprating of cash compensation for free school meals

The cash addition was a once-and-for-all change when the new scheme was introduced. It is not appropriate to carry it forward as a separate element - no other items of expenditure are identified in this way within the rates. new children's rates do increase the overall cash provision for each child in Family Credit compared with cash provision in Income Support - from £2.55 for each child to £2.80.

Uprating: additional expenditure and extra numbers entitled to Family Credit as a result of the uprating

The higher rates of Family Credit will benefit existing claimants when they next renew their award after April 1989 - and will bring new families into eligibility. Up to 45,000 more families could get Family Credit under the new rates. Family Credit uprating costs about £25 million more as a result of the further increase in the children's rates over and above that indicated by the uprating factor and the adjustment because of the child benefit standstill.

7621n

Why Family Credit rates for children rise above the rate of inflation

Uprating the Family Credit rates for children had three elements. There was the normal rise to allow for inflation, and to this was added an increase to compensate for the freezing of Child Benefit. Finally the rates were increased by an extra 50p as a result of the Governments policy to target resources on those most in need.

NOTES FOR SUPPLEMENTARIES

1. REASONS FOR FREEZING CHB

* We are making £70 million of extra resources available to neediest families through income-related benefits - in addition to £135 million being spent on the annual uprating of income related benefit child allowances. These families will gain more from these extra resources than would have done had CHB been uprated. Thus we shall be spending over £200 million to the greater benefit of some 3 million children in lower income families.

* Higher CHB would mean resources going into more benefit for benefit off families, who cannot be said to need it.

* £7.25 per week still worthwhile contribution to cost of bringing up a child.

* CHB already accounts for nearly a tenth of all social security benefit expenditure over £4 1/2 billion this year. Altogether, will be spending over £2 billion more on social security next year - total budget of £51 billion.

2. Freezing CHB is not consistent with Manifesto commitment - means CHB is to wither on the vine

Future level of CHB will be determined at the annual review of benefit rates. This is in accordance with existing law and fully honours Manifesto pledge. We have no plans to change the basis of CHB.

3. Manifesto commitment for next election

It is very early to consider this when the Government was re-elected only last year.

4. REQUESTS FOR A DEBATE ON THE FREEZING OF CHB

The 1986 Social Security Act requires that an uprating order must state the rates of benefits not being uprated, and the draft order in its entirety is subject to approval by resolution of each House after a debate. The House will, therefore, have opportunity to debate the rate of child benefit for next year.

5. The House of Lords made their support for CHB clear by passing an amendment in the Social Security Act 1988 (Section 5)

Section 5 materially duplicates provisions of Section 63 of 1986 Social Security Act which already requires a review benefit rates annually, [but not at any one specific date. In practice it is obviously sensible to conduct the review at the same time as other benefits, in the autumn. A review in April would be unhelpful, since it is a full year before the next uprating would actually take effect.]

The Section 5 sits squarely within existing law and no practical purposes would be served by bringing the Section into effect. The Government have no plans to lay a Commencement Order to bring the Section into force.

6. Adequacy of CHB rate

CHB is not, and never ha been, intended to meet the full costs of a child. We consider that it remains a worthwhile contribution towards the cost of bringing up children. Its level does not affect overall child provision for families on income-related benefits because those benefits are adjusted to take CHB into account.

7. Level of CHB necessary to maintain its April 1979 value

For just a month before it lost office, Labour increased child benefit in April 1979 to the rate, in April 1988 prices, of £7.80. For the rest of labour's five years in office the value of child tax allowance and family allowance/child benefit was less, in real terms, than at any time under this Government.

8. GOVERNMENT'S RECORD ON CHB/CHILD SUPPORT COMPARED WITH LABOUR

Until its last month in office, under the last Labour Government the combined value of child tax allowance and family allowance or child benefit for a family on average earnings was less, in real terms, than at any time under this Government. Only in April 1979 did it increase to a level comparable with the Government's record since 1979.

9. AMOUNT SAVED BY NOT UPRATING CHB

The net annual saving from not uprating CHB will be around £200 million but we are making available an extra £70 million to the neediest families over and above the £135 million which the normal uprating of income related benefit child allowances will cost. The overall social security budget is going up by over £2 billion.

10 Increasing income-related benefits means more people forced to claim

By concentrating resources on neediest families we shall be providing extra help, even though this increases numbers entitled. Is a better use of resources than putting extra into universal benefit which would go also to wealthier families.

Some 45,000 families drawn into benefit (FC and IS) but

- 1.6 million families [1.1 million IS and 450,000 FC] able to receive more help;

- most of the 45,000 are people in work and on the margin of entitlement - might be £1 or £2 better off than if CHB had been uprated;

- the extra cash provided through Family Credit ensures that overall families will almost always be better off by taking a low paid job than staying employed.

11. Poor take-up levels for income-related benefits

Need to encourage take-up, and further publicity is planned. Fact that some do not claim their entitlement to income-related benefits is not valid reason for putting even more resources into a universal benefit.

12. Increasing CHB alleviates poverty

CHB continues to provide mothers with worthwhile contribution towards costs of bringing up children. Those on income-related benefits do not gain from increases in CHB, whereas we have increased help for low income families through income-related benefits. So we are making a range of support available to families while targeting resources on those in greatest need.

13 FAIRER TO MAINTAIN VALUE OF CHB FOR FAMILIES GENERALLY WHILE ENSURING IT IS NOT PAID TO THE WEALTHIEST

We made a commitment in our Manifesto that CHB would continue to be paid as now, and we intend to honour that commitment. The level of Child benefit will be reviewed each year, as the law requires.

14. Freezing CHB while increasing other benefits improves the husband's income at the expense of the wife's

Family Credit goes to mothers. Two-parent families getting income support are able to choose who makes the claim - although it will generally be the father who is more available for work. It would be nonsense to increase child benefit for everyone to help out the minority of wives in better-off working families where the income is not shared equitably.

15. Switching resources to income-related benefits worsens work incentives and increases numbers with high MTRs

We have already done a good deal to improve work incentives by basing income-related benefits on net rather than gross incomes, which ensures an increase in wages means a real increase in net spending power. Under old system, higher gross pay meant people could be worse off because of higher taxes and less benefit. Giving more help to low income families with children has led to an increase in the numbers affected by higher combined rates of tax and benefit withdrawal; but the only practical and affordable alternative would be to cut the amount of help we give these families.

16. Freezing CHB but reducing taxes transfers money from those with children to those without

About 80 per cent of families with children pay tax and therefore benefit from tax cuts. Those who don't pay tax will generally be entitled to Income Support or Family Credit and the level of their CHB will have been taken into account.

17. Tax allowances and child benefit

Families with children - like taxpayers generally - have benefitted from reduced rates of tax and higher personal allowances under this Government. Child benefit has been in its present form for 9 years and must now be judged in terms of its effectiveness as a benefit.

18. Re-introduction of Child Tax Allowances in place of CHB

CHB remains a worthwhile contribution towards the costs of bringing up children and its level will be reviewed annually along with other Social Security benefit rates. Any changes in the taxation system would be a matter for the Chancellor of the Exchequer. But we have no plans to change the form of CHB.

19 CONSERVATIVES NO LONGER "PARTY OF FAMILY"

We are concerned to see that help goes to those families who really need it. That is why from next April we are putting a further £70m into income-related benefits for children over and above what the ordinary uprating will cost.

20. International comparisons

Levels of family benefits vary considerably between European countries and they are not always available in respect of all children eg, in France family benefits not available for first child.

Not unusual in other countries to exclude family allowance from general obligation to uprate social security benefit in line with cost of living. No automatic adjustment in France or Germany.

No other country has equivalent of Family Credit and Income Support system is far more comprehensive than any other country's system.

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3 (1)

BACKGROUND NOTE

Family Credit replaced Family Income Supplement (FIS) in April 1988. Published estimate was that 450,000 would receive help, compared with just over 200,000 on FIS. Estimate based on an assumption of 60 per cent take up (FIS take up had been around the 50 per cent mark for many years; and percentage take up had stayed the same through various changes which had changed the actual numbers on the benefit). By end of November Family Credit caseload had reached 260,000, with 47,000 claims will uncleared. Family Credit expenditure estimated at £409m for 1988-89 (FIS had been about £150m, with a further £40m on free school meals and free milk: these latter replaced by extra cash in Family Credit). Family Credit expenditure is already running at or slightly above the sort of level which had been expected for the full caseload estimate. This probably indicates that those families who are entitled to the greatest amounts of Family Credit are those who have claimed so far: and that those failing to take-up are those entitled to smaller amounts.

PUBLICITY MEASURES

* We have had two major advertising campaigns, using TV commercials and national press. First one coinciding with the start of the scheme in March/April, and then a follow up in July. Cost was nearly £2.5 million.

* During the Summer, Department of Employment's campaign 'How to be better off in work' featured Family Credit as one of the major in-work benefits.

* Last Spring, before the new scheme started, we sent a leaflet about Family Credit to all employers (with the annual distribution of new national insurance tables, etc) so that they could tell their employees, and prospective employees, about the help available.

* A new generation of publicity leaflets introduced from April 1988, covering all the new income-related benefit schemes, including Family Credit (includes a free 66 page Technical Guide to Family Credit).

* On-going local publicity through Regional Information Officers, local office contacts, etc.

* From the end of November until Christmas, Post Offices are issuing a leaflet about Family Credit to all child benefit recipients when they cash their order book. This exercise is being backed up adverts on local radio and other local initiatives.

* FOR THE FUTURE. We plan to have a major advertising campaign, probably to coincide with the uprating next April, coupled with other publicity measures aimed particularly at those who may not at present consider themselves poor enough to be eligible.

Background

In last year's uprating CHB was frozen and the net amount saved was £120 million. But £200m was put into extra income-related benefits for families. This year the net saving from not uprating CHB is about £200 million of which £70 million is to be used to make available extra help for low income families. However, the Government's Manifesto commitment to CHB has been reaffirmed and at £7.25 per child per week CHB continues to provide a worthwhile contribution towards the costs of bringing up children.

Key facts

Rate: £7.25 per child per week.

Numbers: 6.7 million families with 12 million children.

Cost: £4.5 billion in 1988/89 (nearly 10% of total social security budget). Each 10p increase in the level of CHB costs about £45 million net (£63 million gross) a year.

Amount saved by not uprating CHB: £200 million a year net.

Extra amount being paid to low income families for children over and above what an ordinary uprating would have been: £70 million.

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4 (1)

KEY FACTS

NUMBERS

Published estimates were that 450,000 families would get Family Credit - more than twice as many as on FIS (200,000+). Estimates based on a take up rate of 60 per cent: FIS had only around 50 per cent take up. Claims, caseload, etc, since the start of the scheme are as follows:-

	Claims received during the month	Awards made	Claims outstanding at month end	Average clearance time for claims decided in the month	*Live caseload at month end
April	96,505	) 40,213	78,257	Not available	194,418
May	41,721	)	74,357	"	215,260
June	52,293	36,145	73,383	"	236,248
July	46,100	37,912	63,836	26.6	242,998
August	46,376	40,249	46,031	18.1	255,627
September	47,759	24,158	62,978	29.7	241,957
October	56,373	44,944	55,223	25.2	248,216
November	57,850	46,234	46.773	22.9	260,710
Cumulative	444,977	269,855			

* includes cases transferred from FIS

The September figures reflect the effects of the postal strike in reducing the number of claims received and the number cleared and also increasing the claims outstanding. This had the effect of reducing the caseload. About 70 per cent of claims are successful, and applying this to the 46,773 cases outstanding at the end of November could indicate that the underlying caseload is now approaching 300,000.

