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PREM 19/1322

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PART 2

Confidential Filing

Consultative paper on the Reorganisation of the National Health Service

NATIONAL HEALTH

Part 1 : June 1979

Part 2 : January 1980

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
21. 1. 80		11. 2. 81					
23. 1. 80		6. 5. 81					
25. 1. 80		27. 7. 81					
1. 2. 80		31. 7. 81					
15. 2. 80		17. 11. 81					
20. 2. 80		30. 9. 82					
28. 3. 80		5. 10. 82					
4. 7. 80		13. 10. 82					
18. 7. 80		4. 9. 82					
22. 7. 80		13. 10. 82					
23. 7. 80		20. 3. 84					
16. 1. 81		24. 9. 84					
20. 1. 81		27. 9. 84					
23. 1. 81							
29. 1. 81							

TO BE RETAINED AS TOP ENCLOSURE

Cabinet / Cabinet Committee Documents

Reference	Date
H(84) 34	24/09/1984
H(84) 8th Meeting	26/03/1984
H(84) 13	19/03/1984
H(81) 24th Meeting	14/07/1981
H(81) 54	10/07/1981
C(81) 94	26/01/1981
H(81) 2nd Meeting, item 2	20/01/1981
H(81) 6	16/01/1981
H(80) 4th Meeting, item 2	11/02/1980
H(80) 2nd Meeting	22/01/1980
H(80) 3	15/01/1980

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 30/9/2013

PREM Records Team

PA

MR BARCLAY 27/9

27 September 1984

CROMBIE CODE

The Crombie Code provides a financial bonanza for employees displaced in local government or similar statutory reorganisations. The Code itself is not law but has been embodied in regulations; moreover Ministers are obliged under present law to provide some regulations on compensation.

H has already taken the decision to withdraw Crombie terms. So far this has been done by embodying individual repeal within main Acts (such as for the abolition of the GLC). The proposal is now to repeal the general requirement for Ministers to provide compensatory regulations. Without this Crombie terms will have to continue in a few trivial cases that would not warrant individual legislation. The cost of continuation is under £100,000 but comparability will be a problem.

As a side issue the DoE wishes to plug a legal loophole whereby local authorities exceed the compensation benefits laid down by statute; in particular some Metropolitan County Councils have given very generous contractual redundancy terms to their staff in advance of their abolition. It is too late to stop this and future deviations will now hopefully be small.

There is no convenient Bill to which these proposals could be attached and, although worthy, we do not believe they merit their own Bill. No action should therefore be initiated.

Peter Warry

PETER WARRY

MR REDWOOD

Crombie Code

I mentioned to you that a paper had been circulated to H Committee on the Crombie Code of compensation. The reference number is H(84)34.

We agreed that this was a matter on which Mr. Owen might well be eager to offer a view. I should be grateful for his advice by the weekend.

24 September 1984

Weekend Box

SUBJECT FILED ON:
HOUSING: Private Rented Sector
Res Sy

PRIME MINISTER

H Committee

H Committee will be considering three papers at their meeting next week.

Private Rented Sector

The first is Mr. Jenkin's paper, which you have already seen, on the private rented sector. He is seeking approval to the de-regulation of rent for all new lettings. The Cabinet agreed that legislation on this subject might be introduced in 1985/86, if policy approval is obtained.

Crombie Code

The Government is committed to ending use of the Crombie Code of compensation for employees in the public sector. Legislation is required to make this change effective, but there is a dispute between the Department of the Environment and the Treasury over who should promote it.

Commercial Activities in Further Education Establishments

The Education Secretary has circulated proposals for extending the powers of local authority-maintained further education establishments to act commercially. They are at present inhibited from undertaking work for industry and from fully ~~employing~~ exploiting their research ideas. The change proposed by Sir Keith Joseph is attractive, but there may be criticism from those who fear an extension of entrepreneurial competition from the public sector.

I will report the Committee's conclusions to you next week.

DB

20 March 1984

Prime Minister (2) National Health

MCS 15/10

13 October 1982

Policy Unit

PRIME MINISTER

Graham Turner's article shows very graphically what the lack of real authority in the NHS means to the people who work in it.

We shall never manage NHS hospitals properly until we establish clear, simple chains of command which can be understood by every single person in the hospital.

FERDINAND MOUNT

I have also heard a good deal of anecdotal evidence on the same lines as Graham Turner.

MCS.

Who runs the hospitals?

DAILY TELEGRAPH 13 OCT. 1982

GRAHAM TURNER relates in four articles his efforts to discover where responsibility and power lie in the NHS

WHO runs our NHS hospitals? "What worries me," said Tom Richardson, secretary of the Oxfordshire Community Health Council, "is that nobody does. You might think the administrator was the gaffer, but in fact he's got no control at all over the medical side, no control over nursing, no control over catering—that's all *supposed* to be done at district level.

"If his hospital is in Banbury and he sees the kitchen staff doing something he doesn't like, it might take him a week even to get an appointment with the district catering manager here in Oxford.

"Often, all an administrator has at the moment are the admin. staff, the porters and the cleaners — and, in some hospitals, even the cleaning is done by outside contractors. If you talk to a lot of administrators, they don't know what their hospital costs to run, control as little as 10 or 15 per cent. of the staff and can only affect the organisation of the place in small ways.

"So this poor devil who's supposed to be running a hospital has been cut off at the knees. In any managerial sense, it's an underpaid non-job. Manager, in fact, is a misnomer — and it's only if you're really pushed that you'd call them administrators. They've got an awful lot of responsibility and damn-all power."

These sentiments would come as no surprise if Mr Richardson were one of the hammers of the Health Service. But he is not. He is the popular and much-respected chairman of the Oxford Labour party, and an ardent supporter of the NHS principle. Like many of the rest of us, he believes that the Health Service often provides the most dedicated care and skill.

Nor, in his view, is it only our hospitals which are un-managed. There is, he declares, no real management *anywhere* in the NHS.

★

THE district administrator, the next tier up in the hierarchy, also had very little power over how money was spent, said Richardson, partly because each consultant worked as an independent unit, "with whatever care he takes over money, damn all or superb, usually damn all." In any case, the district administrator's job wasn't to manage but to "concense" with just about everybody in sight. He didn't even chair the district management team regularly. That job rotated, on an alphabetical basis, if you please.

Then, if you took the next tier up, the region, they were supposed to monitor the public money they allocated to the district each year, but they didn't do any such thing — "in fact, if you asked me, I'd have a job to tell you what they *do* do, apart from shuffle paper around. Every time I go up there, I think 'what a lovely, staid pace of life!'" (And *this* is the body which has suggested they may not be able to afford to feed long-term patients in future.)

After all his years of involvement with the NHS, he still hadn't been able to discover where power and ultimate responsibility did lie. "The truth is," said Richardson, who was once a BL manager, "I don't think anybody controls the spending of money in the Health Service. They add up what's been spent and, if it comes to what's been allocated to them, it's all right. If not, they go back cap-in-hand for more."

The NHS had a long history of inefficiency. He thought the Health Service workers should get more, but the whole thing had to be managed and publicly accountable. "They've got to be efficient."

Nor is the view from the grass-roots very much different. I talked next to a porter in a Midlands hospital. As a Labour party activist, he said, he had spent a good many evenings making sure that the right people (i.e. Labour trusties) got on to the health authority.

So far as he could see, who ran the hospitals? "In point of fact," the porter replied, "nobody does. I'm certainly not able to assess who the supremo is. It's not the administrator, for sure. There's so many tea-drinking, biscuit-munching wafflers passing things from committee to committee that, from where I sit, you can't tell who it is."

His own administration was "everyday simple simons," tended to look on the head porter and the union as the boss. At least, *they* came along and said things in an authoritative way. As for the so-called administrators, they weren't "bosses unto themselves. It's a puppet-style thing. The only thing is that, in the Health Service, the puppets are controlled by other puppets."

His own house governor was such a gentleman that you could "disrespect" him. If some of the porters happened to be taking a rest on one of the settees in the hospital foyer when he came in, they certainly wouldn't get up — "he just hasn't got the command." Which made it all the more interesting when, later on, the very same gentleman assured me that his porters did regard him as "a person of authority."

How, then, does the situation look from the hospital administrators' point of view? They make the best of it, of course, and some claim to have all the authority they need, but their anecdotes often reveal massive frustrations.

"This," one administrator in the south of England assured me, "is an extremely well-run district, but the way the thing is organised defies belief. Take works. Suppose I want the smallest job done. I'm not even allowed to talk to the building officer I've got on site.

"When I do get through to him, there's always a big argument about where the money's coming from. Even after that, it's up to them *when* they do it. It's taken me as much as three days to get a light bulb changed! For the last six months, I've been pushing him for painting proposals for my hospital this year — not a programme, just proposals!

"It's not that he hasn't tried, but he's got to ask everybody for their opinion and, like me, he's got no authority to demand anything. Meetings go on month after month and get nowhere. It's ridiculous."

Then take catering. He'd been trying for a long time to improve the patients' food, but it was darned difficult when it was provided by a man, the district catering officer, whom he saw twice a year (if he was lucky). He, as the administrator, might want to spend £30,000 on dishwashers, but the catering manager might decide that a servery unit was more essential.

Yes, it was perfectly true that the Department of Health had recommended that more power should be pushed down to unit level but, incredibly, they'd left the decision up to districts and his district had decided to hang on to the power they'd got.

Another administrator, who reckoned that he had a good deal more clout than colleagues in other parts of the country, admitted that he didn't know what his hospital cost — "I suspect it's just under £8 million" — and couldn't say what proportion of the staff he was responsible for "because I don't know how many nurses we've got."

His district authority were talking about giving individual hospitals more power over catering and works but, so far as he could see, "it won't be the great change it's cracked up to be."

★

ONE of his colleagues in another hospital admitted that he found it hard to follow the complexities of the NHS organisation. He spent so much of his day in meetings that there wasn't always time for a proper follow-up of the meetings they'd had already. Nor did he think anybody ever even asked the question of what any given hospital *should* cost. Things were always decided on the basis of what they *had* cost in the past.

"What's right about the Health Service is the spirit of the people in it, despite all the terrible things that happen," said Mrs Jean Robinson, who has been on both the Oxfordshire Community Health Council and Regional Hospital Board and describes herself as "mid-Labour," "but the way it's organised does strike me as terribly amorphous. Whenever you try to put your finger on anything, nobody damn well knows!"

Tomorrow: consultants' and nurses' attitudes to expenditure.

Mr Scholar NATIONAL HEALTH.

I entirely agree.
Can we have working party report, please!
After we have seen NF's reply to Ralph Howell, let us sort out the questions.

fm 1/10

MR. MOUNT

Reform in the National Health Service

The Prime Minister commented on your note about reform in the National Health Service:

> "Some of these questions are rather muddled. I think we should sort them out before having a session with Norman Fowler."

For myself, I think that the first two questions are for Treasury Ministers and not for DHSS Ministers; and that, on the third question, we can easily secure a copy of the inter-departmental working party's report: all I need to do is to telephone Norman Fowler's Private Office. Would you like me to do this? On the fourth question, the Prime Minister has already had lengthy discussions with Norman Fowler about NHS manpower. These have led the DHSS to agree to a proposal for an independent inquiry into NHS manpower. The Secretary of State will within a few days be letting us have a draft reply to the representations made by Mr. Ralph Howell MP on this subject. In this we will see the exact form of the DHSS proposal.

MCS

30 September 1982

Prime Minister (1)

27 September 1982
Policy Unit

Do you wish us to arrange a meeting with Mr Fowler, after the NHS dispute is over? We would need a Treasury Minister, too. MLS 27/9

PRIME MINISTER

REFORMING THE NATIONAL HEALTH SERVICE

During the course of the NHS dispute, we have begun to alert public opinion to the huge and unmonitored costs of running the service. The NHS is said to be the largest employer in Western Europe. It is one of the least accountable for the day-to-day management of its staff and its cash. This is surely the moment to insist on urgent and practical reforms which permit what Keith Joseph calls the "interpenetration" of public and private effort.

Public opinion is ripe for sensible changes so long as they do not close off universal access to the highest quality of medical treatment; that is the humanitarian principle which has to be preserved - and not abolition of prescription charges and similar false shibboleths. People are ready for compromise and partnership.

The DHSS's own comparative study of contracting-out hospital domestic services has just reported that savings of up to 20% are possible.

Norman Fowler (letter to the Home Secretary of 25 July 1982) after rejecting wholesale adoption of social insurance or private insurance, has initiated departmental studies on extending charges, privatisation and fiscal concessions to private health insurance, and on curbing demand for unnecessary health treatment.

We believe that these studies must be pressed ahead and carried into action. But they are only part of a thoroughgoing overhaul of the NHS.

We asked George Bunton and his colleagues in the CPS Health Study Group to prepare a list of questions which they would like to ask the Minister and the Department. The attached twenty questions are based on theirs, although we have added a few of our own. If you don't ask these kinds of questions, who will?

We suggest:

1. an early meeting with Mr Fowler and Mr Clarke to discuss these questions; and
2. that the DHSS should give detailed answers, so far as possible, to these questions.

Some of these questions are rather muddled. I should sort them out before having a session with Norman Fowler etc.

FM

FERDINAND MOUNT

TWENTY HEALTH QUESTIONS

Health Insurance

1. Do we have any plans prepared for extending tax relief on private health insurance? (Treasury to answer MLS)

2. Do we have any estimates of likely take-up and cost for extending tax relief on premiums to (a) everyone; (b) individuals earning below £8,500 a year (which would minimise dead weight); (c) retirement pensioners? (Treasury to answer MLS)

3. To reach sensible conclusions, can we see the report of the inter-departmental working party on alternative financing of the NHS? This was first pressed for by the CPS Health Group which was represented on the working party, but even they do not have access to it now.

no need to ask for this - we can get it anytime MLS

Costs and Staffing

4. In the lifetime of this Government, an extra 67,000 staff have been recruited into the NHS, making a total of 1,250,000 employees. Why? Have we now got an effective manpower watch? Are we satisfied that staffing establishments represent a realistic up-to-date estimate of what is needed?

Ralph Howell enquiry is the way forward here

5. MLS Doctors are overspending on the installation and sometimes superfluous duplication of new technology. What steps are being taken to monitor and deter this trend?

6. Have we established adequate cost controls on the purchase of drugs and other hospital goods, and on prescribing? Are we using the NHS's monopoly buying power with sufficient ruthlessness?

7. Are superfluous hospitals being closed fast enough?

Reorganisation and Planning

8. Are the objectives of the "reorganisation of the reorganisation" being achieved? What is the identifiable saving on the total costs of the NHS?

9. Have we really shortened the chain of command? Have we cut out enough of the top tier of bureaucracy? Are we still duplicating too many of the district functions - planning, nursing, engineering etc - at regional level?

10. Has the NHS made adequate provision to replace the treatment and support for patients which may have been lost as a consequence of the reductions in expenditure on universities?

11. What research is being done into comparative costings of hospital administration and treatment as between different types of NHS, private hospitals and abroad? Ought we not to make detailed unit costings and publish them? How much does it cost to take out an appendix in St Thomas's, in the Fitzroy-Nuffield, in Newcastle, in Hamburg, in Bordeaux?

12. Could not the NHS dispel some of the present atmosphere of distrust (eg over the closure of long-stay beds as part of its "community homes" policy) by publishing its long-term plans and explaining them to the public in detail?

Privatisation and Contracting-Out

13. Can we extend the study of contracting-out domestic services to cover all other ancillary services? Where we have agreed on those services for which contracting-out has been found to make savings, should we issue instructions to hospital authorities to put them out to tender?

14. Would it be desirable or possible to go further and contract-out the management of entire hospitals or groups of hospitals, as is already done in the case of some psychiatric hospitals?

15. Could some hospitals be sold outright to the private sector? For example, the new general hospital at Milton Keynes is standing empty because the health authority, having built it, cannot afford to staff it or run it. Or could the staffing and running be contracted-out?

16. Should we try to take an overall long-term view about the growth of (a) pay-beds within the NHS; (b) private hospitals outside the NHS, bearing in mind that in some parts of the country the recent introduction of new NHS pay-beds has made existing private hospitals no longer commercially viable? Should we beware of the danger of private sector over-provision and hence the risk of sudden closure of hospitals giving private medicine a bad name? Should charges for pay-beds to re-set to encourage or discourage their growth?

17. Should we consider full privatisation for the General Ophthalmic and General Dental services? Or should we just allow the existing de facto trend to privatisation continue by not upgrading the fees for NHS work?

Charges

18. Should we reconsider the introduction of charges for hospital in-patients and, even more so, for out-patients and visits to GPs? Has the DHSS any estimates (a) of how much money might be raised by different levels of charges; and (b) of how many frivolous or vexatious visits to hospital out-patient/casualty departments and to GPs are made?

19. Should pensioners be exempt from prescription charges when they have to pay dental and optical charges unless they are on supplementary benefit? If pensioners were treated the same way for prescription charges as they are for dental and optical charges, what additional revenue would be raised by the NHS each year?

20. From October, foreign patients are to be charged for NHS treatment. Clearly, therefore, it would not be impossible, as used to be alleged, to administer a universal charging system. How do the costs of administration compare with the revenue likely to be raised at various levels, taking account of agreed exemptions from charges?

SECRET

SUBJECT c.c. JV

cattanach

Subject filed on National Health: NHS Pay Dispute 82.

1

10 DOWNING STREET

From the Private Secretary

9 September 1982

Dear David,

Health Service pay dispute

The Prime Minister had a discussion yesterday evening with your Secretary of State about the latest position in the National Health Service pay dispute. Sir Kenneth Stowe was also present.

Your Secretary of State said that his aim was to try to bring the dispute to an end without offering any further money this year, and without prejudicing the Government's objectives as regards the next pay round. To that end he had been exploring a re-arrangement of the money currently on offer. He gave an account of the present position in the dispute on the lines of paragraphs 2-3 of the paper attached to your letter to me of 8 September.

The Prime Minister said that she was concerned that the Government's case was not getting over with sufficient force. While she was in Scotland she had restricted herself to a small number of key statistics - the rapid growth in manpower in the Scottish Health Service between 1961 and 1981, and the reduction in the number of beds over the same period, the growth in the nurses' wages bill since 1979 from £1½ billion to £2.6 billion, and the cost of health treatment of over £1,100 a year for every family of four in the country. Your Secretary of State indicated the extent of the press and broadcasting coverage which he and Mr. Clark had given to the Government's case. The unions were interested in concluding long-term arrangements for determining nurses' pay, but they were in no hurry to do so, and it was now inconceivable that the new arrangements would be in place before April 1984. This fitted in well with the interests of the Chancellor of the Exchequer in regard to the Megaw Report. The aim was to achieve a settlement by building a bridge between the present situation and the long-term arrangements, and this implied a two-year settlement. It was this approach which underlay the proposals he was putting forward in paragraph 7 of his paper.

The Prime Minister said she was concerned that this approach might provide a higher base line for future increases. It would be essential, too, to avoid a settlement which would give the

/ wrong

SECRET

wrong signal for the next pay round. What was the prospect for bringing about manpower reductions in the National Health Service? Mr. Fowler said that until now there had been no proper monitoring of manpower numbers, still less control. He was introducing manpower targets for each region. The Prime Minister said that the very large increase in NHS manpower merited an independent inquiry of some kind, as had been proposed to her by Mr. Ralph Howell, M.P. Your Secretary of State said that he would welcome such an inquiry. What was needed was a Derek Rayner figure with a small team of, say, four people, who could carry out a continuing inquiry into the NHS's use of manpower. This team should be enabled to call upon management consultants, and to make comparisons between regions and with other countries. There was a feeling about that NHS manpower was out of control, and that the Government should take a grip of the situation. The Prime Minister said that she agreed with this approach, and looked forward to seeing Mr. Fowler's proposals in detail.

There followed some discussion in detail of the options set out in the annex to your Secretary of State's paper. The Prime Minister said that she was clear that no more money could be made available this year. She would wish to consider further with colleagues whether one of those options should be pursued.

I am sending a copy of this letter to John Kerr (H.M. Treasury). I should be grateful if you and he would give it a limited circulation.

Yours sincerely,

Michael Stanier

David Clark, Esq.,
Department of Health and Social Security.

CONFIDENTIAL

National Health CH 2/8

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From The Secretary of State for Wales

The Rt Hon Nicholas Edwards MP

30th July 1982

Dear Norman

DEVELOPMENT OF THE PRIVATE HEALTH SECTOR

Thank you for copying to me your minute of 26 July to the Prime Minister. I strongly support the establishment of this study but would ask that I and my department should be kept in the closest possible touch with it. Considerations affecting the private sector differ sharply between London and the South East and other parts of the Country, I think that any study must take full account of this and that this point should be covered in its terms of reference.

I am copying this letter to the recipients of your minute.

Yours ever

Nick

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

CONFIDENTIAL

SECRETARY OF STATE FOR SCOTLAND

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

(2)

Prime Minister

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

MLS 30/7

29 July 1982

DEVELOPMENT OF THE PRIVATE HEALTH SECTOR

You sent to me a copy of your minute to the Prime Minister of 26 July about a proposal that Arnold Elton should chair a small working party, and I have now seen her response.

I am not clear how this fits in with the conclusions of the Health Ministers collectively about the follow-up to the report on alternative finance for the National Health Service. These conclusions were set out in your letter of 25 July to Willie Whitelaw. In that letter we suggested that there should be further studies of a specified kind.

Is the study proposed in your minute to the Prime Minsiter one of these? Your minute does not in fact specify exactly the area he would cover. Nor am I clear whether this is a Party Committee or one serviced by Civil Servants.

I think there should be further consideration with Health Ministers before Arthur Elton's commission is further defined; and I am bound to say that I would strongly have preferred consultation to have taken place before you sent your minute to the Prime Minister.

I am coying this letter to the Prime Minister, the Secretaries of State for Wales and Northern Ireland and the Paymaster General.

GEORGE YOUNGER

SECRET

Prime Minister (2)

MES 28/7

DEPARTMENT OF EDUCATION AND SCIENCE

ELIZABETH HOUSE, YORK ROAD, LONDON SE1 7PH

TELEPHONE 01-928 9222

FROM THE SECRETARY OF STATE

28 July 1982

The Rt Hon William Whitelaw CH MC MP
Secretary of State for the Home Department
Home Office
50 Queen Anne's Gate
London SW1H 9AT

Dear Willie.

Norman Fowler sent me a copy of his letter dated 25 July to you on health care financing.

I am writing to say that I very much hope that we shall keep the door open as Norman suggests for future developments of the sort he describes and indeed that we shall allow ourselves freedom for such further moves as can be practicable.

