PREM 19/1317

Part 2

Confidential Filing

NHS Expenditure and Efficiency

NATIONAL HEALTH

Part 1 begins May

Part 2 begins April

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
6.7.83		10.2.84					
11.7.83		14.2.84					
7.10.83		15.2.84					
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2.2.84							
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7.2.84							

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See Folder at back of file for documents on:

"The Creation of a Proper Health Care System by the Conservative Government in 1984"
- by Mr Donald Longmore (Consultant Clinical Physiologist)

& The Binder Hamlyn Report on the Control of Expenditure on the Family Practitioner Services

PART 2 ends:-

Home Sec to S/S DHSS. 20/2/84

PART 3. begins:-

S/S DHSS to CST 10/3/84

TO BE RETAINED AS TOP ENCLOSURE

Cabinet / Cabinet Committee Documents

Reference	Date
H(84) 2nd Meeting, item 2	01/02/1984
H(84) 3	10/01/1984

The documents listed above, which were enclosed on this file, have been removed and destroyed. Such documents are the responsibility of the Cabinet Office. When released they are available in the appropriate **CAB** (CABINET OFFICE) CLASSES

Signed J. Gray Date 27/9/2013

PREM Records Team

Published Papers

The following published paper(s) enclosed on this file have been removed and destroyed. Copies may be found elsewhere in The National Archives.

House of Commons HANSARD, 8 December 1984, columns 477 to 487: National Health Service (Pharmaceutical)

House of Lords HANSARD, 9 November 1984, columns 802 to 894: National Health Service

Department of Health and Social Security: Forecasting and control of Expenditure on the Family Practitioner Service – July 1983 – Printed and Published by HMSO. ISBN 0 11 320839 1

House of Commons HANSARD, 25 October 1983, columns 168 to 177: National Health Service (Management Inquiry)

Signed J. Gray Date 27/9/2013

PREM Records Team

QUEEN ANNE'S GATE LONDON SWIH 9AT

20 February 1984

D Norman,

AN INSPECTORATE FOR THE PERSONAL SOCIAL SERVICES

Thank you for copying to me your letter of 20 January to Patrick Jenkin about the outcome of your consultations on developing your Department's social work service explicitly into an Inspectorate for the local authority personal social services.

I was interested to learn the results and I welcome the proposal for the creation of a Social Services Inspectorate. You refer in your draft joint statement to the continuation of existing collaboration with HM Inspectorate of Schools and the Probation Inspectorate. I know that the Probation Inspectorate greatly value the co-operation which currently exists, especially in the field of juvenile offenders, and you will know that a joint programme involving inspection of social work and the probation service practice in the handling of supervision orders in two areas has recently been agreed. I am sure it will be right to build on and develop these contacts as part of our joint response to the problems of juvenile crime. The Probation Inspectorate would be glad to help the developing Social Services Inspectorate on all matters where there is a common interest.

I am sending copies of this letter to the recipients of yours.

Yours,

Leon

The Rt Hon Norman Fowler, MP

File

MR TURNBULL AT 17/2

HEALTH SERVICE MANAGEMENT

The draft terms of reference and advertisement for the Chairman of the NHS Board proposed by the DHSS is likely to be amended as a result of comments from other Departments. It is therefore premature to involve the Prime Minister as the DHSS has not come to its final conclusions on the nature of the appointment or how the individual is going to be found.

John Redwood

JOHN REDWOOD
17 February 1984

QO.

NBPM AT 15/2

NORTHERN IRELAND OFFICE
WHITEHALL
LONDON SW1A 2AZ

SECRETARY OF STATE
FOR
NORTHERN IRELAND

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Services
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

15 February 1984

Dear Norman

SOCIAL SERVICES COMMITTEE ENQUIRY INTO NHS MANAGEMENT INQUIRY REPORT

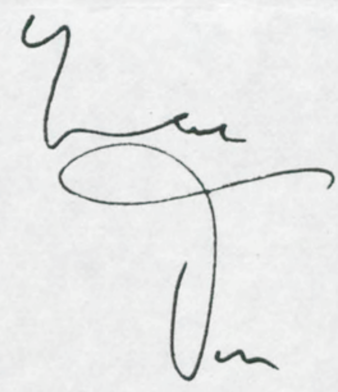
I read with interest your recent correspondence with John Biffen and Nicholas Edwards on the NHS Management Report and am grateful to you for keeping me abreast of developments in England and Wales.

The NHS Management Report is to be discussed with the Chairman of Health and Social Services Boards here before the end of February. I then intend to issue a consultation paper on the implementation of the principles in the Report to Northern Ireland. This exercise will not be straightforward given the need to adapt the recommendations to meet local circumstances, not the least of which is the administrative structure which uniquely in the United Kingdom covers the personal social services as well as the health service. Moreover this integrated administrative structure was only recently reviewed and the changes resulting from that review will not be fully implemented until later this year. While I am confident that various of the recommendations in the Report can be grafted onto the new administrative structure to the benefit of services I am nonetheless anxious that the progress that has already been made in securing more efficient and effective management should not be undermined by any precipitate action on the Government's part.

/...

Meanwhile I endorse Nicholas Edwards' remarks about the need to be fully aware of each other's proposals and their rationale. For this reason my officials are maintaining close contact with yours.

I am sending copies of this letter to those who received yours.



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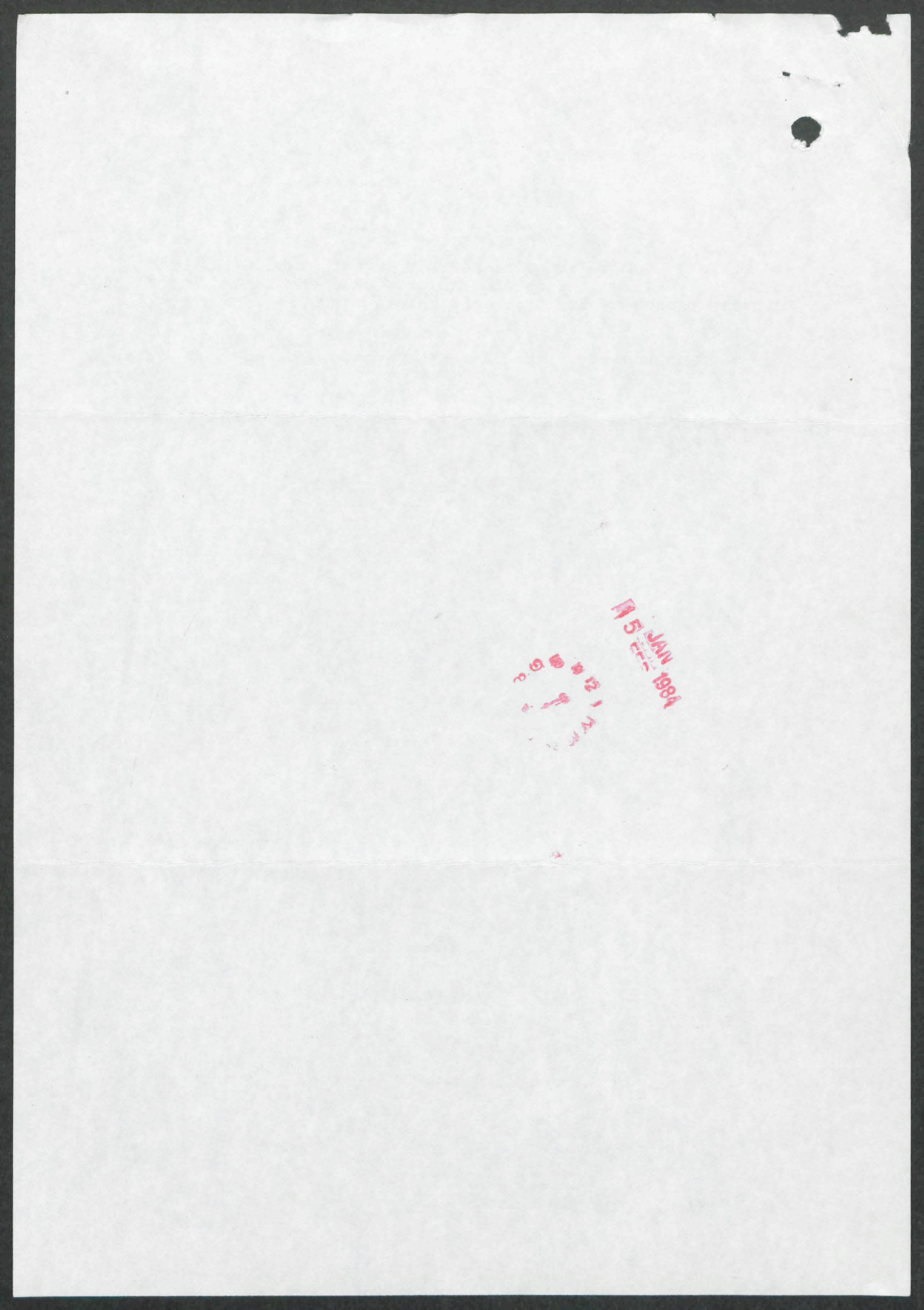


File

RW

PRIME MINISTER

NATIONAL UNION DINNER

I understand that you will be sitting next to Sir Peter Lane who is a senior partner at Binder Hamlyn. Though unlikely, it is possible that he could enquire about progress on Binder Hamlyn's report on the Family Practitioner Service. I have no idea whether he personally was connected with this study but he could have been alerted to it by a colleague.

I attach a copy of the minutes of H Committee. As you will see, there has been some retreat since the FPS was discussed by the Seminar in January. There it was agreed that the report should be published and its recommendations endorsed. In the light of the row with the BMA over deputising services, Mr. Fowler suggested publication of the report, while delaying a full Government response. I understand his Department is also conscious of the need to think through all the implications, e.g. for the medical schools. Other members of the Committee, anxious to avoid a political row, urged postponement of publication. This view prevailed and DHSS and Treasury were given a month to consider the next steps.

If Sir Peter raises this, I suggest you say simply that before publishing the report the Government needs to consider its response carefully.

Following your speech to the Small Business Bureau a Mr. Maynard wrote in. He had attended as a guest of Binder Hamlyn and he mentioned Sir Peter Lane. I attach a copy of the letter to which I have already responded, sending a copy of the speech. The Department of the Environment are dealing with the specific question.

MR. A. TURNBULL

14 February, 1984

CC NØ

NBPM

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

Mr Foster

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
DHSS
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

10 February 1984

Dear Norman,

SOCIAL SERVICES COMMITTEE ENQUIRY INTO NHS MANAGEMENT INQUIRY REPORT

I refer to your recent letter to John 19.1.84 Biffen and to Nick Edwards' letter to you of 2 February.

I should like to associate myself with the views expressed in Nick's letter. While I believe it is important that England, Scotland and Wales should each be able to have management arrangements specific to the needs and circumstances of the National Health Service in the respective countries, we also need to be clear how we stand in relation to each other. I know that officials of our respective Departments have been in touch, and that contact is also being maintained with the Treasury, and I believe it is important that close liaison on this issue should be maintained. But I also welcome his suggestion that we meet soon to discuss the way forward, before any formal guidance is issued.

I am sending copies of this letter to recipients of yours.

Yours ever,

George.

NHS Pt 2

10 DOWNING STREET

From the Private Secretary

①

Prime Minister

At the seminar with DHSS, it was agreed that the Binder Hamlyn report should be published and its recommendations endorsed. In the light of the row with the BMA, Mr Fowler suggested publication of the report while delaying full Government response. Other members of the Committee, sensitive to a political row, urged postponement of publication. This view prevailed and Treasury and DHSS were given a month to consider next steps.

Are you content to leave it there or do you want to inject rather more urgency?

AT
7/2

10 DOWNING STREET

MW

From the Private Secretary

(2)

Prime Minister

To note the conclusions of H on Binder Hamlyn. I am told the Chancellor is unhappy with this, though is inhibited from complaining because the Treasury was represented.

But the lack of urgency is at variance with the discussion at the seminar with DHSS.

You might like to ask Mr Fowler whether matters really need to go this ~~to~~ slowly.

AT

6/2

10 DOWNING STREET

(2)

MW

Prime Minister

You asked for a copy of the Binder Hamlyn report on the FPS.

I think you will get the essence of the report by reading pp's 1-9 and the Summary and conclusions beginning on page 49. The list of abbreviations at the back is indispensable

There may be a first reading discussion of this at the meeting on 12 January with Treasury and DHSS.

It may come to H or E(A) later in the month for formal Ministerial discussion.

AT
5/1

PRIME MINISTER

cc Mr Turnbull

SOCIAL SERVICES INSPECTORATE

In case Mr. Fowler raises it with you tomorrow, you may like to be aware of the attached letter from him to Patrick Jenkin, in which he sought colleagues' approval to convert his Department's Social Work Service into an inspectorate for local authority personal social services.

This proposal has run into vigorous opposition from both the Treasury and the Department of the Environment, on the grounds that it would be an additional burden on local authorities. Mr. Jenkin is also concerned that a professional inspectorate could easily become a lobby for higher levels of spending.

In the light of the opposition from colleagues, Mr. Fowler is re-thinking his approach.

DMB

6 February 1984

"C NO.

2 MARSHAM STREET
LONDON SW1P 3EB

01-212 3434

My ref: J/PSO/10552/84

Your ref:

6 February 1984

Dear Secretary of State

Thank you for your letter of 20 January with which you enclosed a draft of the statement you propose to issue jointly with the local Authority Associations on the establishment of an inspectorate for local authority personal social services.

Whilst I can well appreciate your desire to strengthen the existing Social Works Service, there could not be a more inopportune moment at which to launch the proposed inspectorate on local authorities. In the context of our rate limitation proposals we are resisting growing pressures for the establishment of minimum standards for local government services. The announcement of the proposed inspectorate could only reinforce this pressure. In addition, professional inspectorates are all too often transformed into lobbies for improved standards and their recommendations can also be used to justify existing spending levels. In the RSG debate last month, for example, a number of our backbench colleagues argued that their shire authorities were low spenders on the basis of work done by the H M Inspectorate of Schools and the Fire Inspectorate. In view of this I must ask you to consider delaying any announcement at least until the Rates Bill is on the statute book.

I should add that I am also concerned about the relationship between your inspectorate and the Audit Commission for local authorities. I have asked my officials to write to yours to explore ways of avoiding any duplication of effort.

I am copying this letter to recipients of yours.

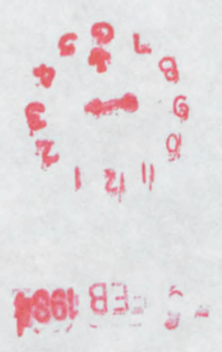
Yours sincerely

for PATRICK JENKIN

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

The Rt Hon Norman Fowler MP

National Health - NHS expenditure + efficiency A2



PRIME MINISTER

FAMILY PRACTITIONER SERVICES
H COMMITTEE

H Committee discussed at its meeting on Wednesday the Binder Hamlyn Report on the control of family practitioner services. The general feeling was one of caution following the row with the BMA over deputising services. It was felt that the original plan to publish the Report together with an announcement that the Government broadly accepted its main approach would unnecessarily antagonise the BMA and prejudice the chances of reaching acceptable economies. The Committee considered two alternatives: first, to publish the Report with an anodyne statement which did not commit the Government in any way; and second, to delay publication and to use time to reach provisional conclusions on the next steps. The Committee favoured the second alternative. Since publication would still be followed by a period of consultation this approach would imply that legislation next Session was unlikely to be possible.

3 February 1984

Nat Health Efficiency Pt 2 CNO

SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switsfwrdd)
01-233 6106 (Llinell Union)
Oddi wrth Ysgrifennydd Gwladol Cymru

The Rt Hon Nicholas Edwards MP

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 6106 (Direct Line)
From The Secretary of State for Wales

2 February 1984

Dear Norman

SOCIAL SERVICES COMMITTEE ENQUIRY INTO NHS MANAGEMENT INQUIRY REPORT

Thank you for copying to me your recent letter to John Biffen (19.1.84) about the handling of this Inquiry.

My Department has not been asked to give evidence but clearly the hearings and findings are of interest to me and I should be grateful if your officials would keep mine informed about the line you propose to take.

I note what you say about pressing ahead with guidance to health authorities in England after the end of February, even if the Select Committee has not responded by then. My Department issued on 13 December 1983 a consultation letter on the implementation in Wales of the principles of the Management Inquiry Report (which I copied to you) and we have asked for comments by 17 February. I have no desire to hold up your action in England, but I should be grateful if I could be consulted again before your guidance is issued. I say this because, for example, guidance on terms and conditions of service in England may also have to be applied in Wales and I would like to satisfy myself that what you propose does not prevent me from doing what is necessary in Wales.

More generally we need to be fully aware of each other's proposals and their rationale so that we can justify publicly any differences in the way the principles recommended by the Management Inquiry are translated into practice in different circumstances. The same of course applies to the responses by Jim Prior and George Younger to the issues posed by Mr Griffiths.

The Rt Hon Norman Fowler MP
Secretary of State for Social Services

/...

Y DDRAIG GOCH DDYRY CYCHWYN

Before final decisions are taken it would be helpful if you George and I could meet to discuss the way forward and we should ensure too that there is close contact at official level at all stages.

I am sending copies of this letter to those who received yours.

Yours
Nick

FEB 1984

ICNO

SECRETARY OF STATE FOR SCOTLAND

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

Await DoE

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

1 February 1984

Dear Norman,

INSPECTORATE FOR THE PERSONAL SOCIAL SERVICES

Thank you for sending me a copy of your letter of 20 January to Patrick Jenkin about your proposal to constitute an inspectorate for the personal social services.

I have no objection to your proposals and I am content with the terms of the draft statement.

I am at present considering whether similar arrangements should be introduced in Scotland. There is a case for doing so but in present circumstances it may not be easy to reach agreement with the Convention of Scottish Local Authorities on a more interventionist approach. I note that your proposals are dependent to a large extent on co-operation by the local authority associations.

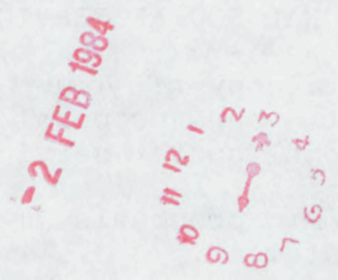
There is no great urgency in Scotland since, under present arrangements, my Department is able to keep closely in touch with the relatively small number of social work authorities. I hope to reach a conclusion later in the year.

Copies of this letter go to the recipients of yours.

Yours ever,

George

Nat Health Exp Pt 2



N LS
PXP

ROBIN BUTLER 30.1.84

Mr Thatcher asked me to let you see this letter which he has written to Mr Longmore, and was grateful for your advice. Perhaps I had better keep this file?

Joy

Joy

Many thanks. If I may say so, I think that Mr. Thatcher's reply is as tactful as it is wise.

Robin.

30.1.84

DENIS THATCHER

10 DOWNING STREET

30 Jan

Dear Mr. Langmore,

I am sorry not to have replied to your kind letter of 6 Jan before now. I have been in South Africa for two weeks on business and returned to the usual round of meetings and correspondence which inevitably follows a two week absence.

I hope you will not regard me as ungracious when I say dislike going round hospitals and always 'bow out' when hospital visits are included in 'tour programmes' when I am accompanying Margaret.

I hope therefore you will excuse me from

10 DOWNING STREET

accepting your most kind invitation and will understand my reason for so doing.

With kind regards

Yours sincerely

Denis Thatcher

P.S. I do not doubt that sooner rather than later I will be

in the position of hoping that advanced Medical Science will 'keep me alive' for that extra time. So be it; but I still don't like going round hospitals!

CF: Await further letter from Patrick Jenkin

Prime Minister 27/1

Content for Mr Fowler to make the attached statement, announcing the

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Patrick Jenkin MP
Secretary of State for the Environment
Department of the Environment
2 Marsham Street
LONDON SW1

January 20 1984

Dear Patrick.

AN INSPECTORATE FOR THE PERSONAL SOCIAL SERVICES

Last April I wrote to Tom King about consultative proposals for developing my Department's Social Work Service (which already exercises some statutory powers of inspection) explicity into an inspectorate for the local authority personal social services. The aim is to steer authorities into making the most effective use of existing professional and other resources, and to disseminate good practice.

We have now had all the responses to the consultative paper which I enclosed with my letter of 7 April, and Kenneth Clarke has discussed our conclusions with the local authority associations. Although there have been some doubts and comments on points of detail, the general aim has been widely welcomed. We have been able to enlist the support of the LA associations - an essential step in securing the co-operation from individual authorities on which the success of the inspectorate will depend.

I therefore propose to go ahead with implementing the proposals for an inspectorate in the consultative paper: if colleagues have any comments, I shall be glad to receive them within the next 10 days. I enclose a copy of a statement I propose to issue jointly with the LA associations at a convenient opportunity in January.

I am sending a copy of this letter and the enclosure to the Prime Minister, Willie Whitelaw, Leon Brittan, Peter Rees, Keith Joseph, Nicholas Edwards, George Younger, Jim Prior and Sir Robert Armstrong.

Yours ever
Norman.

NORMAN FOWLER

SP

SOCIAL SERVICES INSPECTORATE: DRAFT JOINT STATEMENT WITH THE LA ASSOCIATIONS

1. In April 1983, the Secretary of State sent to the Chairman of all Social Services Committees a consultative document proposing development of the Department's Social Work Service - which already exercises inspectorial functions - explicitly into an inspectorate for the local authority personal social services. In the light of a wide range of helpful comments on the consultative document, the Government has now reached agreement in principle with the local authority associations on the way forward.

2. The aim of the Social Services Inspectorate will be to assist authorities in making the most effective use of existing professional and other resources, and to spread good practice. This is more than ever necessary at a time when these resources are under heavy and increasing pressure.

3. Inspections will be of 3 main types:-

a. initiated by Ministers and the Department in exercise of the Secretary of State's formal powers of inspection;

b. issues of general concern outside formal powers and covering a number of local authorities, by agreement with the authorities concerned, and in accordance with a programme agreed by the LA associations; and

c. requested by individual local authorities to cover specific services or activities.

Reports written as a result of formal inspections would be made in the first instance to the Secretary of State, but all other reports would be concurrently to the authorities concerned for their Social Services Committee to see. Reports would normally be documents of public access.

4. Formally, the existing statutory powers of inspection (which are considered sufficient for the purposes of the new Inspectorate) are vested in the Secretary of State, and he will be the Minister responsible for the Inpectorate's management and actions. In practice, however, the operation of the Inspectorate outside formal powers will be a joint concern of central and local government. This will be reflected in a Steering Group of the Government and the local authority associations, whose detailed terms of reference are under discussion with the associations.

5. The staff of the Social Services Inspectorate will consist of members of the existing Social Work Service, supplemented by staff on attachment from local authorities, and when appropriate from other organisations and other relevant disciplines. The Inspectorate will continue existing collaboration with HM Inspectorate of Schools, and the Probation Inspectorate.

6. Inspections envisaged in 1984 under these new arrangements are:-

a. services for elderly mentally disordered people - an inter-disciplinary study under statutory powers of up to 5 authorities, based on residential homes;

b. a formal inspection under statutory powers of community homes for children covering 10% of homes and 25% of authorities; and

c. the home help service - a background study and investigation of services being provided.

NHS Expenditure Pt 2

23 JAN 1984

NATIONAL HEALTH: Expenditure: Pt2.

TF

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon John Biffen MP
Lord Privy Seal
Management and Personnel Office
Whitehall
LONDON SW1

JT 19/1

Dear John

SOCIAL SERVICES COMMITTEE ENQUIRY INTO NHS MANAGEMENT INQUIRY REPORT

The Select Committee on Social Services, which was reconstituted - again under Mrs Short's chairmanship - just before Christmas, is shortly to start an enquiry into the NHS Management Inquiry report which I published and made an oral statement about in the Commons on 25 October.

Mrs Short has given notice that she intends at Business Questions to seek time for a debate on her Committee's report, which is expected at the end of February; and has suggested that in the meantime I should defer guidance to the NHS on implementing parts of the Management Inquiry proposals. I attach a copy of her letter.

In presenting the report to the House on 25 October, I said that the Government accepted its main thrust, and hoped that health authorities would be able to start implementing the "general management function" (a key recommendation) from April of this year. The two month consultation period for the NHS and other interested bodies is now over, and provided that they meet their own deadline (of end February) - the Committee should report just in time for me to consider their report before finalising my guidance; should they over-run, of course, then I have no intention of holding back.

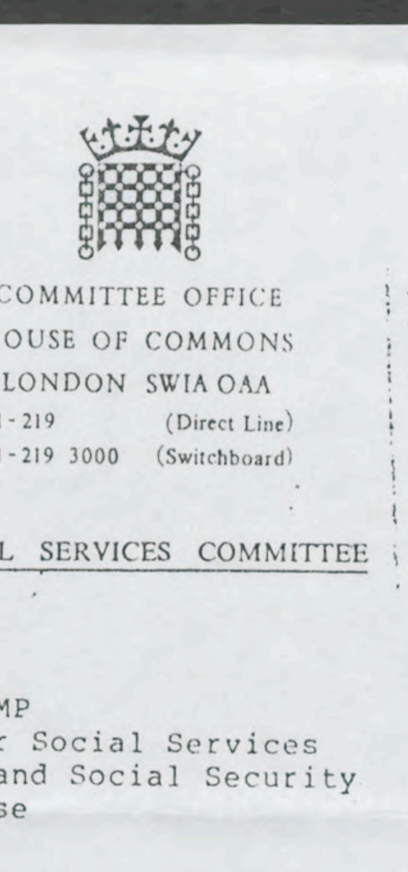
I would not necessarily think it undesirable to agree to Mrs Short's request for a debate on the Committee's report. As well as being a courteous gesture towards the Committee, it might be opportune, in March, for us to explain to the House the progress we had made, and to emphasise again our positive overall strategy for the NHS (including the expenditure provision for 1985-86 and 1986-87 which will by then have been published in the Public Expenditure White Paper). But it would be prudent to suspend judgement on the issue until we can sense better how the Committee's report is likely to shape up; and I suggest that in the mean-time you should be suitably non-committal in replying to Mrs Short at Business Questions.

E.R.

I am sending copies of this letter and its enclosures to George Younger, Jim Prior and Nicholas Edwards; and because implementation of the Management Inquiry report was raised at the general discussion of DHSS business at No 10 last week, to the Prime Minister and Nigel Lawson. I am copying also to Sir Robert Armstrong.

Yours ever
Norman

NORMAN FOWLER



COMMITTEE OFFICE
HOUSE OF COMMONS
LONDON SWIA OAA
01-219 (Direct Line)
01-219 3000 (Switchboard)

SOCIAL SERVICES COMMITTEE

21 December 1983

Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
London SE1 6BY

Dear Norman,

As you may know, the Committee held its first meeting on Tuesday and re-elected me as its Chairman. I am sure that the Social Services Committee will continue the sort of constructive work it carried out in the last Parliament, and I look forward to receiving from you and your Department the cooperation you have given so readily in the past.

The Committee decided to undertake a very quick inquiry into the Report of the NHS Management Inquiry, holding four oral evidence sessions in January and February. We have invited you to give evidence on 8 February, after Mr Griffiths. The Committee was aware that you were intending to issue guidance to health authorities on the implementation of the Report fairly early in the New Year. While the Committee's inquiry is not of itself intended to delay that timetable, I would very much hope that you would be willing to await a Report from the Committee, which we would expect to have out by the end of February, before issuing any such guidance. I imagine that the Committee would also hope to have such a Report promptly debated in the House, and I will be raising that with the Leader of the House at Business Questions.

Yours sincerely
Renée

Renee Short MP
Chairman

Do have a lovely Christmas.

NAT. HEALTH: Exp: Pt 2

PRIME MINISTER

cc: Mr. Thatcher

Donald Longmore telephoned me and said that he had written to DT inviting him to lunch at The Garrick. This letter will presumably be awaiting DT's return. Donald Longmore asked me to join the party but I have already lunched with Donald Longmore at the National Heart Hospital and I do not want to intrude on this lunch at the Garrick.

Donald Longmore mentioned to me that the lunch at the Garrick was being given by the fund-raiser for CORDA, the charity which is supporting Donald Longmore's NMR scanner. This suggests to me that Donald Longmore will put to DT some plan for supporting CORDA's efforts to raise the money they need for the NMR scanner, perhaps by suggesting that you give a fund-raising reception at No. 10.

- I can't. The demands for other similar requests would be endless

In case he does, I attach a copy of a letter from Ken Stowe in which he agrees with my view that you should be cautious about this. The NMR scanner is a thoroughly worthwhile project and Ken Stowe has mobilised help to make sure that it goes ahead. But both he and I are nervous about associating you too directly through a No. 10 reception to raise funds for it. In the politically charged world of health politics where so many people are short of money, it would be bound to attract jealousy. As you will see from Ken Stowe's letter, a better way of supporting the project may be for you to open it in due course. Donald Longmore is a zealot for his project, and there is a risk that he could unintentionally embarrass you.

F.E.R.B.

18 January, 1984

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe KCB CVO

PERSONAL

F R Butler Esq
10 Downing Street
LONDON
SW1

13 January 1984

Dear Robin.

Many thanks for your kind letter of 29 December and subsequent letter of 10 January.

I have not yet had an opportunity to discuss the question of a fund-raising party for CORDA at No 10 with Mr Fowler but, precisely for the reasons you give, I would advise against it - I think he would share my view. There is an additional point. Quite apart from the undoubted risk of a flood of requests from others with good causes to support, there is the difficulty that whilst CORDA is a reputable charity with eminent backers it is not in the forefront of medical charities and could not claim the same status as, say, the British Heart Foundation. Thus there might also be adverse comment on why CORDA had been singled out.

Should Mr Longmore revert to his suggestion that the Prime Minister opens the unit when the NMR scanner is installed, then this would seem the more satisfactory way of showing support for the venture; there is some risk that Mr Longmore might wish to exploit the funding-raising opportunities of the occasion but that could be lived with. I assume that the need for appropriate discretion could be conveyed to him.

Yours ever

Ken.

P.S. Some supplementary detail to follow orally.

10 DOWNING STREET

Prime Minister

To note Sir Alec Merrison's lecture. He develops one or two good points

(i) the problems of an NHS free at point of use

(ii) the pointlessness of robbing Peter to pay Peter

but he fails to follow them through.

On management he is feeble.

AT 13/1

MT

JMc

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe KCB CVO

PERSONAL

F R Butler Esq
10 Downing Street
LONDON
SW1

13 January 1984

Dear Robin.

Many thanks for your kind letter of 29 December and subsequent letter of 10 January.

I have not yet had an opportunity to discuss the question of a fund-raising party for CORDA at No 10 with Mr Fowler but, precisely for the reasons you give, I would advise against it - I think he would share my view. There is an additional point. Quite apart from the undoubted risk of a flood of requests from others with good causes to support, there is the difficulty that whilst CORDA is a reputable charity with eminent backers it is not in the forefront of medical charities and could not claim the same status as, say, the British Heart Foundation. Thus there might also be adverse comment on why CORDA had been singled out.

Should Mr Longmore revert to his suggestion that the Prime Minister opens the unit when the NMR scanner is installed, then this would seem the more satisfactory way of showing support for the venture; there is some risk that Mr Longmore might wish to exploit the funding-raising opportunities of the occasion but that could be lived with. I assume that the need for appropriate discretion could be conveyed to him.

Yours ever

Ken.

P.S. Some supplementary detail to follow orally.

NBPM AT 11/1

3

Treasury Chambers, Parliament Street, SW1P 3AG
01-233 3000

11 January 1984

The Rt Hon Norman Fowler MP
Secretary of State for Social
Services
Department of Health and Social
Security
Alexander Fleming House
Elephant and Castle
LONDON SE1

Dear Norman

Many thanks for your letter of 2 January about spending on the Family Practioner Service.

We shall tomorrow be discussing with the Prime Minister how to bring FPS spending under adequate financial control: I agree with you that this is crucially important, and I hope that progress will be swift, particularly on bringing in the Binder Hamlyn controls. For it is very worrying that your people's latest estimate of overspending on the FPS Vote this year is nearly double the figure they put to you in July, and higher even than the figure I then suggested as a possibly more realistic forecast. As you say, it's now too late to contemplate action to bring FPS spending back in line with the plans for this year: but we must so arrange matters that this year's history does not repeat itself next year.

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

Yours ever
Nigel

NIGEL LAWSON

2

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Peter Rees QC MP
Chief Secretary to the Treasury
Treasury Chambers
Parliament Street
LONDON SW1

January 11 1984

Dear Peter

Thank you for your letter of 22 December about the forecasting of expenditure on social security and family practitioner services.

I am of course as concerned as you that these substantial changes in forecasts occur: but the experience of both our departments makes it clear how difficult it is to achieve any certainty in forecasting how demand-led expenditure will turn out. We shall be talking about this again with the Prime Minister on 12 January: and I enclose copies of notes explaining the background which have already been sent to No 10 by my Permanent Secretary, and have been copied to Sir Peter Middleton. But I can respond to your comments immediately by saying that we are indeed anxious to improve our arrangements; as you know our two Departments have been working jointly on this for some time, with the Government Actuary's Department, and I can certainly undertake to let you have a report by next May.

See Flag F

But it would be rash to anticipate the degree of certainty in forecasting that your letter seems to look for, or to suppose that we can reach a state where forecasting changes can always be offset by programme changes. I could not possibly promise that: nor could I have offered more in the way of savings last time if we had known of these revised forecasts earlier. The facts are that our forecasts are affected quite significantly by minor changes in economic assumptions (for which we rely on the Treasury) and by changes in the pattern of claimant behaviour which it is extremely difficult to anticipate - we have to rely on statistics of recent trends in benefit payments, which are not necessarily a reliable indicator of what is going to occur in the future. The main difficulty occurs over the unemployed, who account for a great part of the sums at issue. We are dealing with unprecedented levels of claims for benefit from the unemployed, and the outturn of expenditure depends not only on forecasts of numbers, but to a significant degree on the split between unemployment benefit and supplementary benefit. The table on page 29 of the "Green Book" for Thursday's meeting shows how the balance between the two benefits has changed over time: past experience is a poor guide to future expenditure on these very large programmes.

Clearly we must aim for the best possible forecasts. But we shall never be able to achieve certainty. New benefits (like Housing Benefit this year) and major changes in schemes (like the change to self-certification for sickness benefit in 1982) have expenditure consequences we cannot exactly predict. A growth in take-up of disability benefits has occurred in the past two years for no apparent reason which we could have predicted. Such uncertainties are bound to occur, and we can only aim to minimise them.

I must say there are a number of points in your letter I take issue with. For instance you refer to Tony Newton's explanation of our approach to take-up of benefits on the "To-day" programme in a way that suggests you think we ought not to be concerned about take-up. We are under endless criticism over this, and could not possibly take any other public stance than the one he adopted (and I quote): "We have two aims in this field. One is to make sure that people who are not entitled to benefit do not get it - the scrounger problem you touched on at the beginning - and the other is to make sure that those who do need benefit, and should have it, do get it."

You claim that the increase in our programme before the Autumn Statement was only made because your officials insisted on it, in the interests of realism. In fact we were having to make adjustments on a rather arbitrary basis because revised Treasury economic assumptions had not been available early enough for us to do a full revision of forecasts in time for the Autumn Statement. We proposed an increase of £93 million which your officials thought was too low and raised to £223 million. We did not dissent.

The latest increase, taking that figure up to £580 million above the estimates available to us at the time of the bilaterals, was the outcome of reworking the May forecasts thoroughly in the light of the revised Treasury assumptions, which we had at the end of October, and of the latest DHSS statistics, particularly those for supplementary benefit claims which were available in mid-November. The results were notified to the Treasury in the first week of December.

As regards the family practitioner service problems which, as you say, have been less severe, we are well ahead with improvements in our forecasting methods on lines endorsed by independent accountants, Binder Hamlyn. But, as with social security, this does not eliminate the uncertainties which stem from the nature of the services and the extent to which they can be controlled. The Binder Hamlyn study examined very thoroughly what the possibilities were for additional short and long-term controls. They saw no scope for short-term controls of the kind that would make cash limits a practicable possibility, but suggested longer term measures for strengthening control. Some of these are controversial and, as you know, I shall shortly be putting proposals on them to 'H' Committee.

I have concentrated in this letter on the larger social security problem, and indicated our concern to secure real improvements from the study we are conducting with you. Since a large element in the problem is the difficulty of expenditure on the unemployed, I wonder whether you could consider a change on your side? As your officials will know, we feel disadvantage in having to work on Treasury assumptions which are not broken down into components relevant to our forecasts. For example they do not break down the figures according to duration of unemployment. It would obviously help to improve forecasts if the

Treasury assumptions could be improved in this way.

I am copying this to the Prime Minister, and the others who are attending tomorrow's meeting.

Yours ever
Norman

NORMAN FOWLER

FILE

87

10 DOWNING STREET

From the Principal Private Secretary

10 January, 1984

I have been playing truant for a week and arrived back to find your letter of 6 January. I am so glad that the N.M.R. project is going so well; but please do not form an exaggerated view of my part in it: whatever people say, my experience invariably is that such projects only prosper on the basis of their merits. I will look forward to hearing further about the plans for opening the project.

I am glad that I can reciprocate your best wishes for 1984 with special confidence!

F.E.R. BUTLER

Mr. Donald B. Longmore

file

84

10 DOWNING STREET

From the Principal Private Secretary 10 January, 1984

PERSONAL

To keep you in touch with the correspondence with Mr. Longmore, I enclose a copy of his latest letter and my acknowledgment. As you will see, he is concentrating more on getting the Prime Minister to open the project than on a reception, but I think that we need to be ready with a view on the merits of both propositions.

BF1

E. E. R. BUTLER

Sir Kenneth Stowe, K.C.B., C.V.O.

✓ NO

NBPM AT 9/1

Treasury Chambers, Parliament Street, SW1P 3AG

Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health & Social Security
Alexander Fleming House
Elephant & Castle
LONDON
SE1 6BY

9 January 1984

NHS MANPOWER

I have been shown the circular you are issuing on health services development which announced amongst other things a new regime for control of NHS manpower.

As manpower accounts for such a high proportion of NHS spending I am naturally interested in any changes in the system by which NHS manpower is controlled. My responsibilities for Civil Service manpower also give me a concern with manpower in other areas of the public service.

I understand that the intention of the changes you are making is to return to the type of system which had been intended originally, but which you departed from following the 7 July measures last year. While I am in principle content with such a change, it is very important that it should not be, nor be seen as, a weakening of the Government's policy to reduce public service manpower. As described in your circular the new system is capable of applying the necessary steady downward pressure on manpower numbers, but much will depend in practice on how the system works in practice. Experience with Civil Service manpower has shown, I have to say, that departments are not always the best judges of whether a manpower target is achievable. I hope that in presenting the circular and operating the system you will make clear that you are determined to use it to achieve efficiency improvements just as we have used the different Civil Service system of manpower targets to do so. I think that will mean rejecting some of the plans put up by District Health Authorities.

I am asking my officials to keep clearly in touch with yours as your new system develops.

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

Yours sincerely

Jon Gieve

f- PETER REES

[Approved by the Chief Secretary]

TELEPHONE: BRISTOL 24161

cc/ Steve Godber DHSS

THE UNIVERSITY,
SENATE HOUSE,
BRISTOL,
BS8 1TH.

VICE-CHANCELLOR:
SIR ALEC MERRISON, D.L., F.R.S.

9th January, 1984

Dear Prime Minister,

You may be interested in this text of a lecture on the National Health Service I shall be giving this week.

It is a long time since I had thought about such problems and it was refreshing to look at it again.

With all good wishes,

Yours sincerely,

Alec Merrison

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

Royal Institute of Public Administration

12th January 1984

IS THE NATIONAL HEALTH SERVICE SERVING US WELL?

ON MARCH 20th LAST - I REMEMBER THE DATE SIMPLY BECAUSE IT WAS MY BIRTHDAY - I FOUND MYSELF THAT SUNDAY EVENING BEING ADMITTED TO HOSPITAL BY A SCOTTISH WARD SISTER OF THE OLD SCHOOL FOR WHAT, HAPPILY, TURNED OUT TO BE MINOR SURGICAL REPAIRS. IN THE COURSE OF OUR CONVERSATION I VOLUNTEERED THE INFORMATION THAT THIS WAS THE FIRST TIME I HAD FOUND MYSELF A PATIENT IN A HOSPITAL. "OH," SHE SAID "THEN HOW ON EARTH WERE YOU ABLE TO WRITE SUCH A CLEVER REPORT ABOUT IT?"

CLEVER OR NOT, WILLIAM PLOWDEN'S INVITATION TO SPEAK ABOUT THE N.H.S. I RESPONDED TO GLADLY SINCE I HAVE ON THE WHOLE ESCHEWED CONTACT WITH THE N.H.S. SINCE THE ROYAL COMMISSION REPORTED IN 1979. SINCE THEN A NUMBER OF THINGS HAVE HAPPENED IN THE N.H.S., THE TWO MOST IMPORTANT BEING A SLOWING DOWN IN ITS RATE OF GROWTH AND THE ELIMINATION OF A TIER OF ADMINISTRATION, BOTH OF WHICH I SHALL TALK ABOUT. PERHAPS THE MOST RECENT EPISODE OF IMPORTANCE TO THE N.H.S. IS THE GRIFFITHS REPORT AND THE ACCEPTANCE BY THE GOVERNMENT OF ITS 'GENERAL THRUST' AND THAT TOO I SHOULD LIKE TO SAY A WORD ON.

BUT IN THINKING ABOUT WHAT I WOULD SAY TONIGHT I WENT BACK TO ONE OR TWO TALKS OF AN EXPOSITORY KIND I GAVE IN 1979 ABOUT THE ROYAL COMMISSION'S WORK AND I WAS VERY MUCH TEMPTED SIMPLY TO REHEARSE ONE OF THOSE. FRANKLY, SO FAR AS THE PATIENT AND THE DIRECT PROVIDER OF HEALTH CARE IS CONCERNED NOT A GREAT DEAL HAS HAPPENED IN THE LAST FIVE YEARS NOR - AND PLEASE DO NOT THINK I AM BEING CYNICAL OR DEFEATIST - NOR WILL IT IN THE NEXT FIVE YEARS.

LET ME QUOTE THE WORDS - UTTERED TWENTY YEARS AGO BUT STILL TRUE - OF SIR RICHARD CLARKE, THEN SECOND SECRETARY OF THE TREASURY:

> "IN THE DISPERSED SERVICES SUCH AS EDUCATION AND HOSPITALS .... UNITS OF ADMINISTRATION ARE SMALL, AND THEIR PERFORMANCE MUST BE UNEVEN. IT IS DIFFICULT TO FORM A JUDGEMENT ABOUT HOW EFFICIENT THOSE RELATIVELY SMALL INDEPENDENT UNITS ARE, AND HOW MUCH SCOPE THERE MAY BE FOR SAVING, AND BY WHAT MANAGEMENT TECHNIQUES AND SERVICES THIS POTENTIAL SAVING CAN BE REALISED - WITHOUT OF COURSE ENDANGERING THE QUALITY OF LOCAL RESPONSIBILITY AND FLEXIBILITY TO LOCAL CIRCUMSTANCES WHICH IS FUNDAMENTAL TO THESE SERVICES.

"ALTOGETHER, THERE IS CLEARLY NO ROOM FOR COMPLACENCY. BUT IT WOULD SEEM DIFFICULT TO ARGUE THAT THERE IS WIDESPREAD INADEQUACY; OR TO POINT TO SUBSTANTIAL IMPROVEMENTS WHICH COULD BE MADE READILY. TO IMPROVE PERFORMANCE IS A LONG SLOGGING JOB."

BUT ANOTHER REASON WHY I WAS DELIGHTED TO RESPOND TO YOUR DIRECTOR-GENERAL'S INVITATION WAS BECAUSE I HAVE BEEN DEEPLY OFFENDED BY THE TALK THERE HAS BEEN RECENTLY OF THE 'DESTRUCTION OF THE N.H.S.', HAPPILY MUTED, OR AT LEAST ATTENUATED, NOW THAT WE HAVE THE ELECTION YEAR OUT OF THE WAY. OF COURSE, CUTS IN INCOME, EVEN IF THEY ARE ONLY CUTS IN THE WAY INCOME IS RISING, ARE NEVER AGREEABLE BUT TO TRY TO TURN THIS TO PARTY ADVANTAGE WITH EXAGGERATED HYPERBOLE IS QUITE SIMPLY IRRESPONSIBLE.

MY TITLE IS CAST IN THE INTERROGATIVE VOICE - ARE WE BEING SERVED WELL BY THE N.H.S.? FOR THE VERY BUSY ONES HERE WHO, PILATE-LIKE, CANNOT STAY TOO LONG THE SHORT ANSWER IS "YES - VERY WELL". THE LONG ANSWER WILL CERTAINLY TAKE UP MY ALLOTTED TIME SINCE I WANT TO ADDRESS ALSO THE QUESTION "DO WE NEED A NATIONAL HEALTH SERVICE?" AGAIN, FOR THE PILATES AMONG YOU, THE ANSWER IS "ALMOST NO".

BUT BEFORE THAT, LET ME MAKE A FUNDAMENTAL POINT. HOWEVER MUCH WE PROVIDE IN THE WAY OF HEALTH CARE, OR FOR THAT MATTER HOWEVER MUCH WE SPEND IN PROVIDING IT, PEOPLE WILL ALWAYS WANT MORE. SO IT IS WHOLLY ILLUSORY TO THINK WE CAN SATISFY THE DEMAND FOR HEALTH CARE, AND IT IS OF COURSE GENERATED BY DOCTORS AS WELL AS PATIENTS. OF COURSE WE CAN AND, SO FAR AS OUR CIRCUMSTANCES ALLOW, WE SHOULD DO MORE. BUT THE BEST WE CAN DO IS TO SEE THAT DEMAND DOES NOT OUTSTRIP SUPPLY IN A WAY WHICH LEADS TO INTOLERABLE FRUSTRATION AND DISCONTENT.

VALUE FOR MONEY

I HAVE ALREADY QUOTED THE RATHER SOBERING, EVEN DEFEATIST , WORDS OF SIR RICHARD CLARKE. SO HOW WELL ARE WE DOING AND HOW MUCH BETTER CAN WE DO IN USING THE VAST BUDGET OF THE N.H.S.?

WELL, BY INTERNATIONAL STANDARDS, WE RUN A SURPRISINGLY CHEAP HEALTH SERVICE.

MY SLIDE (FIG. 1) PLOTS TOTAL HEALTH EXPENDITURE AS A PERCENTAGE OF G.D.P. AGAINST PER CAPITA G.D.P. FOR 21 COUNTRIES. THE SLIDE SHOWS TOO THE TENDENCY OF RICHER COUNTRIES TO SPEND MORE ON HEALTH CARE.

THIS CHEAPNESS IS NOT BOUGHT AT THE EXPENSE OF PROVIDING AN INADEQUATE STANDARD OF CARE. IN TERMS OF COMMONLY USED HEALTH INDICATORS (LIFE EXPECTANCY, PERINATAL MORTALITY, MATERNAL MORTALITY) WE DO NO WORSE, AND IN SOME RESPECTS WE DO BETTER THAN NATIONS WHO SPEND A GOOD DEAL MORE THAN WE DO; FOR EXAMPLE, THE U.S.A., GERMANY AND FRANCE. AGAIN, IN TERMS OF HEALTH CARE, SOMETIMES WE DO WORSE AND SOMETIMES BETTER THAN OTHER NATIONS. THERE IS LITTLE DOUBT THAT, WITH ALL ITS WARTS, THE N.H.S. IS PROVIDING GOOD VALUE FOR MONEY.

ITS CHEAPNESS IS SURPRISING BECAUSE WE HAVE A SERVICE WHICH IS ESSENTIALLY "FREE AT THE TIME OF USE" AND ONE WOULD EXPECT THIS TO LEAD TO ABUSE AND UNNECESSARILY EXPENSIVE CARE. THAT, GENERALLY SPEAKING, IT DOES NOT IS BECAUSE WE HAVE:

OVERALL GOVERNMENT FINANCIAL CONTROL;

GOOD GENERAL PRACTICE AND COMMUNITY SERVICES, WHICH HELP KEEP PEOPLE OUT OF HOSPITAL;

THE REFERRAL SYSTEM WHEREBY A PATIENT IS ADMITTED TO HOSPITAL ONLY IF TWO DOCTORS (HIS G.P. AND A CONSULTANT) PRESCRIBE IT, AND NEITHER HAS A FINANCIAL INTEREST IN ADMITTING HIM;

LOW PAY OF HEALTH WORKERS (DOCTORS AND NURSES) RELATIVE TO THAT IN OTHER COUNTRIES.

BUT BECAUSE AN ANALYSIS OF THIS KIND SHOWS WE ARE DOING WELL LET NO ONE BE COMPLACENT. AGAIN LET ME QUOTE FROM A SOURCE WHICH COULD HARDLY CARRY MORE AUTHORITY:

> "THE NATIONAL HEALTH SERVICE HAS BECOME ACCUSTOMED THROUGHOUT THE 25 YEARS PRECEDING RE-ORGANISATION TO THE PROSPECT OF CONTINUAL GROWTH IN THE FINANCIAL RESOURCES AVAILABLE TO IT. THOUGH AGREEABLE, THE RESULT HAS BEEN TO ALLOW SLACK MANAGEMENT, WITH NO INCENTIVE TO EXAMINE OBSOLETE PATTERNS OF SPENDING, OR TO DEVELOP A COHERENT PLAN FOR THE FUTURE."

IS THIS ONE OF THOSE THRUSTING BUSINESSMEN TALKING TO A TORY SECRETARY OF STATE? NO, IT IS THE REGIONAL ADMINISTRATORS TALKING TO THE ROYAL COMMISSION. AND THEY MUST BE LISTENED TO, EVEN THOUGH WHAT THEY CALL "AGREEABLE" GROWTH HAS SLOWED DOWN.

GETTING AND PAYING FOR HEALTH CARE - THE INTERVENTION OF SOCIETY

THE INTERVENTION OF SOCIETY INTO OUR LIVES TO HELP US WITH ESSENTIAL NEEDS AND TO CONSTRAIN US, IF ONLY BY FORCING US TO PAY TAXES, TO HELP OURSELVES AND OTHERS IS SUCH A SERIOUS ISSUE IN ANY SOCIETY THAT I WANT TO SPEND A FEW MINUTES TALKING ABOUT IT. WHEN THESE AIDS AND CONSTRAINTS REACH SIZEABLE PROPORTIONS WE HAVE THE SO-CALLED WELFARE STATE, AND COMING TO TERMS WITH THE WELFARE STATE IS A MAJOR PROBLEM IN ALL DEVELOPED COUNTRIES.

SINCE OUR DEMAND FOR HEALTH SERVICES WILL NOT BE CONSTANT THROUGH OUR LIVES BUT CAN BE LARGE AT TIMES AND SMALL AT OTHERS THEN A SENSIBLE SOCIETY WILL SEE TO IT, EITHER THROUGH ITS TAX SYSTEM OR COMPULSORY HEALTH INSURANCE, THAT ITS MEMBERS MAKE PROPER PROVISION FOR THEMSELVES THROUGHOUT THEIR LIVES. A COMPASSIONATE SOCIETY WILL IN ADDITION CONSTRAIN ITS RICHER MEMBERS TO CONTRIBUTE TO WELFARE SERVICES NOT ONLY FOR THOSE WHO ARE POORER BUT THOSE WHOSE DEMAND FOR SUCH SERVICES MAY BE DISPROPORTIONATELY, EVEN DISASTROUSLY LARGE. UNFORTUNATELY THESE TWO CLASSES OFTEN COINCIDE.

TO GIVE YOU SOME IDEA OF HOW THIS WORKS IN THE U.K., WHERE WE ESSENTIALLY USE THE TAX SYSTEM AS A LARGE BENEFICENT INSURANCE SCHEME, I CAN RELY ON AN ANALYSIS WHICH MAY BE MADE OF AN ARTICLE WHICH APPEARS ANNUALLY IN THE JOURNAL "ECONOMIC TRENDS" ISSUED BY THE GOVERNMENT STATISTICAL SERVICE, WHICH SETS OUT THE EFFECT OF TAXES AND BENEFITS ON HOUSEHOLD INCOME.

THE ANONYMOUS AUTHORS OF THIS ARTICLE IDENTIFY THE WAY THE GOVERNMENT TAKES MONEY FROM HOUSEHOLDS AND THE WAY IT PUTS MONEY BACK AGAIN BY WAY OF SERVICES AND CASH BENEFITS. THERE IS ONE MAJOR PROBLEM WHICH THE AUTHORS PROPERLY POINT OUT AT THE BEGINNING OF THEIR ANALYSIS AND THAT IS THAT A LARGE AMOUNT OF GOVERNMENT EXPENDITURE AND REVENUES, THAT IS, WHAT THEY GIVE AND WHAT THEY TAKE AWAY, CANNOT BE ALLOCATED TO HOUSEHOLDS IN ANY SENSIBLE WAY. AN EXAMPLE OF THE FORMER WOULD BE DEFENCE EXPENDITURE, AND AN EXAMPLE OF THE LATTER WOULD BE CORPORATION TAX. SO IN THE END THE AUTHORS ARE ABLE TO ATTRIBUTE BY HOUSEHOLD ONLY ABOUT HALF OF GOVERNMENT EXPENDITURE AND ABOUT 60% OF ITS REVENUE. SO ALL THAT FOLLOWS ABOUT HOUSEHOLD ACCOUNTING MUST BE READ WITH THIS IMPORTANT PROVISO IN MIND.

LET US FIRST LOOK AT THE BROAD SCHEME OF THINGS AS PRESENTED IN FIG. 2.

THE HOUSEHOLD STARTS WITH SOME SORT OF ORIGINAL INCOME OUT OF WHICH IT MUST IMMEDIATELY PAY DIRECT TAXES. IT COULD BE THAT IT IS A HOUSEHOLD WHICH RECEIVES DIRECT CASH BENEFITS (FOR EXAMPLE, OLD AGE PENSION OR CHILD ALLOWANCES) AND THESE WILL BE ADDED TO ITS ORIGINAL INCOME, LESS DIRECT TAXES, TO FORM ITS DISPOSABLE INCOME. SOCIETY WILL STILL DEMAND CASH IN THE FORM OF INDIRECT TAXES (FOR EXAMPLE, V.A.T.) ON PURCHASES AND AT THE SAME TIME WILL PROVIDE SUBSIDIES ON CERTAIN PURCHASES AND IT WILL PROVIDE SERVICES (FOR EXAMPLE, HEALTH CARE AND EDUCATION) WHICH WILL BE WORTH CASH. IN THIS WAY WE CAN ARRIVE FOR OUR TYPICAL HOUSEHOLD AT A "FINAL INCOME" WHICH IT CAN SAVE OR SPEND ON ANYTHING IT LIKES.

ALTHOUGH THE TITLES OF THE BOXES IN MY DIAGRAM ARE GENERAL,THE FIGURES YOU SEE IN THE BOXES ARE THOSE I HAVE WORKED OUT FOR WHAT I CALL THE "BREAK-EVEN" HOUSEHOLD, THE HOUSEHOLD GETTING AS MUCH IN BENEFITS AS IT IS PAYING OUT IN TAXES. THE VERY POOR GET A LARGE PART OF THEIR INCOME IN THE FORM OF BENEFITS, PARTICULARLY CASH BENEFITS. THE RICHER ONES AMONG US PAY OUT MORE IN TAXES THAN WE RECEIVE IN BENEFITS SO SOMEWHERE THERE IS A CROSS-OVER POINT WHERE WE FIND OUR BREAK-EVEN HOUSEHOLD. IN 1982 THAT HOUSEHOLD HAD AN ORIGINAL INCOME OF ABOUT £5,000. SINCE WE ARE CONCERNED WITH THE N.H.S. YOU WILL WANT TO KNOW THAT HEALTH CARE ACCOUNTS FOR £571 OF THE £1,315 OF BENEFITS IN KIND, THAT IS TO SAY 43%. EDUCATION ACCOUNTS FOR ALMOST PRECISELY THE SAME SUM SO HEALTH AND EDUCATION MAKE UP NEARLY 90% OF THE BENEFITS IN KIND.

THE INTERESTING FACTS ABOUT OUR BREAK-EVEN HOUSEHOLD ARE THAT IN THE FIRST PLACE ITS ORIGINAL INCOME IS NOT LARGE. BUT PERHAPS EVEN MORE STRIKING IS THE DEGREE OF INTERFERENCE BY SOCIETY IN THE FORM OF BENEFITS AND TAXES, WHICH ARE OF COURSE EQUAL, AND EACH FORMS JUST 50% OF ORIGINAL INCOME, WHICH SEEMS TO ME VERY LARGE INDEED.

AND THE BENEFIT OF HEALTH CARE, WHICH HAS TO BE PAID FOR, FORMS 11% OF ORIGINAL INCOME. ON A NATIONAL SCALE, THE GOVERNMENT'S TOTAL EXPENDITURE IN 1982 WAS £128 BILLION OF WHICH £13 BILLION, A LITTLE OVER 10%, WENT ON HEALTH SERVICES, AND THAT REPRESENTED 5.4% OF G.D.P.

IS ALL THIS A GOOD WAY OF PAYING FOR HEALTH CARE? IT IS ONLY ONE OF A LARGE NUMBER OF VARIANTS, OF COURSE, BUT IT HAS THE GREAT ADVANTAGE THAT THE MONEY IS CHEAP TO COLLECT IN THAT IT IS BEING COLLECTED ANYWAY. ITS MOST SERIOUS DISADVANTAGE IS THAT THE PUBLIC ARE NOT CONSTANTLY AWARE OF WHAT THEY

ARE SPENDING ON HEALTH CARE, WHICH ONE MIGHT THINK WOULD BE AN INCENTIVE FOR THEM TO USE HEALTH SERVICES SPARINGLY AND WISELY. I WILL SAY MORE A LITTLE LATER ABOUT THIS QUESTION OF PROVIDING STICKS AND CARROTS FOR PATIENTS AND PROVIDERS IN THE N.H.S.

THE PATIENT'S VIEW

BUT WHAT DO THE PATIENTS THINK OF WHAT THEY GET? THE ANSWER IS THEY THINK VERY WELL OF IT, MUCH BETTER THAN THEY DO OF ANY OTHER PUBLIC SERVICE. AND IF YOU DON'T BELIEVE THIS BALD ASSERTION THEN DO GO AND STUDY THE MANY SURVEYS WHICH HAVE BEEN CARRIED OUT.

I WELL REMEMBER WHEN THE REPRESENTATIVES OF THE LOCAL AUTHORITIES WERE MAKING THEIR PLEA TO THE ROYAL COMMISSION THAT THEY SHOULD TAKE OVER THE N.H.S., A FAMILIAR CRY OVER THE YEARS. THEY TOLD US THAT THIS WOULD MAKE THE SERVICE MORE DEMOCRATIC AND WHEN PRESSED AS TO WHAT EFFECT THIS WOULD HAVE, LEAVING ASIDE WHAT IT MIGHT MEAN, IF INDEED IT HAD ANY MEANING, WE WERE TOLD THAT THIS WOULD MEAN A SERVICE MORE RESPONSIVE TO WHAT THE PATIENT WANTED. WELL, WE SAID, IF THAT IS SO THEN WHY IS IT THAT THE MAJOR SERVICES THAT LOCAL AUTHORITIES PROVIDE, NAMELY EDUCATION AND PLANNING, GET SUCH A VERY BLACK MARK FROM THE PEOPLE AND THE N.H.S. GETS THE WHITEST OF WHITE MARKS? TO THIS THEY GAVE US NO ANSWER.

BUT OF COURSE THERE ARE THINGS THE N.H.S. COULD AND SHOULD DO BETTER AND MANY OF THEM WOULD COST NO MORE MONEY. WHAT IS IT THAT HOSPITAL PATIENTS COMPLAIN ABOUT MOST? BEING WOKEN UP TOO EARLY IS THE ANSWER, AND NEARLY HALF OF THEM COMPLAIN ABOUT THIS COMPARED WITH 20% COMPLAINING ABOUT WAITING TO BE ADMITTED TO HOSPITAL - SO MUCH FOR THE NATIONAL SCANDAL OF WAITING LISTS.

ONE SHOULD NOT OF COURSE CONFUSE THE ATTITUDE OF THE PUBLIC IN GENERAL WITH THE ATTITUDE OF PRESSURE GROUPS. HEALTH, OF COURSE, ATTRACTS PRESSURE GROUPS LIKE JAM ATTRACTS WASPS; PERHAPS NOT ON THE SAME SCALE AS ANYTHING NUCLEAR - NUCLEAR WEAPONS, NUCLEAR POWER, NUCLEAR WASTE - BUT IN ITS OWN QUIET WAY, ALMOST SO. EVERY ONE OF THEM - RATHER LIKE THE NUCLEAR PRESSURE GROUPS - HAS A REAL POINT, AND UNLIKE THE NUCLEAR PRESSURE GROUPS MOST OF THE HEALTH PRESSURE GROUPS ARE PREPARED TO DO SOMETHING POSITIVE, LIKE RAISING MONEY, RATHER THAN THE SELF-INDULGENTLY NEGATIVE CAPERS WHICH THE NUCLEAR ENTHUSIASTS GO IN FOR. BUT IN THE END THE N.H.S. HAS TO DO WHAT IT THINKS BEST FOR THE GENERALITY OF US RATHER THAN THAT WHICH, HOWEVER SERIOUSLY, HAS FOR THE MOMENT CAUGHT THE ATTENTION OF A SMALL ARTICULATE GROUP.

WHAT MAKES A HEALTH SERVICE ADMIRABLE?

THE DECEPTIVELY SIMPLE FIRST ANSWER MUST BE "PROVIDING GOOD HEALTH CARE". LEAVING ASIDE FOR ONE MOMENT THE COMPLEXITIES LYING BEHIND THAT PHRASE THEN ONE WOULD CERTAINLY WANT GOOD HEALTH CARE FOR A MINIMUM OF EXPENDITURE, SINCE WE ARE TALKING OF SPENDING ON A VAST SCALE, AND ONE WOULD CERTAINLY WANT TOO A SYSTEM WHERE NECESSARILY LIMITED RESOURCES WERE USED FAIRLY AND COMPASSIONATELY.

IN TERMS OF FAIRNESS AND COMPASSION, I FEEL THE N.H.S. DOES NOT DO BADLY. OF COURSE, THERE ARE ALL SORTS OF THINGS ONE WOULD WANT TO SEE DONE BETTER, PARTICULARLY THE PROVISION OF HEALTH CARE IN INNER CITY AREAS, BUT SO OFTEN WHEN ONE SEES PROBLEMS OF THIS KIND THEY ARE VERY MUCH PROBLEMS OF SOCIETY AND THE WAY WE LIVE AND IT WOULD BE FOOLISH TO IMAGINE THAT IMPROVEMENTS RESTRICTED TO THE HEALTH SERVICE WOULD GIVE PEOPLE A VERY MUCH BETTER LIFE.