EXPENDITURE (1988/89)

Estimate in Public Expenditure White Paper was £409 million. Already running at this sort of level even on lower claims load. Indicates that those who are entitled to higher amounts are the ones who are claiming.

UPRATING 1989

Family Credit is uprated by Rossi (4.7%) like all the other income-related benefits.

The new Family Credit rates

	Present rate	New rate	Percentage Increase	Percentage increase taking Child Benefit and child credit together
Adult Credit	32.10	33.60	4.7	-
Child credits,				
aged under 11	6.05	7.30	21.7	9.3
aged 11-15	11.40	12.90	13.2	8.0
aged 16-17	14.70	16.35	11.2	7.5
aged 18	21.35	23.30	9.1	6.8
Threshold (level at which maximum family credit is payable)	Y 51.45	Y 54.80	6.1	

Y Same as income support rate for a married couple over 18.

MOVEMENTS IN THE VALUE OF CHILD BENEFIT

CHILD BENEFIT

Date	ACTUAL LEVEL £	REAL VALUE (1) £	INDEX (2) %
APRIL 1979	4.00	7.79	100.0
NOV 1979	4.00	7.02	90.1
NOV 1980	4.75	7.23	92.8
NOV 1981	5.25	7.14	91.7
NOV 1982	5.85	7.49	96.1
NOV 1983	6.50	7.93	101.8
NOV 1984	6.85	7.97	102.3
NOV 1985	7.00	7.72	99.1
JULY 1986	7.10	7.70	98.8
APRIL 1987	7.25	7.53	96.7
APRIL 1988	7.25	7.25	93.1

(1) Based on the movement in the General Index of Retail Prices between April 1979 and April 1988.

(2) Based on the real valuations - April 1979 = 100 per cent.

CHILD SUPPORT

LABOUR'S RECORD AND GOVERNMENT'S RECORD

1. Labour

- resisted index-linking of CHB;
- were slow to accept annual review of the rate of CHB;
- delayed introducing CHB in full. Originally, full introduction planned for April 1977. In May 1976, proposed to merely extend Family Allowance to the first child allowing child tax allowances to be retained to avoid jeopardising pay policy by reducing take home pay. In September 1976, accepted joint Labour Party/TUC recommendation to introduce CHB in phases. CTAs phased out between April 1977 and April 1979.

2. Value of CHB/Child Support - for those on average earnings with young children, value of child tax allowance and family allowance/CHB higher in real terms under Conservatives than under Labour except for Labour's last month in office.

3. Robin Cook, in interview with "Poverty" magazine this summer (attached), said he couldn't say at what level Labour would pay CHB in the future; it would have to be assessed against competing priorities. So why criticise Government now for not prejudging the future?

4. Law requires annual review of the rate of CHB, in the light of circumstances at the time, Labour would be inviting the Government to break the law if they ask now for statements about future CHB rate.

5. Government's Manifesto commitment is being fully honoured. Statutory requirement to review rate of child benefit each year has been and will continue to be met.

[illegible] the 16- and 17-year-olds?

[illegible] committed to restoring the right to benefit for the unemployed 16- and 17-year-old but would not want to see the level of that benefit in isolation from our other package relating to educational maintenance provision. At the last election we did propose a comprehensive allowance for all 16- and 17-year-olds and I wish to see that retained. It then becomes much easier to take a comprehensive overview and plainly any other sort of benefit has to more or less match the educational allowance.

PH: The government again froze child benefit this year. Are you fully committed to retaining it as a universal benefit?

RC: Yes.

PH: Have you thoughts on the sort of level it should be, and the question of taxation?

RC: At some future date it may or may not be appropriate to tax child benefit. But there is no case for taxing it until you get to a level which actually matches the cost of a child and we are a long way away from that.

The government's philosophy of shifting from universal to means-tested benefits logically compels them to tackle child benefit, and I would be astonished if they don't actually do it openly within this parliament. One thing I would guarantee, there will be no review of it, because every single such review has always come back and said keep it as a universal benefit. Therefore they won't review it, they will just do it, and that's going to be a major battle in the next two or three years.

We are committed to universality but at what level we would pay it I plainly can't answer now because we are talking about three years' time. We don't know what will happen and it would have to be assessed against competing priorities. But there can be no case for allowing the real value of child benefit to decline as this government has — that value has to increase, not go down.

PH: Your document questions mortgage tax relief: are you talking about more than just limiting it to the standard rate of income tax?

RC: It is patently absurd that those who have the largest incomes and buy the largest houses should have the largest subsidy. We will be examining with Clive Soley, our housing spokesman, over the next year, how we can introduce a new system of housing finance. We shall be seeking a solution which enables us to achieve greater social equity and which also provides for a wider housing programme. In the meantime, we have committed ourselves quite explicitly to withdrawing mortgage tax relief from those paying the higher rate of tax and confining their benefit to the standard rate.

PH: What generally do you think is the relationship between your programme to tackle poverty and the question of income and capital taxes?

RC: I think it's fair to say that the policy review document is written as two halves, but it is the result of common work by a common team. We did have extensive discussion about a negative income tax and felt that negative income tax institutionalises the means test right the way through the income scale. Either it is very expensive or it generates a very powerful poverty trap at one point in the scale.

We therefore rejected negative income tax and went instead for the principle of coordinating the tax and benefit system. That means you have to look very vigorously at the thresholds so that people in work are not paying tax on levels of income that are below their entitlement to benefit out of work — the grotesque anomaly of the present situation. One of the best ways of relieving poverty among the low paid would be a sharp increase in the thresholds for tax payment which would remove them from the net; also, tackling the very heavy burden of national insurance contributions which they pay. That is going to be the prime focus, and we will be looking at exactly how we can integrate the two systems over the next year.

PH: The 'poor' are a minority and Labour has to win a majority — how much of a political problem do you see there?

RC: The numbers on all benefits are enormous — you are talking about a cohort of something like eight million, not taking account of adult dependants within those families. Now we only got ten million votes at the last election. Not all those eight million voted for us and some people who work did vote Labour at the last election. I don't accept that we aren't going to get elected by concentrating on the poor. Vast numbers of the poor are not turning out to vote for any party. If I'm going to put in a full year's work devising a system of benefits which I believe will be of great assistance to those who are on benefits, then I want them to be given every opportunity to know about it and to vote for it. If they don't, we are going to have great difficulty getting an opportunity to implement it. If each of them were to vote Labour we could rapidly change the electoral arithmetic.

On average there are 7,500 losers from housing benefit in each Tory-held constituency. That is greater than the majority of over a hundred Tory MPs. It is not the case actually that those who are dispossessed or are in receipt of benefit have no psephological power; they have a great deal if they would only use it in a coordinated and self-interested way.

It only becomes a political problem for us if we allow welfare to be perceived as a matter for the 'poor'. The whole thrust of my remarks is that we should resist the government's attempt to talk about welfare benefits as a system targeted on the poor to relieve poverty. The opinion polls show that the concept of social insurance is held in extremely high regard in the electorate — much higher than one might think from a superficial look at Margaret Thatcher's parliamentary majority. She couldn't comprehend the row that broke out around her ears in April because she herself has none of that fellow-feeling and sense of the need for common community protection. She couldn't get her mind round the fact that millions of people in work, not drawing housing benefit, possibly with their own private superannuation scheme and therefore not solely dependent on future expectations of the state scheme, were nevertheless outraged at seeing what was being done in their name to people whom they regarded as part of their community and part of their society. That sense of common humanity is still very very strong and something to build on.

cst.ps/2ce13.12

MP

FROM: MISS C EVANS
DATE: 13 December 1988

MR SAUNDERS

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

NHS REVIEW: ACCESS TO PRIVATE CAPITAL

The Chief Secretary is content with the draft paper attached to your minute of yesterday.

CE

MISS C EVANS
Private Secretary

Copy No: 2

HC62

NHS Review

DRAFT WHITE PAPER

Note by the Secretary of State for Health

1. I attach for the Group's consideration on 16 December:

* a suggested outline of the White Paper.

* a first draft of the two introductory chapters.

* a first draft of the chapter on self-governing hospitals.

2. Work on the other draft chapters is proceeding as quickly as possible.

December 1988

WHITE PAPER: SUGGESTED OUTLINE

Chapter 1: Foreword

Chapter 2: Delivering a better service

Chapter 3: GP practice budgets

Chapter 4: Self-governing hospitals

Chapter 5: Managing resources

Chapter 6: The role of doctors

Chapter 7: Funding hospital services

Chapter 8: A better organisation

Chapter 9: Working with the private sector

Chapter 10: Health services in Scotland, Wales and Northern Ireland

Chapter 11: A programme of change

Note Subject to the outcome of the Group's discussion of HC63, it may be desirable to add a chapter on managing the FPS.

Draft White Paper

CHAPTER 1: FOREWORD

1.1 This White Paper explains how the Government plans to reform, strengthen and revitalize the National Health Service to make it fit for the 1990s and beyond.

1.2 Underlying everything we propose is a simple aim - a service that puts patients first. To achieve that, we must build on all that is best in the NHS, while standing by the principles on which it was founded. Our Health Service must continue to be available to all, regardless of income, free at the point of delivery, and financed out of general taxation. The society it serves today, however, is very different from that of the 1940s when it was created. Nowadays, we all quite rightly expect better service, higher quality, more choice. It is to those ends that this White Paper is directed.

1.3 To deliver the highest standards of care that we all want the NHS must be run more efficiently. In this respect, it is just like other businesses. Like them, it will benefit from stronger and more flexible management. The spur of competition will sharpen its performance. The quality of its service will be improved if it listens to what its customers want. Greater efficiency is the key to a better, more caring service for patients.

1.4 Change on the scale we propose is never easy. Nor will it happen overnight, for we must be certain that the new, modern NHS has strong and secure foundations. It will require huge effort and commitment from management and staff. I am confident that those who serve the NHS will make that commitment on behalf of those who use it.

Draft White Paper

CHAPTER 2: DELIVERING A BETTER SERVICE

Introduction

2.1 The NHS has an enviable record of success. Since it was established in 1948 it has played a major part in improving the nation's health. Immunisation and vaccination have virtually wiped out previously common diseases such as diphtheria and poliomyelitis. Perinatal mortality has fallen by three-quarters since 1948, and maternal mortality is down to 5% of its 1948 level. Medical advances have meant that people not only live longer but can enjoy a better quality of life. Transplant surgery, for example, is now commonplace, and it has become possible to carry out hip replacements for people in their seventies and eighties. The introduction of antibiotics has revolutionised the treatment of many diseases.

2.2 The NHS itself has grown out of all recognition. Its total gross expenditure has increased from £433 million in 1949 to nearly £24 billion in 1988/89, a fourfold increase in real terms. The number of hospital and community doctors and dentists has grown from [11,000] in 1949 to [43,000] in 1986, and the number of nurses and midwives from [130,000] to [403,000]. These staff now care for [3½ million] more in-patient cases than their counterparts in 1949. [The square-bracketed figures are for England and Wales only. UK figures are in preparation.]

2.3. Progress has been even faster in recent years. The service is treating 1½ million more in-patients, 4 million more out-patients and over half a million more day cases than it was a mere ten years ago. Improved productivity and a substantial increase in the money provided by Government have made this huge stride forward possible. The NHS now employs 15,000 more doctors

and dentists and 70,000 more nurses than it did in 1978.

2.4 But although medical advance has been spectacular since 1948, the organisation that provides that care has not developed at the same rate. That is why the Government announced early in 1988 that it was undertaking a thorough review of the NHS. This announcement has in turn stimulated a wide-ranging debate. Many people share the Government's view that now is the time to bring the Health Service up to date.