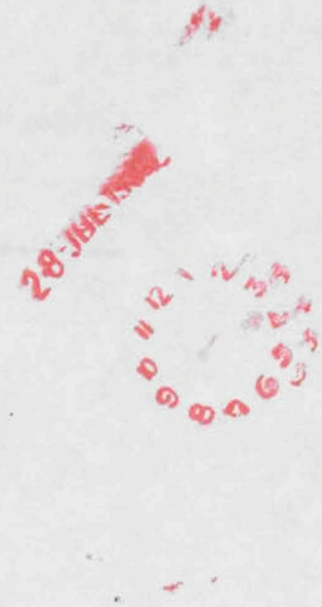
I am, for instance, disappointed that no prospect is evidently seen of contractual cooperation between the NHS and the private sector to provide treatment for which there are long NHS waiting lists. Such an initiative could be both beneficial and popular.

For the longer term I am glad to see from Norman's paragraph 5 that we should explore financing through private insurance and very much hope that, as Norman suggests, we should keep our options open. It would seem, moreover, right to study this possibility vigorously.

I am copying this letter to all who received Norman's.

Yours Keith

SECRET



DSG
bc JV

10 DOWNING STREET

From the Private Secretary

28 July 1982

Dear David,

DEVELOPMENT OF THE PRIVATE HEALTH SECTOR

Your Secretary of State minuted the Prime Minister on 26 July, proposing that he should ask the Chairman of the Conservative Medical Society to chair a small working party on the development of the private health system.

The Prime Minister agrees to this proposal.

I am sending copies of this letter to Adam Peat (Welsh Office), Muir Russell (Scottish Office), Stephen Boys-Smith (Northern Ireland Office), Keith Long (Paymaster General's Office) and to David Wright (Cabinet Office).

Yours sincerely,

Michael Scholar

David Clark, Esq.,
Department of Health and Social Security.

Prime Minister (1)

Agree to this proposal?

Yes MCS 27/7

PRIME MINISTER

DEVELOPMENT OF THE PRIVATE HEALTH SECTOR

I have been approached by Arnold Elton, the Chairman of the Conservative Medical Society, who is very anxious to carry out some work on the development of the private health system. In particular, he would like to explore ways in which there can be better co-operation between the private sector and the National Health Service. One example of this would be that a Regional Health Chairman might decide to contract for a certain number of beds in a private hospital rather than investing in a new public hospital.

I think that this is all very useful work for us to do and I would propose to ask Arnold Elton to chair a small working party on this. It would simply be a working group reporting direct to me and I would discuss with him the names of a few people who could help. Arnold Elton is extremely anxious to do this work and is important to us as the Chairman of the Conservative Medical Society. I also think it would be of great value for the development of policy that such a study should take place.

I am copying this to Secretaries of State for Wales, Scotland and Northern Ireland and the Paymaster General.

26 July 1982

N F

PF

CJV

Prime Minister (1) /

This is, to say the least, not radical.

Do you wish the announcement at X to be made?

MRS 27/7

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 William Whitelaw CH MC MP
Secretary of State for the Home Department
Home Office
50 Queen Anne's Gate
LONDON
SW1

25th July 1982

Dear Willie..

CF
(1) Note
Told David Clark
(2) PA

HEALTH CARE FINANCING

Last Summer the Home Affairs Committee agreed a proposal by Patrick Jenkin to announce the setting up of a working group to make a preliminary study of alternatives to the present method of funding health care mainly from taxation. (His letter of 22 July 1981 refers).

2. This study - by health department and other officials, with two private sector consultants- was received earlier this year. In brief it surveyed two broad alternative ways of financing health care, drawing on experience abroad:

- social insurance, ie funding from a state-managed insurance fund, as in some continental European countries; or

- private insurance, ie funding as for much health care in the United States through the private sector subject to some Government regulation.

The study has also identified a number of possibilities for increasing the role of private supply and finance within the present tax-based funding arrangements.

3. The study was intended to identify possibilities for fuller examination rather than to provide a basis for final decisions. I have discussed it with Nick Edwards, Leon Brittan, John MacKay (representing George Younger), and John Patten (representing Jim Prior). The issues for discussion now are what further studies we set in train, and what public statement we make at this stage.

E.R.

4. We are all agreed that the social insurance possibilities are not worth pursuing further. Expenditure from a social insurance fund would probably have to be classified as public expenditure and the contributions to it as taxation. It would be administratively complex and expensive.

5. We are also agreed that financing through private insurance might be a longer term aim to explore, but we are equally agreed that this is not the time to move in that direction - but our options should remain open.

6. We all have serious anxieties about the future financing of the NHS, which is facing severe pressure from an ageing population and the need to keep abreast of medical advances. We therefore see a need to study carefully various of the possibilities identified in the report which might increase private financing and supply within the present framework and in particular to investigate more fully the scope for:

(i) raising more income from charges;

(ii) privatising some parts of the NHS, particularly the General Opthalmic and General Dental Services;

(iii) reducing demand for treatment by charging patients the full cost of services received and reimbursing them subsequently;

(iv) giving further encouragement to the private health sector through fiscal concessions.

Studies of this kind might yield useful changes within the present system and should help to pave the way for more privatisation in the longer term if in due course we decide to go in that direction. We see most of any new measures that might result from the studies as being for implementation in the next Parliament - for the present one we are, for example, constrained by an electoral pledge not to introduce new charges.

7. It would be unnecessary and undesirable to announce the details of these studies. We have in mind a low-key written Parliamentary answer drawing attention to our creditable record on NHS growth, affirming our commitment to maintaining an efficient largely tax-financed NHS and saying that we would continue to review the scope for introducing more cost-consciousness, consumer choice and private provision.

8. I am copying this letter to all Members of H Committee, the Prime Minister, Sir Robert Armstrong and Head of the CPRS. I would be grateful for agreement to my proposals by 28 July if possible since I would like to make the statement before the House rises for the Summer.

Yours ever,

NORMAN FOWLER

Nat Health

MLS

MNM

MCS to see.

Treasury Chambers, Parliament Street, SW1P 3AG

Rt Hon Norman Fowler MP
Secretary of State
Alexander Fleming House
Elephant & Castle
London SE1 8BY

17 November 1981

Dear Norman,

FAMILY PRACTITIONER COMMITTEE:

I have seen your Private Secretary's letter of 13 November about your announcement by means of an Inspired PQ on 16 November of a proposed change in the status of Family Practitioner Committees.

I think it is a pity that the timing of this letter made it very difficult indeed for recipients to give the matter proper consideration. There is some risk that the proposed change may make it more difficult in practice to bring the Family Practitioner Service within cash limits, should we wish to do so. I shall be writing to you about this shortly. But I note and endorse the understanding reached between our officials that your announcement of the proposed change in the status of FPCs will not be regarded as a reason for opposing the cash-limiting of the FPS, whatever else might be the considerations for and against such a move.

I am sending copies of this letter to the Prime Minister, the Chief Whip, the Secretaries of State for Scotland, Wales and Northern Ireland and Sir Robert Armstrong.

Yours ever,

Leon

DHSS

With the Compliments of
the Secretary of State for Social Services

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Alexander Fleming House
Elephant and Castle
London, SE1 6BY

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
ALEXANDER FLEMING HOUSE
ELEPHANT AND CASTLE
LONDON S.E.1

TELEPHONE: 01-407 5522

David Heyhoe Esq
Private Secretary to the
Lord President of the Council
Civil Service Department
Old Admiralty Building
Whitehall
LONDON SW1A 2AZ

13 November 1981

Dear David,

FAMILY PRACTITIONER COMMITTEES

We propose to announce a decision on the future status of Family Practitioner Committees on Monday by means of an Inspired PQ (copy attached).

This will mean a small change in primary legislation at a date to suit us but as you will see from the reply nothing is promised for this session, and the profession are happy to accept interim arrangements if necessary for several years.

We are under considerable pressure to make an early announcement following the consultative paper, particularly from the profession. Subject to any comments you have on the answer proposed it will be made on Monday and announced in a Press Release the same afternoon.

I am copying this to Private Secretaries to the Prime Minister, the Chief Whip, the Chief Secretary, the Secretaries of State for Scotland, Wales and Northern Ireland and to Sir Robert Armstrong.

Yours ever

D BRERETON
Private Secretary

FAMILY PRACTITIONER COMMITTEES

We have studied carefully the responses to the Consultative Paper issued in March, and have concluded that establishing Family Practitioner Committees as Health Authorities in their own right, with powers to engage their own staff, is likely both to facilitate the development of primary care services and lead to increased efficiency in the administration of the Family Practitioner Services. We shall when time permits seek the legislation necessary to introduce these new arrangements but this cannot be fitted into the Government's programme for the present session. For the time being the present statutory relationship between health authorities and family practitioner committees will, therefore, continue. My decision will in no way affect the Government's intention to reduce the proportio of total NHS resources spent on management by 10 per cent by the end of the financial year 1984/5.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
ALEXANDER FLEMING HOUSE
ELEPHANT AND CASTLE
LONDON S.E.1

TELEPHONE: 01-407 5522

Prime Minister
This Answer is being given today MAP 16/XI

David Heyhoe Esq
Private Secretary to the
Lord President of the Council
Civil Service Department
Old Admiralty Building
Whitehall
LONDON SW1A 2AZ

13 November 1981

Dear David,

FAMILY PRACTITIONER COMMITTEES

We propose to announce a decision on the future status of Family Practitioner Committees on Monday by means of an Inspired PQ (copy attached).

This will mean a small change in primary legislation at a date to suit us but as you will see from the reply nothing is promised for this session, and the profession are happy to accept interim arrangements if necessary for several years.

We are under considerable pressure to make an early announcement following the consultative paper, particularly from the profession. Subject to any comments you have on the answer proposed it will be made on Monday and announced in a Press Release the same afternoon.

I am copying this to Private Secretaries to the Prime Minister, the Chief Whip, the Chief Secretary, the Secretaries of State for Scotland, Wales and Northern Ireland and to Sir Robert Armstrong.

Yours ever
Don

D BRERETON
Private Secretary

FAMILY PRACTITIONER COMMITTEES

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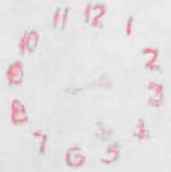

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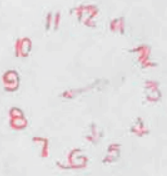

With the Compliments

of the

Private Secretary

Scottish Office,
Dover House,
Whitehall,
London SW1A 2AU.

SECRETARY OF STATE FOR SCOTLAND

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

WR 31/7

John F Halliday Esq
Private Secretary to the
Secretary of State for the
Home Department
Home Office
50 Queen Anne's Gate
LONDON
SW1H 9AT

31 July 1981

Dear John,

In his letter of 22 July to the Home Secretary suggesting a review of the financing of health care, Mr Jenkin indicated that discussion had taken place with the other Health Ministers, including my Secretary of State. For the record I am writing to confirm that Mr Younger is entirely content with what is proposed.

I am copying this letter to the Private Offices of those to whom Mr Jenkin's letter was copied.

Yours ever,

GODFREY ROBSON
Private Secretary

Mr Lankester

CABINET OFFICE

Central Policy Review Staff

70 Whitehall, London SW1A 2AS Telephone 01-233 7765

WM 31/7

From: J. R. Ibbs

Qa 05646

CONFIDENTIAL

31 July 1981

Dear Secretary of State,

I have seen a copy of your letter of 22 July to the Home Secretary proposing an interdepartmental review of the financing of health care.

I welcome this review and I should be glad to offer CPRS assistance with the initial review which you suggest that officials should carry out.

I am sending a copy of this letter to the recipients of yours.

Yours sincerely,

J R Ibbs

The Rt Hon Patrick Jenkin MP
Department of Health and Social Security
Alexander Fleming House
S E 1

CONFIDENTIAL

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

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

The Rt Hon Nicholas Edwards MP

CONFIDENTIAL

27 July 1981

I

28/7

ALTERNATIVE FINANCE FOR THE HEALTH SERVICE

I am broadly content with the objectives and terms of reference of the study proposed in your letter of 22 July to Willie Whitelaw. I also agree the terms of the proposed announcement.

I am copying this to Members of H Committee, the Prime Minister, Sir Keith Joseph and Sir Robert Armstrong.

Nick

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

PV

Nat Healt

CONFIDENTIAL

DEPARTMENT OF INDUSTRY
ASHDOWN HOUSE
123 VICTORIA STREET
LONDON SW1E 6RB
TELEPHONE DIRECT LINE 01-212 3301
SWITCHBOARD 01-212 7676

Secretary of State for Industry

27 July 1981

The Rt Hon William Whitelaw CH MC MP
Secretary of State for the
Home Department
Home Office
50 Queen Anne's Gate
London SW1H 9AT

WR 27/7

Dear Willie,

Patrick Jenkin sent me a copy of his letter to you of 22 July suggesting a review of the financing of health care. I welcome his proposal and write to support it enthusiastically. with PM

I am copying this letter to the recipients of his.

Yours,

Keith.

CONFIDENTIAL

CONFIDENTIAL

cc NIO TMP
CWO/HL
CWO No.12,
Ch.Sec.HMT
Emp.
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10 DOWNING STREET

From the Private Secretary

27 July 1981

The Prime Minister has seen a copy of your Secretary of State's letter of 22 July to the Home Secretary, in which he proposed to set up a group of officials to study alternative methods of financing the NHS.

The Prime Minister is content with your Secretary of State's proposals, and agrees that he should make a low key announcement before the Recess of the setting up of the interdepartmental group.

I am copying this letter to the Private Secretaries to Members of H Committee, to Ian Ellison (Department of Industry) and David Wright (Cabinet Office).

W. F. S. RICKETT

Mrs. Mary McVerry,
Department of Health and Social Security.

CONFIDENTIAL

BK

10 DOWNING STREET

PRIME MINISTER 4

In the attached, Mr. Jenkin proposes to set up a group of officials to study alternative methods of financing the NHS. DHSS, Treasury, Scottish Office, Welsh Office and NIO will be represented on this group, which will draw on the advice of Hugh Elwell and Michael Lee of the Health Services Group of the Centre for Policy Studies. Mr. Elwell and Mr. Lee were closely involved in the report on the NHS produced by the Centre in April.

Content for Mr. Jenkin to proceed in this way, and to make a low-key announcement of the setting up of the interdepartmental group before the Recess?

23 July 1981

YDS

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

The Rt Hon William Whitelaw CH MC MP
Secretary of State for the
Home Department
Home Office
50 Queen Anne's Gate
London SW1

22 July 1981

Dear Willie,

Colleagues will know that for some time my officials have been looking at the strengths and weaknesses of our present system of financing health care compared with other countries. Preliminary work is almost complete and following discussion with the Secretaries of State for Scotland, Wales and N Ireland and with the Chief Secretary to the Treasury, I now propose that our respective officials carry out a review of the financing of health care. Their findings would be presented in a form which might be the basis of a Green Paper by the end of 1982.

NEED FOR REVIEW

Since its inception, the NHS has been financed mainly through general taxation, about ten per cent of costs being met through charges. These services are supplemented by privately-financed health care at present accounting for some three per cent of spending on acute services. There are, however, weaknesses in this system. In particular there is increasing conflict between the need to increase health spending to meet the needs of the very old and to improve standards of health care (including reduction in waiting times), and the need to reduce total public expenditure and taxation. We should also consider whether the system could be made more responsive to costs and give more weight to the wishes of the individual in deciding what level of health care he is prepared to pay for. Our aim should be to keep the best in the present system but to look for new ways of tackling its weaknesses.

OBJECTIVES

More specifically our aims should be:

(a) to sustain a National Health Service providing acceptable standards of care but perhaps with some restrictions in coverage;
(b) to permit improvements in health care as national prosperity

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increases but to reduce the extent to which health services are financed by Government whilst enabling market forces to increase the share of GDP devoted to health care further if the public want and are willing to pay for it;

(c) to secure that the benefits of good health care are distributed equitably between people of different income levels and living in different parts of the UK;

(d) to maintain and build on the strengths of the present system in the field of primary care, care of the elderly and other vulnerable groups and in the relative ease of relationships with other social services;

(e) to explore the potential for increased consumer choice;

(f) to increase the efficiency of health service delivery;

(g) to improve professional morale and performance.

OPTIONS FOR CHANGE

It may be possible to achieve these objectives by changing the balance between the public and private provision of services, or by changes within the public sector, or by some combination of these. Changes within the public sector could include new methods of financing, for instance by greater reliance on health insurance in one form or another, or by substantial increases in the size and range of charges. We should however make it clear from the outset that we will not set out to drive people into the private sector by deliberately depressing standards in the public sector, and that no one should be denied necessary treatment for want of means to pay. The review will also need to take account of regional disparities in the distribution of private health care and of the special position of services for groups less likely to benefit from insurance based systems eg. the elderly, mentally ill and mentally handicapped needing long-term care.

There are a large number of ways in which we could change the present arrangements; their effects may be complex and difficult to assess, and in many cases there is relevant experience in other countries which we should take into account. We must ensure that any major changes will achieve our aims without creating new problems, and that they will command a long-term concensus.

METHOD OF REVIEW

An initial review would be carried out internally by DHSS, Treasury, Scottish, Welsh and Northern Ireland officials, keeping closely in touch with Ministers and drawing on the advice of outside experts, some of whom have already been identified. This would identify and short-list broad strategies for detailed assessment. Ministers would then decide which options should receive more detailed study and at that stage (end 1981) the membership of the group would be reviewed to see whether more outside expertise was needed. The terms of reference are shown at Annex A.

ANNOUNCEMENT

That the subject is under study is widely known. We could now announce, in a low-key way, the setting up of an interdepartmental group. However, we would make it clear that the study would be an internal one exploring options;

there would be no commitment to a Green Paper but we would need to make clear that there would be ample time for discussion of any options we might think worthy of further study. Annex B indicates the kind of thing I have in mind.

I ask colleagues to agree that we proceed in this way. As I should like to make an announcement before the recess I should be grateful for replies by close of play on Monday 27 July.

I am copying this letter to all members of 'H' Committee, the Prime Minister, Sir Keith Joseph and Sir Robert Armstrong.

Yours ever

Patrick.

E.R.

ANNEX A

TERMS OF REFERENCE

1. To identify:

   (a) alternative sources of finance for the NHS, including different forms of social and private insurance, new and higher charges, and any other forms of payments or contributions by individuals or groups;

   (b) alternative ways of promoting more private sector provision of services, including tax concessions (on investment or private insurance), contracting out of state insurance, reimbursement of treatment costs and discontinuing parts of the NHS.

2. To consider how these options might be grouped to form alternative broad strategies (eg. a much higher level of charges might require insurance cover, whilst private insurance financing might require payment by work done).

3. To carry out a quick initial assessment of these strategies having regard to the objectives listed in paragraph 3 of the letter of 22 July to H Committee members from the Secretary of State for Social Services, drawing on relevant information in other countries, and to consider their implications for the overall level of health services and their organisation, delivery, utilisation and control (by Government and by the consumer) as a basis for decision by Ministers late in 1981 as to which strategies should be studied in greater depth.

4. To carry out in the first half of 1982 such further studies as are then commissioned, possibly with enhanced membership, and to present the results in a form which might form the basis of a Green Paper later that year.

E.R.

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ANNEX B

PROPOSED ANNOUNCEMENT

QUESTION: To ask the Secretary of State for Social Services, what progress he is making with his review of alternative means of financing health care.

SUGGESTED REPLY:

My Department is in the process of completing its studies of health care financing in other Western countries, which form the groundwork for consideration of what options there may be to improve health care financing and delivery in this country. In view of the advanced state of this work, I am now able to announce the formation of an interdepartmental working party who will consider, on the basis of its findings, a range of possible proposals to improve the financing and delivery of health care in this country. When this second stage of the review is completed, which I expect to be by the beginning of 1982, I and my colleagues will be in a better position to establish which if any of many possible approaches is likely to be of value here, and to select options for more detailed examination. I shall make a further statement about the progress of the review at that stage.

Officials will be assisted in their work by two specialist consultant advisers with experience of the private health sector in this country. The review will be based on the premise that an adequate standard of health care will continue to be provided for all, regardless of means, and will seek to keep the best in the present system while looking for new ways of tackling its weaknesses. Its key objective will be to identify means of improving health standards and giving greater weight to the wishes of the individual consumer but at the same time recognising the need to contain public expenditure and reduce taxation overall.

The issues involved are complex and of considerable public interest. There will be full consideration and discussion of any proposals which emerge but I believe that the aim of providing better health care for all the people of this country is one with which everyone will agree.

Nat Health

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

6 May 1981

BF. 15/5

WH 8/5

Mike Pattison Esq
Private Secretary
10 Downing Street
LONDON
SW1

Dear Mike

I am sorry not to have responded more promptly to your letter of 6 April about the report of the Health Services Group of the Centre for Policy Studies.

As you may be aware the report follows a series of meetings over the past 18 months - usually attended by the Secretary of State and Dr Vaughan - and the group have received, in confidence, copies of working papers produced by officials here on the options and problems to be overcome. Both Ministers attended a meeting on the report last month - I attach a note produced by our officials which summarises some of the issues yet to be resolved.

The Secretary of State now intends to circulate a paper to colleagues on progress achieved so far and the work which remains to be done, and will propose an official study group led by officials here to take the work forward. The Health Services Group have nominated two of their members to the study group - Mr Hugh Elwell and Mr Michael Lee. I will keep you informed of progress.

Yours ever
D

D Brereton
Private Secretary

ENC.

SM

NOTES ON HEALTH SERVICES STUDY GROUP REPORT AND SUBMISSION - SPRING 1981

Points that might be clarified

Paragraph 2.4 -

appears to be suggesting an item of service basis payment. Is this really regarded as essential and if so why? If the approach is a pluralist one why should this not be left to providers to negotiate with the insurance carriers?

Do they intend payment to be made direct to the doctor/hospital? Is it really the case, as the last sentence of 2.3 suggests, that individual payment is necessary for a proper service?

What does the reference to providers of treatment having "control over their revenues" mean? Deciding what should be paid without control or being free to negotiate with individuals or "communities"? How would "communities" get involved?

Paragraph 3.1.3

The option of compulsory health insurance of some specified kind is favoured, but who would be compelled to make insurance payments to whom? Do they envisage a basic national scheme from which people would be able to opt out if they have equivalent cover? Would contributions be proportionate to income or flat rate? For whom would "credits" be paid - the old, the unemployed, people below a given income level? How would the patient have "responsibility for payment" if the insurance is paying?

More understandably the paper does not come to grips with the UK Government financial convention that compulsory contributions are regarded as taxation and the expenditure met from them is public expenditure. Controlling public expenditure is not merely a matter of limiting the subsidy from general taxation, but would also be a matter of controlling expenditure met from compulsory contributions.

Paragraphs 3.5 and 4.2

These suggest that new arrangements should be allowed to emerge in a free market. There is a case for this if one adopts the opting out and contracting out approaches. But the Group's favoured approach of compulsory social insurance could not just emerge. Though it is not necessary to have fully worked out details, possible models will have to be set out even to encourage a debate.

Paragraph 4.5

The relevance of this quotation to the preferred social insurance model is not clear. The European social insurance systems have in fact financed rising costs from higher rates of compulsory levy.