BUT EFFICIENCY IS A WARM ISSUE AT THE MOMENT, AND SO IT SHOULD BE, AND NOT ONLY AT THIS MOMENT BUT AT EVERY MOMENT. I HAVE SAID ALREADY THAT WE RUN A SURPRISINGLY CHEAP HEALTH SERVICE AND I HAVE GIVEN SOME REASONS WHY THAT SHOULD BE SO. LET ME COMMENT NOW ON SOME OF THE PRESENT ATTEMPTS TO MAKE THE N.H.S. EVEN CHEAPER, AN ABSOLUTELY LAUDABLE THING TO DO.

THERE IS FIRST OF ALL THE WHOLE ISSUE OF "PRIVATISATION"; THAT IS THE PROPOSAL TO TURN OVER SERVICES PROVIDED WITHIN THE N.H.S. TO THE PRIVATE SECTOR. IF THIS WILL BE CHEAPER OR, BETTER STILL, IF IT WILL BE CHEAPER AND BETTER THEN I CANNOT SEE ONE CAN MAKE ANY SORT OF RATIONAL AND WORTHY ARGUMENT AGAINST IT. BUT FROM THE HIGH-FLOWN LANGUAGE USED BY SOME OF THE CRITICS ONE WONDERS WHY IT IS THEY ARE NOT USING THEIR ENERGY TO PERSUADE US ALL THAT THE N.H.S. OUGHT TO BE WEAVING ITS OWN SHEETS OR THROWING AND FIRING ITS OWN BED-PANS, IF INDEED THAT IS WHAT ONE DOES IN MAKING BED-PANS. EQUALLY, THE PRIVATISING ENTHUSIASTS MUST BE CAREFUL THAT THEY ARE NOT CONSTRUCTING A "CLAUSE 4" FOR THE TORY PARTY. THIS WHOLE DISCUSSION AND THE DECISIONS WHICH FOLLOW MUST GO FORWARD ON PERFECTLY SENSIBLE, PRACTICAL GROUNDS, AND THERE IS AFTER ALL PLENTY OF ROOM FOR EXPERIMENT.

AS A GENERAL COMMENT ON EFFICIENCY CAN I DISPLAY TO YOU WHAT THE ROYAL COMMISSION REFERRED TO AS GRADATIONS OF HEALTH CARE (FIG. 3). THE REASON I DO SO IS THAT NOT ONLY ARE PEOPLE BETTER OFF SPENDING THEIR TIME AT THE TOP OF THIS

PARTICULAR LIST AND MORE MISERABLE AS THEY SLIDE DOWN IT BUT THE COST OF PROVISION OF HEALTH CARE GETS PROGRESSIVELY MORE EXPENSIVE AS THE PATIENT SLIDES DOWN. SO THERE IS THE HAPPY COINCIDENCE THAT THE HAPPIEST STATE FOR THE PATIENT HAPPENS ALSO TO BE THE CHEAPEST. SO CLEARLY ONE SHOULD PROVIDE INCENTIVES AND DISINCENTIVES WHICH WILL PERSUADE PATIENT AND PROVIDER TO KEEP THE PATIENT AT THE TOP OF THIS PARTICULAR SNAKE. AND NO ADMINISTRATIVE REFORM WHICH DOES NOT ADDRESS ITSELF TO THIS QUESTION NEED BE CONSIDERED TOO SERIOUSLY.

THE GRIFFITHS REPORT

AT THE BEGINNING OF LAST YEAR THE SECRETARY OF STATE, MR. NORMAN FOWLER, ASKED A SMALL GROUP OF EXPERIENCED BUSINESS MEN, AND A TRADE UNIONIST, UNDER THE CHAIRMANSHIP OF MR. ROY GRIFFITHS TO SEE HOW THE N.H.S. MIGHT BE MADE MORE EFFICIENT. CURIOUSLY ENOUGH, THE TERMS OF REFERENCE OF THE GRIFFITHS INQUIRY WERE VIRTUALLY IDENTICAL WITH THOSE OF THE ROYAL COMMISSION, BUT MR. GRIFFITHS AND HIS COLLEAGUES WERE GIVEN ONLY A FEW MONTHS TO COMPLETE THEIR WORK. THEY DID SO IN OCTOBER AND A FEW WEEKS LATER THE SECRETARY OF STATE ANNOUNCED THAT THE GOVERNMENT HAD ACCEPTED "THE GENERAL THRUST OF THE REPORT".

TO SPEAK PLAINLY, I AM NOT IMPRESSED BY THE ANALYSIS OF N.H.S. ILLS BY MR. GRIFFITHS AND HIS COLLEAGUES NOR BY THEIR RECOMMENDATIONS, AND THE KINDEST WORD I CAN USE TO DESCRIBE THEIR REPORT IS THAT IT IS UNEVEN. THERE ARE SOME THINGS THEY CALL FOR - FOR EXAMPLE, MANAGEMENT BUDGETS - WHICH HAVE BEEN ASKED FOR SO OFTEN BY SO MANY PEOPLE THAT IT IS ASTONISHING THAT WE STILL HAVE TO GO ON ASKING AND IT MUST BE A SOURCE OF SHAME TO THOSE WHO ARE RESPONSIBLE FOR THE N.H.S. THAT THIS SHOULD BE SO.

BUT THERE ARE TWO REFORMS IN PARTICULAR WHICH THE GRIFFITHS REPORT CALLS FOR WHICH I SHOULD WANT TO COMMENT ON IN A LITTLE MORE DETAIL.

THE FIRST IS HIS EXCORIATION OF "CONSENSUS MANAGEMENT" - WHAT AN ABSOLUTELY HATEFUL TITLE - AND HIS PERFECTLY CORRECT ASSESSMENT OF THE IMPORTANCE OF PERSONAL RESPONSIBILITY IN ANY FORM OF MANAGEMENT. LET ME SAY NOW THAT WHEN I STARTED WORK IN THE ROYAL COMMISSION TWO YEARS AFTER THE 1974 RE-ORGANISATION WHICH HAD RAISED CONSENSUS MANAGEMENT TO AN INSTITUTIONAL FORM MY VIEWS ON THIS WERE VIRTUALLY IDENTICAL WITH THOSE OF MR. GRIFFITHS. BUT IN THE END, AND AFTER TAKING A GREAT DEAL OF EVIDENCE, I WAS HAPPY TO JOIN MY COLLEAGUES IN GIVING REASONABLE, BUT QUALIFIED, SUPPORT TO THIS WAY OF DOING BUSINESS. IF I THOUGHT THAT CONSENSUS MANAGEMENT GAVE EACH OFFICER A POWER OF VETO, AS THE GRIFFITHS REPORT CLAIMS, THEN OF COURSE I SHOULD BE TOTALLY OPPOSED TO IT, BUT IT WAS NOT CONSTRUCTED TO DO THAT AND IN MY EXPERIENCE IT DOES NOT.

AT THIS LEVEL THE N.H.S. HAS IN THE LAST TEN YEARS HAD FAR TOO MUCH ADMINISTRATIVE REFORM AND WITHOUT EVIDENCE THAT THINGS ARE GOING SERIOUSLY WRONG - AND I HAVE SEEN NONE SUCH - THEN I HOLD VERY STRONGLY THAT THE CHAPS SHOULD BE ALLOWED TO GET ON WITH THE JOB.

BUT THE GRIFFITHS REPORT IS ABSOLUTELY RIGHT WHEN IT SAYS THAT THE ROLE OF THE REGIONS NEEDS TO BE STRENGTHENED VIS A VIS THE CENTRE, THAT IS THE D.H.S.S. THE ROYAL COMMISSION WAS OF COURSE MUCH MORE RADICAL IN ITS APPROACH TO THIS PARTICULAR PROBLEM AND RECOMMENDED THAT

> "FORMAL RESPONSIBILITY, INCLUDING ACCOUNTABILITY TO PARLIAMENT, FOR THE DELIVERY OF SERVICES SHOULD BE TRANSFERRED TO R.H.A.s"

AND NOTHING THAT I HAVE LEARNED SINCE WOULD CAUSE ME TO RESILE FROM THAT POSITION. THE REGIONAL AUTHORITIES AND THE NEW DISTRICT AUTHORITIES, CARRYING MASSIVE RESPONSIBILITIES, DO SO ON AN ENTIRELY CREDITABLE SCALE AND I BELIEVE THAT GIVEN REAL RESPONSIBILITY AND RELIEF FROM "NANNYING" THEY HAVE THE POTENTIAL TO DO EVEN BETTER.

ONE SHOULD UNDERSTAND THAT A SINGLE REGIONAL AUTHORITY AND ITS DISTRICT AUTHORITIES MAKE UP A VAST ENTERPRISE WITH, SAY, 70,000 EMPLOYEES SERVING PERHAPS 3 MILLION POTENTIAL PATIENTS. IF THEY CANNOT STAND ON THEIR OWN FEET AND DO THIS JOB LARGELY UNAIDED THEN YOU SHOULD GET RID OF THEM.

I AM SURE THAT THE GRIFFITHS JUDGEMENT THAT THE SECRETARY OF STATE NEEDS ONLY A SMALL TEAM AT THE CENTRE - AND, AS GRIFFITHS SAYS, THAT IS ALMOST ALL HE DOES NEED - IS RIGHT. THERE ARE SOME OBVIOUS FUNCTIONS WHICH MUST REMAIN A NATIONAL RESPONSIBILITY, PERSONNEL MATTERS BEING ONE OF A SMALL NUMBER. BUT AFTER THAT AND WITH REAL AUTHORITY GIVEN TO THE REGIONS AND THE DISTRICTS I FEEL THAT THE WAY WE LOOK AFTER THE HEALTH OF THE NATION HAS NOW OUTGROWN THE CONCEPT OF A NATIONAL HEALTH SERVICE. FORTY YEARS AGO NOT ONLY WAS ITS INVENTION BOLD AND IMAGINATIVE: THERE WAS AN ABSOLUTELY ESSENTIAL NEED FOR THE STATE TO ASSUME A RESPONSIBILITY FOR THE HEALTH OF THE PEOPLE. THERE STILL IS SUCH A NEED BUT I BELIEVE THE FORM OF ITS EXPRESSION HAS CHANGED AND WE SHOULD UNDERSTAND THAT.

NOW I WILL INDULGE MYSELF AND QUOTE FROM ONE OF THOSE LECTURES I GAVE IN 1979 EXPLAINING THE WORK OF THE ROYAL COMMISSION. I WILL QUOTE ABSOLUTELY VERBATIM AND WITHOUT CHEATING.

"THE LESSONS TO BE LEARNED

THIS IS TO SOME EXTENT A PERSONAL VIEW BUT I THINK IT WOULD BE STRONGLY SUPPORTED BY THE COMMISSIONERS.

IN TERMS OF VALUE FOR MONEY AND PATIENT SATISFACTION THE N.H.S. IS DOING WELL. THERE IS NO EVIDENCE - INDEED, ALL THE EVIDENCE IS THE OTHER WAY - THAT RADICALLY NEW SCHEMES OF FINANCING WOULD DO BETTER.

IN TERMS OF STAFF MORALE AND RENEWAL OF BUILDINGS IT IS NOT DOING WELL. THE LATTER CAN BE SOLVED ONLY BY MORE MONEY.

THE 1973/4 RE-ORGANISATION, ALTHOUGH ITS PRINCIPLES WERE LARGELY CORRECT, LED TO A BYZANTINE SYSTEM OF ADMINISTRATION WHICH MUST BE SIMPLIFIED. THE TWO MAJOR FAILINGS OF THE 1973/4 RE-ORGANISATION WERE THE LACK OF A "DISTRICT" LEVEL OF AUTHORITY AND THE FAILURE TO CARRY THROUGH THE PRINCIPLE OF "DELEGATION DOWNWARDS, ACCOUNTABILITY UP".

STAFF MORALE WILL IMPROVE WITH BETTER ADMINISTRATION AND BETTER INDUSTRIAL RELATIONS. THESE WILL NOT BE MORE COSTLY, INDEED IF CARRIED THROUGH WITH DETERMINATION THEY WILL SAVE MONEY.

IT IS NOT HARD TO FIND AREAS OF THE N.H.S. WHERE MORE MONEY WILL BE WELL SPENT. NONETHELESS, THE N.H.S. CAN DO BETTER WITH WHAT IT HAS - BUT NOT OVERNIGHT.

WE HAVE A GOOD SYSTEM OF COMMUNITY CARE AND THIS WILL BE CRUCIAL IN FUTURE.

THE N.H.S. LACKS LEADERSHIP AT ALL LEVELS. IT IS MY VIEW THAT TO PUT THIS RIGHT IS THE GOVERNMENT'S MOST URGENT TASK IN THIS FIELD."

SOME OF THE BLACKER THINGS I SPOKE ABOUT FIVE YEARS AGO WE HAVE MANAGED TO REFORM; FOR EXAMPLE WE HAVE ACCOMPLISHED THE NECESSARY INVENTION OF THE DISTRICT AUTHORITY. BUT MY FINAL POINT ABOUT THE LACK OF LEADERSHIP REMAINS AND IS STILL A MOST URGENT TASK FOR GOVERNMENT.

Figure 21.1: RELATIONSHIP BETWEEN SHARE OF HEALTH EXPENDITURE IN GDP AND PER CAPITA GDP (1974 OR NEAR DATE)

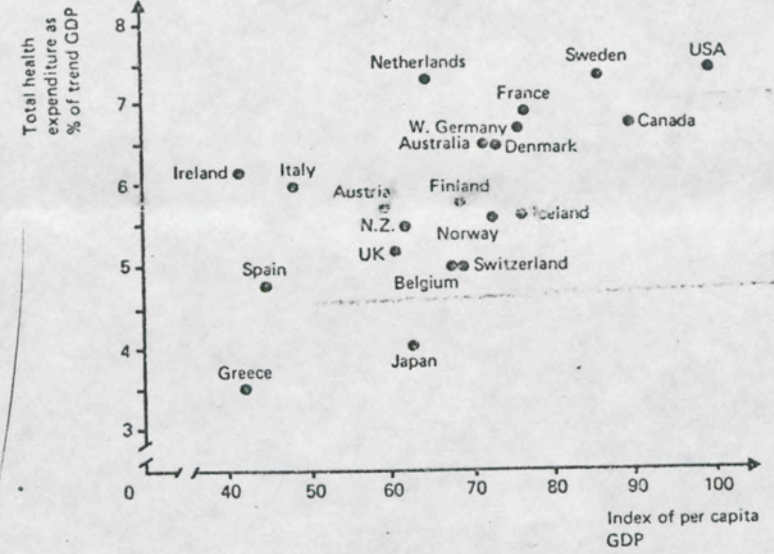
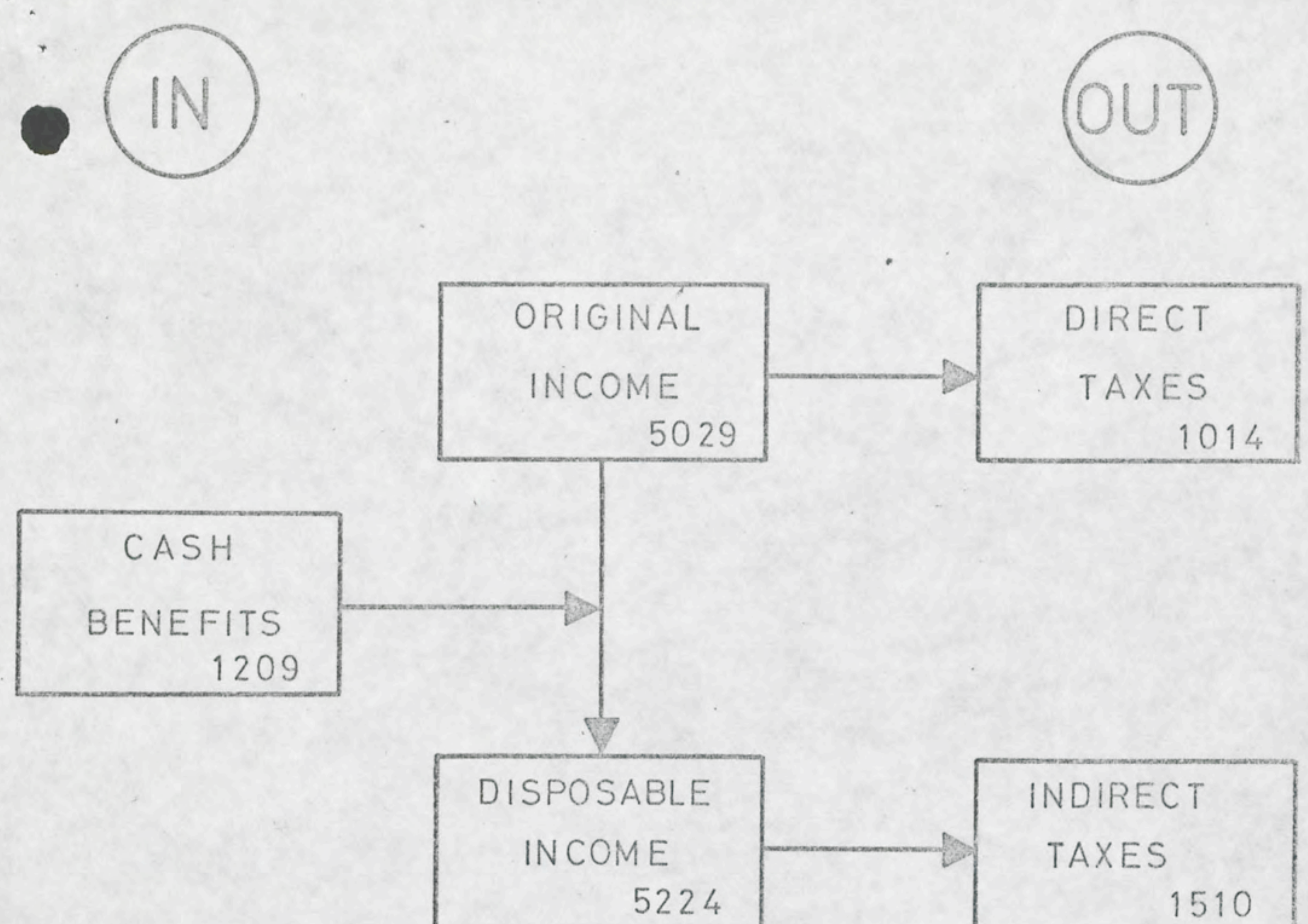
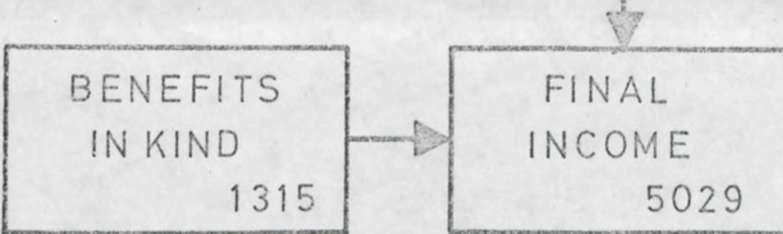


FIGURE 1.





THE "Break Even" HOUSEHOLD 1982

FIGURE 2.

GRADATIONS OF HEALTH CARE

1 THE CARE WHICH A HEALTHY PERSON WILL EXERCISE FOR HIMSELF SO THAT HE REMAINS HEALTHY.

2 THE SELF-CARE WHICH THE SLIGHTLY ILL PERSON WILL EXERCISE WHICH MAY INVOLVE MEDICATION AND TREATMENT.

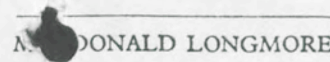
3 THE CARE PROVIDED BY THE PERSON'S FAMILY AND BY THE HEALTH AND PERSONAL SOCIAL SERVICES OUTSIDE THE HOSPITAL

4 THE CARE WHICH CAN ONLY BE PROVIDED IN HOSPITAL OR OTHER RESIDENTIAL INSTITUTION

FIGURE 3.

DEPARTMENT OF CLINICAL PHYSIOLOGY

NATIONAL HEART HOSPITAL



M. DONALD LONGMORE

WESTMORELAND STREET, LONDON W1M 8BA
TELEPHONE 01-486 0824
01-486 4811

Our Ref.

Your Ref.

6th January, 1984

Mr. D. Thatcher,
10 Downing Street,
London S.W.1

Dear Mr Thatcher -

You may remember over dinner at Dunphail I suggested you might enjoy a trip around the Heart Hospital in order that you could see some high technology medicine. Robin Butler has been and will tell you what we are about. If you are interested the suggested arrangement would be for you to come in the morning and have a cup of coffee and see a slide presentation of some of the interesting material, followed by a quiet trip around the hospital and a visit to the most stimulating departments. We could then either lunch here or join Mr. Bill Davis who has invited us to the Garrick Club.

If you feel you could tear the Prime Minister away from her many duties, I would be delighted if she could come too, but would not want to be responsible for adding to her already over-committed schedule.

With all good wishes for 1984.

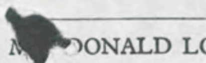
Yours sincerely,

Donald Longmore

Donald B. Longmore, FRCSEd
Consultant Clinical Physiologist

DEPARTMENT OF CLINICAL PHYSIOLOGY

NATIONAL HEART HOSPITAL


M[illegible] DONALD LONGMORE

WESTMORELAND STREET, LONDON W1M 8BA
TELEPHONE 01-486 0824
01-486 4811

Our Ref.

Your Ref.

6th January, 1984

R. Butler, Esq.,
Principal Private Secretary,
10 Downing Street,
London S.W.1

Dear Robin

Previous correspondence 16.12.83

Thank you for your help with the N.M.R. project. The D.H.S.S. clearly made wide enquiries about us and our project at a number of levels. We are fortunate that Mr. Gordon Higson, who is a well respected scientist in the Department, took charge of our affairs. (Mr. Higson was ably supported by Dr. Abrams, whose reputation I do not know.) Mr. Higson is the man who has backed a number of successful projects, including Godfrey Hounsfield's original CAT scanner and he has been at least part of the driving force behind the British effort in N.M.R. He seems to have made some arrangements to help us fund the project, although I am not quite sure yet what these are in detail.

I spent the Christmas period drawing up plans for the building conversion and by next Tuesday should have a date for the completion of the installation. I will then seek your advice about asking the Prime Minister to open this Unit, which I hope will succeed in keeping us ahead of the Americans and much more importantly will enable us to spare large numbers of people unpleasant invasive investigations leading to a reduction in the amount of painful and expensive cardiac surgery required.

Once again many thanks and best wishes for 1984.

Yours sincerely,

Donald

Donald B. Longmore, FRCSEd
Consultant Clinical Physiologist

NAT HEALTH: Exp. Pt 2

9 JAN 1984

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Secretary of State for Social Services

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

January 7 1986.

Dear Nigel

In my letter of 18 July following your statement on public expenditure I agreed that I would look again at the spending situation on the family practitioner services in the autumn. This has taken rather longer than I had expected, not least because of issues which have arisen recently, notably the non-recovery, because of legal problems, of excess payments to pharmacists. But I now have a clear picture. The present position is reflected in our Winter Supplementaries - which you have agreed - and our proposals for Spring Supplementaries. There has of course been extensive discussion between our officials both during and since the conclusion of the PES round.

In Spring Supply we are estimating for an FPS spend this year of £170 million above the Budget Estimate. The present estimate takes account of the savings from the action on drug prices which, for England, I expected would yield £20 million by the end of the year. Allowing for a technical adjustment in relation to the DDRB award included in the July estimate, this all means that we are running ahead of the July excess by about £90 million. Together with expected overspending of some £17 million on European Community medical costs and Welfare Foods, the total additional spending on the Vote is over £100 million.

One major factor in our requirement for extra resources this year is the need to provide for the temporary loss of the excess payments to pharmacists for drugs as established by the recently completed discount enquiry. We have corresponded separately about this and about the proposed legislation to enable us to recover the excess in future years. The amount we have needed to provide against the loss this year is about £30 million. Additionally spending has increased on all four family practitioner services but especially on the pharmaceutical services. Because of the uncertainties about the effect of the action I have taken on the Pharmaceutical Price Regulation Scheme and the way the spending has moved generally, we have deemed it prudent to err on the side of caution in our estimated out-turn for that service so we hope that at the end of the day we shall have some measure of underspend against the Spring Supply figure.

CONFIDENTIAL

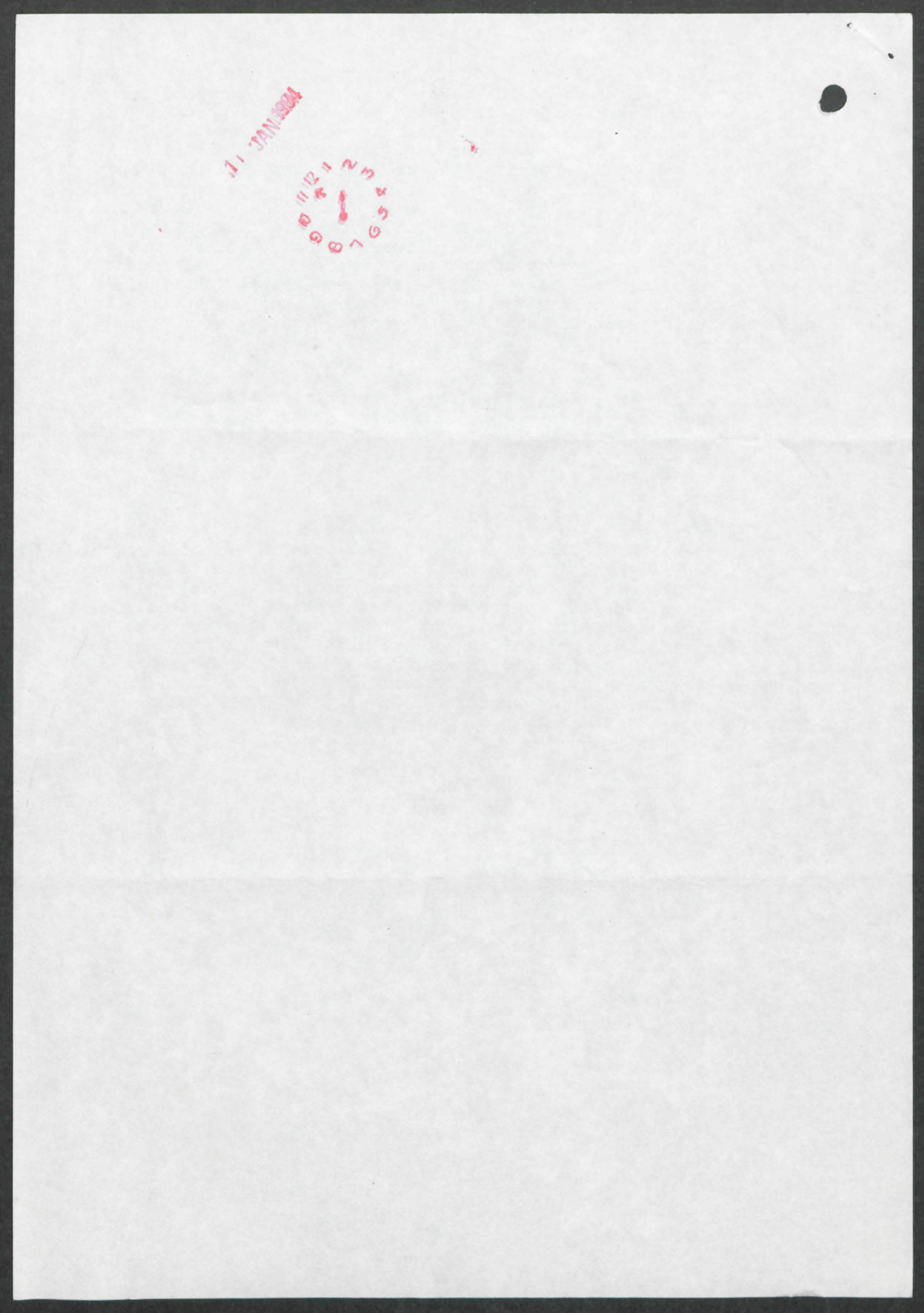
I have always taken a clear line that the adjustments to the HCHS and FPS budgets were not a trade-off between the two health services but part of a wider adjustment of programmes to keep public expenditure as a whole to the planned level. Nevertheless in my letter of 18 July I said that we would need to see whether any action was called for when the later assessment of FPS spending was known. You will I think accept that the increase in spending on the non-cash limited Vote cannot be contained or reduced in-year by any action on my part except by an increase in FPS charges. The lead time into the introduction of new charges and the lag in their appearing in FPS expenditure is such that, at this point in the year we could not expect any savings even with the most urgent action to lay regulations. On the HCHS front, the action I have already taken this year in cutting back expenditure and on staff reductions are as much as health authorities and we can bear and further action is inconceivable.

We have of course taken account of the higher level of spending on the FPS and welfare food in the baseline for PES provision in the future, and in our further proposals to you for additional funding to be included in the Estimates White Paper. To the extent that you have not felt able to go along with our full proposals, we must expect in due course (on the basis of present estimates) a need for some additional provision during 1984/85.

As you will know from the action I have already taken in relation to the PPRS and the General Ophthalmic Service, and propose in relation to the Binder Hamlyn report and charges, I attach great importance to bringing the FPS into a framework of adequate financial control. Equally important for this will be the work to improve forecasting which my officials have in hand, in consultation with yours. But I must emphasise that the problems of securing this control are not capable of quick and easy answers; they will not respond to in-year fine-tuning but as you have recognised in your helpful response to the Binder Hamlyn report require a sustained programme of improved forecasting and selected controls over supply-led features of the services, on which we are about to consult when we publish Binder Hamlyn.

Yours ever
Norman

NORMAN FOWLER



DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522 ext 6981

From the Permanent Secretary

Sir Kenneth Stowe KCB CVO

Prime Minister (2)

You asked to see a copy of this report.

DWB 29/12

David Barclay Esq.,
No. 10 Downing Street,
London SW1

29 December 1983

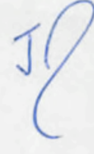
Dear Mr Barclay

I enclose as requested a copy of the Binder Hamlyn Report.

You may like to note that although the Report is not marked CONFIDENTIAL it is being treated as such by the Department pending publication. We also intend to put a paper to 'H' Committee shortly to discuss the Report and hope that it will be taken at the meeting on 18 January.

Yours sincerely

Linda Kerry (Mrs)



10 DOWNING STREET

From the Principal Private Secretary 29 December 1983

PERSONAL

Many thanks for your letter of 22 December. I told the Prime Minister that a way had been found to ensure that the National Heart Hospital could have the NMR Scanner, and she was delighted.

Mr. Longmore has not yet formally raised the suggestion of a fund-raising party for CORDA at No. 10, but I would like to be prepared because he will no doubt revert to it. My hesitation - apart from the consideration that the Prime Minister cannot give fund-raising parties for too many organisations without debasing the currency - has been based on worries about health politics. Is there not a risk either that people will say that this indicates the inadequacy of funding of the Health Service or that it will stimulate others in the Health Services to come forward with a series of similar good health causes, which the Prime Minister would be forced to turn down?

I am sure that the Prime Minister would value Mr. Fowler's and your advice about this. If your view is that the Prime Minister could safely give a fund-raising reception for CORDA without running into trouble on the grounds I have suggested, I am sure that she will want to consider it sympathetically.

E. E. R. BUTLER

Sir Kenneth Stowe, KCB, CVO,
Department of Health and Social Security.

Prime Minister
In the light of your comments on DHSS expenditure you may like to read the attachments to this letter at the same time as the Binder Hamlyn report*
FERB 29.12.
* in box DWS 29/12

2

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522 ext 6981

From the Permanent Secretary

Robin Butler Esq.,
No. 10 Downing Street,
London SW1

23 December, 1983

Dear Robin.

I promised to let you have a copy of the infamous article in "PULSE" (the magazine circulated free to General Practitioners, funded by its advertisements) about the way in which GPs can maximise their income from the NHS at the expense of the Exchequer. I attach a copy of the article together with a note explaining the background to it.

I also attach notes, which you might find helpful, about the problems of forecasting and controlling demand-led expenditure on our two big demand-led programmes-supplementary benefit and family practitioner services. I will not offer any further comment on them because these will, I guess, loom large in the renewed seminar discussion which the Prime Minister wishes to have on 12 January.

I am copying this letter to Robert Armstrong and Peter Middleton.

Yours ever.

Ken.

Pulse 17 Sept.

MONEY pulse

Edited by Sue Russell

Red book use can lead to steep rise in practice cash

Dr John Gray shows that by implementing the Red Book fully GPs can dramatically increase practice income without having to depend on Government largesse.

SEVERAL YEARS ago I was baffled by a GP doyen who at a trainers' workshop euphemistically attributed his seemingly huge income to 'a full implementation of the Red Book'.

I would suspect that to many principals and trainees his remark would still be relatively meaningless.

This was recently highlighted at a local workship meeting sponsored by a pharmaceutical company when the representative suggested that the bulk purchase of their depo-steroid preparation to be dispensed on an FP 10 under section 44.13 of the Red Book was both legitimate and profitable.

The suggestion clearly fell on stony ground.

Over the last 2½ years, our practice's attempts to implement the Red Book and become more efficient have led to a radical change in philosophy and organisation.

The use of recall systems allied to an age-sex register and the ensuing paperwork have grown to such proportions that we have been forced recently to allocate one whole room to our recall clerk.

The table shown here represents the returns from the FPC for our practice at the end of the March quarter for 1981 and 1983.

It does *not* purport to be a strict statistical analysis nor does it represent eventual practice profits.

Dr John Gray: practice returns rose by 40 per cent.

What it does show is that in the areas in which an increase in practice income can be made independent of governmental largesse, quite dramatic increases in percentage terms are possible.

From the table it is possible to note that:

1. Items of service rose by 5 per cent to 21 per cent of remuneration. The most noticeable increase was for 'special drugs' which consist of a combination of vaccines for influenza, vaccines used in routine immunisation, intra-uterine devices, emergency work drugs and depo-steriod preparations (Red Book 44.13).

2. Vaccinations and smears rose some 240 per cent despite a dramatic fall of 40 per cent in maternity fees reflecting a sharp drop in births locally.

Happily this trend is reversing and we should see over the next year an increase in both these elements.

This element varies seasonally (£1,700–£2,500).

3. Night visits rose by 105 per cent due to an increase in population, a disproportionate rise in the fee and a slight increase in actual work load.

4. Element for contraception rose by 61 per cent and this is the area in which I feel there is room for further improvement.

Part of the sum inevitably accrued secondarily to the cervical cytology recalls. However our surgery 'advertising' has played an important role in attracting women away from FP clinics.

	List size 10,000 March 81	List size 10,800 March 83	Percentage
1 Capitation standard	10,920.73	14,284.83	30.8%
2 65-74	271.56	342.16	26%
3 Over 74	240.62	340.99	41%
4 Supplementary	1386.78	1830.87	32%
5 Supplementary practice allow	930	1135	22%
6 Basic practice allowance	4725	5755	21.7%
7 Group practice allowance	825	1005	21.8%
8 Maternity	2126.25	1275.20	-40%
9 Emerg/anaes fees	—	10.90	—
10 Contraceptive services	895.22	1444.28	61.34%
11 Temporary residents	269.50	263.65	-2.2%
12 Night visits	241.50	497.25	106%
13 Vaccinations and immunisations	579.10	1954.70	240.75%
14 Seniority	1335	1973.75	47%
15 Vocational training allowance	—	—	—
16 Special drugs	—	1940.11	—
17 D.M.O. reports	—	—	—
TOTAL	24 736	34 053	40%

Table shows that increased remuneration of four full-time GPs for the same quarter after a two-year interval can be quite dramatic in percentage terms.

5. Practice returns rose overall by some 40 per cent. By comparison the standard fees, namely supplementary practice allowance basic practice allowance and group practice allowance, all rose by approximately 22 per cent.

6. Investment: most small business cannot generate income without investment. GPs are fortunately in the happy position of receiving 70 per cent reimbursement for ancillary staff which offsets the cost for employing a specialised recall clerk.

In addition the costs for postage, printing and so on vary between £70 and £100 for each quarter. These costs (theoretically) should be reimbursed in the practice expenses element.

In my opinion the days of enormous leaps in Review Body awards – between 1975 and 1980 – are gone. This year's increases will not in financial terms reflect the apparent percentage rise of 6 per cent. It will in fact be nearer some 3 per cent.

Next year's award will I suspect be even lower. The pressure to reduce sizes is not acceptable unless income is maintained.

John Gray *is a GP in Chessington, Surrey.*

Ancillary staff and other fees go up

The allowance for related ancillary staff has been increased to £1,565 backdated to April 1. This level will apply until March 31, 1984, and represents an increase of 6.75 per cent on last year's allowance.

GPs who have been missing out on fees for life assurance reports because of the MIRAS scheme (Money Pulse, August 13) will be recompensed to some extent by the new increased fee when examinations are requested again.

For the ordinary form of life assurance report – where the proposed sum assured exceeds £2,500 – the fee goes up to £19. Personal medical attendant reports with niethal medical examination nor opinion go up to £9.50. Both fees are increased on October 1.

Fees for lectures and examinations at ambulance associations are also to go up, to £17.90

OCTOBER PRACTICE DIARY

October 1 FP1 registration
FP4 registration
FP58 registration of newborn
FP19 temporary resident
FP1001 contraception
FP1002 IUCD
FP1003 TR contraception
Prem 1 for practices due for rent review
All above forms to FPC

tetracycline hydrochloride

– the convenient tetracycline in chronic and acute bronchitis

- B.d. dosage — good patient compliance
- Low risk of gastric upset
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Further information is available on request from the Company
Organon Laboratories Ltd, Cambridge Science Park, Milton Road, Cambridge.

MG

GPS' FEES AND ALLOWANCES 1981-1983

"PULSE" ARTICLE, 17 SEPTEMBER

1. This Note sets out some comments on, and the background to, the article in Pulse magazine of 17 September on how a GP practice increased its income by 40 per cent in cash terms over the 2 years 1981 to 1983.

2. The level of fees and allowances for GPs is set by the Review Body: the aim is to pay GPs on average the net remuneration the Government decides is due to them after consideration of the Review Body's report. The complex system of fees and allowances is set out in what is known as the "Red Book": what the article shows, in effect, is how one practice both changed its own behaviour and responded to changing demands by patients. In doing so, it increased its income by some 40 per cent - whilst the fees and allowances were set to produce an average increase of about 21 per cent: it did, of course also increase its workload.

3. The following paragraphs set out in greater detail the working of the system in general and the record of this individual practice in particular.

4. Over the two year period 1980/81 to 1982/83 GPs' fees and allowances generally were set to produce an increase of about 21 per cent. This was to cover

i. a 12 per cent increase in average net remuneration - 6 per cent in 1981/82 and 5.7 per cent in 1982/83

ii. a 20 per cent increase in average expenses estimated at about 11 per cent in 1981/82 and 9 per cent in 1982/83

iii. an increase of about 4 per cent to correct for past under-payments.

5. Broadly speaking all fees and allowances went up by 21 per cent except capitation fees which were increased by about 27 per cent to compensate for expected loss of income through falling average list size. (Adjustments to GPs earnings needed to take account of changes in workload are incorporated by the Review Body in the recommended average net remuneration. Fees and allowances simply aim to deliver the agreed average net remuneration. In fact the Review Body has assumed constant workload for a number of years, falling list size being deemed to be offset by increasing numbers of elderly patients, new treatments etc.)

6. The system aims to deliver the average net income to the average GP. It contains incentives in the form of item of service payments to encourage GPs to undertake particular types of treatment. It is open to any GP to try to increase his income (having regard to the needs of his patients) for example by taking on more patients (up to a maximum) or carrying out more treatments. If as a result the actual average net remuneration received by GPs as a whole exceeds the amount awarded, the Review Body will make a downward adjustment to fees and allowances in a later period and claw back the excess, making net remuneration correct in the longer term if there has been no overall increase in workload.

7. The analysis of gross payments in the last quarters of 1980/81 and 1982/83 provided by Dr Grey shows that income from

a. the basic practice allowance, the group practice allowance and the supplementary practice allowance which are fixed allowances per GP all increased by around 21 per cent;

b. the capitation fees increased by rather more than the 27 per cent fee increase because list size increased;

c. seniority payments increased by more than 21 per cent probably because one partner became eligible for a higher payment because of his length of service;

d. night visits seems to have increased by more than expected because more night visits were made in the later period (39 compared with 23 in the earlier period).

The remaining increases in income were from item of service payments; more contraceptive services were provided, more cervical smears were carried out, more vaccinations given and special drugs administered for patients requiring long term steroid treatment. The latter represents new work for the practice and accounts for 8 per cent of the 40 per cent increase.

8. When additional work is carried out by an individual or practice, as described above, the Department has no choice but to pay for it. And this of course is as it should be if the increase results in better care for the family, for example as a result of GPs responding to appeals to take part in vaccination programmes and setting up systems which ensure that women are recalled promptly when they

become due for cervical smears. The ability of individual GPs to increase their income by adjusting the pattern of work and increasing the services they offer, together with fluctuations in patient demand, makes forecasting and control of GMS expenditure extremely difficult in the short term. In the longer term as Binder Hamlyn recognise, GMS expenditure is more susceptible to control. In spite of these difficulties, control is tighter than in European insurance-based systems. Our payment to GPs are still based principally on the number of patients on the doctor's list rather than on items of service; the DDRB system gives good overall control of practitioners' earnings; and most practice expenses are reimbursed on an average basis which, as Binder Hamlyn points out, gives a powerful incentive to economy.

TH

FAMILY PRACTITIONER SERVICES

1. Existing constraint is dependent upon the contractual arrangements we negotiate with GPs, dentists, chemists and opticians, through negotiation of drug prices and through charges to patients. We cannot and, in Ministers' view, should not control what doctors prescribe for their patients. We have influence on the supply of doctors by tight controls on medical schools intakes, but cannot at present control the numbers of practitioners contracting for services.

Measures to Improve Control

2. Following an independent study by consultants Binder Hamlyn (which will be published in the New Year) Ministers will be putting proposals to H Committee after Christmas to introduce the controversial legislation necessary to strengthen existing controls, notably by taking power to control the numbers of contractors.

3. Other measures to contain expenditure over the next three years include:

(a) saving of over £100 million a year on the drugs bill to result from current negotiations on the Pharmaceutical Price Regulation Scheme, on which the Minister for Health made a recent statement to Parliament;

(b) savings of approximately £20 million from privatising the dispensing of glasses to adults;

(c) proposals to save approximately £60 million a year by moving to a system of cost-related charges for NHS dentistry; Ministers have not yet decided on the timing of this controversial measure.

The measures at (b) and (c) will be contentious, as would cost-related prescriptions, and/or exemption based only on ground of financial need - though the savings could be substantial.

4. In addition, we have commissioned the management consultants Arthur Andersen to advise on improving the efficiency of Family Practitioner Committees in their administration of the FPS and on streamlining their work through computerisation. The Government has just reintroduced the legislation to make these committees independent of DHAs, and to clarify accountability between them and the Secretary of State.

Forecasting

5. Forecasting this expenditure is notoriously difficult because the initiative for changes in costs and the pressure for change, lies in the hands of, mainly, prescribing doctors and in the scientific development of the pharmaceutical industry world-wide.

6. Within the Department, substantial steps have already been taken to improve the statistical and financial basis for forecasting expenditure on the FPS; we are already getting some of the benefit of this and further improvements are expected next year.

7. Most recently we have, at the invitation of the Treasury, provided up-to-date estimates of likely additional requirements for expenditure on the FPS up to 1986-87, in advance of the publication of the Estimates White Paper. The additional sums which we have sought include sums for (a) additional take-up of welfare foods (outside the FPS but demand-led and directly governed by increases in social security entitlement), (b) some upward revision in the number of doctors and dentists and (c) (the largest amount) a further increase (£26 million, £73 million and £106 million) in the estimated expenditure on drugs in the FPS. This requirement is on top of figures which took account of the substantial savings on the drug bill recently announced.

8. The reasons for (c) are revealing. It reflects the latest estimates of trends in numbers of elderly and unemployed people whose prescriptions are dispensed without charge, and in the net ingredient cost of individual prescriptions (which are the clinical responsibility of the doctor). The cost is also influenced by the fact that prescriptions (exempt of charge) for the elderly are also the most expensive per item.

JP

SOCIAL SECURITY

Controls

1. Social security expenditure is primarily controlled through decisions on benefit levels at the annual uprating, through the legislation which determines entitlement and through the delivery system, which pays the benefits so determined. We cannot control the number of beneficiaries and forecasts of their numbers are subject to substantial uncertainties.

Measures to Contain Expenditure

2. Measures to contain expenditure taken under this Government have produced savings of over £2 billion. Those decided in the last PES round will account for £250 million. The Secretary of State is now conducting several in-depth reviews of those parts of the system which are most likely to repay such reviews.

Forecasting

3. Most of the uncertainties revolve around forecasts of supplementary benefit expenditure. These are based on economic assumptions provided by the Treasury, on statistical data about past expenditure and on assumptions about people's behaviour - who will lose or gain jobs and for how long and what benefit entitlements they will take up. All three are subject to doubt. The economic assumptions are not the Treasury's most detailed forecasts of unemployment (which Treasury Ministers have been unwilling to disclose) and they tend to be fairly inaccurate. Our statistical data, particularly data about current expenditure, are available fairly late and involve estimation. The reason for this is the scale of the system we operate and its complexity: obtaining more up-to-date or more detailed data would be very expensive. This is a situation which we expect to improve substantially as our operations become more computerised under our operational strategy, and it would improve even more if Post Office counter services were mechanised, but both of these are developments for the longer term.

4. Estimating what benefit entitlement will be claimed by a

given number of unemployed people has proved difficult because experience in earlier years proved a poor guide to what would happen in the current recession.

5 This difficulty has been compounded by two others. The more important was the Civil Service dispute of 1981: as one side effect of this we lost a very substantial proportion of the basic statistical information for that year. For several months now we have been building on sand as a result of this and it is only within the last few months that reliable and up-to-date statistics have been available to provide a firmer foundation.

6 The other major source of uncertainty was the major change to the system brought about by the introduction of Housing Benefit in April. Now that figures on the new benefit system are becoming available for the first time, various of our assumptions have had to be revised.

7 These last two problems were once for all effects, and we can look for improvements in our forecasting simply because they are now behind us. We are not resting on that alone, however: our Chief Economic Adviser is chairing a joint group with Treasury and GAD to consider what all three Departments can do to improve forecasting and monitoring of social security expenditure. They have set up an expert working party to make recommendations on where improvements will be most cost effective, and to report early in the New Year. We shall be ready to take urgent action to implement recommendations of the Group as they effect DHSS; in the interim, we have already set in hand a number of small improvements in our arrangements.

GJ

PERSONAL

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe KCB CVO

Robin Butler Esq
10 Downing Street
LONDON SW1

22 December 1983

Dear Robin.

Colleagues from here have seen Mr Longmore and discussed with him his plans for securing the first production model from GEC Picker of their latest 0.5 Tesla NMR Scanner. Mr Longmore had been promised by GEC Picker that a charity, CORDA, could have this scanner for £650,000 to install in the National Heart Hospital so long as he could give an undertaking by the end of January 1984 to repay the purchase price to GEC Picker by June 1985. (I enclose a CORDA letter heading and a list of the membership of its Scientific Advisory Council which demonstrate the eminence and breadth of experience of its backers.) We have secured that the scanner will be ordered by the Department of Trade and Industry under their support programme for British industry. This is however on the understanding that CORDA will in fact raise the funds needed - around £½ million on top of what is already promised - both to install the machine and to repay the purchase price in mid 1985 to DTI. Thus although Mr Longmore - or CORDA - will no longer be required to sign a repayment pledge to secure delivery of the machine - it is vitally important that he continue his efforts to raise money so as to repay the capital sum involved. Mr Longmore is hoping that the Prime Minister will host a fund raising party for CORDA at Number 10; I realise that this may not appear to be an attractive proposition. Nonetheless it would be extremely helpful if the Prime Minister were willing to find some appropriate way of expressing her support for this charitable venture.

Yours ever.

Ken.

DETECTION PROTECTION PREVENTION

The Coronary Artery Disease Research Association (Formerly HEART)
47 Wimpole Street, London WIM 7DG Telephone 01-834 5000

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SCIENTIFIC ADVISORY COUNCIL OF CORDA - November, 1983

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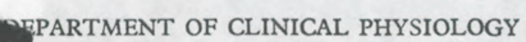


DEPARTMENT OF CLINICAL PHYSIOLOGY

NATIONAL HEART HOSPITAL

MR. DONALD LONGMORE

WESTMORELAND STREET, LONDON W1M 8BA
TELEPHONE 01-486 0824
01-486 4811

Our Ref.

Your Ref.

Pl. file

16th December, 1983

Mr. R. Butler,
Principal Private Secretary,
10 Downing Street,
London S.W.1

Dear Robin

Many thanks for your recent letter and for the quite unnecessary thank you letter about your visit to the Heart Hospital. There is a great deal more to tell you about and show you so perhaps in the New Year when you come with Mr. Denis Thatcher I will be able to show you some more.

Your efforts with the D.H.S.S. have certainly proved to be effective. We are having a meeting on Wednesday afternoon next in order that I can present our case. The D.H.S.S. representatives are Dr. Abrahams and Mr. Gordon Higson. I have no idea how senior they are but on the telephone they did sound knowledgeable, which is a good start.

If we do not talk before Christmas, all good wishes to you and your family.

Yours sincerely,

Donald

Donald B. Longmore, FRCSEd
Consultant Clinical Physiologist

Pl. file

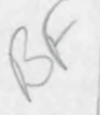
20 DEC 1983

10 DOWNING STREET

From the Principal Private Secretary 14 December 1983

We spoke the other evening about the approach which I had received from Mr. Donald Longmore about the funding of the nuclear magnetic resonance machine which he hopes to acquire for the National Heart Hospital; and you kindly said that you would arrange for Mr. Longmore to speak to the right person in the DHSS and let me know what arrangement was being made.

I have subsequently received a letter from Mr. Longmore, of which I attach a copy, with my acknowledgement.



It would be very helpful if we could have a word on the telephone when you know who will be contacting Mr. Longmore on behalf of the DHSS; and I should be very grateful if I could have advice in due course on Mr. Longmore's suggestion that the Prime Minister should open the unit. In terms of intrinsic interest in the development, I think that the Prime Minister might be well disposed to the suggestion that she should open the unit, but she will of course want to be guided by your Secretary of State's advice in relation to the Government's attitude towards this development and the way in which the Prime Minister's opening of it would be regarded elsewhere in the profession.

Sir Kenneth Stowe, K.C.B., C.V.O.,
Department of Health and Social Security.

10 DOWNING STREET

From the Principal Private Secretary

14 December 1983

Many thanks for your letter of 13 December about nuclear magnetic resonance. I had already spoken to Sir Kenneth Stowe, who told me that he was very willing to advise on the proper channels through which you can discuss this with the DHSS: he said that he would arrange for the right person to make contact with you, and will keep me in touch with the arrangements being made.

It is a nice idea that you might invite the Prime Minister to open the unit, but I imagine it is a little early for you to determine a definite date, or for us to commit her to it. May we consider this further when the progress of the project is a bit clearer?

Donald Longmore, Esq.

dw

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

David Barclay
10 Downing St

13 December 1983

1) Tim ✓
2) Andrew } to see
3) pa

Dear David

DWB 13/12

You might like to have a copy of the statement my Secretary of State issued yesterday on 'radical alternatives' to the NHS - essentially in response to the David Hart article in the Times last week and Ralph Howell MP's pamphlet on the NHS issued by Aims of Industry.

The statement restates the established lines (a) that the NHS will continue to be financed mainly from taxation; and (b) that the Government will pursue better management within the existing structure on the lines recommended by Griffiths

Yours Steve Godber

Press & Public Relations Department.

Phone: 01-222 0151/8
01-222 9000

Conservative Central Office.
32 Smith Square,
London SW1P 3HH

RT HON NORMAN FOWLER MP

Release Time: 19.00 HOURS/MONDAY 12TH DECEMBER 1983

840/83

Extract from a statement by the Rt Hon Norman Fowler MP (Sutton Coldfield), Secretary of State for Social Services, to the officers of the Conservative Medical Society in the House of Commons on Monday 12th December 1983.

THE RIGHT POLICY FOR A BETTER HEALTH SERVICE

Recently solutions to the "problem of the health service" have been coming thick and fast. Some, like the article in The Times last week, advocate that it is "time to sell off the NHS". They suggest replacing the present system of financing the NHS by compulsory private health insurance. Another suggestion had been to make a "radical change" by turning the NHS into something like a nationalised industry headed by a high profile Chief Executive. And there is always the third line put forward by the Left - that there is no problem with the NHS that would not be put right by simply spending a few more billion pounds.

First, let me look at the proposed alternative method of financing the health service: the introduction of compulsory health insurance. There is nothing new in this idea. It is one on which the Government undertook a thorough study some three years ago. We were quite open about what we were doing then and I told Parliament in July 1982 the outcome of that review - "the Government have no plans to change the present system of financing the NHS largely from taxation". That remains the position today.

/...

Printed and Published by Conservative Central Office, 32 Smith Square, London, SW1.

The effort involved in going over to a system of compulsory health insurance would make the 1974 reorganisation like a minor hiccup. It would mean creating new bureaucracy and administration for the collection of revenue. The reimbursement system operated by the French, for instance, would add massively to administrative costs. What the advocates of compulsory insurance have to show is that it is ultimately a more effective and efficient way of providing patient care at reasonable cost. I do not believe that that case can be sustained.

Second, the concept of the NHS corporation, independent of day-to-day political control, seems to me to be subject to two basic fallacies. First, it ignores the fact that the health service is, and will continue to be, largely funded by taxation. It does not get its support from the State to supplement its trading income - as nationalised industries do.A NHS corporation would be about as independent as British Rail without its fares income. Second, it is quite unrealistic to think that the public or Parliament would allow me, as Secretary of State, to give up my responsibility for determining the resources available for the NHS, my duty to determine strategy and priorities in the use of those resources, and my ultimate accountability for the spending of £13 billion of taxpayers money.

I find it strange to see suggestions that we should look to the nationalised industries as our model for good management, efficiency and value for money. Of course we do need better management within the NHS. That is precisely what we are working towards and what the Griffiths Report is all about.

Third, there is the wholly unrealistic approach of the Labour Party - whose only policy is to spend more money on an unchanged service. It is simply absurd to pretend that more money can be spent regardless of the consequences in terms of higher taxation and inflation. Inflation hits the health service as hard as anything else. Michael Meacher should remember that when he was a Minister at the DHSS under the last Labour Government, the policies of that Government led to a situation where the biggest capital cuts in the history of the NHS had to be made.

/...

Our critics should look at the improvements which are taking place right now. The fact is that since we took over performance has improved substantially. In 1981 the health service treated more patients than ever before - some 640,000 more in-patients and day cases and some 2 million more outpatients and emergency cases than in 1978. And this has been done with fewer hospital beds because our use of resources has improved and new and more effective medical treatments have been introduced.

For the future we will be providing extra money to meet the growing pressures on the health service. But that is only the beginning: the real challenge is to get the health service better run and to get better value for money. We are doing that. Ministers are directly involved in scrutinising the performance of health authorities - not to try and run the service for them but to make sure that they account for the way they do the job. We have taken a firm grip on the growth of NHS manpower to make sure that we don't waste staff. And following the Griffiths Report we are going to have a much tighter management system so that everybody knows who is in charge.

Those are the changes and improvements on which I shall be concentrating. That is the real task. There is no need to uproot the whole system by which health care is provided in this country. The facts simply do not justify changes of that kind.

END.

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FINANCIAL TIMES

Fowler rules out alternative NHS

BY PETER RIDDELL, POLITICAL EDITOR

MR NORMAN FOWLER, the Social Service Secretary, last night set clear limits to the Government's forthcoming debate about the future of the welfare state by ruling out the main alternatives to the present system of financing the National Health Service.

His speech, to the Conservative Medical Society, can be seen as an attempt to ensure that the more radical proposals advocated by free market economists are not regarded as serious options in the debate.

Mr Fowler argued that there was: "No need to uproot the whole system by which health care is provided in this country. The facts simply do not justify changes of that kind."

He dismissed recent suggestions that the present system should be replaced by compulsory private health insurance, or that it should be turned into something like a nationalised industry headed by a high-profile chief executive.

The compulsory health insurance option has already been studied in detail and was publicly rejected last year. Mr Fowler said that this was still the position.

"The effort involved in going over to a system of compulsory health insurance would make the 1974 reorganisation seem like a minor hiccup. It could mean creating new bureaucracy and administration for the collection of revenue. The reimbursement system, operated by the French, would add massively to administrative costs."

Mr Fowler also attacked the concept of the NHS corporation independent of day-to-day political control. He said this idea ignored the fact that the NHS is, and will continue to be, largely funded by taxation and does not have trading income. Moreover, he said it was quite unrealistic to think that the public or parliament would allow a secretary of state to give up responsibility for determining the resources available to the NHS or its strategy and priorities.

Mr Fowler attacked the attitude of Labour as wholly unrealistic and pointed to the improvements already taking place through the better use of resources. He said the real challenge was to get the health service better run and to get better value for money.

He pointed to the scrutiny of performance of health authorities, the firm grip on the growth of NHS manpower and a tighter management system.

THE GUARDIAN

Vulnerable Treasury under attack over privatisation

Fowler steps up resistance to NHS switch

By Colin Brown, Political Staff

The Social Services Secretary, Mr Norman Fowler, last night stepped up his efforts to resist Treasury attempts to seek ways of switching the National Health Service to the private sector.

Mr Fowler said that the effort involved in going over to a system of compulsory health insurance would make the 1974 reorganisation of the NHS look like "a minor hiccup."

Mr Fowler was, in effect, attacking the Treasury on its most vulnerable ground — the cost effectiveness of any attempt to force most NHS patients to take out private health insurance. But he also believes that it would be politically damaging for the Government to be seen to be re-examining this possibility in its proposed general review of the welfare state.

Mr Fowler thought he had won the battle to prevent health care being privatised, but the Chancellor, Mr Nigel Lawson, reopened the issue in a recent television interview. Mr Fowler sought to explain the Chancellor's stance as no more than a slip of the tongue.

But Mr Fowler's speech to the Conservative Medical Society at the Commons yesterday could be seen as evidence that the battle within the Cabinet about the future of the NHS is still very much undecided.

Mr Fowler said that the Government undertook a thorough study of compulsory health insurance three years ago. "We were quite open about what we were doing then, and I told Parliament in July 1982 the outcome of that review—'the Government have no plans to change the present system of financing the NHS largely from taxation.' That remains the position today."

Such a change, said Mr Fowler, would mean creating new bureaucracy and administration for the collection of revenue. The reimbursement system operated by the French, for example, would add massively to administration costs.

"What the advocates of compulsory insurance have to show is that it is ultimately a more effective and efficient way of providing patient care at reasonable cost. I do not believe that that case can be sustained," Mr Fowler said.

He dismissed a Tory suggestion that he should become the head of an NHS corporation, because it ignored the fact that the health service was largely funded by taxation. He attacked Labour for claiming that spending more money would solve the problem of the NHS. He insisted that the real task was to make sure that the Health Service produced better value for money.

"There is no need to uproot the whole system by which health care is provided in this country. The facts simply do not justify changes of that kind," he argued.

DAILY TELEGRAPH

6 The Daily Telegraph, Tuesday, December 13, 1983

FOWLER PROMISES TO PRESERVE HEALTH SERVICE

By VALERIE ELLIOTT

MR FOWLER Social Services Secretary, last night assured the future of the National Health Service and stated categorically that the Government had no plans in changing the system of financing it.

He promised to provide extra money to meet the growing pressures on the service but said the real challenge was to run the Health Service better and to get better value for money.

Mr Fowler dismissed suggestions that the health service should be financed by a compulsory private health insurance and said any effort to go over to such a system "would make the 1974 reorganisation like a minor hiccup."

He said it would create new bureaucracy and administration and he did not believe it would prove a more effective and efficient way of providing patient care at reasonable cost.

Addressing a meeting of the Conservative Medical Society in the Commons last night, he also condemned the "wholly unrealistic approach of the Labour party" who believed there was no problem that would not be put right by simply spending a few more billion pounds.

"It is simply absurd to pretend that more money can be spent regardless of the consequences in terms of higher taxation and inflation."

Instead he urged critics to look at health service improvements. In 1981 more patients were treated than ever before—some 640,000 more in-patients and day cases and some two million more outpatient and emergency cases than in 1978.

"And this has been done with fewer hospital beds because our use of resources has improved and new and more effective medical treatments have been introduced."

Mr Fowler promised a much tighter management system

Consultants' role

Hospital consultants' contracts will be renegotiated by a future Labour government to require them to devote more of their working week to NHS patients and less to private practice, Mr Michael Meacher, Shadow Health Minister, said yesterday.

Outlining Labour's health policy he said that their aim would be the complete separation of private health care from the National Health Service.

THE TIMES

Fowler rejects radical change in NHS finance

By Our Political Editor

Mr Norman Fowler, Secretary of State for Social Services, yesterday dismissed nostrums from the Conservative right for changing the basis of health finance and management.

Speaking to the Conservative Medical Society, meeting at Westminster, he repeated that the Government had no plans to change the present system of financing the National Health Service largely from taxation.

The real challenge was to ensure the service was better run and to get value for money.

510

DEPARTMENT OF CLINICAL PHYSIOLOGY

NATIONAL HEART HOSPITAL

MR. DONALD LONGMORE

WESTMORELAND STREET, LONDON W1M 8BA
TELEPHONE 01-486 0824
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Our Ref.

Your Ref.

13th December, 1983

R. Butler, Esq.,
Private Secretary,
10 Downing Street,
London S.W.1

Dear Robin

Thank you for your offer to speak to Sir Kenneth Stowe on our behalf about nuclear magnetic resonance (N.M.R.).

We are in a unique position to help British medicine and British industry to retain their advanced positions in this new field. I believe it is important that we should make every effort to prevent the erosion of our lead. We are in danger of being overwhelmed by the massive American investment in research and development, and the even greater American effort to commercialise N.M.R. For these reasons I have deemed it unwise to delay by proceeding through the normal channels to obtain an N.M.R. scanner.

Inspite of the position of the National Heart and Chest Hospitals in the forefront of cardiovascular disease management and research, we have only just managed to get a nuclear medicine department (the technique is now obsolescent) and are only just installing a CAT scanner; both of these have been achieved by private subscription. Furthermore the Hospitals are under considerable financial strain and it may even prove necessary to close our superb and loyally staffed hospital at Frimley in order to make ends meet. In spite of these difficulties our enlightened administration and Board of Governors have provided us with a building, as much support as they possibly can, plus a number of key salaries so that the N.M.R. project can proceed with due speed. As a result of my association with the research side of G.E.C. we have been offered the first of the 5 kilogauss machines (rather more powerful than most commercial machines) at a discounted price of £650,000 delivered and installed (worth £1.1 million plus). They have also negotiated an interest-free loan for us, repayable in June 1985.