The business of caring

2.5 Experience shows that direct, central government intervention and control is not the most effective way of delivering the services that customers want. By the same token, it is not the best way to deliver services for patients. It is essential that those whose job it is to meet the changing needs and wishes of those patients have the authority, flexibility and incentive to innovate and adapt.

2.6 Whilst remaining unique, the NHS must be run more like other businesses. The best businesses are geared to putting their customers first. They also know that their customers will get a proper service only if the unseen parts of the organisation are working well - if resources are properly managed; if talented people are found and given their head; if everyone working for the organisation is encouraged to give of their best, and rewarded for doing so.

2.7 Making the NHS more business-like will not make it less caring. It will mean that it can deliver better care and more care to more people than every before.

Competition and choice

2.8 Doctors, nurses, managers and others who work in the NHS are committed to improving services for patients, and know how to do so. But they are often held back by the rigid way in which the service is presently organised and financed. The Government intends to free up the system by introducing more competition and more choice.

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

* large GP practices will be able to opt to have their own budgets for buying a range of services direct from hospitals. This will enable GPs and their patients to back their own choices with money, and the size of each practice's budget will depend on how many patients its GPs attract. GPs will be encouraged to compete for patients by offering better services. Hospitals will be encouraged to compete for the custom of GPs.

* hospitals will be given much more responsibility for running their own affairs. Major hospitals will be able to apply for self-governing status within the NHS. This means that they will be free, for example, to set the rates of pay of their own staff [and, within limits, to raise capital in the private market]. They will be free to sell their services to other parts of the NHS, to the private sector and to patients. Because they will have an incentive to attract patients, they will want to make sure that the service they offer is what their patients are looking for.

* funding arrangements will be changed so that each health authority's duty will be to buy the best service it can

from its own hospitals, from other authorities' hospitals, from self-governing hospitals or from the private sector. Conversely, hospitals will be free to sell their services to different health authorities. In this way money will in future go more directly to where the work is done best. At present a hospital or service which becomes more efficient and could treat more patients may be prevented from doing so by its budgetary limits. At the same time, one which is failing to deliver is still paid its share of NHS resources, calculated by means of a complicated formula. Any exercise of choice by patients and their GPs is thereby made ineffective. The Government's proposals will change this.

2.10 These and related reforms are set out fully in chapters [3,4 and 7]. They represent a shift of power and responsibility to people whose job it is, at local level, to advise patients, to provide services to them, or to fund services for them. By placing the patient centre-stage, they will improve the standard of service he or she receives.

Giving management the freedom to manage

2.11 In recent years the Government has given a high priority to strengthening the management of the NHS, most importantly through the introduction of general management following a report by Sir Roy Griffiths in 1983. The reforms outlined in paragraph [2.8] will build on this progress and take it further. It will become all the more important that objectives for improving services, and responsibilities for achieving those objectives, are clear; and that money is not spent ineffectively or inefficiently when it could be used to buy more or better services in other ways. Achieving objectives through the efficient use of resources is the job of management. Local managers in particular must be both freer and better equipped to do that job.

2.12 Chapters [5,6,8 and 9] propose a range of important changes to strengthen local management. They will build on the introduction of general management, and on the proposals for the better management of the family practitioner services (FPS) set out in "Promoting Better Health" (Cm 249). Among the most important aims behind these changes are:

* ensuring that hospital consultants - whose decisions effectively commit substantial sums of money - are involved in the management of hospitals; are directly responsible and accountable for their own use of resources; and are encouraged to use those resources more effectively.

* ensuring that GPs too take greater responsibility for their use of resources.

* introducing new arrangements for the effective monitoring of medical care by doctors themselves.

* providing the audit support which management needs, through a stronger and more independent source of financial and value-for-money audit.

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

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

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

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

Customer care

2.13 All these reforms will in time improve the quality of the service that the NHS is able to offer those who use it. The quality of the medical and nursing care itself is widely recognised as excellent, but there are other changes which will make a real difference to the day-to-day services which patients receive.

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

2.15 The service provided by a hospital is still too often impersonal, inflexible and even stressful. Patients should be treated much more like valued customers. The practical improvements that may often be needed include:

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

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

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

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

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

* rapid notification of the results of diagnostic tests.

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

2.16 The Government has prepared detailed proposals for making the NHS much better able to offer shorter waiting times for treatment and an improved quality of service. The chapters which follow set out these proposals in full.

Draft White Paper

CHAPTER 4: SELF-GOVERNING HOSPITALS

Introduction

4.1 There are currently over 320 major acute hospitals in the UK - "major" defined as having more than 250 beds. This chapter sets out the Government's proposals for enabling as many of these hospitals as are willing and able to do so to run their own affairs.

4.2 Major acute hospitals are substantial businesses. Even the smallest of the management units which currently run these hospitals may have revenue budgets in excess of £10 million a year. The largest may have budgets in excess of £30 million. Yet none of these hospitals can employ its own staff or enter into contracts in its own right. Nearly all of them are run by health authorities which have other responsibilities as well - psychiatric and other single-specialty hospitals, community health services, and so on. In England alone 66 District Health Authorities (DHAs) are responsible for two or more major acute hospitals.

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

4.4 The Government believes that greater independence for hospitals will encourage a stronger sense of local ownership and pride, building on the enormous fund of goodwill that exists in

local communities. It will stimulate the commitment and harness the skills of those who are directly responsible for providing services. Supported by a funding system in which successful hospitals can flourish, it will encourage local initiative and - particularly in urban areas - greater competition. All this in turn will ensure a better deal for the public, improving the choice and quality of the services offered and the efficiency with which those services are delivered.

Hospital Trusts

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

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

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

* of the non-executive members at least two should be drawn from the local community, for example from hospital Leagues of Friends and similar organisations. These two "community" members should be appointed by the Regional Health Authority (RHA). The remaining three non-executive members should be appointed by the Secretary of State on the advice of the chairman. All the non-executive members should be chosen for the contribution they can make to effective management of the hospital. None should be an employee of a health authority or hospital, of a trade union with members who work in the NHS, or of a major contractor or other

hospital supplier. For teaching hospitals, the non-executive members will need to include a representative of the relevant medical school.

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

* the remaining four executive directors should include a medical director, the senior nurse manager and a finance director.

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

Funding and accountability

4.7 A self-governing hospital will need to generate income by selling its services. The main buyers will be health authorities. Other buyers will include GP practices with their own budgets, private patients or their insurance companies, and perhaps other self-governing hospitals. This form of funding will be an opportunity for growth and a stimulus to better performance.

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

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

4.10 Each Hospital Trust's line of accountability will be through these contracts. The consequences of a failure to meet the terms of a contract - potential loss of future business, for example, or renegotiation of the contract - will be for the buyer to settle. The arrangements set out in chapter [7] will ensure that patients who are in need of urgent treatment are not turned away from a hospital simply because their treatment is not, or may not be, covered by a contract with that hospital.

Freedom and responsibility

4.11 The Government proposes to give Hospital Trusts a range of powers and freedoms which are not, and will not be, available to health authorities generally. The Government believes that greater freedom for self-governing hospitals will create more scope for competition, diversity and innovation within the NHS. Greater freedom for their leadership will stimulate greater enterprise and commitment, which will in turn improve services for patients. Self-governing hospitals will be a novel part of a system of hospital care alongside health authority-managed and private sector hospitals, and will increase the range of choice available to patients and their GPs.

Employment of staff

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

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

Capital assets

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

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

* the Trust's management of its assets will be subject to independent audit in accordance with the proposals in chapter [5].

[* sub-paragraph on disposal of assets.]

[* sub-paragraph on charges/"interest" payments on the Trust's initial "debt".]

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

Capital investment

[4.15 Paragraph[s] to be drafted following the Group's decisions on "Capital".]

Achieving self-government

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

4.17 Similarly, the Government is not proposing a rigid definition of what a "hospital" should be for the purposes of self-government. For example, it will often be sensible for two neighbouring hospitals to combine, or for a hospital to retain its existing obligations to run a range of community-based services.

4.18 The Government intends that hospitals should have to meet only a few essential conditions to achieve self-governing status.

It has two main criteria in mind. First, management must have the skills and capacity to run the business, including strong and effective leadership, sufficient financial expertise and adequate information systems. Secondly, senior professional staff, especially consultants, must be involved in the management of the hospital, and there should be a comprehensive system of medical audit along the lines proposed in chapter [6]. The Secretary of State will also need to satisfy himself that self-governing status is not being sought simply as an alternative to an unpalatable, but necessary, closure.

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

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

Implementation

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

experience gained will then inform the process of establishing more Trusts in later years.

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

4.23 The establishment of self-governing hospitals will mean a substantial change in the responsibilities of the DHAs which were previously responsible for their management. The Government does not believe that this implies a wholesale reorganisation of the NHS. But as more and more proposals come forward for establishing Hospital Trusts, RHAs will consider the viability of existing DHAs and, if appropriate, propose mergers of neighbouring Districts. The implications for the role of DHAs are set out more fully in chapters [7] and [8].

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HC63

NHS Review

MANAGING THE FPS: OUTSTANDING ISSUES

Note by the Secretary of State for Health

1. This paper addresses three issues which are outstanding from the Group's discussion of my last paper on managing the FPS (HC51):

* the timetable for changes in budgeting and organisation.

* options for controlling GP numbers.

* incentives to join the GP practice budget scheme.

I BUDGETING AND ORGANISATION

Budgets for prescribing costs

2. We are agreed in principle that we should move towards a system of setting reasonable budgets to cover the costs of prescribing by GPs.

3. We must first be clear about how such a system would work. I suggest that the most practicable scheme to develop and implement would be one along the following lines:

i. a single, national drug budget would be negotiated for each country as part of the annual public expenditure round. It would be set at a level which was designed to achieve the effect described at (iii) below. Forecasting the drug bill is notoriously difficult, and to the extent that the forecasts underlying the budget provision fell short of out-turn, in-year increases would be necessary. Under the present arrangements these are voted through in Supplementary Estimates. It would be necessary to continue this arrangement to ensure that practitioners,

and patients, did not pay the penalty for forecasting errors or, rarely, increased incidence of disease because of an epidemic.

ii. the Department would allocate budgets to Regions. Each budget would constitute that Region's share of the money available nationally for FPS drug spending. If we go down this route we shall need to do more work before the White Paper is published on two important, practical issues:

- the calculation of each Region's share. In principle, some form of simple, weighted capitation would be the best approach, as for the funding of hospital services. At present the (unweighted) average, per-capita cost of drugs prescribed by GPs varies from just over £30 in the Oxford Region to £39 in the North Western Region. We shall need to develop an approach to coping with these variations without an adverse impact on patients.

(How about developing an approach to eliminating them!)

- each Region's information needs for budgetary control purposes. The time lags which are inherent in the present information system would make budgetary control difficult. We might need to invest in establishing an adequate information system.

iii. Regions would then allocate budgets to FPCs (or in due course, if this is the route we decide on, to merged FPCs/DHAs). Each budget would be negotiated with regard to the FPC's "expected" level of drug spending, based on weighted capitation and average unit costs, and their actual current spending (with whatever allowance was agreed generally for increases in costs). The FPC would be accountable to the RHA for ensuring that the prescribing costs of their GPs were held within the budget. As a further incentive to bring down prescribing costs, it would be open to an FPC to agree with its Region a target level of savings, with a proportion of any such savings being returned to the FPC to finance primary care initiatives in their area.

in what way

iv. FPCs would in turn allocate indicative budgets to GP practices outside the practice budget scheme. These budgets would be negotiated in broadly the same way as FPCs' own budgets. There would be scope for adjustment to match particular circumstances which might affect a practice's prescribing costs. (In the first year of the

scheme's operation, "current" spending for the purpose of negotiating budgets might be taken to be spending at 1988-89 levels. This would avoid giving GPs an incentive to push up their prescribing costs in the meantime.) We would need to impose a change to the GP contract to spell out a requirement to conform to their FPC's policies on effective and economical prescribing. To make indicative budgets "bite" at practice level, FPCs would also need

- to buy in independent, medical support, in practice mainly from the Department's Regional Medical Service, and

- to be empowered by Regulations to impose financial penalties where GPs persisted on over-prescribing.