The notion that the onus of contrary proof must lie with those who want to maintain the present system is all right as a piece of polemic, but does not make much sense as advice to Ministers. The costs of change will certainly be substantial and Ministers will have to present a positive case to show that the benefits are likely to justify the cost.

Appendix 1

The growth in the private sector is common ground. The extrapolation of recent growth rates to 1984 is of course more dubious. In so far as the growth takes place, criticisms of the NHS 'monopoly' become less convincing.

The comparisons of administration costs between the private sector do not compare like with like. On the private sector side they take the insurer's costs in collecting money and paying out benefits and compare these with the health service costs of planning and managing services. A true comparison would need to take into account both types of cost in both sectors. The point is touched on in footnote 2 on page 2, but commenting only on the information missing on the NHS side of the equation and not on the information missing on the private sector side. The marginal cost of raising additional revenue for health purposes through the general tax system or social security contributions is in fact very small.

Appendix 2 -

fits oddly with the rest of the Report, which is arguing for greater spending on health through a social insurance scheme. European social insurance schemes appear to have larger per capita expenditure than the NHS (though we are looking into this in more detail at present). The Appendix purports to show that health cover can be provided for a good deal less.

6 April 1981

The Prime Minister has seen the Centre for Policy Studies' discussion document, produced by its Health Services Group.

She would like to know how your Ministers propose to respond to the issued raised in the paper.

MAP

Don Brereton, Esq.,
Department of Health and Social Security.

FILE

VLB

2 April 1981

Thank you for forwarding to the Prime Minister a copy of your Health Services Group Report. Mrs. Thatcher will see this over the coming weekend.

M A PATTISON

Alfred Sherman, Esq.

4

10 DOWNING STREET

PRIME MINISTER

The Centre for Policy Studies have sent this discussion document to DHSS.

Do you want us to enquire about Mr. Jenkin's proposed response?

M/F

Yes please

2 April 1981

Centre for Policy Studies

8 Wilfred Street · London SW1E 6PL · Telephone 01-828 1176 Cables: Centrepol London

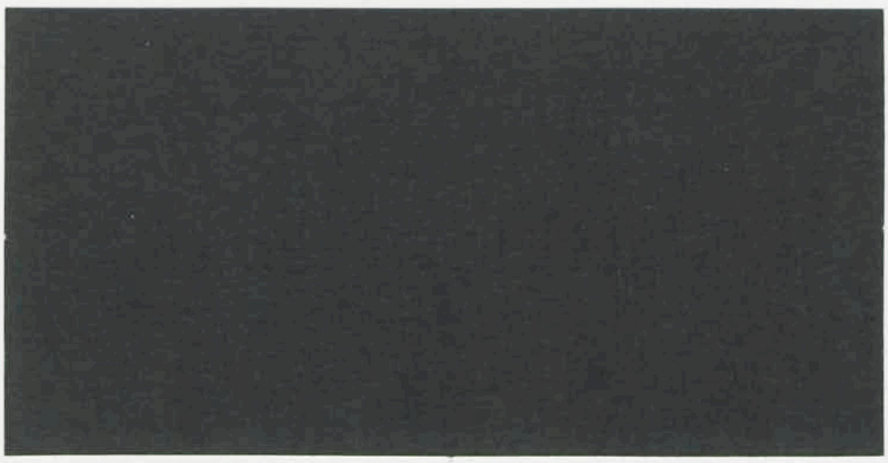
27 March 1981

I enclose a courtesy copy of a document which our Health Services Group produced for discussion by our Health Ministry at Sir Keith Joseph's request.

Yours sincerely

Alfred Sherman

The Rt Hon Margaret Thatcher MP
Prime Minister
10 Downing Street



Centre for Policy Studies

8 Wilfred Street, London SW1E 6PL. Telephone : 01-828 1176

Confidential

HEALTH SERVICES STUDY GROUP:

REPORT AND SUBMISSION, SPRING 1981

Published by the CPS and Health Services Study Group

HEALTH SERVICES STUDY GROUP

George Bunton M Chir FRCS (Chairman)

Roger Eddison

Hugh Elwell

Michael Lee BSc Econ

Andrew Moncreiff MA

Dr John Noble MB BS FRCGP

Dr Francis Piggott FSA RCS

Arthur Seldon

George Teeling-Smith BA FPS(Hon) M Pharm

Nigel Morgan (Secretary)

In attendance

Christopher Mockler

Alfred Sherman

1.1 In the introduction to our first report in 1979 we said that no document about the NHS, written at the present time, could be composed without a sense of sadness at having witnessed over a 30 year span, the inevitable decline of a service born into a post-war era of hope and expectation. Since then it has become clear that there is some growing willingness to consider reform but there are still some entrenched attitudes and ways of thinking which we had expected might prove difficult to alter - not least in the DHSS.

The NHS, having been cast into its mould in 1948, has solidified into a pattern which successive governments and hence the public, have found impossible to change, except by minor alterations in organisation, which have done little to modify its basic financing and structure.

It is not therefore unwillingness, but sheer inability to give serious thought to the implications of fundamental change in the financing and therefore the organisation and administration of health services. Reform is not only long overdue but would clearly be of benefit to both the people and the state. As Christian Morganstern put it:

> And thus, in his considered view,
> What did not suit - could not be true.

The ideal enshrined in the NHS is that we, as a community, ensure that the sick are adequately treated irrespective of their means. This ideal remains but we contend that the NHS has failed to fulfil it, and those who still champion the Service and who would oppose any thought of change must be prepared to prove to us:

1 That the NHS has in fact done what it was set up to do in the interests of the poor, the needy, the under-priveleged, the stupid and the feckless - all those in real need of care.

2 That is <u>really is</u> egalitarian, when there is evidence of gross discrepancy in available standards of care. [1]

3 That central financing <u>is not</u> more wasteful and expensive than peripheral financing. [2]

4 That political motivation and expediency <u>are not</u> involved in policy decisions at both central and local government level, nor involved in the distribution of resources.

5 That the terms and conditions of service for doctors, nurses and other staff <u>are not</u> divisive, morale-sapping and the cause of industrial conflict, frustration and the practice of bad medicine.

---

1 see Working Group on Inequalities in Health ("The Black Report") DHSS April 1980

2 In official comparisons of costs between the NHS, on the one hand, and private or institutional provision on the other, the real costs of NHS financing - that is cost to Government, taxpayer and the economy of raising the revenue - is ignored. Whereas the cost to private and institutional health schemes of raising revenue is always fully measured.

2.1 As a service free at the time of use, the NHS is centrally financed. The administration is therefore inward looking and does not respond effectively to the patient's needs or demands at personal level, in total spending or in allocation of resources. The challenge is to explore ways in which treatment of the sick may be improved and made more responsive to individual need. The objective must be to ensure that the sick are treated compassionately and promptly by a service which is shaped more closely around their needs whether rich or poor.

We are particularly concerned about this last point. It was in the name of the poor that the NHS was conceived and yet it is the poor who are now suffering most from its defects and inadequacies.

2.2 There is no reason to confine medical care to the resources that the State can finance from taxation. Whatever can be done to use resources more efficiently there is no need to shut off other sources of money or to finance health services only by taxing when they could be paid for in other ways.

2.3 A variety of methods such as direct payment, insurance or other collective financing arrangements, are flexible and could raise more money than a centralised state system because they are tailored to the needs, circumstances and preferences of the individual. No impersonal service can satisfactorily replace the direct link between individual payment and service.

2.4 We propose a system in which each item is costed and paid for, and under which the providers of treatment, either individual or institutional, have control over their revenues. They would then be responsible in a direct manner to the individuals or communities which they serve, who would in turn know the cost and be prepared to pay for the services they want.

2.5 It is essential that resources are so organised and managed that they are used efficiently and directed effectively. However much more money and improved resources are provided, there will never be enough to satisfy every demand for treatment that may arise.

2.6 We are of the opinion that the present National Health Service should be eventually replaced by a comprehensive range of health services, both public and private, which will give choice to the patient and adequate financial resources to meet his expectation of good medical care and at the same time enhance professional status and responsibility.

3.1 There appear to be three courses open to us.

1 The maintenance of a system of opting out which presumes the persistence of the present structure of the NHS and private medical treatment. The private sector is currently growing at a substantial rate. If maintained it will mean that a significant proportion of the population will have made financial provision of their own for treatment by the mid 1980's (approximately 12 million). They have made provision to opt out of the NHS as medical episodes arise, but still maintain the right to be treated as NHS patients at will. The major drawback to this course is that apart from a competitive challenge, it does little or nothing to reform the NHS.

2 This may be described as contracting out, under which various sectors of the community, eg employment groups etc - can contract out of the NHS in return for tax relief, to provide a comprehensive private insurance system such as exists in a number of other countries.

3 The third course is to replace the centrally financed monopolist NHS by a system of financing from the periphery. This would allow a variety of providers, both public and private to compete in meeting the needs of the patient. They would be paid by a variety of insurance agencies - again both public and private.

Health insurance of some specified kind would be compulsory, inadequacy of income being met by a system of credits of varying sorts. This fundamentally changes the nature of financing health services so that at the point of use the patient, advised by the doctor, has choice and the responsibility for payment for the type of medical care provided. Treatment should be available within institutions now provided by the NHS or within the growing sector of independent hospitals. The minimum level of cover must

be fixed to ensure that people can obtain no less than they do at present; health services must be costed and described, and this assumes that services currently available in the NHS will be included.

3.2 We believe this last option to be the best and what we describe provides the same universality as the NHS and will not descriminate against lower socio-economic groups. The objective being to provide choice between kinds of health services and methods of paying for them. It will then allow the State to concentrate its efforts to help those who cannot make adequate provision for themselves.

3.3 We believe that insurance as the method of financing health services carries with it inherent advantages in costs and their control, auditing and review, particularly as competing services and financing systems seek to minimise costs in order to widen their markets.

3.4 In measuring efficiency the insurer, the provider and the insured have common interest. The insurer wishes to be involved in the least payment and therefore it is in his interest to see that treatment is prompt, efficient and leads to the least possible disability. Therefore he is interested in making sure that medical skills available are of the highest order. The provider has the onus of providing as good a service as possible otherwise he will not succeed. The insured is interested in getting the best return for the least premium. This is in direct contrast to a state monopoly which interposes political decisions and a self-interested bureaucracy between doctor and patient. Politicans and civil servants have perfectly understandable but nonetheless independent interests that do not necessarily coincide with the patients' or doctors' interests and may even conflict with them.

3.5 While it might be apparently simple to propose an "Insurance" scheme in detail, this approach is too elementary. A study of systems in other countries shows that a number of financial and administrative arrangements exist which can provide treatment better than the NHS. But a prepared solution in detail takes no account of how a free market might develop. Different arrangements will appeal to different people and all we can predict is that the more advantageous systems will displace the less advantageous. Indeed there may emerge better alternatives not yet considered, since technical development, higher incomes, more sophisticated information and social policy techniques have developed since 1948.

3.6 What is clear, as shown in the Appendices, is firstly that the search for better health care outside the NHS is gathering momentum and now includes Trades Union members. Secondly that the administrative costs of insurance-based systems are not necessarily greater than in a centralised service and thirdly that insurance premiums can be as comprehensive as the NHS.

4.1 After thirty years experience - and experiment - we do not believe there has ever been a decisive case for a permanent all embracing monopolistic Health Service. It has rested on two hypotheses that are not plausible. That individuals put public spirit before personal interest sufficiently to husband allegedly "free" services, and that resources would be plentiful enough to permit the best medical services to be universal. These expectations have been encouraged by all political parties and have caused increasing dissatisfaction, not only with the NHS but with the democratic processes that had promised them.

4.2 Government must turn from running a National Health Service to creating an environment favourable to the development of health services based on alternative theories of financing and organisation. It must allow as much space as possible for a combination of government and independent organisations financed by taxes and rates, social insurance and private insurance, compulsory and voluntary insurance, fees and charges that would emerge from the efficiency of competing suppliers and the preference of patients.

4.3 Government policy is easier to apply in a closed than in an open society, but if it tries to achieve its purpose of efficiency and equality by exclusion or coercion it demands too high a price and is unacceptable. The NHS confronts intensifying coercion or eventual collapse. If the centralised NHS is not replaced by a multiple choice system it will solidify still further until it is incapable of reform except by convulsion, in which both patients and providers will suffer even more than in the gradual changes that are still possible.

4.4 The lesson of all health systems - from the NHS and the state-controlled systems in Eastern Europe to the decentralised systems of Western Europe, is that finance ultimately determines the power, structure, organisation and administration, the political influence on policy and the capacity of occupational vested interests to resist reform, and the ability of the patient to exert his sovereignty. No system that could be devised is perfect - but it is much more difficult to remove the faults of a National Health Service than those of market orientated health services. We maintain that experience round the world supports our view.

4.5 In conclusion, we cannot improve on what was written 10 years ago by Ivor Jones:-

> " So long as the present financial structure of the National Health Service is maintained the Government must either impose further considerable increases in taxation or face a deterioration in the standard of medical care which it provides for the British people. The alternative is to accept that it has become impossible to finance the rising cost of universal provision of <u>all</u> the health services from compulsory levies and taxation if the rising standards which the legitimate expectations of our people demand are to be achieved.
>
> The restraints on personal consumption necessary to combat inflation as a basic aim of political policy are easier to achieve if they are buttressed by an outlet for voluntary spending on the health services. There is a limit to the level of taxation which is either acceptable to the people or compatible with a sound economy."

We believe that acceptance of these facts must inevitably lead to acceptance of the principles upon which the system of financing health services outlined here is based - and that the onus of contrary proof must lie with those who would obstruct any thinking that change might be either desirable or necessary.

4.6 If this acceptance is forthcoming then Blue Prints and transition arrangements will need to be prepared.

Appendix 1

During 1980 the number covered by private health schemes rose by 812,000. This increase was by far the highest ever recorded. On average over 15,600 people were recruited each week to the major Provident Associations, making provision to opt out of the NHS.

At the end of December 1980, the three major schemes had 1,647,000 subscribers, covering a total insured "provident population" of 3,577,000. This represents some 6.4% of the total national population, or about one person in fifteen.

The most notable feature is the increasing rate of growth. During 1980, subscriber numbers increased by 27.5%. This compares to 15.6% growth in 1979 and 5.8% growth for 1978. The Provident Associations saw no growth in 1977, and slight declines during the two previous years.

If the 1980 annual growth rate persists till 1985, the provident population will exceed 12 million persons or over 20% of the national population.

Table 1

Provident Associations Administration Costs. 1976 to 1979

Year	Administration costs (BUPA, PPP & WPA)			
	Total £m	Per cent subscriptions earned	Provident Population Numbers million	Provident Population £ costs per head
1976	8.270	11.7	2.28	3.62
1977	9.781	10.8	2.25	4.34
1978	12.335	11.7	2.32	5.31
1979	17.286	14.2	2.54	6.79

Notes

1 Data are derived form Annual Reports and Accounts for BUPA, PPP and WPA - Consolidated Revenue or Consolidated Income and Expenditure Accounts.

2 The figures cover items described as Administration and development, plus Special Contribution to staff pension funds (BUPA); Administration, Development Special contribution to pension fund (PPP); Administrative expenses, Development (WPA).

3 Data for subscriptions earned are derived from Table 3 Lee Donaldson Associates, Provident Scheme Statistics 1979. The total Provident Population is a mid year estimate for 1976 to 1978 from Table 2 (LDA Report) with actual figures for June 1979.

The NHS now costs 12,000 million or £220 per annum for each person in this country. Thus a family of four is paying out £880 per annum; almost £17 a week.

Data have been gathered on costs of the administrative systems in the existing private sector and the NHS. These are confined to costs of those controlling bodies who administer rather than directly provide patient care.

In the private sector these are the Provident Associations (BUPA, PPP, WPA).

In the NHS they can be defined as the Regional, Area and District administrations plus Boards of Governors and Community Health Councils.

The Department of Health's central administrative costs are excluded, though DHSS statistics give a figure of £43 million for central administration for 1977/78 (Royal Commission, Table E9).

Table 1 sets out the costs of administration of the three main provident associations for the years 1976-79. The costs are expressed as a percentage of subscriptions earned and as costs per head of the population insured.

Table 2

NHS Administration costs 1977/78 England

Health Authority	NHS Administration Costs £m
Regional & Area	135.8
District	79.1
B'd Governors	2.4
Community H.C.	3.1
Total	220.4
Percent NHS Revenue exp.	4.4%
Per head population	£4.75

Notes

1 Data are derived from NHS Summary Accounts for 1977/78 for Regional and Area Administration and for Community Health Council. DHSS abstract for District and Boards of Governors administration.

2 The total £220.4 million is expressed as a percentage of £5,041 million Net Revenue Expenditure NHS England 1977/78 (NHS Accounts) and estimated mid year Home population 46.352 million (OPCS).

3 Data for DHSS on central administration are difficult to interprete in terms of NHS costs. The Health Department's Statistics give a figure of £43 million for Central Administration for 1977/78 (Royal Commission Table E9).

In 1976 the administrative costs amounted to £8.270 million. By 1979 the figure had risen to £17.286 million. In 1976 to 1978 the costs amounted to between 10% and 12% of subscription income. 1979 was a year of rapid growth when administrative costs came to 14% of subscription income. If we consider costs in terms of the service provided and express them as costs per head of the population insured:-

The cost for 1976 was 3.62 per cap. rising to 6.79 by 1979. The rise is 87% or 32% if expressed in terms of constant retail prices.

The cost for 1977 was £4.34 per cap.

Table 2 summarises data for the NHS in England for the financial year 1977/78. It shows costs published in summarised accounts for administration of the Regional, Area and District health authorities and for the Boards of Governors and Community Health Councils.

Total administrative costs for the year amounted to £220.4 million, this amounting to 4.4% of the NHS net revenue expenditure. The cost for the national population averaged £4.75 per cap.

The differences in the proportion of total income and expenditure spent on administration reflect the different characters of the health services constituted by the NHS and private medicine in the UK. The data however argue that the total administrative costs per capita for a system of insurance payment is not necessarily greater than for a system which controls and distributes central funds.

Appendix 2

It is possible to provide a model of the approximate cost of insuring the national population by considering two actuarially typical lives - male and female - calculating the cost of insuring them from birth to death, and adjusting the premiums to cover all medical services. This is intended purely as an example of the possibilities and as an exercise dealing with basic insurance principles.

Table 3 follows a typical male life from birth to his independence at 19, through a marriage during which he supports two children to their independence, and on to his death at age 70, his actuarial life expectancy. The premiums are those quoted by a leading health insurance group for a scale of benefits which covers the cost of more than 80% of the country's hospitals; and the 'experience' on which the premiums are based arises (almost equally) from the use of private NHS facilities and of independent private hospitals and nursing homes.

It is assumed that throughout the man's life the bread-winner is covered by a company scheme as a result of which a discount of 40% is obtained against published scales (this appears to be in line with current practice and should be viewed in the context of a 20% discount being obtainable on company schemes covering as few as twenty or even a dozen people). The total cost over 70 years is £3,334.11 and the average annual premium is £47,63.

The table for the female life is similar except that it is assumed that she is a second child, marries a year younger and lives to age 76, giving an average annual premium of £52.71. Averaging these two figures brings us to £50.18 as the per capital premium for a large, actuarially typical population, which is less than one quarter of the average NHS cost per head of the population. Of course the private

insurance does not cover the same population or services as the NHS. Some of the differences between them are considered in the following paragraphs.

Private insurance does not cover General Medical, dental, opthalmic or drugs expenditure which account for about 24% of NHS costs.

Table 3

Actuarially Typical Male Life

Age	Status	Number in family	Age of oldest member of family	Annual Premium (discount of 40% off standard published scale)	Annual Premium per head	Number of years	Cost (premium per head) x number of years
1-2	Child	3	18-29	£111.60	£37.20	2	£ 74.40
3-5	Child	4	18-29	£111.60	£27.90	3	£ 83.70
6-18	Child	4	30-49	£123.98	£31.00	13	£403.00
19-21	Single	1	18-29	£ 44.64	£44.64	3	£133.92
22-23	Married	2	18-29	£ 89.28	£44.64	2	£ 89.28
24-26	Father	3	18-29	£111.60	£37.20	3	£111.60
27-29	Father	4	18-29	£111.60	£27.90	3	£ 83.70
30-44	Father	4	30-49	£123.98	£31.00	15	£465.00
45-47	Father	3	30-39	£123.98	£41.33	3	£124.00
48-49	Married	2	30-49	£ 99.22	£49.61	2	£ 99.22
50-64	Married	2	50-64	£138.82	£69.41	15	£1,041.15
65-70	Married	2	65+	£208.37	£104.19	6	£625.14
1-70	TOTAL LIFETIME COST FOR A TYPICAL MALE					70	£3,334.11

Average annual insurance cost over a typical male life £47.63

The insurer from which the figures are taken was able to set 25% of his income aside for capital expenditure and to reserves. (The previous year it was almost 30%). The NHS costs contain no provision for reserves or capital expenditure and to get a strict comparison the private sector premium should be reduced by 25%. In practice however some provision for reserves should always be expected in a privately funded system, probably of the order of 10% of income. Capital investment does not present any difficulty in these comparisons. To the extent that physical facilities already exist the only problem is the practical one of ensuring that they are available to be used by those who need them when they need them. Transfer of resources would need to be studied carefully at a practical and operational level but in principle it should provide the insurance sector with the necessary facilities and the government with a source of cash to finance the transitional costs of the change-over.

The private cover contains certain exclusions which limit liability and these fall into two categories:-

(i) Geriatric

14% of the population are over 65. In the actuarial model considered above 25% of the premiums are paid by people over 65, but the over 65's account for 36% of the costs of the NHS.

Associated with this discrepancy is the the fact that many of the NHS costs (especially for the over 65's) are really welfare rather than medical costs and result from the failure of other branches of the welfare system. It could be argued that these extra welfare services undertaken by the NHS need not and would not be carried by private medical insurance.

(ii) Medical catastrophe

The enormous costs associated with medical catastrophe are often quoted as a reason why insurance is impractical; but this is equivalent to saying that all third party accident risks must be covered by the government. The individual cost may be high but because of its rare occurrence it can be insured for a small premium over a large population - far from being uninsurable, it is a classic example of an insurable risk. This is only valid however if the insured population is both large and typical whereas that covered by private health insurance is at present exactly the opposite and it is largely for this reason that the private insurers have chosen to limit their liability, knowing of course that the NHS provides a safety net.

If the total insured population were large enough and sufficiently representative of the population as a whole the cost of medical catastrophe could be calculated, covered and financed and the overall cost would be small relative to the total. Most of the large company schemes now being negotiated have no upper limit to benefits and the indications are that in a large private market the limit could be removed with an increase in premiums of no more that 10%.

No comment can be made about maternity or psychiatric care because no accurate figures have been found for them.