There can be no-one else in the U.K. in so fortunate a position as our group. For a decade we have been aiming towards early detection and early diagnosis of cardiovascular disease. We thus have an understanding of the earliest stages of its progress. We have been associated with N.M.R. research from the time that the first human images were produced. At that time we started biological testing of the safety of N.M.R. In order to further our aims of eliminating cardiovascular disease we have carefully assembled a team of hardworking people with outstanding expertise in physics, computer programming and biochemistry. In parallel with this we have acquired the computing power and the expertise needed for high-quality documentation and rapid, detailed analysis of all the data we obtain, well ahead of many other groups in the field, centred as they are on physics departments and working in isolation.

During the past two years we have been working in association with G.E.C. Hirst Research, and due to the generosity and co-operation of the Hammersmith Hospital, we have been able to do practical work in the evenings and at weekends. This work has resulted in two major advances:

1. A better gating system. This means that the many projections needed to construct an N.M.R. image can all be taken in the same part of the cardiac cycle to an accuracy of within 5 milliseconds. Other workers are working within an accuracy of 150.

2. Although we are impressed with the work done by Radda and his group in Oxford on the effects of diminished blood flow on the chemistry of muscle, including heart muscle, we believe that it is more important to go further back in the disease process. The best way to achieve this is to try to detect diminished blood flow at the earliest stage. To this end we have already developed very accurate methods of measuring blood flow in small arteries. We are now pressing on to extend these techniques to measure blood flow in the main coronary arteries.

Because we have been associated with fundamental research on the pathogenesis of atheroma, we were pioneers in the use of prostacyclin (John Vane's Nobel prize-winning discovery) in animals and then in man. We are in close touch with drug companies who have organised clinical trials of materials which may reverse atheroma. As soon as it is ready, our N.M.R. blood flow technique will be ideal for monitoring the efficacy of these compounds.

I had hoped that the CORDA charity founded nearly a decade ago by Robert Carr, myself and John Stephenson in order to solve this problem, would be able to finance the N.M.R. project. Although they can fund projects to be carried out in the Unit there is only a remote chance that they can meet the deadline of January 31st by which time the commitment to the £650,000 plus the £100,000

required for the building conversion must be pledged in writing. I appreciate that we are in competition for funding within the D.H.S.S. framework of other N.M.R. projects as well as projects in many other areas. Perhaps our strongest point is the combination of the relevance of what we are trying to do in making health care more cost-effective, coupled with the enlightened attitude of our local administration and the majority of my colleagues who see the importance of this work.

With all good wishes.

Yours sincerely,

Donald

Donald B. Longmore, FRCSEd
Consultant Clinical Physiologist

Do you think the Prime Minister would like to open the unit in June or July 1984?

DBC.

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With permission, Mr Speaker,

I would like to make a statement on the discussion that I and the Secretary of State have been having on behalf of all the UK Health Ministers with representatives of the pharmaceutical industry on the scope for savings in the NHS drugs bill and other matters of mutual concern.

2. Prescription medicines cost the NHS in England about £1,250 million in 1982/83. Drugs account for about 40 per cent of the total cost of the FPS, and about 10 per cent of the cost of the NHS as a whole. The pharmaceutical industry's profits from NHS sales are governed by the non-statutory Pharmaceutical Price Regulation Scheme which was introduced in its present form in 1978. In the words of the published Scheme, it is a key objective that "safe andeffective medicines [should be] available on reasonable terms to the NHS, but also that a strong, efficient and profitable pharmaceutical industry" should exist in the UK. The industry's present target profit level was set by the Labour Government in 1978. Like our predecessors we recognise that there is a major and successful industry providing 67,000 jobs and with a net balance of exports over imports of around £600 million a year.

3. However, the present Scheme has run unaltered for over five years. A review of the PPRS and its role in relation to the industry and the NHS was announced earlier this year. After extensive discussion with the industry's representatives and having taken account of the 10th Report of the PAC published in April, we have decided both to reduce the level of profit from NHS business and the level of sales promotion allowed as an expense under the Scheme.

4. First, under the scheme each phurmaceutical company participating in it is assigned a target rate of profit taking account of "the circumstances of the individual company, the contribution which it makes or is likely to make to the economy, including foreign earnings, investment, employment or research". We have decided that these targets should be reduced by an average of four percentage points which will represent a saving to the NHS in the UK of about £40 million a year. We have also decided that the discretion which our Department allows in certain circumstances when companies exceed their target profit rates should be tightened and related more closely to a company's particular circumstances. Companies will be told what their new targets are very shortly.

5. Second, the industry will spend about £180 million this year on sales promotion. Some, but not all, of this amount is an allowable expense under the PPRS. Such promotion is funded largely from NHS sales, and we have concluded that the allowable level should be reduced. We propose, first, that companies should be asked to repay to the Department a sum equivalent to any sales promotion expenditure which exceeds the level allowed under the scheme; and, second, that the industry limit should be reduced from the present level of 10 per cent of turnover to 9 per cent in 1985/86. We estimate that when fully implemented these measures should reduce actual expenditure on sales promotion by 25 per cent but we will review this area again to see if further reduction can be made.

through a modified licence to cover such safety matters as storage, labelling and tracing.

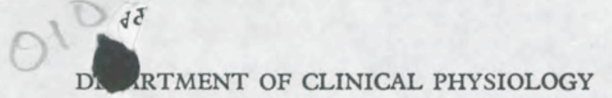
8. There remains the question of generic substitution which we have also been considering in the context of the PPRS review, as announced earlier this year. The Greenfield Committee proposed that a pharmacist should substitute an equivalent generic preparation for proprietary medicine unless the prescribing doctor had specifically indicated that this should not be done. The Committee acknowledged that they had not taken account of the wider implications, for example, on the pharmaceutical industry, of their recommendation. Consultation on the Greenfield report earlier this year showed professional opinion to be divided on this recommendation - which was only one of 14. It become clear that many general practitioners were concerned that their patients would be supplied with formulations of drugs that their doctors had not prescribed. General practitioners and pharmacists foresaw problems of divided responsibilities for the treatment of patients. The various procedures considered all raised serious practical problems. We have therefore decided not to proceed with generic substitution. We do, however, intend to start a new campaign to encourage generic prescribing by doctors. As to the other recommendations of the Greenfield Committee, we have already announced our acceptance of these or referred them to the appropriate educational bodies.

6. All measures I have announced will take effect from 1 April next year. In a full year they will produce savings on the NHS drug bill rising on present estimates from £65 million in 1984/85 to well over £100 million in later years. This compares with the industry's total profit from sales in the UK in 1983 of an estimated £200 million. The changes will mean that the price freeze on drugs - introduced in August as part of the £25 million savings agreed then - will continue, with few exceptions, through 1984/85 and beyond. Furthermore, the price freeze will be at the level established by the 2½ per cent cut of August.

7. We have also discussed with the industry the problem of parallel importing of medicines. This occurs when an importer takes advantage of exchange rates and low regulated prices of particular drugs in other countries to import or reimport those drugs into this country in competition with the identical or near identical products already marketed here. At present, an exemption order under the Medicines Act is being used by parallel importers, in a way not envisaged when the order was made, to bring into Britain substantial quantities of medicines without a licence. Clearly there are potential health hazards if a drug has not been properly manufactured or stored, or if labels are in a foreign language, or if there is difficulty in tracing a batch of drugs found to be faulty. We are not aware of any actual injury to patients but we propose to guard against that possibility. We are statutorily required to consult on these matters, and we will therefore shortly issue a consultative document on proposals which will ensure that medicines parallel imported for general dispensing must be licensed under the Medicines Act, either in the ordinary way, or in the case of medicines also licensed in the European Community,

9. Finally, there are a number of other matters arising from the review of the PPRS which have still to be resolved in discussion with the industry. In particular, a study of transfer prices, which are the prices charged by a foreign-based company to its UK subsidiary, is being conducted by independent consultants and our Department is undertaking a study of pharmaceutical wholesalers' profit margins.

10. In framing these proposals the Government has sought to achieve a balance between the interests of the NHS as customer and the interests of the industry. We recognise the research achievements of the industry and the contribution it makes to the UK economy and we want to see it continue to flourish. However, there is an urgent need to contain the drugs bill for the health service and this we are also determined to achieve. I very much hope that the industry will accept this position as we wish to continue with the price regulation scheme on a non-statutory basis.



DEPARTMENT OF CLINICAL PHYSIOLOGY

NATIONAL HEART HOSPITAL

MR. DONALD LONGMORE

WESTMORELAND STREET, LONDON W1M 8BA
TELEPHONE 01-486 0824
01-486 4811

Our Ref.

Your Ref.

7th December, 1983

Mr. R. Butler,
Private Secretary to the Prime Minister,
10 Downing Street,
London S.W.1

Dear Robin,

In answer to your query about the staff of the National Heart Hospital, the breakdown is as follows:

42.9 medical WTE (whole time employees)
123.5 nursing WTE
63.3 technical WTE
6.0 administrative WTE
35.1 clerical WTE
12.0 domestic WTE

We have been fortunate in that our administration has managed to find the staff cuts from the administration and ancillary staff and has not blunted the clinical edge too much, although we are taking the unprecedented step of having the hospital closed for three weeks over Christmas. Taking the surgical figures only into account we aim to salvage 15 plus people a week on this cost saving exercise but which also could be said to be murdering by neglect 45 people.

I enjoyed your visit. I do hope you come again with Mr. Thatcher when perhaps you will have a little more time and I can show you more going on.

With all good wishes. Yours sincerely,

Donald.

Donald B. Longmore, FRCSEd
Consultant Clinical Physiologist

Report will be ready by Week End
D.B.L.

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

1) Press Office: to see. I agreed with John Graham that honour was now satisfied.
2) CF/GR: please p.a.

Dons 7/12

David Barclay Esq
Private Secretary
10 Downing Street
LONDON

7 December 1983

Dear David,

Thank you for your letter of 11 November about the Sunday Mail campaign on the Health Service. You subsequently telephoned me on 17 November about a Question which Mr Donald Dewar put down to the Prime Minister on the campaign.

In fact my Secretary of State had a general article published in the Sunday Mail on 6 November, which at the request of the Editor included a response to the Mail's campaign. I enclose a copy. A further article specifically about the campaign by a Scottish Minister would therefore in our view be superfluous and in any case would be unlikely to be accepted by the Editor.

Yours sincerely,

John Graham

J S GRAHAM
Private Secretary

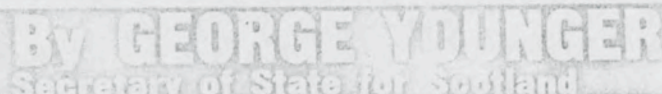
ENC

YES, I SEE HOPE FOR THE FUTURE

WITH five years of the new Parliament ahead of us, I'm often asked what's my greatest wish for Scotland.

It's simply this: That it will be in the forefront of the nation's recovery.

I can just hear the reaction in some quarters to that! There are certain people who are only happy when they're being miserable.



But it's no fanciful pipedream on my part.

It can be achieved.

Because unlike previous painful recessions, Scotland is showing a resilience which leaves us better poised than other parts of the UK to take advantage of the upturn now underway.

Mind you, I'm not predicting anything dramatic.

It will continue to be a slow process. We'll all have to be patient.

The UK is not alone in its search for new jobs to replace those now being lost in older, declining industries.

But Scotland is better placed than most people recognise. We're in the forefront of technological change.

Expansion IS happening.

For example, IBM (2400 employees and expanding) make computers at Greenock: Motorola (1200 and expanding) manufacture semi-conductors at East Kilbride; NEC have set up the largest greenfield development by a Japanese company in Europe at Livingston, promising 800 jobs; while the John Wood Group in Aberdeen (2000) is engaged in international oil and energy projects.

TWO of our older industries going through sticky spells are steel and shipbuilding.

On steel, the future of Ravenscraig is the central issue.

The Government have still not seen any firm plans from BSC about what is called "the American DEAL."

But if plans are put to us I will consider them carefully with the best interests of Scotland at heart.

The Government have clearly shown their commitment to the UK shipbuilding industry by giving British Shipbuilders more than £800 million since 1979.

But the plain fact is there are too many shipbuilders in the world chasing too few orders.

Only the best and most productive yards will survive.

This has been painfully highlighted for us through the action Britoil has taken with Scott Lithgow because the rig being built there has fallen behind schedule.

Scott Lithgow's future is all about customer confidence.

Even now I hope that an agreement can be reached to allow this contract to be completed so that there can be some hope for the yard.

Enormous changes have taken place in the past few years in the shape of Scottish industry.

Electronics companies now employ around 36,500 people — almost one of ten of all those in manufacturing industry.

North Sea oil continues to provide twice that number of jobs.

Scottish companies involved in the health care industries now employ around 7000 and by 1990 that's expected to rise to 15,000.

We shall, as a Government, continue to do everything possible to encourage and support industries which have new ideas.

But there is still a resistance to new technology on the grounds that it means fewer jobs or even redundancies.

Often the fear of new technology is a fear of the unknown.

These are understandable human reactions. I take them seriously.

But I have to say that reluctant workers and sceptical trade unions don't create an atmosphere for success.

THE National Health Service in Scotland has come under a great deal of attack.

But the critics have conveniently overlooked some basic facts.

Since 1979-80, spending on the NHS in Scotland has gone UP by around 66 per cent and will total £1719 million in the current financial year.

After allowing for inflation, we're spending seven per cent MORE on the NHS.

- More staff than ever before — [illegible] in 1982 compared with [illegible] in 1979.
- More patients than ever before. Last year the NHS dealt with 5.4 million outpatients and discharged 898,000 inpatients.

The response by readers to the Sunday Mail's campaign showed enormous concern about "weakening" the NHS.

I hope the facts I've given will help to explain the true position.

LAW and order has been one of our prime concerns.

Since 1979 we've given police powers to detain suspects and to search for offensive weapons.

We've banned drinking at football grounds, which has greatly improved conditions.

Now those who kill policemen or prison officers, who commit crimes with firearms or who assault children, must expect to serve long sentences.

I attach great importance to family life and decent values.

By next year I hope we'll have stiffer laws to protect young people against violent, sadistic or "sex" videos.

Finally, just a word about national housekeeping.

There's no shortage of people calling for millions to be spent on this or that, whether by the Government or the local authorities.

Just remember—it's all YOUR money.

It doesn't come out of thin air. It comes out of your pockets and purses.

Whatever else this Government is doing, it's certainly making a tremendous effort to spend as little of YOUR money as it can.

And to make sure that what it does spend is spent wisely.

pf

CB1 TF

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Secretary of State for Social Services

Andrew Turnbull Esq
Private Secretary
10 Downing Street
LONDON
SW1

Dear Andrew, 5 December 1983

STATEMENT ON NHS PHARMACEUTICAL PRICES AND PROFITS

I attach a draft of the statement on NHS pharmaceutical prices and profits which my Secretary of State intends to make on Thursday. Perhaps you and recipients could let me know if you have any comments as soon as possible.

Copies go to Charles Marshall (Lord Privy Seal's Office) John Gieve (Chief Secretary's Office) Johnathan Spencer (Department of Trade and Industry) Judy Roberts (Welsh Office) John Graham (Scottish Office) and Noel Cornick (Northern Ireland Office).

Yours sincerely,
Ellen Roberts
ELLEN ROBERTS
Private Secretary

DRAFT 5.12.83

CONFIDENTIAL

1. I would like to make a statement on the discussion that the Minister of Health and I have been having with representatives of the pharmaceutical industry on the scope for savings in the NHS drugs bill and other matters of mutual concern.

2. Prescription medicines cost the NHS in England about £1,250 million in 1982/83. Drugs account for about 40 per cent of the total cost of the FPS, and about 10 per cent of the cost of the NHS as a whole. The pharmaceutical industry's profits from NHS sales are governed by the non-statutory Pharmaceutical Price Regulation Scheme which was introduced in its present form in 1978. In the words of the published Scheme, it is a key objective that "safe and effective medicines [should be] available on reasonable terms to the NHS, but also that a strong, efficient and profitable pharmaceutical industry" should exist in the UK. The industry's present target profit level was set by the Labour Government in 1978. Like our predecessors we recognise that there is a major and successful industry providing 67,000 jobs and with a net balance of exports over imports of around £600 million a year.

3. However, the present Scheme has run unaltered for over five years, and a review of it was announced earlier this year. After extensive discussion with the industry's represenatives and having taken account of the 10th Report of the PAC published in April, I have decided both to reduce the level of profit from NHS business and the level of sales promotion allowed as an expense under the Scheme.

4. First, under the scheme each pharmaceutical company participating in it is assigned a target rate of profit taking account of "the circumstances of the individual company, the contribution which it makes or is likely to make to the economy, including foreign earnings, investment, employment or research". I have decided that these targets should be reduced by an average of four percentage points which will represent a saving to the NHS in the UK of about £40 million a year. I have also decided that the discretion which my Department allows in certain circumstances when companies exceed their target profit rates should be tightened and related more closely to a company's particular circumstances. Companies will be told what their new targets are very shortly.

Second, the industry spends about £180 million each year on sales promotion. Some, but not all, of this amount is an allowable expense under the PPRS. The UK industry spends proportionately less on Sales promotion than any other comparable country. Nonetheless such promotion is funded largely from NHS sales, and I have concluded that the allowable level should be reduced. I propose, first, that companies should be asked to repay to the Department a sum equivalent to any sales promotion expenditure which exceeds the level allowed under the scheme; and, second, that the industry limit should be reduced from the present level of 10 per cent to 9 per cent in 1985/86. We estimate that when fully implemented these measures should reduce actual expenditure on Sales promotion by 25 per cent but we will review this area in 1985/86 to see if further reduction can be made.

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7. Among the other issues discussed with the industry is the problem of parallel importing of medicines - that is to say medicines purchased at a relatively low price in one country for sale in another in competition with identical or virtually identical products already marketed there. At present, an exemption order under the Medicines Act is being used by parallel importers, in a way not envisaged when the order was made, to bring into Britain substantial quantities of medicines without a licence. Clearly there are potential health hazards if a drug has not been properly manufactured or stored, or if labels are in a foreign language, or if there is difficulty in tracing a batch of drugs found to be faulty. We are not aware of any actual injury to patients but I propose to guard against that possibility. I am statutorily required to consult on these matters, and my Department will therefore shortly be issuing a consultative document on proposals which will ensure that medicines parallel imported for general dispensing must be licensed under the Medicines Act, either in the ordinary way, or in the case of medicines also licensed in the European Community, through a modified licence to cover such safety matters as storage, labelling and tracing.

8. There remains the question of generic substitution which I have also been considering in the context of the PPRS review, as announced earlier this year. The Greenfield Committee proposed that a pharmacist should substitute an equivalent generic preparation for proprietary medicine unless the prescribing doctor had specifically indicated that this should not be done. The Committee acknowledged that they had not taken account of the wider implications, for example, on the pharmaceutical industry, that their recommendation might have. While consultation on the Greenfield report earlier this year showed opinion to be divided on this recommendation - which was only one of 14 - it is clear that general practitioners in particular found the procedure involved in the Greenfield recommendation unacceptable, and I do not propose to proceed with it. I do, however, intend to start a new campaign to encourage generic prescribing by doctors. As to the other recommendations of the Greenfield Committee, I have already announced my acceptance of these or referred them to the appropriate educational bodies.

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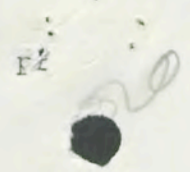

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STRICTLY PERSONAL

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe KCB CVO

Robin Butler, Esq.,
No. 10 Downing Street,
London SW1

2 December, 1983

Dear Robin.

NHS MANAGEMENT ENQUIRY

It occurs to me that you might find it helpful to have the enclosed copy of a letter and enclosures which I have today sent to Peter Middleton and Robert Armstrong about the re-structuring of DHSS to implement Griffiths in the NHS.

As soon as I have the necessary clearance from the Treasury and MPO, Mr. Fowler will want to report progress and next steps to the Prime Minister. As you will see from the papers, however, we are now embarked upon an urgent and substantial programme along the path that has been firmly laid down by my Secretary of State.

Yours ever.

Ken.

STRICTLY PERSONAL

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe KCB CVO

Peter Middleton, Esq., CB,
HM Treasury,
London SW1

2 December, 1983

My dear Peter.

IMPLEMENTATION OF GRIFFITHS REPORT ON NHS MANAGEMENT

My Secretary of State, with his Ministerial colleagues concerned, has now been able to consider the application of the Griffiths Report to the Department, and its implementation.

Mr. Fowler has already announced, with the Prime Minister's and Chief Secretary's support, that the Government accepts the broad thrust of Griffiths and that he is setting up a Health Services Supervisory Board in the Department, as recommended.

... We have now got down to the detailed consideration of implementation in the Department. I enclose a copy of my notes of a presentation to Ministers earlier this week, together with a record of the discussion and the conclusions reached by Ministers. I should be grateful if circulation of these papers could be confined to the necessary minimum of people, since the jobs and careers of many people in this Department may be affected and the proposals will need to be carefully presented here in due course.

I draw your attention especially to what is recorded in the papers about:

a) the importance of speedy and effective implementation;

b) the constraints within which change has to be effected (in particular no erosion of Ministerial responsibility and no increase in Wardale, i.e Open Structure posts); and

c) the timetabled programme which has to be achieved if we are to lead the NHS into implementation of Griffiths

Contd.....

MANAGEMENT IN CONFIDENCE

from the start of the next financial year.

We are now setting up a project team to work out in detail for Ministers the nucleus of the NHS management group in the Department as defined in the presentation, so that this can be in place early in the New Year: and above all, so that RHA Chairmen and the NHS can be told in January that this will be in place and will be the new determinant of their relationship with the Department from 1 April 1984.

The immediate purpose of this letter is to seek your and Robert Armstrong's approval in principle for the recruitment from outside the Department of a Chairman of the NHS Management Board. We believe this should be at Second Permanent Secretary level but we shall have to be flexible about salary especially if it is a short-term appointment. This post would, of course, be within the Departmental Open Structure and would, in my judgement be in substitution for an existing administrative Deputy Secretary post (of which there are 3) in the HPSS area of the Department. I envisage that the Chairman would be supported by one of the remaining administrative Deputy Secretary posts, perhaps as Deputy Chairman of the Management Board with the Board itself constituted at Under Secretary level. The third administrative Deputy Secretary post would deal with the other Health and Personal Social Services function outside the NHS Management Group and report to me. I propose no change (nor would my Secretary of State want it) in the responsibilities of the Principal Establishments Officer and Principal Finance Officer who would report to me as at present.

For the purpose of recruiting the Chairman of the Board we shall need to have an agreed job description and the services of head-hunters. Work is in hand on this - Norman Clarke is discussing with Richard Wilding and he has already sent him an outline job description. We shall need to agree a draft job description in sufficient detail (after approval by my Secretary of State) for discussion with the head-hunters. May we have your agreement to the use of head-hunters? I hope we can also agree an outline job description next week.

I am copying this letter and enclosure to Robert Armstrong, whose agreement I also seek.

My Secretary of State will want to report progress to the Prime Minister as soon as possible, so I should be grateful for early replies.

Yours ever

Ken.

MANAGEMENT - IN CONFIDENCE

MEETING: 29 NOVEMBER 1983

Present: The Secretary of State
Mr Kenneth Clarke (Minister for Health)
Mr John Patten (Parliamentary Under Secretary of State)
Sir Kenneth Stowe
Sir Henry Yellowlees
Sir Geoffrey Otton
Dr Acheson
Mr N E Clarke
Mr Hulme

Subject: Implementation of the Griffiths Report in DHSS

1. Sir Kenneth Stowe referred back to the meeting on 11 November when the Secretary of State had asked how the general manager and the personnel director would be selected and appointed. Sir Kenneth had outlined a series of steps which would have to be undertaken beginning with an analysis of current departmental functions and how they might be restructured. That analysis had been undertaken over the last two weeks and the working papers produced were now before Ministers. The purpose of the meeting was to bring out the issues which have arisen in this work and seek guidance on the direction and timetable for taking it forward.

2. The issues were presented as follows:

Background

(1) The Problem identified in the Griffiths report, as seen by the Permanent Secretary and as reflected in the views of Parliament and of the Health Service had,as the common thread,the absence of a full-time senior focus in the Department for the management of the National Health Service.

(2) The Machinery for Control in the Department showed a sharp contrast between the direct management line for social security operations and that of the health service where there was a clear line of authority from the Secretary of State to the health authorities but a whole series of "dotted line" relationships between them and their officers, the Department and professional bodies. Action to tackle the problems arising was constrained by the statutory provisions for health authorities'functions and the importance of professional bodies who have much control and influence over the way in which treatment to patients isprovided

(3) The Management Functions identified in the Griffiths report as required to be done centrally were widely diffused within the organisation of the Department.

(4) The Proportion of Staff involved at Headquarters in NHS management functions varied depending on grade so all of the 18 officials at Under Secretary and above in HPSS administrative divisions had some responsibility for NHS management functions. Below Principal the proportion dropped to about 35%.

(5) The Traffic between the Department and the NHS was both heavy and spread amongst a large number of Divisions. The circulars which went to all authorities numbered 590 last year though this was a considerable reduction on 1978/79 when there were 1,200. The less formal traffic was much heavier for example there were an estimated 50,000 incoming calls a year to P2 Division.

Prior Considerations to Action

(6) The Objectives were to respond positively by setting up a clear focus for the management role of the centre with a visible initial impact early in 1984 and a measurable response by March 1985 whilst maintaining the ability to develop and co-ordinate wider health policies. One aspect of the measurable response by March 1985 would be the impact on the pattern and quantity of the traffic between the Department and the NHS.

(7) The Main Constraints were that Ministerial, Regional and District accountability remain unchanged, the numbers of DHSS staff including top management could not increase and the costs of any changes should be kept low. It had been made clear both in the report and accompanying statements that there was no change in the statutory framework but there were those who looked for a separate corporation to run the NHS outside the Department.

(8) Some Guidelines which had emerged from the discussions on implementation were that the general management function should not be overburdened with functions in the initial period; existing sources of advice in support of the Secretary of State's wider functions should not be duplicated; there should be a stronger NHS management input into policy making; the division of functions between the management box and elsewhere should be flexible; and officials who report to the general manager but are part of specialist or professional disciplines should continue to look to their specialist/professional head for professional advice.

Proposals for Action

(9) The Proposal was for Early Establishment of a 'Nucleus' of a stronger management focus. The alternative was to spend more time on a comprehensive plan.

(10) The Nucleus would constitute at the minimum the functions of Regional Liaison Division, Finance Division A and Personnel Division 2, together with professional support, under a unified management.

(11) The Identification of the Nucleus from existing commands would be a substantial task because as demonstrated by the analyses of current functions the responsibilities for NHS management are embedded in Divisions with separate or wider responsibilities. The task was considerably helped however through the existence of the second round of Divisional Management Accounts.

Timetable

(12) The Establishment of a Nucleus to achieve a visible impact by the Spring of 1984 ie to fit in with the timetable for NHS changes would require a crash programme. This would only be justified if Ministers agreed that it was desirable to make progress now whilst taking forward the action required to recruit and appoint the general manager.

(13) The Alternative Approach was to concentrate on defining the role of the general manager, find and appoint the right candidate and only then proceed with the necessary changes within the Department under the direction of the general manager.

Summary

(14) The Programme of Work for the Department and the NHS was strenuous whichever path was taken. The hypothesis put forward was that the prompt establishment of a nucleus of the stronger management focus within the Department was the most practicable way of securing progress but no alternatives had been pre-empted or closed by the work undertaken so far. This reflected the agreement at the previous meeting that Ministers should see the exploratory work and decide the direction to be taken.

3. The Secretary of State said he was grateful for the clear presentation and all the work which must have preceded it. He would like to concentrate intially on the question of whether work should start at once on the initial restructuring of Departmental activity. His strong,inclination was to take that course whilst pressing ahead as quickly as possible with the action required to allow the early selection and appointment of a general manager. It was vital to maintain the momentum of work in both the Department and the NHS. Mr K Clarke and Mr Patten supported the Secretary of State's approach whilst noting that the work undertaken in advance of the appointment of a general manager must not pre-empt the general manager's scope and authority to make changes.

4. The main points then covered in discussion were:

1. The Status of a NHS Management Board. The question was raised as to whether the intention was to create a board which appeared as near as possible to a separate corporation within the current statutory framework. The Secretary of State said that any attempt to present the board as a 'corporation in embryo' would be a fiction and would quickly be identified as such. The objective was to regroup the Department's activities to establish a single clear focus on general management issues in the NHS, accountability, performance review and so on.

2. The Size of the Nucleus. It was agreed that the nucleus should be sufficient to provide a general manager on appointment with a secure working base without limiting his role and leaving flexibility for further changes.

3. Accounting Officer Responsibilities. Sir Kenneth Stowe said that he had an open mind on whether or not the Accounting Officer responsibility for hospital and community health services expenditure should be devolved to the general manager. There were obvious advantages in that course but there were possible disadvantages to be considered too from the general manager's point of view. No final decisions could be reached until the responsibilities of the general manager were clearly defined and could be related to specific votes.

4. Pay and Grading of the General Manager. The Secretary of State said that the terms available for this post and that of the personnel director must allow the option of appointing people of calibre from outside the public service on fixed renewable contract. Officials reported that initial discussions with central Departments had not indicated any insoluble problems. The approach taken with the appointment of the Director of the Operational Strategy provided a helpful model.

5. The Role of Professional Groups. Sir Henry Yellowlees and Dr Acheson drew attention to the potential difficulties of any regrouping of functions for professional groups. Their numbers were relatively small yet a key part of their activity was the capacity to provide immediate authoritative advice to Ministers on professional and wider health issues. It was agreed that the Secretary of State's requirements could only be met by ensuring that he received authoritative professional advice from a single source. The Minister for Health said that the arrangements in the Department for health professional staffs support of the general management function needed to be considered carefully as they would be a signal to how such arrangements should work in the NHS. It was important that aspects of their work such as manpower planning were firmly related to the general management function.

Action

5. It was agreed that action should be put in hand immediately as follows:

1) A small team of officials should be put full-time onto the programme of implementation working to the Permanent Secretary (Mr N E Clarke).

2) Sir Kenneth Stowe to write by 9 December to Sir Robert Armstrong setting out the outline job description of the proposed general manager and seeking approval for arrangements for selection and recruitment.

3) Detailed proposals should be put to Mr Patten and Mr Clarke on the content of the nucleus of a 'management box' and its establishment at a date no later than mid February next year for clearance and submission to the Secretary of State before Christmas (Mr N E Clarke).

2 December 1983

D B
PSU

cc Those present
Members of TOTO

IMPLICATIONS OF THE GRIFFITHS REPORT FOR DHSS HQ

PRESENTATION TO THE SECRETARY OF STATE

November 1983

PSU

THE PROBLEM

a) <u>as stated by Griffiths</u>

"We are convinced that you will need to be supported at the centre, by a small, strong, professional management group, able to devote considerable time to running the NHS through a General Manager seen to be vested with your authority and to be acting on your behalf and as your right-hand man, in ensuring that the statutorily appointed authorities manage the NHS effectively. This appointment would leave undisturbed your clear responsibility for overall policy direction and for the handling of the public and political sensitivities of the service. This will require major changes in the stance and style of management at the centre and in the public and parliamentary requirements of the NHS management process." [Background to Recommendations, paras. 10-12]

"The units and the authorities are being swamped with directives without being given direction."

b) <u>As seen by the Permanent Secretary</u>

Responsibility for the various management functions in relation to the NHS is scattered over many parts of the Department, with no individual below the Permanent Secretary having responsibility for the whole. Moreover, among those having the responsibility, no-one - certainly not the Permanent Secretary - works full time on all those management functions. [See Chart I below]

c) <u>As seen by Parliament</u>

Uncertain whether the Department has the skills, motivation and direction to ensure good management of and in the NHS.

d) <u>As seen by the NHS</u>

Need for greater clarity about priorities, stronger leadership on implementation, and closer partnership on setting management objectives.

MACHINERY OF CONTROL

CHART I

NHS "MANAGEMENT" FUNCTIONS CARRIED OUT IN DHSS AND CENTRAL SHAs ETC

1. General management

organisation; structure, appointments, accountability; monitoring performance; information.

2. Personnel

pay, terms and conditions of service; industrial relations; training; career development; manpower planning and control.

3. Finance

allocation; funding; monitoring outgo against cash limits; budgeting; financial management systems.

4. Service Planning

planning guidelines; translation of policies and priorities into service plans; monitoring implementation; areas subject to close central control (eg private practice).

5. Procurement

purchasing goods and equipment; quality control.

6. Works and Estate Management

large capital schemes; standards for buildings,maintenance etc; disposal of surplus land.

7. Scientific and High Technology Management

computers; information technology; supra-regional specialties.

Chart II shows where these functions fit into the present organisation.

CHART II

Secretary of State

Other Ministers

Permanent Secretary

Chief Medical Officer

Second Permanent Secretary

MEDICAL

PERSONAL SOCIAL SERVICES

HEALTH

COMMON SERVICES

SOCIAL SECURITY

Social Security Operations

Social Security Policy

Chief Medical Adviser

Director of Social Work Service

HPSS Services Development Group

Health Regional Group and Supplies

Works Group

NHS Pay and Personnel Group and Medicines Division

PFO Finance & Analysis

PEO Personnel & Admin

Information Division

Solicitor

Chief Scientist

Medical aspects of Public Health, Supplies and Medicines

Medical aspects of Hospital Services, Manpower and Prevention

Medical aspects of Planning and Client Group Services

Nursing

Dental

Pharmacists

Catering & Dietetics

Domestic Service Management

FACTS

Manpower involved wholly or in-part in NHS "management" functions

under secretaries and above:	18
assistant secretaries & S/Prins:	around 30
principals:	between 70 and 80
staff:	around 500
Total	over 600

NB: i) admin only
ii) rough guide only

Some Measures of traffic between NHS and Department

Formal, written:	590	"dear administrator" letters, health circulars, hazard notices etc in year ending April 1983.

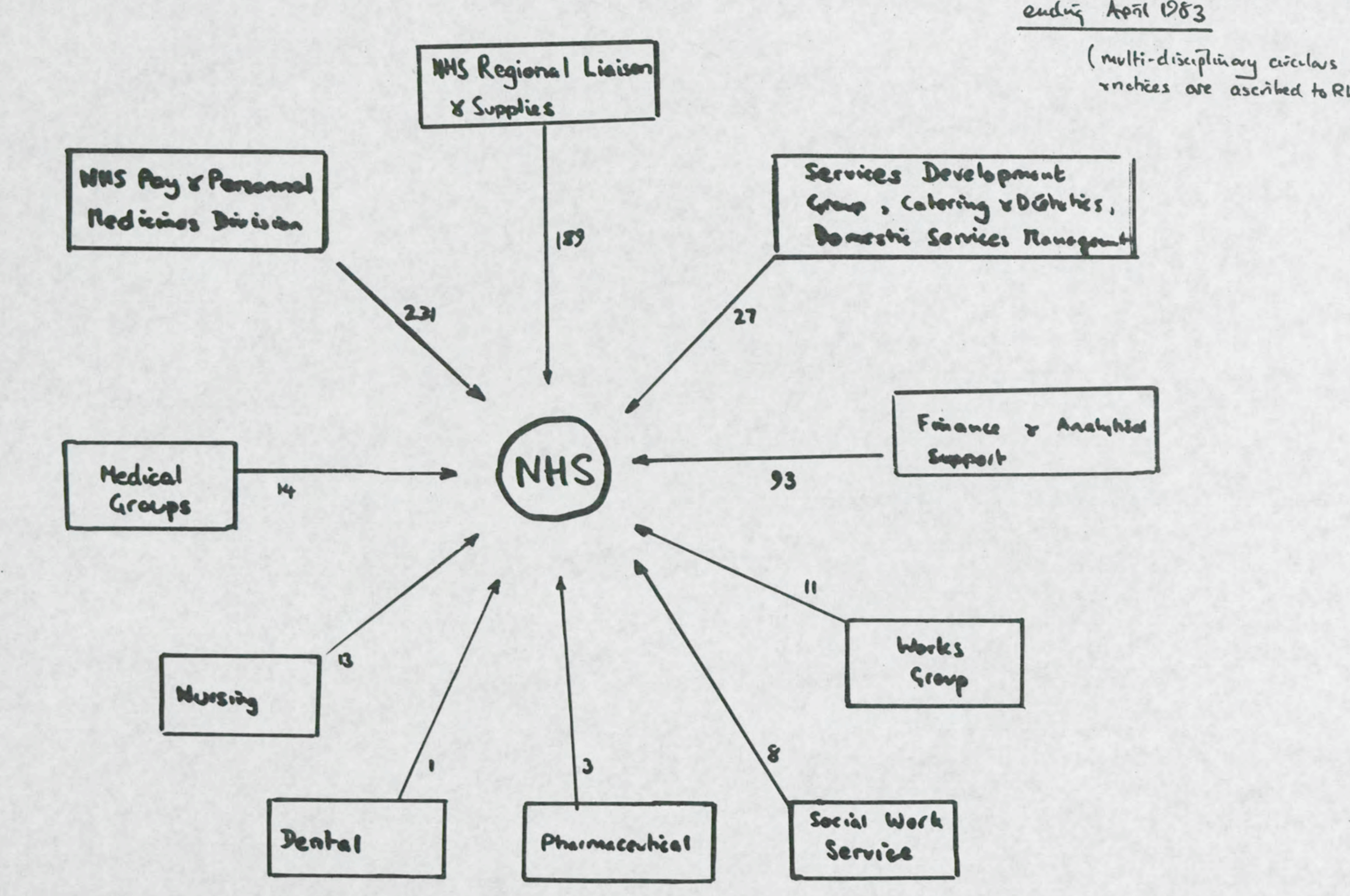
This covers only letters etc sent to all health authorities. Chart III shows the number of those originating from each group, which shows how diffuse DHSS seems to NHS.

Informal, written: (annual)	3,000	incoming letters to P1 Divisions on hospital doctors' and dentists' pay
	7,000	incoming letters to P2 Division on personnel work.
Face to Face: (annual)	14	regional reviews and 9 SHA reviews.
	6	meetings with regional chairmen.
	about 50	unidisicplinary meeting with regional officers from 15 different disciplines.
	135	Whitley Council meetings in P2 Division alone.
Telephone: (annual)	10,000	incoming calls to P1 Division on hospital doctors' and dentists' pay.
	50,000	incoming calls to P2 Division on personnel work.

CHART III

Breakdown of the 590 Formal communications to the NHS in the year ending April 1983

(multi-disciplinary circulars & notices are ascribed to RL)



PRIOR CONSIDERATIONS

1. <u>Objectives</u>

a) to respond positively to the problem by setting up a clear focus to begin action on what Griffiths saw as the general management role of the centre:

- implementation of policies
- leadership for management in the NHS
- control of performance
- consistency and drive over the long-term.

b) to give initial effect to our response early in 1984 and to achieve measurable response by March 1985.

c) to have some immediate impact, which is visible to the NHS, to Parliament and to the Public.

d) to maintain ability to develop and co-ordinate "wider health" policies.

2. <u>Constraints</u>

a) Ministerial, Regional and District accountability and authority to be unchanged ie within current statutory framework; no corporate status.

b) no increase in DHSS manpower, and within that no increase in posts at under-secretary level and above.

c) low cost.

3. Guidelines

Five broad principles which have emerged from Departmental discussion

a) When in doubt, leave out

In the initial period, the management box is likely to work best if it is not over-burdened with functions which are not essential to its task. Eg: negotiations with opticians, dentists, pharmacists.

b) No duplication

The management box should not duplicate sources of advice or channels of contact which exist to support the Secretary of State in his wider health functions (eg consultation with the Joint Consultants' Committee) and to support him in his Cabinet and Parliamentary activities.

c) Stronger management input into policy making

The Secretary of State's responsibilities for development of health policy (eg smoking), are wider than those of the management box; but the management box should have a strong influence on policy making on order to reflect the NHS "management" viewpoint. EG: switch to community care of the mentally ill and mentally handicapped.

d) Flexibility

Issues may be reallocated into or out of the management box as emphases change over time as between Secretary of State's policy development and management implementation. Eg: primary care (cf pensions).

e) Professional and functional links

Members of the management box should be accountable to the NHS general manager; those who are also part of specialist or professional disciplines should continue to look to their professional head for professional guidance.

ACTION: PHASE 1

Aim: To identify by January 1984 and have effective by March 1984 the nucleus of the management box.

The initial moves must create for the HCHS at least a nucleus under unified management comprising three components, including appropriate professional support:

1. General management for HCHS
   - organisation, structure, appointments
   - communications, information
   - accountability, performance review

2. Personnel for HCHS
   - pay, terms and conditions of service
   - industrial relations, Whitley
   - manpower planning and control

3. Resources and Planning for HCHS
   - financial allocation, funding, monitoring outgo against cash limits.
   - budgeting,financial management systems.

A first analysis of how these components might be constructed from the existing divisions is being undertaken. Chart IV illustrates this process for Finance Division A. The five administrative groups, the medical groups and the nursing group have all beeen analysed in this way and an initial summary prepared for each of them.

CHART IV

ILLUSTRATIVE ANALYSIS OF FINANCE DIVISION 'A'

Responsibilities as shown in DMA

1. Assessment of future needs for resources and cash, taking account of Ministers' policies and priorities and external factors, advice and support to Ministers on public expenditure negotiations.

2. Translation of agreed public expenditure into financial allocations to businesses.

3. Advice to Ministers on sources of finance.

4. Monitoring trends in use of resources, outputs and productivity for HPSS.

5. Overview of longer term costs of service development policies for HPSS.

6. Preparation of evidence to Social Services Committee on financial matters; co-ordination of Department's dealings with this and other Select Committees.

7. Advice to policy branches in SDG, P Group (excluding FPS), Works Group and RL on financial aspects of policy and programme review, including costing, evaluations and availability of resources.

8. Financial control of health authorities, including funding, banking arrangements, monitoring of in-year expenditure to keep within cash limits.

9. With RL colleagues, advice to Ministers on health authority revenue and capital allocations, short term planning guidelines, and long-term resource assumptions. Preparation of HCHS public expenditure forecasts, Parliamentary estimates, and cash limits.

10. Development of better financial management in health authorities, including budgeting, finance aspects of planning and performance review, option appraisal, training and information.

11. Advice to Ministers on financial aspects of Regional reviews, and finance input to SHA reviews.

12. Financial control of, and development of better financial management of fringe bodies and other centrally funded services whose budget holders are in SDG and P Group (excluding FPS), including the UK CC for nursing. NHS training authority, Central Blood Laboratories Authority, NRPB Special Hospitalsgrants to voluntary bodies and welfare milk.

13. Scrutiny and processing of claims for free welfare milk to day nurseries.

14. Advice to Ministers on LA PSS financial matters, including public expenditure, GRE's for PSS, and rate support grant. Chairmanship of PSS Expenditure Steering Grou

15. Casework, PO cases, PQs and briefing for Ministers, PAC, Social Services Committee.

16. Management of FA including FMI implications.

[solid box] = wholly in management box

[dashed box] = partly in management box

IMPLEMENTATION

Part I - DHSS

1. Put a small team of officials full-time onto this work

- NOW

2. Define more clearly the three components of the nucleus and settle an operative date [Feb/March] for their establishment

- BY 2 DECEMBER 1983

3. Seek Treasury/MPO authority to draw up, in consultation with head-hunters, job descriptions for the general manager and personnel director and then recruit

- BY 9 DECEMBER 1983

4. Resolve unified management and interim reporting arrangements for nucleus, and settle provisional communication lines with NHS (consulting NHS as necessary) and with rest of DHSS

- BY END DECEMBER 1983

5. Discuss with RHA Chairmen emerging picture

- 18 JANUARY 1984

6. Set up nucleus, including accommodation changes, and bring into operation.

- FEB/MARCH 1984

7. Plan second phase - ie completion under the direction of the supervisory board of the complete NHS/management board structure.

IMPLEMENTATION

Part II - NHS

1. Draft guidance on general management function and involvement of clinicians in management in the light of comments received on the Secretary of State's letter of 18 November

\- DECEMBER 1983

2. Complete consultation process - 9 JANUARY 1984

3. Discuss results of consultation and guidance prepared with RHA chairmen

\- 18 JANUARY 1984

4. Issue initial guidance on general management function, including timetable for appointments, DHSS management arrangements and future channels of communication

\- END FEBRUARY 1984

5. Identify general managers in regions, districts and units

\- MARCH ONWARDS

6. Issue further guidance on detailed personnel issues arising from general manager role

\- END MARCH

7. Extension of accountability reviews to units

\- APRIL ONWARDS

8. Each authority to set in hand a programme of work to:

\- APRIL ONWARDS

a. consider organisation of management structure, clarification of roles of chief officers, and of authority members

b. review and reduce need for functional management structures

c. initiate cost improvement programmes

d. follow guidance on involvement of clinicians

e. establish unit budget

f. clarify district financial management processes

g. ascertain acceptability of service output; use as a performance measure.

9. Priority tasks for the NHS general manager and the personnel director on appointments will be:

a. review levels of decision taking (GM)

b. review all consultation arrangements (GM)

c. ensure development of a property function (GM)

d. develope streamlined procedures for major capital schemes (GM)

e. ensure "Review of Works Function" gives priority to requirements of management box (GM)

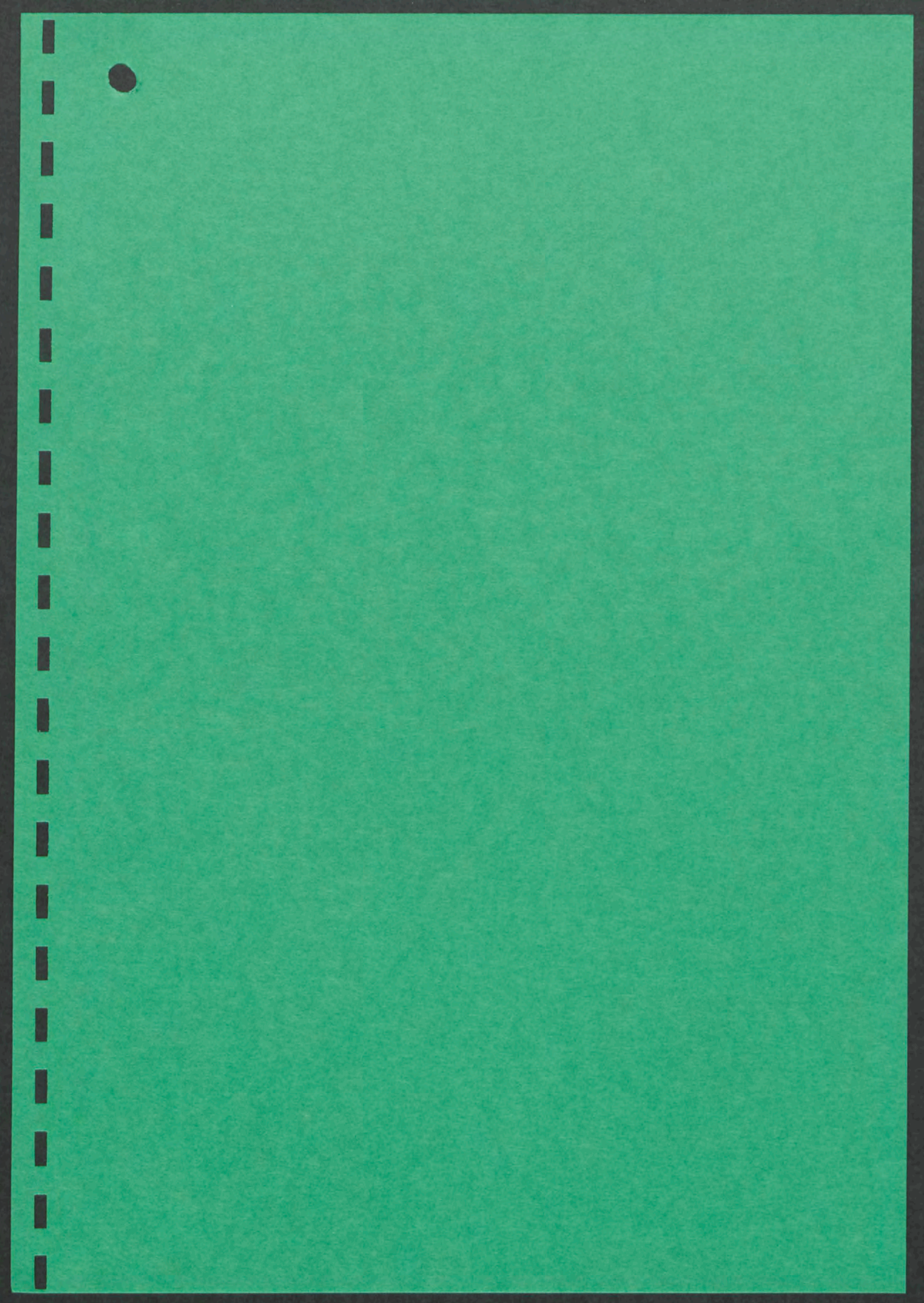
f. review implications of remuneration system for incentives (PD)

g. assess management training (PD)

h. review of personnel functions and conditions of service (PD)

i. study nursing manpower levels (PD)

j. study of other manpower levels (PD).



ALLOCATION OF FUNCTIONS: THE FINANCE GROUP

Summary

At present the Finance Group has a manpower allocation of 1398.5. Of these 451.5 are in the 2 health divisions FA and FB, 356, are in three specialist groups - Statistics and Research (SR), Economic Advice (EAO), and Operational Research (ORS) - providing services to the whole Department, and 591 are in the division, FC, which deals with social security Finance and the cost of DHSS Administration.

The initial analysis was that FC and the specialist divisions providing common services, SR, EAO and ORS would not be within the remit of the NHS Management Board but might provide some services to it as they do to Headquarters generally. The functions of FA and FB divided roughly 1:3 into functions which must be within the Management Board's remit and those which could fall outside. The allocation is shown in the attached chart (the precise balance depends on the decisions on the issues below).

Key issues are:

- The overall HPSS financial policy and planning and handling of PESC is shown outside the Management Board.

- Financing of the FPS is shown outside the Management Board although general medical services is within it under the proposed allocation of Personnel functions.

- The audit responsibilities of FB4 are shown outside the Management Board and they include the support for the Accounting Officer in responding to the CAG and PAC. This may need to be reconsidered in the light of final decisions on Accounting Officer responsibilities in a new structure and in the balance of workload between Divisions.

- Finance branches liaison duties with HQ policy branches ie financial control, budgetting, monitoring etc are assumed to continue outside the Management Board; their extent depending on the extent of policy work to which they relate.

- The chart assumes a strengthened capacity for improving financial management systems in the NHS - an objective which was stressed by Griffiths and would stand whatever the allocation of functions.

EXISTING FUNCTIONS BY DIVISION

Finance Division A	Possible reallocation of functions
- PES negotiations and procedures for HPSS, analysis and presentation of trends in use of resources, consideration of longer term expenditure needs and sources of finance.	- outside NHS Management Board
- Funding and cash limit control of health authority expenditure; regional allocations & financial planning guidelines; financial management in health authorities, finance aspects of regional reviews, finance liaison work with various policy branches.	- inside NHS Management Board with additional emphasis on financial management systems
- Local authority personal social services; RSG; grants to voluntary bodies; welfare foods; finance liaison.	- outside NHS Management Board

Finance Division B	Possible reallocation of functions
- Central accounting for HPSS votes; NHS accounts and costing returns; budgets of centrally financed services (HPSS's finance liaison work).	- outside NHS Management Board except for NHS accounts and costing returns and centrally financed services which are within the Board.
- Family Practitioner Services and related bodies (eg Dental Estimates Board, PPA, Medical practices Committee; hospital and community health doctors and dentists (costs) finance liaison work.	- outside NHS Management Board except for finance work on hospital and community health doctors and dentists; general medical practitioners; and FPCs
- Accountancy and audit for DHSS HQ; statutory audit for certain non-Departmental public bodies; external audit of NHS; training and support for Accounting Officer.	- outside NHS Management Board subject to decisions on accounting officer responsibilities

ALLOCATION OF FUNCTIONS: THE REGIONAL GROUP

Summary

At present the Regional Group has a manpower allocation of 518. Of these, 94 are employed in Regional Liaison Division, 413 in Supply Division (this figure does not include 972 administrative and technical staff stationed at 30 ALAC and other centres), and 6 in the Health Services Information Branch.

An allocation of functions for these two Divisions and the HSIB is shown in the attached chart. Key issues are.

- The Management Board will have to strengthen arrangements for securing implementation and control of Ministers' objectives and policies. This role is not fully reflected in the current functions of Regional Liaison Division although the programme of regional reviews etc has become and increasingly important part of their work. Whilst therefore all the functions of the Divisions are shown within the Management Board these will need to be reviewe by the Board and modified as necessary to reflect new thinking about the way the health service should be managed.

- The exact position of the Supply Council within the aegis of the Management Board remains to be decided. How that question is decided will also influence how Supply Division's functions are treated.

- It for consideration whether services - such as the artificial limb and artificial eye services - which are run and financed directly by the Department should come within the scope of the NHS Management Board. A review of the management of ALACs is pending.

- All the functions of those branches of Supply Division which are concerned with support for health industry and exports are shown outside the Management Board although their work is clearly linked with procurement.

Existing functions by Division	Possible reallocation of functions
1. Regional Liaison Division	
- Liaison between the NHS and the Department; eg securing implementation of Ministers' service policies; advising Divisions on NHS implications of policies; arranging formal communications; support for Ministers in Parliamentary duties.	- inside NHS Management Board
- Advising on issues requiring central decision; eg resource allocations; approval of major capital schemes; hospital closures.	- inside NHS Management Board
- Devising and operating systems for securing, and measuring, effective management; eg accountability reviews and examination of authorities plans; management costs; performance indicators; manpower controls.	- inside NHS Management Board
2. Health Services Information Branch	
- Co-ordination of response to, and advice to Ministers on, reports of Korner Committee on Health Services Information; co-ordination of action arising from Ministers' decisions.	- inside NHS Management Board
3. Supply	
- Staff support to the Supply Council	- inside NHS Management Board
- Procurement of / contracting for: vaccines, hearing aids and environmental controls, aids and appliances for NHS.	- inside NHS Management Board (transfer of some contracts to supply Council under discussion)
- Running Artificial Limb and Artifical Eye services, the procurement and maintenance of wheelchairs, trikes and cars, contracts for surgical appliances and administering Heywood Central store.	- centrally financed services: allocation to be considered

- Promoting strength and export performance of domestic health-care and pharmaceutical industries	- <u>outside</u> NHS Management Board
- Operation and policy on the Pharmaceutical Price Regulation Scheme	- <u>outside</u> NHS Management Board
- Research on / procurement of medical equipment and supplies of adequate standards of safety, efficiency, and economy; includes administrative responsibility for Bioengineering Centre	- <u>outside</u> NHS Management Board

ALLOCATION OF FUNCTIONS: THE PERSONNEL GROUP

Summary

At present the Personnel Group has a manpower allocation of 379. Of them, 260 are in the 3 Personnel Divisions, concerned with the full range of personnel functions in respect of staff groups in the NHS, and 119 are in Medicines Divisions, which deals with the operation of, and policy on, the legislation governing the licensing and control of medicines.

The initial analysis was that Medicines Division would not be within the remit of the NHS Management Board. An allocation of the functions of the remainder of the Personnel Group as between those within the remit of the Board and those outside is attached in chart form. Key issues are:

- Advising Ministers on pay. The strengthened personnel function within the Management Board must play a major role. But NHS pay issues including evidence to Review Bodies is only one aspect, though a very important one, of the overall strategy for public sector pay and public expenditure. It is difficult to judge how much of the pay policy work should be within or outside the Management Board.

- Medical manpower and training. Again this is an important part of the personnel function in the Griffiths structure. The proposed allocation puts linked areas such as PG Medical Education within the Management Board as well but this might be left within whatever medical structure is outside the Board.

- The Family Practitioner Services (FPS) are shown as outside the Management Board, with the exceptions of the General Medical Services (GMS) and of the management of Family Practitioner Committees (FPCs). The essential place of GMS in the integrated delivery of health care argues for their inclusion. This and the advantage of having the pay of all doctors within the same structure might be considered to outweigh the disadvantage of splitting the General Medical Practitioners (GMPs) from other FPS professions (ie dentists, pharmacists, opticians). Although much of FPC's work is routine administration of contracts, they provide a mechanism for achieving drive and direction in the GMS towards integrated health care. This allocation has, however, to be judged against the disadvantage of separating FPCs from the main responsibility for the FPS.

- The community dental service is shown as inside the Management Board's remit. The question arises, however, as to whether it is operationally viable to separate this aspect of dental services from the general dental services, which are shown as outside the Board.

- The arguments on the list, and particularly the second and third issues, are very evenly balanced, and no solution is wholly satisfactory. Some of the decisions should be taken in conjunction with decisions about the arrangements for handling the work of the professional divisions.

Existing functions by Division	Possible reallocation of functions
P1 Division	Inside except possibly general evidence to the Review Body.
Support for Doctors and Dentists Review Body, implementation of reports, negotiations on terms of service for all doctors and hospital dentists and administration of pay systems.	
NHS Superannuation	Outside NHS Management Board
General policy on FPCs including expenditure/manpower forecasting and control, management and administration of FPCs and related policy issues.	Inside NHS Management Board
Disciplinary appeals and representations	Inside NHS Management Board
Medical manpower planning including career structure, improvements in General Medical Services, liaison with UGC, community medicine and overseas doctors.	Inside NHS Management Board
PG medical education vocational training, GP training.	Inside NHS Management Board
Other NHS Training	Inside NHS Management Board
GMC/EC Medical Directives	Outside NHS Management Board
P2 Division	
Pay policy: advising on and implementing pay policies in the NHS.	Inside NHS Management Board (except for general pay policy issues: see summary)
Personnel and industrial relations: advising on and implementing policies.	Inside NHS Management Board
NHS Whitley: improvement of system; servicing and representing Ministers on Management Sides; exercising statutory powers of approval of agreements.	Inside NHS Management Board
Personnel liaison work with policy branches.	Inside NHS Management Board
Training grants in paramedical professions.	Inside NHS Management Board

Existing functions by Division	Possible reallocation of functions
P3 Division	
Family Practitioner Services: functions in respect of general dental practitioners, opticians and retail pharmacists relating to:	
- providing and developing an acceptable service	Outside NHS Management Board
- negotiating remuneration	Outside NHS Management Board (but see summary)
- terms and conditions of service	Outside NHS Management Board
- fixing charge structure and levels	Outside NHS Management Board
- liaison with professional bodies over legislative framework (registration, education, discipline)	Outside NHS Management Board
- EEC questions	Outside NHS Management Board
DEB, PPA, Rural Dispensing Committee	Outside NHS Management Board
Other dental questions: community dental services, manpower planning, post-graduate education.	Inside NHS Management Board
Nurses, midwives and health visitors: pay, manpower planning, agency nurses, education and training.	Inside NHS Management Board (but see summary for pay issue)

ALLOCATION OF FUNCTIONS: THE SERVICE DEVELOPMENT GROUP

Summary

The Service Development Group (administrative Group) has a manpower allocation of 296, in four Divisions: Children, Community Services, Health Services, Mental Health. The titles are approximations eg health education (including adults) is covered in Children's Division. Working closely with NHS are the small Catering and Domestic Services (professional) Branches[16 staff].

Most tasks require joint work with staff in Medical, Nursing and Social Work Service Divisions. Many tasks - but not all - involve policy appraisals running across PSS as well as NHS and, especially where tasks are supportive of work in which professional aspects predominate (eg control of infectious disease outbreaks), look to links with the professional bodies, universities etc. The initial analysis reflects the necessity of maintaining coherent staff support, from administrative and professional divisions, to the Secretary of State in his responsibility for the wider health and social policies, and for local authority social services. However it aims to place within the Management Board functions which are predominantly about implementation of Ministerial policy objectives through NHS management. The allocation is shown in the attached chart. (The precise balance depends on decisions on issues below).

Key issues are:-

(1) The allocation follows the broad principle that work on the formulation and review of strategic objectives - for decision by Ministers, advised as appropriate by the Supervisory Board - would be done outside the Management Board, taking full account of, amongst other factors, NHS management requirements; and that the implementation of strategic objectives would be for the Management Board (in so far as the NHS was concerned). Thus, general social and health policies for the client groups (eg the vulnerable elderly) would be articulated outside the Management Board but the mechanisms for implementation, eg securing reports of NHS performance against objectives and the review process, would be inside the Management Board.

(2) In deciding the initial allocation an element of pragmatism is also necessary, to reflect the current balance between policy and management objectives. Thus primary care, which is coordinated in SDG and of which a major review is proposed for 1984, is shown outside the Management Board but would be closely coordinated with the personnel functions for the general medical services inside the Board. Similarly, the established community care policy for the elderly and mentally ill and handicapped is seen as best substained by staff work including performance review and efficiency measures across the whole of HPSS and is allocated outside the Management Board. On the other hand, hospital development including, acute services and their technical and support services, are placed inside the Management Board as they relate only to the NHS and the current emphasis is on good management, not on policy development. The same consideration explains the suggested allocation of the treatment of overseas visitors, pay beds, and road accident cases inside the Management Board. Where available information - whether from the NHS,

contd.....

via the Management Board, from professional bodies, or from elsewhere - suggested that policy review was needed in areas initially allocated to the Management Board because of the current emphasis on management objectives, such review could be carried out in the 'secretariat' outside the Management Board. The 'secretariat' would not necessarily keep all service policy areas under review at all times but could have a general programme review function, the priorities for review being decided by Ministers, making use of the DMA system.

(3) Where the administrative work is closely linked to professional functions, the placing of the latter functions outside (or inside) the Board should be a deciding factor.

(4) The chart assumes that SDG functions relating to patients as consumers (community health councils, complaints, Health Service Commissioner reports, confidentiality of health records) would be within the Management Board, contributing to its (new) function of pressing consumer interests on NHS management. This overrides the argument that these functions of criticism shold be, and be seen to be, independent of management.

(5) The Health Advisory Service and Development Team are not Departmental staff - except for small secretariats. They help to safeguard especially vulnerable patients (long stay, mentally ill, mentally handicapped) by providing objective and independent professional advice to local management. Their future administrative link is provisionally shown inside the Management Board, but their links to wider health and social policy-making, and their tie-up with SWS, must be safeguarded.

contd.....