More detailed proposals in each case are set out in HC 51.

4. An approach along these lines would have the following, important characteristics:

the opposite of what we want to do!

i. it would keep the drug budget separate from other FPS or hospital spending. This separation would reflect the fact that there is a particular, and widely recognised, justification for driving down prescribing costs. It would also ensure that excessive prescribing was tackled in its own right and not deflected into unjustified pressures on other services.

ii. the use of indicative budgets for GPs would recognise the difficulty - which we have acknowledged in the context of practice budgets - that real budgets would be difficult and expensive to manage at the level of the small or average-sized practice. Giving them to FPCs allows more scope for absorbing unexpected pressures whilst controlling overall expenditure.

iii. negotiating indicative budgets for FPCs in the way I propose would allow the overall rate of growth in drug spending to be steadily ratcheted downwards by focusing on the highest spending practices.

5. We can expect vociferous opposition from the profession. It would be wise to try to defuse some of this opposition by being willing to consult on the detailed application of the scheme, for example the basis on which budgets might be adjusted for individual practices. A willingness to consult might also help to deal with accusations that the Government was reneging on the implied commitment in the Primary Care

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White Paper to rely for the time being on "voluntary means" to more effective and economical prescribing.

6. Subject to the outcome of such consultations, I suggest we aim if we can to bring the new scheme into operation from April 1991. It would necessarily be a little rough-and-ready to begin with, and we shall need to invest in the management as well as information capacity to make it work. A 1991 target date should allow adequate time not only for consultation but also for any necessary renegotiation of the Pharmaceutical Price Regulation Scheme. It should also allow time for FPCs to gain at least some working experience of the new "PACT" information system, which will be available to all FPCs by 1990-91. With improved timeliness, "PACT" information could then be used for monitoring expenditure against budgets.

The future of FPCs

7. A majority of the Group is in favour of merging FPCs and DHAs in England and Wales, and it was suggested at our last meeting that the case for doing so should be set out as an option in the White Paper.

8. I have given this further thought since our last meeting. My firm view is that, whatever conclusion we reach on its merits, this must not be a "green" issue. Politically, the Government must be seen to know its mind. We have already consulted once on the subject, and the responses to consultation are entirely predictable. It would not be difficult for our opponents to caricature a consultative proposal as indecision about whether to reverse a decision (or even about which decision to reverse). We can expect no public interest in yet another debate about administrative and boundary changes, merely another protracted argument with the profession. Managerially, consultation would simply generate wasteful effort and uncertainty.

9. I do not rule out the possibility that merger may become desirable in due course. But I believe the White Paper should say, at most, that it is far too soon to reopen the issue. I shall not repeat here the arguments I have advanced before for keeping FPCs separate in England, but two further points are relevant in the context of my proposals for drug budgets:

there is only one.

i. merger is not necessary to achieving the objectives set out in paragraphs 2-6 of this paper. Merger and budgets are quite separate issues. In so far as the purpose of merger is to create the scope to vire between drug budgets and HCHS spending, the same flexibility could be achieved in practice through my proposal to give

the cash for drug spending to Regions. In any event, as I have argued in paragraph 4(i), there are strong arguments for keeping drug spending separate, at least in the first instance.

ii. developing and implementing drug budgets will be a substantial additional challenge to FPS management. By distracting attention, merger would get seriously in the way of these and other steps which are needed if GP contracts are to be effectively managed along the lines which were set out in the Primary Care White Paper and which will be reinforced by the outcome of the present review. I do not believe that administrative and boundary changes are our real priorities.

10. In short, I urge colleagues to agree that we can and should achieve our objectives whilst leaving FPCs separate. We shall still need primary legislation to secure the accountability of FPCs to RHAs, but that is a much more limited - though still essential - change. I believe we should also strengthen FPS management along the lines proposed in HC51, in brief by

i. taking powers to reduce the size of FPCs and make lay members a clear majority over professional members, and

ii. recruiting higher quality chief executives.

II GP NUMBERS

Options

11. At the Group's last meeting I was asked to circulate a further note on options for controlling GP numbers, including in particular the possibility of doing so through increasing the capitation element in GPs' remuneration.

12. I have identified two options for the Group to consider. The first is that of imposing direct, statutory controls along the lines proposed in HC51. The second is to use the remuneration system, partly but not exclusively by increasing the capitation element. The two options are not necessarily mutually exclusive. The following paragraphs spell out how the second option might work.

Using the remuneration system

13. The average GP received an income of £55,000 in 1987/88. This covered remuneration and all expenses, and was the total cost of delivering general medical services, excluding drugs, to 2000 patients. In round terms it was made up as follows:

- remuneration through fees and allowances £27,000
- expenses met through fees and allowances £12,000
- expenses directly reimbursed £16,000

14. The £39,000 which is paid through fees and allowances is made up as follows:

	£	%
Basic Practice Allowance (paid in full for 1000 or more patients and prorated for fewer numbers)	8,000	21
Capitation fees	18,000	46
Allowances (eg seniority payments, group practice allowance, training allowances)	6,000	15
Fees (eg childhood immunisation, cervical cytology)	7,000	18
	39,000	100

15. There are two levers here which we could pull to exert downward pressure on the growth in GP numbers:

i. increasing the proportion accounted for by capitation fees. Colleagues are familiar with the arguments here. The Government is already committed to this policy, although not specifically as a means of reducing the rate of growth in GP numbers. The position as stated in the Primary Care White Paper is:

> "It is the Government's intention to make the NHS contract with family doctors more sensitive to the range of services provided. This will be achieved over time by adjusting the balance between the doctor's income from capitation fees and the income

from allowances. A basic core of health provision is expected for the payment of capitation fees which in turn will be complemented by incentive payments designed to encourage the provision of services targeted at specific health care objectives (for example, high levels of vaccination, immunisation and cervical cytology). At present capitation fees form an average 47 per cent of the doctor's income. The Government intends to raise this to at least 50 per cent in the first instance. As public awareness increases and services improve, the Government intends to move further in this direction in order to encourage doctors to practise in ways that meet patients' needs."

ii. increasing the number of patients needed for a GP to qualify for the basic practice allowance (BPA) (which is in effect a form of capitation, paid to meet running costs). Under present arrangements a full BPA of £8,560 is paid into the practice for each GP if the average number of patients exceeds 1000. So if by dividing the number of patients by the number of GPs in the practice plus one the result is still 1000 or more, the practice has a strong incentive to recruit another GP. Increasing the qualifying number would tend to discourage practices from expanding and from replacing retiring partners. This in turn would reduce the growth rate, although at the expense of reducing the incentive to increase practice sizes.

16. Changes along both these lines are currently being discussed with the profession as part of the negotiations flowing from the Primary Care White Paper. Specifically, we have proposed that

i. capitation fees should be increased, as a proportion of fees and allowances, to over 50%.

ii. qualification for the full BPA should be changed from 1000 to 1500 patients.

The potential impact of these changes on the rate of growth in GP numbers has not been modelled, but we might reasonably expect a reduction from 1.9% to, say, 1.0% a year over a number of years. Assuming that such a reduction were achieved steadily over a period of 5 years, the revenue saving by year 5 would amount to about £45 million, with further cumulative savings of £15 million a year thereafter.

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17. By pursuing this approach we could change the structure of remuneration to something along the following lines:

	Current	Future (approx)
Basic Practices Allowance	21%	25%
Capitation fees	46%	60%
Allowances	15%	(
Fees	18%	(15%
	100%	100%

This would still allow scope for targeted incentive payments, for example for childhood immunisation or cervical cancer screening. But there is little doubt that the profession would oppose changes on this scale, so that we would almost certainly have to impose them.

18. Other developments which will tend to depress growth in the numbers of GPs are: compulsory retirement of GPs on reaching the age of 70; the retirement over the next few years of the post-war bulge in GPs (having attained 40 years' NHS service); and the departure of GPs unwilling to give the extra commitment which will be necessary under the new contract to maintain current levels of income.

Impact of the Review Body

19. Colleagues have raised the question whether the impact of such changes could be negated by the Review Body's recommendations. The Review Body's job is to recommend changes in GPs' income due to inflation and workload. Each year it recommends an intended average net income and average expenses, both to be reimbursed through fees and allowances. If capitation fees are to form a greater proportion of income, that would be a Government decision. It would then be for the Review Body to set fees and allowances so that capitation represented on average the required percentage of income from fees and allowances.

20. The Review Body would need some help over the transition, and officials are meeting the Review Body secretariat to discuss ways and means in respect of the changes currently being discussed with the profession. But I do not think that the Review Body's activities need frustrate the Government's aims. If the average GP's workload and expenses increase, the Review Body will recommend an appropriate increase in the intended average income including indirectly reimbursed expenses. But to meet the workload and expenses costs of the

Primary Care White Paper, £48 million (from the new charging arrangements) is already to be made available from April 1990. Our discussions with the Review Body secretariat are designed to ensure that the Review Body does not exceed that amount in its recommendations. We can and should try to maintain this line, although there remains a risk that the Review Body will make consequential recommendations with a total cost exceeding this sum.

Conclusion

21. Tackling the growth in GP numbers through the remuneration system would be feasible. It would also be consistent with the approach we are taking generally to reforming the NHS through changing incentives and increasing competition. But it would be uncertain in its effects, and changing the qualification for the BPA would tend to depress the size of practices. Taking direct manpower controls would be a surer approach, and easier to fine-tune. But it would be bureaucratic and would need primary legislation. The Group will wish to discuss these relative advantages and take a view on them.

22. Under either approach we would need to secure an adequate number of practice vacancies for good, young doctors wishing to enter general practice. (At present there is a more than adequate supply of such candidates everywhere.) I shall need to give further thought to this, too. The best approach, as I suggested in HC 51, might be

i. in due course, to reduce from 70 to 65 the retirement age for GPs which we are introducing through the Health and Medicines Bill.

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.

(can they?)

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

III GP PRACTICE BUDGETS: INCENTIVES

23. I was asked to consider further what could be done to strengthen incentives for GP practices to opt into the practice budget scheme.

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Incentives currently envisaged

24. As we have so far developed the scheme, the main incentive to participate is the opportunity it gives GPs to improve the services they offer. For example, it enables them

i. to use hospitals which might discourage referrals if the money did not go with the patient.

ii. to generate funds to improve their practice by viring within the scope of the budget, for example by employing more staff or improving practice premises.

25. We have not so far introduced any element of direct, financial incentives to GPs personally. But there will be an important, indirect incentive of this kind to the extent that participating practices attract more patients and therefore increased remuneration through capitation fees. Any increase in the capitation element of the remuneration structure would, of course, increase this incentive effect.

Possible additional incentives

26. The possibility of introducing a personal, financial incentive of a continuing kind needs careful consideration. In earlier papers I have taken the view that direct, personal gain should not be permitted. My concern has been that we could be accused of diverting into GPs' pockets money which was intended - and had been voted - to provide services to patients. We would need to be sure that we had good answers to such a charge.