The cost of private health care would also be affected by various other influences which should be mentioned. About three-quarters of the cost of the NHS is absorbed by the hospital service and there is no doubt that the private insurers could make substantial savings compared with the costs now built into their premium scales. In order to compete with a 'free' service the private sector sells privacy, colour television, a more personal service etc. and it charges accordingly. In an open market those who can afford it would

still pay extra for their privacy and convenience but the general service could be considerably cheaper. A simple awareness of economics should also lead to significant savings through, for example, greater use of para-medical facilities, particularly nursing and convalescent homes, protected housing for the elderly, or cash subsidies for those convalescents able to make their own arrangements in the total community or within their own families.

On the other hand General Practice would be more expensive in a private system since the GP would be spending more time with each patient and might make more home visits. Some of this extra cost would be recouped by an easing of pressure on the hospitals, particularly urban casualty departments.

A decline in the monopoly purchasing power of the state might increase the price of drugs but a more personal service from GP's might reduce the volume of drugs prescribed.

A significant and at present unqualified factor is the extent to which the private sector costs are distorted by the fact that the sample is "self-selected" and therefore unrepresentative of a cross-section of the national population. The population covered by the Provident Associations is predominantly middle-aged and made up of middle and upper income groups. There are indications that these figures may seriously under-estimate the medical costs of a typical cross-section of the overall population. There is insufficent evidence at present to determine whether this is so and if so then to what extent the figures are distorted.

The actuarial model indicated about £50 per head as an insurance premium based on current scales and experience. The differences and adjustments which can be approximately quantified suggest a premium level very roughly of the order of £75 but still subject to adjustments and uncertainties some of which have been touched on above and many of which can only be guessed

at in the light of our existing knowledge. However, if it turns out that this last figure must be doubled, or even trebled, to cover a comprehensive national population, it would still not compare unfavourably with present NHS costs of over £200 per head per year.

At the very least these figures raise some fundamental questions for those proponents of an NHS monopoly to justify their position and show why experiments with alternative systems should not be tried.

CONFIDENTIAL

VLS

cc: HO
DEmp
DHSS
DOE
DES
CSO, HMT

Nad
Health

10 DOWNING STREET

From the Principal Private Secretary

11 February 1981

Co

National Health Service Reorganisation: Compensation Terms

The Prime Minister has seen the Lord President's minute of 9 February 1981 about NHS compensation terms and she agrees that the Secretary of State for Social Services should go ahead with the New Towns terms.

I am sending copies of this letter to John Halliday (Home Office), Richard Dykes (Department of Employment), Don Brereton (Department of Health and Social Security), David Edmonds (Department of the Environment), Peter Shaw (Department of Education and Science), Terry Matthews (Chief Secretary's Office) and David Wright (Cabinet Office).

C. A. WHITMORE

Jim Buckley, Esq.,
Lord President's Office.

CONFIDENTIAL

DOE

CONFIDENTIAL

Prime Minister.

Agree not Mr Jenkin's proposal to discuss with the New Towns terms?

Yes please.

10/2

PRIME MINISTER

NATIONAL HEALTH SERVICE REORGANISATION: COMPENSATION TERMS

As requested in your Private Secretary's minute of 27 January, I held a meeting last Thursday with Michael Heseltine, Patrick Jenkin and Leon Brittan.

Leon Brittan and myself were agreed - as were colleagues on H Committee earlier - that Patrick Jenkin should be allowed to go forward and apply the New Towns redundancy terms to National Health Service staff in his reorganisation. Patrick is perfectly clear that without this the reorganisation could not be achieved. Michael Heseltine felt unable to agree because of the potential repercussions for local authority staff. I think Michael puts too much weight on this: after all, the precedent of the New Towns terms has been before them for some time without apparently causing difficulties.

Michael said he would go away and think over the issues and write me a letter. This he has done and I attach a copy. After a further talk, he told me that he did not want to exercise his right to bring this to Cabinet, but he did want you and Geoffrey Howe to be aware of his feelings. I told him I would send you a copy of his letter and that I would ask Leon Brittan, who knows the arguments, to speak to the Chancellor. We left it that if you agreed Patrick, who feels a sense of urgency, could go ahead with the New Towns terms.

I am copying this to Willie Whitelaw, Jim Prior, Patrick Jenkin, Michael Heseltine, Mark Carlisle, Leon Brittan and Sir Robert Armstrong.

S

SOAMES

9 February 1981

CONFIDENTIAL

SECRETARY OF STATE FOR THE ENVIRONMENT

2 MARSHAM STREET
LONDON SW1P 3EB

My ref:

Your ref:

5 February 1981

NHS COMPENSATION TERMS

I listened very carefully to the arguments advanced this morning for proceeding with Patrick Jenkin's proposal and I have considered the matter further since then. I am afraid that I have no choice but to come back to you without being able to change my position.

The basic situation as I see it is as follows. The 1974 reorganisation of the National Health Service and the coincidental reorganisation of local government were conducted on the basis of terms called the Crombie Code. Following this period, local government negotiated its own terms for dealing with redundancies with the unions. At about that time, central government offered local government a set of terms which were also on offer to new towns. Local government rejected these proposals as being far too generous and central government therefore applied them only to new towns.

As I understand it, the NHS has not yet completed the negotiation of general management terms which could apply to the new reorganisation, although the terms at present on offer to the staff are parallel to those applying to local government.

I am fully sympathetic to Patrick Jenkin's objective in trying to secure the early reorganisation of the NHS in order to produce the savings which should accrue. But I feel that if we now offer to improve the NHS terms by bringing them into line with those for new towns the consequences would be a very immediate reopening by the unions concerned of the terms currently in existence for local government. Indeed I understand that the local government unions have already made noises in this direction. One only has to look at the very marked differences between the benefits of new towns terms against those existing in local government to prove the point. The attached note shows that the number of weeks' compensation pay would be increased from 22 to 48 for pensionable and from 17 to 38 for non-pensionable staff. It must be realised that, broadly speaking, local government staff are comparable with NHS staff in terms of the types of job that they do, the amount of money they get paid, the geographical locations in which they work, and the unions which represent them.

I have tried to calculate what the possible costs to local government would be of applying new towns redundancy terms. If we make

he reasonable assumption that we could face 5% redundancies for pensionable local government staff in their 40s and 10% redundancies for those outside the pension scheme - there are several examples of redundancies of this order already this year - we could see a bill of some £67 million (see the note attached). These figures are for England and Wales only and take no account of teachers who are also local authority employees and whose unions would doubtless react in the same way. The clear point that emerges from all this is that, however desirable the NHS reorganisation may be - and I entirely accept the need for such reorganisation - the savings that it would achieve could easily be dwarfed by the possible consequential costs in local government.

So far I have concentrated on the spin-off effect that such leap-frogging would produce. We are not, of course, a party to local government negotiations. But the local authority employers would justifiably feel badly let down if by extending new towns' terms to a major part of the public sector (the NHS) we forced them to reverse their own earlier and entirely prudent decision to offer a less expensive package.

And here I would like to comment on the Treasury view on the NHS proposals to which I have perhaps not given as much attention as I should have done. Leon Brittan's position, as I understand it, is that the Treasury would be prepared to agree to Patrick's proposal provided a ring-fence was put round the NHS, and that it was secured by making it clear that there was no more money available to extend compensation terms in local government, should there be any weakening of local authorities' resolve in this respect. Frankly, I do not believe that this is a meaningful proposition. Firstly, because even if we took the line that no more taxpayers' money would be made available, we have no power to prevent the bills being passed on to ratepayers. Either way, the money spent would rank as public expenditure. But the technicalities are particularly difficult here. We have no legal way of differentiating for the purposes of rate support grant between redundancy costs based on one code rather than another. All staff costs rank for RSG purposes and to make any change in that system would require primary legislation.

In these circumstances, I simply do not feel able to agree to what is proposed. At a time when the public sector is already under criticism, any proposal for improving redundancy terms which is conspicuously more generous than that which is operating in the private sector would simpy redouble this criticism. I cannot therefore believe that we should go forward as proposed.

I am copying this letter to Patrick Jenkin, Leon Brittan and Mark Carlisle.

Yours ever

MICHAEL HESELTINE

Lord Soames

2F

LOCAL GOVERNMENT

ESTIMATED ADDITIONAL COST OF APPLYING NEW TOWNS COMPENSATION TERMS ON REDUNDANCY OVER THOSE OF THE LOCAL GOVERNMENT SCHEME

1. Staff Affected - only those in the 41 to 49 age range and a small number aged 50 or more who would not qualify for premature retirement compensation.

2. Staff Numbers (a) pensionable employees - total 951,000

   (b) non-pensionable employees - total 865,000

3. Numbers Affected - proportion (in years) of 41 to 49 age range of total service range (say 20 to 65) = 18%. Adjust for larger proportion who may be expected to have stayed by this age and for those aged 50 or more who may be eligible for New Towns terms - say 22%.

   Pensionable employees - 22% of 951,000 = 209,220 with an assumed redundancy rate of 5% = 10,500

   Non-pensionable employees - 22% of £865,000 = 190,300 with an assumed redundancy rate of 10% = 19,000

4. Average Age - 45

5. Average Length of Service (a) pensionable employees - say 20 years

   (b) non-pensionable - say 15 years

6. Average Salary (a) for all pensionable employees this is £5,500. Assumed increase for fairly senior staff - say £7,000 (ie about the mid point of the HEO pay scale and comparable with NHS mid band)

   (b) for non-pensionable staff this is £3,250. Assumed increase for older, longer-serving staff - say £4,000.

7. Redundancy Entitlement (as a number of week's pay)

	Pensionable Staff	Non-Pensionable Staff
Under New Towns Scheme	48	38
Under Local Government Arrangements	22	17
New Towns Improvement over Local Govt.	26	21

8. Compensation (a) Pensionable Staff 10,500 x 26 x $\frac{7}{365}$ x £7,000

   = £36.6 millions

   (b) Non-pensionable staff 19,000 x 21 x $\frac{7}{365}$ x £4,000

   = £30.6 millions

4

National Health

10 DOWNING STREET

PRIME MINISTER

This article from the British Medical Journal shows that the medical profession is conscious of a real drive for decentralization under Mr. Jenkin's direction.

29 January 1981

Is the DHSS signing off?

NORMAN ELLIS

"We are determined to see that as many decisions as possible are taken at the local level."[1] The implications of this and other ministerial statements emphasising the dual themes of devolution and local autonomy seem to have fallen on deaf ears. This fundamental change of view, which occurred in May 1979, has been disbelieved or unnoticed in some quarters. This is not entirely accidental, since the interests of those who wish to reduce the impact of this policy are best served if the change is implemented by stealth. The change is evident in the contrast between the 173-page "Grey Book"[2] and the seemingly endless flow of over a hundred circulars that poured out of the Health Departments during the 1974 reorganisation, and the seven-page circular on Health Service development structure and management[3] accompanied by a promise of little more to follow, issued in July 1980.

In 1974 the DHSS produced a blueprint for the Service which described in detail the structure of management and interprofessional relations. The complexity of the Grey Book's diagrams of management structure—appropriately described as exhibits—makes the plan of the Paris Metro look quite simple. The Government does not intend to repeat the experience of 1974 and will not be laying down central prescriptions for the Service. The DHSS no longer sees itself as all knowing and all wise, capable of establishing working relations between the various groups in the Service. Because the 1974 reorganisation weakened hospital administration the Department was irresistibly drawn into prescribing what should happen at the local level. For the 1982 reorganisation the Department will issue only the minimum of guidance. The process of reorganisation is now left to local initiative.

This emphasis on local autonomy was made in a recent ministerial statement outlining the considerably reduced function of the regional health authority. The Secretary of State, Mr Patrick Jenkin, said that he was determined to "ensure that regional health authorities too are slimmed down and their functions reduced. This is essential if we are to advance the greater local autonomy we seek."[4] Each new district health authority now has to decide for itself which managerial structure it should adopt. "Each DHA should have wide discretion in determining its management arrangements. Accordingly, the prescription of particular posts contained in previous circulars is now withdrawn."[3] The one remaining prescription is simply that there should be a district management team, consisting of a community physician, nurse, treasurer, administrator, consultant, and general practitioner, and that each authority should arrange its services into units of management, each with an administrator and a director of nursing services. The composition of the district management team will therefore remain unchanged.

What posts are at risk? The various hierarchies originally prescribed by the DHSS for the professions supplementary to medicine could well wither or disappear in many districts. For example, the existing area and district level posts in chiropody, dietetics, the remedial professions, speech therapy, radiography, and health education are probably at risk. No doubt each of these groups will argue that their particular circumstances merit a special circular from the centre. But such special pleading will not overcome the Department's view that once it attempts to prescribe the position of one group it will inevitably have to do so for all other groups. In addition, the removal of the area tier should eliminate further posts in nursing and administration. Finally, the requirement that a 10% reduction in management costs should be achieved by 1985 will add impetus to the elimination of these hierarchies. There is, of course, another hierarchy that should wither: "the DHSS, on its part, is required by the Government to intervene less and to stand back more, encouraged by pressures to cut the size of its headquarters by at least 15% over the next three to four years." This statement was made by Sir Patrick Nairne, DHSS Permanent Secretary, in a speech to the Institute of Chartered Secretaries and Administrators on 15 October 1980.

Though the Government has emphasised that it does not want to see new hierarchies created in the new districts, the philosophy of local autonomy means that this could well happen. It is left to the DHAs to determine their own management arrangements, and the medical profession locally will no doubt want to influence their decisions. "It really is essential that the decisions on the structure of the management under the new district health authorities should be left to these authorities after they have been formed."[4]

Rule by local discretion

The philosophy of local autonomy has ramifications well beyond the reduction of posts and hierarchies. On a wide range of matters local discretion will rule, and this trend is already apparent. A recent circular from the DHSS[5] authorises health authorities to depart from national agreements on remuneration and conditions of service over a wide range of subjects without reference to the Department. This has already increased the scope for local discretion and reduced the participation of civil servants in the running of the Service. One matter delegated to local discretion by this particular circular that directly affects doctors is the national agreement on excess rent allowances.

But there are signs that a few wayward authorities are prejudging the pattern of devolution by exercising an improper degree of discretion on important matters affecting the medical profession. For example, some authorities have recently tried to depart from national agreements on study leave and removal expenses, despite firm guidance to the contrary from the DHSS. These authorities have lost no time in taking advantage of the devolution prescription, no doubt motivated by the need to cut the costs of medical care.

In the long term we can expect to see nearly 200 autonomous DHAs established. Within an overall cash limit each DHA will be free to exercise a wide measure of discretion in determining how this is spent. Thus the most important decisions on health care will in future be taken at the local level. These include local management arrangements, priorities for health care, and the crucial choices to be made concerning the competing demands of the now well-organised occupations in the Health Service, each articulating its own claim for an increased share of the limited resources available. As one seasoned BMA observer put it, "the choice between more doctoring or more portering has been left firmly on our doorstep."

There are important decisions to be taken during the next year as the new DHAs build their management structures. These decisions, though not irrevocable, will inevitably establish the

concluded on page 248

British Medical Association, BMA House, Tavistock Square, London WC1H 9JP

NORMAN ELLIS, MA, PHD, under secretary and senior industrial relations officer

Is the DHSS signing off?—*continued*

framework of health care in each locality. The danger is that these decisions may be taken speedily and without regard for the DHSS's advice that DHAs should "avoid full-time posts at district level or below in any discipline or function unless they are sure that there is work to warrant them."[3]

"High risk" policy?

The 1974 reorganisation reflected Whitehall's concern to prescribe standardised health care across the country. Central administrators treated health care as a commodity to be packaged and allotted in equal proportions like social security and unemployment benefit. And they relied on a watertight framework of standardised hierarchies and job descriptions to achieve this.

A senior civil servant has described the policy of delegation and autonomy as "high risk" because it means more local responsibility and initiative than has ever been expected or shown before and requires considerable local management talent to carry it through successfully.

From the medical profession's point of view a heavy new responsibility will be placed on the new medical advisory machinery (p 239) and on the local organisation of the BMA. The prospect of 200 autonomous new health authorities, each evolving its own package of policies, means that there will be a wide range or issues that transcend particular crafts on which the whole profession will need to take a view. I suggested in a previous article[6] that the BMA division is the obvious machinery for formulating and presenting the profession's view. [This article was prepared before the report on medical advisory machinery by the Chief Medical Officer's working group (p 239) had been published.—ED]

The craft committees will undoubtedly continue to service their various branches of the profession at the local level in the newly developed service, fulfilling functions analogous to those of the central craft committees. But it is on these other, wider issues, most of which will arise from a DHA's freedom to spend its own budget, that the medical profession will need to be united, active and vigilant.

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4 Anonymous. Slimming down RHAs. *Br Med J* 1981;282:247.

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6 Ellis N. Is the BMA division really necessary? *Br Med J* 1980;280:1151-2.

Medical advice to the NHS—*continued*

whichever body elected him and should keep it informed and consult with it as occasion demands.

Doctors should remember that the medical members of health authorities do not represent doctors working in the district and are not sitting on the authority to give formal medical advice. They are members of the health authority for their own personal qualities and to see that the appropriate medical advice is obtained through the channels described in the working party's report—namely, the clinical DMT members elected by and responsible to their colleagues.

NHS reorganisation mark II has given us another opportunity to look at how medical advice should be given to health authorities. In my view the working group's report outlines a simplified adaptable way for the profession to give advice at district level with a minimum of delay and little extra commitment for the practising doctor. The Department of Health has asked for views on the proposals by the end of March. The profession should discuss them thoroughly so as to ensure that in 1982 the NHS has a medical advisory structure in which doctors have confidence and which health authorities respect.

RESTRICTED

cc: DOE JS
DHSS
Ch. Secretary
CO.
file

further copy to DHSS + Home Office

10 DOWNING STREET

From the Principal Private Secretary

27 January 1981

Dear Jim,

NATIONAL HEALTH SERVICE REORGANISATION: COMPENSATION TERMS

The Prime Minister saw last week the record of the discussion in H of the problem of compensation terms for NHS staff made redundant on reorganisation (H(81) 2nd meeting), and she has now seen the Lord President's paper setting out the issues for his Cabinet colleagues (C(81)9).

After reading these papers carefully, the Prime Minister takes the view that this is not the kind of question which should engage the attention of the Cabinet and she believes that it ought to be possible for those Ministers directly concerned to solve it without troubling their colleagues. She very much hopes therefore that the Lord President will be ready to hold a meeting with the Secretary of State for the Environment, the Secretary of State for Social Services and the Chief Secretary to try to bring the matter to a conclusion.

I am sending copies of this letter to David Edmonds (Department of the Environment), Don Brereton (Department of Health and Social Security), Terry Mathews (Chief Secretary's Office) and David Wright (Cabinet Office).

Yours ever,

Clive Whitmore.

Jim Buckley, Esq.,
Lord President's Office.

BK

CONFIDENTIAL

1.

PRIME MINISTER

NATIONAL HEALTH SERVICE REORGANISATION: COMPENSATION TERMS

You were unhappy with the proposal which you saw over the weekend in Sir Robert Armstrong's Business Note that the question of compensation terms for redundant NHS staff should come to Cabinet.

You subsequently had a word with the Home Secretary, and he explained that H had failed to reach agreement on the matter when they discussed it on 20 January. The majority of H favoured the option of improving redundancy payments for NHS staff and considering any proposals for similar extensions to other areas strictly on their merits and with regard to the financial implications. But Mr. Heseltine was strongly opposed to this concession for the NHS because of the possible repercussions for local government staff. Because he was not prepared to give way, the Home Secretary had no alternative but to agree that the matter should be put to Cabinet.

H agreed that it was for the Lord President to put the matter to Cabinet, and his paper setting out the issues came round today (Flag A). I also attach the H Minutes (Flag B).

If, after reading these papers, you are still of the view that this question should not be taken by Cabinet, the only way in which we can proceed is for the Ministers directly concerned - the Lord President, the Secretary of State for the Environment, the Secretary of State for Social Services and the Chief Secretary - to meet and to try to reach the agreement which has eluded them so far. Shall we arrange for them to do this?

Yes please ms

I take it that you would not wish to chair such a meeting yourself?

No.

fhw.

26 January 1981

CONFIDENTIAL

PMG NOTE 57/80

Nat Health 2

PRIME MINISTER

MS

REORGANISATION OF THE NATIONAL HEALTH SERVICE

The Government has announced its plans for the reorganisation of the NHS and the removal of one tier of administration. The announcement follows publication in December 1979, of a consultative paper "Patients First".

MG

The present 90 Area Health Authorities with 199 districts, will be replaced by new District Health Authorities generally serving populations of between 150,000 and 500,000. It is expected that most of the changes will be made on or by 1 April 1982.

In his announcement in the House of Commons on Wednesday, 23 July 1980, Mr Patrick Jenkin, Secretary of State for Social Services, said:

> "The main purpose of the changes I am announcing is to provide a Health Service which is better and more efficiently managed, and where local decisions can be taken more quickly by local people. At the same time I am confident that it will be possible to make significant reductions in management costs, and I have told the Health Service that I expect these to be reduced, after a transitional period by some 10 per cent, equivalent to about £30 million a year at present costs. This will release resources which could be used for patient care."

The main points of the Government's proposals are:

- Area Health Authorities will be replaced by District Health Authorities following as far as possible the boundaries of existing health districts (including single district areas). They are expected to serve communities with populations up to 500,000.

- The new authorities will have - on average - sixteen members each, four of them nominated by local authorities. This is fewer than suggested in "Patients First".

- Decision making to be brought as far as possible down to hospital and community level with strengthening of management at that level - i.e. "bringing back 'matron'".

- Regional Health Authorities will remain for strategic purposes. Their functions are to be reviewed later.

- Community Health Councils are to remain - one for each new district authority. Their membership and functions are to be reviewed.

Paymaster General's Office
Privy Council Office
Whitehall
LONDON

24 July 1980

NATIONAL HEALTH SERVICE (ENGLAND)

The Secretary of State for Social Services (Mr. Patrick Jenkin): With permission, Mr. Speaker, I shall make a statement on changes in the organisation and management of the National Health Service in England. My right hon. Friend the Secretary of State for Wales is announcing his proposals for Wales today, and my right hon. Friend the Secretary of State for Scotland will be announcing his proposals next week. My Department—[*Interruption.*]

Mr. William Hamilton: On a point of order, Mr. Speaker. Can it be made clear at the outset that there will be a separate statement on the Floor of the House from a Minister representing Scotland? The Health Service in Scotland is an entirely different organisation from that in England and Wales.

Mr. Speaker: The only request that I have received is for the statement that is about to be made.

Mr. Hamilton: It is an outrage.

Mr. Jenkin: The hon. Gentleman may not have heard what I said because of the noise that was being made by many of his hon. Friends. My right hon. Friend the Secretary of State for Scotland will be announcing his proposals next week.

Mr. Hamilton: In the House?

Mr. Speaker: Order. There will be time for questions after the Secretary of State's statement.