Existing Functions by Divisions

Children's Division	Possible Reallocations of Functions
- Children in local authority care, adoption; child abuse	Outside NHS Management Board
- Community Health Councils, complaints by patients, Health Service Commissioner, Confidentiality of health records	Inside NHS Management Board
- Control of Infectious Diseases, vaccination policies	Outside NHS Management Board
- Prevention of Illness, Health education, nutrition, smoking, welfare foods	Outside NHS Management Board
- Support for Ministers in developing and assessing cost effective health and social policies for mothers and children, and responsible parenthood. School health. Family planning and abortion matters; child abuse; nurseries; childminding; legislation. Maternity Services Advisory Ctte.	Outside NHS Management Board
- Primary health care and community nursing services, health centres.	Outside NHS Management Board,

Health Services Division

- Hospital scientific and technical services, blood transfusion service, ambulance service	Inside NHS Management Board
- Public Health Laboratory Service, Radiological Protection Service, Toxicology, chemical Health hazards	Outside NHS Management Board
- Specialised services, supra-regional services and special financial arrangements	Inside NHS Management Board
- Private Health Insurers and Hospitals; Nursing Homes; registration and development	Outside NHS Management Board except that control of NHS pay beds and contracting by NHS with the private sector would be inside the Management Board
- Catering and Domestic Services; contracting out of services	Inside NHS Management Board
- Secretariat to Standing Medical and Nursing Advisory Committees and to nurmerous expert advisory committees.	Outside NHS Management Board, except where the expert group relates to a function which is within the Management Board
- Policy on treatment of overseas visitors, road accident cases	Inside NHS Management Board
- Food Hygiene and safety	Outside NHS Management Board
- Rehabilitation of disabled people, aids for the handicapped	Outside NHS Management Board
- Development and performance review of hospital services (other than maternity, mental health, geriatrics and chronically disabled).	Inside NHS Management Board

Mental Health Division

- Management of Broadmoor, Rampton, Moss Side and Park Lane Hospitals (in the case of Rampton Hospital there is a Board with special health authority status)

  Outside NHS Management Board (the management of these Special Hospitals is currently under review, which might lead to a different allocation at a future date).

- Mental Health Act Commission and Tribunals; implementing the 1983 Act. Legal aspects of detention and treatment. Liaison with Home Office, prisons, and the Courts

  Outside NHS Management Board, except possibly for any continued central support for the Regional Secure Unit programme.

- Support for Ministers in developing and assessing comprehensive policies, including the transfer to community care, for mentally ill and mentally handicapped people, involving local authorities, voluntary bodies, health service management, professional bodies and social security and other Departments in their implementation; by research and pilot projects; and by contributing to setting objectives and performance indicators and to the Review process within NHS management. Framing and staffing implications of the policy.

  Outside NHS Management Board except possibly for any central support required by NHS management in the major closures programme.

Community Services Division

- Personal Socal Services, and general responsibility for relations with local authorities and with the voluntary sector	Outside NHS Management Board
- Secretariat to Korner Committee Administrative support of Health Advisory Service Guidance to NHS on planning activities Co-ordination of policy input to Regional Reviews	Inside NHS Management Board
- Framing and reviewing care in the community policies for the elderly and disabled (except mental health); rules for joint finance and central management pilot projects	Outside NHS Management Board, except for specialised NHS items such as hospital bed location (See under key issues).

ALLOCATION OF FUNCTIONS: THE ADMINISTRATION GROUP

The Administration Group is responsible for Departmental manpower and personnel, for social security operations (both at the two Central Offices and in the Regional oranisation), for international relations (HPSS and social security), and for management services and computers.

The initial analysis was that of the areas of responsibility only that concerned with management services and computers in the NHS could be considered as potentially coming within the remit of the NHS Management Board. Three branches (totalling 43 staff) of Management Services and Computers Division (MSC) are concerned. A suggested allocation of their functions is shown in the attached chart. Key issues are:

- The future of the Computer Policy Committee: Griffiths recommended that the Management Board be responsible for computer policy and the allocation of functions attached follows that. The precise relationship between the Board and the Computer Policy Committee would need to be defined. It needs to be borne in mind that if the Management Board, as Griffiths recommended, is composed of DHSS civil servants working full-time on the NHS management matters, this seems to rule out the chairman of the CPC as a member of the Board.

- The advantage of including the small Management Services branch which concentrates on studies related to the health service under the management board has to be weighed against the possibility that the professional expertise of this branch will be weakened in removing them from MSC, the central focal point for management services and computers. This is a point which may need to be considered in the light of the CIRC review, the inter-departmental scrutiny of review and consultancy capabilities.

EXISTING FUNCTIONS BY DIVISION	POSSIBLE RE-ALLOCATION OF FUNCTIONS
<u>Management Services and Computers 2 Branch</u>	
- Management Services in the NHS: carrying out O+M studies in NHS; DHSS/NHS liaison on management services; central O+M training.	- <u>inside</u> NHS Management Board
<u>Management Services and Computers 3A Branch</u>	
- NHS computing: policy; Computer Policy Committee; direction of computer projects.	- <u>inside</u> NHS Management Board
<u>Management Services and Computers 3C Branch</u>	
- Computing aspects of implementing Korner Committee management information systems.	- <u>inside</u> NHS Management Board

ALLOCATION OF FUNCTIONS : THE MEDICAL DIVISIONS

1. This paper is a response by the Medical Divisions to the Secretary of State's wish that the NHS should see the Department give a clear lead to the implementation of the Management Enquiry. In particular it seeks to deal with the most urgent of the eight components of the analysis identified by Sir Kenneth Stowe at the meeting with the Secretary of State held on 11 November. These are:

(a) the identification of those functions which should be under the Management Board irrespective of who currently undertakes them and where they are located (the content of the "executive box");

(b) the identification of other functions ie those parts of DHSS within HPSS which are not within the remit of the Management Board ("secretariat box");

(c) preparation of an organisation chart with

(d) reporting lines.

2. The medical divisions have a number of important functions outside the National Health Service. These embrace international developments which infringe on the public health such as communicable disease control and reciprocal health agreements, the safety of the environment, nutrition, food additives, the safety of medicines and devices, the control of drug abuse and addiction, and health in the schools. Some of these functions come within the responsibilities of the Secretary of State for Health and Social Services while others are the responsibility of the Home Secretary, Secretary of State for Education and Science, and other Government departments. It is essential that following the implementation of the Griffiths proposals lines of accountability remain which ensure that cohesive and credible advice continues to be given by the medical divisions on these and other aspects of health.

3. An analysis of the functions of ten medical divisions (and ALAC) is attached. The functions are classified according to whether they relate predominantly to the Management Board to the Secretariat or to both. Attention is drawn to the large number of functions which have relevance both within the NHS and outside it. This is because the issues which underlie health and disease are extremely broad and because the role of the NHS is predominant in medical care and it also has important functions in preventive medicine and the promotion of health. In relation to its work in "client groups" such as children and the mentally ill, the medical divisions unlike the administrative divisions within the Department, have responsibilities to other Government departments.

4. Any consideration of the implementation of Griffiths by dividing functions between the "executive box" and "secretariat box" should take into account that there are many fields in medicine in which the same expert must advise on policy and management. A topical example is the field of blood transfusion where the same team gives advice both on the development of policy for the control of the AIDS syndrome, self-sufficiency in blood products and effectiveness of local services. In other fields the realities of the manpower position

exert an absolute constraint on re-organisation. Thus in relation to mental handicap in children both policy and management advice are given by a single member of the medical staff who devotes two-thirds of their time to other subjects.

5. The National Health Service in England is clearly also related intimately to the service in Wales and in Scotland. In a number of important fields, eg medical manpower, the career structure for doctors and postgraduate medical education DHSS through the CMO gives a lead to the United Kingdom. This would need to be taken into account in relation to the function of the "personnel member" of the NHS Management Board.

6. The development of strategic policy in relation to the National Health Service inevitably involves wider considerations which relate to the social services function of the DHSS and the other aspects of health mentioned above. For this reason we consider that strategic planning should be a function of the "secretariat box".

Divisions Predominantly Outside The NHS Management Board

7. The Medicines and the Toxicology and Environmental Health Divisions fall most easily into this category. The function of the former is to implement the Medicines Act 1968 and EEC Directives 75/318 and 75/319. The International and Communicable Disease Division may also be categorised here because all of its functions have an element external to the NHS although many of them (see chart) also have obvious relevance within it. Within the Primary Care and Regional Services Division a substantial part of the time of the Regional Medical Officers is taken up with the examination of patients referred to them who are receiving various types of social security benefit (the so called "reference system"). This function is also clearly outside the remit of the NHS Management Board although another portion of the work of these medical officers is clearly within its remit (see below).

Divisions Easily Placed Within The NHS Management Board

8. The most obvious and easily classified is Management Planning and Organisation. Much, though not all, of the Scientific Equipment and Building Division is also exclusively related to the NHS and this should also probably be classified under this heading. At least part of HPS would fit within the executive box eg hospital policy, supra regional policy and some of the hospital specialty work. The Artificial Limb Appliance Service and the Central Blood Laboratories Authority also clearly come under this category. There is a major dilemma about the placing of Primary Care. Without it there is a real risk that the Management Board will underestimate the importance of its function in relation to the community services, lose the capacity to transfer care into this field and come to be seen as a "Hospital Management Board". On the other hand inclusion might well be seen as an infringement of the independent contractor status of the general practitioners. This would be extremely sensitive with the medical profession particularly as the Griffiths Enquiry did not examine the General Practitioner Service or conduct consultations in this field. If it were decided that negotiation of the terms and conditions of service of general practitioners should be conducted through the "secretariat box", that element of the function of the Regional Medical Officers which advises general practitioners on prescriptions, premises etc and exercises some

control on standards and expenditure in this field should be a function of the Management Board. Unfortunately, however, the fragmentation of the Primary Care and Regional Medical Services Division in this way would have serious disadvantages as it would render any co-ordinated management or planning of the Primary Health Care Services in the National Health Service extremely difficult.

Divisions With Mixed Functions

9. Within the remaining divisions the Nutrition Unit (CDN) and Special Hospitals (MHI) are clearly secretariat functions. Much of the work of the Division concerned with Children and Disablement and that of Mental Health and Illness relates to client groups whose interests straddle the NHS (the elderly within HPS are also in this category) or to areas with wide implications such as alcohol and drug abuse (MHI) and prevention including health education (CDN). Family planning, abortion and private practice are examples with similar implications within HPS, and it should be noted that in relation to abortion the CMO has statutory duties. In a number of these areas there is a responsibility through the CMO to the Home Office or DES. It is suggested that these divisions should be allocated to the secretariat in line with SDG. The CMO's responsibility in relation to the Abortion Act cannot be delegated.

Medical Manpower and Education

10. Doctors, their numbers, distribution, staffing structure, terms of service, education and discipline are obviously of crucial importance to the NHS and are highly sensitive areas both politically and professionally. The development of policies relating to these matters are negotiated at the highest level on a United Kingdom basis with key outside bodies such as the GMC, the Royal Colleges, the UGC, the BMA and other Government departments such as the Home Office (control of overseas doctors, immigration) and DES. It seems essential therefore that policy development as well as the negotiation of these policies as distinct from their implementation should be reserved to the secretariat box. Once policies have been settled the day to day personnel issues arising could be dealt as a management function.

Lines of Accountability

11. The lines of accountability must provide for the following:

(a) cohesive medical advice to the Secretary of State (DHSS) on health matters which go beyond the remit of the NHS;

(b) medical advice to the Chairman of the Management Board on relevant matters;

(c) retain the credibility of the CMO as the principal adviser on health matters to other Government departments;

(d) retain satisfactory lines of communication between the CMO and the General Medical Council, the Medical Research Council, the Royal Colleges;

(e) retain the confidence of the medical profession without whom no effective working of the National Health Service is possible;

(f) avoid at all costs the risk of the Secretary of State receiving conflicting medical advice from the Management Board and from the CMO.

It is submitted that these objects can only be secured if there remains a clear line of accountability of all medical staff to the CMO.

MEDICAL DIVISIONS - LIST OF PRINCIPAL FUNCTIONS

DCMO - DR E L HARRIS

	NHS MB BOX	SECRETARIAT BOX	BOTH
ALAC (Artificial Limb Vehicle and Appliance Service)	+		
SEB (Scientific, Equipment and Building)			
Policy on supplies	+		
Laboratory management	+		
Export supplies		+	
Standards (professional)			+
Blood transfusion	+		+
Hospital pathology services	+		+
PHLS			+
CAMR			+
Dangerous pathogens			+
Radiology	+		
Radiation protection			+
Building	+		
Computers	+		
Cancer services			+
Lasers, collection of pituitaries		+	
IMCD (International, Microbiology of Food, Communicable Diseases)			
WHO			+
Commonwealth relations		+	
European Community			+
Council of Europe		(+)	
Bilaterial Health Agreements			+
Immigration			+
Microbiology of food		+	
Communicable Disease			+
Infection in hospitals control			+
Immunisation			+
Environmental hygiene		+	
MD (Medicines Division)		+	

DCMO - DR E SHORE

	NHS MB BOX	SECRETARIAT BOX	BOTH
CDN (Children, Disablement and Nutrition)			
Nutrition Unit (also MAFF)		+	
Disablement			+
Children (also DES)			+
Prevention (also DoE, MAFF)			+
MHI (Mental Health and Illness)			
Mental Health (also Home Office)			+
Mental Handicap			+
Drugs, Addiction (also Home Office)			+
Alcoholism (also Home Office)			+
Special Hospitals (also Home Office)		+	
Forensic psychiatry (also Home Office)			+
PCR (Primary Care and Regional Services)			
Prescribing	+		
Regional Medical Services referral		+	
visiting	+		
GP terms and conditions		+	
Appeals	+		
Primary care policy			+
MPO (Management, Planning and Organisation of NHS)			
Planning	+		
Performance Indicators	+		
Korner	+		
Medical Audit	+		
Reg Liaison	+		
Data Protection	+		

DCMO - DR G FORD

	NHS MB BOX	SECRETARIAT BOX	BOTH
MME (Medical Manpower and Education)			
Policy		+	
Day to Day Personnel matters	+		
HPS (Hospital Policy and Services)			
Hospital policy	+		
Supra regional	+		
Abortion and foetal abnormality (N.B. CMO's Statutory Duties)			+
Family planning			+
Maternal deaths			+
Private practice			+
Hospital specialty work	+		+
Elderly			+
TEP (Toxicology and Environmental Health			
Toxicology, Environment, Food		+	
Toxicology Unit			+

SUMMARY

DCMO - DR E L HARRIS

ALAC	NHS Management 'Box'
SEB	Mostly NHS Management 'Box' but some work has important implications outside NHS (eg export)
IMCD	Mostly Secretariat 'Box'
MD	Secretariat 'Box'

DCMO - DR E SHORE

CDN	Apart from Nutrition, which is Secretariat 'Box', straddles the two boxes
MHI	Most of these have important aspects within and outside the NHS
PCR	See text
MPO	NHS Management 'Box'

DCMO - DR G FORD

MME	Day to day personnel function in Management 'Box' development and negotiation of policy Secretariat 'Box'
HPS	All have NHS Management implications but many also have external implications
TEP	Secretariat 'Box' except for the Toxicology Unit

Predominantly NHS Management Box	Both	Predominantly Secretariat Box
ALAC		IMCD
SEB	PCR	MD
HPS	MME	TEP
MPO		CDN
		MHI

Branch M6B of Med SS at Norcross, some of whose function is devoted to processing NHS Superannuation claims in which the claimant is seeking early retirement on health grounds is also within the compass of the NHS Management Board.

ALLOCATION OF FUNCTIONS: NURSING DIVISION (SUMMARY REPORT)

At present Nursing Division has a manpower complement of 71. The Chief Nursing Officer is supported by a Deputy, 9 Principal Nursing Officers and 29 Nursing Officers. Administrative and secretarial staff in support total 31.

The initial analysis was that, except in respect of specific professional responsibilities and policies on which Nursing Division was in the lead, the allocation of the functions of the Division would follow general decisions about the distribution of work, based on the allocation of the administrative 'lead'. A suggested allocation is shown in the chart opposite. Key issues are:

- The need to weigh consistency of professional allocations with administrative allocations, which leads to 4 of the 8 functions listed being shown as inside the NHS Management Board, against the need to ensure that the Chief Nursing Officer's position is not weakened in her wider role of support to the Secretary of State across the full range of his HPSS and wider health responsibilities. The underlying issue here is the reporting relationship of professional staff working within the NHS Management Board.

- In a professional division individual officers often have a particular expertise. In the service development field in particular the allocation of functions, and so of the responsibilities of the 3 Principal Nursing Officers and 14 Nursing Officers who work on them, will need to have regard to this factor.

NURSING DIVISION

Existing functions	Possible re-allocation of functions
NHS service development: policy formulation and evaluation	- *In general*: allocation to follow administrative 'lead' - *Specific* professional policies and initiatives to be considered individually
Personnel:	
- pay, conditions of service, manpower planning, agency nurses, recruitment	- *Inside* NHS Management Board
- education and training, including liaison with statutory bodies	- *Outside* NHS Management Board
Regional liaison functions: professional aspects	- *Inside* NHS Management Board
Building and supplies	- *Inside* NHS Management Board (except possibily work on *exports* - following administrative lead)
Research	- *Outside* NHS Management Board
Information and computers	- *Inside* NHS Management Board
International	- *Outside* NHS Management Board

With the Compliments of
the Private Secretary to
the Secretary of State

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JW

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DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

G.T.N. 2915

From the Secretary of State for Social Services

Charles Marshall Esq
Private Secretary to
Lord Privy Seal

1 December 1983

Dear Charles,

We spoke yesterday about my Secretary of State's wish to make an oral statement next Wednesday on NHS pharmaceutical prices. You thought that, subject to any unforeseen developments, this was unlikely to present any problems.

I am copying this to Tim Flesher (Prime Minister's Office) and Peter Moore (Chief Whip's Office).

Yours sincerely,

Ellen Roberts

ELLEN ROBERTS
Private Secretary

10 DOWNING STREET

Robin

Do you have the material marked at X on the attached letter. It is not on file and DHSS say they sent it to you marked "Secret + Personal"

D.

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Secretary of State for Social Services

Tim Flesher Esq
Private Secretary
10 Downing Street

30 November 1983

WPB

Dear Tim

You wrote to Ellen Roberts on 15 November asking whether there was scope for greater public use of information about the scope for economies in the NHS and about comparative performance within it.

The short answer is 'yes'. As the Prime Minister has noted, my Secretary of State has made considerable use of such examples in speeches in recent months. The material is drawn from three main sources:

(i) Information collected by our auditors in the course of their work with Health Authorities. This reflects the increasing emphasis which we, and they, have been putting on wider value for money audits of health authority activities. A list of examples of such savings was provided to Robin Butler by Sir Kenneth Stowe early in October. x|

(ii) The results of the Rayner scrutinies which we have set up in the NHS. These are now beginning to report and are showing the prospect of significant benefits.

x| (iii) The performance indicators which we published at the beginning of October and which Sir Kenneth also sent to Robin. Performance indicators give detail of the comparative use of resources (manpower, finance etc) and levels of activity (patients treated, ambulance trips etc) between different hospitals, districts or regions. These published statistics show wide variations. There are often good reasons why such differences may exist. We are anxious therefore not to imply that a particular difference implies that one district is necessarily more efficient than another. What the statistics do is to give local management a basis for questioning their performance and seeking to improve it.

It is in this spirit that we are now using the material available: as part of a process of questioning, both publicly and in regional accountability reviews, the effectiveness of the NHS and the scope for improvement. But it needs to be set in the positive context provided by the Griffiths report: not as part of a negative approach to the NHS but as identifying one of the major tasks for which we require stronger management and which authorities and their general managers, once appointed, will need to face.

Although much of the material I have mentioned is already available to you, you might find it useful to have the attached note which summarises the main strands both in the identification of waste and inefficiency and our approach to reducing it.

Yours

Steve

S A Godber
Private Secretary

ACHIEVING VALUE FOR MONEY IN THE NATIONAL HEALTH SERVICE

The National Health Service will spend £15½ billion this year. The taxpayer has a right to know if that money is well spent.

NEED TO IMPROVE MANAGEMENT

There are 4 common criticisms of the health service which the Government is determined to tackle:

* Too many people in the chain of command - leading to duplication and diffusion of responsibility.

* No clear management responsibility to identify and deal quickly with immediate problems.

* Poor planning and control of manpower.

* Poor and out-of-date information on costs, performance and efficiency.

GOVERNMENT ACTION ON MANAGEMENT

Action has been taken to deal with each of these criticisms:

The chain of command

One administrative tier has been abolished cutting the number of management teams in England from 251 to 193.

The money spent on people engaged solely on "management" is being reduced by 10 per cent.

Management responsibility

Through regional reviews the Chairmen now have to account annually to the Secretary of State for their plans and performance.

In the same way District Chairmen are held to account annually by the Regional Chairman.

Action on the report by Roy Griffiths will strengthen and reinforce the clear line of individual management responsibility.

Manpower

Regional authorities are now required to have specific manpower targets related to their service plans.

There is now a quarterly count of staff employed in the 14 regions instead of once a year.

Information on costs, performance and efficiency

Action taken by this Government includes:

- the publication this year of comparative performance indicators for each region and district;

- the introduction of Rayner type scrutinies;

- the use of commercial auditors;

- a review of management information (Körner Working Group).

Again this will be strengthened and reinforced by action on the Griffiths Report.

EXAMPLES OF WASTE AND SAVINGS ACHIEVED

National

In 1981/82 efficiency savings of £29 million were achieved. In 1982/83 authorities were asked for efficiency savings of £40 million (0.5 per cent). Savings from external audit in 1981/82 were estimated to be £12.6 million.

Local

Examples of waste are:

Overlap in nurses duty rostas - cost to the authority, £700,000 per annum.

Too many general stores - extra cost to authority, £80,000 per annum.

Failure to use central buying arrangements - extra cost to authority, £22,600 per annum.

Storing 8 incubators for 18 months - cost to authority, £11,000.

Examples of savings achieved are:

Review of catering services - savings to authority, £100,000 per annum.

Closure of hospital farm - capital saving of £275,000 plus elimination of £20,000 loss per annum.

Review of laundry services - saving to authority of £100,000 per annum.

Competitive quotations for supplies - saving to authority of £40,000 per annum.

Closure of extra dining room - saving to authority of £35,000 per annum (previously two dining rooms in 10 minutes walk of each other).

DIFFERENCES IN PERFORMANCE
(Taken from published Performance Indicators)

- One district pays four times as much per 100 items laundered as another.

- One specialist maternity hospital costs three times as much per delivery as another.

- Variation in ambulance service costs per 1,000 patient journeys in between £7,500 and £17,400 nationally. Cost in two neighbouring rural counties differs by 30 per cent.

EFFICIENCY IN DHSS

The Government is equally concerned to make the Civil Service more efficient and effective. Achievements in DHSS include:

A reduction in HQ staff of about 20 per cent between 1979 and 1 April 1984.

A reduction in the number of regional social security offices from 12 to 7 with savings of 1,000 staff.

A 20 per cent reduction in the unit cost of paying supplementary benefit.

Confidential

Treasury Chambers, Parliament Street, SW1P 3AG

Kenneth Clarke QC MP
Minister of State
Department of Health & Social Security
Alexander Fleming House
Elephant & Castle
LONDON SE1 6BY

29 November 1983

Dear Minister,

PHARMACEUTICAL INDUSTRY

Thank you for your letter of 25 November about the final proposals which you wish to put to the representatives of the pharmaceutical industry.

When I agreed in my letter of 1 August to Norman Fowler to the original package of measures, I said that I would be content if in the event your talks with the industry led to minor changes in the detail. I see from your letter that for the most part such changes as have occurred are indeed minor, with the exception of the industry's proposals on promotional expenditure. I am naturally pleased, if somewhat surprised, that these changes have enabled you to forecast savings of £120m in a full year as against the £60m Norman was expecting in July. My officials, who have not had the chance to study these figures in detail will be in touch with yours to discuss them further, but meanwhile I am quite content for you to put your proposals to the industry.

I have two comments on your letter not related to the immediate issue of your talks with the industry, but to the slightly longer term.

First, I can well understand that, having reached an understanding with you on allowed rates of return and so forth, the industry will be unwilling to change the figures frequently. But we must remember the difficulties which can be created by continuing figures agreed in one set of circumstances into later years when circumstances may have changed radically. I should be grateful therefore if you would avoid any commitment not to change the figures for a specified period, even though I can understand the industry's natural wish for a period of stability.

Confidential

Confidential

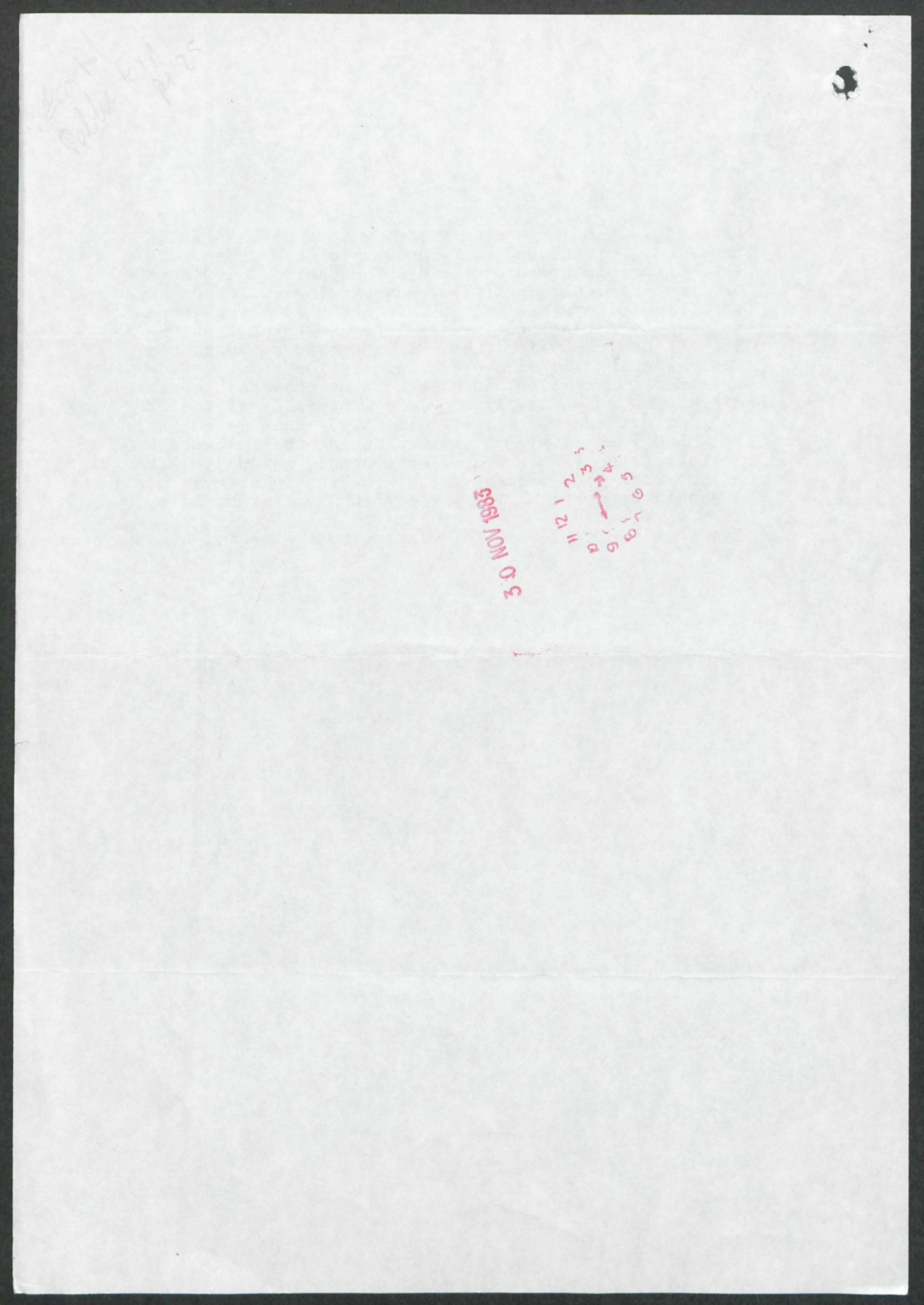
Secondly, I am increasingly coming to feel that it is anomalous for the NHS to refund any of the promotional expenditure incurred by the drug companies. In the absence of direct price competition, advertising and other sales promotion offers one of the main means for drug companies to compete for NHS business. I do not think that the NHS itself should pay for that. If there is a function of disseminating within the NHS information about new drugs or other formalities, it occurs to me that that could be discharged more cheaply and less wastefully if the NHS carried out the work itself directly. This is an issue to which I shall wish to return during the full-scale review of the PPRS which, I understand, is due to take place after your current talks with the industry. Meanwhile I should be grateful for any comments you might have.

I am sending copies of this letter to the recipients of yours.

yours sincerely

PETER REES

(approved by the Chief Secretary & signed in his absence).



With the Compliments of
the Private Secretary to
the Minister of State

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House

Elephant and Castle

London, S.E.1.

MA

CONFIDENTIAL

NBPM AT 28/11

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Minister for Health

The Rt Hon Peter Rees QC MP
Chief Secretary of the Treasury
Treasury Chambers
Parliament Street
LONDON
SW1

25th November 1982

Dear Mr Rees,

Norman Fowler wrote to you on 21 July outlining the measures we proposed to reduce the NHS drugs bill, and you replied on 1 August broadly endorsing our proposals. We have had extensive discussions with the pharmaceutical industry's representatives since then, and we are now ready to put final proposals to them.

You will recall that we proposed reductions under the Pharmaceutical Price Regulation Scheme in three areas. As regards the target return on capital for the industry as a whole, the industry's representatives appear to be resigned to a cut of four percentage points, one point more than suggested in his letter to you, which will bring the target down to 21 per cent ROC. We can look at this if necessary in the light of the forthcoming report of the Review Board for Government Contracts, though we would hope not to have to make further changes, up or down, for some time. Frequent changes in profit rates make the scheme difficult to administer and heighten uncertainty in the industry.

The industry sets great store by maintaining a sufficiently large area of flexibility above a company's target profit rate (the "grey area") to provide the incentive to research and develop new drugs and promote efficiency. They have suggested that the size of the grey area should, instead of being at the present flat rate of 10 per cent, be related to individual company targets, and we think this has a lot to commend it. We propose to pitch it at one third of target which will mean that companies on the new maximum target rate of 21 per cent ROC will have a grey area of seven percentage points, while those at the lowest target rate will have one of five.

The industry's representatives have also suggested a different method of controlling expenditure on sales promotion. At present the limit is 10 per cent of industry sales, but the total for the industry is invariably exceeded. The proposal is that a company which overspends its limit should in future "repay" to the Department £1 for £1 overspent. This penalises the overspenders and avoids the present difficulty that a company whose profits are below target can spend heavily on sales promotion without incurring any penalty (which in turn encourages other companies to overspend). If the scheme can be made to stick, we think it should persuade most companies to keep within the limit; and if they do not, should enable us to recover the overspending. We believe that the proposal is sufficiently promising to introduce it at the existing limit of 10 per cent of sales, but we propose to put the industry on notice that

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we shall reduce the limit to nine per cent next year and review it thereafter. The change of system should enable us to recoup about £20 million extra at levels of sales promotion even before there is any reduction in the 10 per cent limit.

Although the sales promotion proposal has come from the industry's own representatives, it is by no means certain that it will prove acceptable to member companies. Norman has no statutory powers to require companies to repay excess sales promotion expenditure, or for that matter excess profits. We shall make it clear to the industry that if the new arrangement is not honoured we shall have to revert to present arrangements and a lower target, as proposed in Norman's letter.

The combined effect of these measures, whichever of the sales promotions options we take, will rule out all but a very few price increases during 1984/85, thus in effect continuing the current price freeze imposed following the July restraints on public expenditure. We estimate that this will be worth some £65 million in 1984/85 (bearing in mind that prices were lowered by 2½ per cent in the summer), and perhaps as much as £120 million in later years as the measures take full effect. In addition, we are at present reviewing costs and profits in transfer prices and hope that by means of more use of accountant manpower in the scrutiny of companies' annual financial returns to the Department some further savings may be achieved. Our officials have been in touch with yours about ways in which this additional input can be funded, and we hope that an early and satisfactory result can be achieved.

There is little additional savings to be achieved from generic substitution and parallel imports, as you acknowledged in your letter of 1 August to Norman. However, we regard it as important to continue the quest for more effective means of reducing prescribing costs. We shall very shortly be issuing a consultative document on proposals to ensure that parallel imports of medicines for general dispensing are properly controlled.

I am copying this letter to the Prime Minister, and the Secretaries of State for Trade and Industry, Scotland, Wales and Northern Ireland.

yours sincerely

[signature]

for KENNETH CLARKE

(approved by the Minister and signed in his absence)

28 NOV 1983

FILE TL

10 DOWNING STREET

From the Private Secretary

15 November 1983

The Prime Minister is grateful for the very comprehensive briefing which your Department has provided especially during a period when the National Health Service has been a particularly live issue in the House of Commons. In this context she was interested in the examples used in your Secretary of State's speech during the National Health Service debate on 27 October about the scope for economies and greater efficiency in the NHS. She wondered therefore whether there was scope for greater use to be made of the comparative statistics of hospital performance to which Mr. Fowler referred briefly in his speech, to the effect that it cost one specialist maternity hospital three times as much to deliver a baby as another. I should be grateful if you could consider the availability of such material on comparative hospital performance and the scope for its greater public use to draw attention to good and bad practice. It would be helpful to have this advice by Tuesday 29 November.

BU

Tim Flesher

Miss Ellen Roberts,
Department of Health and Social Security.

THE ROYAL COLLEGE OF NURSING OF THE UNITED KINGDOM

ANNUAL GENERAL MEETING 1983

PRESIDENT'S ADDRESS

EMBARGOED - NOT FOR PUBLICATION IN WHOLE OR IN PART BEFORE 14.00 HRS
WEDNESDAY, NOVEMBER 9, 1983

TO BE CHECKED AGAINST DELIVERY

Welcome to the 1983 Annual General Meeting of the Royal College of Nursing, the first to be held in this city since 1967. It was here in January 1918, less than two years after the establishment of the College of Nursing in London, that the very first local Centre, known as East Lancashire, was established.

Their activities were reported in the first issue of the Bulletin of the College of Nursing published in January 1920, when the Centre was just two years old. Among those activities was a Bazaar, which realised £7,346 for the Nation's Fund for Nurses. Later, the Finance Committee sent altogether £12,500 War Funding Loan to this Fund for the endowment of the College. No other local Rcn entity has a longer history of continuous and enthusiastic membership activity than the East Lancashire Centre and its successor, the Greater Manchester Centre.

The message of this year's Professional Conference was to 'get political'. It was a message that caught the imagination of the meeting and the membership. Let's put it into action, 'let's get political' but let us remember that we will be at our most effective politically if we 'stay professional',and every time I mention the word political in the context of the Rcn's activities I mean political with a small 'p'.

For once, nurses' pay is not our predominant concern today, that must be reserved for the state of the Natinal Health Service. But first, let us look at

(our progress in other)

our progress in other fields, both professional and political.

I begin with the College's work on nursing structures because it exemplifies the way in which the professional side of the College's activities underpins our work in other fields- most importantly, in this instance, nurses' pay. The Report of the Rcn Working Group 'Towards a New Professional Structure' was ratified by Council in March of this year as College policy, and the principles contained within the Report will be embodied in our evidence to the Review Body.

It is nearly three years since the publication of 'Towards Standards' which set out a clear philosophy of the professional responsibility for maintaining standards, and the College is entering on a new phase of its work, in an effort to devise guidelines for standard setting which will be able to be used by nurses in a variety of clinical settings. I hope that by the New Year we shall have a document able to be utilised by you, the members, in assisting you to make objective assessments of standards of nursing care. This work has become even more urgent in a climate of continuing cuts, which makes it essential for nurses to be able to be precise about the effects on care.

As the old gave way to the new statutory bodies on July 1 this year, we have the beginnings of a new statutory structure for nursing which the Rcn foresaw as being essential to the future of the nursing profession as long as forty years ago. A vision which began to feel like a pipe dream, but has finally emerged as reality eleven years after the Briggs Report.

We can be justifiably proud of the extent to which the Rcn has influenced the development of the new bodies both before and after the enactment of legislation in 1979. The College's own Working Group on the Nurses, Midwives and Health Visitors Act has continued to monitor and make representations to the new statutory bodies on all the key issues relating to the implementation of the legislation. In particular, the Rcn has been at pains to ensure that any new

(rules for nursing made)

rules for nursing made at the initial stage should not be so radical as to pre-empt the more substantial changes that are rightly the prerogative of the reconstituted and elected bodies.

Now that we have passed the period designated as 'the end of the beginning' of the new statutory structure, considerable College input is needed. We will not wait passively for the new statutory bodies to tell us what changes in nursing education should take place, and how they should be implemented. We are determined to be at the forefront in shaping such changes ourselves and providing the leadership that nurse educationists need in a period when they feel themselves to be more than usually vulnerable - a leadership within which the educationists themselves must take a major role. The implications of the Griffiths Report for nurse education are particularly uncertain, and sadly, nurse education lacks the kind of public support that clinical nurses can harness in the face of antipathetic governmental policies. The College intends to take the initiative here; and at its meeting next week Council will have on its Agenda an item concerned with a major new Rcn activity to focus on the whole field of nurse education and training. This could be a major initiative on a scale not carried out since the Council set up in 1961 the Special Committee that, under the chairmanship of Sir Harry Platt, produced that radical document, 'A Reform of Nursing Education'.

Moving now to issues in which our professional concern finds expression in areas beyond the immediate nursing arena - in other words, our growing political consciousness - one very successful report was that of the Rcn's Working Party on the implications for nursing of Nuclear War Civil Defence Planning chaired by Marian Morgan, the Deputy President. It received a very favourable reception from many quarters, and two weeks ago, it was praised and quoted during a House of Commons debate.

The principal areas of concern highlighted in this report were the problems associated with civil defence planning in relation to the NHS, and the lack of

(consultation among nurses)

consultation among nurses - a complaint widely expressed in the 1982 Representative Body meeting debate on the resolution that led to the setting up of the Rcn's Working Party. The Rcn was subsequently invited to a joint meeting with Home Office and Department of Health Ministers. A dialogue was established at this meeting which the College confidently looks forward to being continued, both Ministers expressing a willingness to consult further with the College on a new draft circular on civil defence planning in relation to the NHS now in preparation, and on the revised edition of the now notorious Home Office booklet 'Protect and Survive'.

Among new legislation that came into force this year and for which the Rcn can take a share of the credit is that relating to the wearing of seat belts in cars, for which the College has been pressing hard for some years. Government action has also been promised if not precisely scheduled on lead in petrol; again, the Rcn has been in the forefront of those organisations that have campaigned for the banning of this fuel additive on health grounds.

Now to progress on the pay front. The offer of a new Review Body to determine nurses' pay was made by the Secretary of State in the House of Commons exactly one year ago today. Three and a half months then passed before the Government's consultative document saw the light of day, and it was not until the end of July this year - eight and a half months later and over three months after the closing date for comments to be received - that the terms of reference of the Review Body were announced. A record of speedy inactivity?. The Government might well take to heart its exhortations on the efficiency drive in the NHS and apply them to the way it tackles its own tasks. We must I think extend a cautious welcome to this new mechanism, however sketchy our present knowledge of how it will operate may be. The College welcomes, too, the appointment of a man of the stature of Sir John Greenborough to chair the Review Body, but we seem to be in another period of typical Government inaction where nurses are concerned awaiting the names of the

(rest of the team.)

rest of the team.

I do not believe that any of us have any illusions about the Review Body. It is not an instant cure for the ills suffered under the Whitley Council system and not even the greatest optimist could expect that from April 1 next year all of the deficiences in the present nursing pay structure will have been remedied. But we do actually have the prospect of a truly independent body taking evidence from all appropriate sources about nurses' pay and making recommendations for establishing a new order in which the levels and the structure will be right for nursing.

The College will not be party to any game of put and take. Our long term objective must be a revamping of the whole system which currently governs nurses pay.

To this end we will be arguing the case for a much more flexible pay system for nurses, one more attuned to the need to relate pay to what people do and can do in terms of qualifications and specialist experience - a system that encourages nurses to develop their clinical ability and undertake wider responsibilities, and reward them accordingly. The present arrangement of incremental scales is perfectly adequate as a system for rewarding nurses as employees; it is not a system which does justice to professional practitioners, nor encourages us to develop and extend our professional expertise.

It was this belief in ourselves as members of a profession ready to accept all the responsibilities which that entails, that underpinned our contention that the Review Body should deal exclusively with qualified nurses and those in training for a statutory nursing qualification - an attitude, not always supported among nurses themselves and seen as elitism. A favourite critical phrase levelled against the Rcn is that we do 'too little, too late'. Perhaps we can be forgiven sometimes for the feeling that the inability of the profession to take a united stand on a major professional issue sends our negotiators into the

(arena with one hand tied)

arena with one hand tied behind their backs. When will we 'get political' in that respect? This new and more stable system of pay determination gives us a unique and continuing opportunity to convey this message to an independent body and we shall do so determinedly. As the voice of nurses and nursing in this country, we intend to submit a major memorandum of evidence to the Review Body; and we will seek to support the written with oral evidence.

Now to the most serious matter of all - 'the state of the NHS' - a short-hand phrase to denote a proud health service reeling under the consecutive blows of reorganisation, cash limits, manpower targets and, most recently the 'Griffiths' Report. Concertinaed together, as they have been in the space of a year, it is difficult to see how these measures can serve the long or short term interests of the service and its consumers.

I am prepared to be blunt about the College stand with regard to Government policy towards the NHS, lest our position may be in danger of being misunderstood. Within a month, no less an institution than 'The Times' has referred successively to 'apocalyptic interventions' by the College, that we are 'crying wolf', and that our 'new rather unattractive activist clothes' ill become us. It is good to see how seriously we are being taken.

But lest we be brushed aside with those who complain on doctrinaire rather than rational or humanitarian grounds, let me first try to establish some common ground with the Government, difficult though that may be. Earlier this year the DHSS identified (in the publication 'Health Care and its Costs') a number of weaknesses in the planning and management of health authority resources - excessively long chains of command, duplication of effort, little or no manpower planning strategy, unjustified growth in non front-line staff, a lack of sustained and systematic pressure to increase efficiency - the Rcn would not substantially disagree with any of these.

The Government is right to want to maximise value for money in the NHS, so long as efficiency savings are directed into improving patient care services

(and not simply spirited)

and not simply spirited away back to the Treasury as an excuse for even further cuts in progressive years.Without in any way wishing to endorse the recommendations of the Griffiths' Report. I think it perfectly possible that modern commercial practice may have something to teach NHS managers in all disciplines.

Where the Rcn has to part company with this Government, however, is in the specific blood-letting regimen it is determined to impose on the health service - in terms of what is being cut, where it is being cut, and the time-scale within which it has got to be cut.

Let me first look at the timing of DHSS circulars on cash limits and manpower targets over the last year, in the context of what they were asking health authorities to do, and in the light of what most NHS managers interpreted in 'Patients First' and subsequent circulars as a governmental objective to achieve 'maximum delegation of responsibility' to District Health Authorities.
The phrase 'maximum delegation' is beginning to sound like a very empty platitude. There is always an unbridgeable gap between what the DHSS preaches - maximum delegation to the health authorities - and what it practises - maximum direction in the management of finance and manpower.

July 1982 - the DHSS asked regions about district plans for making efficiency savings of half a per cent for the then current financial year and for 1983/84, and 'to strengthen the setting of manpower targets'. The more efficient, and one is now beginning to think gullible, authorities proceeded to do what they were asked to control manpower growth, only to be penalised later - but more of that in a moment.

January 1983-- regional allocations for 1983/84 were announced together with guidance on their use; these allocations showed a 1.2 per cent increase for the year.

June 1983 - long term revenue resource assumptions were issued, this circular asking health authorities to assume a growth rate of half per cent per year over the next ten years.

(July 1983 - revised)

July 1983 - revised cash limits for 1983/84 were announced, superseding those announced in January and reducing the figure of 1.2 to just 0.21 per cent. At the same time the DHSS called for a reduction of between 0.75 and 1 per cent in overall staff numbers from the total employed at 31 March, 1983.

These revised cash limits and manpower targets largely reflected the health service's share of the burden of the Chancellor's massive public spending cuts announced on 7 July, but what manager, in a service which the Secretary of State has stated to be the biggest in Western Europe, can be expected to plan and deploy resources effectively and efficiently when faced with a continually changing hotch-potch of requirements such has been issued by the DHSS in the last fifteen months, and where the most radical arrive well into the financial year when expenditure is heavily committed?

At the same time, the so-called 'restructure with minimum turbulence' developed into a long drawn-out reorganisation with maximum buffeting. We could put a date to the 1974 Reorganisation - all we can say about the re-structure is that it has occupied all the 1980's to date. The effect on staff has been devastating, especially for managers.

Let me next look behind the manpower figures that the Government have quoted to support their claim to reasonableness. By the beginning of October the 8000 jobs that Ministers were originally looking to cut had been reduced in negotiations with the Regional Health Authorities to 4837. 'It is ludicrous to charge', Mr Fowler told the Conservative Party's Annual Conference on 13 October, 'that a reduction of one half of one per cent of the staff of the biggest employer in Western Europe marks the end of the health service as we know it'. A convincing enough retort to the complainers, you might think, were such a reduction to be sought from within a service that had not over the years been subjected to a more or less continuous chiselling away of its

(resources, and were the)

resources, and were the figure quoted really a genuine one half of one per cent.

But the Secretary of State's calculations were based solely on a head count of employees at 31 March, 1983 and took no account of the very many posts unfilled due to NHS reorganisation or, ironically, authorities keeping posts unfilled for as long as possible to save money in the name of efficiency. Nor were the personnel needed to staff new developments yet to become operational taken into account. Even regions whose target appears to show a modest increase lose their apparent advantage when the sums for developments turn that modest increase into a considerable reduction. The result will be brand new developments unable to accept patients because they simply will not have the staff to man them.

This governmental fudging of the figures should not, perhaps, surprise us. Do you remember the pre-election boast of 45,000 extra nurses, with no acknowledgement ever made of the fact that more than half these 'extra nurses' were required simply to accommodate the reduction in the working week?

The Government's message, then, is clear: these cuts are necessary and they can be made without significant detriment to standards of patient care. Unfortunately, or fortunately from the patient's point of view, the DHSS's own forward costings dispute this. The rate of annual growth needed to keep pace with demographic changes tending towards a continually increasing proportion of elderly people in the population is set at 0.7 per cent. A further half per cent per year of additional expenditure is required 'as a contribution to the costs of the constant process of medical innovation'. The Government's growth figure for the next ten years is half of one per cent, not allowing for further cutbacks in the future, which cannot be ruled out. The prospect, therefore, must be of a continuously deteriorating health service unless the shortfall can be made up from efficiency savings. The NHS cannot be squeezed much more without incurring an enormous human cost.

(Our message then must be)

Our message then must be equally clear: this Government is demanding too much too quickly; these cuts cannot be imposed without standards of care - and patients - suffering. Let's get political in getting our professional message across.

The College's 'Nurse Alert' campaign has produced abundant testimonials from members, and the public, to support this position, and we hope shortly to publish this documentary evidence that we are still collecting. Meanwhile, I ask you to be our eyes and ears in the hospital and the community, and to let us know the specific impact of cuts in your immediate locality.

I am not going to make foolish predictions about the imminent collapse of the NHS. But I am convinced that unless a more rational and humane approach is taken to improving the 'effectiveness and efficiency' of the health service, the NHS, in terms of what the patient can reasonably expect to receive from it, will steadily deteriorate. And on the subject of patient expectations, let me nail the myth of 'natural wastage'. This simply means, to give one example, that instead of the district nurse being made redundant, her post is left permanently unfilled when she retires. It matters little to the patient: whatever the cause, the effect remains the same - there is no nurse.

I have deliberately concentrated on the effect of government cutbacks in the NHS on patients. They do, of course, have an equally devastating effect on staff. For nurses, the Griffiths Report will have dealt a further damaging blow to their morale.

This is indeed a deeply disturbing report for the nursing profession, and the Rcn believes that if the Griffiths Report is implemented, nurses are in danger of returning to the handmaiden role they left twenty years ago.

Once again the College is in the position of agreeing with the need to make more effective use of manpower and related resources in the NHS - the objective that gave rise to the establishment of the NHS management inquiry - but has to take strong issue with the recommendations the inquiry team has made. The

(report is characterised by)

report is characterised by an absence of any serious consideration having been given to the nurse as a manager within the NHS, even though nurses make up some two thirds of the total workforce, have greater contact with patients than any other professional or occupational group, and their performance as members of management teams of equals has not previously been questioned.

The Rcn views with grave suspicion, proposals to establish general managers at regional, district and unit level - especially the last - because, despite disclaimers to the contrary, such restructuring could effectively strip nurse managers of the control they should properly be exercising over all matters relating to nursing and nurse education. We are concerned for the future of the Nursing Division at the DHSS, a centre of nursing excellence and expertise that enjoys an international reputation. We are particularly concerned that our Chief Nursing Officer is not mentioned as a member of the Health Services Supervisory Board. Her colleague, the Chief Medical Officer is. We shall not let that pass unchallenged.

The Rcn urges the Secretary of State not to implement the recommendations of the Griffiths Report without giving the fullest consideration to the likely effects on those very groups of staff whose morale has been hardest hit by reorganisation and the continually changing demands, with regard to cash limits and manpower targets, that they have had to face over the last eighteen months. In particular, I echo the message that emerged loud and clear from the national meeting held in London last week: leave Units alone, Mr Fowler, at least for the immediate future. At that meeting Mr. Griffiths twice reminded us that the NHS is not the prerogative of the professions. In reply to that we would say that neither is it the prerogative of the politicians. It belongs to the people of this country who use it, and who rely on those giving direct care to deliver the goods.

I wish to end on a confident note. Every Rcn Council believes that times are worst during its own particular term of office. I will claim no more than to say - I think with a large degree of understatement - that we have not had an

easy time over the last four years.

And yet look what we have achieved in that time - an increase in membership from 150,000 to 225,000 - a growth rate that, according to the 1982 Annual Report of the Certification Officer, made us by far the fastest growing of any trade union at the beginning of the 1980s.

This achievement is not accidental. The Rcn is, we believe, not only the trade union of today - it is the model of an effective trade union for the future, combining as it does, established educational and professional functions with those relating to the role of its members as employees, and, more importantly, successfully balancing the sometimes conflicting demands of each.

By now you will have caught the theme of this address. Let me end by spelling out the phrase to characterise Rcn action in the coming year - 'Let's get political, but stay professional'.

END

PRIME MINISTER

NATIONAL HEALTH SERVICE

As you will see from the attached PA Report, the leaders of the Royal College of Nursing have been attacking the Government in particular on kidney and bone marrow patients. You have already given the House some figures on kidney patients which shows that under this Government more people have been treated. I am getting similar figures for bone marrow patients. As you will recall, Kenneth Clarke announced an increase in the provision for such transplants of £150,000 to £500,000 a year.

Of the material you have and have not so far used, perhaps the most telling is that under this Government the proportion of GDP devoted to the Health Service has increased from 4.7% to 5.5%, whereas under Labour it fell from 5.3% to 4.7%.

On the specific issues of kidney and bone marrow patients, perhaps the best line is that this Government has increased provision (figures to be supplied). We would all like to devote more resources to such deserving cases but as the Merrison Committee pointed out, they "had no difficulty believing the proposition put to us by one medical witness that we 'can easily spend the whole of the Gross National Product'".

TF

9 November 1983

Prime Minister (2)
Some good advice from Sir Robin Ibbs
AT 8/11

EFFICIENCY UNIT

70 WHITEHALL, LONDON SW1A 2AS
Enquiries : 01-233 8412
Direct line : 01-233 7359

2 November 1983

The Rt Hon Norman Fowler MP
Secretary of State for Social Services

Dear Norman

NHS MANAGEMENT ENQUIRY

Thank you for sending me a copy of your minute to the Prime Minister about the management enquiry report, which I have now had chance to read. I thought the proposals offer an excellent opportunity to start switching the emphasis in the public mind from "cuts in services" to the effective management of available resources at all levels.

2. The proposed management structure seems sensible and I have no reason to question the conclusions. But they amount to a sizeable change in emphasis and I would not understimate the difficulties of implementing the substance rather than the form.

3. The whole of my experience is that the problem to concentrate upon is how to move from where we are now to where we want to be without falling on our faces. Management of the transition is crucial when, as in this case, the new management structure is intended to change the culture of the service and to change behaviour.

4. For example, merely to bring in business managers will not be enough. No matter how good, they will be swamped by the opponents of change unless the ground has been thoroughly prepared for success. The fact is that the NHS has to continue to function to acceptable standards during the change and a serious falling away - no matter what the cause - would discredit the changes you are seeking to make.

5. I am very willing to discuss this further with you and your officials. But in short, my advice would be to set four priorities:

(1) To get good people into the key general management positions. These must include some who know their way around the system and can use

its existing levers of power to deliver what you want.

(2) To put the management load on to the new system quickly and in particular to curtail headquarters drastically so that the new structure holds sway.

(3) To insist that the new management sets and monitors targets for improved performance at all levels down an unbroken line of management from you to the individual NHS employee. (I am troubled by the current divisions between administrators and medical staff and between civil servants and NHS staff.)

(4) To keep up the momentum for greater efficiency and change on the ground (such as through the NHS scrutiny programme, for example) which will encourage people at different points in the NHS who know what is needed to make changes.

6. Let me repeat that I and the Efficiency Unit are very willing to talk to you or your staff about the transitional arrangements or any other aspect of the report and to help in whatever way we can.

7. Copies of this go to the Prime Minister and other recipients of your minute of 11 October.

SIR R IBBS

Robin Ibbs

Nat Health, Expenditure, pt 2

Donald LONGMORE

16/12 ~~AH2/12~~ VC.
~~BH 18/11~~

10 DOWNING STREET

From the Principal Private Secretary

27 October 1983

Thank you for your letter of 27 October. I am sorry that your initial reaction to the Griffiths Report is unfavourable.

I think that the Prime Minister would find it very helpful if you had time to let her have your views on it. If, alternatively or additionally, you would like me to arrange for you to have a talk with those concerned in the DHSS I will gladly do so - but it may be that you have the necessary contacts there already.

FERB

Donald Longmore, Esq., FRCSEd

DEPARTMENT OF CLINICAL PHYSIOLOGY

NATIONAL HEART HOSPITAL

MR. DONALD LONGMORE

WESTMORELAND STREET, LONDON W1M 8BA
TELEPHONE 01-486 0824
01-486 4811

Our Ref.

Your Ref.

27th October, 1983

Mr. R. Butler,
Principal Private Secretary,
10 Downing Street,
London S.W.1

Dear Robin

Thank you very much for sending me a copy of the Griffiths Report. I have had a preliminary read through it and find several aspects of it very disturbing. Once again an extra layer of administration is proposed. Although separation of health care from Social Security is implied, the D.H.S.S. will remain; thus the bulk of money intended for health care will continue to be diverted into irrelevant administration. The new health board will still be answerable to higher authority, which will include of all the ludicrous things the Prinicpal Medical Officer. The Report seems to be largely based on what the D.H.S.S. and previous reports have said rather than a real analysis of the problem. Where they suggest that Florence Nightingale pacing the wards with her lamp would find it difficult to find someone responsible and in charge, I venture to suggest she will find it difficult to find a nurse, but to find numbers of people she would have to carry her lamp into the administrative blocks of the Regions and Districts etc.; all of which have nothing to do with patient care.

Implementation of this Report in this form without further thought will deliver the coup de grace to the Health Service and in my view would hasten the demise of the Government. I do hope the great opportunity for sensible reform is seized whilst everyone is in the mood for change and reform.

Do you think it would be helpful when I have read the Report through carefully, annotated it and made notes, that it would be worthwhile to send a critique of it to Mrs. Thatcher?

All good wishes.

Yours sincerely,

Donald.

Donald B. Longmore, FRCSEd
Consultant Clinical Physiologist

CONFIDENTIAL

NBPM

AT 26/10

H M Treasury
Parliament Street London SW1P 3AG
Switchboard 01-233 3000
Direct Dialling 01-233 ....

A M Bailey CB
Second Permanent Secretary
Public Services

Sir Kenneth Stowe KCB, CVO
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
London SE1 6BY

25 October 1983

Dear Ken,

NHS MANAGEMENT ENQUIRY

I have seen the copy of your letter of 7 October to Robin Butler, and copy of the Griffiths Report, which you sent to Peter Middleton.

2. Like you, I think it is excellent. Your Secretary of State is making a statement today, and no doubt you will be thinking how best to follow up the various proposals.

3. Clearly there are a number of important issues here, relating particularly to the organisation of DHSS. In view of this, I would very much like to have an early meeting with you to discuss how you propose to carry matters forward; I am asking my secretary to see if a convenient time can be arranged.

4. I imagine that your first step will be to set up the Supervisory Board, and then the Management Board. I note the reservation in your letter about the size, composition, and grading of the Board; but I am not clear how you propose to integrate it into the present DHSS structure. An early talk should help us to understand and approve your proposals when you are ready to put them to us.

5. I am copying this letter to Robert Armstrong and Robin Butler.

Yours,
Alan

A M BAILEY

National Health: Expenditure & Efficiency

A2

27 OCT 1983

PRIME MINISTER'S QUESTION TIME
25 OCTOBER 1983

HANSARD Col 141

Q2. **Mr. Fisher** asked the Prime Minister if she will list her official engagements for Tuesday 25 October.

The Prime Minister: I refer the hon. Gentleman to the reply that I gave some moments ago.

Mr. Fisher: Will the Prime Minister confirm that as a result of the Government's cuts in NHS manpower, the real job loss in the NHS in the west midlands is not the 140 that her Secretary of State claimed but 3,626? Will she report this fact to her "Star Chamber" of Ministers when they next discuss the cuts that the Government are making?

The Prime Minister: The numbers employed in the NHS went up enormously during the lifetime of the last Government—very much more than in the lifetime of the Labour Government. The same is true of the amount spent on the NHS. Even after a reduction of half of 1 per cent. in NHS manpower in Great Britain, the numbers employed under this Government will far exceed anything under the last Labour Government.

NHS file

STATEMENT ON NATIONAL HEALTH SERVICE MANAGEMENT INQUIRY:
TUESDAY 25 OCTOBER 1983

With permission, Mr Speaker, I would like to make a statement on the publication of the advice given to me by the National Health Service Management Inquiry. As the House will recall I set up an inquiry into the management of the health service under the Chairmanship of Mr Roy Griffiths, the Deputy Chairman and Managing Director of Sainsbury's, in February of this year. I asked him to review current initiatives to improve the efficiency of the health service in England and to advise on the management action needed to secure the best value for money and the best possible service to patients. I have today placed in the Vote Office copies of the report which I have now received from the Inquiry Team.

The Inquiry Team endorses the main initiatives that the Government has already taken to make health authorities accountable for the performance of the services they provide. However, they say an enormous programme of management action is still needed. The Inquiry Team found that at all levels in the National Health Service there is a lack of a clearly defined general management function. Responsibility is too rarely placed on one person. Although they would like to harness the best of the consensus management approach, they found that at present consensus management can lead to lowest common denominator decisions, and long delays in the management process. Another effect is that the process of devolution of responsibility is ineffective.

Accordingly the Inquiry Team propose a series of changes aimed at making the existing organisation work better in practice rather than aiming at yet another restructuring of the service.

Inside the Department of Health the Team propose that I should set up and chair a new Health Services Supervisory Board. The Board would have some external members and directly accountable to it would be a Management Board which would bring together the present management functions of my Department relating to the Hospital and Community Services, the Family Practitioner Services and Special Health Authorities. A new Chairman of the Management Board would be appointed probably from outside the Service. The report also proposes that a Personnel Director should be recruited.

At the regional and district level the report recommends the identification of a General Manager for each authority. Such a manager would be drawn from any discipline - that is from any of the professions engaged in the management of the National Health Service and his job would be to secure effective management of the Authority's services.

The report also recommends that hospitals and other units of management should as far as possible take all the day to day management decisions. Doctors should be closely involved in local management through the development of management budgets for which they would be accountable. The Team also recommends the identification of a General Manager for every major hospital and other unit of management.

In short, the key recommendation is that a clear management responsibility should be identified for carrying out all National Health Service management functions and that this responsibility should be devolved as near to the patient as is practicable. The report is also in no doubt that major cost improvement programmes can and should be initiated in the National Health Service aimed at much higher efficiency to be sustained over much longer periods than at present.

There are three additional points to make on this report.

First, the report does not propose any further structural reorganisation. All its recommendations are designed to take place within the existing statutory structure and without affecting the constitutional position of Parliament, Ministers and the health authorities.

Second, the recommendations will not add to existing costs or staff numbers. Indeed inside the Department of Health they should lead to a reduction of activities and staff.

Third, the report emphasises that the National Health Service is about delivering services to people. It is not about organising systems for their own sake. The Team say that the driving force behind their advice is their concern to secure the best deal for patients and the community within available resources; the best value for the taxpayer; and the best motivation for staff.

Mr Speaker, the Government very much welcomes the general thrust of this advice and is very grateful to Mr Griffiths and his colleagues.

I shall be setting up within my Department the Health Services Supervisory Board as recommended. Among its first tasks will be to establish the Management Board and to initiate action in respect of health authorities. Clearly I will consult with the health authorities and professional and other interests involved, but subject to the outcome of these consultations I would hope that authorities would be able to start implementing the general management function from April 1984.

The National Health Service is one of the largest undertakings in Western Europe. The Service needs and deserves the very best management we can give it. One of the best contributions we can make to patient care is the improvement in National Health Service management along the lines recommended by the Griffiths Report.

24 October 1983

MR TURNBULL

THE NATIONAL HEALTH SERVICE

Our case on the National Health Service is that we should seek greater value for money. Value for money has three important aspects. Firstly, there is the need to reduce and control costs, the side of the argument that we have stressed continuously in recent weeks. Secondly, there is the need to redirect some resources from those areas of the National Health Service where they are being wasted to other priority areas where care is insufficient. Thirdly, there is the need to define the standards and range of service that can be delivered for £15,000 million, and to guarantee certain standards of patient care in a positive way. It is this third element in value for money policy which has received little attention, and on which more work should be done.

We have recently talked to auditors involved in the last 2 years in District and Regional Health Authority audit. They bear out the message of Griffiths in a vivid way:

1. A lack of financial control. For example, a district was paying for several telephones that had long since been buried in the bottom of cupboards, or were installed in Halls of Residences by mistake and were being used by the staff for free personal calls.

2. Lack of control over payroll costs. Whilst some doctors are working very long weeks on punishing rotas, other doctors are failing to work the rotas required under their contract. There is no attempt to tie in work rotas to the payroll system.

3. Overtime. In some hospitals and districts, up to 5 per cent of the payroll costs can be saved by proper control over overtime, and making sure that it is only authorised when real work needs to be done. In one hospital examined, every maintenance man was being paid the maximum bonus and the maximum on-call rate, whereas only one-tenth of the maintenance men needed to be on call at the time.

4. Stock control. There is practically no effective stock control in any DHS hospital. It is well known that linen, for example, is often stolen by patients or staff, and there is no real control over the losses.

5. Drugs. Drug wastage occurs on an enormous scale, whilst there is often a preference by the doctors to prescribe branded rather than generic drugs, although the generics would be cheaper and would do the job just as well.

6. Administrative staff. There has been a tendency in the districts to appoint too many senior tiers of administrator. A district need only have one tier of senior management communicating direct to the people doing the job on the ground.