27. I proposed in HC 47 that, in addition to viring within the scope of the budget itself, practices within the scheme should be able to

i. carry forward any underspend, up to a limit of, say, 20% of their budgets, so that they could save up for, say, premises improvements.

ii. spend any surplus on aspects of the practice which fell outside the budget, but only subject to the agreement of the FPC.

One approach to incentives would be to offer practices within the scheme an optional, performance-related variant. Under this approach, practices which met specified performance standards would be free to retain without restriction up to, say, 5% of their budget in any one year, on condition that an

equivalent sum was clawed back by the Region. (On the basis of the assumptions in HC47, 5% would amount to around £3,000 or so for each GP.) We would need to develop and present this carefully as a way of buying high standards, not as a way of cutting costs at the expense of patients, and we would need to select the performance standards carefully with this in mind.

28. The Group will wish to consider whether we should float something along these lines in the White Paper. If so, I shall need to work up the detail, including some possible performance standards, in the meantime.

December 1988

B:DC6.7/38

HC 64

PAY AND CONDITIONS OF NHS STAFF

Joint paper by the Secretary of State for Health and the Chief Secretary to the Treasury

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

Background

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

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

Flexible pay systems

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

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

Flexibility in the main-stream of the NHS

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

- performance-related pay for about 2,000 top managers together with some discretion to vary basic rates according to job weight. These arrangements are being extended to cover a further 7,000 staff with provision for market flexibility elements for hard to fill posts.

- regional variations for IT staff.

- bonus schemes for manual staff and

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

7. Health authorities also have responsibility for grading staff within centrally agreed grading structures, which affords some flexibility of a kind which varies between different groups of staff. There is some evidence that some authorities, particularly in London and the South East, have been exceeding the proper limits of this flexibility in order to overcome recruitment and retention difficulties.

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

9. More detail on these proposals is given in Annex 2. They have not yet been discussed in detail with other departments. The changes will need to be carefully managed to avoid the risk that local variation in pay could lead to a general escalation of pay levels rather than a more finely targeted, and hence more cost-effective, outcome than across the board increases, particularly since few NHS managers have direct experience of pay bargaining and they will be dealing with trade union officials who are likely to have much more.

10. A radical internal review by DH of conditions of service is also nearing completion. Greater devolution is a key objective, giving managers greater freedom to devise employment packages more suited to local needs. The review has highlighted a number of central controls which should be abolished. It ought to be

possible to give local management progressively greater freedom as they gain experience and develop the expertise to run a more highly devolved system.

Self-governing hospitals

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

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

13. First, self-governing hospitals will not be starting from scratch. They will be taking on their existing staff who will have existing contracts of employment which explicitly or implicitly relate to pay and conditions determined under the existing mechanisms. These cannot be altered unilaterally and changes can realistically only be brought about by negotiation at hospital level of new contracts of employment.

14. Second, any proposal to take the staff of self-governing hospitals out of national pay bargaining processes will be contentious politically and will create pressure for a commitment not to pay less than Review Body or Whitley Council rates.

15. Third, it will be important to ensure that the new arrangements do not simply generate higher pay costs which are passed on to the health authority as customer, and touch off a pay spiral which affects not only the hospital in question but also main-stream hospitals in competition with it for staff. There are particular risks in relation to the Review Body groups. If self-governing hospitals attract these staff away from other hospitals, there will be pressure on review bodies to match the pay rates which self-governing hospitals agree.

16. In principle, genuine competition for the provision of services ought to be an effective constraint on hospital management against letting pay get out of control. They would

simply lose business if they did. But in some parts of the country, and in some specialities, the competition would be limited, particularly in the immediate future. In addition it will be necessary to rely upon the combination of:

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

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

17. Finally, even in self-governing hospitals management capacity will constrain the pace of change which can be managed. Existing managers will have little or no experience of, or capacity for, driving hard pay bargains and it will almost certainly be necessary for them to buy this in initially.

Conclusion

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

19. If they are to achieve their full potential, and because this is consistent with their underlying philosophy, there is a strong argument for giving self-governing hospitals much greater flexibility in the pay and personnel management area, not excluding breaking away entirely from existing mechanisms for determining pay and conditions, if that is what they want. Going down this road does, however, depend upon having sufficient

confidence both in the ability of the managements concerned to manage pay negotiations with trade unions and in the effectiveness of competition and other mechanisms to prevent it leading to pay leap-frogging and increases in the NHS salary bill which it would in practice be difficult not to fund.

20. Against this background we propose that self-governing hospitals should have removed from them any obligation to observe centrally determined pay and conditions. This would leave them free, by agreement with their staff, to continue to follow central arrangements, to introduce entirely different arrangements, or to adopt some intermediate position. Satisfying the Secretary of State that the hospital had the managerial and personnel capacity to handle this degree of freedom would be one of the conditions of self-governing status. The Secretary of State could also retain reserve powers to reintroduce controls if necessary.

21. Colleagues are invited:

i. To note the Secretary of State's intention to bring forward proposals to increase the extent of flexibility in the main-stream of the NHS affecting both pay and other conditions of service.

ii. To agree that self-governing hospitals should be dealt with as in paragraph 20 above.

12 December 1988

DETERMINATION OF PAY AND CONDITIONS OF SERVICE FOR REVIEW BODY GROUPS

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

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

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

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

PROPOSALS FOR INTRODUCTION OF GREATER LOCAL FLEXIBILITY

The problem

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

Senior managers

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

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

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

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

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

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

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

Administrative and clerical staff

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

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

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

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

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

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

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

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

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

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

Nursing and midwifery staff

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

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

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

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

Other staff groups

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

FINANCIAL ARRANGEMENTS FOR SELF-GOVERNING HOSPITALS

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

Introduction

1. Self-governing hospitals will offer better value for money, higher efficiency, increased choice for patients and closer links with their local community, providing a spur for the improvement of standards in the rest of the hospital service. To achieve these objectives they will need the maximum freedom and flexibility in managing their financial affairs consistent with maintaining public expenditure control and accounting propriety. This paper considers what financial arrangements will be required.

2. We consider that the best available model for the financial framework for these bodies is that of the public corporation. Thus self-governing hospitals would have:

(i) ownership of their assets and the freedom to use them as they think best subject only to certain reserve powers of the Secretary of State;

(ii) freedom to retain surpluses and to build up reserves;

(iii) freedom to manage any temporary deficits;

(iv) freedom to borrow to finance their working capital and capital investment.

The Secretary of State and the Chief Secretary agree that the hospitals' access to private sector capital should not be subject to over-rigid public expenditure constraints. The Chief Secretary considers that, like other public corporations, self-governing hospitals should be subject to an annual financing limit.

Freedoms of self-governing hospitals

i) Ownership and use of assets

3. The assets of self-governing hospitals would be vested in their boards, in keeping with the overall objective of giving them the maximum possible freedom to run their own affairs. They should also have the freedom to make use of their assets to provide the pattern of service they think best. This should include the freedom to dispose of assets subject only to a reserve power for the Secretary of State to intervene if the disposal was against the public interest.

4. To impose the necessary commercial discipline, the hospitals should not be given these assets as a free good. We propose that - like Trading Funds - the hospitals should be given an interest bearing originating debt, equal to the value of their initial assets at vesting. This would have the same financial management advantages as the capital charging system to be introduced into the rest of the hospital system from 1991 onwards. Self-governing hospitals would be set financial targets designed to cover the cost of capital employed.

ii) Retention of Surpluses and Reserves

5. To give self-governing hospitals end-year flexibility on their operating surpluses, they should be allowed to retain these surpluses. They should also have the freedom to build up reserves to improve their services and help finance capital investment. This will give them an additional incentive to maximise their efficiency and keep their costs down. (The legislation will need to specify the form in which these reserves can be held.)

iii) Deficits

6. We cannot be certain that self-governing hospitals will invariably be able to balance their budgets every year. A hospital may end a particular year with a deficit despite being in a sound underlying financial position. A requirement that hospitals could not run end-year deficits would be an artificial and unnecessary

constraint on their activities. However, a self-governing hospital should not be entitled to run a continued deficit: this would undermine its viability and build up potential liabilities for the Exchequer. This would be avoided by setting a requirement that they should break even taking one year with another.

iv) Working Capital and Capital Investment

7. Self-governing hospitals' income and expenditure cash flows are unlikely to match each other at all times throughout the year. They will therefore need access to working capital through loans/ overdraft facilities. (They will need a loan at their foundation to give them the necessary working funds until the income from their contracts starts to flow.) More significantly, they will also need access to funds for capital investment so that they can maintain and expand their facilities to meet demand and provide the required standard of service. They are unlikely to be able to finance their capital investment solely from sales of assets and/ or the reserves they have built up. They should therefore be able to meet their capital requirements through loans, which they would have to service from their income in the same way as hospitals in the rest of the NHS will be charged for capital.

8. There is a degree of disagreement between us when it comes to the arrangements for controlling the scale of the borrowing of self-governing hospitals. As public corporations, all the hospitals' borrowing from whatever source and their other external finance would be public expenditure. Moreover, the liability for any borrowing by the hospitals would lie ultimately with the Government. The Chief Secretary considers that to maintain public expenditure control there will therefore need to be annual limits to the amount the hospitals can borrow. The overall limit for the self-governing hospital sector would be set in the Public Expenditure Survey with each individual hospital then receiving an annual financing limit.

9. The Secretary of State considers that this remains too restrictive. He considers that self-governing hospitals' access to private sector capital should not be subject to public expenditure constraints. Discipline would be exercised by audit;

by the need to cover costs at price levels which attract business and therefore income (which in the case of contracts with district health authorities would come from within the cash-limited allocations for health authorities' revenue); and by the existence of certain reserve powers requiring, for example, hospitals to obtain the approval of the Department if they wished to borrow above given levels. The Secretary of State believes that self-governing hospitals will prove at least as capable as Universities and Polytechnics at managing their investment programmes and these higher education bodies have considerably greater freedom. The Chief Secretary notes, however, that these are private sector bodies.

10. The Chief Secretary considers that the arrangements for self-governing hospitals proposed by the Secretary of State would leave their impact on public expenditure entirely open-ended. The absence of any financing limit on private borrowing would seriously undermine control of public expenditure and set a very unwelcome precedent for other public sector bodies, which are not absolved from annual expenditure control, still less allowed to borrow as they see fit.

11. Self-governing hospitals could be allowed to borrow from the private sector and/or the Government. Loans from commercial banks would be more expensive - even if covered by Government guarantees - and in practice the Chief Secretary believes that the hospitals would almost certainly want to use the Government for their capital borrowing. (This would also be more transparent to Parliament.)

12. Loans from voted funds, rather than the National Loans Fund, would be the appropriate source of borrowing from the Government. This would reflect the Department of Health's responsibility for the NHS and for self-governing hospitals in particular. It would be for the Departmental Accounting Officer to satisfy himself that the loan would be serviced, and repaid, in full. Otherwise, if borrowing was from the NLF, the Treasury would share this responsibility, which would unacceptably muddle accountability to Parliament for the hospitals.

13. There would need to be arrangements to ensure that funds borrowed from the Government could not be put on deposit at higher rates of interest since the Accounting Officer would be open to criticism if loans were used for this purpose.

Maintaining financial standards in self-governing hospitals

14. Self-governing hospitals should have the maximum freedom consistent with normal Accounting Officer principles. As they remain public bodies, the Secretary of State will need some controls over their exercise of their powers. He will, of course, be able to dismiss the board of a hospital and remove its self-governing status. However, these are draconian sanctions for use in extremis if it is clear that a hospital is no longer fit to run its own affairs. It will also be necessary for him to have the power to intervene if abuses of self-governing status are occurring. Since self-governing hospitals will not be subject to the general direction of the Secretary of State in the manner of the rest of the NHS, he will need some limited specific powers, for example, regarding the sale and purchase of assets and size and use of reserves. These powers would only be for use where there was a serious risk that a hospital was abusing its freedoms or getting itself into difficulties.