Mr. Orme: On a point of order, Mr. Speaker. I wish to ask the Secretary of State whether—[*Interruption.*]

Mr. Speaker: Order. The right hon. Gentleman must address his point of order to me.

Mr. Orme: On a point of order, Mr. Speaker. Will the statements regarding Scotland and Wales be made as oral statements in the House—Wales today and Scotland next week?

Mr. Speaker: I cannot answer that point of order. The Secretary of State will be subject to questioning at the end of his statement.

Mr. Jenkin: Perhaps I may respond to the right hon. Gentleman's point. My right hon. Friend the Chancellor of the Duchy of Lancaster has taken note of what he said, but that is a matter for next week.

Mr. Rowlands: Will you advise us, Mr. Speaker? The Secretary of State said that the Secretary of State for Wales will be making a statement today. If he is not to make it orally, and as the statement that has just started is described as being about England and not about Wales, are we to understand that the Secretary of State for Wales may simply issue a press release, or something like that, and not make a statement in the House and be subjected to the same interrogation and questioning as the Secretary of State for Social Services?

Mr. Speaker: The House must understand that I cannot order any Minister to make a statement in the House. I have to deal with the statement that the Secretary of State for Social Services is making. I cannot advise the hon. Member for Merthyr Tydfil (Mr. Rowlands), except to say that I have received no request for a statement about Wales.

Mr. Rowlands: Will you tell us, Mr. Speaker, whether it will be in order for us, on this statement, to question the Secretary of State for Social Services on what is to happen in Wales?

Mr. English: On a point of order, Mr. Speaker. Is it not correct that it is only by courtesy that the House hears a ministerial statement? Would it not be a good idea if we refused to hear the statement until the Government have got themselves in order?

Several Hon. Members *rose*——

Mr. Speaker: Order. I think that I should call on the Secretary of State make his statement.

Several Hon. Members *rose*——

Mr. Speaker: Order. Mr. Michael Foot.

Mr. Foot: Obviously, Mr. Speaker, the House is in a considerable state of confusion. The right hon. Gentleman proposes to make a statement that refers only to England, and he suggests that there is to be a statement next week about Scotland, but in the meantime

[Mr. Foot.]
we are not at all sure what is to happen about Wales. It would appear, therefore, that Welsh Members are to be deprived of the opportunity of putting any questions on what is to happen about Wales, as the statement is to be made not in this House but elsewhere.

I suggest that that is not the right way to treat the House and that the best course for the Government would be not to make the statement today but to consider the matter and tomorrow ask the leave of the House to make a proper statement. If such a course is not followed, Welsh Members will be deprived of their rights. I know that Conservative Members may not worry about that, but it worries Opposition Members. In view of the confusion in which the Government have placed us, I suggest that they should not proceed with the statement now but should make it tomorrow, when they have sorted the matter out.

Mr. Arthur Lewis: On a point of order, Mr. Speaker. Is it not the case that you have the sole right to decide whether to grant permission for a statement to be made, although invariably you grant that permission? We know that it is done in order that the House may be advised and informed of certain matters. In view of the fact that a full report of the statement has obviously been leaked by the Minister and appears in today's *Daily Telegraph*, I suggest that no harm would be done if you were to withdraw permission for the statement to be made, as my right hon. Friend the Member for Ebbw Vale (Mr. Foot) suggested. Then we could all read the statement in *The Daily Telegraph* and come back tomorrow well prepared to put our supplementary questions to the Minister.

Mr. English: Will you allow me, Mr. Speaker, to move that the leave of the House be not given for this ministerial statement?

Mr. Cryer: I will second that.

Mr. Pavitt: On a point of order, Mr. Speaker. Is it not the custom that before a statement is made Opposition spokesmen are issued with copies of it, so that they may give some prior consideration to it? Are you able to tell us whether in this case the Opposition spokesmen for Scotland and Wales have been issued with statements, so that they may be in a position to deal with the problems that will face them?

Mr. Onslow: On a point of order, Mr. Speaker. I understood you to have called my right hon. Friend to make a statement, and I do not see how you can, so to speak, "uncall" him. Would it not be a great deal more orderly if he were to be allowed to make his statement? Hon. Members who found some deficiency in it could jump up and down afterwards.

Several Hon. Members *rose*——

Mr. Speaker: Order. The hon. Member for Woking (Mr. Onslow) is right. I have called on the Secretary of State to make his statement. I have been taking these points of order as a preliminary to the statement that the Secretary of State is likely to make.

Mr. Ennals: On a point of order, Mr. Speaker. At the time when you called the Secretary of State, presumably you did not know that the statement would not be dealing with Scotland and Wales, or that no announcement would be made about Scotland and Wales. May I, therefore, second the motion that has been put by my hon. Friend the Member for Nottingham, West (Mr. English), that permission be not granted for the statement to be made?

Mr. Speaker: I cannot accept such a motion at this stage. I have already called the right hon. Gentleman to make the statement.

Mr. Ioan Evans: When "Patients First" was issued, it was issued by the Welsh Office and by the Department of Health and Social Security. I understand that there is to be a statement about Scotland in the House next week [*Interruption.*] I thought that that was understood. That may happen. My point is that the present statement does not relate to Wales and that the announcement about Wales is apparently to be made somewhere else. We have not been told where it is to be made. Are not the Welsh Members being denied the opportunity to question the Secretary of State on what is contained in that statement?

Mr. Speaker: It is not my intention to confine questions to English Members— [*Interruption.*] I can do no more to help the House.

M[illegible]oot: It is quite true, Mr. Speaker, as you have said, that you had called on the right hon. Gentleman to make his statement and that he had started to make it. Points of order have been made by several hon. Members, and certainly those from Wales have the larger grievance. Surely, in the light of what has occurred, it would be possible for the Leader of the House to say that he will make arrangements for a statement to be made tomorrow about England, as well as such statement as the Government may wish to make about Wales.

If the Leader of the House were to rise and make that suggestion, it would, I am sure, meet with the wishes of the House. It would get us out of the difficulty. Otherwise, there will be complete confusion about when a statement is to be made about Wales, when the Minister can be questioned, and how the rights of Welsh Members can be protected. I suggest to the Leader of the House that he is the person to rescue the House and the Government from the difficulty. It would be perfectly within the province of the Leader of the House to suggest that statements on both England and Wales should be made to the House tomorrow.

Mr. Speaker: Mr. Secretary Jenkin.

Several Hon. Members *rose*——

Mr. Speaker: Order. Points of order can be raised but they must relate to the rules of the House. I have tried to help the House as much as I can. I cannot do any more than call the Secretary of State, who has already started to make his statement. I suggest—[*Interruption.*] Order. I suggest that it is in the best interests of the House that we keep questions until after the statement has been heard.

Mr. Faulds: Further to that point of order, Mr. Speaker. There is, of course—[HON. MEMBERS: "Speak up."] I think hon. Members will hear. There is another avenue of approach open to you, Sir. You could—it is within your powers—either on your own decision or at the request of the Chancellor of the Duchy of Lancaster order a temporary suspension of the sitting of the House. That would give an opportunity—[*Interruption.*]

Mr. Speaker: Order. The hon. Gentleman must be allowed to make his point.

Mr. Faulds: Thank you, Sir, for your protection. That would give the Chancellor of the Duchy an opportunity to order his minions, the Secretaries of State for Scotland and Wales, to come here, where they should be, and make statements to the House rather than to issue press releases that are not open to immediate question by Members.

The Chancellor of the Duchy of Lancaster and Leader of the House of Commons (Mr. Norman St. John-Stevas): Mr. Speaker, as far as I can see, the difficulty arises not over the statement being made on England, but because a statement is not being made on Wales. We have had an indication that a separate statement is to be made on Wales. I suggest that while my right hon. Friend the Secretary of State for Social Services is making his statement on England I should pursue the matter to see whether the interests of other hon. Members can be met and consult my right hon. Friend the Secretary of State for Wales, who is here.

Mr. William Hamilton: On a point of order, Mr. Speaker. The Leader of the House could go much further than that. I think that Scottish and Welsh Members would be disinclined to accept that unless we got a specific guarantee that separate statements will be made on the Floor of the House next week, or some time soon. We must have that specific undertaking before we are prepared to consent to the statement being made by the Secretary of State for Social Services.

Mr. Rowlands: On a point of order, Mr. Speaker. I appreciate what the Leader of the House is trying to do, but without a clear assurance before the Secretary of State for Social Services makes his statement, many hon. Members will be in a dilemma. You have already said that you might not confine your calling of hon. Members to English Members. Unless we know that the Secretary of State for Wales is to make a separate statement this afternoon we shall not know whether to pursue our questions with the Secretary of State for Social Services. I hope that the Leader of the House will be able to state categorically that the Secretary of State for

[Mr. Rowlands.]
Wales, who is present, will make a statement on the Welsh aspects of this problem now.

Mr. Robert C. Brown: On a point of order, Mr. Speaker. As a humble English Back Bencher, I should like to refer to the ruling that you gave a few minutes ago. I appreciate that you were trying to be extremely helpful to the House. You intimated that if the Secretary of State were to be allowed to make his statement you would not restrict questions to English Members. I am sure that you were trying to be very helpful, but it must be apparent that the moment the Secretary of State for Social Services is asked a question appertaining to Wales by a Welsh Member or a Scottish question from a Scottish Member, he will say that it does not fall within the purview of his responsibility. No matter how responsible and helpful you have tried to be, Mr. Speaker, the Secretary of State clearly will not be able to answer for Scotland or Wales. I feel that we are entitled to a further statement from the Leader of the House.

Mr. St. John-Stevas: Mr. Speaker, I have taken advantage of those exchanges to have a word with my right hon. Friend the Secretary of State for Wales. I hope that the House will be satisfied with this suggestion: with your permission, after my right hon. Friend the Secretary of State for Social Services has made his statement, the Secretary of State for Wales—[*Interruption.*] Just a minute; one think at a time—the Secretary of State for Wales will make a statement, and the Secretary of State for Scotland will also make a statement on this subject, on a subsequent date, from this Dispatch Box. I think that we have done all that we can to be reasonable, even in July.

Mr. Jenkin: In response to the consultative document "Patients First", my Department received over 3,500 comments. I have had an analysis of these comments prepared and a copy has been placed in the Library. Further copies will be available in the Vote Office in a few days. There is considerable support for our proposal that the organisation of the National Health Service should be streamlined. Therefore, I am today issuing a circular to health authorities on the changes to be made to achieve this. Copies of this and of my statement are in the Vote Office.

On structure, we have decided to remove a tier of administration. Instead of 90 area health authorities administering 199 districts, we will create a single tier of district health authorities. Each will serve a population of—generally—between 150,000 and 500,000. I have asked the regional health authorities to make recommendations to me on the boundaries of the new authorities by the end of next February after full consultation with interested bodies. I have told them that in order to minimise upheaval the new district health authorities should as far as possible follow the boundaries of existing health districts—including single district areas—because this should in most cases provide a satisfactory pattern.

I want the new authorities to enjoy considerable autonomy in managing their affairs. Greater freedom should encourage a greater sense of responsibility; and smaller authorities, closer to the communities they serve, should be more responsive to local needs.

With a view to enhancing local autonomy still further, I intend later on to review the role of regional health authorities. Regions' responsibilities for strategic planning, the allocation of finance to the districts and the maintenance of financial discipline will remain. Talks will be held between representatives of the doctors, my Department and the National Health Service on the future management of medical staff contracts with a view to seeking a way of reconciling my desire for more autonomy at the local level with the doctors' genuine concern that the benefits which have resulted from the existing arrangements should not be lost.

There is also strong support for our other main proposal—to strengthen management at the local level and remove the intermediate tier between the district and the local unit. Each district health authority, which will be served by a single management team, will therefore arrange the district's services into defined units, appoint senior people to manage them and give those people their own budgets. As far as possible, support services will be organised at that level. My objective is to get decision-making down to the

hospital and the community level. In order to give authorities greater flexibility on this, I am cancelling most of the existing instructions that require them to appoint specified officers to a substantial number of posts. District health authorities will decide for themselves what posts to create.

I attach high importance to effective collaboration between the National Health Service and local authorities. I propose, therefore, to retain the present statutory requirement for joint arrangements for collaboration. The creation of new district health authorities will, however, mean that in many parts of England health authorities and local authorities will no longer have common boundaries on a one-to-one basis. It is my hope that in most cases two or more district health authorities will make up one complete non-metropolitan county. I am proposing, in line with many views put to us, that health authorities should average around 16 members—significantly fewer than existing area health authorities. Within this total, I propose that local authorities should appoint four nominees.

There has been considerable support for community health councils; they will be retained in the new structure, with one CHC for each district. Later this year I shall issue a consultative paper seeking views on their membership, role and powers. When, after a few years, we have had experience of the working of the more locally-based district health authorities, I shall review the longer-term case for retaining these separate consumer bodies.

As foreshadowed in "Patients First", I intend to retain the structure of family practitioner committees, but I shall wish to study all the suggestions that have been made to improve collaboration with health authorities, especially in the planning of primary care.

I attach importance to close working between the National Health Service and universities with medical schools. I shall discuss with interested bodies the present arrangements for designating some health authorities as teaching authorities, taking account, for instance, of the extent to which medical students are now taught in hospitals run by non-teaching authorities.

The changes that I have announced imply no criticism of Health Service managers. They have had to work in what turned out to be an unduly complicated structure. It is much to their credit that the Service has achieved what it has. However, staff at all levels will be affected by the changes, and there must be full consultation with staff interests on the ways in which change takes place. Staff must know that they are going to be treated fairly. We have put forward what I hope are seen as fair proposals for the filling of posts in the new authorities, for staff protection and for early retirement and redundancy compensation. These proposals are being discussed with the staff sides and I hope that satisfactory agreements can be reached soon.

The 1974 reorganisation represented a major step forward in the integration of hospital and community health services, including primary care. It is the Government's policy, like that of our predecessors, that people should receive care in the community wherever possible. Further, the National Health Service is often criticised for neglect of prevention and of the more positive aspects of health promotion. The changes that I am announcing in structure and management will, by making the Health Service much more a local service serving local communities, reinforce this priority for community care, and should lead also to the closer involvement of the public with policies to promote good health. In this, the role of the relatively new medical speciality of community medicine will be of increasing importance.

The main purpose of the changes that I am announcing is to provide a Health Service that is better and more efficiently managed, and where local decisions can be taken more quickly by local people. At the same time, I am confident that it will be possible to make significant reductions in management costs, and I have told the Health Service that I expect these to be reduced, after a transitional period, by about 10 per cent., equivalent to about £30 million a year at present costs. This will release resources which could be used for patient care.

Management and structure, though important, will not solve all our problems. The Government have already embarked on a number of initiatives designed to get better value for money, improve links between the Health Service and local communities, and raise standards. In the

[Mr. Jenkin.]

autumn I intend to issue a document outlining the Government's strategy and priorities for health. The proposals that I am announcing today will, when carried into effect, help to achieve what we all seek—a better service for our people.

Mr. Orme: The Secretary of State for Industry should have been present on the Government Front Bench to witness the U-turn that the Government have made on the National Health Service and the correction that they are attempting to make to his disastrous reorganisation. We shall want to consider the statement in detail. It contains a great deal of information and far-reaching proposals.

The Secretary of State has spoken of making a statement later in the year on future proposals. I have before me a document that the right hon. Gentleman sent to the chairmen of regional area health authorities recommending the extension of private practice within the Health Service, to which we are totally opposed. Within that document he excludes certain areas for consultation. He states that certain areas cannot be taken as a basis for consultation.

I welcome the fact that the right hon. Gentleman is to retain community health councils despite the antipathy shown by him and other Ministers towards the councils when they came into office. Why does not the right hon. Gentleman concede defeat on this issue? Why does he not accept that the councils have a crucial part to play in representing patients within the NHS and allow them to play their full part?

I note what the right hon. Gentleman has said about savings. It seems that the Government's proposals will lead to a reduction in managerial staff of about 10 per cent. leading to savings of about £45 million gross. It is my understanding that that will mean the loss of about 4,500 management jobs and a net saving to the NHS of about £30 million a year. We want to know exactly how that is to be achieved and how it will affect the morale of the staff within the NHS.

That leads me to the redundancy agreement that the right hon. Gentleman has failed to reach with the trade unions, not least with NALGO. He has failed to agree to a staff commission, which NHS members have correctly requested, that their position may be considered along with the issue of redundancies. Are there to be redundancies, or is there to be natural wastage and reorganisation?

Linked with redundancy is the issue raised by my hon. Friend the Member for Wood Green (Mr. Race), namely, consultations with the TUC and unions in the Health Service such as COHSE, NALGO and NUPE. Is the Secretary of State having consultations with those unions? If so, how are the consultations proceeding?

Mr. Michael Morris: What about the patients?

Mr. Orme: When we dealt with community health councils, we were dealing with the representatives of patients. It was the Conservative Party that wanted to get rid of that representation. We are concerned about patients. We did not hear very much about patients from the right hon. Gentleman.

I turn to the question of democracy within the Health Service. The Government are taking a backward step by reducing local government representation on the new district health authorities. To reduce that representation from a third to a quarter with a maximum of 16 members means that where there have been eight local government representatives in the past there will be only four in future. Local government representation, which is an indirect method of democracy, has, in effect, been removed.

My next concern is the size of districts. There seems to be a change in the statement and in the paper that the right hon. Gentleman has issued from that which was proposed in "Patients First". It applies to sizes and areas. I hope that he will comment on that and will tell us the number of areas in which he envisages there will be more than one district. I had hoped that reorganisation would get rid of overlapping in the National Health Service.

Paragraph 33 of the Secretary of State's circular states:

> "The disappearance of AHAs . . . will impose special strains which could lead to a serious breakdown . . . This must not be allowed to happen."

What does the Secretary of State mean when he says that it should

> "not be allowed to happen?"

How will he prevent it? What action will he take?

Conservative Members should recognise that we are dealing with patients and with 1 million employees. This is an important subject. The Tory Government made such a hash of the previous reorganisation that we want to get it right this time. I notice that there is an appendix to the document which deals with London. However, it does not deal completely with London, and there is an urgent need to hold a major inquiry.

The Secretary of State has made his statement against a background of public expenditure cuts in the National Health Service. We are concerned about the maintenance and improvement of the National Health Service. We are also concerned about patients within the National Health Service, and about funding. While some of the proposals for reorganisation may be seen as a sign of progress, the proposals do not meet the problems of the National Health Service today.

Mr. Jenkin: Given that the Labour Party has always expressed itself broadly in favour of such streamlining, I think that that was a fairly uncharitable response from the right hon. Gentleman. The document is not concerned with private practice, although perhaps it is characteristic that the right hon. Gentleman should have made that his first question. I have never shown any antipathy towards community health councils. Over the next few years those bodies must be seen to justify their existence, because they cost money.

Most of the staff associations and unions that responded to the document "Patients First" expressed themselves broadly in support of the proposals for streamlining and decentralisation. The terms for protection and redundancy and the other issues that the right hon. Gentleman mentioned, are being negotiated by a special negotiating group, which is a sub-committee of the general Whitley council.

I consulted all the main unions involved in the National Health Service. Either my hon. Friend the Minister or I met the unions and discussed their representations. We agree with the Royal Commission that collaboration between health authorities and local authorities depends, above all, on the will to collaborate. It does not depend on the number of local authority members on health authorities.

The right hon. Gentleman was right about the size of the district. In "Patients First" we leant towards the larger district. However, the representations that were made to us suggested overwhelmingly that the smaller district would be more in accordance with the wishes of those who run the National Health Service. That is why we made that shift.

I shall now turn to finance and the risks of breakdown mentioned in paragraph 33 of the circular. When the National Health Service was last reorganised, control over finance was not as good as it should have been during the change that took place after the election. We intend to take steps, through regional treasuries and, in particular, by setting firm manpower management cost limits on each health authority, to ensure that financial control remains intact.

I understand the right hon. Gentleman's wish for a more general inquiry into London. I have appointed an advisory committee under the chairmanship of Sir John Habakkuk, to advise me on all the issues involved. The appendix gives advice on the reorganisation of London and it is one of the first pieces of work that the advisory committee has done. It is attached to the circular with my blessing. London has difficult problems. However, I do not believe that an open public inquiry, which would necessarily take a long time, would help towards their resolution.

Mr. Beith: Will the Secretary of State note that we certainly support any attempt to undo the damage done by the Secretary of State for Industry when he wished such a ridiculous structure on the National Health Service? Does the right hon. Gentleman recognise that getting decision making down to the local hospital and local community level is at least as important as removing a tier from the administration? Will he continue to emphasise that point? Does he accept that community health councils will remain essential unless there is more democracy in the National Health Service and unless Ministers appoint fewer people, not more? Are there not too many jobs for the boys in the appointment of such bodies?

Mr. Jenkin: I support the hon. Gentleman's remarks about the need to make decisions at the community and hospital level. In "Patients First" we said that that was the most important feature of reorganisation. We want to make it work effectively. As long as almost all finance comes from central Government and from my Department in the form of cash allocations to the National Health Service the Department is accountable. I or the regions therefore, must, appoint the members of health authorities. As the hon. Gentleman knows, we are examining alternative methods of financing the National Health Service. By getting greater decentralisation by means of an insurance system, local health authorities may become more accountable to local communities.

Mr. Crouch: I am glad that my right hon. Friend and his colleagues on the Front Bench have responded to the genuine demand for three separate statements. There are three separate health organisations and that is, therefore, appropriate. I am grateful to my right hon. Friend. I am delighted that he has taken note of the desire to retain community health councils. They provide an element of democracy for the community and for the patient. They cost the small sum of about £4 million a year. If the number of elected local government representatives on the new district health authorities is to diminish, my right hon. Friend should consider whether the amount of money provided should be increased and whether it is possible for such representatives to put in the proper amount of time.

I am concerned about democracy in this essential aspect of our social services. My right hon. Friend said that local decisions, taken more quicky by local people, was his aim. I have heard nothing this afternoon from my right hon. Friend to suggest that decisions about disputes among the one million employees will be taken at a local level. If they were taken at a local level and not referred all the way to the Secretary of State, we might eliminate the disputes that must arise when people are employed by an employer, who is also a Secretary of State.

Mr. Jenkin: I thank my hon. Friend for his support. The community health councils and those who spoke for them have made their case. One of the arguments that weighed with me was that community health councils have many members from voluntary bodies. They are often best placed to speak on behalf of the Cinderella services, such as the services for the mentally ill, the mentally handicapped and the very old. Such people might otherwise not receive the priority treatment that successive Ministers have desired to give them. We shall be issuing a consultative paper on community health councils later in the year.

As I said in answer to the hon. Member for Berwick-upon-Tweed (Mr. Beith), local decision-making is a crucial part of the reorganisation. We intend to ensure that the people who run the show in the hospitals and in the communities have seniority and experience, and their own budgets, so that they can take decisions on the spot. Such people will include the administrator and senior nurse who might be called the director of nursing services. They will have the authority.