There are many other examples such as these of how the failure to implement sound management practice results in enormous losses. On the other side of the equation, despite the large number of statistics produced, there is a shortage of reliable information on how the real needs of patients are going to be met. For example:

1. Waiting lists. There is no agreed standard on how to calculate a waiting list, and little effort to manage hospital services in such a way that the numbers on the waiting list are reduced as quickly as possible.

2. There are inadequate records for a hospital authority to decide on the priorities in the allocation of both its capital budget and its manpower between the different kind of needs within the community for health care.

3. Although we are now pledged to strengthening preventive medicine, we do not seem to have put much flesh on the bones of this policy. We need to explain more how we are going to encourage better diet, reduction in smoking, use of vaccines and screening to catch health problems early in their development.

In summary, we need to use some specific ammunition in arguing our case about the need for cost reductions, and we should

launch the idea of a patients' charter which illustrates the range and type of health care a patient deserves and should have access to, and acts as a standard by which the different District Health Authorities will be judged in the delivery of their service. By shifting the argument to the more positive features of the delivery of health care, we would do the Health Service and ourselves a great service.

JOHN REDWOOD

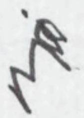
10 DOWNING STREET

Prime Minister

Some useful ideas about how the Government can go on the offensive. But we should surely be cautious about underwriting a particular standard of service to which patients are entitled.

AT

24/10



NBPM

AT 25/10

CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street, SW1P 3AG

Ellen Roberts
Private Secretary
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

24 October 1983

Dear Ellen

The Chief Secretary has seen your letter of 21 October enclosing a draft statement on the NHS Management Inquiry.

He thinks that the statement should make clearer the Government's commitment to implement the proposals and might also clarify, right at the beginning the general, theme of the report. This might be achieved on the lines of the attached amendments.

I am copying this letter to Andrew Turnbull, Colin Jones, John Graham, John Lyon and Colin Marshall.

Yours sincerely

J.R. Gieve

JOHN GIEVE
Private Secretary

At the end of the third paragraph insert the following.

"Key recommendations underlying the report are that there should be clear managment responsibility identified for carrying out all NHS functions, and that this responsibility should be devolved to the lowest level at which it can be effectively carried out.

The Government accepts the recommendations of the Inquiry team, and I intend to implement them as quickly as possible."

Fourth paragraph, line 7

Insert after "together" "and clarify"

Paragraph 6 - Start as follows:

"The presumption is that, unless there are overriding reasons to the contrary, Units of Management......

Line 2 - delete "as far as possible"

Paragraph 9 - delete "the Government .....advice

Line 10 - replace "determine" with "consider"

Line 12 - insert after "health authorities". "They will involve significant changes in present management practice, and it is right for me to consult them and the professional, and other interests involved;"

Line 13 - delete "subject ...consultation" insert "but"

Add new paragraph at end to read as follows:-

"Mr Speaker, I would like to take this opportunity to thank the Inquiry team for their work. I believe their proposals will help to make the NHS even more efficient and responsive to patients' needs. The Government intends to implement the recommendations as quickly as possible."

~ at Health,
NHS Exp,
pt 2

25 OCT 1983

Prime Minister

To note that Scotland are endorsing the NHS Management Enquiry

AT 24/10

SECRETARY OF STATE FOR SCOTLAND

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

Andrew Turnbull Esq
Private Secretary
10 Downing Street
LONDON

24 October 1983

Dear Andrew,

STATEMENT ON NHS MANAGEMENT INQUIRY

My Secretary of State has been keeping in close touch with developments on this matter and has decided that, while the inquiry report is not written in terms which are directly applicable in Scotland, he should nevertheless indicate his general agreement with the principles on which the report is based and also what further action he intends taking. This will be done by means of an arranged PQ the text of which I now enclose.

I am copying this letter to Colin Jones (Welsh Office), John Lyon (Northern Ireland Office), John Gieve (Chief Secretary's Office), Ellen Roberts (DHSS), and Charles Marshall (Lord Privy Seal's Office).

Yours sincerely

Eddie Gowans.

EDDIE GOWANS
Private Secretary

DRAFT ARRANGED PARLIAMENTARY QUESTION FOR ANSWER BY THE SECRETARY OF STATE FOR SCOTLAND ON 25 OCTOBER 1983

Q. To ask the Secretary of State for Scotland, what implications the Report of the NHS Management Inquiry has for Scotland

A. Though the National Health Service Management Inquiry which was set up by my right hon Friend the Secretary of State for Social Services did not cover Scotland, and the Inquiry Report is not written in terms which are directly applicable in Scotland, I am in general agreement with the principles on which the Report is based. I shall consider without delay how these principles can be applied to the management of the Scottish Health Service, consult the various interested parties and make a further statement in early course."

CONFIDENTIAL

Smp

10 DOWNING STREET

From the Private Secretary

24 October 1983

Dear Ellen,

Statement on NHS Management Inquiry

The Prime Minister has seen the draft statement attached to your letter of 21 October. She wonders whether the tone could be made rather more positive, emphasising the contribution to the health service which the Government can make by improving the quality of its management. More specifically, she has commented that the Chairman of the Management Board should be the Chief Executive of the entire health service. If this is the intention she feels it does not come out very clearly from the current draft. Subject to these points she is content for the statement to be made on Tuesday.

I am copying this to Colin Jones (Welsh Office), John Graham (Scottish Office), John Lyon (Northern Ireland Office), John Gieve (Chief Secretary's Office) and Charles Marshall (Lord Privy Seal's Office).

Yours sincerely
Andrew Turnbull

Andrew Turnbull

Miss Ellen Roberts,
Department of Health and Social Security.

CONFIDENTIAL

D/C

BM

10 DOWNING STREET

(1)

Prime Minister

Is this upbeat enough? Refers to "energetic management" but could go further.

Agree subject to slightly higher tone?

AT
21/10

Surely the Chairman of the Management Board should be the chief Executive (i.e. Managing Director) of the entire Health Service? If this is the intention, it doesn't come out very clearly. MT

CONFIDENTIAL

cc. BI
AWT

For Tuesday

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

Andrew Turnbull Esq
Private Secretary
10 Downing Street

21 October 1983

As you know, my Secretary of State is to make an oral statement to the House on Tuesday on the NHS Management Inquiry. I attach a draft, on which I would be grateful for any comments by Monday.

I am copying this to Colin Jones, John Graham, John Lyon, John Gieve and ~~Colin~~ Clare Marshall.

Ellen Roberts

Ellen Roberts
Private Secretary

CONFIDENTIAL

DRAFT

NHS MANAGEMENT INQUIRY: SECRETARY OF STATE'S STATEMENT TO THE HOUSE ON PUBLICATION

With the permission of the House, Mr Speaker, I would now like to make a statement to the House on publication of the advice given to me by the NHS Management Inquiry.

I have today placed in the House of Commons Library and the Vote Office copies of a report dated 6 October from Mr Roy Griffiths, leader of the Management Inquiry team. This summarizes their advice on the two main tasks I set for the Inquiry on 3 February: to review current initiatives to improve the efficiency of the NHS in England; and to advise me on the management action needed to secure the best value for money and the best possible services to patients.

The Inquiry team endorses the main initiatives the Government has already taken to make Health Authorities accountable for the performance of the services they provide, and they have made further important recommendations about necessary management action for the three levels of the NHS: my Department, the Regional Health Authorities and the District Health Authorities.

The report recommends that I should set up and chair a new Health Services Supervisory Board. The purpose of the Board is to strengthen the existing arrangements within my Department for the oversight of the NHS. The Board will have some part-time external members. The report recommends a Management Board, directly accountable to the Supervisory Board, to bring together the present management functions of my Department relating to the hospital and community health services, family practitioner services and special health authorities. It should have full-time members recruited from the private sector - probably including the Chairman and at least one other member initially -as well as from the NHS and my Department.

The report also recommends the identification of a general manager for each Regional and District authority, drawn from any discipline, to secure effective management of the Authority's

Units of Management in the health service, for example the District General Hospital, should, as far as possible, take all their own day to day management decisions. Doctors should be closely involved in local management through more effective advisory arrangements and the development of management budgets for which they would be accountable. The team also recommends the identification of a unit general manager, again identified regardless of discipline.

In short the report recommends changes in the arrangements for consultation and decision, so as to speed up and simplify local management action. Additional recommendations on personnel, finance, works and property functions complement the energetic style of NHS management now proposed.

There are three important points to make on this report:-

first - the report does not propose any further structural reorganisation: all its recommendations are designed to take place within the existing statutory structure and without affecting the constitutional position of Parliament, Ministers and the statutory health authorities;

secondly - the recommendations will not add to existing costs or staff numbers, indeed the report emphasises the scope for initiating major cost-improvement programmes within the NHS.

Thirdly - underlying all that the report recommends is the desire to secure the best deal for the patient, the best value for the taxpayer and the best possible working environment and career opportunities for staff.

The Government very much welcomes the general thrust of this advice. I shall be appointing, within DHSS, the National Health Service Supervisory Board, which I shall chair. I am pleased to announce that Mr Roy Griffiths has agreed to serve

on the Supervisory Board, to provide, on a transitional basis, the external business advice recommended by the Inquiry team. [I am also pleased to say that the other members of the team, Mr Blyth, Mr Betts and Sir Brian Bailey have agreed to continue to assist the Board.] Amongst its first tasks will be to determine the composition and membership of the Management Board. The remaining important recommendations call for action by the health authorities. I am consulting them and the professional and other interests involved; subject to the outcome of this consultation I hope Authorities will be able to start implementation by 1 April 1984.

NHS file

Original sent to Appointments.

10 DOWNING STREET

Prime Minister

Norman Fowler wishes to invite Roy Griffiths to serve on the new NHS Supervisory Board (which is above the management board). He wants to write to Sir John Sainsbury asking for Griffiths to be released for this part time work. He would like to be able to say "I am sure the Prime Minister will join me in ~~[illegible]~~ hoping that you will make Roy available".

Agree ?

AT
19/10

Note - Prime Minister agreed. I informed Sir Kenneth Stowe's office

Prime Minister ②

A helpful step forward. We are taking steps to achieve X.

AT 18/10

SECRET

Treasury Chambers, Parliament Street SWIP 3AG

Steve Godber Esq
PS/Rt Hon Norman Fowler MP
Secretary of State
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

18 October 1983

Dear Steve

Following the Chief Secretary's meetings with your Secretary of State on 4 and 18 October, this letter records the agreements reached.

On the health side your Secretary of State is now prepared to carry forward to later years the 7 July cuts in return for an understanding on the financing of pay in 1984-85 and for provision of sufficient growth in health service resources to maintain standards for the growing number of old people. The following additions to the survey baseline are, therefore, agreed

1984-85	1985-86	1986-87
+5	+123	+370

As discussed, the Chief Secretary confirms that the figure appearing in the White Paper for total English health service expenditure in 1984-85 will be £13,130m. Your Secretary of State considers that the increase proposed in 1986-87 will only provide sufficient resources for the cash limited services if inflation turns out to be around 3 per cent. The Chief Secretary accepts that the figures for the final year will need to be reconsidered on both sides in subsequent reviews in the light of inflation, other economic factors and the growing demands on the health service. He understands that although your Secretary of State considers there is a strong case for a larger figure for 1986-87in this Survey :

(and would wish to return to this point if the cash increase for programmes as a whole were changed or decisions were taken leading to large savings on other programmes) he is reluctantly prepared to settle on this basis.

On health service pay, the Chief Secretary clearly could not give the Secretary of State an absolute commitment to fund all of any excess above 3%. But he recognises that the Secretary of State faces two particular difficulties which taken together place him in a special position. Over half of NHS staff are covered by review bodies; and he cannot hold back funds to finance any significant excess above 3% without this being obvious, so that if the major part of the excess were to be financed from existing NHS provision, it would require in-year cuts.

The Chief Secretary is willing to agree to the following assurance:

> If the pay settlements agreed by Ministers for NHS groups covered by review bodies exceed the 3% cash provision, it is agre that the excess beyond the provision should be financed by:
>
> (a) DHSS and Treasury examining whether any offsetting savings towards the excess can be found without damaging health services;
>
> (b) If there is any remaining excess beyond the agreed savings at (a), the provision should be increased by that amount from the Contingency Reserve to finance the balance.

In limiting the assurance to the review body groups, the Chief Secretary is not intending to rule out the possibility of access to the Contingency Reserve for other groups, if Ministers were to agree to pay settlements for them which could not be fully financed from offsetting savings.

On social security, your Secretary of State has agreed to provide public expenditure savings in total of £251m in 1984-85, £374m in 1985-86 and £407m in 1986-87. In addition he will take measures to reduce rate rebates by some £50m in each year (these do not count as public expenditure). The Chief Secretary has agreed to accept the bid for replacement of HNCIP and to certain additions to the baseline for demand led expenditure and administrative costs. The net effect on public expenditure, measuring from the PESC baseline, is as follows:

1984-85	1985-86	1986-87
- 60	- 50	+ 323

The Chief Secretary has asked me to thank the Secretary of State very much for his cooperation in this; he is pleased that it has been possible to close the gaps on both the health and social security sides. When Cabinet comes to discuss the results of the bilaterals there will be outstanding disagreements with a number of Ministers but the £2½ billion target will be attainable if they are prepared to agree to the savings which the Chief Secretary is seeking. He will however have to make it clear to Cabinet that, if this is not achieved, it will be necessary to consider whether further savings should be sought from other programmes.

The Social Security programme could not be excluded from this, despite the difficult measures which would need to be taken.

X The Chief Secretary understands the difficulties that your Secretary of State would face should the details of this agreement leak out before the public expenditure negotiations are complete and the Autumn Statement has been published. He will do all in his power to ensure that this does not happen. His minute to the Prime Minister will be classified CMO.

I am copying this letter to Sir Robert Armstrong and to Robin Butler.

Yours sincerely

J.S. Gieve

JOHN GIEVE
Private Secretary

SECRET

CONFIDENTIAL

SH

10 DOWNING STREET

From the Private Secretary

17 October, 1983

Dear Steve,

NHS Management Inquiry

The Prime Minister has seen your Secretary of State's minute of 11 October. She agrees that the Government should accept the recommendations of the Griffiths Report and that your Secretary of State should make a statement before the Debate on the Health Service on 27 October. She hopes this statement will be cast in a positive way, stressing the need to give the NHS the best management that can be found for it rather than giving the appearance of just another cost cutting exercise.

She has commented that the success of the proposals depends crucially on getting the right people into a few key posts. She has asked whether your Secretary of State has any names in mind.

I am copying this letter to Private Secretaries to the Lord President, Chancellor, Chief Secretary, Secretary of State for Northern Ireland, Secretary of State for Scotland, Secretary of State for Wales, Lord Privy Seal, Sir Robert Armstrong and to Sir Robin Ibbs.

Yours sincerely

Andrew Turnbull

ANDREW TURNBULL

S. A. Godber, Esq.,
Department of Health and Social Security

CONFIDENTIAL

10 DOWNING STREET

(4)

Prime Minister

Yes but see below.

NHS Management Inquiry

Agree:

(i) that Government should accept Griffiths' recommendations, pages 3-9. (To note in particular creation of a Supervisory Board and a Management Board)?

(ii) that a statement be made before Debate?

To note Policy Unit advice that statement should be positive, stressing that NHS is being provided with best management available, not just being subjected to ~~[illegible]~~ cost cutters.

AT 14/10

None of this will work unless we can find the right people. Have we any names in mind?

MT

MR TURNBULL

14 October 1983

cc Mr Mount
Mr Ingham

Mr Fowler proposes to publish this report a day or two before the Debate on the Health Service on 27 October. There are two issues which ought to be clarified by then:

(i) has the DHSS fully thought through the implications of the report?

(ii) how should the report be presented in a way which will win back the initiative on the health service?

The Recommendations

There is no question but that the Government should accept the main thrust of the report - the need to inject a managerial approach into the NHS, to replace "consensus management" by real managers, who will be identifiable, accountable for the use of their resources and responsible for health care performance. Everyone in the NHS would then know the answer to the question: who is in charge here? The answer at present is: everybody and nobody! Clinicians, nurses and administrators can each veto proposals and appeal, via their own vertical lines of authority, to the next tier in the hierarchy. The veto and the right of appeal will no longer be available under the proposed arrangements. The general manager, at the hospital, district or region, will have, and be seen to have responsibility for decisions.

The report records a ground swell of support in the NHS for this approach. It probably underestimates the difficulties of securing the changing attitudes needed. It will be important, in presenting these proposals, to stress that the NHS manager will be the best person for the job and that he, or she could have a medical, administrative or business background. The replacement of a number of existing staff would probably be needed.

Regional Health Authorities

We are anxious to see the very minimum of duplication of district functions at the regional level. The report states that

"the role of regions needs to be strengthened". The intention is that the RYAs would exercise a taut control on a few but important matters, not that they will acquire more functions. The report is too vague on this point. We think that Mr Fowler will need to emphasise at the outset that decisions will be pushed down the hierarchy.

Problems at the Centre

The proposed reforms will only achieve their intended results if the logic of the report is fully followed through at the top. The hidden message in the report is that part of the NHS problem lies in the DHSS itself:

(i) its structure resembles that of the NHS in the sense that two Permanent Secretaries - an administrator and a Chief Medical Officer - and their respective staffs, work in parallel, coming together only at the Ministerial level;

(ii) the DHSS sees itself as being politically responsible for any and all of the operations of the NHS, answering PQs on bed utilisation in Stoke Poges, or whatever.

The intention of the authors of the report is to depoliticise the NHS to an important degree. There is no point in appointing good managers and securing acceptance of their authority by their staff if at the same time they are subjected to detailed political interference on operational matters. If Mr Fowler is to make his reforms work he, and his successors, will need to be prepared:

(i) to back the authority of the Chairman of the Management Board (let us settle on a better title: Director-General?);

(ii) to reply to parliamentary colleagues that operational matters are the responsibility of NHS management. The logical counterpart to this is that NHS managers must go out of their way to respond to what the public wants, rather than just waiting for complaints.

A useful bi-product of this approach is that the DHSS could shed many of the posts concerned with looking after the NHS.

Conclusions

Our advice is that, in reply, the Prime Minister might:

(i) endorse the report and the handling of it which is proposed;

(ii) says that she hopes that Mr Fowler will consider how to give authority to the Chairman of the Management Board, along the lines indicated above;

(iii) looks forward to hearing how Mr Fowler proposes to present this initiative. It will be important to present the changes in the most positive possible way, avoiding any suggestion of a cost cutting exercise eg "that in view of the importance of the NHS in our national life it deserves the very best management that it is possible to obtain".

Agreed

NICHOLAS OWEN

10 DOWNING STREET

PRIME MINISTER

Attached is a letter from Neil Kinnock returning to his request in Government time for a debate on the National Health Service. Since Mr. Kinnock is already aware of the answer he will get I suggest that you reply in rather cursory tone and a draft along these lines is attached. I gather that Mr. Kinnock at present intends to lead in the proposed debate. I see, however, no reason why this should alter your earlier view that we should not treat the debate as being a particularly special occasion and that, therefore, DHSS Ministers should respond to it.

12 October, 1983

TF

cc NO

PRIME MINISTER

NHS MANAGEMENT INQUIRY

I have now had the opportunity of reading and digesting the attached report from the Management Inquiry Team and the covering personal letter from Roy Griffiths, which Ken Stowe copied to your office last Friday.

Subject only to one or two minor presentational points this is an admirable document which has my full support. I want to implement its main recommendations, starting within DHSS to show we mean business. It provides an invaluable validation of all we are doing, and intend to do, to improve the management of the NHS. It will also help us to meet the criticism we are getting over manpower targets and expenditure cuts.

It will be most important to publish the report in full before the Debate on the Health Service on 27 October. I envisage publishing the report, probably by way of a statement, no more than a day or two before the Debate. I shall want to make it clear that the Government accepts the Griffiths recommendations and intends to implement them vigorously in consultation with health authorities and appropriate bodies including the Professions.

I will be circulating to you and the other recipients of this letter the terms of my proposed statement on publication of the report. My broad approach will be to accept the report in general and ensure its vigorous implementation by the health authorities and other bodies concerned as urgently as possible, subject to some necessary adjustment at the edges in the light of consultation.

I am copying this letter and the report to Willie Whitelaw, Nigel Lawson, Peter Rees, James Prior, George Younger, Nicholas Edwards, John Biffen, Robert Armstrong and Robin Ibbs.

11 October 1983

N F

Press
Lord Privy Seal
DHSS
Murdo M'LEAN.

cc - MA 11/10

HOUSE OF COMMONS
LONDON SWIA OAA

The Office of the Leader of
the Opposition

11 October 1983

Dear Prime Minister,

Thank you for your letter of 7 October responding to my request for a debate in Government time on the Health Service. I must record my disappointment with your response.

I gather from your reply that you appear to think that your Government has a creditable record in Health Service matters. And yet you will not give Government time to presenting that record.

Your Secretary of State feels obliged - according to recent press reports - to address a meeting of Conservative MPs on the matter. But it seems that he would not, without the prompting of the Labour Opposition and the facility offered by an Opposition Day, be fulfilling the same obligation to the public.

As you are aware, because of the recent changes in procedure from Supply Days to Opposition Days, the Opposition has less flexibility in the timing of debates. We will, if there is no other means of securing a debate on the Health Service, use one of those days because it is an issue of critical importance to the country. But a Government which obviously does not have such severe constraints upon the Parliamentary time at its disposal should surely not require an Opposition to use up its restricted time. This is particularly true of an issue recognised by the Government itself to be of a significance that is so great as to require private explanations by Cabinet members.

2/...

With these factors in mind, I must ask you to reconsider your initial reply and arrange for Government time to be given to a Health Service debate within a week of the return of Parliament.

In view of the importance I attach to this matter, I am releasing this letter to the press.

Yours sincerely

Neil Kinnock

Rt Hon Margaret Thatcher MP

cc: M.A

a DHSS
LPS
CWO
Press Office

10 DOWNING STREET

THE PRIME MINISTER

7 October 1983

Dear Mr. Kinnock,

Thank you for your letter of 7 October asking for a debate on the National Health Service.

As you will know from the last Business Statement the Leader of the House has arranged for an Opposition Day on Thursday, 27 October. This will provide an opportunity for the debate you seek. Norman Fowler and Kenneth Clarke would, I know, welcome the chance to set out the increased provision for the Health Service made over the last four years.

Yours sincerely

Margaret Thatcher

Neil Kinnock, Esq., M.P.

cc Press
Charles Martin
LPS office

OVO

HOUSE OF COMMONS
LONDON SW1A 0AA

The Office of the Leader of
the Opposition

7 October 1983

Dear Prime Minister,

I am writing to you to ask for a debate, in Government time, on the crisis in the National Health Service. I am sure you will regard it as a matter of priority for the first week of the new session of Parliament.

There is mounting concern throughout the country about the future of the National Health Service. The most recent cuts have raised further doubts about its long-term future.

I look forward to your favourable response to my request for the debate which would clarify the position of your Government to this most important of our services.

Yours sincerely

Neil Kinnock

Rt Hon Margaret Thatcher MP

M. Turnbull - to see
Mr Barclay
file

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe KCB CVO

Robin Butler, Esq.,
No. 10 Downing Street,
London SW1

7 October, 1983

Dear Robin.

- dated 6/10

I enclose a copy of Roy Griffiths' report on NHS Management, as promised.

My own view is that it is excellent - just what I was hoping for. It validates all I have been doing - with Norman Fowler's enthusiastic backing - and gives us a base for moving forward.

We are handling the report on a very restricted basis at the moment because it is essential that it be presented to the NHS in terms of our choosing and not via a press leak. We want to pave the way in the Secretary of State's speech to the Party Conference. And we then want to promulgate it with announcement of immediate action so that it hits the ground running.

I have one reservation which I have already mentioned to Robert Armstrong. The Report deliberately and wisely avoids the single-bullet prescription (page 18) for establishing the general manager function but breaks its own rule for the Department as to the size, composition and (implicitly) grading of the Health Services Management Board. The idea of the Board as an effective device for getting things done is good. But I doubt if we need it to be souped up to the point where we have, in effect, another Permanent Secretary and five more Deputy Secretaries in the Department, three of them at £80,000+ salaries! The effect on the NHS pay scene can be imagined.

I am copying this letter and its enclosure to Robert Armstrong and Peter Middleton.

Yours ever

Ken.

NHS MANAGEMENT INQUIRY
Room D402
Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone: 01 407 5522 X7684/ 6604

Leader of Inquiry:

Roy Griffiths

Team Members:

Michael Bett
Jim Blyth
Sir Brian Bailey

Support Staff:

Cliff Graham
Kay Barton

PERSONAL

6th October, 1983

The Rt. Hon. Norman Fowler, M.P.,
Secretary of State for Social Services,
Department of Health & Social Security,
Alexander Fleming House,
Elephant & Castle,
LONDON,
S.E.1. 6BY.

Dear Mr. Fowler,

I attach a letter from the Management Inquiry team. It has been drafted in two distinct parts; first the recommendations, which are reasonably self-contained and, secondly, a background commentary which briefly gives the main reasons why we have arrived at the particular recommendations.

The recommendations themselves have been drafted to meet our own assessed requirement of rapid implementation, should it be so decided. For that, amongst other good reasons, we have not recommended any kind of statutory corporation for the Health Service. One of the arguments, however, in favour of a separate statutory body was that it might have been easier to recruit and reward people to be brought in from outside. We feel, however, that in any case, no obstacle should be placed in the way of such outside recruitment necessary, at least at the outset, to give both credibility and experience to the change in management style which is necessary.

It is important to appreciate the impact which a few very able professional top managers could make, both on the quality and cost of the Service. To attempt to implement the recommendations without these catalysts would be to accept the form but not the substance.

Equally, we emphasise that we are not talking simply about more appointments at the Centre.

/ Cont....

We should, even in the short term, be talking about a considerable reduction in numbers.

It would have been presumptuous to have included any timetable for implementation and it is probably unnecessary even to emphasise that implementation right through the NHS will be a long hard job and will require considerable skill, sensitivity and leadership. We believe, however, that it is both necessary and possible, almost regardless of the level of resources to be committed to the NHS.

Equally, we have not mentioned any priority of implementation, but clearly this would be to take action at the Centre to establish the nucleus of the Supervisory and Management Boards at an early date.

If there is any clarification or further justification needed of any of the recommendations, then we are available to help.

Very best wishes.

Roy Griffiths.

E.R. GRIFFITHS

Attach:

FOR RETURN TO C/F

COPY NO. 23

NHS MANAGEMENT INQUIRY
Room D 406
Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone: 01 407 5522 X7684/6604

Leader of Inquiry:

Roy Griffiths

Team Members:

Michael Bett
Jim Blyth
Sir Brian Bailey

Support Staff:

Cliff Graham
Kay Barton
Tim Stevens

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY.

6 October 1983

Dear Secretary of State,

NHS MANAGEMENT INQUIRY

This letter is not intended to be a major addition to the already considerable library of National Health Service literature. We were asked by you in February to give advice on the effective use and management of manpower and related resources in the National Health Service; to inform you as our inquiries proceeded; and to advise you on progress by the end of June. In particular, it was emphasised that we had not been asked to prepare a report, but that we should go straight for recommendations on management action. You have been kept in touch with our work and we have reported progress to you.

Our main recommendations are set out below. They are presented in the form of the management action to be taken by you, or the Health Authorities or other bodies concerned. You have already set the direction by instituting the regional reviews. There is still an enormous programme of management action necessary. Speed of implementation is essential. To that end the letter is in two parts: first, the recommendations which are self-standing and provide the basis for the necessary action; the second part makes some general observations and sets out the reasoning behind the recommendations.

One important prelude to the recommendations: we believe that a small, strong general management body is necessary at the centre (and that is almost all that is necessary at the centre for the management of the NHS) to ensure that responsibility is pushed as far down the line as possible, i.e. to the point where action can be taken effectively. At present devolution of responsibility is far too slow because the necessary direction and dynamic to achieve this is currently lacking. Staff within the Health Services have to be assured that in future when changes are being made, demands made on them will as far as possible be part of an orderly management process. Government and Parliament must be sure that, whatever level of resources is allocated to the NHS, the means to effect the necessary changes are available. We believe that our proposals would speed up that process.

All our recommendations are designed to be implemented without undue delay: none of them calls for legislation nor for additional staff overall; and all of them are completely consistent with present initiatives to improve costs. You will see that, in respect of our recommendations for management budgets and stronger management at Unit and hospital level, action is already underway in 6 hospitals and 4 District Health Authorities with the support of DHSS and the NHS and the doctors concerned.

RECOMMENDATIONS FOR ACTION

- THE SECRETARY OF STATE

1. The Secretary of State should set up, within the existing statutory framework a Health Services Supervisory Board and a full-time NHS Management Board.

2. The role of the Health Services Supervisory Board would be to strengthen existing arrangements for the oversight of the NHS. It would be concerned with:

    a. determination of purpose, objectives and direction for the Health Service;

    b. approval of the overall budget and resource allocations;

    c. strategic decisions;

    d. receiving reports on performance and other evaluations from within the Health Service.

   It should be chaired by the Secretary of State and also include the Minister of State (Health), the Permanent Secretary, the Chief Medical Officer, the Chairman of the NHS Management Board and two or three non-executive members with general management skills and experience. It would relate to statutory and professional bodies in the same way as Ministers and the DHSS do at present.

3. The role of the small, multi professional, NHS Management Board would be to plan implementation of the policies approved by the Supervisory Board; to give leadership to the management of the NHS; to control performance; and to achieve consistency and drive over the long term. The Board would have no separate corporate status. It would include a Chairman, who would perform the general management function at national level, e.g. as general manager,

chief officer or director general. He would act on behalf of, and be seen to be vested with executive authority derived from, the Secretary of State. As such he would ensure that Regional Chairmen were fully consulted and involved in the discharge of responsibility reserved to the Secretary of State. It would be consistent with these functions for him to be appointed as Accounting Officer for Health Service expenditure. The membership of the Management Board would include other functions such as personnel, finance, procurement, property, scientific and high technology management and service planning.

4. The Chairman of the NHS Management Board would need to have considerable experience and skill in effecting change in a large, service-oriented organisation and the Personnel Director would need a similar background. To meet these criteria, and to achieve credibility in establishing the new management style, these appointments would initially almost certainly have to come from outside the NHS and the Civil Service. Other functions would have to be strengthened by people with management experience in business, the NHS and Government. For example, the finance function would need strengthening from business, in respect of management accounting, and from the NHS for management budgets. In short, the NHS Management Board might have about nine members drawn from business, the NHS and the Civil Service.

5. The Management Board should cover all existing NHS management responsibilities in DHSS, including Regional and District Health Authorities, Family Practitioner Committees, Special Health Authorities, and other centrally financed services.

- REGIONAL HEALTH AUTHORITIES AND DISTRICT HEALTH AUTHORITIES

6. Regional and District Chairmen should:

6.1 extend the accountability review process right through to Unit managers;

6.2 identify a general manager (regardless of discipline), at Authority level, charged with the general management function and overall responsibility for management's performance in achieving the objectives set by the Authority;

6.3 be given greater freedom to organise the management structure of the Authority in the way best suited to local requirements and management potential;

6.4 clarify the roles of Chief Officers accordingly;

6.5 make explicit the main decisions reserved to the Authority meeting itself; the major reports and regular information required of particular officers by the Authority at set times; and how individual members should be involved in particular spheres of interest;

6.6 review and reduce the need for functional management structures, at all levels from Unit management to chief officers at Authority level, and ensure that the primary reporting relationship of functional managers is to the general manager;

6.7 initiate major cost improvement programmes for implementation by general managers.

7. Regional Chairmen should be directly involved in the appointment of District Chairmen by the Secretary of State.

- UNITS OF MANAGEMENT

8. District Chairmen should:

8.1 plan for all day-to-day decisions to be taken in the main hospitals and other Units of Management. If decisions are to be taken elsehwere in the NHS management process, Chairmen should require justification;

8.2 involve the clinicians more closely in the management process, consistent with clinical freedom for clinical practice. Clinicians must participate fully in decisions about priorities in the use of resources. The recommendations in the three "Cogwheel" reports (produced by the Joint Working Party on the Organisation of Medical Work in Hospitals in 1967, 1972 and 1974), and subsequent developments should provide the basis for such participation. Clinicians need administrative support, together with strictly relevant management information, and a fully developed management budget approach. This approach should prompt some measurement of output in terms of patient care, and should ensure that the time at present spent by doctors in meetings, committees, etc., will be reduced and employed more purposefully.

Closer involvement of doctors is so critical to effective management at local level that, with the support of the doctors concerned, the Inquiry has already undertaken small-scale studies in six hospitals. These illustrated the practicalities of involving clinicians in management and have stimulated local management action. The Management Board will need to prompt Chairmen to take similar action everywhere;

8.3 clarify the general management function and identify a general manager (regardless of discipline) for every Unit of Management;

8.4 see that each Unit of Management has a total budget;

8.5 arrange for district procedures to spell out:

8.5.1 the role of the Treasurer's department in providing management accountant support to Unit managers in the development of their budgets and in monitoring performance against them;

8.5.2 virement between Unit budgets and between individual budgets within the Unit, including the use of planned and unplanned savings;

8.5.3. authorisation limits and the flexible use of total resources; and,

8.5.4 the financial relationship between Unit budgets and any District-wide budgets for functional services on which the Unit may call;

8.6 ensure that each Unit develops management budgets, which involve clinicians and relate work-load and service objectives to financial and manpower allocations, so as to sharpen up the questioning of overhead costs. This is such a vital management tool that the Inquiry has already set up demonstrations in four District Health Authorities, under a joint Inquiry/DHSS Steering Group, which will maintain the impetus and stimulate wider implementation pending the appointment of the NHS Management Board to drive through this initiative.

- PERSONNEL

9. The Secretary of State should appoint, as a member of the NHS Management Board, a Personnel Director. His main responsibilities should include:

9.1 to co-ordinate the NHS management evidence to the review bodies and to organise the management sides and objectives in the Whitley pay negotiations for bodies not covered by the review bodies, after full consultation within the NHS;

9.2 to review the remuneration system and conditions of service for management so as to overcome the lack of incentive in the present system and the inability of Chairmen to reward merit or take action on ineffective performance;

9.3 to ensure with line management that a policy for performance appraisal and career development operates, from the Unit to the centre, to meet both the aspirations of staff and the management needs of the service;

9.4 to assess how far the management training of different staff groups, including clinicians, meets the needs of the Service and to stimulate the provision of appropriate training courses, inside and outside the NHS;

9.5 to review procedures for appointments, dismissal, grievance and appeal, identify any conditions of service which are not cost effective in management terms, and secure the maximum devolution of responsibility for such matters;

9.6 to carry forward the DHSS work, stimulated by the Management Inquiry, in determining optimum nurse manpower levels in various types of Unit, having regard to the needs of the local situation and the maintenance of professional standards, so that Regional and District Chairmen can re-examine fundamentally each Unit's nursing levels;

9.7 to secure reviews of manpower levels in other staff groups.

\- PROPERTY

10\. The Chairman of the NHS Management Board should ensure that:

10.1 a property function is developed so as to give a major commercial reorientation to the handling of the NHS estate;

10.2 procedures for handling major capital schemes and disposal of property are streamlined and speeded up and provide maximum devolution from the centre to the periphery;

10.3 the DHSS "Review of the Works Function" gives priority to the requirements of the NHS Management Board.

- LEVELS OF DECISION-TAKING

11. The Chairman of the NHS Management Board should undertake a general review of levels of decision taking in the NHS, to reduce the numbers and levels of staff involved in both decision taking and implementation.

- CONSULTATION

12. The Chairman of the NHS Management Board should review all consultation arrangements required by legislation or administrative order, e.g. closure or changes of use of health buildings, property transactions, Capricode and Estmancode, to speed up and simplify the essential consultation required. Chairmen should take similar action in respect of the local consultation process.

- PATIENTS AND THE COMMUNITY

13. The Management Board and Chairmen should ensure that it is central to the approach of management, in planning and delivering services for the population as a whole to:

    13.1 ascertain how well the service is being delivered at local level by obtaining the experience and perceptions of patients and the community: these can be derived from CHCs and by other methods, including market research and from the experience of general practice and the community health services;

    13.2 respond directly to this information;

    13.3 act on it in formulating policy;

    13.4 monitor performance against it;

    13.5 promote realistic public and professional perceptions of what the NHS can and should provide as the best possible service within the resources available.

GENERAL OBSERVATIONS

We were brought in not to be instant experts on all aspects of the NHS but, because of our business experience, to advise on the management of the NHS. We have been told that the NHS is different from business in management terms, not least because the NHS is not concerned with the profit motive and must be judged by wider social standards which cannot be measured. These differences can be greatly overstated. The clear similarities between NHS management and business management are much more important. In many organisations in the private sector, profit does not immediately impinge on large numbers of managers below Board level. They are concerned with levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development, and the long term viability of the undertaking. All things that Parliament is urging on the NHS. In the private sector the results in all these areas would normally be carefully monitored against pre-determined standards and objectives.

The NHS does not have the profit motive, but it is, of course, enormously concerned with control of expenditure. Surprisingly however, it still lacks any real continuous evaluation of its performance against criteria such as those set out above. Rarely are precise management objectives set; there is little measurement of health output; clinical evaluation of particular practices is by no means common and economic evaluation of those practices extremely rare. Nor can the NHS display a ready assessment of the effectivemeness with which it is meeting the needs and expectations of the people it serves. Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question.

It therefore cannot be said too often that the National Health Service is about delivering services to people. It is not about organising systems for their own sake, In proposing the NHS in 1944, the Government declared that:

- the real need is to bring the country's full resources to bear upon reducing ill health and promoting good health in all its citizens; and,

- there is a danger of over-organisation, of letting the machine designed to ensure a better service itself stifle the chances of getting one.

Our advice on management action is not directly about the nature of the services provided to patients. But the driving force behind our advice is the concern to secure the best deal for patients and the community within available resources; the best value for the taxpayer; and the best motivation for staff. As a caring, quality service, the NHS has to balance the interests of the patient, the community, the taxpayer and the employees.

One of our most immediate observations from a business background is the lack of a clearly-defined general management function throughout the NHS. By general management we mean the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance. The NHS is one of the largest undertakings in Western Europe. It requires enormous resources; its role is very politically sensitive; it demands top class management.

Management is currently provided:

a. by the Secretary of State and the Minister of State (Health), who can spend about half a day a week on it, given that they have to attend to their many other demanding responsibilities within DHSS, Government and Parliament and to the electorate;

b. by a Permanent Secretary who can spend about one day a week on it, given the demands of the other main businesses within the DHSS and the requirement for him to support Ministers in their other responsibilities;

c. at Regional and District level by Chairmen appointed on a non-executive, part-time basis (notionally two days a week, but in practice demanding much more time).

This position is understandable but the problem arises in that the required management support is given at the centre within the DHSS by senior officials and groups, none of which is concerned full time with NHS management; and at Regional and District level by professional officers required to work in consensus management teams where each officer has the power of veto. The

position is complicated by the fact that Unit managers (administrator, nurse and clinician) are still being appointed following the 1982 reorganisation. At no level is the general management role clearly being performed by an identifiable individual. In short if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge.

Absence of this general management support means that there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement. It means that the process of devolution of responsibility, including discharging responsibility to the Units, is far too slow. The centre is still too much involved in too many of the wrong things and too little involved in some that really matter. For example, local management must be allowed to determine its own needs for information, with higher management drawing on that information for its own purposes. The Units and the Authorities are being swamped with directives without being given direction. Lack of the general management responsibility also means that certain major initiatives are difficult to implement.

The accountability review process is a good, recent development which provides a powerful management tool. But the management task is so demanding and continuous that, without moving in the direction we are recommending, it is difficult to see how this process can be sustained effectively given the other pressures on Ministers and senior officials. The Review process needs to be extended beyond Districts to Units of Management, particularly the major hospitals, and it should start with a Unit performance review based on management budgets which involve the clinicians at hospital level. Real output measurement, against clearly stated management objectives and budgets, should become a major concern of management at all levels.

Above all, of course, lack of a general management process means that it is extremely difficult to achieve change. To the outsider, it appears that when change of any kind is required, the NHS is so structured as to resemble a "mobile" : designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction. There are good reasons as to how this has arisen and, indeed, some argument as to why in fact

it is desirable. But, over the rest of the decade when there is likely to be very considerable pressure on resources, at least as compared with likely demand, the NHS needs the ability to move much more quickly. Equally if the emphasis is on devolution, then it needs a strong management process to enable this to be achieved, simply holding at the centre sufficient control to ensure that appropriate standards and services are maintained.

On the other hand, the presence of a general management process would be enormously important in :

a) providing the necessary leadership to capitalise on the existing high levels of dedication and expertise among NHS staff of all disciplines, and to stimulate initiative, urgency and vitality;

b) bringing about a constant search for major change and cost improvement. It can be argued that the NHS delivers an effective, low cost, medical service to the individual patient. But, given an effective management process, the same level of care could be delivered more efficiently at lower cost, or a superior service given at the same cost. We were not asked to look for detailed ways of increasing efficiency or making savings, or to highlight specific inefficiencies we may have observed. Line management should be free to determine how to achieve this, drawing on established management techniques and recent developments in audit or "Rayner scrutinies". Major cost improvement programmes can and should be initiated within the NHS, aiming at much higher levels of efficiency to be sustained over much longer periods than at present. These should carry with them the inbuilt incentive that a significant proportion of the savings made can be used locally to bring about further change and improvement. It is almost a denial of the management process to argue that the modest levels of cost improvement at present required of the NHS are unachievable without impacting seriously on the level of services;

c) securing proper motivation of staff. Those charged with the general management responsibility would regard it as vital to review incentives, rewards and sanctions. Merit awards would be considered.
Redeploying the non-efficient performer would also be important, with dismissal as a last resort;

d) ensuring that the professional functions are effectively geared into the overall objectives and responsibilities of the general management process. The primary reporting relationship of the functional managers should be to the general manager, who should set, by agreement with the functional managers, the priorities and programmes for their work. The relationship with the professions at other levels should simply be one of seeking guidance or monitoring of the professional aspects of their work. The present position leads to unnecessary duplication of staff; too many purely professional meetings, from the centre to the Unit; and the tackling of overall tasks in a fragmented and divisive manner. Any apparent advantages of the functional specialisms are nowadays more than offset by the need to establish the general management process effectively;

e) making sense of the process of consultation. The NHS is a matter of considerable importance to all members of the community and is political in the best sense. A very great deal of importance is attached to ensuring that the views of the community at all levels are taken into account in any decision. The reality is, however, that by any business standards the process of consultation is so labyrinthine and the rights of veto so considerable, that the result in many cases is institutionalised stagnation - a result particularly enhanced by the fact that the machinery of implementation is generally weak and, as such, cannot ensure that the processes of consultation are effectively implemented and quickly brought to a conclusion.

BACKGROUND TO RECOMMENDATIONS

- SECRETARY OF STATE

We are convinced that you will need to be supported at the centre, by a small, strong, professional management group, able to devote considerable time to running the NHS. This is in no way intended to derogate from your statutory role as Chairman and Chief Executive, but in fact to allow that role to be given expression through a General Manager seen to be vested with your authority and to be acting on your behalf and, as your right-hand man, in ensuring that the statutorily appointed authorities manage the NHS effectively. This appointment would leave undisturbed your clear responsibility for overall policy direction and for the handling of the public and political sensitivities of the service.

A case could be made for an independent corporation as the 1979 Royal Commission recognised. This has a variety of defects, not least that one would have to formalise unnecessarily the role of the corporation vis-à-vis the Secretary of State, which would be extremely difficult in such an intensely politically sensitive operation. Additionally, it would require legislation and would be far too delaying.

The appropriate effect would be achieved by what we propose: a Health Services Supervisory Board chaired by you; and an NHS Management Board chaired by the new "right hand man" we are recommending. This will require major changes in the stance and style of management at the centre and in the public and parliamentary requirements of the NHS management process. For example:

a) it is not for the centre to engage in the day to day management of the NHS. It must make sure that the statutorily appointed Authorities do so effectively in accordance with the requirements of Government and Parliament. Sufficient management impression must be created at all levels that the centre is passionately concerned with the quality of care and delivery of services at local level. As a coherent management process is developed, of planning, implementation and control, the DHSS should rigorously prune many of its existing activities;

b) the NHS Management Board should cover all central aspects of NHS management, including Health Authorities and non-departmental bodies. It should control directly the work of the Supply Council and the NHS Training Authority, together with work on computer policy and health information, since at present their position in the NHS executive management line is not clear;

c) the requirement for central, isolated initiatives should disappear once a coherent management process is established. Parliament and the taxpayer have rightly shown a keen interest in cost control. Since manpower accounts for such a large part of the cost of the NHS, this has attracted particular attention at the centre in the last couple of years. This, in turn, has led to such recent central initiatives as the control of NHS management costs, the establishment of RHA manpower targets, the requirement for particular, isolated, efficiency savings and the development of national performance indicators. We believe that once a tight budgetary system has been established, based on management budgets operating within the context of the total management process we recommend, means of effecting change in the use of resources should be left much more to local management in the light of the local situation;

d) a real demonstration of management will, at the centre, will be required, if the NHS is to break free from the present top-down approach to detailed management and yet be held to proper account for performance and achievement. For example the DHSS must not set out to acquire detailed information on, say, what use is being made of different kinds of specialty beds in every District, so as to give specific instructions to Health Authorities to secure a higher or lower utilisation rate or answer Parliamentary Questions;

e) the DHSS will have to adjust its activities in order to support the new management role of the Supervisory Board and of the Management Board. This should be planned at the outset for immediate implementation.

- REGIONAL HEALTH AUTHORITIES AND DISTRICT HEALTH AUTHORITIES

The role of Regions needs to be strengthened. RHAs are responsible for the total delivery of health services within the Region. They will inevitably concentrate on planning, resource allocation and control. Within this overall statement, Regions will need to ensure that Districts, Hospitals and Units are liberated to get on and manage the service <u>and</u> be held to proper account for performance and achievement.

In many cases a management gap exists between the Authority members and their officers, in particular at District level. Each Authority needs to clarify its own role and consequently the general management function by identifying:

- the major decisions the Authority should reserve to itself and the information it requires from its officers and when;
- what should be left to the Chairman;
- what tasks should be undertaken on behalf of the Authority by the general manager and chief officers; and,
- the role of the individual member.

As a consequence of this clarification, the NHS Management Board will need to review the method and process of selecting and appointing Chairmen and Members and advise the Supervisory Board accordingly on adjustments required.

A general manager should be identified from within the existing team or elsewhere according to the Chairman's view of the local requirement. This is not intended to weaken the professional responsibilities of the other chief officers, especially in relation to decision taking on matters within their own spheres of responsibility. It is intended to sharpen up the process, first, of decision taking on other matters where there is disagreement and, second, of implementation, by identifying personal responsibility to ensure that speedy action is taken and that the effectiveness and efficiency of such action is kept under constant review. In this context, it certainly appears to us that consensus management can lead to "lowest common denominator decisions" and to long delays in the management process. It has been suggested to us that the absolute need to get agreement overshadows the substance of the decision required. We therefore propose the identification of a general manager to harness the best of the consensus management approach and avoid the worst of the problems it can present. The general manager would be the final decision taker for decisions normally delegated to the consensus team, especially where decisions cross professional boundaries or cause disagreements and delay at present.

The Chairman of each Authority should be responsible for initiating this change according to local requirements and possibilities. The main criterion should be the identification of general management skills and experience: the further away from direct patient care the more important it becomes to look for such skills not necessarily professional disciplines. There can be no "single-bullet" solution for the whole of the NHS and the timescale will vary according to the task to be tackled.

- THE UNIT

Units of management (particularly the major hospitals) provide the bedrock for the whole NHS management process. It is there where most of the patients are seen, most of the money is spent and most of the staff are employed. Surprisingly, given the welter of reports on almost every aspect of the NHS over the past 30 years, there has been no major review of the internal management of the hospitals since the Bradbeer Report of 1954 (when most hospitals had an individual manager in the shape of the hospital secretary, house governor or medical superintendent). We have therefore commissioned some small-scale studies, with the support of the clinicians at six hospitals, looking, from the perspective of the patient and the clinician, at the management of the Unit as reflected in the treatment and administrative handling of the patient.

The 1982 NHS reorganisation has not yet resulted in the devolution of real decision taking to Unit and hospital level. Many hospitals do not yet have budgets. Most hospitals and Units are big enough in management terms to take all their own day-to-day management decisions. The onus should be on higher management to argue away from this position, if they think there is clear and accepted justification for taking particular decisions at an identified higher level of management.

We believe that urgent management action is required, if Units are to fulfil their role and provide the most effective management of their resources. This particularly affects the doctors. Their decisions largely dictate the use of all resources and they must accept the management responsibility which goes with clinical freedom. This implies active involvement in securing the most effective use and management of all resources. The nearer that the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers. This should be more explicitly recognised:

- in the doctors' training - undergraduate, postgraduate, in-service, and in preparation for particular clinical management posts; and

- in constructing the system of management budgets in a way which supports this work and meets the medical requirement and interest.

We have not recommended that all consultants' contracts should be held at District level - even though many strong representations were made to us that that should be the position; we believe that if there is a coherent management process, it should not matter where the contract of employment is held. If our recommendations are implemented, we believe the management problems related to the holding of contracts at present felt to exist would disappear.

In identifying a Unit general manager we believe that the District Chairman should go for the best person for the job, regardless of discipline. The main criterion for appointment should be the ability to undertake the general management function at Unit level and manage the total Unit budget.

OTHER ASPECTS OF MANAGEMENT

- PERSONNEL

In the personnel field, as in all other aspects of our recommendations, the essential changes required will need to be led from the top by an energetic, new style of management. We have accordingly proposed the appointment (initially from outside the NHS and the Civil Service) of a Personnel Director whose main responsibility would be to ensure that personnel relations support the new style of management we are recommending. The opportunities to influence pay, career appointment and retention of staff are all important aspects of line management's responsibility to ensure real motivation of all staff, characterised by the more thrusting and committed style of management which is implicit in all our recommendations. In particular the Personnel Director would ensure that formal structures of communication and informal means of consultation were established to secure the full commitment and involvement of staff.

To achieve this the Personnel Director will need to lead a review of Whitley agreements, pay structure, terms and conditions of service etc., examining each to ascertain whether greater devolution is possible. He will need to be given a period of years to achieve the target resulting from his review, with the full support of the Secretary of State and the Chairman of the NHS Management Board.

Devolution in personnel matters will imply a strengthening of the personnel function at each level and its close support of line management. The most important development to be achieved is one of morale and attitudes: this will be done by the line management leadership, and the perceived professional competence of the Personnel Director and an injection of enthusiasm and pride in the quality of personnel service provided.

Line managers need to accept their responsibility for their staff and will require better training in personnel matters. This is only part of the general upgrading of the quality of management which the NHS requires. As in any process of change, there will be a need to take staff along in a positive sense, by top-class communications and training. There must be incentives for staff, through proper reward for performance and career prospects. The sanction of removing the inefficient performer must also be more easily available than at present, though always as a last resort.

Senior managers, in particular, must be given proper incentives, by way of greater opportunities for career progression, both through to the new NHS centre and also out of their primary professionalism.

To effect change, some outside catalysts will be required; but there are enough people at all levels within the NHS enthusiastically committed to wanting change and capable of making a contribution to ensure that it can largely be effected from within. Staff in general can only benefit from changes to be brought about. A better-run service, more local say in decisions, a more satisfied customer, better communications with management, proper reward for performance, better career prospects: all these should add up to a happier working environment and a more satisfied staff.

- PROPERTY

A property function needs to be established as part of the general management responsibility. An important aspect of this is the commercial exploitation of the NHS estate, so that property is regarded as an active contributor to overall NHS resources. Direction of this approach is needed at the centre. At the same time, the Works Function throughout the NHS should be critically examined,because of its large demands for professional staff, and the ability of any capital project to spawn meetings, expenses and travel within and between the different levels in the organisation.

- LEVELS OF DECISION TAKING

Works is an outstanding example of a function where analysis is needed of the level at which decisions are taken and professional work actually carried out.

There is no doubt that at the moment such analysis is not tackled effectively either in Works, Personnel or other functions. The level at which decisions are taken affects the needs for services and for professional and other staff elsewhere. The qualities required by the Managers at each level, the design of communication networks, and the way in which controls are set up are all important factors in this analysis. The present lack of a stringent approach and emphasis on functional management mean that staffing is too heavy and there is unnecessary delay in decisions being taken and activity carried out.

- PATIENTS AND THE COMMUNITY

Underlying all that we recommend is the desire to secure the best possible services for the patient. At present consumers' interests are principally in the hands of the lay members of Health Authorities and of the Community Health Councils (CHCs). We have not made any judgments about the effectiveness with

which they perform this function, although we have been impressed with the grass-roots work of some CHCs. We have concentrated, rather, on the management angle: on ensuring that management plays an active, not merely a reactive, role in relation to patients and the community, and makes them central to its activities.

CONCLUSION

As you know, we have conducted this Inquiry mainly through discussions with individuals, groups and associations, and by visiting GPs, hospitals, Community Health Services, Health Authorities and other bodies. We have had many discussions in DHSS, and we have visited Wales and Scotland. We have reviewed all existing central management initiatives and considered the appropriate reports. We have faced no significant or serious objection to the general line of inquiry we have been pursuing and we have gained general support for our developing ideas. We have emphasised that we are not a Royal Commission in search of evidence and in pursuit of a major report. Nonetheless, we have been besieged with evidence and points of view during and following all the many meetings we have attended. It is extremely heartening to find that so many people working in, or related to, the NHS care so passionately about the service and the way it should be managed.

We have listened to all that has been said and we have read all that has been written for us. We clearly cannot set out all the many points of view in a document which must be brief and action-oriented; but our advice really does reflect all that has been put to us even where we have not agreed with a particular point of view. Indeed, in many of the specific areas drawn to our attention, we have gone further and made our views available to the DHSS so that those concerned with acting on our main advice can take the points put to us into account in the implementation phase. In particular, we should like to pay tribute to the Permanent Secretary in DHSS and his senior staff, who have helped in the formulation and discussion of the recommendations.

Our advice has tended to concentrate on the hospital services. We recognise, however, that both Community Health Services and Family Practitioner Services play a most important role in delivering health care. On your advice, we have stayed clear of a detailed consideration of these particular areas because of the current work going on at the centre between DHSS and the professions; but we have had discussions with GPs and their representatives which provide support for our general views. Hospitals, FPS and CHS clearly interact with, and affect, each other; and, more important, the patient observes no such separate services, he just deals with the NHS. But much more needs to be done to recognise this interaction, in everyday management, in policy-making and planning, and in the allocation of resources. There is a clear need for these issues to be brought within the scope of the coherent management process we are now proposing. For example at the centre they should be the responsibility of the Chairman of the Management Board and his fellow Board Members. At Unit level and below, in the absence of more fundamental reorganisation, there should be a general management forum to ensure that hospital clinicians, GPs and Community Health Services staff take real management action to shift resources (and patient care) between the various sectors.

At the same time we have recognised that it is impossible to review the NHS without appreciating the major social factors which cause extensive demands on the Service and actually have little to do with medical treatment. This is the broader canvas of government, both national and local. No part of the Health Service can be self contained.

It must be emphasised that our task was not:

- a manpower inquiry: it is pointless to discuss manpower except in the context of the overall task and objectives of the NHS. Nevertheless, manpower does account for over 70% of total NHS costs, so better management of resources must mean better use of manpower;

- a remit to change the statutory structure, organisation or financing of the NHS: the NHS is in no condition to take another restructuring, and much more can be achieved by making the existing organisation work in practice. We have tried to give the necessary dynamic to the process;

- a search for specific areas in which costs might be cut: this is the responsibility of NHS management, using established management techniques and incorporating new intitiatives such as the "Rayner scrutiny" and the "Financial Management Initiative";

- a search for areas that might be contracted out to the private sector: NHS management itself, however, should continually be asking how services are organised elsewhere; considering whether particular NHS functions could be performed to the same standard outside at less cost; and examining why if functions can be performed more cheaply, the NHS itself should not do so;

- to cover Scotland, Wales and Northern Ireland: we have visited the central departments and Health Authorities in Scotland and Wales and their observations were helpful in framing our specific recommendations for the NHS in England.

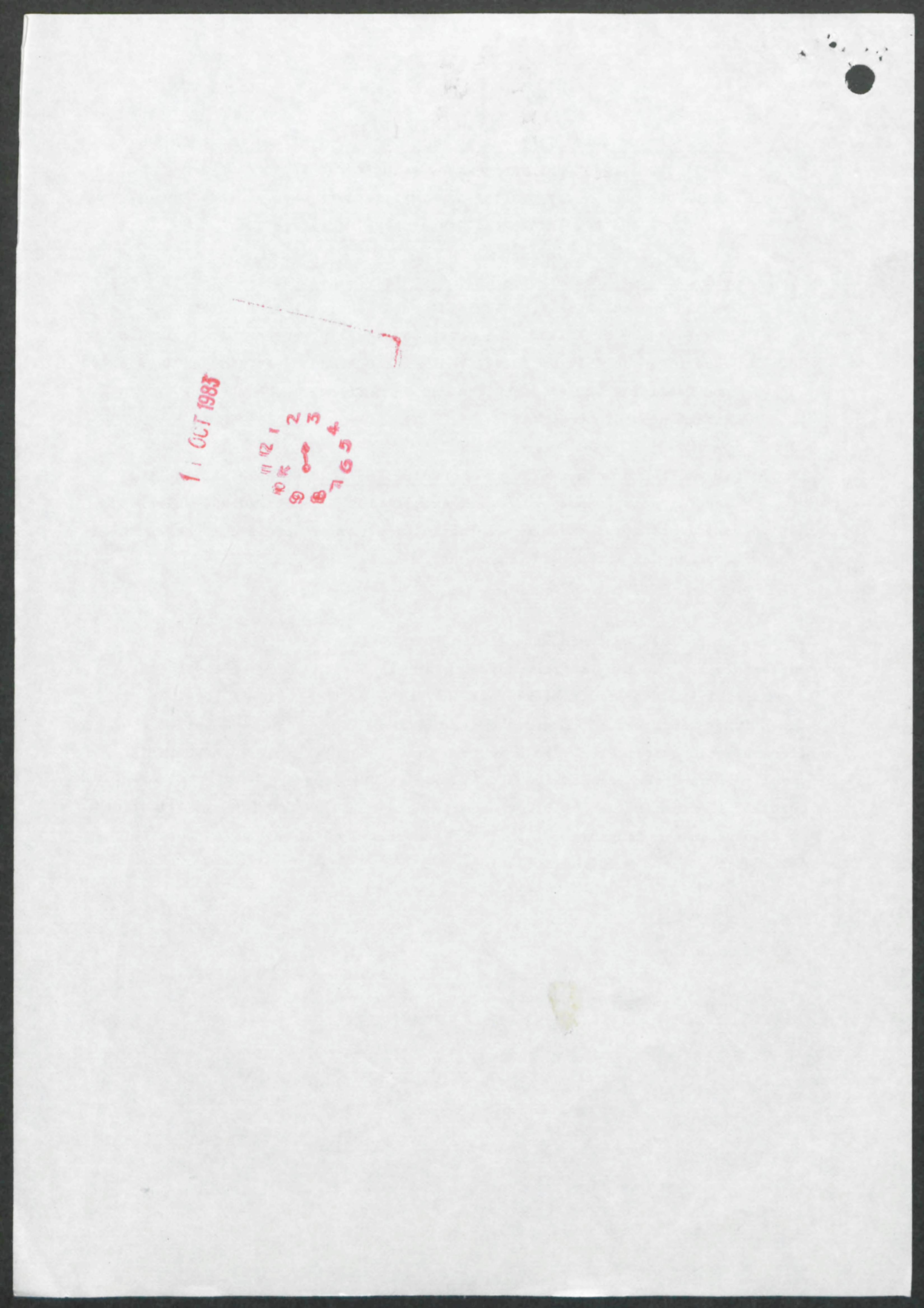
We have shaped our recommendations with an eye to practicality of implementation. We have refrained from over-elaboration because there is a danger of being too prescriptive particularly over the needs at local level. Our primary remit was not to launch a whole lot of new inquiries but to look at the available evidence. There have been over the years many working party reports of, and much discussion about, many of the areas we have considered. The point is that action is now badly needed and the Health Service can ill afford to indulge in any lengthy self imposed Hamlet-like soliloquy as a precursor or alternative to the required action.

On behalf of the Management Inquiry Team

Yours sincerely,

Roy Griffiths.

E.R. GRIFFITHS.



10 DOWNING STREET

THE PRIME MINISTER

Thank you for your letter of 7 October asking for a debate ~~in Government time~~ on the National Health Service.

The Government would ~~be delighted to have such~~ welcome an opportunity to set the record straight on this subject, in view of the many misleading and exaggerated comments which have recently been ~~given prominence~~ made. ~~I note that, during the week that the House returns, Thursday 27 October has been allocated as an Opposition Supply Day. I suggest therefore that you use that occasion for the debate you propose.~~

As you will know from the last business statement the Leader of the House has arranged for a supply day on Thursday the 27th October. ~~This will provide an~~ ~~Should you~~ This will provide an opportunity for the debate you seek. ~~I~~ ...

Neil Kinnock, Esq., M.P.

~~the rec~~ set out &. the ~~[illegible]~~

~~record on the Health Service~~ increased

resources for the Health Service each

over ~~during~~ the last 4 years.

SECRET

PERSONAL

c. Mr. Mount

2

Prime Minister

Some potentially useful material for H.C. Party Conference speech

FERB 6.10

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe KCB CVO

NHS Management

Robin Butler, Esq.,
No. 10 Downing Street,
London SW1

6 October, 1983

My dear Robin.

NHS MANAGEMENT PERFORMANCE

You asked me what was behind the Woodrow Wyatt and Economist articles about comparative costs and performance in NHS hospitals. The short answer is our publication on September 22nd of nationally classified performance indicators (P.I.'s) for NHS hospitals in England and some purposeful briefing thereon - in particular my Secretary of State explained the story to Woodrow Wyatt himself.

... I attach copies of the Press Notice, the national P.I set and, as illustration, a P.I set of the kind that each individual district will have had. You will see that the various tables, opened almost at random, will prompt a host of questions about the reasons for the wide variations in e.g. cost per case in our large general hospitals (pages 106-113) or length of stay in, say, South East Thames Region's general medical service (page 37) which ranges from 17 days to 8.5 days (column 5).

The publication of the P.I's is the result of a major battle fought and won by the Department over the past five years to establish the concept of comparative performance and to build up the data, and system of analysis, for use as a tool of management. The P.I's are intended for the intelligent manager and clinician to use as a means to secure better performance. There will be a learning process to go through. We are making available a floppy disk for computer use which holds all the programmes and data needed to set out the indicators in graphs or histograms.

The issue of P.I's does not of course guarantee its use by management but - as already seen - it opens up a whole new

SECRET

PERSONAL

Contd.....

source of informal questioning by the public, the press and above all by the 215 Health Authorities, about performance by management.