15. Further controls may need to be provided to prevent any hospital with a local monopoly of health care provision unfairly exploiting its position by, for example, charging high prices for its services. The system of capitation funding for health authorities will provide some protection. An authority will have a fixed sum to purchase services for its population which will constrain what it can pay the self-governing hospital. Its contracts with a self-governing hospital may not by themselves provide all the funding the latter requires. The hospital may need to compete for business from outside its home district and this will affect the prices it can charge. However, it will be necessary to consider whether this needs to be reinforced by specific powers.

Other issues to be settled

(i) Tax

16. The tax treatment of the surpluses made by self-governing hospitals needs to be considered. (As the law currently stands, the view of the Inland Revenue is that health authorities are probably liable to tax on their profits from treating private patients and other income generation activities.) The VAT treatment of contracts let by health authorities to these hospitals is another issue to be considered.

(ii) Accounting for Capital

17. Self-governing hospitals would be required to maintain their own accounts. These should include provision for depreciation. The interest self-governing hospitals should pay on their inherited assets, the method of valuation and accounting for depreciation will need to be considered further in tandem with the details of the capital charging scheme: the different arrangements should not result in self-governing hospitals being placed at a competitive advantage or disadvantage to the rest of the hospital sector.

(iii) Accountability

18. The operations of self-governing hospitals will be subject to audit by the Audit Commission like the rest of the NHS. As our intention is that these hospitals should be as autonomous as possible, they will not be under the same direct control of the Department as the rest of the NHS. The Department's Accounting Officer will not be accountable for each individual hospital but he will have an overall stewardship responsibility for their use of public funds. (As now, he will remain accountable for payments, including loans, made from his votes to the hospitals and, in his capacity of Accounting Officer for the HCHS, for payments to health authorities.) To protect the position of the Accounting Officer it will therefore be necessary to ensure that there are adequate monitoring arrangements.

19. The NAO will remain responsible for auditing the consolidated accounts of the NHS and for scrutinising the Departmental Vote under which loans are made to the self-governing hospitals. They will have right of access to papers relating to the accounts and audit of self-governing hospitals and will also be able to include self-governing hospitals in their value for money studies of the NHS. In each self-governing hospital there will therefore need to be a single person with overall financial and accounting responsibility.

Conclusion

20. The Group needs to decide whether self-governing hospitals should be subject to annual limits on all their finance or whether these should not apply to their access to private sector capital. With the exception of this issue, we are in agreement that the financial regime outlined above should be created by the legislation establishing self-governing hospitals.

CONFIDENTIAL

HC66

ACCESS TO PRIVATE CAPITAL

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

Our paper HC56 said that we would report back to the Group when we completed our further work on this question.

2. We have examined a range of projects which individual health authorities would like to undertake. In so doing, we have applied two general principles: that value for money must be secured on behalf of the taxpayer; and that, where the capital costs of a project ultimately devolve onto the taxpayer, there is a presumption that it should not be additional to the agreed public expenditure programme.

3. For the most part, the application of these principles to particular cases is clear, and we have found no reason why they should impede the projects from going ahead. The following are among the examples we have considered, and which we see every reason to encourage:

a. a joint venture between the NHS and the private sector, who share the construction of hospital facilities, with costs apportioned according to the use they plan to make of them. There would be opportunities for trading between the two sectors, with the private sector selling capacity to the NHS and the NHS selling diagnostic services, etc to the private sector. The NHS would receive rent from the private health care provider in respect of the land;

b. leasing NHS land, buildings or other facilities to private sector health care providers. The private sector would run facilities on an NHS hospital site. The lease might be on conventional repayment terms, or might enable the NHS as landlord to share some of the profits generated by the lessee;

c. as b., but with the lessee providing a non-health facility. This might be a hotel, shops, or a sports centre. It could sell its services to the hospital, to patients and to visitors. Again, the lease could either be conventional or involve an element of profit-sharing. This would be an alternative to the sale of the freehold, if the health authority considered that it offered a better deal;

d. leasing part of a hospital site to a housing association which would provide low-cost accommodation for NHS staff. The NHS might subsidise the lease, and possibly share in the profits. The housing association could either build afresh or refurbish existing accommodation.

4. In all these cases, there are no complications resulting from the private finance principles. The health authority needs to assess the commercial risks it faces from the venture (eg if its partner went out of business) and to ensure that it has the right management capacity and skills to deal with this as appropriate.

Contracting out

5. Contracting out is an issue, however, which raises slightly more difficult questions. In principle, if a service is contracted out to the private sector, the need for capital in the NHS is reduced. But since the contractor's fees will involve an element for the cost of financing its capital expenditure, the health authority's current costs rise. In principle, therefore, health authority capital allocations should be reduced, and current allocations increased. Where services have been contracted out so far, however - mainly, catering, cleaning and laundry services - the capital element in the contractor's fee has been so small as not to warrant any adjustment. But, at the other end of the spectrum, there are

cases where adjustments between capital and current allocations are clearly appropriate - for example, in the hypothetical case of a health authority which decided to contract out all its hospital services.

6. There is a grey area in the middle. It has already been explored for contract energy management schemes, under which a contractor takes over the energy management of a hospital, including perhaps the installation of a new boiler incorporating modern technology, with the aim of substantially reducing energy costs. Guidelines for taking account of the contractor's capital expenditure have been agreed across government. Rather similar issues will be raised by the need to upgrade or replace NHS incineration plant to comply with new statutory controls on emissions. Again, this is an area where the expertise resides in the private sector, and where significant capital expenditure by the contractor may be involved. Another case is that of a health authority which is seeking to contract out the care of some geriatric patients, rather than to replace itself an outdated and crumbling hospital.

7. Our two Departments are in touch bilaterally on these issues. We propose that officials should continue their work to clarify the ground rules in such cases.

Cost-saving projects

8. we have however identified one more difficult case. This is the financing of cost-saving projects of the sort now proposed for Bromley District Health Authority. In this case, outdated town centre facilities would be moved to a greenfield site just outside the town with the capital costs largely financed from the proceeds of selling the present sites. There would be recurrent savings from rationalisation. There is however a timing problem in that the land sales receipts are not available until after the new hospital has been constructed and the patients moved into it.

9. We are agreed about the desirability of such projects going ahead. In principle, there are three ways in which they could be financed:

a. by making room in the region's capital programme to finance the expenditure, taking credit for the associated receipts in later years;

b. by expenditure from a separate "fund" which is held back for allocation centrally rather than by regions, to which the eventual receipts are also scored. Such a "capital loans fund", which could be expected to be self-financing after about three years, was proposed by Department of Health in this year's public expenditure survey;

c. to enter into an arrangement with a contractor under which he builds the new hospital in return for vacant possession of the land so released. In effect he provides bridging finance between the construction costs and the land sales receipts. But such finance would carry a higher rate of interest than if the project were financed conventionally, as in options a. or b.

10. The Secretary of State considers that the Region's capital programme is fully committed for several years ahead, and health authorities have no objective basis for comparing cost-saving projects with those that meet service objectives. So service development inevitably tends to take priority in regional capital programmes. In the Secretary of State's view, the practical choice facing health authorities in this situation is between mounting the cost-saving project now using private finance or mounting it considerably later using public finance. In these circumstances, the Secretary of State believes that the extra costs would be outweighed by the benefit of bringing the project forward.

11. On the other hand, the Chief Secretary would argue that projects promising such a good return should be accommodated within the level of capital expenditure agreed for the NHS, even if regions do not give them high priority. This could be ensured by an arrangement on the lines of option b. Option c. would also mean giving greater freedom to health authorities than to local authorities, where we have recently been tightening up.

12. The responsibility of the Accounting Officer to secure best use of resources also needs to be considered. This issue is being addressed at present in the Bromley case, and will need also to be considered in any other such projects which are put forward.

13. We will be considering these options carefully in the Bromley case, with a view to agreeing how to proceed, with if possible an announcement around the time of the White Paper.

Conclusions

14. In conclusion, we invite colleagues:

a. to note that private finance considerations are fully compatible with a wide range of co-operative ventures which health authorities wish to enter with the private sector;

b. to agree that our two Departments should do further work on the detailed application of the general principles to the different types of contracting out which are possible;

c. to note that we shall be considering further the options for cost-saving schemes in the light of the specific Bromley case, with a view to reaching a conclusion next month.

st2.ar/docs/13.1.12.88

SECRET

PWP

FROM: R B SAUNDERS

DATE: 13 December 1988

CHANCELLOR

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

NHS REVIEW: MEETING ON 16 DECEMBER 1988

There are five papers for this meeting, which are expected to be taken in the following order:

- Pay
- Self-governing hospitals
- Access to private capital
- Managing the FPS
- Draft White Paper.

The first three are joint papers by the Chief Secretary and Mr Clarke. The other two were circulated under cover of the letter of 9 December from Mr Clarke's private secretary.

Pay (HC64)

2. The paper circulated to the group now has agreed conclusions. Mr Clarke has dropped his earlier idea that self-governing hospitals should have freedom over pay and conditions forced upon them, and indeed now claims that this was never what he had in

mind. In return we have agreed that self-governing hospitals should have removed from them any obligation imposed from the centre to observe either Review Body recommendations or Whitely agreements, leaving them free to decide for themselves whether to do this voluntarily or to adopt some other arrangements. Satisfying the Department of Health that they have the necessary management capability to determine their own pay and conditions would be one of the conditions of achieving self-governing status in the first place. The Secretary of State would also retain reserve power to reassert control if that proved necessary. Whether self-governing hospitals will be in a rush to make use of this kind of flexibility to any significant extend remains to be seen. The Department of Health rather doubt that they will.

3. This is an acceptable outcome from our point of view. But it does require a leap of faith that the degree of competition experienced by self-governing hospitals will, together with cash constraints on district budgets, be sufficient to provide an alternative discipline on pay costs, and that any increases in rates will be offset by greater efficiency as the result of the release of managerial energies. The flexibility will inevitably only be used in one direction, to pay more than nationally agreed rates.

4. As far as we know, there is no reason to expect discussion of this item to be controversial now that we and the Department of Health are in agreement.

The financial arrangements for self-governing hospitals (HC65)

5. The proposals in this paper remain broadly as discussed at your meeting last week. Mr Clarke has only one objection, to the proposal that individual self-governing hospitals should be subject to EFLs. He argues that it is the intention to set self-governing hospitals free of government control, and this would be negated by placing an overall limit on their ability to raise funds. He proposes that there should be a limit on their

borrowings from the public sector, but not on their borrowings from the private sector, although there might be some reserve powers, eg that they should ask the Secretary of State's permission before borrowing more than a certain amount.

6. This is not acceptable to us. Self-governing hospitals will be statutory public bodies, and as such their borrowing - from whatever source - will count as public expenditure. This is a classification issue, not a policy issue. In the course of discussion, Department of Health have tried to quote various precedents to the contrary, and I attach a note by Mr Griffiths dealing with them. Since the borrowing is public expenditure, then it must clearly be subject to a limit. Otherwise, their borrowing would be effectively treated as demand-led. There are no grounds for treating self-governing hospitals any differently from the generality. Mr Clarke's suggestion of limiting borrowing from public sources only is no limit at all, since the hospitals could easily switch to borrowing privately when their public allocations had been used up.