I am surprised at what my hon. Friend said about disputes. We brought to fruition the initiative taken by the right hon. Member for Norwich, North (Mr. Ennals) for establishing local disputes procedure. Since I have been in office no industrial dispute has been decided by any Minister in this Government.

Mr. Speaker: Order. I remind the House that there is to be a statement by the Secretary of State for Wales. If questions are succinct I shall be able to call more hon. Members.

Mr. Ennals: Does the Secretary of State recognise that most people in the country and in the Health Service will welcome the decision to put right most of the gross errors committed by the present Secretary of State for Industry? Is he aware that most people will also welcome the decision to retain the community health councils? We welcome the tribute that he paid to the administrators, who have done a difficult job.

The Secretary of State referred to decisions being taken at a local level. I agree with the spirit of that. May we have an assurance that the Service will continue to be a National Health Service, with national standards? Many

of the criticisms of "Patients First" implied that the Secretary of State was looking too much towards a hospital-based service as opposed to a community-based service. Will he comment on that criticism, since such a proposition would be a backward step?

Mr. Jenkin: I thank the right hon. Gentleman for his welcome for the main thrust of our proposals. Of course, we have a National Health Service and we shall progressively work towards achieving more national standards through the resources allocation process. The speed at which we can do that depends on the money available. The view that "Patients First" was hospital-orientated was partly due to inadequate drafting and partly due to a misunderstanding by the readers. There was never any intention that it should be so.

If the right hon. Gentleman studies the circular he will discover that it fully endorses what I say. For example, a unit can be a mental illness hospital, the psychiatric community services, and the psychiatric services in a district general hospital. I believe that a more local service will reinforce the general proposition that as many patients as possible should be cared for in the community.

Mr. Paul Dean: Will my right hon. Friend confirm that the essential element in his statement is that we can now welcome back the hospital matron and that management decisions will be made in the local hospital and in other places where health care is given? Will my right hon. Friend keep an open mind about having exactly the same pattern of administration throughout the country? Does he accept that in some compact counties, such as Avon, savings on administration and co-operation with a university and with the social services of the county council might be best achieved by having one tier of administration rather than several based on the districts?

Mr. Jenkin: I am grateful for my hon. Friend's welcome. If a health authority decides, with the consent of the staff, that the senior nurse in a hospital should be called a matron, I shall have no objection. Of course, it is not an appropriate title for a male nurse. I believe that there will be wide support for the proposition that there should be a senior authoritative chief nursing officer in each hospital to reassert authority.

My whole instinct leans towards the pattern of district health authorities that I outlined in my statement. The overwhelming thrust of representations reinforce that view. Bodies and organisations running the health services on the ground are in favour of that pattern of reorganisation. It will be for the regions to put forward proposals for the structuring in their regions. My hon. Friend and others who have views should put them with all the force that they wish to the regional health authorities so that they can be taken into account.

Mr. Pavitt: The Secretary of State has made a wide-ranging and comprehensive statement, which will affect the whole of the National Health Service. It is the prelude to a number of statutory instruments arising from the Bill that will reach the statute book shortly. May we have an undertaking that the Secretary of State will consult the Leader of the House so that immediately after the recess we might have a full-scale debate on the matters which are too complex for a question and answer session?

The regional health authorities are to advise the Secretary of State on the boundaries for the new district health authorities. What is the position of Members of Parliament? Do we make our representations about boundaries to the regional health authorities? Will we have the opportunity, through a Select Committee for example, to discuss that matter?

Will the Secretary of State say more about coterminosity with the social services departments? The Secretary of State has made a hospital-oriented statement. What will happen to the family practitioner commitees? Will they be split up and become part of the district health authorities? In what way will the general practitioner be integrated with the new work? Will there be a further tier at hospital level comprising a committee governing the district general hospital, for example?

Mr. Jenkin I am grateful for the hon. Gentleman's welcome of the proposals. He will know that it was agreed earlier in the year that there should be a full day's debate at some stage which could be linked with the statutory instruments

[Mr. Jenkin.]
which carry into effect the first stage of the reorganisation. The precise date is a matter for the Leader of the House.

In the first instance the Regions will recommend boundaries after consultation. In the end I shall decide in any case over which there is a dispute.

"Patients First" makes it clear that it would be ideal if it were possible to have a viable district health authority coterminus with its local social services authority. There is wide-spread recognition that in 1974 the principle of coterminosity was elevated to the point where it operated to the detriment of the management of the Health Service.

The question of family practitioner committees will have to be considered when we know the district structures and to what extent it is necessary to make use of the powers in the Bill being considered in another place, which reorganises the family practitioner committees.

Mr. McCrindle: Is my right hon. Friend satisfied that the welcome moves that he has announced really will lead to a reduction in bureaucracy within the Health Service? Is he aware of the widespread fear that the staffs of the area health authorities will be queueing up to join the newly formed district authorities? Is he aware of the fear that the district authorities might start operating more highly staffed than is strictly necessary? When my right hon. Friend considers the composition of the community health councils, will he take into account the possibility of voluntary bodies being more prominently represented?

Mr. Jenkin: I am grateful for my hon. Friend's support. Our settled determination is to reduce the amount of bureaucracy in the National Health Service. We shall impose strict management cost limits and it will not be open to health authorities to overstaff their structures. There is widespread support for the view that voluntary bodies should be more fully represented on CHCs. That is one of the matters on which we shall consult interested bodies later in the year.

Mr. Arthur Lewis: I am the only hon. Member present who had the pleasure of voting for the Health Service, against the Tories, when it was introduced, and I was overlooked by you, Mr. Speaker. May I therefore congratulate the Secretary of State on retaining community health councils—a decision that gives my constituents and myself great pleasure? The right hon. Gentleman avoided the question of the hon. Member for Berwick-upon-Tweed (Mr. Beith) on costs. How many thousands of millions of pounds has "Joseph's folly" cost the Exchequer and the taxpayer? The Government wish to cut expenditure, and perhaps the right hon. Gentleman can later give us a figure for the cost of "Joseph's folly".

Mr. Jenkin: The hon. Gentleman will recognise that his second question, by its nature, is impossible of answer. There is widespread recognition that the structure is over-elaborate and cumbersome, which has hampered decision-making. Some very unkind remarks have been made about my right hon. Friend the Secretary of State for Industry, but at the same time Labour Members have been swift to praise community health councils. He invented them.

Mr. Hordern: Does my right hon. Friend recollect that when area health authorities were formed during the previous reorganisation of the Health Service the number of administrators increased by about 20,000, which was 25 per cent., in what my right hon. Friend describes as an unduly complicated structure, which the Labour Government did nothing to correct? As area health authorities are to be abolished, may we expect a commensurate reduction in administrators?

Mr. Jenkin: Although in Health Service terms people are called administrators, the great majority are managers. Competent and effective management is essential to manage £8 billion or £9 billion. We want to make sure that that management works within a structure in which it is possible to manage effectively. I believe that that will mean fewer administrators, which will in no sense reduce the enormous importance to be attached to the administrative function of managing the National Health Service.

Mr. Joseph Dean: As an ex-local authority member of an area health board, may I tell the Secretary of State that his proposals to increase the reduction from 20 per cent. to 25 per cent. will be greeted with dismay? Bearing in

mi[illegible]y recent experience, of which the right hon. Gentleman is aware, does he really believe that his proposals will democratise the Health Service? When I wrote to the right hon. Gentleman on 2 July I pointed out that the chairman of the Yorkshire regional health authority had refused point-blank to let me have, as a Member of Parliament for a Leeds constituency, the proposals that area health authorities were making in response to "Patients First". Sir William Tweddle is answerable to no one, and apart from the refusal I have received only an acknowledgement card. May we be assured that we shall be given more consideration over these proposals?

Mr. Jenkin: There is not universal support for reducing the number of local authority members. However, apart from local authority associations, which wanted a measure of retention or increase, virtually everyone concerned primarily with the Health Service argued for much smaller health authorities and smaller local authority representation. That is the view that we accepted.

Mr. Race: How many?

Mr. Jenkin: The hon. Gentleman will be able to look at the summary of the responses to "Patients First" and make a judgment. Without wishing to comment on the issue raised by the hon. Member for Leeds, West (Mr. Dean), in the light of the consultations, regions have been taking informal soundings in their areas on how they might respond once they saw which way the wind was blowing. Those soundings are informal, purely to inform the administrators at regional level what may come forward. The formal consultations required by the circular that I am issuing today will take place on a wide and public basis, and Members of Parliament are included among those who will have to be consulted.

Mr. Kershaw: May I welcome my right hon. Friend's retention of community health councils, which is a prudent insurance? Will the greater independence that it is proposed to give to local bodies include the possibility of their collaboration with the private sector in medicine, if that seems to them to be a good idea?

Mr. Jenkin: We are consulting the Health Service on how best to bring forward collaboration with the private sector. It is not in the best interest of patients and people generally to maintain the medical apartheid that our predecessors invented. We wish to encourage collaboration in every way possible. I hope that the new local health authorities will be able effectively to carry that forward.

Mr. Speaker: Order. I propose to call the three Conservative Members who have been standing and four Labour Members.

Mr. Faulds: Has the right hon. Gentleman requested a letter of apology, regret and contrition from his right hon. Friend for having created the chaos, which he has a genius for doing with whatever he touches, by his original reorganisation of the NHS, from which the right hon. Gentleman is now trying to extricate us? If not, should he not do so?

Mr. Jenkin: The hon. Gentleman should recognise that one of the main purposes of my right hon. Friend's reorganisation six years ago was the much closer integration of hospital services, community services and primary care. That has been substantially achieved, and we are building on that achievement.

Dr. Mawhinney: May I congratulate my hon. Friend on his most welcome statement, which is not only moderate and sensible but puts patient care first? Does he plan to say anything about the ambulance service in the near future?

Mr. Jenkin: When my hon. Friend studies the circular he will see that there is a paragraph about services that are currently carried on at area or other levels. It will be for health authorities to make recommendations and to consult on how best those services can be carried on in the new structure. A whole range of options are open to them.

Mr. Race: Will the Secretary of State assure us that when the consultative document on community health councils is issued later this year there will be no proposal to reduce the statutory power of a CHC to refer a hospital closure to the Minister? Will he also assure us that there will be no attempt to reduce the proportion of local authority representatives on

[Mr. Race.]
community health councils? Can he confirm that regional health authorities will also be asked to make a 10 per cent. reduction in management costs, notwithstanding the amount of management expenditure that they incur at present?

Mr. Jenkin: With regard to the hon. Gentleman's question about the consultative paper on CHCs, I am sure that he will agree that both the points that he raises are matters on which it would be wise to consult a wide range of people before we determine the matter. It will be for the regions to decide in relation to each of the health authorities for which the management cost limit is imposed, what is the appropriate limit. It would be impossible for me to do that centrally.

Mr. Latham: Since the county of Leicestershire, with 800,000 people, which currently has one area and three district health authorities, will presumably have two or even three district health authorities under the proposals, will my right hon. Friend assure us that he will not allow bureaucratic co-ordinating committees to be set up to deal with the lack of coterminosity?

Mr. Jenkin: The word "flexibility" has shone through a great many of the representations that have been made. We have been asked to leave the maximum flexibility for local health authorities to decide on their own structure. The only statutory requirement will be to have a team of officers at district level and senior managers at hospital and community level, and to have a joint consultative committee. Apart from that, it will be for local health authorities to determine how best to organise their management structure, which will include the matter mentioned by my hon. Friend.

Mr. Hardy: Is it not clear that, whatever changes are made, the areas that receive an inadequate share of NHS resources will continue to experience severe need? South Yorkshire patients come second. In carrying out the changes, will the Secretary of State guarantee the improvement in provision without which no administrative change can be successful?

Mr. Jenkin: I am not sure that that arises out of the statement, but I refer the hon. Gentleman to the public expenditure White Paper, which proposes an increase in resources nationally of nearly 2 per cent. a year up to 1984.

Mr. Michael Morris: Is my right hon. Friend aware that the extent of his consultations on "Patients First" is widely welcomed? What safeguards are there for the district health authorities that disagree with the apportionment they receive from the regional health authority, as happens now, certainly in the Oxford region?

Mr. Jenkin: I have not detected that district health authorities are slow to bring their grievances to the attention of Ministers, either directly or through their Members, and that channel will remain open. In the end, the allocation by the regions must be a matter for them, because otherwise there would be an enormous mass of centralised decision making in my Department.

Mr. McNally: Where do health centres fit in to the right hon. Gentleman's general philosophy on primary care? Will he give an assurance that when an area authority is convinced that, because of low income or social stress, a health centre is needed in a particular area, there will be no attempt by the Government to dissuade it from going ahead?

Mr. Jenkin: Two factors that must dominate in deciding whether a health centre is built are whether there is a demand for it and whether it will be used effectively. If those criteria are satisfied and the resources are available, a health centre may be built. But too many health centres have stood empty or been used for other purposes. That is why we are taking a more cautious view on the building of health centres.

Mr. Moyle: No doubt the Secretary of State will agree that, apart from looking after patients first, one of the major arguments for reorganising the NHS is to improve staff morale. A series of officers of health authorities—laundry officers, catering officers, works officers and those in personnel and medical records, together with some nurses—are being organised on a functional basis which is to be swept away. They will be placed in district health authorities without a structured organisation underneath them. What action does the right hon.

Gentleman intend to take to protect those groups?

The right hon. Gentleman did not answer a question put by my right hon. Friend the Member for Salford, West (Mr. Orme). Will he institute a staff commission to look after the staff? After all, we calculate—and I should like the right hon. Gentleman's confirmation—that about 4,500 management jobs in the NHS in England are likely to go.

The right hon. Gentleman's proposal to subject community health councils to continual review will be regarded in the country as a rather clumsy attempt, which will fail, to emasculate bodies that should be essentially independent if they are to do their job. Does the right hon. Gentleman realise that his fragmented approach to the future planning of health services in London is not carrying the people of London and that that will lay up trouble for the future?

Will the right hon. Gentleman look again at the problems of community and social service planning? The organisation that he has introduced has made that much more difficult by moving away from coterminosity, reducing the number of local authority representatives on health authorities and making the institution of joint planning machinery between the two groups much more difficult. Is he aware that some district health authorities, covering populations of 150,000, will be too small to do their job?

Mr. Jenkin: The action to protect the groups to which the right hon. Gentleman referred is the subject of negotiation in the special negotiating group to which I referred. The question of a staff commission has been raised with me by the unions, but I am extremely loth to go for the sort of cumbersome, bureaucratic staff commission that was set up under the 1973 Act. I am certainly prepared to consider a national appeals procedure for the few cases that cannot be resolved through the regional appeals machinery.

There will not be a continuous review of CHCs. I said that it would be right to look at them again after some years. The councils can plan for the next few years on the basis that they have a clear function to perform.

We have been over the ground on the provision of health services in London, and I disagree with the right hon. Gentleman's views. I want to see reorganisation in London taking place, if possible, within the same time scale that applies to the rest of the country. The massive public inquiry that the Labour Party is advocating would make that impossible.

As for planning with social services, the logic of the right hon. Gentleman's question is that, if we are to keep a whole number of one-to-one coterminosity arrangements with every local authority, the NHS will retain its existing over-cumbersome, bureaucratic structure. The right hon. Gentleman cannot have it both ways.

Dr. M. S. Miller: On a point of order, Mr. Speaker. May I ask you whether, when future statements affecting England are made and we are promised by the Leader of the House that later statements will be made for Wales and Scotland, you will make that clear to us beforehand so that those of us who represent Scottish constituencies will know where we stand? Even those of us who represent Scottish constituencies have general interests affecting the NHS and we should like to have been brought into the debate.

Mr. Speaker: I understand the hon. Gentleman's feelings. I made the offer to the House earlier that I would call hon. Members from all parts of the United Kingdom. It was brushed aside and the demand for another statement continued. Another statement is about to be made, and the House has been given an assurance that there will be a statement on Scotland next week. I felt that I had better confine myself to calling those who represent English constituencies, and even so many English Members have not been called.

Mr. Cryer: On a point of order, Mr. Speaker. I wish to raise a point that I have raised on a number of previous occasions. I thank you if you have used your influence in getting the statement of the Secretary of State for Social Services deposited in the Vote Office today. You have demonstrated your sympathetic support for statements to be deposited in the Vote Office when they are made by a Minister to the House.

It was of assistance to have today's statement put in the Vote Office. The process was relatively painless for the

[Mr. Cryer.]

Government—at least as regards the depositing of the statement—and was helpful to Back Benchers. If you used your influence, Mr. Speaker, I urge you to continue to use it with other Ministries so that, as a matter of routine, most major statements are put in the Vote Office when they are made. It is a step forward and should be marked as such.

Mr. Speaker: I should tell the hon. Gentleman and the House that the virtue that he attributes to me belongs to the Leader of the House, because the statement was not deposited in the Vote Office as a result of pressure from me.

Mr. Kenneth Lewis: On a point of order, Mr. Speaker. As a mere Englishman, I am sorry to prolong the proceedings, but we are setting an unfortunate precedent if, when a statement is made by a United Kingdom Minister, statements on similar lines have to be made by the Secretaries of State for Scotland and Wales. I object to that. It is not in conformity with the best traditions of Parliament, and I hope that it will not happen again.

Mr. Speaker: With the name that the hon. Gentleman has the privilege of enjoying, he might have claimed to be Welsh.

Mr. Parry: On a point of order, Mr. Speaker. Would it be possible for you to call Members from the regions? We on Merseyside have hospitals being closed at a rate exceeded only by the rate of unemployment in Liverpool.

Mr. Speaker: Order. It will be intolerable if I am to be told that I must go into almost every constituency. The hon. Gentleman is not being fair to me. I have to think of the rest of the House. I called an hon. Member from Lancashire, as the hon. Member for Liverpool, Scotland Exchange (Mr. Parry) will see if he looks at the list.

NATIONAL HEALTH SERVICE (WALES)

The Secretary of State for Wales (Mr. Nicholas Edwards): With permission, I should like to make a statement on changes in the organisation and management of the National Health Service in Wales.

I have today published a statement "The Structure and Management of the National Health Service in Wales" which sets out my preliminary conclusions following the consultations on "Patients First". I emphasise that these are preliminary conclusions, and, in effect, this is a consultative document.

It reaffirms my intention that responsibility for managing the Service should be delegated as close as possible to the point at which patient services are provided by creating a new system of strong health management units at local level. I confirm also that community health councils are to be retained as are the existing arrangements for administering family practitioner services. There has not been general support for the view that it is not necessary for Wales, in its particular circumstances, to suffer the upheaval of breaking up the existing eight area health authorities in order to get the benefits of good management. It is evident, however, that many people have not understood the full implications of the proposal to delegate management authority to health units. I have therefore concluded that before I make final decisions there should be further opportunity for comment in the light of the explanations in the statement and of local consultations about the pattern of health units. I am also inviting further comment on the arrangements at all Wales level, where I propose to set up an advisory Welsh health council comprising representatives of the health authorities, the professions and the Welsh National School of Medicine. My intention is that the council should meet in public thus facilitating public awareness of debates on major health issues. I also propose to promote further co-operative working between health authorities.

I wish to minimise continuing uncertainties, particularly for NHS staff, so I am asking that further comments be submitted to me by 31 December, and I would then hope to publish final decisions early in 1981.

Alec Jones: First, I hope that the Secretary of State has learnt a valuable lession this afternoon that, in the discussion of matters as important as this, it is not on to try to get away with it by dealing with it in a planted written question by an hon. Member who is not even present in the House. This is seen by Opposition Members as a matter of some considerable discourtesy because my hon. Friends have still not been able to obtain a copy of the parliamentary answer that the Secretary of State read out so eloquently, or a copy of the statement to which his answer refers.

Certainly, the Opposition welcome the decision to retain the community health councils in Wales, but we still suspect that these councils will have insufficient teeth. I notice in his statement, the Secretary of State for Social Services indicated that a consultation paper would be issued about the community health councils, their powers, their role and their membership. I would hope that there would be a similar consultation paper for Wales.

What consideration was given more fully to integrate the family practitioner committees into the area health authorities? I recall that when the NHS was reorganised in its present structure this matter demanded some attention.

I believe that the decision to set up an advisory Welsh health council is at least a step in the right direction, but I wonder why the Secretary of State has decided not to have an all-Wales health authority. Why not give the Welsh health council the powers that regional health authorities exercise in England?

Finally, I understand that the Secretary of State's statement indicates that there will be further discussion before the pattern of the health units is decided. All the arguments put forward this afternoon by the Secretary of State for Social Services apply equally in England as they do in Wales. If England is to have locally-based district health authorities, why should this not apply to Wales as well? We would like a much fuller explanation of that point.

The English statement referred to the present NHS structure as " unduly complicated ". We do not want such a structure for Wales, but I am not convinced that the right hon. Gentleman's statement does much to ensure that we do not get it.

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Mr. Edwards: I assure the House that I was not attempting to get away with anything in not making a statement in the House. Genuine problems occur when there are three different Ministers responsible for similar subjects. We do not want to overload the House. The reason why I had not intended to make a statement is that we are issuing a new consultative document and there will be plenty of opportunity for hon. Members to make representations and debate the issues. I did not think that it was the best way forward to deal with the issues that are handled in this document simply by a quick exchange across the Floor of the House. I am not announcing any final decisions about the structure of the NHS in Wales this afternoon.

The right hon. Gentleman referred to community health councils having insufficient teeth. We propose, in at least one major respect, that they should be given an important new role. We are suggesting that in Wales they should establish sub-committees to work very closely with the new health units at local level so that we can inject into the management of the health units at local level a real participation by local people through the community health councils. This is an interesting development. We are putting forward suggestions and we shall welcome people's views. This is a real step forward and a major new role for CHCs in Wales.

On the question of family practitioner services, I do not believe that we received significant representations on this point in the round that we have had so far.

On the question of the regional body, there is a real difference between the situations in Wales and England. The relationship of the Minister with 14 different regions is clearly very different from that of the Secretary of State who has overall responsibility for the Health Service generally. He cannot step aside from the situation in Wales and his responsibility covers precisely the same area as the regions. There is the problem of avoiding unnecessary duplication of these two roles. The view has been held in the past that it would be a duplication of services and an unnecessary complication to set up a full-blown regional health authority. None the less wide representations were made to us about

[Mr. Edwards.]

the fact that the strategic role of the Welsh Office was insufficiently understood and appreciated, and there was insufficient opportunity for public debate of strategic decisions for Wales as a whole. We are trying to meet this difficulty by producing a committee that will come up from the health services underneath, so that the main constituent members of it will be the chairmen of the area health authorities. Others will be involved as well, including the medical profession. The committee will meet in public and will provide a forum for advice and debate that will be very valuable. This is a new proposal. We did not touch on it in our previous proposals and there will be every opportunity for consultation on it.