The P.I's have to be seen in their context. We have now completed the first stage of slimming down the super-structure of the NHS by taking out the Area Authorities. We have established the principle and regular practice of accountable management, based on performance review, from the unit back to the Department. We have insisted on the establishment as a matter of urgency of effective manpower management related to cash limits and development of services, with lower overall manning levels (you will have noticed the recent noises.) We have begun the establishment of value for money audit (I append some recent notes I asked my auditors to produce for me showing examples of the potential savings which VFM audits have already identified - N.B the examples relating to use of nurses). And we have now given NHS management, in P.I's, a powerful tool.

Two obvious questions:

i) Why not make much more high profile use of the P.I's? Answer: we want the responsible authorities to put the pressure on. If DHSS had launched into an attack using P.I's we would simply have provoked in part a defensive apathy and in part a suspicion that this was but a passing fad inside the Department. Why? This leads to the second quesion.

ii) Who is going to be responsible then for securing better performance? This is the gap in our management strategy, and we have made ready to fill it. We expect to get Roy Griffiths' report next week. He will be recommending, inter alia,

a) the introduction of the role of general manager accountable to the statutory authorities at all levels in the NHS, up to and including the Department, and

b) the development of management accounting at the unit level (i.e the hospital or part of it) with clinicians taking responsibility for their financial budgets.

It all then falls into place - and (as Griffiths puts it) then it is a long haul for young people to make it work.

Finally a cautionary word. None of this is going to be warmly and unanimously welcomed and we deceive ourselves if we think it can be made acceptable by "presentation". It can only be made acceptable by winning the argument that both the patient and the taxpayer are entitled to a better service out of the NHS than they are getting now.

Yours ever,

Ken.

Department of Health
and Social Security

Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone 01-407 5522

PRESS RELEASE

83/181 22 September 1983

FIRST NATIONAL PACKAGE OF PERFORMANCE INDICATORS FOR THE NHS

The first national package of performance indicators for the National Health Service was issued to all regional and district health authorities today (Thursday). The indicators - which enable health service managers to compare their local performance with other health districts and with the country as a whole - cover clinical activity, finance, manpower and estate management.

John Patten, Parliamentary Secretary for Health, said today:

"The Government is determined to improve NHS management continually. It is crucial to make sure that money is being used as efficiently as possible at a time of record NHS spending. Performance indicators have a vital role to play in this process.

"This package gives local managers, for the first time, the facility to compare local performance with what is happening elsewhere in the NHS. Performance Indicators help illuminate local activity and use of resources, and will enable people to spotlight aspects of their services which warrant investigation. It is important that they approach their investigations with an open mind. They may find that what appear to be relatively high costs are explained by even higher levels of activity. On the other hand, they may find that there is real room for improvement, enabling them to redeploy resources and thus improve the quality and quantity of patient care in other services.

"So Performance Indicators will not give them answers, but they will certainly help them to pose questions. In carrying out their investigations managers will have to work very closely with those who provide the services under scrutiny - the doctors, nurses and other professional staff.

"Over the next two years we aim to improve the scope of the package so as to provide the NHS with an even more useful management tool."

The performance indicators package is in 15 parts. A national book sets out all the data for all the districts in the country. A booklet for each region sets out the data for all districts in the region and includes graphical presentations of much of the information for the region. Each part contains definitions of the data and the sources, and a guide to users.

The guide stresses the need to compare like with like. Where possible the information in the package takes account of differences between districts, for example in the allocation of beds among the various clinical specialties. But it cannot allow for differences in the kinds of patients treated or for other special local features.

NOTE FOR EDITORS

Performance Indicators have been developed over the last two years, including a period of development with the co-operation of the Northern region, and they were tested in use in the last seven of the Regional Reviews in 1982. Now, after further development, they are being published for the whole country. They are being issued to all district health authorities, who are expected to carry out investigations where the indicators suggest that this is needed.

A joint DHSS/NHS Group has been established to develop Performance Indicators further. They will concentrate initially on improving the present package and making it more comprehensive.

Copies of the national summary and the 14 regional booklets can be obtained from DHSS Leaflets, PO Box 21, Stanmore, Middlesex HA7 1AY at £14 national summary and £6.50 each regional booklet.

HN(83)25

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities) for action
District Health Authorities)

Special Health Authorities for the London Postgraduate Teaching Hospitals)
Boards of Governors)
Family Practitioner Committees) for information
Community Health Councils)

September 1983

HEALTH SERVICES MANAGEMENT

PERFORMANCE INDICATORS

SUMMARY

This Notice encloses Performance Indicators (PIs) based on data for 1981, sets out arrangements for their use by health authorities and asks for feed-back on the use made of PIs.

BACKGROUND

1. Performance Indicators covering clinical activity, finance, manpower and estate management functions, have been developed over the past 2 years, including a period of collaboration with Northern Region, to make available to local management comparative statistics about activity and the use of resources at District level, as an aid to the assessment of performance. The PIs are not comprehensive but they cover a range of functions which most Districts might be expected to provide.

2. A first set of PIs was introduced in 1982 on an experimental basis and their applicability was tested in the final 7 Regional Reviews in that year. The broad reaction from health authorities was that PIs were welcome as a useful management tool but that they needed further development. The PIs were refined in the light of comments from the NHS and elsewhere and in January a revised list of indicators was announced. The package of PI data enclosed with this Health Notice is based on that list. It relies, in the main, on statistical information which is submitted routinely to the Department.

3. To carry the initiative forward, the Secretary of State has appointed a Joint NHS/DHSS Group on Performance Indicators (JGPI) to advise on the future development, publication and use of PIs, and to report back to him. In carrying out their task, the JGPI will liaise as appropriate with the Steering Group on Health Services Information.

THE PACKAGE

4. Enclosed with this Circular for all authorities in each region is a booklet containing the following:

i. A User's Guide explaining the basic principles and giving hints on interpretation of PIs;

ii. All PI data for each District in the Region ranked within the national perspective together with a selection of graphical presentations of the data; and

iii. Appendices providing data sources and definitions.

A national summary containing all the PI data for every District in England, plus the User's Guide and Appendices is available to health authorities on request, and to others as a priced document. This is a much larger package and so one reference copy has been sent to each Region. Some data are ranked for the country as a whole, and the summary facilitates comparison of performance in any district with that in any other district in England.

USE OF PERFORMANCE INDICATORS

5. PIs supplement the management information already available and in use in Districts, and are intended to give further help to health authorities and their managers in identifying aspects of the services which warrant investigation. They are experimental and although some account is taken of the specialty mix no account is taken of case mix within specialties nor of many other features of health services, so the ranking of the data does not of itself allow judgements as to whether services are good, bad, efficient, inefficient etc. There are no indicators as yet which measure the quality or outcome of service provided; the JGPI will be considering the feasibility of developing such indicators. The User's Guide makes it clear that PIs may help formulate questions but that investigation is necessary before decisions can be taken whether there should be change, whether corrective action is necessary, or what targets might be set. The responsibility for ensuring that investigations are initiated and carried through to their conclusion rests with District Health Authorities. Before preparing reports for DHAs, district teams may wish to seek, via the RTO, support from Regional professional staff in the analytical disciplines in their initial interpretation of PIs.

6. Regional Health Authorities are responsible for ensuring that DHAs make arrangements for reviewing performance and for securing improvements where appropriate, in line with Regional and national guidelines on priorities where these have a bearing.

COMPUTER FACILITIES

7. The Department has developed a suite of computer programs which can be used to display graphically and analyse selected items of performance indicator data. Examples of some of the displays are included in the PI booklet. At present the programs analyse clinical and manpower PIs. Copies of these programs and all national 1981 data used for the indicators, together with simple documentation, are available free of charge for use by health authorities. Appendix A to this circular gives details of the service available and incorporates an application form.

8. Programs for estate management PIs will also be available to Districts as part of the WIMS system.

TRAINING

9. Regions may wish to organise seminars on the use of PIs. Departmental staff currently working on Performance Indicators will be available to participate in a limited number of such seminars.

FEEDBACK

10. The Joint Group (JGPI) mentioned above would welcome health authorities' comments based on their experience of testing PIs in use, which would help the JGPI in their task of developing PIs further. Comments and suggestions should be sent to the Secretary, Mr Malcolm Jefferies, Room 1406 Euston Tower, as soon as is practicable and ideally no later than 31 March 1984.

FUTURE PUBLICATIONS

11. The Department is now working on an integrated data set to allow the speedy and accurate production of PIs. This will reduce significantly the heavy workload and the costs incurred in the Department and in Regional Health Authorities in producing and validating this year's package, and will facilitate earlier issue of 1983 data in 1985 based on the JGPI's proposals. The JGPI has recommended and Ministers have agreed that PIs based on 1982 data should not be published in 1984. This decision means that in 1984 Health Authorities will need to compare their data for 1982 with those included in this publication, to take note of shifts over the year and to investigate where appropriate.

ACTION

12. District Health Authorities should set in train studies of PIs and other management information with a view to identifying aspects of their services to be investigated; and should arrange for investigations and to receive reports. Copies of the Regional booklet are enclosed for the District Chairman, and each member of the District Management Team. RHAs should consider the arrangements in districts for reviewing performance, and liaise with districts on any analytical support to be provided. One copy of the national booklet is enclosed as a reference copy for Regions; copies of the Regional booklet are enclosed for the Regional Chairman and each member of the Regional Team of Officers. Copies of the appropriate regional booklet(s) are enclosed for the post-graduate Special Health Authorities and Boards of Governors, and for Community Health Councils.

From:

Regional Liaison Division 2E
DHSS
Euston Tower
286 Euston Road
LONDON NW1 3DN

Tel. 01-388 1188 Ext 984

P1/5/15

Enquiries to Mr G Powner

Further copies of this Circular and booklet may be obtained for NHS use from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting serial number appearing at top of right-hand corner. Copies of the national booklet are also available from that address.

PERFORMANCE INDICATORS (1983): COMPUTER SOFTWARE

1. The Department has developed a suite of computer programs which can be used to display and analyse selected items of performance indicator data. At present programs are available to analyse clinical and manpower PIs. Copies of these programs and all national (1981) data used for these indicators, together with simple documentation are available for use by Health Authorities. For copyright reasons these programs are available only to the NHS. The programs will be supplied in compiled Microsoft BASIC and are ready to run on most microcomputers which employ the standard CP/M operating system and have at least 64K bytes of RAM.

2. Please note copies of these programs can be supplied only on receipt from authorities of a blank 8" single-sided, single density (IBM standard format) floppy disk for each request made. No other floppy disk is suitable, and two floppy disks should be sent if both clinical activity and manpower programs are required. Disks should be sent in a suitably protective envelope.

3. The disks contain a simple program which can be used to configure the main analysis programs to run on various computers and/or terminals. The Department is, however, not able to offer advice on the suitability of particular equipment for running the programs. People who would like to avail themselves of copies but are unsure about the suitability of these disks for their computers should consult the Regional Computer Services Officer.

4. If you are interested in obtaining and using the programs please complete the attached form and send it together with your blank disks(s) to the address shown.

OUR REF: PI/5/3

To: Miss D Capaldi
DHSS
Room 1407, Euston Tower
286 Euston Road
LONDON NW1 3DN

1. Please forward a copy of the Department's programs for analysing the data for clinical activity/and/-manpower* performance indicators used in 1983.

2. I enclose one/two* 8" single sided, single density floppy disk(s).

3. I understand that all the material on the disk(s) is either Crown copyright or copyrighted by Microsoft Corporation and undertake not to supply the data and programs outside the NHS or to take any more than one back-up copy of the disk(s).

4. Please return the disk(s) to:

Name and title:

Health Authority

Address:

Signed: ____________________

Position: ____________________

* Delete as applicable.

NB The Department cannot accept responsibility for loss or damage to the floppy disk(s).

SAVINGS ARISING FROM AUDIT VALUE FOR MONEY EXERCISES

1. Catering Services

A saving of £100,000 per annum has been made by one authority as a result of a review of catering services following an audit report. The main avenues for savings were shown to be:

a. stricter budgetary control based on need rather than automatic increases;

b. re-assessment of patient feeding requirements with menu reductions, especially cooked items;

c. tighter control of raw ingredient issues to kitchen using sophisticated aids (DHSS Catering Division micro-computer etc).

2. Cleaning

Following discussions with chief officers about the control of incentive bonus schemes and overtime an authority decided to reduce the frequency of cleaning at a large teaching hospital thereby saving £60,000 in the part year 1982/83 with recurring savings of £160,000 in each subsequent year.

3. Stores Organisation

At one Authority, served by eight general stores, the cost of the salaries and wages of stores staff and heating was £178,000 in 1981/82. A review of the organisation of the stores revealed that savings in excess of £80,000 per annum and greater operational efficiency would result from a rationalisation of these stores. The savings result from a reduction of staff and heating costs and further savings would be generated by reduced stock holdings and greater operational efficiency.

4. Purchase and Hire of Stores and Equipment

i. Failure to use nationally or regionally negotiated contracts had resulted in excess expenditure of £22,600 per annum. Further savings are possible by the negotiation of local contracts in the absence of national or regional contracts.

ii. A review of the arrangements for control of equipment on hire could produce significant savings eg at one authority eight incubators on hire had been held in store for 18 months at a cost of £11,000. Further savings could accrue from the purchase rather than long term hire of medical equipment such as incubators (possible saving £600 per annum per incubator), hospital beds and oxymist tents.

5. Staff Dining Rooms

The closure of a second dining room resulted in a recurring saving of £34,850 per annum. The two dining rooms were situated on one site and were within 10 minutes walk of each other.

(. Cessation of Farm Trading Activities

For several years audit drew attention in discussion with Chief Officers to trading losses incurred at a Hospital Farm and recommended that serious consideration should be given to the cessation of all farming activity. As a result the farm has now closed with consequent recurring revenue savings in excess of £20,000 per annum plus a capital saving of £275,000 from the sale of the land.

7. Control of Provisions Expenditure

As a result of improved portion control and the production of priced dishes for inclusion in staff menus savings of £45,000 have been achieved.

8. Rationalisation of Laundry Services

i. A large efficient hospital laundry was under-utilised (working at only two thirds capacity) while at the same time other hospitals within the Authority were sending their linen etc to:

a. a commercial firm.

b. a smaller inefficient hospital laundry. (Highest costs in the Region).

ii. As a result of Audit Report the Authority:

a. did not renew the contract with the commercial firm, transferring the linen etc the the under-utilised hospital laundry.

b. have under consideration the closure of the smaller inefficient laundry but meanwhile have reduced costs considerably.

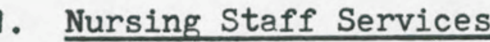
iii. Estimated saving overall is £100,000 per annum.

9. Central Sterile Supply Departments

Following an audit report, which questioned the economic viability of a Parfusion Fluids Factory, a review of CSSD supplies throughout the region was undertaken as a result of which it was decided to utilise spare capacity to produce dressing and Intra-uterine device packs instead of purchasing them resulting in an annual recurring saving, as calculated by the Authority, of £45,000.

10. Stores Purchasing

An audit review of procedures in the supplies department revealed serious deficiencies in internal financial control one of which was the failure to obtain competitive quotations on tenders for the supply of a number of commodities resulting in higher prices being paid than market level. Competitive quotations or tenders are now being obtained and the recurring savings identified are £40,000 per annum.



11. Nursing Staff Services

i. An audit review of nursing shift arrangements in a large acute hospital revealed that the duty rotas in operation provided for an overlap of 3¾ hours from 13.00 to 16.45 hours. Based on the audit test period the annual cost of this overlap was nearly £700,000. The Authority's officers, recognising the potential for savings, have set up a working party to review the existing rotas.

ii. At the same hospital four 28 bedded post-natal wards were staffed when the occupancy level indicated that three would be sufficient to meet demand. The Authority have now closed one ward at an agreed saving of over £200,000 per annum.

12. Operating Theatre Staff

A review of theatre utilisation and associated nursing and other staffing resulted in a reduction of eight WTE Operating Department Assistants with a consequent saving of £50,000 per annum.

13. Nursing Staff

A detailed study of nursing organisation and management was undertaken by audit and the results were used to demonstrate that the number of additional staff required to re-open a geriatric ward could be reduced. The projected savings on nursing staff costs agreed after discussion with the authority's officers amounted to £115,000 per annum.

14. Nursing - Midwifery Staff

An audit review of nurse staffing levels in a maternity unit indicated that there was an adequate level of staff for the workload involved when compared with like units. At the time of the audit discussion with the DA, DT and DNO there was an application before the DMT for the appointment of 12 additional midwives, but in the light of the audit findings it was agreed that:-

i. the overall establishment of the unit did not need to be increased, and

ii. the mix of nursing staff was unsuitable and 12 SRNs already in post would be trained as midwives.

The net financial saving from this decision was calculated by the authority to be £85,000 per annum.

Prime Minister 2

THE GENERAL ELECTRIC COMPANY, p.l.c.
1 STANHOPE GATE · LONDON W1A 1EH
01-493 8484

19 September, 1983

Dear Margaret,

Thank you for your letter of yesterday, and indeed for taking the trouble to write about NMR in the midst of so many pressing preoccupations, and in the course of travelling, to boot.

We are in close touch with Donald Longmore, and fully understand his views. Basically, he wants a small machine capable of cardiac diagnosis. So do we. There are considerable technical problems, and the R and D costs will be large. But we want to do it.

Before getting too far down the road on this project, however, we need to do more work on the machines we are already making in Wembley and in the United States. We must get a greater consistency in the results without recourse to operating teams of a quality higher

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there is likely to be available. We would like to increase the power of the cheaper version of the machine, and to bring its performance to a higher level. And all this work is highly relevant to what Longmore wants us to do anyway.

Longmore is a very capable fellow, and a great enthusiast. It is not so long ago that he wanted me to commit heavily to development of ultra sound machines (which we pioneered here) in the belief that they could do what experience has so far indicated they cannot. I do not want to pour cold water on the proposal for a small N.M.R., especially since we intend to do it, but we should not approach it with reckless abandon.

I will arrange to see Longmore sooner rather than later, and I am at your disposal if you want more information on the subject. Your interest in it will certainly serve to spur us on.

Yours,

Arnold

P.S. I hope you were able to enjoy the delicious smoked eels and fresh herrings we were eating in Holland during the week-end.

10 DOWNING STREET

Robin

The Prime Minister has written a personal letter to Lord Weinstock over the weekend. Attached

Andy 18/9

10 DOWNING STREET

THE PRIME MINISTER

18 September 1983

Dear Mr. Longmore,

I am writing to thank you very warmly for your letter of 14 September and for the fascinating papers which you attached to it.

I was able to draw on your note about the organisation of health care in a talk which I had with Norman Fowler on Friday. Both he and I share your view that the nub of the problem is to get more of the money we devote to the Health Service spent effectively on patient care and much less spent on administration. And under the heading of spending the money effectively, I also agree with you that we must take full advantage of the opportunities of prevention which developments like the nuclear magnetic resonance machine provide. I gather that you have no objection to my showing Norman Fowler your paper privately, and I shall do that.

I agree that this is an area of major political importance, and I am very grateful to you for your help in setting down your diagnosis and your prescription so clearly.

I have just written to Arnold Weinstock urging him to bring forward the appointment to see you.

Yours sincerely

Margaret Thatcher

Donald Longmore, Esq.

10 DOWNING STREET

THE PRIME MINISTER

Personal 18th September 1983

Dear Arnold

I recently met and had a long talk with Dr. Donald Longmore of the National Heart Hospital about the National Health Service but more particularly about Nuclear Magnetic Resonance and the early diagnosis & treatment it makes possible. I am discussing these matters with Norman Fowler.

I understand that Dr. Longmore is very anxious to have a meeting with

you to ensure that the potential of N.M.R is fully exploited & that opportunities are not missed. Your staff say the first time you can see him is NOVEMBER. Can it be brought forward?

I am going to the States on the 20th September. If you are having any difficulties with marketing this device through the company you have acquired — I should like to know before I go so that I can pursue the matter if you so wish.

In haste

Yours ever

Margaret

Lord Weinstock
Letter to A-W to
the Sunday point if possible
4

PRIME MINISTER

You may like to read over the weekend Donald Longmore's letter and his paper on the NHS. You do not need to read all the enclosures.

In my view, the diagnosis in Donald Longmore's paper is better than the prescription on the National Health Service, which looks rather naive. But the criticisms ring true, and there is no mistaking the sense of frustration with all the bureacracy, which runs through his paper.

Donald Longmore told me that he would have no objection to your showing his paper to Norman Fowler, and, if you agree, I will do that, asking Norman Fowler to keep it personal to himself, Kenneth Clarke and Ken Stowe.

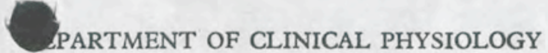
Another aspect on which you may like to take action is the letter of 5 August to Lord Weinstock's personal physician about the risk that GEC will miss the opportunities provided by the NMR. I gather that Donald Longmore has asked for an appointment with Arnold Weinstock but has not been able to get one until November. You might consider telephoning Lord Weinstock and telling him that you have met Donald Longmore and perhaps urge him to see Longmore and Dr. Ian Young a bit sooner: it would not do you any harm for you to be urging Lord Weinstock to do something for once rather than the other way round!

Finally I attach an acknowledgement to Donald Longmore for your signature. If you telephone Lord Weinstock over the weekend, you may like to add a sentence on the lines:

> "I have already spoken to Arnold Weinstock about the NMR and have urged him to see you as soon as possible and take seriously what you say about it."

F.E.R.B.

16 September 1983



DEPARTMENT OF CLINICAL PHYSIOLOGY

NATIONAL HEART HOSPITAL

MR. DONALD LONGMORE

WESTMORELAND STREET, LONDON W1M 8BA
TELEPHONE 01-486 0824
01-486 4811

Our Ref.

Your Ref.

14th September, 1983

The Rt. Hon. Margaret H. Thatcher,
10 Downing Street,
London S.W.1

Dear Prime Minister.

As requested by you during our recent enjoyable visit to Dunphail, I am sending you a number of documents which may be of interest. I was concerned about boring you with too many medical matters and too much discussion about the Health Service and the future of medicine at what was clearly intended to be a relaxing weekend for you. However, as someone working in the field I feel that the Health Service presents much bigger and more immediate problems than is generally appreciated. There is an impending crisis.

As you will see from the enclosed papers, I am worried that the biggest foreseeable hazard facing you relates to the Health Service, as we discussed under various headings.

Hector invited me to meet you because I was one of the founder members of CORDA (Coronary Artery Disease Research Association), a national charity of which he is an enthusiastic patron. CORDA is dedicated to changing our approach to cardiovascular disease from the present costly notion of salvaging people with end-state symptomatic disease, to that of prevention. Since occlusive vascular disease (blocked arteries) accounts for approximately half of all deaths and probably more than half of all the incapacity, the elimination of this disease will have enormous social implications. It will probably extend the normal life span by only a few years, but by enabling the elderly to stay fit enough to contribute to society and to look after themselves, it could eliminate the drudgery of old age. For this reason

we have studied the age-population structure and examined some aspects of the relationship between those who are generating our national wealth and those who are consuming it. This is why we touched on the retirement age in our

Flag A - discussions and why the properly annotated graph is enclosed.

We have recently finished a book (in press) for CORDA which argues in detail the case for a change in the approach to the treatment of cardiovascular disease. A copy will be sent to you as soon as it is published. In the meantime, in the next week or two, I will send you a copy of the typescript and illustrations of the introductory chapter which covers the most important points.

Whereas a few years ago the idea of preventing cardiovascular disease would have been merely theoretical, two major advances now make it a practical possibility:

1. N.M.R. (nuclear magnetic resonance) when used to its full potential will be ideal for early diagnosis.

2. Arising from John Vane's Nobel Prize winning discovery of prostacyclin (a substance which prevents blood clotting within us), recent discoveries relating to the genesis of atheroma.

These two major developments have placed within our grasp the necessary prerequisites for the conquest of the disease, namely accurate early detection and effective treatment before it becomes serious.

We discussed N.M.R. briefly and I mentioned to you my concern about British industry's role. Most of the innovations which have made N.M.R. imaging practicable are British. Notable amongst them have been the efforts of Nottingham University, regrettably damaged by mismanagement of the cuts in spending at the University which has closed most of its physics department yet kept the department of Hebrew studies. Fortunately, Professor Peter Mansfield, the first man to produce a human image, following it with movie N.M.R. pictures, has remained in this country. Due to the efforts of Sir Godfrey Houndsfield who won his Nobel Prize along with Cormack for producing the mathematics which made image reconstruction possible, part of E.M.I. (later taken over by G.E.C.) produced the only really satisfactory working

machine. This is now at the Hammersmith Hospital. Lord Weinstock, I think wisely, has purchased an American X-ray company in order to market this device in the U.S.A. but is experiencing the usual problems encountered when the Brtish try to get something done in the U.S.A. I am concerned that he is at risk of letting this hugely profitable section of British industry, the biggest prize ever in medical engineering, slip from his grasp. A few weeks ago Dr. Louis Freedman (Lord Weinstock's personal physician) discussed the matter with me, as a result of which I wrote to him (a copy of this letter I enclose in confidence). It sets out my understanding of the position. I am hoping shortly to meet Lord Weinstock and Dr. Ian Young (the brains behind the new generation of equipment) in order to try to set this situation aright.

Flag B —

About ten years ago I tried to set up an association of British companies involved in medical engineering. It was disappointing to see that one by one the firms concerned either failed, were nationalized, or allowed their internecine struggles and inefficiencies to delay their progress and thus let the Americans and Japanese overtake them. Virtually all we have left is the N.M.R. project. If this fails we may as well abandon hope for the British medical industry. Enclosed is an article written in 1969 when I was becoming concerned about this inadequacy and when I was trying to set up some kind of concerted British effort. In this context, it was wonderful to hear that you have broken the monopoly of the British Technology Group. Its existence has caused me and other inventors of medical equipment a great deal of grief; most of our ideas have been developed abroad. The existence of N.R.D.C., later B.T.G., has meant that if they have not supported an idea no-one else was prepared to look at it.

Flag C —

CORDA was originally chaired by Robert Carr (one of its founder members), who saw the need for a change in the emphasis in medicine and who has put in an enormous amount of time and effort, resulting in an excellent organisation and a powerful group of patrons. It was under the guidance and chairmanship of Mr. Cyril Roberts that CORDA began its active campaign. The charity is now chaired by Cecil Clothier (the Ombudsman) who sees very clearly the opportunities presented by Dr. Young's conception of second generation N.M.R., and understands both the national and medical implications of the

British development of this mainly British technology. It is my hope that when CORDA has funded basic N.M.R. research it will move on to support the more important plan of the mobile diagnostic units, about which a paper is enclosed. The worldwide export potential for these units, based on a British vehicle, British instrumentation, British training and British expertise is enormous. The markets encompass Europe, wealthy countries like Saudi Arabia and developing countries which are leap-frogging the present costly approach; curative rather than preventive medicine. It is my ambition to make this work before they screw the lid on my box!

immediately below

Turning away now from the affairs of CORDA to the main substance of our discussion, the document concerning the National Health Service describes the situation as I see it, not from any political standpoint. It is a genuine, concerned attempt to save the government from what I see to be a very major crisis which will arise sooner rather than later. It has always surprised me that Dr. David Owen (to whom I once taught surgery and who has an intimate knowledge of the deficiencies of the Health Service) has not yet been clever enough to see that a combination of a swing to the right and an attack on the present management of the Health Service could enormously strengthen his political position. I do not believe that the Health Service can be saved in its present form, because the Department is now so big and powerful (yet irrelevant) that it can no longer be pruned sufficiently to leave a viable Health Service.

Nye Bevan said:

> "The new Health Service has been having a most uneasy gestation and a very turbulent birth, but all prodigies behave like that ....."

I would like to see you gain the credit for the birth of a new and effective second generation health care scheme.

Please remember that if I can help in any way I will do what I can.

With all good wishes to you and Denis.

Yours sincerely,

Donald Longmore,

Donald B. Longmore, FRCSEd
Consultant Clinical Physiologist

encs.

THE CREATION OF A PROPER HEALTH CARE SYSTEM BY THE CONSERVATIVE GOVERNMENT IN 1984

This document deals with the urgent need for a re-structuring of the health care system in the U.K. It discusses the alternatives of the abandonment of the Health Service, trying to re-vitalise the existing Service, and outlines a new scheme which is satisfactory both to the needs of the country and of the Conservative Government.

In addition to the unforseeable hazards of political accidents and international events, the Government is at risk from entirely predictable sources.

The general public will tolerate many things provided that they are seen to be beyond anybody's control. Thus turmoil in the Middle East, Africa and Central America; unease about the similarity between the acquisitive behaviour of Moscow and the military ambitions of Nazi Germany; the bizarre behaviour of extreme right and left and the world economic situation, are accepted. The public are opportunistic about the inefficiencies of the tax and social security systems and regrettably corruption has become part of life. Even mistakes are forgiven provided they are seen to be genuine.

Should blame be assignable to the government of the day, however, their tolerance disappears; that the problem has been developing for decades will not be taken into account. The informed public accept the realities of the economic situation and the need to control inflation, as clearly demonstrated by the general election results. They are not, however, prepared to be neglected or exploited when they are genuinely ill. Sooner or later the advent of sickness and the inadequacies of health care affect every family. The apparent neglect of the Health Service is slowly but surely creating massive discontent.

The key factor in maintaining confidence in the Government amongst the general public is its integrity as a custodian of the health services, making them available to any who should really need them. They must not appear unconcerned, nor should they. All tribes, societies and civilisations have been forced to adopt some communal approach to health care, sometimes using it as a means of exerting influence. The Christian churches lost influence coincidental with the secular take-over of medicine, hospitals, the care of old people, and schools. Apparently Nye Bevan was conscious of the political influence of health care and used it to advantage:

> "Society becomes more wholesome, more serene and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knoweldge that not only themselves, but all their fellows, have access, when ill, to the best that medical skill can provide."

The National Health Service presents particular problems to any government trying to be responsible in the field of health care. Many believe that the demands of medicine will always grow and could never be met. Certainly the responsibilities of the Health Service includes very disparate fields, from geriatrics to intensive care, from chronic psychiatric disease to accident surgery. Unfortunately, the mass media, encouraged by some

medical practitioners, have led the public to believe that certain very glamorous and very expensive fields such as open heart surgery represent the growing edge of medical progress. Confidence in what can be done increases, with it grows expectation of better performance from the health services. This has the twin effects of increasing demands to unrealistic levels and diverting funds from unglamorous areas, which if neglected, generate social problems on a scale large enough to topple a government.

The Government could turn this unpromising situation to its advantage by being seen to be sponsoring a realistic and cost-effective system which tackles the more relevant but less glamorous problems (see Appendix 1 - the medical need for mobile cardiovascular diagnostic units).

At present, with the emphasis on cost ineffective and largely unsatisfactory management of advanced disease, the level of dissatisfaction with medical care in the U.K. is higher than in any other country practising similar medicine, or spending only a slightly larger proportion of its national wealth on health. In 1979 the U.K. spent 5.4%, U.S.A. 9%, W. Germany 5.7%, Holland 8.6%, Italy 6.3% (1976), Denmark 7.4%. Norway 7.6%, France 7.2%, Japan 4.4%, Switzerland 6.9% (1977), Australia 7.6%; the average excluding the U.K. is 7.1%. The difference lies only partly in our lower expenditure and the increased expectation of health care in a country with a health service. The real problem is the cost-ineffectiveness of the organisation of medicine, including its present uncomfortable relationship with the social security system. In the countries listed, virtually all of the 7.1% of the Gross National Product is spent on patient-related activities. Here, a large proportion of the lesser sum is wasted.

There is no historic reason why a Conservative government could not solve the problem quickly. The Labour party is still allowed to take the credit for the inception of the Health Service. Nye Bevan is revered for turning the nation's post-war dream into legislation, against the opposition of the medical profession, within the span of one government. In reality the scheme for a high standard of health care for all was the natural outcome of the organisation of medicine in war-time Britain and Beveridge in Churchill's Coalition Government. Some of the more comprehensive recommendations came in 1943 from Henry Willink, a Conservative M.P. The Labour party do not have a historical monopoly for health care. The unions are conspicuously absent in the lists of donors to medical research, in the creation of health centres in deprived areas, in supporting old peoples homes etc. When CORDA (see Appendix 2) was founded it was a Conservative ex-Cabinet minister , not a Socialist, who was prepared to devote months of spare time to hard work to create the charity.

It cannot be said that the faults of the present system were not anticipated by the public and by the medical profession. In 1943 the Ministry of Information commissioned Mass Observation to survey public attitudes towards a National Health Service. There was widespread enthusiasm for the principle but fear of a more bureaucratized service. Throughout, the British Medical Association expressed fears of interference from bureaucrats "entirely ignorant of medical matters". As it has transpired, it is not so much interference that has damaged the National Health Service, it is the less tangible existence of a huge bureaucracy skilful enough to avoid interference or even performing any identifiable function which could be commented on or criticised.

There are three possible courses of action:

1. To abandon the Health Service by total immediate privatisation or by neglect.

2. To continue to prop up the present inefficient system at enormous cost.

3. To start again with a new and cost-effective health care system with the intrinsic faults of the existing system eliminated.

For the following reasons only the third option is viable.

A case could be made for the Health Service to be abandoned, arguing that it is unique to the U.K. and inspite of our great pride in it, no other country has tried to imitate it because it is not viable. No government could withstand the outcry which would follow an attempt to abandon the Service by immediate privatisation. Although the expanding private sector <u>appears</u> to be making a success of certain sections of medical care, closer inspection shows that this is not true overall. Only lucrative areas such as short-stay surgical care are being taken over and even here the private sector is failing to pull its weight, using Health Service laboratory facilities, providing no after-care and funding no research. No attempt is made by the private sector to tackle such long-term problems as senile dementia, epilepsy, Parkinson's disease or terminal care. A totally privatised system would thus provide a distorted service with fragmented endeavour and very poor response to social needs or government policy. Further unworkability would arise from a lack of machinery to deal with patients who needed care from more than one company or who due to error, or to unusual presentation of an illness, had gone to the wrong company.

An alternative is abandonment by neglect. For a number of years, successive governments appear to those dedicated to making the Health Service work, to be covertly eliminating the Health Service and not just ignoring it due to preoccupation with other pressing issues.

Inefficiencies and waste have been allowed to continue to debilitate the system so that it cannot even compete with the private sector in the management of short-term illnesses. If we liken the Health Service to a firm, it is retaining its high overheads which result from out of date buildings, equipment, working practices and chronic under investment. It also continues to carry a massive, very unwieldy and largely irrelevant administration. It has also lost important revenue from abroad, not only in charges for competitively priced medical care of a high standard, but also in hotel accommodation and other spending by relatives. This failure to cope with readily treatable disease increasingly leaves the taxpayer responsible for only the expensive, difficult and unsatisfactory areas of medicine. Any savings resulting from attempting to trim down the existing system will be disproportionately small.

Since abandonment of the Health Service is not a practical alternative, can the country afford to retain the Service either as it is or in a modified form? Given a huge amount of money, a powerful minister and a large slice of luck, an ideological optimist might consider this to be possible. There are, however, now so many factors and factions working against the Service in its present structure that even increasing the investment to an unrealistic 10% of the Gross National Product would only delay the collapse.

It would be easy to catalogue the complaints about the present system. The media and medical writers, the unions, doctors, nurses, and everyone whether involved or not, has an opinion about the root cause of the troubles in the Service. These are not reiterated in this document; a few examples are given illustrating problems at several levels.

If a region or a hospital is asked to economise the first step is to sack say 1,500 nurses and to close wards. This increases waiting lists and the frustration of those who are trying to work, further harming the image of the Government. Much greater savings could be made by eliminating the administrative waste. An example will illustrate the point:

Open heart surgery to bypass blocked coronary arteries is now the commonest operation in the U.S.A. The trend is similar here both in the Health Service and in the private sector. Although the surgical results are good, there is a very high

incidence of diffuse brain damage (see Appendix 3 - Lancet leader). The causes of this are many, but important are the toxic substances released into the patient's blood-stream from the tubing and the sterilising agents. The majority of imported equipment used for oxygenation of the patient's blood is made of polyvinyl chloride using phthalate plasticisers, and sterilised by ethylene oxide poison gas; both have F.D.A. approval (see Appendix 4 - Unsafe Regulation). This is in spite of the fact that it is well known that many foods cannot be stored in P.V.C. because toxic phthalates leach out into them; that most countries do not allow blood to be stored in P.V.C. bags, and that there have been frequent reports of phthalates in the blood of renal dialysis patients.

It is now also common knowledge that ethylene oxide is an unsatisfactory sterilising agent because its residues poison the patients. Yet the D.H.S.S. have steadfastly refused to listen to an advisory group of surgeons and physiologists who have explained to them both in committee and in private, the issues involved. The Department has preferred to set up a voluntary system of inspecting and licensing manufacturers in the U.K. and abroad, which produce this kind of equipment. Equipment made out of very dangerous materials and sterilised in a risky way, is condoned by inspection. When tackled about this the Department's response is that it cannot dictate to doctors what equipment they should use; it has no power to ban materials, and no mechanism for changing sterilising techniques. If this is the case, why exist at all? Even worse, why appoint further costly bureaucrats to inspect manufacturers, when the only results of this can be the demise of the remnant of the British medical industry and the exploitation of the system by foreign manfacturers who often use cheap home labour to assemble equipment, neatly avoiding tax and reducing labour costs.

The very office and officers which are facing us in this and other respects cost very substantially more than the 1,500 nurses they will sack to save money. A giant irrelevant organisation is strangling medicine by siphoning off an unacceptable proportion of the money devoted to health care and by creating long and unnecessary delays. Attempts to throw back the administration of health care into the local community have also failed, deflected by this organisation. Meanwhile, practising doctors are frequently faced with the scandalous situation of sitting on committees to decide whether patient 'A' or patient 'B' should be murdered by neglect because of the inadequate facilities. The committees sit in administrative blocks well insulated from the reality of the problems of patients 'A' and 'B'.

Bureaucratic torpor turns simple tasks into mammoth endeavours. If there is a dripping drain, no longer can we go to the basement of the hospital and ask the engineer to fix it, we have to approach the hosptial engineer through his secretary. After a decent interval we are allowed to go to see him to explain the problem. He then reports to the secretary of the group engineer who after a further delay will ask for resources from the area engineer. After it comes up in committee, we will probably be told that there is not enough money to devote to mending dripping drains in 1983. The whole system has become one of self-perpetuating administration. Health care no longer comes into consideration.

Every new area of endeavour is efficiently responded to by the Department by the creation of suitable divisions. Some years ago when we wanted to apply for computers in medicine, we found that a new building had been leased because there was no longer room in the two blocks at the Elephant & Castle or the Supplies Division in Russell Square. The new building in Holborn housed a number of C.R. (Computer Research) divisions. After a year's negotiations with C.R.5 it was made clear that if we wanted computers we would have to buy and maintain them ourselves. We suggested that the Computer Research Divisions might actually like to work on the computers, evaluating them in parallel with us. This was met with incredulity.

Bureaucracy is not only a problem in the hospital service. In North West Kent, an administrator has recently reprimanded the nurse in charge of diabetic patients and a dietician who wished to hold a function in their own time, at their own expense and in their own home, to enable the parents of diabetic children to pool resources and help each other in the management of this difficult problem. They were told not to become involved with their patients. The same administration still insists on the use of glass syringes at much greater cost than disposable plastic ones. In the same area, in common with most of the country, parents of diabetic children are expected to buy their own diabetic monitors, costing about £100 to the patient whereas they can be bought in bulk for about £60. The improvement in the management of the patients using this equipment reduces overall costs. This is further evidence of remote adminsitration handicapping the workers in the field and unnecessarily reducing the standard of patient care.

The examples quoted, all true, are those furthest removed from music hall farce. Even figures published by the D.H.S.S. itself have a whimsical air. The Health Service Manpower Summary for 30th September 1980 shows that in England at that time 43,725 medical practitioners were served by 105,430 administrative and clerical staff. 26,503 people were employed in the Works

Departments and there were 61,893 professional and technical employees. It is hard to believe that for every doctor employed, 2.4 administrative/clerical, 1.4 professional/technical and 0.6 works staff were needed. In this age of computers and operations research, 14,554 ambulancemen/women were supervised by 3,214 ambulance officers/control assistants, i.e. each officer supervised only 4.5 ambulancemen. The message is quite plain. Further injection of funds into the existing Health Service will not solve its problems. Asking the present D.H.S.S. to economise will result only in further damage to the image of the government because vital services will be closed down whilst those areas which need to be pruned will survive.

In spite of the high staffing levels at the D.H.S.S., controls seem not to work. Taking the building of new hospitals for example, my hospital was built with the post-mortem room directly above the kitchens so that leaks in the floor had disasterous consequences. It was also built of inferior materials and the ceilings fell causing a partial closure of the hospital for many months; that happened in the 1960s. About a decade later the facing materials at the new Cardiff Hospital began to fall off. A decade later still the new block at the Great Ormond Street Hospital which cost several million pounds, could not be opened because it had major structural faults. Surely this is evidence of a combination of poor control and failing to learn from experience.

The planning for hospitals and new facilities is also unsatisfactory. For a long time the Department had a policy of phasing building programmes for new hospitals. Phase 1 gets built, often not to be followed by successive phases. Thus in North London we have a hospital consisting of mainly old buildings plus a new phase one, which consists of a superb laundry capable of serving the new hospital which will probably never be built. There is obviously no official in the Department of Health, or group of officials, who are actively trying to damage the Service, the system in which they work seems to make it impossible for reasonable people to do a good job. The system whereby no one person actually makes a decision and which makes it impossible for us, the consumers, to actually find somebody responsible means that mistakes can be repeated and no one appears to be accountable. At the individual level, there seems responsibility without authority, collectively there is authority without responsibility.

The current state of the National Health Service makes one wonder why it has not collapsed before. The answer lies in the dedication of the people who actually work in the hospitals, in practices and who have patient contact. They try to make the system work in spite of all the obstacles.

Throughout the Service there are doctors and nurses working unreasonably long hours attempting to cope with the clinical load, never stopping to question why they are so overworked.

Any new system intended to look after the nation's health alone must capitalise on this goodwill and demonstrate to the bona fide health workers a committment to urgent reform.

The proposal is that a new British Health Corporation should be set up. This should be chaired by someone renowned for getting things done (like Hector Laing). The new Corporation would be controlled by a very small board of management. It would consist of one government representative, one general practitioner, one representative of the ancillary services, one consultant, one scientist and one lawyer.

Its brief would be simple; to provide the best possible health care for the community operating within financial constraints which would ultimately be set at 5% of the Gross National Product and subject to review, upwards only to bring it into line with the rest of the Western world. In its constitution would be prohibited sub-committees, quangos, general purpose and finance committees etc., and any other committee structures which would grow to undermine the authority of the Board. This new organisation would inherit the freehold of all premises owned at present by the D.H.S.S., including hospitals but excluding the headquarter buildings at Elephant & Castle, Russell Square, Holborn and the very large number of administrative blocks scattered throughout the country as district and area authorities. The new board will be responsible for the salaries of certain categories of staff in the new health care scheme, including doctors, nurses, diagnostic technicians, radiographers, physiotherapists, occupational therapists, rehabilitation workers etc., and for the salary of one clerk per hospital. Each hospital would have a small allowance, limited by statute, to pay for administrative services. Each would be enabled to run its clinical services by electing its own medical superintendent (who would be spared for a short period from clinical duties each day) and the chief nursing officer as the matron and a hospital secretary or clerk to get on with the day to day running of medical practice. The new board would not be responsible for any of the salaries in the Central Department of the D.H.S.S., areas or the districts. Group practices and single-handed medical practitioners, would not be affected in any way.

The total sum available for Health would be divided into two; one part would be handed to the new authority for patient care, and the other part would be the cost in salaries and overheads of the existing Health Service administration. This would make a clear distinction between that part of the nations wealth which is spent properly on patient care and that part which is spent totally on irrelevancies. Over a three year period of transition, the new board would have the option of taking from the old D.H.S.S. structure any part of it which they considered useful, up to a maximum of say 10%, a figure written into the constitution. A financial disincentive to over-recruitment would be included, by making the board find 25% of the salary and overheads of any D.H.S.S. staff taken on.

During the three year period of transition, the existing D.H.S.S. would from the beginning take no active part in the management of health care. It would be instructed only to co-operate with the new board if asked for help. This would regularise the existing situation whereby a major proportion of the funding intended for health care is actually spent on matters which are valueless. It would lay the ground for the general public to see that an identifiable institution contributed nothing to health care but consumed a substantial proportion of its budget. The hospitals and local communities would be encouraged to ask for a larger share of the money allocated to health, and this would have to come out of the funds being used to support the old D.H.S.S. This shifts any unpopularity for redundancies and running down the old D.H.S.S. administration from Government to popular demand.

The board of the British Health Corporation service would be advised directly by representatives from the various medical associations and the unions, and by the universities. It would retain a small central office which would have computer links to the 2,000 or so existing health service hospitals which will be under its charge. Statistical information and other data about any hospital would thus be directly and immediately available to the board. Each hospital would interface with the community through a board of governors, under a chairman nominated by the board, approved by the Prime Minister. The governors would typically comprise a local magistrate, a teacher, a general practitioner, a hospital consultant, and an elected representative of the local council.

At the end of the three year period the corporation would review progress. Those parts of the present administrative section of the D.H.S.S. which would be clearly seen to be redundant would be eliminated. The buildings would be sold or converted into hospitals. From that time on, the whole of the 5% or more of the G.N.P. devoted to health care would be spent on just that. The appointment of the chairman of the British Health Corporation should be the responsibility of the Prime Minister of the day, advised by the Cabinet, but certain constitutional constraints would apply to ensure effective management.

The creation of a new health service is not a scheme which can be dealt with piece-meal, nor would a completely new plan readily survive the normal processes of prolonged debate distortion by the media and the onslaught of the traditional opponents of whatever a Conservative government is trying to do. The truth is an unimportant commodity in contemporary debate. For some reason, the general public are aware of any differences of opinion in Cabinet, and our excessive media are always hungry for any opportunity to fill their pages and their screens with unseemly debate. Perhaps some method should be sought to deal with this problem on a higher plane than is usual about routine government matters. The first question always asked by the media following any debate is "What is your reaction to .....?" This is a telling question for the media react to and distort events. They are able to drive a London bus through the eye of a political needle. In the case of something as important as the Health Service, would it not be possible to recruit the aid of the media in a unique way to deal with a unique problem, that of getting value for money from our health care system.

September 1983

This is a copy of a draft document which is currently being prepared for submission to a British company for support.

"Of no distemper, of no blast he died,
But fell like autumn-fruit that mellowed long,
Ev'n wondered at because he dropp'd no sooner.
Fate seemed to wind him up for fourscore years
Yet freely ran he on ten winters more;
'Till, like a clock worn out with eating time,
The weary wheels of life at last stood still."

Dryden 1678

The goal of every doctor and all who are interested in health care should be the universal achievement of a full life span, unsullied by disease and untarnished by dementia in old age.

SUMMARY OF THE BACKGROUND AND PRINCIPLES OF THE MOBILE DIAGNOSTIC UNIT

Until recently cardiovascular disease causing just over half of all deaths and immense morbidity has been undetectable in its early stages. No treatment of occlusive vascular disease was envisaged. Contemporary medicine attempts to ameliorate the effects of end state disease and endeavours to establish risk factors for occlusive vascular disease. Presently we have to wait a generation to see if any preventive concepts actually work.

In any science, medicine included, from time to time there are advances, often the ability to measure a new parameter, which make quantum leaps possible. Just such advances are becoming available in medicine now. Non-invasive cardio-diagnostic techniques, hitherto relatively weak, now include N.M.R. This promises to measure dynamically and precisely all the anatomical and physiological parameters necessary for diagnosing occlusive vascular (and many other) conditions. Used in combination with certain of the existing non-invasive diagnostic modalities, detection of occlusive vascular disease will shortly be available at an earlier stage than has hitherto been dreamed of, even in the invasive laboratory.

It would be meddlesome, however, to detect vascular disease in the community at an early stage were we not within sight of offering treatment rather than advice. Furthermore the advice we give our patients is not accepted; the currency of preventive advice is debased by unseemly debate between the proponents of possible irrelevancies such as margarine versus butter, to jog or not, to exercise, alcohol in moderation etc.

Following the discovery of prostacyclin, there has developed a new understanding of the genesis of atheroma. The role of the blood platelet in atheroma formation and the response of the vessel wall to adherent blood platelet have suggested new promising lines of research into the control of the platelet and of vessel wall response.

The two important coincidental advances of diagnostic ability and therapeutic possibility herald a new era in the management of cardiovascular disease. Within a decade the unacceptable reduction in quality and duration of life and financial burden on the insured community should be reduced.

For over five years the mobile diagnostic unit has been planned in order to detect occlusive vascular disease at its earliest stages. To achieve this, several prerequisites are necessary:

1. The diagnostic instruments must be non-invasive, cause no distress, yet be accurate and powerful, not producing a high incidence of false-positive tests. The non-invasive tests must reach far further back into the development of the disease than can the exercise ECG.

2. The tests must be taken to the "at risk" community and repeated regularly. Only by doing this can the natural history of the disease be studied. More importantly, the efficacy of preventive measures can be monitored (as shown in fig. 1 in section 1.1 of the main document).

It is proposed that the relevant diagnostic instruments, including the new generation N.M.R. machine, should be combined in the form of mobile diagnostic units which can be taken to factories, schools etc. in order to screen repeatedly the population within them.

3. In order to promote public awareness of the problem, the mobile diagnostic units will also be designed to carry educational video films describing the functioning of the unit, telling what is known about occlusive vascular disease and its avoidance. Facilities for demonstrating the immediate harmful effects of cigarettes will be incorporated.

Although the patient interface and the tests as far as the patient is concerned will be simple, the units will contain the most advanced instrument and computer technology available. The mobile diagnostic unit will produce data in several forms:

1. In the form of single patient records stored magnetically and interchangeable from M.D.U. to M.D.U.

2. Encoded magnetic cards which the patients can take to any M.D.U. to access their records.

3. In a main-frame computer store which can be retained for analysis and research.

The mobile diagnostic units will be self-financing by charging a fee to patients or workplace. A national chainstore and a major clearing bank have expressed an interest in cardiovascular screening using the M.D.U. facilities.

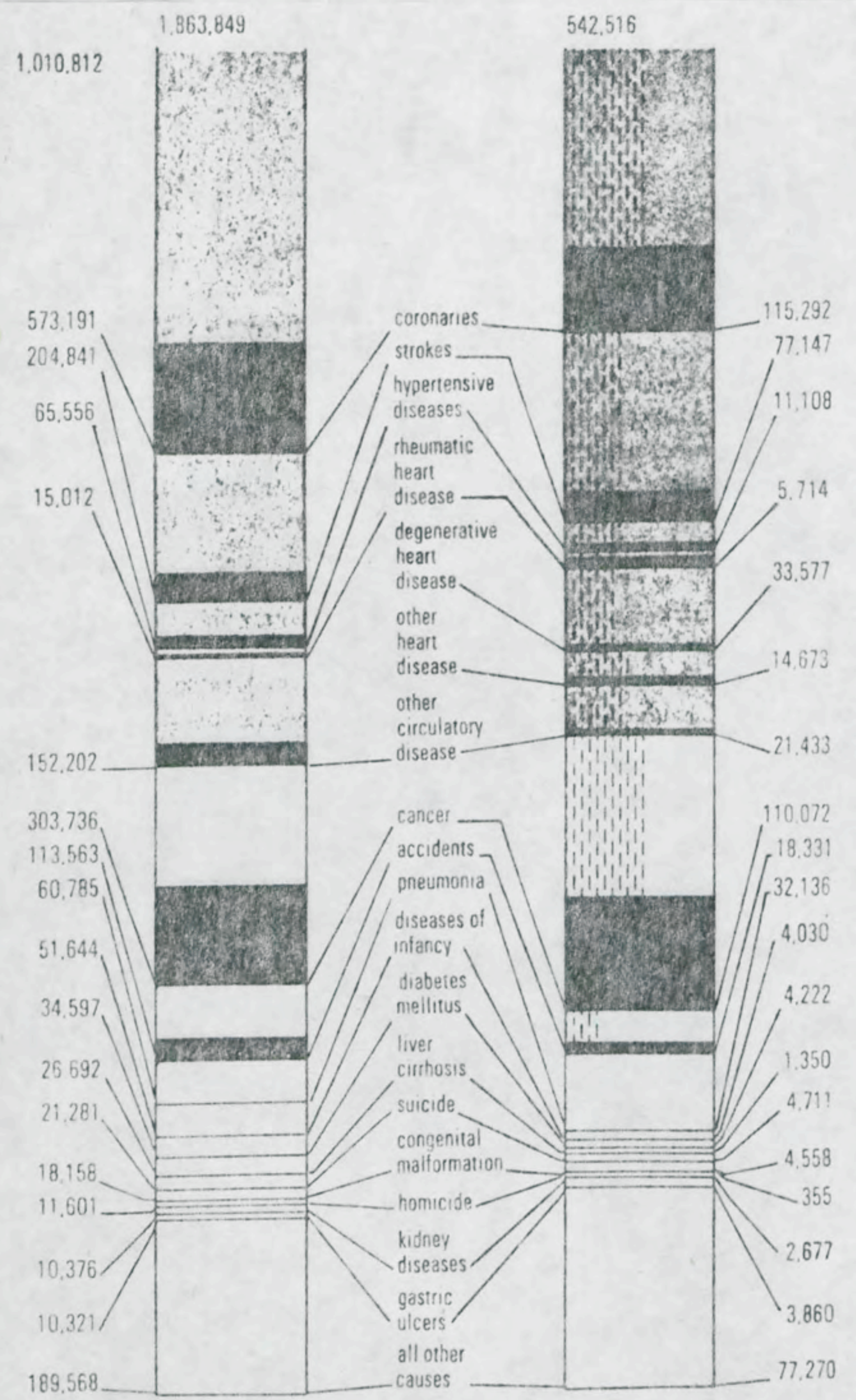
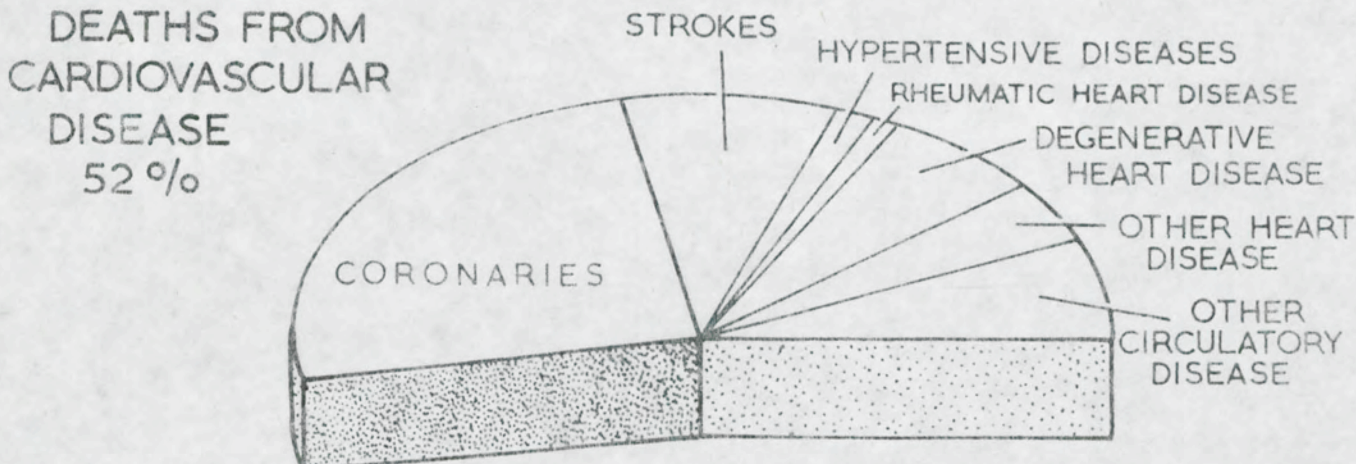


FIGURE 1a and 1b

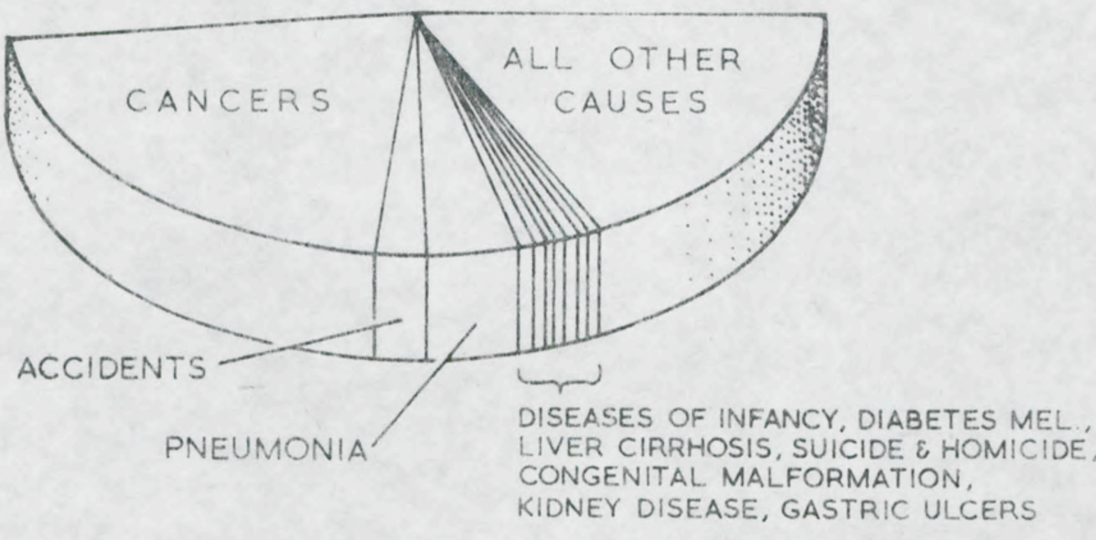
These charts compare cardio-vascular disease (shaded) and other causes of death in the USA (left) and England & Wales (right). The figures are typical. Instead of averaging many years, I have picked 1966 (USA) and 1967 (E&W) as representative. Both histogra are reduced to the same height of comparison. With the exception of homicide, suicide and liver cirrhosis the figure are almost identical in the 2 countries. For some diseases, deaths in the working age grou are shaded grey, and the proportion of males is shown b stippling. This highlights th coronary deaths in the working male population.

Fig. 1b emphasises the relationship between the incidence of cardiovascular disease and cancer.

FIG. 1b



DEATHS
FROM ALL
OTHER
CAUSES
48 %



THE ROLE OF THE MOBILE DIAGNOSTIC UNIT IN CARDIOVASCULAR DISEASE

S E C T I O N   1   (Part 1)

Background: The medical need for an M.D.U.

1.1 CARDIOVASCULAR DISEASE AND THE COMMUNITY

In the Western world, cardiovascular disease accounts for just over half of all deaths (fig. 1). Note that coronary and stroke, caused by occlusive vascular disease, are responsible for the most deaths (followed by cancer* (see footnote)).

1.2 The mortality from occlusive vascular disease is readily quantified. The morbidity caused by this disease process is enormous, making it so universal that it is accepted as a part of everyday life.

Occlusive vascular disease is probably avoidable.

An unfortunate family with young children might have two grandmothers incapable of coherent thought due to diffuse occlusive vascular disease. Both grandfathers and father have died as a result of a coronary attack and the mother is incapacitated due to a stroke.

The consequences of occlusive vascular disease are not often so extreme in any one family, but it is rare for a family to escape the disease. The social consequences are universal. In addition to the pain and suffering of individuals, the cost to the community is significant. An adult who dies of a coronary is typically a male in the prime of life. His contribution to the Gross National Product stops and his family may become a burden on insurance funds and the State. The calculated cost to the community in 1973 was £8,135,000,00(

1.3 The insiduous nature of the disease is such that whilst it is well recognised that it affects an individual progressively over many years, it only becomes apparent that that individual is affected late in its course. Therefore contemporary medicine tends to intervene when "end state disease" is established. Conventional medical therapy and cardiac surgery try to treat symptoms and extend life in those already suffering from advanced occlusive vascular disease. Even the best attempts at detecting the disease process early such as the exercise ECG only detect well-established disease.

* The mobile diangostic unit is primarily designed to detect cardiovascular disease. It has the capability to detect some cancers at an early stage.

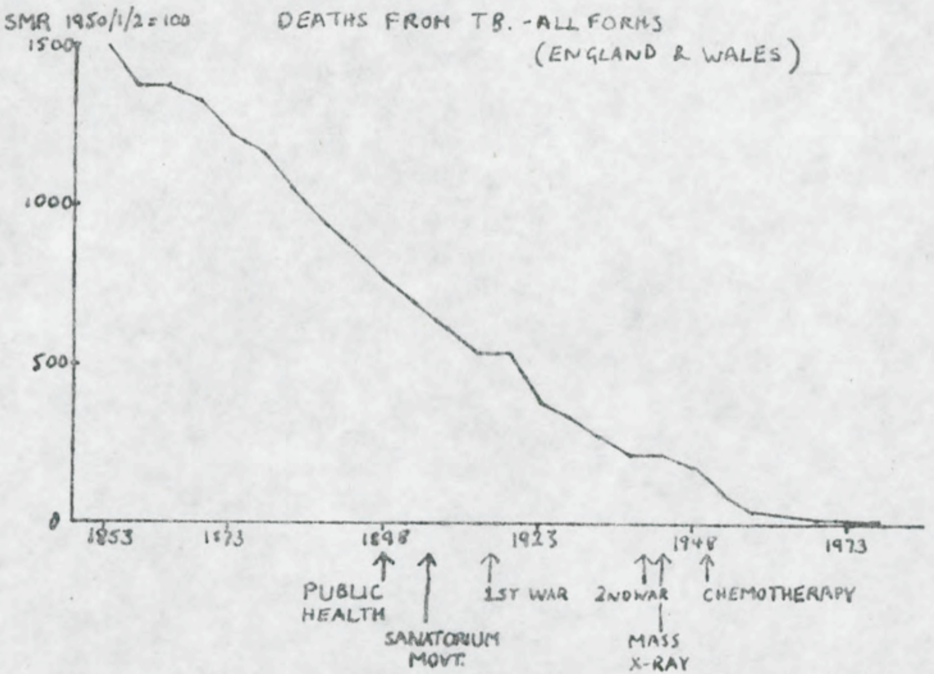


FIGURE 2

Death rates from tuberculosis from 1881 to 1981 related to pub
health measures, the sanatorium movement, World Wars 1 & 2, mass X-ray a
chemotherapy. The fall is uniform except for brief static periods durin
the Wars.

At the moment, little can be done to detect occlusive vascular disease before symptoms occur. Attempts to educate the public in measures to prevent such disease are of necessity inadequate because so little hard information is available about the causative factors and natural history of the disease process, particularly in its early stages.

1.4 Historically, the conquest of most diseases has not been achieved by intervention with dramatic surgery and high technology medicine applied to the management of end state disease; rather by an understanding of the disease process itself, knowledge of its causative factors and public awareness of the need for preventive measures.