7. This is an absolute point of principle for the Treasury. To concede to Mr Clarke would drive a coach and horses through public expenditure controls.

Access to private capital (HC66)

8. We have made good progress on this issue, and Mr Clarke has agreed to the circulation of a paper which sets out the large measure of agreement which exists between us, and does not seek to debate specific proposals (eg Bromley). He has also come off his earlier enthusiasm for letting health authorities take on high risk business like property development. The paper is however short on specific proposals, and may therefore provoke a difficult discussion.

9. The main points we need to get across are the following.

a. The private finance rules have a much less inhibiting effect than many health authority managers believe. This is made clear in the paper. There is a useful job to be done in explaining to health authorities what they can do rather than what they cannot do.

b. It is much better to deal with concrete examples than theory. This is how we have established such a good measure of agreement so far. So it is better to discuss cost-saving projects in the specific instance of Bromley than in the abstract.

c. On the Bromley scheme itself, we have still not had proposals from Department of Health (although we understand that South East Thames region have made a submission to the Department). We cannot judge them until we have seen what is proposed. Assuming DOH deliver these in time, we will aim to announce a decision at the same time as the White Paper.

d. As to Bolton (the health authority where it is proposed to contract out care of the elderly to the private sector), we are still in discussion with the Department of Health about the scheme, some of whose financial details are a bit obscure. If pressed, however, you can indicate that, subject to satisfactory resolution of the outstanding points, we will not be seeking a control total adjustment in this case.

e. The paper is mainly about district-managed hospitals. The same principles should apply to self-governing hospitals, just as they do in the rest of the public sector: the Ryrie rules for nationalised industries and the action recently taken by Mr Ridley to tighten up on local authority schemes. But they will be subject to much less tight regulation on capital, and in practice can be expected to be able to exercise greater freedom in particular types of scheme.

Managing the FPS: outstanding issues (HC63)

10. This paper is however awful. There are four main issues.

11. First, drug budgets. Paragraph 3(i) says that there would be a national drug budget. But if it is overspent it will be increased. If that is to be the case, what is the point of setting a budget? The paper goes on to propose methods for allocating this budget first to regions, then to FPCs, and then "indicative" budgets for GP practices. This seems pointless bureaucracy if the budgets are not intended to exert any real downward pressure on expenditure.

12. To have any effect, budgets would have to be real, with FPCs able to take action against persistent over-prescribers. They would form part of a cash-limited total, so that overspending on drugs would have to be offset, for example, by reduced spending on accommodation. The approach to allocating drugs budgets suggested in paragraph 3(ii) seems too simplistic: the distribution should surely reflect the pattern of spending across the country, which presumably results from factors such as age structure and morbidity. By all means let us start with shadow budgets, but the intention should be to move, within a defined timetable, to real budgets.

13. Second, Mr Clarke reopens merger of FPCs and districts. This will presumably mean a re-run of the earlier discussion. The arguments are familiar to you.

14. Third, GP numbers. The paper discusses the possibility of increasing the proportion of GP remuneration accounted for by capitation fees, and of increasing the number of patients needed in order to qualify for the basic practice allowance (BPA). Both are being discussed with the GMSC following the primary care White Paper. On capitation fees, however, the proposal is very modest - to increase the proportion from 47 per cent to "over 50 per cent". It is also suggested that it might be "reasonably expected" that increasing the BPA threshold should roughly halve the rate of growth in GP numbers. But no evidence is offered for this.

SECRET

15. But nowhere is the option of abolishing the basic practice allowance discussed. This would have a much more dramatic effect on the proportion accounted for by capitation fees than suggested in the table in paragraph 17.

16. Moreover, the arguments in paragraph 21 against taking direct manpower controls - "it would be bureaucratic and would need primary legislation" - are feeble in the extreme. The second is particularly silly when the outcome of the review is going to be a substantial Bill in the 1989-90 Session.

(can't we go straight to cash-limits?)

17. Getting control over GP numbers is an essential prerequisite of cash limits or otherwise controlling FPS expenditure. The obvious way is to take direct controls, and we have yet to see any convincing argument against this.

18. Fourth, GP practice budgets. The discussion in this paper reinforces our doubts about this scheme. For example:

a. Paragraph 24(ii) says that underspending on drugs and referrals could be switched to staff and accommodation expenses. But 70 per cent of such expenses are already covered by direct reimbursement. The balance of 30 per cent is expected to be covered by the GPs themselves out of the fees and allowances they receive. If underspends can be used in this way, then in practice the GPs themselves are pocketing the money, since their need to contribute from their other income is reduced.

b. Paragraph 27(i) suggests that there should be 20 per cent end-year flexibility on practice budgets. This is far in excess of anything allowed elsewhere. It has never been discussed with the Treasury. You should say it is unacceptable.

c. Paragraph 27(ii) says that surpluses could be spent on other "aspects of the practice", presumably in addition to those covered by the direct and indirect

reimbursement systems. What will be allowed? And, if they are not covered by present reimbursements, are they an appropriate use of public funds?

d. Paragraph 27 goes on to suggest that GPs would be free to retain up to 5 per cent of the budget for themselves if they underspent. But surely this runs into the same problem as identified in paragraph 26 - Mr Clarke's concern not to divert into GPs' pockets money voted to provide services to patients. In any case, as argued at a. above, his existing proposals will have the same effect.

19. A lot more work is needed on GP practice budgets before we can say we have a viable scheme. I have already sent Department of Health a six page examination paper about how contracts between districts and hospitals will work. I shall be sending them something similar on practice budgets before long.

Draft White Paper (HC62)

20. These draft chapters are broadly like those we discussed last week, although there has been some reordering. I suggest the following main points to make on them.

a. There is a need for a chapter on value for money immediately after chapter 2

b. Chapter 2 ends with the point about improving the service to patients, presumably because there are relatively few specific proposals. This is wrong. It should start with the patients. There should also be some specific proposals for getting waiting lists down and for achieving the objectives listed in paragraph 2.15. Setting target waiting times, as suggested in Mr Parsonage's minute of 7 December, would be a start.

c. Paragraph 2.4 is still a pretty unconvincing answer to the question why the review was needed, if the NHS is doing as well as paragraph 2.1-2.3 say it is.

d. The emphasis on GP practice budgets (eg paragraph 2.9 and the outline) seems unwise in view of the serious questionmarks remaining over them, for example those identified above.

e. The chapter on self-governing hospitals will need a lot of rewriting in the light of the paper HC65.

21. We will also have a large number of more detailed comments, not least on the style at some points. But they would better await the next draft.

R B SAUNDERS

ANNEX

FINANCIAL ARRANGEMENTS FOR UNIVERSITIES, POLYTECHNICS AND OPTED-OUT SCHOOLS

Universities, polytechnics and opted-out schools are all classified as private sector bodies and nearly all have charitable status. They receive all or most of their funding from the Exchequer but own their assets and are not subject to the direct control of the Government. Their boards are not appointed by the Government, although there is provision for the Secretary of State for Education if necessary to appoint up to two members of the board of self-governing schools. Nor does the Government have the power to dismiss the boards.

The institutions have the freedom to retain surpluses and build up reserves. But this is subject to certain constraints: any carry-over of funds by opted-out schools from one year to the next must be in accordance with the accounting practices of their local authority; and the financial memoranda between the University Funding Council and the Polytechnics and Colleges Funding Council and their respective institutions are expected to set general limits to this freedom. Universities and polytechnics are not subject to any specific controls over their borrowing since, as they are private sector bodies, this does not score as public expenditure, although again the financial memoranda are expected to lay down certain ground-rules. City Technology Colleges also have the power to borrow but must obtain the specific approval of the Department of Education beforehand. However, opted-out schools are expressly prevented by legislation from borrowing.

CABINET OFFICE

70 Whitehall London SW1A 2AS Telephone 01-270

SECRET

P 03302

P Gray Esq
Private Secretary
10 Downing Street

13 December 1988

Dear Paul,

NHS REVIEW

I enclose the remaining papers for the meeting of the Ministerial Group on Friday 16 December. As to agenda, I suggest that the Prime Minister may wish to take the items in the following order:

1. Pay and Conditions of NHS Staff (HC64, attached): joint paper by the Secretary of State for Health and the Chief Secretary to the Treasury.

2. Financial Arrangements for Self-governing Hospitals (HC65, attached): joint paper by the Secretary of State for Health and the Chief Secretary to the Treasury.

3. Access to Private Capital (HC66, attached): joint paper by the Secretary of State for Health and the Chief Secretary to the Treasury.

4. Managing the Family Practitioner Service (HC63, circulated on 9 December): paper by the Secretary of State for Health.

5. Draft White Paper (HC62, circulated on 9 December): paper by the Secretary of State for Health.

I would be grateful if recipients would ensure that the papers are seen only by those with a strict operational need to do so.

I am copying this letter and the enclosures 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 ever,

R T J WILSON Richard

week.12.12/m.3

Mike - there was a booklet (blue) on this. Can you find?

FROM: H PHILLIPS
DATE: 14 December 1988

CHANCELLOR

Thanks. I will write to Mr Clarke, copy to Mr Anson & Mr Saunders.

cc CST
Sir P Middleton
Sir T Burns
Mr Anson
Mr Saunders
Mr Parsonsage
Mr Call

HEALTH TECHNOLOGY ASSESSMENT

You drew to my attention a case study produced by the Office of Technology Assessment in the United States and asked what I could find out about the organisation that produced it. The case study concerned was on the Effectiveness and Costs of Continuous Ambulatory Peritoneal Dialysis. As I have mentioned to you separately I thought this was a clear and well presented piece of work helpfully free of jargon with the minimum of technical explanation.

Health Technology Assessment in the United States

2. There are two main national agencies in the USA which are engaged in the business of assessing developments in health technology. The one you drew to my attention the Office of Technology Assessment (OTA), serves the Congress; the other, the Office of Health Technology Assessment (OHTA) does some similar work but from within the US Department of Health and Human Services. Both bodies publish their reports but the fact of publication does not represent endorsement of the recommendations either by Congress or by the Federal Administration.

3. The OTA has a bipartisan Congressional Board of 6 Senators and 6 Representatives; an Advisory Council of 10 distinguished outsiders; and permanent staff of about a 100 mainly specialists in physical, life and social sciences, engineering, the law, and medicine. It has been going since 1972 following a long period of debate in Congress and outside on the lack of relatively objective information about the complexity, cost, and implications, of

developing health technology. Our Embassy's assessment of the OTA, after some experience of dealing with them, is that it produces high quality reports which are well respected by Congress and by the informed public outside. The permanent staff, I am told, are of very high calibre and are regularly supplemented by outside professional expertise. The health and life sciences division of the OTA has published a substantial range of reports including ones on technology and ageing; on payment for physician services; on payment for hospital services; on specific proposals to increase competition in healthcare; and on Aids etc. All the assessments that the OTA has undertaken take about one or two years to complete.

4. As far as I can tell our Department of Health's main contact with health technology assessment in the United States is not with the OTA but with the OHTA. My impression is that their assessment process is based more on a comprehensive review of medical literature and of talking to practitioners in the field than I think the more original and lengthier approach of the OTA. The OHTA's assessments are concentrated on the safety and effectiveness of new or unestablished medical technologies that are being considered for coverage by the publicly funded medical programme. Their emphasis is primarily on clinical assessment rather than on the consideration of cost effectiveness which seems a particular hallmark of the OTA.