On the question of the pattern of health units and the structure of the NHS in Wales, we propose a precisely similar pattern at the lower level to that in England. We are not attempting to duplicate the districts, but the Welsh areas that we propose will be similar in size and role to the new districts in England. We propose exactly the same structure of powerful units between them, with the same management responsibilities and the same involvement in budgetary and administrative control at local level. We seek to achieve exactly the same ends in Wales as we hope to achieve in England.

I plead guilty to one mistake which has led to some of the misunderstandings. We did not publish a full document originally. By including a short passage in "Patients First" we have brought about some misunderstanding of our objectives, and that is precisely why we want to set the position out clearly and give the opportunity for a further round of consultation.

Mr. Garel-Jones: I welcome my right hon. Friend's statement. However, does he not agree that the discussions hold out a real hope, not only for Wales but for the rest of the United Kingdom, of an improvement in standards of service to patients? In particular, I welcome the suggestion of my right hon. Friend that community health councils should work in close contact with the new units.

I do not wish to raise the temperature, but does not my right hon. Friend feel that it is, perhaps, unfortunate that the Opposition should have chosen to [illegible]ate such an incident of the way in which this statement was made? I ask that particularly because the Labour Party has just published a draft manifesto which scarcely contains a reference to Wales at all.

Mr. Edwards: My hon. Friend's credentials entitling him to speak on Welsh affairs are unchallenged. I believe that the relationship that we propose between the community health councils and the new units offers an opportunity for local participation in the running of hospital, medical and related services. That is an important step forward.

Mr. Rowlands: Is the right hon. Gentleman aware that one of the reasons why we feel strongly that discourtesy has been displayed to us is that the consultative document referred to has not been placed even in the Vote Office? We are entitled to at least the same rights as people outside the House.

Turning to the contents of the statement, we feel that the advisory Welsh health council should have a strong and significant lay representation. Representation should not be confined to chairmanships of area health authorities. There should, possibly, be representatives on that advisory body from the community health councils. The AHCs represent the patient at the most obvious local level.

After the Secretary of State's statement, and his subsequent answers, we are confused about the exact relationship that will exist between area health authorities, whose powers we understand will be totally untouched, and the district health teams and structure. Has not the right hon. Gentleman received considerable representations to the effect that the district structure is closest to the needs, wishes and feelings of the local community and that power should be devolved from the powerful area health authorities to district authorities and that, as has happened in the past the responsibilities of district authorities should not be whittled away?

I hope that the Secretary of State intends to make clear exactly what the relationship between area and district will be.

Mr. Edwards: The council that we propose, and about which we are inviting

representations, would include representatives of all the health authorities, the main professions and the Welsh National School of Medicine. The council will advise on strategic decisions and we think that it is right that its prime constituents should come from area health authorities which have responsibility in their parts of Wales.

On the matter of the relationship between area health authorities, districts and units, we believe that the proper way forward is to replace the existing district by strong management units. We contemplate that there will probably, be about 50 such units in Wales which will be truly local and be related to the main hospital facilities of an area.

Such bodies would have a strong management role with overall responsibility to the area authorities. But there will be real delegation of power and responsibility to the unit. Given that situation, with strong units, it is not self-evident that one could easily fit in an intervening round of districts. There are many parts of Wales where, if we did that, the obvious unit is the existing district. In my own constituency I think it likely that the natural unit would be based on Withybush hospital and the facilities in South Pembrokeshire and Preseli. Therefore, we would have a direct overlap between the district and the unit, which does not seem to make sense. We are putting forward proposals based on the existing structure of area health authorities, but with strong delegaton of powers to units.

However, to enable people to understand and assess the situation properly, we are asking the area health authorities to begin consultation now so that they can publish their plans for units in their areas. Thus people will be able to make judgments about the area and district structure against the background of a known, planned pattern of units. I think that that is the sensible way forward, but I emphasise that we attach great importance to unit management.

Mr. Best: I thank my right hon. Friend for giving such a full reply to what was, essentially, my written question to him. That question prompted this discussion. May I draw the attention of my right hon. Friend to two matters in the document? I think that Members on both sides of the House will agree that we must study it in closer detail before making any full comment on it.

Mr. Alec Jones: Where did you get it from?

Mr. Best: Some hon. Members are more assiduous than others.

Mr. Ray Powell: On a point of order, Mr. Deputy Speaker. The hon. Member for Anglesey (Mr. Best) is referring to a document which some Opposition Members have not seen. Is it in order for the hon. Member to refer to a document that we have not had the opportunity of examining?

Mr. Best: Further to that point of order, Mr. Deputy Speaker. I understand that there is a copy of the document on the board available to every Welsh hon. Member. If the hon. Member for Ogmore (Mr. Powell) has not gone to the board to collect his copy, that is a matter for him.

Mr. Powell: Further to that point of order, Mr. Deputy Speaker. I left the board scarcely a minute before the Secretary of State rose. There was no copy of that document on the board for me.

Mr. Deputy Speaker (Mr. Bernard Weatherill): I regret that I have no knowledge of the document to which the hon. Member for Anglesey (Mr. Best) is referring, or even whether it refers to the Secretary of State's statement.

Mr. Best: If my use of the document causes difficulty, I shall not refer to it. I turn to the issue of lay involvement. As I understand my right hon. Friend, he is saying that he wishes to see community health councils taking a greater role at unit management level. I understand that he contemplates, subject to consultation, appointing additional lay members to area health authorities. Will my right hon. Friend confirm that that is the case? If it is, I certainly welcome the proposal. I am sure that many other hon. Members will welcome a greater lay involvement in the management of the NHS in Wales. On many occasions, lay people feel that they are kept away from the management of the health service.

Mr. Edwards: In relation to the points of order just raised, it was intended to provide information by a written answer. Papers were sent out to go on the board

[Mr. Edwards.]
at 4 pm and I am sorry if hon. Members have not had the chance to collect their copies. We intended to get copies into the hands of right hon. and hon. Gentlemen at the earliest opportunity. It is precisely because this is a major consultative document that people will wish to consider it carefully. For that reason, we thought that the best way forward was to issue the document and allow people to think about it before we became involved in a series of exchanges.

We do not propose to make major changes in the membership of the area health authorities, although there may be some room for adjustment in size. I think that there is room for an interesting experiment in the involvement of community health councils in local management. By involving the community health councils in the affairs of their local units, I believe that lay participation will thus be brought into the Health Service at its most sensitive point. That is the point nearest to the patients.

Mr. Alan Williams: On a point of order, Mr. Deputy Speaker. I have been out to check the board. It appears that a wedge of envelopes arrived there but there was no indication that they were urgent or immediate. Therefore, they have been put into the post. That is not the fault of the attendants. There was no indication as to the urgency of the material. How is it that one Back Bench member has a copy when the copies intended for the rest of us are lost in the post? Will you investigate that, Mr. Deputy Speaker?

Mr. Deputy Speaker: It is an unfortunate matter, but it is not one of order for the Chair. The document is not essential. I am sorry that it is not available, but it is not for me to make documents of this nature available. The Secretary of State said that it is a consultative document. There is a heavy programme of business before the House and therefore I suggest that short answers and short questions will help.

Mr. Ioan Evans: We understand that the question was planted and that, since the hon. Member for Anglesey (Mr. Best) planted it, he should receive a planted answer——

Mr. Best: On a point of or[illegible] Mr. Deputy-Speaker. Is it within the rules of order for one hon. Member to accuse another of acting as some sort of Government lackey—[HON. MEMBERS: "Yes."] —The hon. Member for Aberdare may have been an unfortunate recipient of that treatment at some time in the past, but I hope that he will not accuse me of such action now.

Mr. Deputy Speaker: I have heard the phrase "planted question", but I do not really know what it is.

Mr. Evans: If I have accused the hon. Member for Anglesey of being approached by the Welsh Office or someone in it to table a question and that has not happened, I would be prepared to withdraw the accusation. I should prefer that he rose to deny the allegation before I withdrew it, however.

I realise that the Secretary of State has made an ad hoc statement. Welsh Members have a right, when the Secretary of State for Social Services makes a statement in respect of England, to have a statement dealing with Wales.

Since thit is an interim statement, will the Secretary of State for Wales, when he has preperaed his final recommendations, make that statement to the House? Why did the Secretary of State for Social Services make an eight page statement when the Secretary of State for Wales has made one only half a page long? Is the Secretary of State for Wales covering the same topics as his right hon. Friend?

Since there is strong support for the community health councils, in reaching his conclusions will the Secretary of State for Wales ensure that they are retained in the new structure? The earlier statement contained a reference to the possibility of a change in this respect in the long term.

Will the right hon. Gentleman ensure that if management costs are reduced the money that is allocated to the Health Service will be maintained at existing levels? If the advisory health council for Wales is set up will it replace any existing bodies? Is it to be a Government quango? If it is to be an advisory body will those serving on it be drawn from existing bodies in the NHS in Wales?

Mr. Edwards I can give the undertaking that when we reach firm conclusions to put before the House about the pattern of the Health Service I shall make a statement to the House about them. We had not intended to do so today only because we were issuing a consultative document. That is also why my statement is different from that of my right hon. Friend the Secretary of State for Social Services who has announced a lot of firm conclusions for the Health Service in England. If the hon. Member for Aberdare (Mr. Evans) wants to compare the size of statements, he should bear in mind that I have issued a consultative document, the English language version of which runs to 23 pages. We can double that figure if we include the Welsh language version. He cannot complain, therefore, about the amount that he is getting.

We have made clear that we intend to retain the community health councils. That is firm, not provisional. Their role is being strengthened at unit level.

It is clearly to the advantage of the Health Service if it can reduce its administrative costs in every way. That will leave more money to be spent on patient care, and we all ought to be in favour of that. The all-Wales body will basically be composed of representatives of the area health authorities and of the professions, but that is a matter about which we are consulting in the document.

Mr. Ray Powell: Is the right hon. Gentleman aware that he has abused the House by not presenting a proper statement? It is impossible for us to examine the booklet today or to go through his statement in detail. If the closing date for consultation is to be 31 December, and if the bodies that he is to consult will be similar to those he consulted in respect of his first consultative document, when will he be able to inform the House or the Welsh Grand Committee of his final proposals?

Mr. Edwards: It is because there are difficulties in issuing a long and major consultative document that there is something to be said for simply issuing it and letting people consider it before we embark upon question and answer across the Floor of the House. I shall always come to the House when I have firm conclusions on which to be questioned. I sometimes wonder whether it is not to the benefit of the House with consultative documents for hon. Members to be given time to consider them and then to have the chance to debate them in the Welsh Grand Committee or somewhere else.

We shall complete our consultation by 31 December and announce our decisions early in the new year.

Dr. Roger Thomas: I am sure that Welsh Office Ministers will not be surprised that there is resentment in Wales that in the document "Patients First" Wales was dismissed in two comparatively short and complex paragraphs. As the only Welsh Member to sit on the Standing Committee examining the Health Services Bill, which is now being discussed in another place, I received a deluge of communications from all parts of Wales. The theme of those communications was a desire to get rid of area health authorities just as they are being abolished in England. I cannot understand why the Minister says that we in Wales should still have to tolerate these authorities, representing as they do an extra tier of administration.

Mr. Edwards: I have already acknowledged that I think that we made a mistake in not issuing a separate consultative document at the first round, which is why I have decided to issue one now. We have received for the first time a whole range of representation—the hon. Member for Carmarthen (Dr. Thomas) was involved in this—about the all-Wales area. This is a totally new issue on which we wish to take opinions.

I think it was precisely because we failed to make clear the strength and pattern of the units and their possible duplication with the district pattern that some of the representations were made on that aspect. I want to consult people on the basis of a unit pattern so that they put forward their views with a clear understanding of exactly what is proposed and what that will involve in their districts. We received many more representations from Dyfed than from the rest of Wales put together, and the hon. Member for Carmarthen will understand that. In our document we particularly asked for further views about the position in Dyfed.

CONSETT STEELWORKS COMMON OWNERSHIP

5.20 pm

Mr. David Watkins (Consett): I beg to move

That leave be given to bring in a Bill to transfer the British Steel Corporation works at Consett to the control of the people working there; and for purposes connected therewith.

The background to my Bill is that the British Steel Corporation is proposing to close its Consett works at the end of September. It is a viable and profitable works with productivity among the best in Europe. If it were closed, 3,700 steel workers' jobs would be lost, plus many more in associated occupations. There is great opposition locally to that proposal, which is not surprising. With unemployment already at 14·9 per cent. in the area and rising, the consequences of the closure would be devastating.

It is coincidental, but important and worth mentioning, that on the very day that I seek the leave of the House to introduce the Bill, the representatives of the Consett steel workers are meeting the representatives of the British Steel Corporation in Middlesbrough to present their plans for the survival of the works. That is background to the Bill.

The Bill would establish a new enterprise. It might even revive a famous old name, the Consett Iron Company. It would not revive the old days when Consett was a classic example of a company town. The new company would reverse the old process of company dictatorship. It would be democratically owned and controlled by people working in it. As such a high proportion of people in Consett work there, it would be a notable example of local democracy.

In accordance with the terms of the Bill, the constitution of the enterprise would accord with section 2 of that powerful and pioneering piece of legislation, the Industrial Common Ownership Act 1976. I say with due modesty that I had the privilege of introducing that legislation as a Private Member's Bill, and of piloting it to the statute book with all-party support. The Bill would require the registrar to issue a certificate approving the new company as a body without share capital, limited by guarantee, and a bona fide co-operative society. The registrar would also require to be satisfied that only persons employed there would be members, and that the rules would guarantee the right of all employees to be members with equal voting rights at meetings of the body. The Bill would contain provisions to ensure a continuing relationship with the British Steel Corporation., but on a basis of mutual co-operation.

I turn to the financial aspects. No public expenditure would be involved. On the contrary, there would be a large saving. The Govenment have already announced, and are committed to, an expenditure of £12 million to attempt to encourage new industries into the Consett area, and a further £10 million to clear the site of the steelworks. If the works were closed there would be additional expenditure of more than £30 million in redundancy payments, plus large and continuing social security payments. I remind the House that the estimated Exchequer figure is that every unemployed family man costs Britain at least £4,000 a year.

The consequences of the closure, not only in immediate expenditure but in continuing social expenditure, would be very high indeed. The Bill would avoid that taking place. The same amount of money would effect the transfer of ownership, but there would be no actual physical expenditure of money. It would be a straightforward bookkeeping transaction.

I wish to emphasise strongly that the Bill would create an enterprise entirely different from the so-called workers' co-operatives. There are two great differences. First, the co-operatives were endeavours to save loss-making products of private ownership. The Bill is an endeavour to retain a viable, highly productive plant, and to maintain it in genuine public ownership. Secondly, the so-called co-operatives in reality never were co-operatives. They did not have bona fide legally defined co-operative constitutions. The new Consett Iron Company, as proposed in the Bill, would have precisely such a constitution.

I remind the House that since the 1976 Act there has been a rapid growth of common ownership enterprises in Britain. About 300 are registered at present. The Bill would extend that democratic form of ownership to a viable works whose

2

PRIME MINISTER

Statements on the Health Service

I told you a little bit about the atmosphere in the House this afternoon before and during Mr. Jenkin's statement on the Health Service (copy attached).

At 3.30 there were twenty-five minutes of points of order because there was not going to be a separate oral statement on the future of the Health Service in Wales. After a lot of enjoyable and spurious indignation from the Opposition orchestrated and led by Michael Foot, the Chancellor of the Duchy gave way with a twinkle in his eye and said that Mr. Edwards would make an oral statement after Mr. Jenkin, and that Mr. Younger would make an oral statement on the Scottish Health Service next week. The atmosphere cooled down rapidly.

I was not present for Mr. Jenkin's statement itself, but I came back in to find that Mr. Edwards had made life a little more difficult for himself for failing to get his Consultative Document out to the Welsh MPs.

I doubt that any of the substance of this will be raised with you tomorrow, although it may well be with the Chancellor of the Duchy at Business Questions. All the signs are, however, that the mood of the House has changed and that we can expect end of term behaviour from now on.

MJS

23 July 1980

STATEMENT BY THE RT HON PATRICK JENKIN, SECRETARY OF STATE FOR SOCIAL SERVICES. WEDNESDAY 23 JULY 1980

"PATIENTS FIRST"

1. With permission, Mr Speaker, I will make a statement on changes in the organisation and management of the National Health Service in England. My Rt hon Friend, the Secretary of State for Wales is announcing his proposals for Wales today; and my Rt hon Friend, the Secretary of State for Scotland will be announcing his proposals next week.

2. My Department has received over 3500 comments in respnse to last December's consultative document, "Patients First". I have had an analysis of these comments prepared and a copy is in the Library; copies will be available in the Vote Office in a few days. There is considerable support for our proposal that the organisation of the NHS should be streamlined. I am therefore today issuing a circular to health authorities on the changes to be made to achieve this. Copies of this and of my statement are in the Vote Office.

3. On structure, we have decided to remove a tier of administration. Instead of 90 area health authorities administering 199 districts, we will create a single tier of District Health Authorities.

Each will serve a population of, generally, between 150,000 and 500,000. I have asked the Regional Health Authorities to make recommendations to me on the boundaries of the new authorities by the end of next February after full consultation with interested bodies. I have told them that in order to minimise upheaval, the new District Health Authorities should as far as possible follow the boundaries of existing health districts (including single district areas) because this should in most cases provide a satisfactory pattern.

4. I want the new authorities to enjoy considerable autonomy in managing their affairs. Greater freedom should encourage a greater sense of responsibility; and smaller authorities, closer to the communities they serve, should be more responsive to local needs.

5. With a view to enhancing local autonomy still further, I intend, later on, to review the role of Regional Health Authorities. Regions' responsibilities for strategic planning, the allocation of finance to the Districts and the maintenance of financial disciplines will remain. Talks will be held between representatives of the doctors, my Department and the National Health Service on the future management of medical staff contracts, with a view to seeking a way of reconciling my desire for more autonomy at the local level with the doctors' genuine concern that the benefits which have resulted from the existing arrangements should not be lost.

6. There is also strong support for our other main proposal - to strengthen management at the local level and remove the intermediate tier between the District and the local unit. Each District Health Authority, which will be served by a single management team, will therefore arrange the district's services into defined units, appoint senior people to manage them and give those people their own budgets. As far as possible, support services will be organised at that level. My objective is to get decision-making down to the hospital and the community level. In order to give authorities greater flexibility on this, I am cancelling most of the existing instructions which require them to appoint specified officers to a substantial number of posts. District Health Authorities will decide for themselves what posts to create.

7. I attach high importance to effective collaboration between the National Health Service and local authorities. I propose therefore to retain the present statutory requirement for joint arrangements for collaboration. The creation of new District Health Authorities will however mean that in many parts of England, health authorities and local authorities will no longer have common boundaries on a one-to-one basis. It is my hope that in most cases two or more district health authorities will make up one complete non-metropolitan county. I am proposing, in line with many views put to us, that Health Authorities should average around 16 members - significantly fewer than existing Area Health Authorities. Within this total, I propose that local authorities should appoint four nominees.

8. There has been considerable support for Community Health Councils; they will be retained in the new structure, with one CHC for each District. Later this year I will issue a consultative paper seeking views on their membership, role and powers. When, after a few years, we have had experience of the working of the more locally-based district health authorities, I will review the longer term case for retaining these separate consumer bodies.

9. As foreshadowed in "Patients First" I intend to retain the structure of Family Practitioner Committees, but I shall wish to study all the suggestions that have been made to improve collaboration with health authorities, especially in the planning of primary care.

10. I attach importance to close working between the National Health Service and universities with medical schools. I will discuss with interested bodies the present arrangements for designating some health authorities as teaching authorities, taking account, for instance, of the extent to which medical students are now taught in hospitals run by non-teaching authorities.

11. The changes I have announced imply no criticism of health service managers. They have had to work in what turned out to be an unduly complicated structure. It is much to their credit that the Service has achieved what it has. However, staff at all levels will be affected by the changes, and there must be full consultation with staff interests on the ways in which change takes place. Staff must know that they are going to be treated fairly. We have put forward what I hope are seen as fair proposals for the filling of posts in the new Authorities, for staff protection and for early retirement and redundancy compensation. These proposals are being discussed with the Staff Sides and I hope that satisfactory agreements can be reached soon.

12. The 1974 reorganisation represented a major step forward in the integration of hospital and community health services including primary care. It is the Government's policy, like that of our predecessors, that people should receive care in the community wherever possible. Further, the National Health Service is often criticised for neglect of prevention and of the more positive aspects of health promotion. The changes I am announcing in structure and management will, by making the Health Service much more a local service serving local communities, reinforce this priority for community care, and should lead also to the closer involvement of the public with policies to promote good health. In this, the role of the relatively new medical specialty of community medicine will be of increasing importance.

13. The main purpose of the changes I am announcing is to provide a Health Service which is better and more efficiently managed, and where local decisions can be taken more quickly by local people. At the same time, I am confident that it will be possible to make significant reductions in management costs, and I have told the Health Service that I expect these to be reduced, after a transitional period, by some 10 per cent, equivalent to about £30 million a year at present costs. This will release resources which could be used for patient care.

14. Mr Speaker, management and structure, though important, will not solve all our problems. The Government has already embarked on a number of initiatives designed to get better value for money, improve links between the Health Service and local communities, and raise standards. In the Autumn, I intend to issue a document outlining the Government's strategy and priorities for health. The proposals I am announcing today will, when carried into effect, help to achieve what we all seek, a better service for our people.

cjt

cc Mr Ingham

(1) MAP to see
(2) PRIME MINISTER

Mr Sakin's draft NHS statemt for tomorrow

MS 22/7

21.7.80

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

Nick Sanders Esq
Private Secretary
10 Downing Street

Dear Nick,

"PATIENTS FIRST" : STATEMENT WEDNESDAY 23 JULY

I attach a draft of the Secretary of State's oral statement on "Patients First" to be made at 3.30 in the House on Wednesday afternoon; it is still subject to detailed amendment. Lord Cullen will repeat the statement to the House of Lords. I understand that the Secretary of State for Wales will announce his proposals in a Written Statement the same day and the Secretary of State for Scotland in a Written Statement next week.

Copies of this letter and statement go to John Halliday (Home Office), Jim Buckley (Lord President's Office), Alastair Pirie (Treasury), Godfrey Robson (Scottish Office), John Craig (Welsh Office), Robin Birch (Duchy of Lancaster) and Murdo McLean (Chief Whip's Office).

Yours ever

D BRERETON
Private Secretary

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YDS

"PATIENTS FIRST" : DRAFT PARLIAMENTARY STATEMENT

With permission, Mr Speaker, I will make a statement on changes in the organisation and management of the National Health Service in England. We have received over 3500 comments in response to last December's consultative document, "Patients First". I have had an analysis of these comments prepared and copies are available in the Vote Office. There is considerable support for our proposal that the organisation of the NHS should be streamlined. I am today therefore issuing a circular to health authorities on the changes to be made to achieve this. Copies of this, too, are in the Vote Office.