For example, tuberculosis was not relegated to near social irrelevance as a result of the sanatorium movement, nor by chest surgery, nor even by the introduction of anti-tuberculous drugs. The mortality from tuberculosis has fallen steadily for over a century. Fig.2 illustrates the steadily diminishing death rate and relates this to the ineffectual medical interventions; better housing, public awareness and two World Wars did have positive and negative effects.

The evidence for the decline in the incidence of tuberculosis is paralleled by many other diseases, notably the infectious diseases which were virtually conquered before the introduction of antibiotics.

Coronary artery disease and stroke, by contrast, continued to increase until recently. There is evidence that during the past few years in the United States, possibly because of public awareness and interest, the incidence of coronary disease has begun to fall. Similar trends are just beginning to show in England & Wales. Rheumatic heart disease is virtually eliminated from the more affluent countries by better social conditions. Why therefore are similar principles not applied to occlusive cardiovascular disease?* (see footnote).

The medical profession might have been expected to shift its interest away from the unsatisfactory management of end state disease to early detection and prevention. There is sound historical reason for the development of cardiology. In its present form,

* Occlusive vascular disease (completely or partially blocked arteries) is the underlying disease process causing coronary, stroke, peripheral vascular disease (pain in the calves when walking) and some senile dementia. The actual process is discussed in Appendix 2.

cardiology is the study of heart disease, not its prevention. Until a mere 35 years ago, medicine could do little for any form of cardiac disease other than to alleviate its symptoms with drugs. There was little incentive, apart from academic satisfaction, for accurate diagnosis. Vague terms such as apoplexy and anasarca were used to cover stroke, the acute coronary and a failing heart.

The combination of surgical ambition to open the last chambers in the body and the surfeit of plastics and electronics technology available after World War II made heart surgery possible. There was then an urgent requirement for the surgeon to know the exact nature and site of the lesion on which he was to operate. In the early days of cardiac surgery the time available for work within the heart was counted in minutes not hours; an incomplete or wrong diagnosis resulted in a dead patient. Cardiologists met the challenge. A second generation of cardiologists now exists capable of diagnosing anatomical lesions within the heart with remarkable accuracy.

1.5 The diagnostic techniques which are used require catheters to be passed into the heart, the use of X-rays and radio-active isotopes. All are potentially dangerous.

Nevertheless, used skilfully, invasive cardio-diagnosis is now capable of producing detailed anatomical studies of the heart and the blood vessels supplying it, occasionally with great discomfort, but, in skilled units, with insignificant mortality. The surgeon sometimes still has to operate on patients in whom the diagnosis is inadequate, for although the lesion may be anatomically defined, the heart muscle may be undetectably irreparably damaged and the patient unable to survive.

1.6 Cardiologists have been less desirous and less able to measure essential heart function than structure. The diagnostic techniques used are still mostly directed towards assessment of structural abnormality, not functional disturbances and towards producing images not performance figures. The remarkably successful efforts to produce images have obscured the need for vital functional data which is more difficult to understand. The function of the heart is to pump blood without unnecessary expenditure of energy.

2.1 The concept of assessing the efficiency of the heart as a pump (albeit an extremely complex one) upon which life in all organs, including the heart itself, depend, is central to the idea of the mobile diagnostic unit.

A pump can fail to work efficiently for a multiplicity of reasons:

a) It is not designed or built properly (failure in genetic design or construction: congenital deformities).

b) It is damaged (by disease processes, such as viral illnesses, rheumatic fever, alcoholic myocarditis and heart antibodies etc.).

c) The valves become blocked or leak (heart valve disease either rheumatic or due to wear on congenitally abnormal valves).

d) Because it is consistently called upon to perform a task which is beyond its design capability (pumping against a consistently elevated blood pressure, or at an excessive volume rate etc. due to abnormal control mechanisms, or external influences such as over-production of thyroid and other cardio-active hormones).

e) Its power supply is inadequate (the blood vessels supplying the heart and coronary arteries with energy may be partially blocked).

2.2 Diagnostic techniques originally intended for detailed anatomical diagnosis are not capable of detecting pump failure due to excessive demands, or an inadequate power supply, until the disease process is far advanced.

2.3 The fit heart has a capacity to pump blood in excess of the body's everyday requirements. Any inadequacy of its power supply will not be manifest until the heart has to meet considerably increased demands. Even in situations when increased output requirements cannot readily be met by the under-nourished heart, it may appear to be coping normally in the short-term without symptoms. Compensatory mechanisms exist both within the heart itself and in the body to overcome such short term pumping deficits. The heart can incur a temporary energy debt whilst the body can for short periods divert blood from non-essential areas.

Even over a long period, a heart working with a diminished blood supply may be symptom-free except in periods of exertion when breathlessness or pain may occur.

2.4 When symptoms of cardiac inadequacy do occur, heart disease is already well advanced. It is known that the area of one or more major vessels supplying the heart muscle with blood can be reduced by 70% without producing symptoms. Post-mortems on allegedly fit young U.S. servicemen killed in the Vietnam war revealed remarkable evidence of unsuspected occlusive coronary disease in the apparently very fit fighting soldier.

2.5 There is a powerful argument against leaving contemporary medical thought and diagnostic techniques to solve the problem of early detection. Occlusive vascular disease must be searched for in its early stages in the asymptomatic general population. Painful and potentially dangerous invasive techniques such as cardiac catheterisation and methods involving the use of X-ray and radio-active isotopes cannot be used. Even if it were argued successfully that invasive methods could be used in the early detection of the disease process, it would not be feasible to use them repeatedly, say every 9 months.

3.1 Two changes in medical thinking are required if the disease is to be detected at the earliest stages.

a) Instruments must be designed specifically for early detection, to measure function with sufficient sensitivity to detect disease and degeneration of performance before symptoms arise. They must, of course, be non-invasive, and not unpleasant to the patient.

b) Along with this change in diagnostic technology must go a desire to prevent the disease reaching the end state, i.e. that state whose management is the foundation on which our present health care system is built.

3.2 The arguments which might be used against screening for heart disease are similar to those against screening for any disease process. They do not, however, apply in this case.

Screening for relatively uncommon diseases may be so cost ineffective as to be worthless. The massive incidence of heart disease negates this argument. Most screening has been done for various forms of cancer, notable examples being soft tissue X-rays for breast cancer and the cervical smear for cancer of the neck of the womb. There is doubt as to whether

intervention in breast cancer makes any significant difference to the outcome and there is tenuous evidence that soft tissue X-rays might even increase the incidence of cancer in the breast. The actual procedure is uncomfortable, since the breast has to be clamped in a machine under considerable pressure. The cervical smear is not exactly a non-invasive procedure, and it has arguably not shown itself to be as valuable as hoped in reducing deaths from cancer of the cervix.

Detection of other cancers, such as those of the pancreas or stomach at an early stage might conceivably lengthen the life expectancy of the sufferers from a potential life span measured in months to one measured in years. The survival rate from a discovered cancer of the stomach is such that only a few percent are alive at the end of a year. The discovery of lethal, untreatable diseases by screening increases human suffering rather than reducing it.

The siutation is quite different with heart disease. The time taken to die after the initial coronary attack may be many years. There is evidence in the experimental animal that the disease process can actually be reversed, and evidence in man that removal of certain causative factors (risk factors like smoking and obesity) can restore a potentially diminished life expectancy to that of the general population. In the experimental laboratory, biological extracts to control the development of occlusive vascular disease and even to reverse its progress show considerable promise. Some extracts of naturally occurring compounds are presently undergoing clinical trials. For these reasons, the usual arguments against screening do not apply to the cardiovascular system.

3.3 Some cardiovascular disease is so universal (at least 50% of the adult population) that a false-positive test would not have such dire consequences on the subject and his family, as say, a false-positive for a breast cancer or a cancer of the cervix. It would merely result in a stricter and better lifestyle for the subject. In sections 1.5 and 1.6 the short-comings of invasive cardiodiagnostic techniques, their dangers and the irrelevance of the data they produce were pointed out.

Non-invasive, painless, harmless tests which are not unpleasant to the patient can be carried out to assess cardiac function. The tests available before the advent of nuclear magnetic resonance have not all been widely used in cardiology for several reasons:

a) They did not yield the detailed anatomical information required by cardiologists assessing patients for surgical treatment.

b) They did not yield images which could be discussed and stored.

c) Most importantly, each non-invasive instrument used in isolation is relatively weak. Often they are troublesome to use. The incentives to purchase and use an instrument which requires great operator skill, and which yields only weak information about an aspect of an organ not central to the requirements of anatomical diagnosis, are small.

3.4 The proponents of various non-invasive instruments have sometimes claimed that they are capable of producing more information than is in fact the case. They have tried to make non-invasive instruments produce data which fits the thought processes of the traditional cardiologist and the cardiac surgeon. For example, the transcutaneous aortovelograph (TAV machine) was designed to measure the acceleration of blood ejected from the heart, an important measure. This it does quite well in the patient in whom there is no lung in the way of the ultrasound beam. Acceleration of blood, however, is information not readily understood or appreciated. Attempts to measure the cardiac output and other better known parameters using this instrument have not been successful. Another example is the impedance cardiograph which measures changes in electrical resistance between a conducting band round the neck and one round the abdomen, plotted against time. The curves produced are complex and probably informative, but again they do not tell us about cardiac output and cannot produce familiar images of the anatomy of the heart.

3.5 Nuclear magnetic resonance (N.M.R.) suffers few of the limitations of other instruments. Using computer based predictive cardiac gating, low field N.M.R. can produce finely detailed static images of the heart. These can be in the form of single slices, multiple slices or blocks of data. Using N.M.R. techniques at their limits, acceptable "movie" images can be produced. It is already known that coronary arteries can be visualised in their long axis and transversely. Blood flow measurements are already possible in larger vessels

and will probably soon be available in coronary arteries. Atheroma can similarly be seen in large vessels, hopefully soon to be measured in coronary arteries. At the moment all the low field measurements depend on proton density. Some advances, utilising basic physical principles, suggest that low field machines may be used to measure the concentration of metabolites other than water, notably potassium and phosphorus.

3.6 High field N.M.R. machine can be used to assess some biochemical processes directly. The levels of energy rich and energy poor phosphorus metabolites have already been measured using a technique known as topical magnetic resonance (T.M.R.). This technique produces only vague images but important clinical data.

These high field machines are not suitable for use in the M.D.U. for several reasons, notably:

a) The high fields require expensive liquid helium cooled superconductor magnets, or resistive magnets with large current consumption and corresponding cooling requirements.

b) High field magnets are readily disturbed by moving masses of metal such as passing cars.

c) High fields are hazardous to pacemaker patients at distances up to 30 feet. Similarly metal objects can be pulled into the magnet causing injury.

The use of low field N.M.R. machines in the M.D.U. will probably not prove to be disadvantageous in any way. The use of high field machines may soon be shown to be unneccesary and will, therefore, be abandoned.

Although N.M.R. used alone will provide most of the information required for cardiac diagnosis, its use in early detection will be enhanced by combining it with a limited number of other non-invasive instruments.

4.1 There follows a brief review of existing well tried, and new non-invasive instruments, from which the few chosen for the M.D.U. were selected, (see Table 1) listed here arbitrarily, in alphabetical order bearing no relationship to their importance (see page 12).

Apex cardiograph (ACG)

Ballistocardiograph (BCG)

Compliance cardiograph (CCG)

Displacement cardiograph (DCG)

Central Doppler methods (Doppler)

Other peripheral Doppler methods (Doppler)

Echocardiograph - various forms (Echo)

Electrocardiograph (ECG)

Frequency cardiograph (FCG)

Impedance cardiograph (ICG)

Magnetocardiograph (MCG)

Mass spectrometer (MS)

MAVIS 'C'

Nuclear & topical magnetic resonance (NMR & TMR)

Percutaneous blood gases (PCBG)

Superconductor quantum interference device (SQUID)

Systolic time intervals (STI)

Thermography (Therm)

Transaortic velography (TAV)

TABLE 1: Potential value of instrument/technique in clinical area

	ACG	BCG	CCG	DCG	DOPPLER	ECHO	ECG	FCG	ICG	MCG	MS	MAVIS C	NMR & TMR	PCBG	SQUID	STI	THERM	TAV
Screening of normal population (MDU)	3	1	4	3		4	4	4	1	0	2	3	4	2	?	4	2	2
Preliminary O/P studies	2	1	2	2		4	4	4	1	0	2	2	4	1	?	3	1	1
Cardiac catheter back-up	1	1	0	2		3	4	3	1	0	2	1	4	1	?	1	1	1
Monitoring in theatre	0	0	0	1		1	3	1	1	0	2	1	0	2	?	1	1	0
Monitoring in ICU & CCU	1	0	0	1		2	3	1	1	0	2	2	0	2	?	1	1	1
O/P follow-up & prevention	3	1	1	3		3	3	3	1	0	2	2	4	2	?	3	1	1
Use as research tool by itself	1	1	3	2		3	3	3	1	0	2	2	4	2	?	3	0	1
Use as research tool in combination	3	2	4	3		4	4	4	3	1	4	4	4	4	?	4	2	2
See note no.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18

Scoring key:
- 4 - maximum utility
- 3 - high diagnostic potential
- 2 - definitely applicable
- 1 - of possible slight value
- 0 - inapplicable
- ? - not yet known

* Areas of importance for early diagnosis studies by MDU

TABLE 1A: Section of cardiac cycle studied

	ACG	BCG	CCG	DCG	DOPPLER	ECHO	ECG	FCG	ICG	MCG	MS	MAVIS 'C'	NMR & TMR	PCBG	SQUID	STI	THERM	TAV
Systole - before valve opening	1	0	0	2				3	0	0	0	0		0	?	4	0	0
Systole - between valve opening & peak pressure	2	1	0	1				0	2	0	0	3		0	?	3	0	4
Systole - between peak pressure & valve closing	3	1	0	1				0	2	0	0	3		0	?	1	0	2
						SEE NOTES							SEE NOTES					
Systole - between valve closing & lowest vent. pr.	4	1	0	2				0	0	0	0	3		0	?	0	0	1
Diastole	1	0	0	0				0	1	0	0	3		0	?	0	0	1
General circulatory status	0	0	4	0				0	0	0	3	4	2	3	?	0	3	1

Scoring key:
- 4 - maximum utility
- 3 - high diagnostic potential
- 2 - definitely applicable
- 1 - of possible slight value
- 0 - inapplicable
- ? - not yet known

* Areas of importance for early diagnosis studies by MDU

PRACTICAL NOTES ON TABLE 1

These notes relate only to selection of the instruments and are not intended to be exhaustive. See appropriate appendices for fuller discussion of the instruments themselves.

1. APEX CARDIOGRAPH (ACG)

The present mechanical system is cumbersome but gives good information concerning relaxation of the heart. The ACG is already used in combination with the echocardiograph. The information given is accepted by many cardiologists. Many potential improvements using Doppler sound and R.F. are under development.

2. BALLISTOCARDOGRAPH (BCG)

This instrument has its problems, related to satisfactory attachment of the patient to the instrument, and to problems in transducer design. Nonetheless, it gives a lot of information, some of general interest and some of interest to specialist cardiologists.

3. COMPLIANCE CARDIOGRAPH (CCG)

A method using two Doppler probes to determine the rate of propogation of the pulse wave in order to determine the flexibility of the vessel wall.

4. DISPLACEMENT CARDIOGRAPH (DCG)

This yields very good empirical results when used by a trained operator. Incorrect siting of the transducer over the patient can distort the signal. It has great potential but further research is required before it can be incorporated in the combined instrument system.

5. DOPPLER (SEE MAVIS 'C' & TAV)

Useful when measured by Doppler shift combined with echo cardiography in conjunction with non-invasive blood pressure measurements to gain information on the state of the peripheral blood circulation.

6. ECHOCARDIOGRAPH (ECHO)

This instrument can be used in several modes. It is non-invasive and has received the largest amount of investment during its development. Its ultimate value is limited by shadowing and the slow and variable speed of sound in body tissues. Resolution is limited by the physical properties of ultrasound producing sidelobes, blurring etc. It gives good imaging data and some mechanical information about the heart. It can be used with computer technology to examine movements of parts of the myocardium across the whole of the cardiac cycle. Computer

technology has also extended the value of the echocardiograph by allowing analysis of the reflected wave from within the muscle mass as a method of assessing scarring, infiltration of fibrous tissue and possibly the blood supply.

7. ELECTROCARDIOGRAPH (ECG)

This is the oldest of the non-invasive instruments, about which a mass of empirical information is available. Its output is well trusted but without exercise this can be unhelpful. The Avionics treadmill is well set up to maximise information from the exercise ECG. Spatial and high frequency ECGs require further study. The ECG is essential as a reference for timing other instruments in the combined system. Although the ECG does not give direct information about the mechanical performance of the heart, multi-lead spatial ECG does give information about areas of the heart which can be expected to be non-contractile.

8. FREQUENCY CARDIOGRAPH (FCG)

This is a new system being developed at the National Heart Hospital, London. It promises to be a method of obtaining pressures inside the heart by non-invasive means. It depends heavily on a major computer program. It has already had a successful pilot study.

9. IMPEDANCE CARDIOGRAPH (ICG)

This produces empirical information from which several parameters, such as cardiac output, can be theoretically derived. A mass of empirical data exists about "point in time" comparisons with invasive studies. It needs further continuous assessment.

10. MAGNETOCARDIOGRAPH (MCG)

This measures expensively and with difficulty the very weak magnetic field associated with the electrical activity of the heart. The ECG is probably more informative.

11. MASS SPECTROMETER (MS)

This does not give direct information about any part of the cycle but can be used to give a measure, non-invasively, of the cardiac output. It can also be used to measure percutaneous blood gases, which can also be measured using fuel cells. The transpired skin gases are unreliable in a collapsed patient.

12. MAVIC 'C'

This Doppler ultrasound instrument gives accurate measurement of peripheral blood vessel size, blood flow, the velocity profile, and the presence of turbulence. It is vital for an assessment of the general state of the circulation and blood flow to the brain.

Practical notes on Table 1 contd/..

13. NUCLEAR & TOPICAL MAGNETIC RESONANCE (NMR & TMR)

This technique is still under development. Cine-films of the beating heart have already been produced. The problems of improving picture quality are solved. Oxygen affects magnetic images and this effect has allowed the use of oxygen as a marker. Other N.M.R. markers are under investigation. Peripheral blood flow measurements and measurements of phosphates in muscle have also been made. Problems arise from the lack of portability and from the effects of magnetism on other objects, e.g. pacemakers.

14. PERCUTANEOUS BLOOD GASES (PCBG)

An excellent device for obtaining pO_2 (concentration of oxygen in arterial blood) and pCO_2 (concentration of carbon dioxide in arterial blood) when used in combination with thermography to define areas with blood flow.

15. SUPERCONDUCTOR QUANTUM INTERFERENCE DEVICE (SQUID)

This is a new instrument which may be useful in determining biochemical changes in heart muscle and other tissues. Its role is as yet undermined. Its suitability for the M.D.U. is under investigation.

16. SYSTOLIC TIME INTERVALS (STI)

A well-known method of assessing cardiac performance.

17. THERMOGRAPHY (THERM)

The technique of comparing peripheral temperatures with core temperatures is commonly used to determine whether the peripheral circulation is deteriorating or improving. A thermoscan can be used to give more accurate information about the changing peripheral circulation.

18. TRANSAORTIC VELOGRAPHY (TAV)

In suitable subjects and when used by skilled operators, this gives valuable information about the acceleration of blood from the heart, total blood flow, cardiac output and sometimes of coronary flow. It is not suitable for all patients.

Used singly, each of these instruments can contribute little to our knowledge of cardiac function. If a patient were sent from department to department to be assessed non-invasively on a range of instruments, the clinician trying to study the patient would have before him a series of unrelated traces run on different sets of heartbeats with no time relationship between them.

Only a few centres in the world have working N.M.R. machines and no centres exist where all the non-invasive instruments are available and used simultaneously on any patient. Hospitals and clinics do exist where several non-invasive instruments may be used independently and randomly and the physician may attempt to correlate the data they produce.

4.2 With modern computer techniques for data acquisition and processing, a new potential exists for using a series of non-invasive instruments simultaneously on a run of 180 heartbeats, also used to construct an N.M.R. block of data. This one step enhances the diagnostic power of these instruments in several ways. At the simplest level they are time related and looking at the same heartbeats, but the advantages of their combination are far greater than accrue from this single benefit. In section 2.1 the heart was considered as a complex pump. The main pumping chambers of the heart have a filling phase and a pumping phase. The first part of the pumping phase serves to raise the pressure within the chamber sufficiently to open the outlet valve. The second part of the pumping phase actually does useful work in moving blood into the circulation of the lungs or of the body. After ejection is complete the pumping chambers spring open to recommence filling. In Table 1 which lists the value of the various non-invasive instruments currently available and being developed, it can be seen that some instruments are better at looking at one part of the cardiac cycle than another. In 1921 a physiologist Carl J. Wiggers plotted the time relationships of the pressure changes in the various chambers of the heart. Figure 3a shows schematically some events in the cardiac cycle relevant to this discussion. Figures 3b and 3c show which parts of the cardiac cycle are best examined by various instruments.

4.3 Another novel part of the mobile diagnostic unit concept is that of combining a small number of key non-invasive instruments giving them mathematical weighting related to the part of the cardiac cycle which they examine best. The frequency cardiograph for example is mathematically zero rated except for the short period during ventricular pumping before the outlet valves open. The TAV machine is given zero rating during that phase of the cardiac cycle, but portrays best the next part of the cycle as shown in Figure 3a.

Another original part of this plan relates to further mathematical weightings adjusting the value of the information obtained from the various instruments in two more ways:

a) Relating to the accuracy and quality of the signal obtainable from the instrument under optimal conditions in the M.D.U. expressed as a fraction of the N.M.R. data (see Table 1 and notes).

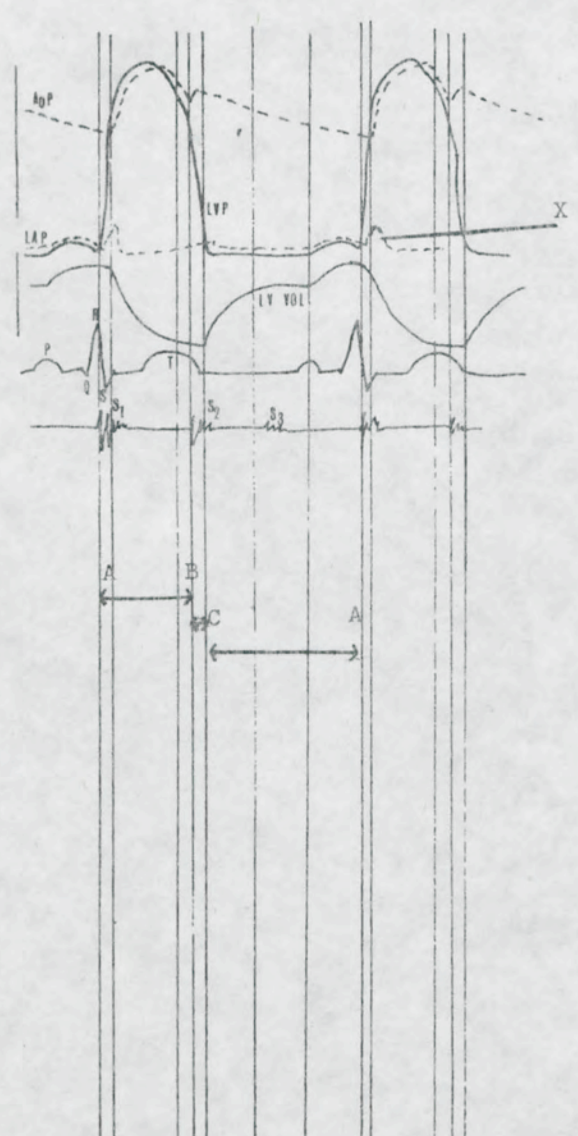
b) To the quality of the actual signal being analysed, rejecting data which contains noise.

It is anticipated that in a number of instruments examining a sequence of say 300 heartbeats, it should be possible to obtain and bank information from 180 heartbeats in which acceptable signals are obtained from all the instruments in use. It is necessary to examine excess heartbeats because the heart functions within a control framework depending on various feedback mechanisms. It will over-pump for a period and then under-pump, adjusting its output to the body's needs. Effects of breathing, emotion and the beginning and ending of even small amounts of exercise induce considerable changes in its performance. Trend recordings always show this "hunting" of cardiac performance. Detailed analysis of the performance of the heart is best done at the points of minimum change rather than those of maximum change. In an ensemble of 100 beats such points of minimum change will occur several times.

FIG. 3a

In this diagram the aortic pressure, the left ventricular pressure, the left atrial pressure, the left ventricular volume, the E.C.G. and the heart sound are all related to each other. Between line A and B the heart muscle is actively working and consuming energy. Between B and C, the active early diagnostic phase, a small amount of energy is being consumed and between C and A, during the remainder of diastole the heart is receiving the flow of blood from the coronary arteries. Therefore the slower the heart rate and the longer the gap between the working periods the better the ratio of blood supply to muscle work. Conversely a rapid heart rate means a less well nourished heart. Thus pulse rate is an informative natural non-invasive instrument. This can be detected by the Doppler shift instrument which can give further information as in the peripheral cardiograph.

X is the peak of the left atrial pressure curve related to the bulging back of the atrio-ventricular valve.



PRESSURE VOLUME CURVES IN THE HEART AND GREAT VESSELS

FIG. 3b

THE ELECTROCARDIOGRAPH

D

AORTIC PRESSURE CURVE

E

C

EJECTION STARTS HERE

LEFT VENTRICULAR PRESSURE CURVE

CONTRACTION STARTS HERE

LEFT ATRIAL PRESSURE CURVE

B

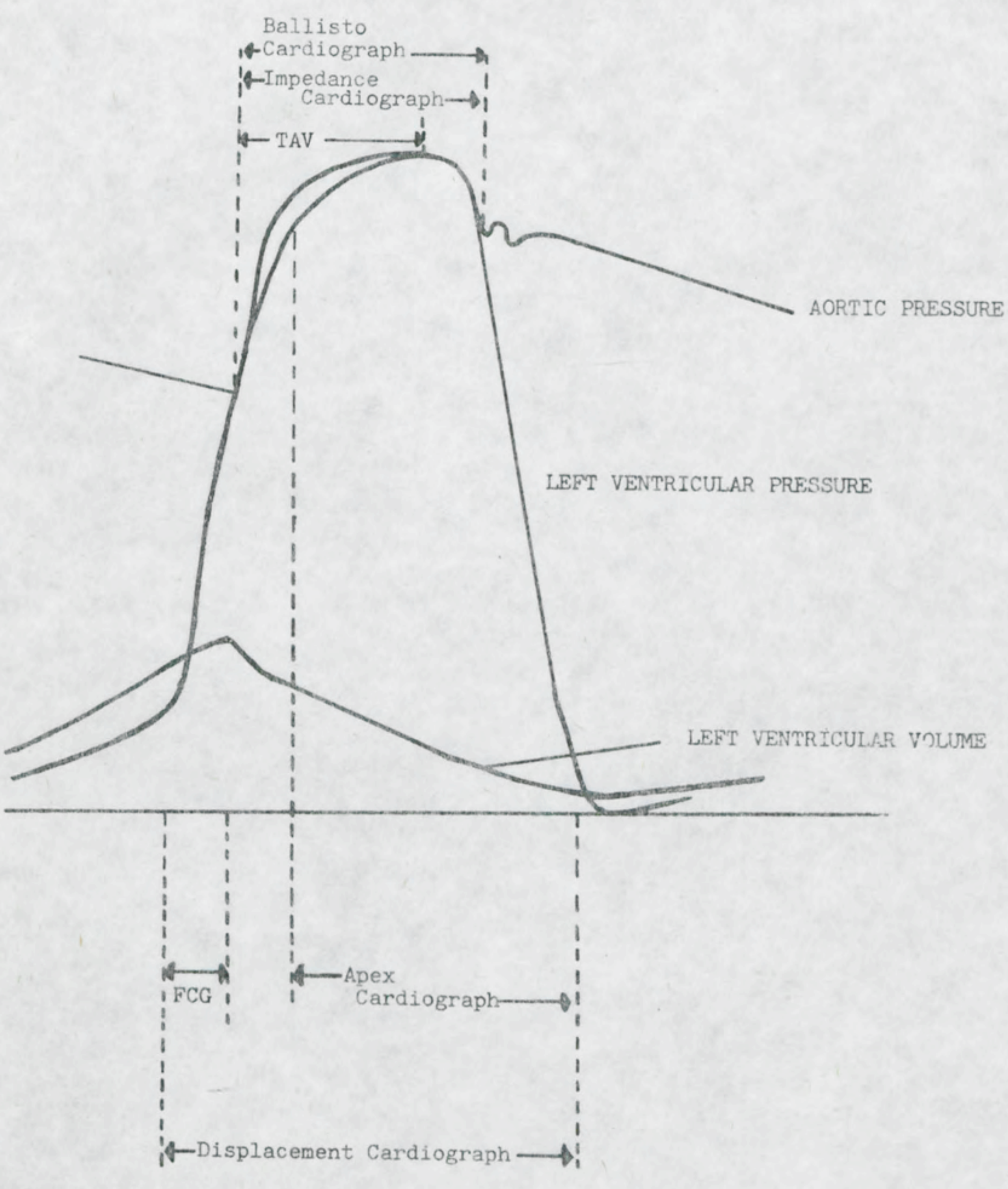
A

F

The pressure rise in the left atrium corresponding to the rise in left ventricular pressure before ejection starts demonstrates the bulging back of the mitral valve showing that the left ventricular muscle shortens during the isometric contraction phase.

The left ventricular pressure rises from Point A because it is topped up by atrial contraction. From Point B the rise in pressure is due to the onset of ventricular contraction. At Point C the aortic valve opens. By Point D the left ventricular pressure is beginning to fall off but inertia is still carrying blood forwards in the aorta. At Point E the aortic valve is closing and aortic pressure after an initial bounce begins to fall as blood flows to the periphery of the body and coronary flow starts. At Point F the ventricle has finished its mechanical work and opened itself into its cylindrical shape ready to accommodate blood which begins to refill the ventricles and causes the left ventricular volume to increase again.

FIG. 3c



THE RELATIONSHIP OF SOME OF THE NON-INVASIVE INSTRUMENTS TO EACH OTHER AND TO THE CARDIAC CYCLE.

5.1 The potential value of the mobile diagnostic unit lies in several areas:

a) Early detection of occlusive vascular disease, avoiding the need for expensive cardiac surgery and hospitalisation.

b) Clinical diagnosis of undetected established heart disease.

c) The monitoring of the efficacy of preventive therapies, drugs and diets etc. without the need to wait for a generation.

d) As a research base for the evaluation of new non-invasive instruments by comparing them with data from well tried and validated combined instruments.

e) Chance finding of other treatable diseases.

f) Fitness tests for aircrew and other key personel which virtually eliminate risk of acute cardiovascular dysfunction.

5.1a <u>Early detection of occlusive vascular disease</u>

Combination and enhancement of the diagnostic power of non-invasive instruments improves their resolution of disease processes. When an instrument without enhancement would only respond when the cross sectional area of the coronary arteries were reduced so extensively that cardiac performance is impaired, an enhanced set of instruments should be able to respond when only a small reduction of cross sectional area is lost. N.M.R. is capable of looking at the vessel wall directly measuring atheroma deposition and would anticipate even this event. The mobile diagnostic unit will detect a whole range of pathologies in patients who would be assessed as normal by present day techniques. Even in a cardiac centre, these newly discovered pathologies will consist of presently undetected early disease not recognised or described. Since the unit is designed to measure overall heart performance, (ultimately expressed as a single figure - the cardiac performance index) repeated examination of patients allows not only for the detection of early pathology but also its severity to be quantified. The scale of such measurement would be a continuous spectrum ranging from "very healthy" to the borders of symptomatic disease (Fig. 4).

5.1b **Clinical diagnosis of undetected established heart disease**

A patient presenting himself for screening may have attributed mild symptoms of serious heart disease to "indigestion" or some other vague self diagnosis. He may have deemed it was unnecessary or impractical to see his doctor. Even in a health centre, a G.P. does not have the facilities or the time to perform an adequate cardiac assessment of the patient. The computer enhanced diagnostic power discussed in previous pages allows diagnostic facilities well in excess of those available at some of the best hospital out-patient departments or private screening clinics. For these reasons, the mobile diagnostic unit would allow exhaustive evaluation of relatively advanced symptomatic disease, although this is not its primary function.

5.1c **Monitoring of the efficacy of preventive therapies etc.**

The ability to measure the presence and to quantify the severity of early disease, means that by repeated measurements improvements or losses in performance could be established. A subject in the study whose performance was deteriorating more rapidly than mere ageing could account for, would be one in whom therapy and the institution of all known preventive measures should be applied. If the therapy were successful, subsequent cardiac performance indices would show arrest or even reversal of this accelerated decline. If not, the decline would proceed unchecked. In this way, the usefulness of certain manoeuvres in treating or preventing occlusive vascular disease would be ascertained in less than a tenth of the time that it currently takes. The results would also be more accurate and more complete than those currently obtained by waiting a generation to study mortality figures.

5.1d **As a research base for the evaluation of new non-invasive instruments**

Once the mobile diagnostic unit is running it will provide an ideal baseline for comparison for newly invented non-invasive instruments. At present these are capable of producing trend records over a long period of time and evaluated by comparing a point in time with invasive catheter laboratory data which itself is distorted because of the laboratory environment.

5.1f **Fitness tests**

At present air crew and key personel frequently are passed as fit by an ECG, while others are denied a livelihood on the basis of an abnormal ECG which may be insignificant. The diagnostic power of an M.D.U., including nuclear magnetic resonance, is so great that it should be possible to guarantee that there will be no cardiovascular catastrophe possible within the next month or two, with rare exceptions of rythmn disturbance, ruptured congenital aneurysms etc.

6.1 The mobile diagnostic unit is aimed at detecting occlusive vascular disease, including coronary artery disease, at its earliest stages. It must be designed to measure the earliest occurrence in the chain of events which leads to symptomatic coronary artery disease.

6.2 Three approaches are available (not mutually exclusive):

a) To look directly at the coronary artery walls to detect some aspect of them which becomes abnormal at an early stage (N.M.R.).

b) An alternative is to detect the results of abnormality of the coronary arteries by measuring changes of flow in the coronaries directly, non-invasively using N.M.R.

c) By measuring changes in the pumping performance of the heart and the synchrony of its contraction. Although the abnormalities in pumping action are not the earliest events in the chain (since they are caused by partially blocked coronary arteries) they are closer to these events than the onset of symptoms

MOBILE DIAGNOSTIC UNIT COSTINGS

CAPITAL COSTS ALL AT JANUARY 1983 PRICES (Approx to 0.5K/item)

Instrumentation costs are approximate. Research at the National Heart Hospital is underway to define which instruments are essential and which may be discarded. The new generation N.M.R. equipment is central to the project.

Instrumentation

a) DIAGNOSTIC - including new generation constrained field N.M.R.

Electrocardiograph for timing
2D echocardiograph
Compliance cardiograph
Apex cardiograph
Frequency cardiograph (computer programme plus simple phonocardiogram)
Arterial pulse recorders for CCG
MAVIS or equivalent — 300K

b) GENERAL

Video recorder) For patient who is waiting,
Colour TV) giving information about
Cost of video film) examination
Computer interrogation terminal using simplified keyboard
Software for computer interrogation (included in main software package) — 25K

c) COMPUTER EQUIPMENT

Main Trivector computer system to control instruments/process data
Software for same — 150K

Colour TV monitor for computer system output including CTV converter
Hard copy printer for computer system output — 150K

d) PATIENT DATA SOTRAGE (Mobile Unit)

Magnetic card record system for patients
Terminal to read/write magnetic cards
Back-up hard disc system for data storage & computer "note taking"
Radio (telephone) link for clarification of records and to call in emergency maintenance, ambulance, etc. (hopefully to use Air Call system) + running costs — 15K

Power supply

G & M ONAN vibration-free generator	5K

Crew accommodation

Staff sleeping accommodation
Cooking facilities
Refrigerator
Staff washing facilities
Water supply — inc. in gen. fittings + 1K

Emergencies

a) VEHICLE BREAKDOWN/INSTRUMENTS BREAKDOWN

Fire extinguisher - FREON autofire
Tools for vehicle repair
Tools for adjustment of instrumentation

b) PATIENT COLLAPSE

Resuscitation trolley with defibrillator
ECG monitor
Drip stand
Drug cupboard — 10K

Internal fitting of vehicle as (mobile) clinic

Lining walls
Cupboards
Benching
Wiring
Lighting
Soft furnishings e.g. chairs in waiting area and for computer interrogation, also couches.
Air conditioning/heating — 15K

External fitting of vehicle

2 educational films to run simultaneously (including cost of films)
2 television sets for showing films
2 videorecorders for showing films
Awning to keep spectators dry and cool
Umbilicus for connecting to a hospital switchboard
Sockets, wires & system for transmission of day's data to central computer via telephone system (unless radio-link above can be used) — 20K

Central hospital computing office (research)

Trivector main computer
VDU with keyboard
Hard copy printer for generating letters
System for communicating by telephone with mobile units
Radio telephone link (? on Air Call system)
Disc/tape system for main aspects of data storage
Software to service above — 12K

Vehicle

$1\frac{1}{2}$ decker low cab bus with WC's — 60K

RUNNING COSTS FOR FIRST YEAR - including training costs for staff for subsequent M.D.U.'s and research overheads

Staff

a) MOBILE UNIT

Item	Cost
1st doctor (including 20% overhead National Insurance etc.)	12K
2nd doctor	10K
State Registered Nurse	9K
Technician	9K
Driver (casual labour)	0.5K

b) CENTRAL HOSPITAL COMPUTER SYSTEM (RESEARCH)

Item	Cost
Clerks to operate system/radio link	7K

Consumables

a) FOR COMPUTER SYSTEM (MOBILE)

Item	Cost
Hard discs Paper for printer	3.5K

b) FOR CENTRAL COMPUTER SYSTEM

Item	Cost
Hard discs, floppy discs & magnetic cards Back-up tape Paper for letters produced by printer	1.5K

c) FOR TRANSDUCERS

Item	Cost
e.g. ultrasound jelly ECG electrode jelly & other incidentals	1.5K

Fuel

Item	Cost
Diesel for bus Diesel for vibration-free generator	0.5K

Radio telephone/telephone links

Item	Cost
Standing charges Running costs	0.5K

Mail

Item	Cost
Costs of postage to patients & GPs	0.5K

Insurance

Insurance/road tax of vehicle Insurance of instrumentation/mobile computer Insurance of central computer facilities	1K

Maintenance

Maintenance of vehicle Maintenance of instrumentation/mobile computer	1K
Contract with Trivector Maintenance of central computer facilities Contract with Oxford Instruments (or other)	10K

Entertainment

Literature for publicity Catering for local dignitaries & GPs/ health centres Circularisation/publicity costs	up to 10K

N.B. 2nd and subsequent years, including possible use of D'Arcy, Macmannus & Maceus, and Welbeck for public relations — 5K

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Originator & Director of Project

Mr. D. B. Longmore, F.R.C.S.Ed.

Advisors to Project

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Mr. D. B. Forbes (Fund Raising)

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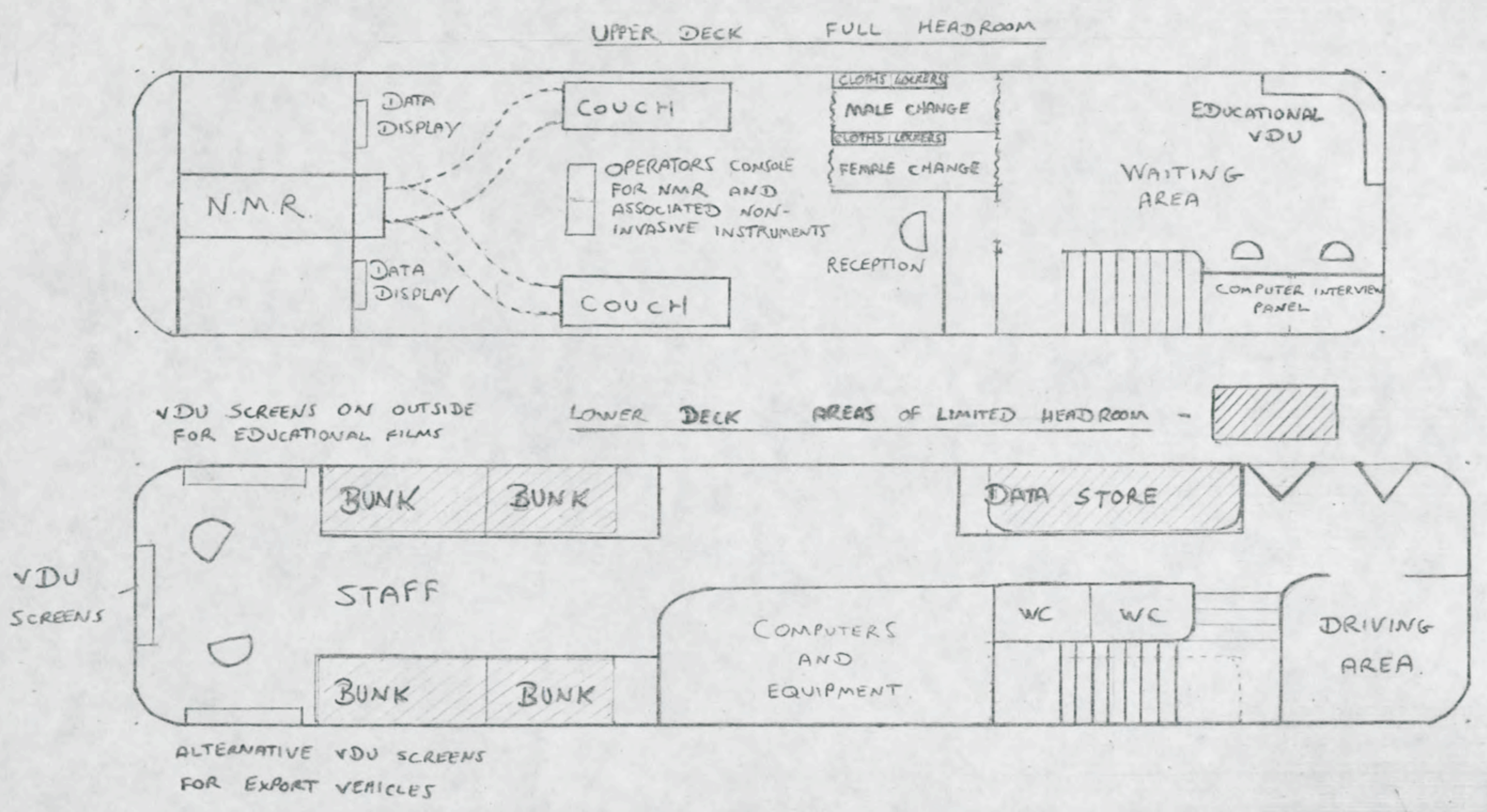
Miss L. J. Pehl, A.M.S.

FIG. 5 Suggested diagrammatic layouts for trailer unit



A suggested layout for the vehicle is shown diagrammatically in Fig. 5.

The likeliest of the existing non-invasive instruments to be used in association with N.M.R. ar listed in the section on costs. The first unit is designed as a prototype for field study. The experience gained with the first unit will be used to refine the design for future units.

A P P E N D I X   1

FORMAT OF LETTER TO G.P. FOR MODE 1 OPERATION OF UNIT

Dear Doctor,

The M.D.U. is a registered charity. It has a mobile diagnostic unit which, using safe, painless non-invasive instrument in a new way appears to be capable of diagnosing early vascular occlusive disease before it progresses to coronary and stroke. The unit is staffed by two senior doctors and a nurse. It will be available to demonstrate to you its capabilities in the week starting ....

We suggest that it might be of interest for you to be screened yourself and for you to bring your family along for a check up. In addition to showing you the unit we would show you a two-tier educational video demonstration which explains the procedure, its significance and what preventive measures might be taken.

The first video film is intended for the interest of you and your colleagues, the second is for whichever of your normal list of patients you may wish to refer for screening.

The unit will be capable of evaluating 100 to 300 of your practice at each visit. We would of course like to follow their progress at intervals of not more than one year. This will enable us to study the natural history of heart and general vascular disease as a research project. In addition, we could help you to monitor the efficacy of any preventive measures you recommend to your patients. We look forward to hearing from you and to co-operating with you in this venture.

For some categories of subject a small charge will be made. A proportion of this will be paid to pay for the extra work involved.

For this study it is hoped that you will be able to select subjects who are well-established in your area and likely to be available for further evaluation at six to nine monthly periods. It is hoped that we can work closely together helping you with a follow-up capability using the computer in the mobile diagnostic centre to monitor your preventive measures, thus increasing the power of your clinical capability.

Yours faithfully,

Members of the Scientific Advisory Council:

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Sir Cyril Clarke KBE FRS
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it is possible that the myocardium thus preserved may be of little functional value (and, indeed, if it remains ischaemic it may even be arrhythmogenic), the limitation of infarct size by early beta-blockade obviously raises the possibility that such intravenous treatment may have an important effect on mortality.

But there is as yet no reliable, direct evidence. Fourteen small randomised trials[27-40] (on a total of only 2000 patients) have involved short-term treatment starting with only an oral beta-blocker but, as noted above, because of the slowness of an oral beta-blocker to take effect, their pooled relative risk (1·07, with standard error 0·14) is not only statistically but also medically uninformative. The seven randomised trials[23-25, 41-44] of short-term treatment that have at least started with an intravenous dose are unfortunately even smaller. So, even if the 1-week mortality in these trials is pooled with that in the three randomised trials[11,13,14] in which intravenous treatment was followed by long-term treatment, this yields a total of only 81/1569 control deaths and 76/1596 treated deaths. This difference is not statistically significant, but the figures do at least suggest that early intravenous beta-blockers need not be as hazardous as was once feared (especially if injected slowly, with close monitoring, into patients without contraindications such as severe failure, second-degree heart block, or unusual risk of bronchospasm).

Unfortunately, the uncertainty as to whether the promise of early intravenous treatment will be fulfilled has not been dispelled even by the excellent study of intravenous metoprolol followed by 13 weeks of oral metoprolol.[11] For, not only was the mean time from onset of pain to intravenous treatment so long (11·3 hours) that the overall mean enzyme reduction was hardly significant, but also the reduction in mortality was chiefly seen not in the first week (23 placebo versus 18 metoprolol deaths) but in weeks 2–13 (39 placebo versus 22 metoprolol deaths). Although mortality in weeks 2–13 might have been favourably affected by early treatment, it is impossible from that study to know whether it really was, or whether only the long-term treatment was important. Moreover, the preliminary results[14] from a similar, though smaller, study of metoprolol are somewhat less promising.

Thus, for the moment it is difficult to disagree with the consensus that emerged from a meeting in New York at which the results from the largest[1] of the long-term beta-blocker trials were presented and discussed. By randomisation in eleven trials of over 13 000 patients, the effects on mortality of long-term beta-blockade after myocardial infarction have now been reliably estimated; but, at present, those of early intravenous short-term beta-blockade during the actual development of myocardial infarction have not. And perhaps they will not be until many thousands of early treatments have also been randomly allocated.

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Brain Damage after Open-heart Surgery

THE mortality-rate for open-heart surgery—2·7% in 15 399 cases of congenital and acquired heart disease managed in six centres[1-6]—is only twice that reported for general surgery in a British teaching unit.[7] In the U.S.A., coronary-vein grafting is now as commonplace as hysterectomy and appendicectomy: some 100 000 are done a year, with a mortality rate of under 1%. Unfortunately, brain damage sometimes arises during these operations. The reported incidence has fallen—from 44% in 1970[8] to 15% in 1975[9]—but much depends on the sensitivity of the tests. Cerebral damage may not be obvious at routine follow-up, showing itself

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only to spouses and families in changes of mood or personality. After open-heart surgery, children underachieve.[10] In one American study, less than half the patients who were physically fit after coronary-vein grafting were at work[11] (in others[12,13] the proportion who returned to work was more encouraging). On the initiative of RODEWALD, SPEIDEL, and KATZ,[14,15] an international group of surgeons, anaesthetists, physicians, physiologists, psychologists, and other interested parties has been trying to devise tests which will detect damage without distressing the patient. In Britain, a Department of Health advisory group envisages a computerised central register which will quickly identify any types of equipment associated with brain damage. Meanwhile, what tests are on offer?

Firstly, there is the cerebral function monitor: both in animals and in man, abnormalities in the record correlate with events likely to cause brain damage during operation.[16,17] Next there are psychometric tests, including word rotation,[18] memory recall,[19] and conceptual logic;[20,21] the more exhaustive the tests, the more dysfunction emerges. These inquisitions, however, are not popular with patients or hospital staff just before an operation.[22] EYSENCK[23] has suggested that intelligence may correlate well with "average evoked potential",[24] so this is a possible non-invasive approach; another is nuclear magnetic resonance, for detecting areas of brain dysfunction. Then there is the information to be gained from cerebrospinal fluid (CSF). The level of creatine kinase BB isoenzyme in CSF correlates with brain damage[25] and has already been used to evaluate other techniques.[25] On p. 1139 this week, Dr ÅBERG and co-workers explore the potential of another enzyme, adenylate kinase, and the levels in CSF correlated with changes in intellectual function from before to after open-heart surgery. Nobody, of course, will think of doing lumbar punctures routinely in these circumstances but—if enough volunteers are forthcoming—CSF adenylate kinase could well prove a valuable index of the brain damage associated with different techniques of cardiopulmonary bypass. Another promising technique is regional cerebral blood-flow measurement by dynamic emission computed tomography after inhalation of xenon-133.[27]

Although the origins of the brain damage often remain a mystery, almost every aspect of the bypass procedure is unsatisfactory. The disposable apparatus through which blood passes is made of various plastics. Polyvinyl chloride is commonly used for tubing. PVC contains potentially toxic plasticisers and fillers, and its surface is rougher than that of endothelium.[28] Ethylene oxide, often diluted with freons, is frequently used to sterilise oxygenators and reservoirs. These gases loosely combine with the plastics and may not be fully desorbed before tubing is used; a long shelf-life certainly does not guarantee elimination of toxic residues.[29] During bypass, emboli enter the brain from various sources—debris from the circuit and the prime, flakes of plastic from the pump tube, silicone antifoam, and precipitates from added drugs[30]—but most are gaseous or from blood.

Heparin is used routinely as an anticoagulant with protamine reversal. Heparin interrupts the clotting cascade at various levels but stimulates platelet aggregation.[31-33] Continuous adequate heparinisation is not always achieved, so that thrombosis takes place.[34,35] Platelets are consumed and activated during bypass;[36,37] a 60% fall in platelet count is usual, and most of the remaining platelets are non-functional.[22] Prostacyclin (PGI_2), the most potent platelet

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stabilising substance yet discovered,[38-40] preserves platelet number and function, preventing platelet aggregation and deposition, and sparing heparin.[22,41,42] Routine use of prostacyclin should lessen the incidence of complications due to intracerebral thromboses, platelet emboli, and toxic materials arising from platelet granular release, and lessen the propagation of platelet aggregates on the surface of emboli from other sources.

Bubble oxygenation exposes blood to several square kilometres of gas without any protective layer, and to similar areas of antifoam; the result is haemolysis and protein denaturation.[43] Inadequate debubbling allows a constant stream of small gaseous emboli to pass along the arterial line, with greatly increased numbers during cardiotomy suction.[44] These bubbles can be detected in the carotid arteries. Many are very small and consist of pure oxygen; thus they may implode harmlessly. Other sources of gaseous emboli are cavitation bubbles with high energy levels, from maladjusted or damaged arterial pumps.[45] If the perfusionist allows the level to drop in the open-topped circuit, lethal air embolism can result. Filters trap air but present a large surface area for platelet aggregation. The volume of "surgical air" trapped in cannulae and the heart often exceeds that introduced from the pump.[44]

In the mistaken belief that a reduction of the blood gas flow ratio to around unity would lessen the chance of gas embolism, manufacturers have abandoned proven oxygenator designs. Physiological $PaCO_2$ and PaO_2 levels, on which cerebral blood flow depends, are now often unobtainable. The resultant low PCO_2 can make cerebral vessels constrict, so diverting blood to damaged areas where the blood vessels are unresponsive.

Finally, until better anticoagulants and equipment are available, there is a case for using drugs (with or without hypothermia) to protect the brain during cardiopulmonary bypass—in much the same way as cardioplegic solutions protect the myocardium.[46-49] Barbiturates,[49] etomidate (a non-barbiturate hypnotic anticonvulsant),[50] and flunarizine (a calcium blocker)[51] are possible candidates for this purpose.

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WHEN IS PULMONARY TUBERCULOSIS CURED?

SOME heated correspondence was provoked last year by Buechner in New Orleans,[1,2] who claimed that almost all previous trials of antituberculosis chemotherapy were either invalidated or wrongly interpreted. He blamed design faults and loose definition of words such as relapse and cure. Using strictly microbiological criteria, Buechner further concluded from his reinterpretation of existing studies that only a full 18 months of modern chemotherapy was sufficient to produce what he regarded as cure. His definition of cure ran thus: the patient's sputum should be rendered negative by both smear and culture at least six months before completion of therapy and remain negative for life. Such a strict definition does indeed invalidate nearly all existing work, but it contains serious flaws. First is the failure to recognise that a successfully treated (cured) patient may become reinfected; immunity is not absolute, and many previously treated patients are at increased risk of reinfection because of alcoholism, social deprivation, and other factors. A second flaw is the insistence on negative sputum for 6 months before discontinuation of treatment; in several studies—for example, the British Thoracic Association trial in the U.K.[3] and the Medical Research Council trials in Singapore[4] and Hong Kong[5]—patients have proceeded to a satisfactory clinical outcome with consistently negative microbiology despite positive sputum within the final six months of their chemotherapy. Lastly, it is absurd to insist that patients must be followed for life before a conclusion is drawn; if this were the case we should still be waiting for the results of the first streptomycin trial in 1948.[6]

Clearly Buechner overstated his case, but the ensuing correspondence served to highlight the difficulty in defining cure of tuberculosis—a difficulty exacerbated by the conflicting views of clinicians and microbiologists. Evidence from many trials suggests that the appearance after the completion of chemotherapy of one or two isolated positive sputum smears or cultures, preceded and followed by negative sputa, does not necessarily herald clinical relapse. From a purely microbiological viewpoint, such isolated positive cultures certainly make it difficult to pronounce the patient cured, even though he may be clinically well; conversely, they do not constitute a relapse, since the patient may have no further positive tests during many years of

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UNSAFE REGULATION

Government regulation rarely arrives slowly after studied contemplation. Rather, regulatory legislation usually springs from public reaction to an event which theoretically might have been avoided by regulation. Trade laws followed the public's first bitter taste of fraud. Motoring laws arose after the first fatal traffic accidents. In this regard, regulation of the pharmaceutical industry, which has developed apace over the past two decades, is not unique. Contemporary drug regulations arose out of the tragedies of a few early cases of apparently unsafe drugs provided to the public in the late 1950's and early 1960's. Regulations aimed at exceptions, in practice, have affected all drugs. The increasing encroachment of regulations has now reached the point of introducing new hazards, no less hazardous than the unsafe drugs they are directed towards.

The legislative growth which initially arose in the United States has spread. Politicians in Europe are obviously aware of American regulatory developments and may find it difficult to argue against similar legislation. Rigid United States standards are spreading as well, and are now being multiplied by varying standards in Europe.

The cry for safety without necessarily a reference to efficacy in our drug supply is politically popular, and therefore an easy standpoint for the politician. However, effective new drugs, albeit with their unavoidable effects, can save lives and vast sums; for example, chemotherapy for tuberculosis rapidly saved the cost of sanatoria and returned

people to a productive life. With each "scare" the regulatory bureaucracy tightens its grasp with no detectable consideration of the long-range threat to the public's well-being posed by the regulations themselves. Momentary concern over a particular drug inevitably leads to a more restrictive climate for all medicines.

The heightened regulatory pressure which followed the Medicines Act of 1968[1] in this country, and the 1962 Amendments[2] to the Food, Drug and Cosmetic Act of 1938[3] in the United States, has dramatically increased the amount of time and money required to bring a drug from the development stage to market. This is largely the result of a change in regulatory climate, rather than as a direct by-product of the legislation. Caution and delay have their natural effect upon new medicines.

The average pre-market time in both countries is approaching a decade, compared with approximately two years in the late 1950's and early 1960's [4]. During the same period, the average research and development cost per drug has increased from a few hundred thousand pounds in the United Kingdom and roughly half a million dollars in the United States, to a present range of £16-40,000,000[5] and $ 50-70,000,000[6] respectively. It is therefore not surprising to discover that the number of distinctly new medicines (as opposed to the so-called "me-to" drugs which follow a commercially successful drug) has decreased[7]. Such a decrease is a sobering demonstration of the loss of benefit from the advantages of modern science. There are

further dangers including developing "black market" practices (e.g. Laeotrile) and of commercial exploitation by countries which do not have the same safety standards.

Government regulation is by no means the sole cause of this alarming increase in the cost of drugs. In response to increasing litigation and fuelled by concern for public goodwill, the pharmaceutical industry has substantially increased its testing of new drugs. If the drug firms learned nothing else from the thalidomide episode in the United Kingdom and the MER/29 debacle in the United States, they at least received the clear message from the courts and public reaction that the marketing of an apparently unsafe drug will certainly not be to the financial benefit of the company. It is necessary only to consider the sum of over twenty million pounds [8] and the undisclosed millions of dollars[9] paid to victims by the manufacturers of those two drugs. One is compelled to enquire as to the necessity of excessive regulations of an industry already exercising caution for its own benefit, indeed its own protection.

It is essential that the regulators and the public recognise that people suffer and die from the lack of a new drug as readily as from the use of an unsafe drug. The former danger is subtle and receives little attention, yet the incentive in delaying the approval of new drugs is clear. For example, the decision-maker at the Food and Drug Administration(FDA) is faced with the possibility of erring in one of two ways. The first is to approve an unsafe drug. Resulting public and political attention would focus on the mistake and perhaps bring a Congressional investigation, the United States equivalent of Questions in the House.[10]

The other mistake is by excessive caution to delay or block an effective drug whose benefit to the public far outweighs a miniscule element of hazard. The result to the public welfare will be the same as that of approving the unsafe drug in terms of morbidity and death. Nevertheless, under the present system no one will know. There will be no public or political attention.

Alexander Schmidt, a former Commissioner of the Food and Drug Administration, has pointed out that Congressional enquiries into FDA approval of particular drugs were so numerous that no accurate count was possible, whereas there had not been one enquiry into FDA failure to approve a drug[11]. The impact of these disincentives has fostered the continued emphasis away from encouraging the introduction of new drugs and in favour of cautious delay. What is desperately needed is that equal attention be directed at the effects of delay in approval of a beneficial drug as upon the negligent approval of a harmful one.

The innovation cost of this delay is subtle, yet significant. The discovery of new drugs by private industry accounts for the major portion of innovative work in drug development, responsible in 1970 for 82% of new drug discoveries[12]. Investment in drug research and development is thus governed by business considerations. Such decisions are becoming increasingly risky, however, especially for the smaller concern. An annual investment by American drug firms of 1.15 billion dollars now yields approximately ten new drugs achieving FDA approval. This contrasts with the 60 or so generally approved annually in the 1950's and early 1960's.

It is estimated that only one in 10,000 pharmaceutical laboratory discoveries will reach the marketplace as an approved drug[13]. Considering this fact together with the substantial research and development cost required to bring that discovery along the journey towards the marketplace, it is not surprising that the number od companies introducing new drugs has dropped by over 50% in the past twenty years[14]. While some drugs generate a healthy profit for the manufacturer, the overall high drug development cost has caused many smaller concerns either severely to curtail their innovation activities or to eliminate them altogether[15]. A large pharmaceutical firm can absorb the tremendous development cost of a drug which does not receive approval; smaller concerns cannot.

Even among those "pioneer" companies which have continued to pursue the development of new drugs, the rate of return has been unpredictable. Many companies probably could have produced better profits by more safely investing elsewhere. A recent economic survey confirms that three quarters of new drugs developed by pharmaceutical firms fail to recoup their research and development cost, plus generate a profit[16]. In the final analysis it is the public which suffers most from the government disincentives imposed on the pharmaceutical industry.

The recent extension of general patent life in the United Kingdom from 16 years to 20 years will obviously be of benefit to the "pioneer" companies still engaged in innovative development. Yet the root problem of erosion of

patent protection during the approval process remains since the patent runs from the discovery, not from the time of approval. The net result is that whereas the manufacturer of a new cooker will receive a full 20 years of patent protection, the pioneer drug company will never be accorded the same reward for innovation.

Management has been forced to make some logical, yet difficult decisions. The result of those decisions is occasional unfortunate consequences for the public. The increased costs have prohibited a business decision to invest in the development of a drug benefitting a limited number of people. The financial return from such drugs, even when sold at high prices, would clearly be inadequate to recover the investment in development and extensive testing required for government approval.

Drug firms must also limit the number of discoveries which will follow the long and expensive path to an application for government approval. Since a highly innovative new drug often carries with it some substantial question marks and thus greater government scrutiny and consequently greater cost the incentive to develop new versions of conventional medicines is clear. The end result is that the public will find new drugs aimed at the largest number of potential users chosen for their likelihood to have clear sailing through the MC or FDA. The sufferer of sinusitis may benefit; the individual inflicted with an uncommon disease will undoubtedly suffer(17).

There is an alternative to drug research and development resting in the hands of business managers who are required to make decisions based on the profits to be derived from those decisions. That option is to achieve the same objective solely through government funding of academic or university laboratories. Such a solution would allow us to leave profits out of drug innovation considerations, and for this many would welcome the change. Yet government funding brings with it its own disastrous consequences. In addition to encouraging further growth of an already burgeoning bureaucracy, one must seriously consider the place such a vague item as drug research would occupy when the budgetary axe falls, as is now being witnessed in both the United Kingdom and the United States.

Politicians who recognise the political advantage of calling for greater drug regulation are often those who are quickest to attack the drug industry for generating profits. It must be seen that any attack on profits is also an attack on the most effective supply of innovative drugs which the world has. Nations which rely on alternatives to private industry for the development of drugs have contributed little[18].

The cost to the public of failure to approve beneficial drugs is not measured solely in terms of suffering or mortality. The consumer bears the burden of increased prices for drugs which flow from satisfying expensive heightened regulatory requirements, whether that cost is paid indirectly through the National Health Service by the British taxpayer, or directly by the American consumer.

Professors Wardell and Lasagna of the University of Rochester Center for the Study of Drug Development have kept a running account of the "drug lag" in the United States effected by the heavy burden of FDA regulations. The data which they have collected reveal the increasing delay in the introduction of new drugs into the United States market compared with the rest of the world, and the dramatic decrease in new drugs approved in the United States[19].