Health Technology Assessment in the United Kingdom

5. There is no comparable body to the OTA in the UK. A significant amount of health technology assessment is organised and funded by the DoH, where it is coordinated by the Health Technology Assessment Committee chaired by the Chief Scientist. Most of the Department's work in this field is organised by the supplies technology division of its procurement directorate but some is arranged by the Chief Scientist's research management division. The assessment of new medical equipment takes place in DoH-designated clinical centres and is mainly technical/clinical in nature but it does also consider costs. The assessment does not extend to clinical evaluation of the effects on patients

health outcomes as was the case with the OTA study which you passed on to me.

6. The majority of health technology assessment is undertaken independently of the Department of Health: principally by interested clinicians in university medical schools and in the NHS generally. Other academic bodies such as the King's Fund Institute carry out some evaluations of new medical technologies and equipment manufacturers fund some assessment work.

7. The Medical Research Council is most involved with clinical evaluation but has tended to concentrate on new and existing therapies rather than trials of new technologies.

Conclusion

8. The quantity of health technology assessment taking place in the United Kingdom seems small relative to the health technologies that remain to be evaluated so the risk of duplication of effort by the different groups involved here is probably small. I would judge that there is certainly room for a better focus in the UK on the cost effectiveness of health technology than now exists, and the work and approach of the OTA seems a useful model.

9. As a next step we could get the DoH to explain to us what their plans are for developing work on cost-effectiveness in this increasingly important area. Do you want to mention this in the Review Group, or write to Mr Clarke? Or would you prefer me to take it up at official level?

HP.

HAYDEN PHILLIPS

CONFIDENTIAL

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

14 December 1988

Dear Alison,

CHIEF SECRETARY
REC. 14 DEC 1988
ACTION Miss Pearson
COPIES TO Ch, Sec'y Middleton
Mr Anson, Sec't. Burns
Mr Phillips, Mr Beastall
Mr Potter, Mr Saunders,
Mr Call

AUDIT OF THE NATIONAL HEALTH SERVICE

The Prime Minister was grateful for the Lord President's minute of 12 December. She is content for a paving provision to be included in the Housing and Local Government Bill on the lines set out. She also thinks it would be helpful for the Secretary of State for the Environment to make a speech on audit issues in early January along the lines proposed.

I am copying this letter to Stephen Williams (Welsh Office), Roger Bright (Department of the Environment), Flora Goldhill (Department of Health), Carys Evans (Chief Secretary's Office), Alex Allan (HM Treasury), David Crawley (Scottish Office), Mike Maxwell (Northern Ireland Office) and Trevor Woolley (Cabinet Office).

Yours,
Paul

(PAUL GRAY)

Ms. Alison Smith,
Lord President's Office.

CONFIDENTIAL

Secret

NORTHERN IRELAND OFFICE
WHITEHALL
LONDON SW1A 2AZ

SECRETARY OF STATE
FOR
NORTHERN IRELAND

15/12

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

14 December 1988

Dear Secretary of State

NHS REVIEW: WHITE PAPER

Thank you for copying to me your letter of 7 December to Peter Walker. My understanding has been as you suggest, that the first draft of the White Paper will be in terms appropriate to England, and that we shall discuss at the next meeting the shaper of the chapter covering Scotland, Wales and Northern Ireland.

I have indeed been thinking about what the White Paper may need to say in relation to Northern Ireland, and I am putting a note to the Prime Minister on the local implications of the Review, taking account also of Peter Walker's paper of 21 November. When we have seen the shape of the first draft of the White Paper, we shall need quickly to prepare a chapter relating to the other three countries, and work on this is in hand here.

I am copying this letter to recipients of yours.

Yours sincerely

TK

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

Prime Minister

NATIONAL HEALTH SERVICE REVIEW

1. The timetable for the completion of the NHS Review will leave little opportunity for discussion of particular Northern Ireland issues. I therefore felt that it would be useful to highlight now those local issues which I should like to see addressed in the relevant chapter in the White Paper or in a supplementary local paper. In doing so, I am taking account of the points made by Peter Walker in his memorandum of 21 November.

IMPROVED SERVICE TO THE CONSUMER

2. The main recommendations of the Review will, of course, apply equally to Northern Ireland as to other parts of the United Kingdom. My intention is to build on existing initiatives designed to improve management performance and services to patients. In particular I want to delegate responsibility further to hospital level, and to provide the medical profession with the information and tools for them to become more involved in management not only in hospital but also in the community.

3. I am sure we should preserve and strengthen the present integrated service in Northern Ireland which, uniquely in the United Kingdom, brings together not only hospital and community health services (including the family practitioner services) but also the personal social services, within a unified management structure. While the full potential of this structure has still to be realised, I am confident that it provides substantial benefits to the consumer in terms of continuity of care and is a significant advantage in driving forward our strategy of a shift in the balance of care towards the community services.

4. My principal objective is, as elsewhere in the United Kingdom, to obtain discernable improvement in the services to patients and clients. I want to see reductions in waiting times for outpatient appointments, diagnostic tests and inpatient care, together with better screening services. I also intend to encourage the publication by Health and Social Services Boards of guides to the services available in individual hospitals and GP practices, including an indication of the quality of the care to be expected, in terms of waiting times, etc.

MORE EFFECTIVE MANAGEMENT

5. The completion of the NHS Review coincides with the completion by the four Health and Social Services Boards in Northern Ireland of a detailed management audit. As expected, the audit has identified various weaknesses which I wish to correct speedily. In particular, I wish to build on the introduction of general management by pushing further decision-making to the local level. General Managers have been in place for some years at board level, but Units are currently managed by Unit of Management Groups. This arrangement reflects the belief at that time that it would be counter productive to impose general management on services at the local level, where no general management culture existed and that its imposition would risk alienating those professions whose co-operation and support was required to implement effective management change, not least the medical profession.

6. I now believe that the emerging management culture at local level would support the appointment of Unit General Managers in major acute hospitals, where the process of driving down and controlling costs is particularly important. Similarly, within the psychiatric field there is a growing realisation that the process of change from institutional care to care in the community requires a more effective management focus in a Director of Psychiatric

Services. I am encouraged in the belief that a change in the management culture is taking place through the increasing willingness of hospital consultants to assume management responsibility and to take the lead in developments in the information field, including resource management projects which are underway in two of our hospitals.

7. I do not, however, propose at this stage to introduce Unit General Managers in community care where the existing management arrangements, which include social services staff, are operating reasonably well. What is decided on the future organisation of community care nationally will affect how we proceed in Northern Ireland.

MANAGEMENT OF CONSULTANT CONTRACTS

8. I should like to emphasise the importance which I attach to better arrangements for the monitoring and control of consultants' contracts. I welcome the thrust of the relevant papers, but would be anxious to underline the need for a strong management involvement in the process, including the revised Distinction Awards System. The role of medical audit is of course an essential ingredient in ensuring high quality and cost-effective care.

SELF-GOVERNING HOSPITALS

9. The introduction of Unit General Managers in major acute hospitals will also enable us to progress towards self-governing status for a small number of hospitals. As in Wales, most of Northern Ireland's major acute hospitals are widely dispersed and hence the scope for competition in elective surgery is limited. Only two or three hospitals would fit the criteria outlined by the Department of Health; these hospitals are located in Belfast and

provide most of the Province's regional medical services, together with acute services for the local population.

10. The management of these major teaching hospitals requires significant improvement and I would wish to ensure that their arrangements for financial control are substantially improved before I would contemplate self-governing status. Initiatives are in train to improve their management, including the implementation of improved information systems for both management and clinical purposes, which will take time. But more needs to be done.

11. I therefore intend to create a new divisional structure within the Board responsible for the major Belfast teaching hospitals, led by a Divisional General Manager. The latter's first task will be to bring forward proposals for the rationalisation of their services and their complementary working, as a first step in their possible development to self-governing status. Another step will be the implementation of effective financial and clinical information systems enabling the other Boards to "buy" the regional and other services they require for their resident populations. As elsewhere in the United Kingdom, effective safeguards would be required to prevent these hospitals abusing their position as monopoly supplier, including the Department acting as an arbitrator. This risk is particularly significant in a market isolated from the rest of the United Kingdom. Nonetheless Boards could still shop around for services, including in the Republic of Ireland, with whom I wish to develop a market in health care.

12. The final stage in the route to self-governing status would be the definition of a strategic framework which would ensure the continued delivery of a range of basic services to the local community and their continued linkages with community services. The framework would also secure the place of their teaching and research responsibilities.

GP PRACTICE BUDGETS

13. There are only 10 GP practices in Northern Ireland with more than 11,000 patients and the majority of them are just above this "cut-off" figure. Like Peter Walker in Wales, I doubt the capacity of GPs in Northern Ireland to assume responsibility for practice budgets. A substantial training programme in the requisite management skills would be required, together with a substantial investment programme in information systems and personnel. For a relatively small number of GPs it is doubtful if the necessary investment could be justified, although it might be possible to take advantage of parallel developments in Great Britain. I also share Peter Walker's concern over the investment of underspends, arrangements for monitoring the quality of care and the problem of determining budgets.

14. While I am keen to explore the potential for opting-out, I am anxious that the initiative should not detract from our current efforts in Northern Ireland to improve our primary care services by a range of initiatives, including the greater involvement of GPs in the delivery of community health and social services, and improvements in prescribing habits and referral patterns.

MEMBERSHIP OF HEALTH AND SOCIAL SERVICES BOARDS

15. I face special difficulties in Northern Ireland on the proposal to remove local political representatives from the membership of health authorities. There are few opportunities for elected representatives in Northern Ireland to contribute to the discussion of local issues. Their removal from Health and Social Services Boards will be widely interpreted as a further erosion of local democracy. Moreover, with local authorities in Great Britain continuing to administer personal social services, it will be argued that I am breaking parity with Great Britain.

16. On the other hand the contribution of District Councillors has generally been ineffective. In general, they have opposed government policy and promoted sectional interests. I am therefore disposed to apply the national policy in Northern Ireland and weather the resulting political storm.

17. To balance the removal of District Council representation from the Boards, I would wish to strengthen existing consumer committees - the equivalent of Community Health Councils in Great Britain. These District Committees currently shadow particular Units of Management and include in their membership representatives of the District Councils as well as voluntary and other interests. Their limited remit and highly localised focus has not given them an effective consumer voice. I therefore intend to replace the existing network of 16 District Committees by four area based Committees which would shadow each of the four Boards, with significant local authority representation.

AUDIT

18. On the audit of health authorities, I agree with Peter Walker that the government should set minimum standards in order to lessen the risk that audit will drive up costs. I support the new role for the Audit Commission, but its activities do not currently extend to Northern Ireland. Instead, I propose to continue progressively to privatise the external audit function in Northern Ireland against audit standards set nationally.

FINANCIAL SYSTEMS

19. I intend to replace the present PARR formula (a derivative of RAWP) for the allocation of revenue resources to Health and Social Services Boards by a simpler capitation-based formula, as in Great

Britain. The adoption of the new approach will require, as in the rest of the United Kingdom, better and more timely financial information on the cost of treating patients in other Board areas.

20. I understand that a paper on pay will be available for the next meeting of the Review Group. Despite the outcome of this year's Survey, I believe that pay remains a major uncertainity for health authorities throughout the United Kingdom. The position would be eased if the date for non-Review Body settlements could be brought forward, as happened recently with Review Body settlements. The Northern Ireland position is exacerbated by the timing of pay awards for social services staff who are employed on the same terms and conditions as their counterparts in local authorities in Great Britain. If pay settlements were made in advance and over an extended period, health authorities would know where they stood and have a more stable base on which to plan.

CONCLUSION

21. Whether I publish a more detailed supplementary paper for Northern Ireland will obviously depend on the space.

I am copying this minute to Nigel Lawson, Kenneth Clarke, Peter Walker, 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.

pp TK

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