Their valuable work has been complemented on an economic basis by Professors Grabowski and Vernon of Duke University, who have presented the clear economic effects of oppressive regulation. In addition to their figures on total research and development, Grabowski and Vernon have also pointed out the centralisation of innovation activities in a very few concerns[20]. Professor Peltzman of the University of California at Los Angeles, has demonstrated that the 1962 Amendments to the Food, Drug and Cosmetic Act, originally intended to protect the consumer economically from ineffective drugs, have instead led to a 5% "regulation tax" on American consumers' drug purchases[21].

Professors Reekie and Webber of the University of Edinburgh have presented similar figures for the growing economic effect of regulation in the United Kingdom, specifically the increase in cost and time required to bring a drug to market[22]. Unfortunately, there has been only limited consideration of the effect of British drug regulation. This is no doubt due to the fact that the full effect of these regulations, which arose a decade after the American ones, is only now being appreciated.

There have thus been several such studies of particular aspects of the impact of regulations on the public from both sides of the Atlantic. What is now needed is an overall consideration of the various aspects of the problem - pharmacological, economic, legal and medical - in both the United Kingdom and the United States. The Authors have embarked upon a project to present such a perspective as a complement to those cited. For this exercise, initial funding has been provided by industry, administered by a trust dedicated initially to this purpose. The final objective is to produce a politically and socially acceptable and viable alternative to the present unsatisfactory system.

There are many possible alternatives available to remedy the current situation. First, a return to the former voluntary system. In view of the economic cost of the drug disasters of twenty years ago, it is difficult to argue that drug firms would not be sufficiently concerned for public safety in the absence of pervasive regulation. Second, some form of industrial policing of member's quality control and concern for safety. Whilst we recognise the danger of a small unscrupulous firm taking a quick profit and then disappearing, such a possibility could be anticipated by appropriate safeguards. Third, an ombudsman review of drug production, with the ombudsman provided with effective power when action is required. Fourth, some form of review committee overseeing the government bureaucracy, with an eye towards correcting the disincentives referred to above. Whilst these are only four

alternatives and have been mentioned only superficially, they need to be considered and developed. Urgent change is required in one form or another to institute such a remedy for the public benefit.

Due consideration must also be extended to the pressures which are rising for some form of international review board, whose task it would be to pass on new drugs. While such a system has the advantage of centralization, it also has the potential danger of requiring unreasonable evidence as a result of the cumulative effect of each member nation demanding its own demonstrations of safety and efficacy. On the other hand, greater mutual recognition of foreign testing and approvals would be of considerable benefit.

Perhaps the most dangerous effect upon the public of the modern regulatory climate, and yet most subtle, is the mistaken belief, instilled by the bureaucratic assurance of safety, that there exist "safe" drugs. The unfortunate result is that the regulators and the public have fallen into a pattern of encouraging each other's expectation of entirely safe drugs, rather than producing a more rational analysis and weighing of the risk and benefit inherent in all drugs. (A caution voiced by Dr. Cavalla and the participants in a symposium organized by Cavalla in 1980, which addressed the need for risk-benefit analysis in our drug supply[23]). Risk and benefit are inextricably bound together. The less the risk we are willing to tolerate, the less the benefit we may reasonably expect to obtain. The ultimate danger of a breakdown in this analysis is achievement of the lowest

common denominator, drugs which carry little risk but promise equally little benefit.

In answer to questions in Parliament in April of 1980, Sir George Young, the Under-Secretary of State for Health and Social Security addressed this most important aspect of the problem:

"This House, the media, the pharmaceutical industry and the professions carry a serious responsibility to ensure that the public accepts that modern drugs inevitably have risks as well as benefits, and that complete safety is attainable only at a cost which most of us would regard as unacceptable - that is, turning our backs on progress."[24]

Our intention is to adjust the present impact of disincentives at work upon the decisions of the regulators, to encourage the continued innovation of the drug industry, yet maintain a rational expectation of safety. Our Trust[25] has been established to help prevent the incipient failure of medicine to turn promise into performance in vital new therapeutic areas.

Mark C. Young
Doctor of Jurisprudence
&
Donald B. Longmore, FRCSEd
Consultant Clinical Physiologist

November, 1981

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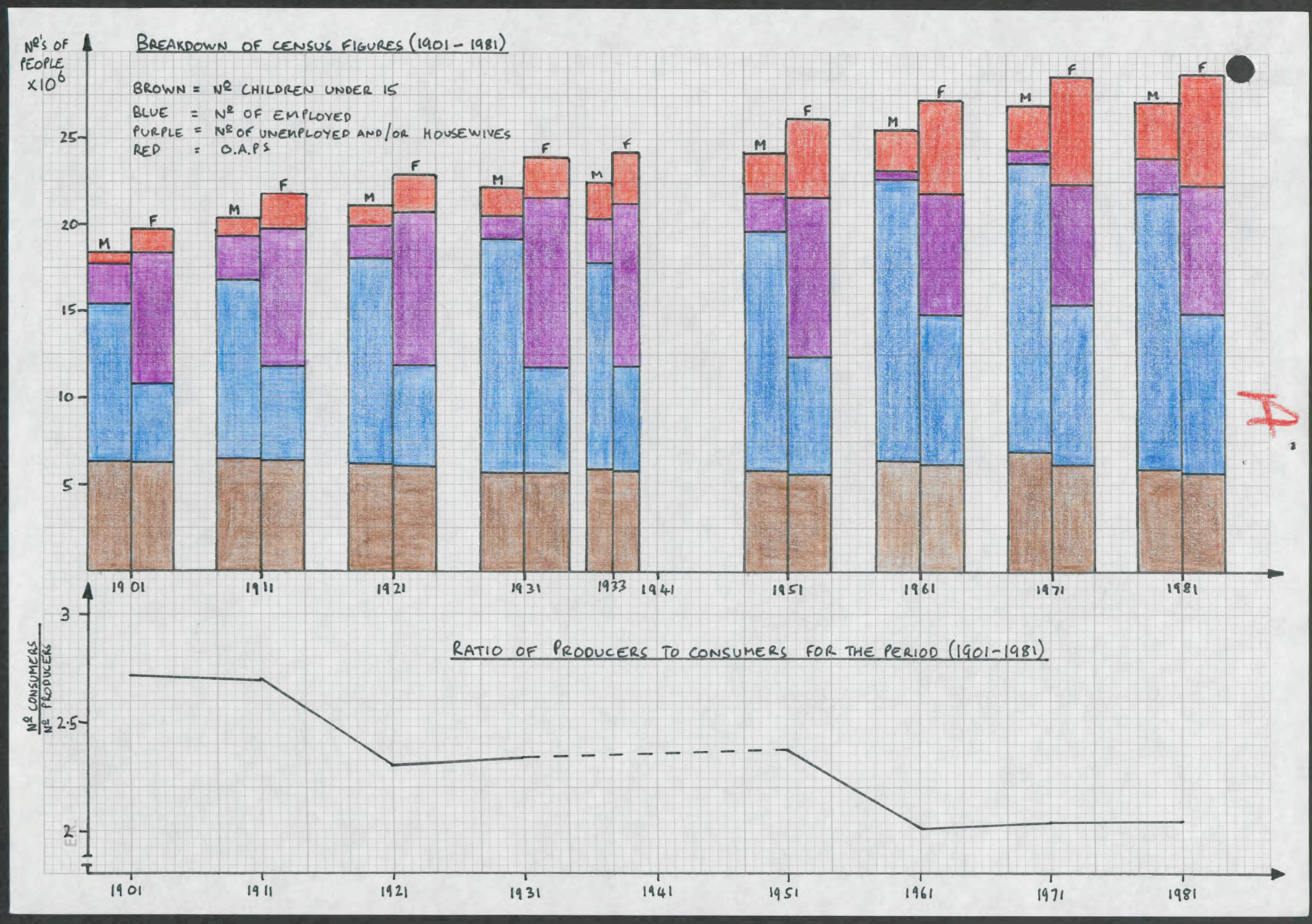
Chairman,
First Mississippi National Bank,
100 Hardy Street,
Hattiesburg,
Mississippi 39401
U.S.A.



BREAKDOWN OF CENSUS FIGURES (1901 - 1981)
Nº'S OF PEOPLE x10^6
BROWN = Nº CHILDREN UNDER 15
BLUE = Nº OF EMPLOYED
PURPLE = Nº OF UNEMPLOYED AND/OR HOUSEWIVES
RED = O.A.P.S
M
F
25
20
15
10
5
1901
1911
1921
1931
1933
1941
1951
1961
1971
1981
RATIO OF PRODUCERS TO CONSUMERS FOR THE PERIOD (1901-1981)
Nº CONSUMERS / Nº PRODUCERS
3
2.5
2

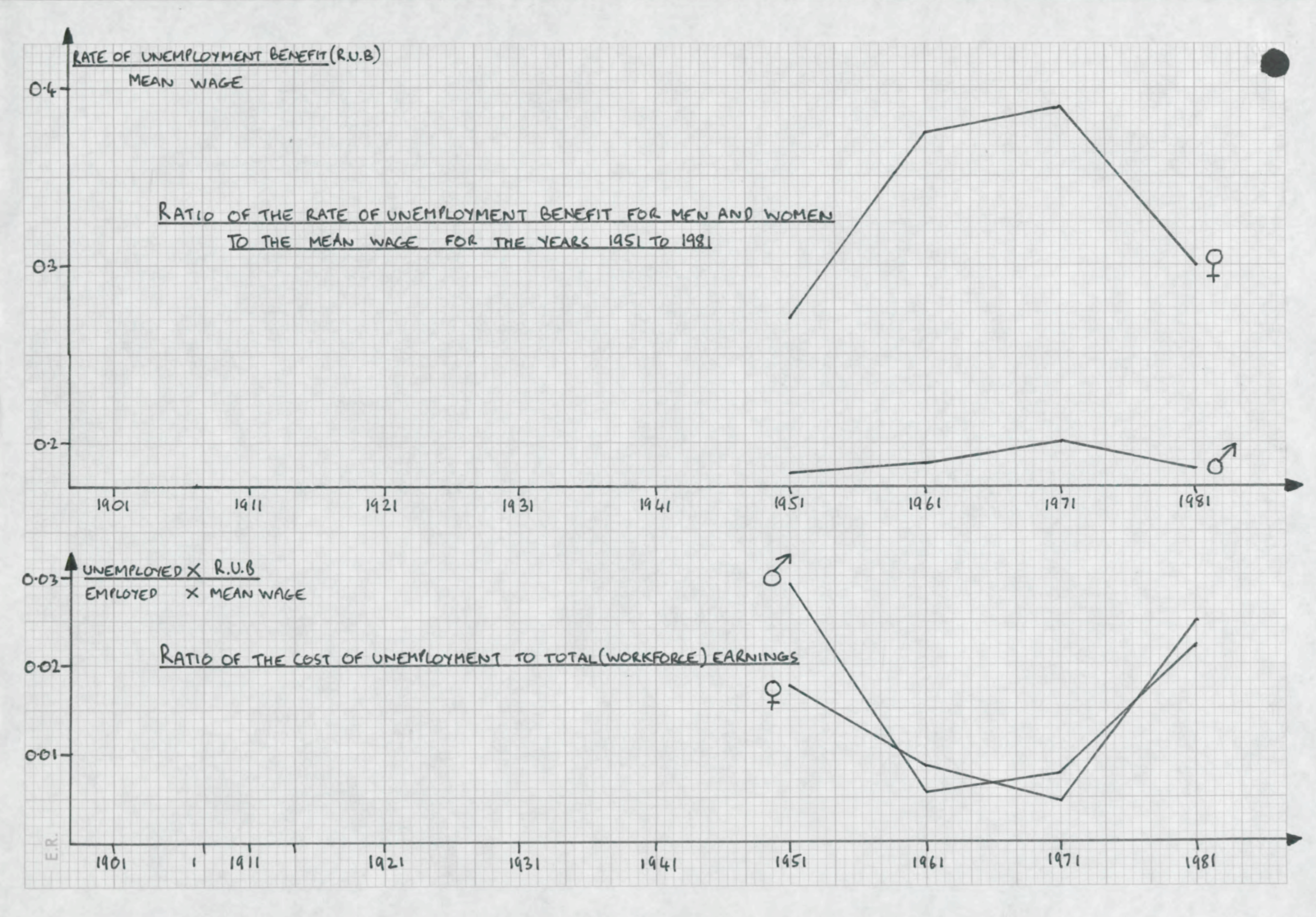

RATE OF UNEMPLOYMENT BENEFIT (R.U.B)
MEAN WAGE
0·4
0·3
0·2
RATIO OF THE RATE OF UNEMPLOYMENT BENEFIT FOR MEN AND WOMEN TO THE MEAN WAGE FOR THE YEARS 1951 TO 1981
♀
♂
1901
1911
1921
1931
1941
1951
1961
1971
1981
UNEMPLOYED X R.U.B
EMPLOYED X MEAN WAGE
0·03
0·02
0·01
RATIO OF THE COST OF UNEMPLOYMENT TO TOTAL (WORKFORCE) EARNINGS
♂
♀
1901
1911
1921
1931
1941
1951
1961
1971
1981

TABLE 1

YEAR	TOTAL POPULATION THOUSANDS	♂ POP. THOUSANDS	UNDER 15	15 - 65	65 +	UNEMPLOYED	EMPLOYED	CONSUMERS / PRODUCERS	R.U.B / AV. WAGE
1901	38237	18492	6214	11493	784	2242	11548	2.73	
1911	42082	20357	6497	12895	965	2515	12930	2.67	
1921	44027	21033				2002	13 0	2.27	
1931	46038	22060	5643	14946	1471	1552	14790	2.34	
1951	50225	24118	5781	16089	2248	2213	13906	2.38	0.182
1961	52709	25481	6321	16782	2378	486	15994	2.01	0.189
1971	55514	26952	6873	17275	2804	618	15602	2.19	0.20
1981	55837	27132	5897	18011	3224	1918	14066	2.20	0.185

TABLE 2

YEAR	TOTAL POPULATION THOUSANDS	♀ POP.	UNDER 15	15 - 60	60 +	UNEMPLOYED	EMPLOYED	CONSUMERS / PRODUCERS	R.U.B / AV WAGE
1901	38237	19745	6206	11937	1602	10247	4732	2.73	
1911	42082	21725	6472	13339	1914	11432	5356	2.67	
1921	44027					11966	5701	2.27	
1931	46038	23978	5531	15497	2950	12055	6265	2.34	
1951	50225	26107	5544	15983	4580	476	7271	2.38	0.27
1961	52709	27228	6015	15858	5355	193	8863	2.01	0.375
1971	5554	28562	6515	15836	6211	106	8797	2.19	0.39
1981	55837	28705	5603	16657	6445	763	9323	2.20	0.3

B

DEPARTMENT OF CLINICAL PHYSIOLOGY

NATIONAL HEART HOSPITAL

MR. DONALD LONGMORE

WESTMORELAND STREET, LONDON W1M 8BA
TELEPHONE 01-486 0824
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Our Ref.

Your Ref.

5th August, 1983

Dr. L. Freedman,
Flat D,
21 Devonshire Place,
London W.1

Dear Louis

Thank you for sending me a copy of Dr. Young's proposal and the relevant correspondence, also for the telephone call. His outline proposals are sound. I hope I can continue to contribute to G.E.C.'s lead in N.M.R.

No doubt with their outstanding success in the N.M.R. field, G.E.C./Picker have a matchless prize within their grasp, nevertheless they appear to me, as an outsider, to be at some risk of letting it slip away. I perceive three problem areas:

1. the production machines do not work properly;
2. the American end of the company unwittingly may jeopardise the future of the whole enterprise;
3. they do not seem to appreciate the potentially much larger market for the important second generation "contained field" machines conceived by Dr. Young.

Of course the production machines do not yet work properly, they are not "chinese copies" of the Hammersmith machine. That is the only practical clinical N.M.R. in the world. It is the gold standard against which all others are rated. Few will match it in the near future because the production magnets made by Oxford are not quite as good as the prototype magnet installed at Hammersmith. This constraint, however, applies to all N.M.R. manufacturers. In order to avoid further handicap Picker need to market machines which are exactly to Young's original specification and not "improved on" in any way either intentionally or by default, by those with no practical

experience or understanding on which to base developments. Every surgeon knows that when he adopts a new operation his results are subject to a "learning curve". We develop major new procedures here to a stage where the mortality rate is say 3% our careful imitators do well if they achieve a 10% mortality until they have learnt every detail, often taking over a hundred cases. Those who "adopt and adapt" end up with much higher mortality rates for an unacceptable period.

Basic surgical techniques are simple, as are the basic physical principles used in N.M.R. Major heart surgery and contemporary N.M.R. machines push both to the limit of our understanding. In N.M.R. even small changes in the design or the sequences used may result in a startling degradation in performance. Let me give an example: The Hammersmith machine uses a Data General computer programmed in Fortran and in Assembler. The production machines probably for sound reasons use a different computer. It should come as no surprise that the Fortran does not work in the same way when transferred. Assembler is not readily transferable, the programmes are probably best written de novo. This single change could put them back into the realm of software bugs in common with their competitors. The software Sword of Damocles now hangs over G.E.C./Picker as well as the rival firms. No one knows which bit of software will malfunction and under what conditions, a recipe for generating costly customer complaints. The problem may well be compounded by apparently small and insignificant changes in coil design, the methods of turning etc. M & D in Glasgow, the other British manufacturers of N.M.R. machines, are finding out these facts to their cost. Last month they showed me pictures nearly as good as those produced over five years ago by Peter Mansfield at Nottingham University.

One is always concerned about the manufacture of British designs in the U.S.A. I remember clearly the parallel position when Sir Godfrey Houndsfield was having problems with the CAT scanners manufactured by the E.M.I. subsidiary in the U.S.A. The Americans were unable to bring themselves to listen to the English engineers preferring to listen to local competitors who at that time had no working machine. There must be similar pressures on Picker to manufacture and market inappropriate machines. They have to resist the temptation to look for inspiration to G.E. and other American competitors.

It is fortunate for G.E.C. that G.E. and most of the major rival manufacturers have decided to produce N.M.R. machines which depend on the use of high magnetic fields with all their attendant problems. There is one notable exception, Bill Oldendorf in California, one of the pioneers of CAT scanning, has gone into partnership with a company to make a permanent magnet N.M.R. machine. His concept is not so many years behind Dr. Young's ideas for the new machine.

Through their American facility E.M.I. policies were influenced by the sales force rather than by Houndsfield and his group who knew what could work. Thus by management errors E.M.I. succeeded only in setting up an excellent training school in which their American competitors could learn our technology. It is fortunate that G.E.C. management is made of sterner stuff.

The longterm future of N.M.R. does not lie in costly high field machines intended for use in high technology hospitals. All the scientific evidence suggests that machines of the type proposed by Dr. Young will fulfil the real market requirements. Fashion favours high field machines capable of studying potassium and phosphorus. The use of a high field requires a corresponding high radio frequency. Such very short radio waves bend and refract, and cannot produce adequate spatial resolution. The facts are that:-

a) movie images are produced in Nottingham on a simple low field N.M.R.;
b) the best images in the world are produced at Hammersmith using low field;
c) our own heart gating work and our own preliminary blood flow studies show it is possible to visualise the coronary arteries with a low field (we have already produced velocity profiles showing not only amount of flow in the vessels but the characteristic of blood flow, all done with a low field).

For imaging, a low field is undoubtedly advantageous. Also it may soon be possible to study potassium and phosphorus in a low field using physical effects which are not yet fully explored.

Young's proposed design overcomes the three main objections to N.M.R. as a new diagnostic technique, a safe practical X-ray replacement and a machine useful for population screening. It will be cheaper to buy and run, there will be no biohazard from stray field and patients will not be pushed into a claustrophobic tube. It does not surprise me that Dr. Young has come up with a potential winner. He has a track record of sound ideas and the ability to make them work. There are other powerful reasons for adopting his proposed design with all expediency. Magnet technology is not quite as simple as it appears and Oxford Instruments are already unable to meet the demand for high quality magnets with a homogenous field. The proposed G.E.C. machine takes the magnet technology out of the hands of Oxford back into G.E.C.'s own areas of expertise. The power division of G.E.C. is probably second to none in the design of the kind of magnets which Young's machine needs. The type of magnet proposed is of course more stable and less susceptible to interference than those favoured by most firms.

In fairness I should make it clear that I have an axe to grind as a proponent of this mahcine. As you (and Lord Weinstock) know, for a number of years I have been trying to crack the problems of heart disease by detecting it at an early stage and monitoring its progress under treatment (see appended note which was prepared for a patron of the C.O.R.D.A. charity). A practical, easy to run N.M.R. machine, combined with a few other non-invasive instruments (one of which I have created to work in association with N.M.R.) gives us the opportunity to look at the normal population say every 9 months. Anybody who is deteriorating will be spotted; any patient who is treated can be repeatedly assessed to see if the treatment is working. This use of N.M.R. is far more important than its immediate role in replacing equipment and techniques aimed at the management of end state disease. The potential new market for a combined N.M.R. non-invasive set up is of course unknown but must exceed any market explored so far. There are a number of countries which have decided, or been forced to leap-frog the present inefficient expensive and unrewarding management of cardiovascular disease. In the West we wait till more patients than we could possibly cope with

have end state disease and then manage what we can, at enormous expense, with heroic surgery. (The coronary vein graft is now the commonest operation in the United States having overtaken the old favourites of hysterectomy and appendicectomy.) Other countries have decided to wait until prevention of cardiovascular disease is possible (this is dependent on early diagnosis). Nearer to home, the charity C.O.R.D.A. is dedicated to detection, protection and prevention. Its Board of Management and Scientific Advisory Council have been quick to see the value of N.M.R. in its carefully focussed and vital area of interest. I hope the charity will be supported adequately in its endeavours which will of course be helped by the availability of practical N.M.R. machines.

This rather long letter is of course an incomplete summary of a complex situation. If it would be helpful I am prepared to amplify any specific points.

If G.E.C. make the current machines work like the Hammersmith installation, help us apply N.M.R. to cardiovascular disease (54% of all disease) and show determination to develop the new machine with all haste, the time has come to buy all the G.E.C. shares you can afford.

Do not forget you are welcome here at any time to see what is going on.

All good wishes.

Yours sincerely,

Donald.

Donald B. Longmore, FRCSEd
Consultant Clinical Physiologist

FUTURES

Benign management or malignant bureaucracy?

If the British medical service could settle on a coherent plan for its future, worked out in fair detail, it would command and lead the support of a biomedical and biochemical engineering industry that would put the rest of the world in the shade. Why do we persist with the present anarchic free-for-all?

Longmore

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is consultant physiologist at the National Heart hospital, London, and
Malcolm Ross-Macdonald
is a freelance writer

Ross-Macdonald

One easy way for a TV producer to gain a reputation for making honest, hard-hitting documentaries is to turn his camera lenses on any aspect of the British medical scene. From top to bottom he will find plums ripe for picking: the inadequacy of the Ministry and its ad hoc approach to planning; the ancient autarchy of the part-time consultants; the dwindling role of the lone GP; the bitter discontent of junior doctors and nurses; antediluvian buildings kept going at disgraceful cost; and social euthanasia that passes for care of the aged and the mentally inadequate; our endless waiting lists for operations that are life-enhancing rather than life-saving; our absolute dependence on overseas doctors and nurses; our charmingly stochastic methods for financing research; the approaching collapse of the whole service; there seems no end. Even the successes—the new hospitals, the community care centres, the units for specialized therapy—even these can be attacked as "far too little, almost too late".

Such piecemeal attacks on the structure of medicine are, in effect, doubly pernicious. In the first place they create dissatisfaction—among medical workers who know they are true, among the public who feel they ought not to be true, and among administrators and planners who (in the short term anyway) know why they are true. In the second place they narrow the focus on to particular evils in so dramatic a way that a rational discussion of the *total* structure, the structure that permits the evils, becomes too abstract to command attention. The dissatisfaction cannot be met nor can the discussion be attempted as long as we are distracted by such piecemeal scandal.

Many an empire builder, military and industrial, must have faced equally despairing situations: occupied countries or taken-over companies swamped by day-to-day problems, unaware both of their place in the grander design and of their pathway toward it. Medicine is very like that: a ramshackle empire run by moderate dissidents and foundering for lack of vision. Yet the techniques for transforming such situations are already well established in industry and could quickly be adapted to make medicine more fitted to our needs in the final third of this century.

Wise industrialists have learnt to begin by asking not "where do we *want* to be two decades from now?" but "where would it be *possible* for us to be . . . ?" From a survey of the possible futures they pick those that currently suit their purposes best and they start making the necessary changes—in organization, staffing, training, investment, reserves, mergers, research . . . and so on. From time to time they review their original decisions, modify them if necessary, and check their current progress toward these rationally chosen and rationally modified goals. Medicine could be very like that, too.

Those who care about the future of medicine are all too apt to ask "where-do-we-*want*-to-be" questions—and, of course, to get pie-in-the-sky answers. We should begin by asking "what would it be possible for us to achieve, say, between now and the end of this century?" In fact there have already been numerous delphic studies of the futures in medicine, bioengineering and fundamental biology. We do not lack for basic, serious, and well-informed prediction.

As a next step we could admit: 1. that not all the advances will be simultaneously within our resources—though, of course, we must include on the credit side of the ledger the often neglected bonus of medicine: the numbers returned to productive work, whose efforts repay the capital invested in therapy; 2. that some may, within the 30-year term of a review, be actually harmful—for example we may exacerbate the effect of the continuing rise in world population; 3. that some may contain hidden perils (one thinks particularly of genetic medicine and iatrogenic disease) and should be applied on a limited scale in last-resort situations even though one could think of more general outlets; 4. that the return on some, however defined, may not yet justify the human and financial investment; 5. that medicine, properly organized, will have important regulatory roles that it cannot now command—in education and industry, for instance.

This brief list by no means exhausts the major considerations, but it does show the sort of sieve we could apply in our "first-order" decisions about the future. None of them involves specialist training of any kind; all concern the scope and quality of medical services. They could, and should, form the basis of the widest possible public debate, both formal and informal. Of course, popular TV and

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many papers will reduce the debate to the "computer - will - say - say - 99" and "pill - will-determine-sex" level; but as long as this is overlaid with more serious discussion in the quality media and as long as the main participants in the debate argue from informed positions, we will achieve most of the necessary decisions. The debate could range for years, though one would hope that major decisions will be taken early rather than late.

Such a debate would lead to a clear ministerial directive embodying as coherent a view as possible of the likely future. The debate need not—indeed, could not—end there; like the wise industrialists, we would have to review our decisions in the light of progress and reverses both here and elsewhere. Nevertheless, such a formal statement of aims would illuminate every part of medicine. It would make us the most precious gift of all: time. Time to re-educate. Time to make all the necessary changes—in building, investment, research, reserves and, above all, in attitude.

The debate would have to be accompanied by a very thorough "second-order" debate, which, by its highly technical nature, would be confined to the profession and its administration. To change the terminology slightly, the first-order discussions constitute "feed-forward"—an organized search of the terrain yet to be covered in order to discover the best goals and optimum paths. The second-order negotiations constitute "feedback". It is at this level that we construct systems for monitoring our current progress—a bland-seeming statement that, in fact, proposes the most radical reform of medicine ever contemplated. Every researcher, every GP, every therapeutic unit, every administrative department, would find his or its work related to first-order goals.

It is impossible to convey the sense of invigoration that can follow when every individual can relate his effort to the whole. Many who work in industry must know the feeling: researchers, workers, and managers in moribund companies taken over by dynamic firms with a clear vision of the future.

But, as the strikes that sometimes follow such takeovers show, there is a price to be paid by those whose line of work or whose performance fails to match that vision. Every medical worker, unit, and administration will find his or its performance checked—after all, that is precisely what feedback means. A medical degree would then be seen in its true light: a passport to continuing education in both general and specialized medicine. (At the moment we rely almost exclusively on random experience gained under stress and often in an enervating environment.) It is at this level that the success or failure of the new system will be determined. We all know of organizations that chose impeccable goals but were rather casual about their progress. We have no choice but to be ruthless with ourselves; if we are not, the ineluctable laws that govern complex systems willl combine to cheat us of our goals anyway.

In stressing the internal advantages to medicine we must not overlook the far greater advantages to the community. By removing medicine from the bear-pit of politics, where its largely unplanned direction is at the mercy of every secret power group, every accusatory splash in the mass media, we could bring an urgently needed stability and sense of overall purpose. In such an atmosphere the quality of care would vastly improve. To show this in particular and concrete terms let us consider just three very specific questions about the service and show possible answers to them today. Then we will look at possible answers under the new system.

Q.I Why is care of the subnormal and the chronically mentally ill so inadequate?

1. Because the Ministry has apportioned budgets in such a way as to starve mental medicine of funds.
2. Because mental medicine does not offer prestige and awards comparable with other fields—so the service is weighted by the less motivated who can easily get shoved to the back of the queue.
3. Because people don't care enough to put the pressure on the government.
4. Because our economic priorities do not allow it to be better.

Q.II Gastrectomy for cancer and the transplantation of kidneys, heart and liver are all palliative operations in that they may prolong life, may even return a patient temporarily to help the economy—but even where they do not, they can still turn a distressing and painful death into one far milder and more pleasant. Is our present apportionment of money between these therapies reasonable?

1. Gastrectomy has been established for almost a century, and although its success rate is no better than that for transplantation it would be wrong to compare the established with the experimental.
2. We do not know.

Q.III Many millions are spent on medical and related biological research. Unaccountable millions more go into the development of biomedical machines, chemicals and systems. How cost effective is this vast expenditure?

1. The industrial expenditure, being subject to market forces, is fairly effective. But research funds handled by government, universities, institutions, and charities are scrutinized by accountants looking for fiddles—not be investment—manager types looking for return. Cost-effectiveness is bound to be low.
2. Research as such is pretty effective—Britain has a good record here. It's the industrial investment that is poor. Industry in America, Sweden and Germany is far better at exploiting biomedical research and turning discovery into currency—earning hardware.
3. Effectiveness doesn't come into the picture. Department A gets money out of charity X with the voting support of faculty B. Faculty B, of course, will rely on department A next time around. It sounds terrible but fortunately they're all responsible people and so it works pretty well. Anything more formal would only fossilize the prevailing state of anarchy.
4. We do not know.

These three specific questions can be taken to stand for large and important areas of the service. The first question, suitably extended, covers facilities, conditions, rewards. The second question covers the benefits, however measured, derived from all forms of treatment. Question three covers the effectiveness of our investment in the future. The answers, all of which we take to be honestly (even if a little cynically) held by some important section of the profession or the public, reveal the thoroughly unsatisfactory state of anarchy now prevailing.

How would we be able to answer these same three questions under the new system? QI poses a difficulty because, in our view, mental welfare could not possibly come out of a rational plan as badly as it now comes out of our free-for-all. But, for the sake of the exercise, suppose the question were still relevant, we would be able to reply:

> Because in a long and wide ranging debate two years ago, a debate in which you could have—may have—played a part, the consensus came down in favour of other goals. Nobody enjoyed such a decision but the alternatives and their costs *were* made clear, and they proved even less palatable.

To QII we could say:

> By the criteria provisionally accepted two years ago the benefits of therapy A have been overestimated in relation to those of therapy B. True they are for different ailments, and so are difficult to compare; in fact, it is clear that the accepted criteria already need modifying. Until we have our new yardsticks we are not proposing any changes. But if they show the same disproportion we shall certainly make changes in our promotion of these therapies.

Obviously we could have made a different answer; This one was chosen because it reveals that the new system must be both flexible and adaptive.

For QIII we could say:

> Industry and other sources of R & D grants now know the expected direction of medicine for the next 30 years. It is gratifying to see how quickly they have responded to the lead. Many have formed joint committees with one another to cut out wasteful overlap and promote competition. For instance, there is now only one British researcher working on "rare blood groups in the Bamingui and related tribes", while over 30 co-ordinated groups are now studying various aspects of haemodynamic regulation—precisely the reverse of the situation four years ago. In practical ways, too, they are getting for more investment conscious. For instance, Charity Y did a survey of all the machines bought by researchers out of Y grants. They found almost half of it—£84 000 worth—was hardly used. The researchers had been quietly holding on to the stuff for fear their next grant would be cut. At least £50 000 worth of this machinery has since been redistributed among existing grantholders—who actually needed it. These are just two of hundreds of ways in which the funding bodies are enabled, by the new system, to double or treble our return on each £1 of investment.

This answer has enabled us to introduce the clinching argument in favour of rationalization in medicine: economics. We are a rich and ingenious nation with excellent traditions in biological and medical research, and electronic and mechanical design. We have on paper and could have in reality a centrally organized medical service. If that service could produce a coherent view of its future, worked out in fair detail, it would command and lead the support of a biomedical and biochemical engineering industry that would put the rest of the world in the shade. Just as the town of Rochester, Minnesota, now lives off the fall-out from its prestigious Mayo Clinic, so the entire bioengineering industry in the United Kingdom thriving in an assured market with a known future, could undersell the world and make medicine one of our biggest earners of foreign exchange.

That last statement sounds extreme—until we remember that mankind is approaching three gargantuan crises, any one of which is larger than any crisis in our history: population, urbanization and global pollution. Medical remedies, medical advice, medical hardware, medical planning—all will play a central role in preventing these crises from engulfing us. Medicine as at present organized—not just in Britain but throughout the world—is ill-fitted for such a role. For different historical reasons no country is so well-poised as Britain in the 1970s to make the necessary changes. We have the skill; we have the resources. We have the stick—that is, the knowledge that failure would widen and deepen our present malcontent. Let us hope we do not lack the carrot—the will and the vision.

CHIEF SECRETARY TO THE TREASURY

M 1/8

Treasury Chambers, Parliament Street, SW1P 3AG

Rt Hon Norman Fowler MP
Secretary of State
Department of Health &
Social Security
Alexander Fleming House
Elephant & Castle
London SE1 8BY

1 August 1983

Dear Secretary of State,

PHARMACEUTICAL INDUSTRY

Thank you for your letter of 21 July.

I think that the cuts you seek in the PPRS ahead of the main review are very much a matter of negotiating judgement, which I regard as a matter for you. I am glad of your undertaking to secure £60 million (UK) in a full year, and on this basis I am content to leave the precise nature of the package to you. But it does seem to me that your present proposals are right, that you should treat them as firm objectives to be achieved, and that you should be reluctant to depart from them. The drugs industry will undoubtedly want to see some changes as a result of their talks with you, and this might be best achieved by your overbidding initially (with, say, a 5% cut in RoC), thus allowing you to treat the desired outcome as a fallback.

I assume that you have settled on the £60 million figure as the maximum achievable in practice. The corollary of course is that there are no further savings on drug prices available to meet the overall savings I shall be seeking on your programmes following the recent Cabinet discussion, and that the balance will need to come from elsewhere.

On generic substitution and parallel importing, I broadly agree with what you propose. Given the operation of the PPRS, there are no significant savings here. But I hope you would not rule out measures to encourage generic prescribing, perhaps as part of a Greenfield package, or the possibility for the future of encouraging imports as a means of encouraging competition in the drugs industry.

I am copying this letter to the recipients of yours.

yours sincerely

PETER REES
(approved by the Chief Secretary & signed in his absence)

Econ Pol, Public Expenditure, pt 23

CONFIDENTIAL

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

Prime Minister

MES 21/7

Peter Rees QC MP
Chief Secretary to the Treasury
Treasury Chambers
Great George Street
LONDON SW1

21 July 1983

Dear Peter.

Pharmaceutical Industry

You will recall that I announced on 8 July that I had informed the pharmaceutical industry's representatives that I intended to save £25m on the NHS drugs bill in 1983/84 as part of the Government's measures to control public spending. Our officials have also been discussing a number of other matters which affect the pharmaceutical industry in the context of the recent PAC report on Dispensing of Drugs in the NHS and the announcement of the PPRS review earlier this year (a copy of the statement to the PAC is attached). I am now ready to put proposals to the industry which would reduce their profits in the coming years, ie after 1983/84, and enable us to make considerable savings in the NHS bill, mainly in the family practitioner services.

There are two preliminary points I should make. First, I need hardly say that there is consternation in the industry at the £25m cut (equivalent to a £50m, or 25 per cent reduction in profit in a full year), and acute anxiety about the future. We already know of companies which are holding up UK investment plans and foriegn owned firms which are rethinking their investment strategy. I must end the uncertainty as soon as possible, and I have promised the industry's representatives that I will put proposals to them before the end of July which will deal with the major matters outstanding with the industry, including the Greenfield Committee's recommendation on generic substitution and the problem of parallel importing.

Second, I have been able to persuade the industry to co-operate in achieving the £25m saving only on the assurance that the Government - unlike the Opposition - has no intention of damaging the industry which, as you will know, has an outstanding international reputation for its research and development of ethical medicines, contributes a net surplus of some £600m pa to our overseas trade, provides over 67,000 jobs, and attracts very considerable foreign investment. While there is no question of backing away from the Government's intention to reduce

CONFIDENTIAL

profit levels, I must discuss our proposals as a whole with the industry's representatives, and adjust them, if necessary, if it appears that particular measures would be damaging to the industry.

Pharmaceutical Price Regulations Scheme

Officials have started work on the review of the PPRS announced to the PAC, but this will take some months to complete, and therefore without waiting for this I propose to take the opportunity offered by the PAC report itself to reduce the profits we allow the industry on its sales to the NHS.

The PPRS is agreed between the Government and the industry, but decisions on profit levels and certain allowances are reserved to Ministers, subject to Treasury consent. I propose to attack on three fronts and reduce the return on capital (ROC) allowed to the industry, the area of flexibility above the ROC permitted individual companies to encourage efficiency and endeavour (the 'grey area'), and the expenditure on sales promotion allowed as expenses. The reductions would take effect from a current date, but would take some time to work through, and maximum savings would not be achieved for 2 or 3 years.

The 25 per cent return on capital (ROC) at present allowed to the industry was related to the return on non-competitive contracts recommended in the 1978 report of the Review Board on Government Contracts. The Board is due to report again at the end of this year and we will want to reconsider the ROC level in the light of its recommendations. Meanwhile I propose to aim for a reduction of 3 percentage points (ie from 25 per cent to 22 per cent). In practice, the scheme is at present running slightly over its target and we should therefore have to impose larger cuts when allocating targets to individual companies. Each precentage point reduction is worth approximately £10m pa off the NHS drug bill, so the effect of this proposal alone would be to take over £30m pa out of the industry's profits on sales to the NHS.

Second, I propose to aim for a reduction in the size of the 'grey area' from the present 10 to 5 percentage points above a company's target ROC. The grey area allows a company to retain extra profits above its target where this is due to introducing new products or through improving its efficiency and reducing costs. It is a matter of judgement how big a grey area is needed, but the present one is clearly too high. Savings from a reduction are impossible to quantify accurately, since they depend on the commercial decisions of the companies covered by the scheme, but our best guess is that a 5 point grey area might lead to savings of up to £25m pa for the first year or two, though this would fall as the new rules are applied.

Third, I propose that we should lower the ceiling of expenditure on sales promotion allowed under the PPRS. At present companies can charge in the price of NHS medicines up to approximately 10 per cent of the value of their sales. Expenditure over this figure is counted as profit. Each percentage point reduction in the permitted allowance is worth approximately £14m pa. I propose that we should reduce the allowance from 10 per cent to 8 per cent forthwith and seek further restrictions in later years. We might save £28m pa by this means.

The reductions described above are maximum figures. If achieved, they would lead, after two or three years, to annual savings of up to £70m pa, though savings in earlier years would be smaller. The industry's target profit from NHS sales is currently approximately £240m, and the effect of the cuts proposed above would be to reduce the target by something like 30 per cent. We cannot expect the industry to accept this without a fight. I shall therefore need to link these

proposals with settlement of the other matters outstanding with the industry referred to in paragraph 2 above. From the industry's point of view, the most important of these is generic substitution.

Generic substitution

As we expected, comments on the Greenfield Report recommendation on the introduction of a form of generic substitution (the substitution by the pharmacist of a generic drug where one is available for the branded equivalent) have shown very limited support for the Committee's proposal. The industry point to damaging effects on foreign markets linked with the UK with loss of export earnings; and to the effect that Government endorsement of generic substitution would have on foreign investment in the UK. I do not believe they are entirely crying wolf, and I do not think that on merits the case for the introduction of generic substitution in the form proposed is proven. If, on the other hand, we consider the proposal strictly from the point of view of savings to the NHS, (and that, after all, is the only reason for considering generic substitution) there are better ways in which they can be achieved. I shall of course urge on the industry the merits of some form of generic substitution (perhaps on an "opting in" basis), but we cannot realistically expect to achieve both the savings from the changes in the PPRS proposed above, and the potential savings of £5m to £20m which might accrue if the Greenfield proposal could be introduced. Rightly or wrongly the industry feel extremely strongly about generic substitution, and we may need to give way here to achieve the wider objective. Nor must we overlook the fact that reductions in profit levels will work mainly through branded drug prices and will reduce the price differentials between branded and generic drugs, thus reducing potential savings from generic substitution on the Greenfield model.

Parallel Imports

Our concern here is to close a loophole in the import exemption order made under the Medicines Act which is at present being exploited and which carries a serious potential risk to health from uncontrolled medicines. We also need to meet the judgement of the European Court by introducing a licensing scheme for parallel imports from the EC, which will seek to ensure that these imports are safe and can be traced back if needed. Just before the election EQO agreed to our proposals which cover both these points together. There is little or no financial benefit to the NHS from what is at present happening: the beneficiaries are those chemists who are able to buy drugs cheaply in Europe, and the importers who have taken advantage of the present position. Meanwhile losses are being incurred by certain wholesalers and manufacturers. The industry will, however, be pleased that we are introducing measures to control the abuse.

Conclusion

I should be grateful to have your agreement and those of colleagues to whom this letter is copied to putting these proposals to the industry. I do not intend to put them forward as a basis for negotiation, since these are all matters falling to my discretion outside the detailed PPRS itself but I may want to be flexible to settle a total package provided that I secure £60m in a full year, bearing in mind that the Government will be looking again at profit levels when the Review Board reports in a few months time. A number of minor matters, including the point mentioned by the PAC about the position of small firms whose profits are determined on the basis of sales (rather than capital), would be picked up in the detailed review of the PPRS referred to above.

E.R.

I am copying this letter to the Prime Minister, the Chancellor of the Exchequer, Secretaries of State for Trade and Industry, Scotland, Wales and Northern Ireland. Achievement of the £25m savings in the current year, depends on the co-operation of the industry, and I must honour my undertaking to put proposals to them this month for settling the matters referred to above. It would therefore be very helpful to have a quick reaction to these proposals. I am, of course, ready for an urgent meeting.

NORMAN FOWLER

PERMANENT SECRETARY'S STATEMENT TO THE PAC

1. The PPRS was introduced by agreement between the Health Departments and the ABPI in 1978. It succeeded similar arrangements for regulating the prices paid for prescription medicines which had run since 1969. Before 1969 the Health Departments attempted to control the prices of individual medicines.

2. Ministers consider that it would now be appropriate to review the working of the scheme because:

a. it has been running, unaltered, in its present form for nearly 5 years during which time there have been important developments both within and outside the NHS.

b. pharmaceuticals account for about 10% of NHS expenditure and should not be exempted from the search for greater efficiency.

c. the pharmaceutical industry's ROC has been creeping up, and it is necessary to consider whether this is consistent with the purposes of the scheme.

Ministers will want particularly to consider:

i. the rate of ROC allowed to the industry;

ii. the incentives to efficiency and profit it offers to individual companies;

iii. the costs allowed as chargeable expenses under it; and

iv. the relationship to issues raised in the Greenfield Report.

3. Ministers therefore propose that the scheme should be reviewed by the Health Departments in consultation with other interested Departments and the industry to make sure that the interests of the patient, the taxpayer and the industry are being properly served, and to propose any changes that may be needed. They will, of course, want to take account of any views the PAC may express on the working of the scheme.

LW

I don't think this is now going to be ... but you might like to show Michael if the ... M.

hh 6/7

(PWP)

(PA)

FROM: J G COLMAN
DATE: 6 JULY 1983

1. MR RAYNER
2. PS/CHANCELLOR

c.c. PS/Chief Secretary
Mr Bailey
Mr Wilding
Mr Watson

1. cc Personal to Mr Scholar.
2. prop. JGM. 8/vii

LONG-TERM RESOURCE ASSUMPTIONS FOR HEALTH AUTHORITIES

You told me that it was possible that when the Chancellor sees her today the Prime Minister might refer to Mr Fowler's announcement last week about long-term resource assumptions for health authorities. You asked me for a note.

2. The background was described in my submission of 27 June. I attach an extract of the relevant part of the health circular which was issued last week. If the Prime Minister raises this issue, I suggest that the main points the Chancellor might make are as follows:

a. - this is not a case of Mr Fowler making an unauthorised new commitment: it was agreed in February that he could issue the guidelines

b. - the ½% real growth assumption is explicitly not a commitment that the Government will find the money. Health authorities are warned that the actual provision could be less; and because the assumption is expressed gross of income from charges there is no presumption that whatever money is provided would all come from the Government rather than patients

c. - the assumption is expressed in real terms, despite the fact that Government expenditure is planned in cash, for good reasons:

- a 10 year assumption in cash would involve taking a view on prospects for inflation 10 years ahead. Health authorities are not equipped to do this.

- an assumption in cost terms would likewise involve forecasting relative price effects over a long forward period. Past experience shows that

it would not be prudent to make firm plans on the assumption of nil relative price effect. (This is a quite separate issue from whether the Government's own cash plans, for only 3 years ahead, should make provision for relative price effect.)

J. G. Colman

J G COLMAN

PERSONAL

2

Prime Minister - to see

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe KCB CVO

29th June, 1983

Robin Butler Esq.,
10 Downing Street

Noted
[initials]

Dear Robin

I talked to the Prime Minister last night about some of our concerns in the NHS; and was left in no doubt that she is looking for progress in reducing costs. This prompts me to alert you to an imminent development which will almost certainly entail approaches to the Prime Minister.

We want to reduce the cost of the NHS drug bill and have in mind a packet of policies and specific measures which we have already broached with senior representatives of the pharmaceutical industry. I attach a note which indicates what we have in mind. The industry will not like it. I know from private sources that they are preparing their defences which will certainly include Sir Austin Bide (GLAXO) approaching the Prime Minister; Sir Robin Ibbs (ICI) doing the same, Sir Graham Wilkins (BEECHAM) will be approaching the Chairman of the Conservative Party at the Department of Trade and Industry; and Mr Shepperd (BURROUGHS WELLCOME) will be pitching in to the City. We know that they will threaten to hold up investment decisions or target them abroad in support of their case.

I write not only to give you advance warning but also to urge that the Prime Minister backs us up with a robust response. There is no need, in my view, for her to get deeply involved. Her stance could be that she expects Norman Fowler to attack the costs of the NHS in every dimension and the drugs bill cannot be excluded. It is then up to the industry and the Department to reach a constructive understanding, which I believe we can do.

Yours ever,

Ken.

UK PHARMACEUTICAL INDUSTRY - POSSIBLE REDUCTION IN COST TO NHS

(Figures are estimates for calendar year 1983)

	£m	
1. Drug bill (cost of NHS prescribed medicines, excluding chemists' remuneration and wholesale discount).	1400	
2. Industry target profit (present PPRS rules).	240	(25%)
3. Industry actual profit (estimated and assessed by DHSS).	250	(26%)
4. Proposed adjustments (Note: these are my judgement of a likely outcome of negotiation; our opening bid will be more severe).		
a. cut in target profit of 4 percentage points - saving	40	
b. cut in tolerance allowed over target profit from 10 to 5 percentage points - saving	25	
c. cut in expenses on sales promotion allowed to be offset against profits, from 10% to 8% of sales - saving	28	
5. Total estimated annual savings 4a-c (equivalent to 5.7% off drug bill and 33% off target profits).	80	

NOTES

1. Items 2 and 3 - are return on historic capital employed.

2. Item 4b this tolerance (called the 'grey area') - is the additional profit permitted to companies over their targets to encourage efficiency and endeavour.

3. Item 5 total savings - is not the simple total of 4a to 4c because the elements of the PPRS interact. Full estimated annual savings would not be achieved for 2 or 3 years. The impact would vary as between individual companies as their performance varies - inevitably the companies making the biggest exessive profits would lose most.

4. Other elements in the overall "packet" of measures will be (a) action on closing a loophole which allows excessive parallel importing of medicines into this country and (b) action on the question of the Greenfield Report's views on "generic substitution" (the substitution of a cheaper generic version of the drug prescribed by a doctor).

LCC NO

Management and Personnel Office
Whitehall London SW1A 2AZ
Telephone 01-273 } 4400
GTN 273 }

21 April 1983

The Rt Hon Norman Fowler MP
Secretary of State for Social
Services
Alexander Fleming House
Elephant and Castle
London SE1 6BY

NBPM

MUS 22/4

Dear Norman,

EFFICIENCY IN PERSONAL SOCIAL SERVICES

Thank you for sending me a copy of your letter of 7 April to Tom King.

I welcome the proposals you outline, especially for increasing the number and broadening the purpose of secondments into the Social Work Service; the development of models of good practice; and the increase in the number of formal inspections. I very much hope that these proposals receive a good response from the Local Authority Associations and the Local Authorities since they seem to me squarely in line with our wish as a Government to strengthen assurances to the public that services provided to them are as good as they can be made.

I am copying this to Tom King and our other colleagues.

Yours ever

Janet

BARONESS YOUNG

22 APR 1983

Social Services

NBPM

MWS 19/4

CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street. SW1P 3AG

Rt Hon Norman Fowler MP
Secretary of State
Department of Health
and Social Security
Alexander Fleming House
Elephant & Castle
London SE1 8BY

18 April 1983

D Norman,

EFFICIENCY IN PERSONAL SOCIAL SERVICES

Thank you for sending me a copy of your letter of 7 April to Tom King about the proposed Social Services Inspectorate, based on your department's existing Social Work Service. Like Nicholas Edwards I would welcome some more time for these proposals to be considered fully, not least because your intention to take on new functions raises manpower questions even though you do not envisage an increase in the permanent staff of the SWS. I can of course also see the potential merits of an efficiency Inspectorate - if indeed that were what the SSI would turn out to be.

I understand the consultative paper is already being issued. It will be useful to have the responses to it. Once we have these, we shall have to take a considered view on the merits of the proposal.

I am copying this letter to the Prime Minister, Willie Whitelaw, Keith Joseph, Nicholas Edwards, George Younger, Janet Young, Tom King and Sir Robert Armstrong.

Yours

Leon

LEON BRITTAN

Social Services April 83

Efficiency in Personal Service

9 APR 1983

2 MARSHAM STREET
LONDON SW1P 3EB
01-212 3434

NBPM

MLS 14/4

My ref: K/PSO/12036/83

Your ref:

14 April 1983

Dear Norman

Thank you for your letter of 7 April about the new role for your Department's Social Work Service.

I have no objection to what you propose, but I do hope that you will make the Service aware of the role of the Audit Commission, one of whose duties as you know is to conduct comparative value for money studies to identify best practice in the provision of local authority services. I think it would be to the advantage of everyone if the Commission and the Social Work Service were to keep in contact about their work.

I also assume that the Social Work Service will be kept in close touch with developments in policy on central/local relations. I have in mind, for example, the implications, for the promotion of value for money in local government, of our Financial Management Initiative; and also, of course, the general question of constraints on local authority spending. It is obviously important that the Service should be able to make any recommendations in the light of full knowledge of national policy objectives.

I am copying this letter to the recipients of yours.

Yours
Tom

TOM KING

The Rt Hon Norman Fowler MP

SOCIAL SERVICES : Efficiency in Personal Social Services : April 1983.

Y SWYDDFA GYMREIG
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WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switsfwrdd)
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WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 6106 (Direct Line)
From The Secretary of State for Wales

NBPM
MCS 13/4

The Rt Hon Nicholas Edwards MP

13 April 1983

Dear Norman

EFFICIENCY IN PERSONAL SOCIAL SERVICES

Thank you for copying to me your letter of 7 April to Tom King about proposals for developing the inspectorial role of the Social Work Service in England. In view of the likely repercussions for Wales, it would have been helpful to have had a little longer to consider your document before it issued.

Naturally I have every sympathy with the overall objectives of securing greater professionalism and efficiency in the personal social services. I will be giving further thought to how these objectives can best be pursued in Wales, and will shortly be consulting on these issues in the Principality.

Copies of this letter go to recipients of yours.

Yours ever

Nick

The Rt Hon Norman Fowler MP

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Tom King MP
Secretary of State for the Environment
Department of the Environment
2 Marsham Street
LONDON SW1

7 April 1983

Prime Minister

Mr Fowler intends to turn the DHSS' Social Work Service into an inspectorate to steer local authorities into making the most effective use of their personal social services. He will issue a consultative document next week. (a draft is attached)

WR 7/4

Dear Tom,

EFFICIENCY IN PERSONAL SOCIAL SERVICES

I have been concerned for some time that the task of local authorities in providing personal social services has not been subject to the same scrutiny of efficiency to ensure value for money that I have been insisting on in other fields. The interest of the District Audit and in future of the Audit Commission - in this area is of course welcome.

I now envisage a considerable change in the role of my Department's 'Social Work Service'. The Service would in effect become an inspectorate (it already exercises some statutory powers of inspection), whose aim would be to steer authorities into making the most effective use of professional and other resources. It would inspect the work of individual authorities and submit a report, which would usually be a public document, to the authorities own Social Service Committee so as to increase the responsibility and role of elected members. It would also study the work of authorities generally so as to disseminate good practice more effectively.

I would not increase the permanent staff of SWS. Instead we would recruit people on short secondment from local authorities - so as to keep in touch with work on the ground - and also from industry and outside professions such as accountants.

There would be no requirement for legislation, and the costs would be contained within my Department's administrative budget.

I intend to issue my proposals next week, suitably in advance of the local government elections, as a short consultative paper. I shall be sending a copy to the local authority associations and, under cover of a short letter, to the Chairmen of local authority social services committees. Copies of these documents are attached for information.

I am sending a copy of this letter and enclosures to Willie Whitelaw, Keith Joseph, Nicholas Edwards, George Younger, Leon Brittan, Janet Young, the Prime Minister and Sir Robert Armstrong.

Yours ever,
Norman

NORMAN FOWLER

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

Dear Chairman.

All Chairmen of Social Services Committees recognise the importance of demonstrating to Parliament, to the public and particularly to local rate-payers, that personal social services are giving good value for money.

I want to increase the effectiveness of my own Department's Social Work Service and I commend to local authorities for their consideration the proposals in the short consultative paper, a copy of which accompanies this letter. Their purpose is greater participation by staff from the field, and more attention to questions of management and efficiency. We shall look forward to receiving comments through the local authority associations.

I believe that other recent developments, such as the helpful general reports from District Audit on services for children, have been widely welcomed by Social Services Committees. Your Committee and managers in the social services department will have your own programmes for increasing the efficient use of resources. If there are further steps you think I and my Department can take to help you, I hope you will write to me.

Yours sincerely,

Norman Fowler.

NORMAN FOWLER

SECOND DRAFT

THE SOCIAL WORK SERVICE OF DHSS:
A CONSULTATIVE DOCUMENT

The Second Report from the Social Services Committee, Session 1981/1982, and the Barclay Report (Social Workers: Their Role and Tasks, NISW, 1982) commented on an inspectorate in the personal social services in ways that should influence the future role and functions of the Social Work Service of the Department of Health and Social Security.

The Select Committee received evidence about the present role of SWS and concluded (Recommendation 35): "We favour the idea of an inspectorate based on the present Social Work Service and envisage an improved inspectorial capability as representing an important means of facilitating a more fruitful dialogue between the Department and local authorities, and of increasing the professionalism and efficiency of PSSDs".

The Barclay Report recommended that an independent inspectorate should be established. A minority of the working group considered that extending the powers and duties of SWS would be the best means of achieving this, and the Secretaries of State were asked to consider this. Most of the groups consulted by the Department about the Barclay Report have indicated that if there is to be such an inspectorate, they would favour basing it on SWS.

The Social Work Service is a professional service of the DHSS. It has three closely related groups of functions:-

i. contributing to the development and implementation of policy within the Department's responsibility;

ii. acting as a principal point of contact between social services authorities and the Department and undertaking inspectorial activities, including regulative functions on behalf of the Secretary of State;

iii. contributing, as a professional service, to other relevant Departmental business.

A more detailed description of the functions of SWS was given in DSWS(79)1, The Social Work Service of DHSS.

The Social Work Service will continue to discharge these principal functions. It is proposed to add to them, however, by increasing the scope and nature of its inspectorial activities in the followi ways:-

1. At present, the Social Work Service benefits from short secondments of staff from personal social services authoritie for work in conjunction with the Health Advisory Service. It is proposed to increase the number and broaden the purpose of short secondments into SWS; and to include staff from other relevant professional disciplines (in local government and industry and the professions) as well as staff from authorities and agencies providing personal social services. The field for secondment should be wide in order to meet the particular objective of the Select Committee of "increasing the professionalism and efficiency of PSSDs" and should extend for example, to officers with particular experience in local authority and financial management. Staff so seconded would work with officers of SWS, mainly on tasks on a regional or national basis. The programmes of work would be drawn up after consultation with the local authority associations or with the local authorities concerned. Reports on work in individual authorities would be made to the authorities' own Social Services Committee; a composite report would be published in the series of Social Work Service Papers. A principal objective of these exercises would be to acquire and distribute information about aspects of the organisation and provision of personal social services that demonstrated the most effective use of professional and other resources.

2. The Government proposes, while this programme is being prepared, to establish a Working Group, with the local authority associations, to study social services departments' own systems of controlling the effectiveness and efficiency of the services provided, with a view to recommending models of good practice. Such a Group should include representation

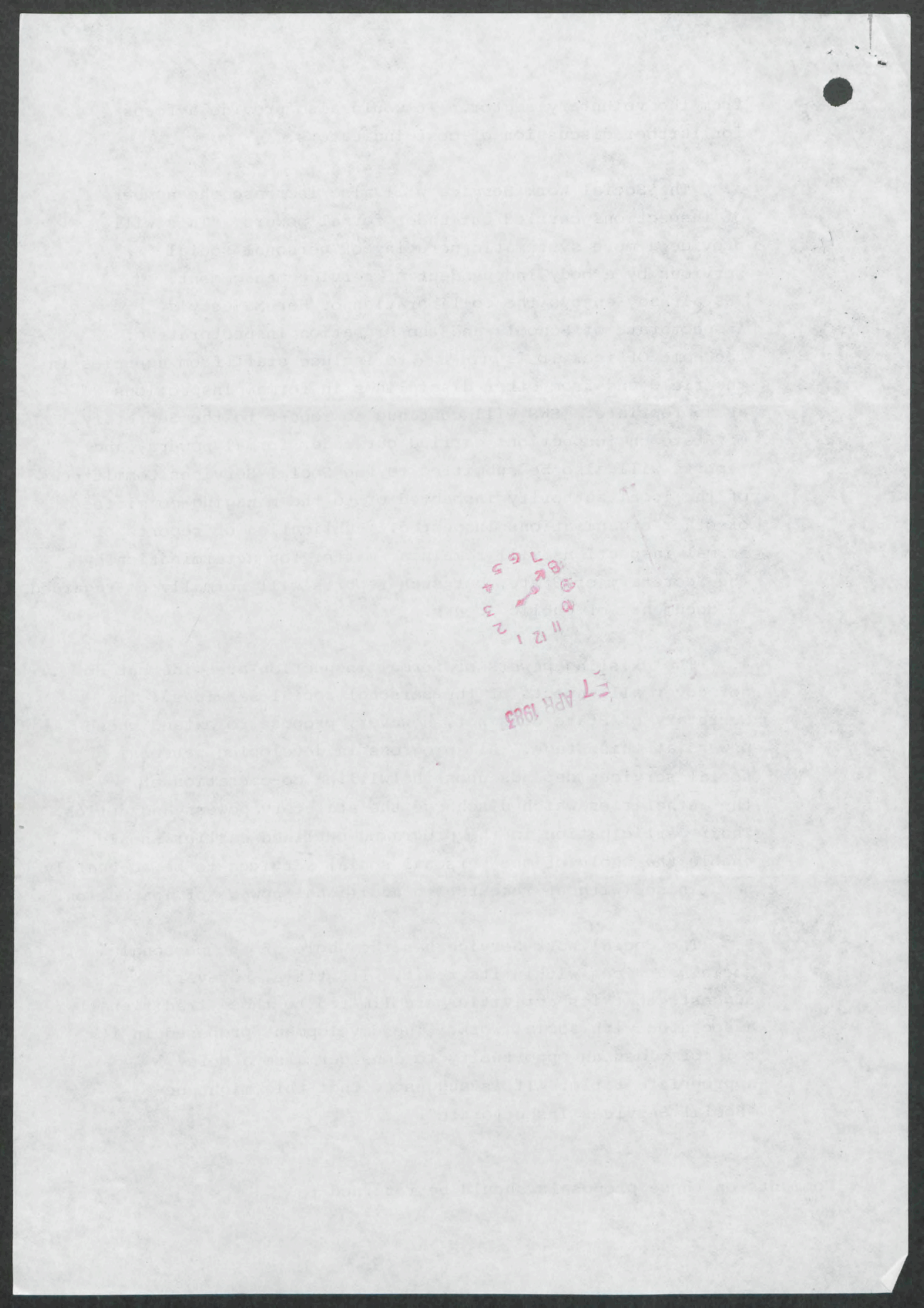
from the voluntary sector. It would also provide a focus for further discussion of cost indicators.

3. The Social Work Service will also increase the number of inspections carried out under formal powers. This will provide a more systematic scrutiny of personal social services by a body independent of service management. SWS already enjoys the collaboration of Her Majesty's Inspectorate of Schools and the Probation Inspectorate of the Home Office. It is proposed to include staff from agencies in the field and from other disciplines in formal inspections as appropriate. SWS will continue to report to the Secretary of State on inspections carried out under formal powers, and reports will also be submitted to the Social Services Committee of the local authority inspected or to the managing committee of other organisations inspected. Publication of reports of formal inspections will remain a matter for determination by the Secretary of State, but such reports will normally be regarded as documents of public access.

4. The existing powers of formal inspection are wide but do not cover all aspects of the personal social services. The Secretary of State does not, however, propose to extend these powers at this stage. All progress in developing personal social services depends upon the willing co-operation of the authorities which discharge the statutory powers and duties. Their participation in the programme outlined earlier should enable the whole of the personal social services to be adequately scrutinised without recourse to additional powers of inspection.

5. The Social Work Service has the whole of the personal social services within its remit. Its title, however, suggests that its activities are limited to those traditionally associated with social work. The development proposed in its role provides an opportunity to consider also a more appropriate title. It is suggested that this might be "Social Services Inspectorate".

Comments on these proposals should be returned to
by



PART 1 ends:-

DHSS to MCS 14.3.83

PART 2 begins:-

S/S DHSS to S/S Env 7.4.83

KODAK Q-60 Color Input Target

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
A																							A
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2007:03

FTP://FTP.KODAK.COM/GASTDS/Q60DATA

Q-60R2 Target for
KODAK
Professional Papers