2. On structure, we have decided to remove a tier of administration. Instead of 90 area health authorities on top of 199 districts, a single tier of District Health Authorities will be created. Each will service populations of, generally, between 150,000 and 500,000. I have asked the Regional Health Authorities to make recommendations to me on the boundaries of the new authorities by the end of next February after full consultation with interested bodies. I have told them that in order to minimise disruption, the new District Health Authorities should as far as possible follow the boundaries of existing health districts (including single district areas) because this should in most cases provide a satisfactory pattern.

3. I want the new authorities to enjoy considerable autonomy in managing their affairs. Greater freedom should encourage a greater sense of responsibility; and smaller authorities, closer to the communities they serve, should be more responsive to local needs. Regional Health Authorities have an important role to play in this transition; they will continue longer term mainly for strategic purposes, including the allocation of resources. Later on, I will review other aspects of their role in the light of the simplified structure below regional level, with a view further to enhancing local autonomy. In the light of these changes, representatives of the doctors have agreed to enter

into talks with my Department and the NHS on the future management of medical staff contracts. The discussions will seek a way of reconciling the doctors' concerns with the greater autonomy for districts now planned.

There is also strong support for our other main proposal - to strengthen management at the local level and reduce intermediate tiers between the District and the local unit. Each District Health Authority, which will be served by one single management

team, will therefore arrange the district's services into defined units, appoint suitably senior people to manage them, give those people their own budgets and arrange that as far as possible support services are organised at that level. My objective is to get decision-making as far as possible down to the hospital and the community level. In order to give authorities greater freedom to do this I am removing most of the existing requirements to appoint specified officers.

4. I attach high importance to effective collaboration between the NHS and local authorities. The creation of new District Health Authorities will mean that in many parts of England, health authorities and local authorities will no longer have common boundaries on a one-to-one basis, though it is my hope that in most cases two or more district health authorities will make up one complete non-metropolitan county. I am proposing, in line with many views put to us, that Health Authorities should average around 16 members - significantly fewer than existing AHAs. Within this total, I propose that local authorities should appoint four nominees. I propose to retain the present statutory requirement for joint arrangements for collaboration.

5. There has been considerable support for Community Health Councils; they will be retained in the new structure. There should be one Council for each DHA. Later this year I will issue a consultative paper seeking views, on such matters as their membership role and powers. When we have had experience of the working of the more locally-based district health authorities, I will review the longer term case for retaining these separate consumer representative bodies.

6. As foreshadowed in "Patients First" I intend to retain the structure of Family Practitioner Committees, but I shall wish to study all the suggestions that have been made to improve collaboration with health authorities, especially in the planning of primary care.

7. I attach importance to close working between the NHS and universities with medical schools. I will discuss with interested

bodies the present arrangements for designating some health authorities as teaching authorities. I wish to take account of, for instance, the extent to which medical students are now taught in hospitals in non-designated AHAs and districts.

8. The changes I have announced imply no criticism of health service managers, who have had to work in what turned out to be an unduly complicated structure. It is much to their credit that the Service has achieved what it has. However, staff at all levels will be affected by the changes, and there must be full consultation with staff interests on the ways in which they are carried out. Staff must know that they are going to be treated fairly. We have put forward what I hope are seen as fair proposals for the filling of posts in the new Authorities, for staff protection and for premature /early/ retirement and redundancy compensation. These proposals are being discussed with the Staff Side, and I hope that satisfactory agreements, providing substantial reassurance to staff, can be reached soon.

9. The 1974 reorganisation represented a major step forward in the integration of hospital and community health services including primary care. It is the Government's policy, like that of our predecessors, that people should receive care in the community wherever possible. Further, the National Health Service is often criticised for neglect of prevention and of the more positive aspects of health promotion. The changes I am announcing in structure and management will, by making the Health Service much more a local service, serving local communities reinforce this priority for community care, and should lead also to the closer involvement of ordinary people with policies positively to promote good health. In this, the role of the relatively new medical specialty of community medicine will be of increasing importance.

10. The main purpose of the changes I am announcing is to provide a Health Service which is better managed, and where local decisions can be taken much more quickly by local people. At the same time, I am confident that it will be possible to make significant reductions in management costs, and I have told the Health Service that I expect these to be reduced, after a special period by some 10%. At present costs, this should enable some £30 million a year to be added to the resources to go directly into spending on the health of the people.

11. Mr Speaker, management and structure, though important, cannot solve all our problems. In the Autumn I intend to issue a document outlining the Government's strategy and priorities for the National Health Service, which will deal with many more of the recommendations of the Royal Commission and other matters. Moreover, the Government has already embarked on a number of initiatives designed to get better value for money, restore better links between the Health Service and local communities, and improve the quality and standards of the care which our people are entitled to expect. The proposals I am announcing today will, when carried into effect, help us to achieve these objectives.

Nat Health

V
MS

Treasury Chambers, Parliament Street, SW1P 3AG

D Brereton Esq
Department of Health
and Social Security
Alexander Fleming House
Elephant & Castle
London SE1 8BY

22 July 1980

Dear Dan,

"PATIENTS FIRST": STATEMENT

Thank you for sending me a copy of your letter of 21 July with a draft of your Secretary of State's oral statement for tomorrow afternoon on NHS reorganization.

In the light of the recent Ministerial exchange of letters the Chief Secretary is generally content but would hope that some reference to improving the efficiency of the health service could be included. He suggests therefore:

i) that the third sentence of paragraph 3 might end:

"including the allocation of resources and assisting in the maintenance of overall financial control";

ii) that the first sentence of para 10 should read:

..."is better and more efficiently managed", and

iii) that the last sentence of para 10 be revised to read:

"at present costs, this would save some £30m a year".

I am copying this letter to Nick Sanders and to other recipients of yours, as well as to David Edmonds (DOE) given the DOE interest in the links between health and local authorities.

Yours sincerely,
Alistair Pirie

A C PIRIE
(Private Secretary)

Civil Service Department,
Whitehall,
London, SW1A 2AZ

With the Compliments

of the

Private Secretary

to the

Lord President of the Council

Not Health.

Civil Service Department
Whitehall London SW1A 2AZ
01-273 4400

From the Private Secretary

18 July 1980

John Craig Esq
Private Secretary to the Secretary of State
for Wales
Gwydyr House
Whitehall
LONDON SW1A 2ER

Dear John,

THE NHS IN WALES

1. We have seen a copy of your Secretary of State's letter of 4 July to Patrick Jenkin setting out his proposals for the NHS in Wales.

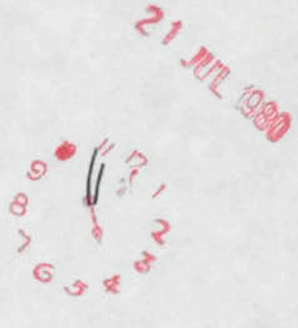
2. This Department's main comment is about the proposal for a new advisory body - the Welsh Health Council - to act as a forum for public discussion of strategic planning matters. We share your Secretary of State's reluctance to see yet another "quango" created, particularly since this one could well turn out to be a lobby for increased expenditure and criticism of the Government. On the other hand, we recognise that the Health Council would be greatly preferable to the creation of a full blown Regional Health Authority and if it is judged that the pressure for one can be headed off only by the creation of an advisory body, we should of course be happy to abide by that assessment. But if the arguments are more evenly poised, it might be desirable not to commit ourselves to the creation of the Health Council at this stage.

3. A second point concerns presentation. As noted in your Secretary of State's letter there was a good deal of misunderstanding about the proposals for Wales in "Patients First". Part of this may have arisen because the authorities comparable to the district authorities proposed for England are called area authorities in Wales. There might be a risk of causing further misunderstanding if what is described in England as a "unit" is called a "division" in Wales. Although we have no particular preference between the two terms, it seems desirable to use the same word in both countries.

4. I am copying this to the Private Secretaries to the Prime Minister, members of Cabinet including the Minister of Transport and to David Wright in Sir Robert Armstrong's Office.

Yours sincerely,
Jim Buckley.

J BUCKLEY


21 JUL 1980

PRIME MINISTER

You might like to glance at Mr Biffen's comments on Mr Jenkin's NHS proposals

MAP 9/VII

Treasury Chambers, Parliament Street, SW1P 3AG

Rt Hon Patrick Jenkin MP
Secretary of State
Department of Health
and Social Security
Alexander Fleming House
Elephant & Castle
London SE1 8BY

8 July 1980

Dear Patrick,

NHS: CHANGES IN STRUCTURE AND MANAGEMENT ARRANGEMENTS

Thank you for sending me a copy of your letter of 1 July to Willie Whitelaw outlining your proposals for changes in the structure and management of the NHS. Bearing in mind the criticism of the present system which accompanied preparation and publication of Sir Alex Merrison's report on the NHS and the constructive responses you have had to "Patients First", we are now in a good position to put into effect our plans to the running of our health services and build up a sound basis for a viable relationship between the NHS and private medicine.

I welcome your proposals to reduce bureaucracy by removing one tier and for giving greater scope for local decision taking. I am particularly concerned that the new system should not lead to any weakening of financial control or in any way add to the risks of a breach in your health cash limit. Nor would we want to impede the development of a system of monitoring which ensures the taxpayer gets value for his money. I should therefore be grateful, if as until now, my officials could be kept closely in touch with the way in which the financial aspects of your proposals are put into practice.

With the removal of the "area" and concentration on the "district" there may in certain cases be less scope for redeployment of resources between districts to cope with such matters as changing priorities and the larger building projects, for overseeing audit arrangements or, say, for ensuring the benefits of large scale purchasing. Given the necessarily wide gap between the Department and any district, I therefore see a continuing and important role for regions in ensuring effective financial management of public funds.

The maintenance of financial discipline will be vital not simply when the new structure comes fully into operation, but also in the difficult interim period. While I appreciate the burden that the changes will impose on NHS staff, I am sure you would agree that it is important not to relax the other important initiatives which you have in hand to provide improved value for money, such as the supplies council, in the drug area, on improved financial appraisal of capital projects, on medical manpower, information systems and of course streamlining the health department's own organization.

While I appreciate that any document on the structure of the NHS tends to devote most of its attention to the hospital service, we ignore the close links with the Family Practitioner Service and the Personal Social Services at our peril. In any given local area, deficiences in these two services can put an added strain on the cash-limited hospital services. Effective collaboration between the NHS and the various Local Authorities is crucial. And, given the family doctor's fundamental influence over his patients' access to the hospital service, joint planning of the FPS and Hospital and Community Health Services HCHS must be pushed ahead. One of the short-comings of the 1974 re-organisation was that it did not adequately bridge the divide between the two sides of NHS. While there is growing interest and willingness among GPs to keep their medical knowledge and practice up-to-date by using the local hospital, encouragement of these links can only be to the patients and our financial advantage. I should therefore like my officials to explore further with yours the Royal Commission proposal for joint-budgetting of the FPS and HCHS and I would hope that our range of options there are not unnecessarily curtailed by the current restructuring.

As your proposals aim to make the system more responsive to local needs, I doubt whether the case for continuation of Community Health Councils is proven. I accept however they should be retained for the time being. But I would hope in any announcement that in making this clear, you will point to the need to review their usefulness once the new health authorities are in operation.

I welcome your intention to insist on a 10% reduction in management costs once the transitional costs of redundancy payments etc are out of the way. You have I am sure been pressed to go for a higher figure. But we need a target which is plausible, achievable and has a degree of support both within the NHS and outside. We need to ensure highly trained medical and nursing personnel do not have their time wasted on unnecessary administrative chores: and we require personnel throughout the service who can continue to look for ways of improving the service's efficiency (e.g. on stock control, on records, financial system etc). Too large and too arbitrary a cut could well, I fear, lead to loss of cost effectiveness and you will no doubt have weighed the comments of the medical and other personnel in the NHS. There is clearly nothing magic about 10%, but after the sharp rise in administrative posts since 1973, some further pruning, over and beyond the efforts already made in recent years, could usefully release further resources for

patient care (and provide suitable justification for your title "Patients First").

I am sending copies of my reply to the Prime Minister, other Cabinet colleagues and Sir Robert Armstrong.

Yours

John Biffen

JOHN BIFFEN

Nat Health

NEW ST. ANDREWS HOUSE
ST. JAMES CENTRE
EDINBURGH EH1 3SX

V/MS

The Rt Hon Patrick Jenkin MP
Secretary of State for Social Services
Department of Health & Social Security
Alexander Fleming House
Elephant & Castle
London
SE1 6BY

4 July 1980

Dear Patrick

TPMd

NATIONAL HEALTH SERVICE: CHANGES IN STRUCTURE AND MANAGEMENT ARRANGEMENTS

Many thanks for sending me a copy of your letter of 1 July to Willie Whitelaw.

I also have in mind before the end of this month to make a statement about the policy I propose to pursue in relation to NHS structure and management. I shall, of course, let you know what line I am proposing to follow and shall, like you, circulate these proposals to colleagues.

Our present structure in Scotland is of course different from yours and our proposals for change differ accordingly. I therefore have only one comment on your proposals. I note that you agree "on balance" that community health councils should be retained. It is in relation to the comparable Scottish bodies - local health councils - that I find most difficulty in deciding how we should proceed. The arguments are indeed finely balanced, and I have not yet made up my mind. The fact that you propose to retain community health councils is a factor of which I shall have to take account.

I shall write to you again very soon about my proposals.

I am copying this letter to the Prime Minister, to all members of Cabinet and to Sir Robert Armstrong.

Yours ever,

George

Prime Minister. 2.

Mr Edwards proposes a separate consultation paper on NHS in Wales. See in particular proposal for a new quango at "x" overleaf.

Y SWYDDFA GYMREIG
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WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switsfwrdd)
01-233 6106 (Llinell Union)

Oddi wrth Ysgrifennydd Gwladol Cymru

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

The Rt Hon Nicholas Edwards MP

MAD 4/7/80

4 July 1980

Dear Mr. Jenkin,

TPM

Thank you for the copy of your letter of 1 July to Willie Whitelaw setting out your proposals for action in England. I have of course been kept closely in touch with the development of your thinking and there is nothing in your proposals which I would want to take issue on.

You and colleagues will however want to be aware of the rather different prospects in Wales. We had a substantial volume of comment following the issue of "Patients First" (including an undertow of criticism that we had not published a separate paper) and I feel I must reply to it at some length. It did not provide a sufficient basis of support for my proposals to retain the existing 8 health authorities in Wales to enable me to confirm them finally at this stage, indeed there was considerable pressure, most notably from my own constituency and Dyfed at large, for new smaller authorities based on districts as in England. But evident in this was a good deal of misunderstanding about the different realities in Wales and I remain far from convinced that it would be beneficial to incur the trauma of breaking up the existing authorities here or to incur the considerable extra administrative cost which it would undoubtedly mean here. There has also been considerable pressure for changes at the all-Wales level, based on criticism of the way the Welsh Office carries out the strategic "regional" role and on the lack of opportunity for public debate which follows from the absence of an RHA here.

What I have in mind therefore is a document - which I hope would issue at about the same time as your own - which would announce certain decisions in keeping with what you propose for England - notably on Community Health Councils and Family Practitioner Committees - and for the rest would explain the reasoning behind my original proposals in much greater detail and confirm them provisionally while offering further consultations before they are finalised. As part of this I am laying great stress on the importance of delegation of responsibility.

/within

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

within authorities to local level - what you call "units" and I am calling "divisions" - and am calling on authorities to consult locally straight away on the pattern of "divisions" which they would propose to introduce. I hope this will help to produce a more favourable response to my proposals this time.

At the all-Wales level I shall obviously be rejecting firmly any idea of a fully-fledged RHA in Wales but I have to acknowledge force in the criticism, particularly about the absence of machinery in Wales for the discussion of health service policies and priorities for the country as a whole - except of course in Parliament itself. I would like to go some way to meet this criticism, and I am also anxious to encourage the health service in Wales to accept responsibility for running certain all-Wales activities themselves without the intervention of the Welsh Office. What I have in mind is that management support functions which need co-ordination should be carried out by a joint committee of the 9 main Authorities supported by a small staff unit and that strategic planning matters should be discussed in public by an advisory council which would essentially bring together the Authority chairmen and representatives of the main professions. To be effective its numbers would have to be tightly controlled, particularly so that chairmen could ensure realism in the advice. I am reluctant to suggest a new Quango of this kind but it seems to me the least objectionable way of getting out of our difficulties.

I propose to offer consultation on these ideas too. The period of consultation will end by December at the latest and I shall aim at final decisions early in the new year to match the completion of your own regional reviews.

I do not think there is anything in this which, allowing for our different circumstances, makes for embarrassment. I should perhaps mention LA membership of authorities. Since I am not proposing that AHAs in Wales be broken down into smaller, more local authorities, it follows that I do not have your case for reducing LA representation and I am not suggesting it. One other point. I am following up the idea - which I owe to you - that CHC members might have a role to play at 'unit' or 'divisional' level.

I am copying this letter to the Prime Minister and other recipients of your own. I would be grateful for any comments as quickly as possible. The consultation document is being finalised and will be circulated in draft to interested Departments in the next few days.

Yours sincerely,

P J Morgan

Approved by the Secretary of State and signed in his absence

cc Press Office

4

Prime Minister
A summary of Mr Jenkin's proposals following the consultation period based on "Patients First"
1 July 1980 MAP 2/VII

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 William Whitelaw CH MP
Secretary of State for the Home Department
50 Queen Anne's Gate
London
SW1

MT

Dear Willie,

NATIONAL HEALTH SERVICE: CHANGES IN STRUCTURE AND MANAGEMENT ARRANGEMENTS

The consultation period on "Patients First" (the discussion document we issued last December) ended on 30 April. In general the comments we have received have supported the main thrust of the Government's proposals, and following discussions with Regional Health Authority Chairmen I am now in a position to make firm proposals for action.

See pt. 1

Structure

I propose in effect to remove a tier of administration, the one at Area level. In general, the new operational authorities would be created from the districts into which the two-tier Area Health Authorities are already divided. (Single-district Areas would normally be translated into new style district health authorities). We would thus produce smaller statutory authorities, less remote from the populations they serve and generally more effective. Forming the new authorities from the existing district will ensure that one or more district health authorities will together make up a complete county, thus minimising the effects of the change on collaboration with social service authorities.

Arrangements for implementation

The Regional Health Authorities will be given the job of initiating the review and making proposals for the new structure. They will be required to carry out formal consultation with local authorities, universities, staff organisations and other bodies in the Region, and will then make proposals to me by the end of next February. I shall no doubt feel it necessary to receive deputations from dissenting bodies, but I would nevertheless hope to reach decisions by the end of May at the latest. The new structure should be completely established by the end of 1983, but I share the general view of health service managers and staff that the process should be completed as soon as possible and I expect April 1982 to be a common date for change. When appointed the new authorities will be required to simplify their management arrangements and to get decision-making down to a local level. Management at that

E.R.

level will require some strengthening, but posts at intermediate levels will disappear. I propose to issue the very minimum of guidance: for example, as regards the appointment of officers, the only requirement will be to establish a district management team and an administrator and a nurse manager for each operational unit.

Arrangements with local authorities

The statutory Joint Consultative Committees will be retained, but how the arrangements for collaboration between health and local authorities are best made can only be settled locally. I shall however be asking district health authorities to discuss with local authorities how they should provide adequate advice and services for environmental health, child (and school) health and personal social services.

Membership of District Health Authorities

The proposal in "Patients First" to reduce local authority representation on DHAs from one third to four has been generally well received by health authorities but opposed by the local authority associations. It was the previous Government which raised the proportion to its present level. There has been much dissatisfaction with this proportion, and we have decided that authorities should generally have fewer members. Gerry Vaughan has seen each of the main local authority associations, so that they have had adequate opportunity to express their views. Nothing they have said has altered our intention, and we now propose to confirm that the local authority representation on a DHA will normally comprise four members. In metropolitan areas these would be drawn from the metropolitan districts or London Boroughs, in other parts of the country from the county councils (though we intend to introduce legislation later that would give two of the latter's places to district councils).

Community Health Councils

"Patients First" raised the question whether these should continue. Most health authorities favour keeping them in existence (possibly as a safeguard against inappropriate advice and action by their officers). I agree that on balance they should be retained, at least until we have seen what effect the creation of smaller, more local, authorities has had on the responsiveness of the NHS to local needs. However, I propose in the meantime to review the membership and powers of CHCs.

Family Practitioner Committees

There has been opposition from health authorities to the proposal that the present arrangements for FPCs should be unaltered, but I believe that what really lies behind this is the view that family practitioner services should be more closely integrated within the NHS. There is no prospect of changing the independent contractor status of the general practitioner, but I shall be considering further the relationship between the FPCs and the new authorities in the planning of services.

Consultant contracts

"Patients First" said that I would discuss with the medical profession the proposition that the contracts of consultants should be held by the DHAs and not the RHAs as at present (thus bringing England into line with Scotland and Wales). The profession are strongly opposed to this (as I had expected) but I am still discussing the matter with them with a view to making this change.

E.R.

Regional Health Authorities

We need the RHAs to initiate the changes and to see them through. But I propose to review their functions later.

Management Costs

The NHS is reluctant to accept that the new authorities will be cheaper. But I intend to insist on a 10 per cent cut in management costs (after the transitional costs of redundancy payments etc). We will use the existing control machinery to ensure that this target is achieved once the new structure has been installed and the new authorities have slimmed down the management arrangements they inherited.

I believe that our proposals will produce a slimmer and more effective health service, with authorities that are more responsive to local needs and quicker on their feet. And I am encouraged by the general welcome given to the proposals by the NHS and the professions who work in it. My officials have just sent to the Departments concerned a draft of the circular which will set out these issues in more detail, but I wanted colleagues to have the outlines of the package I propose to announce next month. If any have comments on it I should be grateful to receive them by 7 July.

I am copying this letter to the Prime Minister and all members of the Cabinet and Sir Robert Armstrong.

Yours ever

Patrick

PERSONAL FILE NS

National Health.

10 DOWNING STREET

From the Private Secretary

28 March 1980

I promised to let you have some material about the Prime Minister's remarks during the Election campaign last year on prescription charges and health charges more generally.

There are two separate sources: the Press Conference at Conservative Central Office on 18 April 1979 and a speech in Beeston on the same day. I attach a transcript of the Press Conference. The section which may be quoted is that which I have sidelined at the top of page 3. In defence, Mr. Jenkin could quote the earlier answer about prescription charges on page 2. You will see, however, that the material needs to be handled carefully.

A transcript of the relevant part of the Beeston speech is also attached, together with a couple of Press cuttings reporting it. You will see that the Prime Minister did indeed say at Beeston that "the Conservative Party has no plans for new National Health Service charges". I also attach, as promised, a copy of the transcript of Denis Healey's broadcast.

N. J. SANDERS

Don Brereton, Esq.,
Department of Health and Social Security.

PERSONAL

File

DSS
National Health

20 February 1980

The Prime Minister has seen the Home Secretary's minute of 19 February, in which he reported that the members of H Committee had now reached agreement on a premature retirement scheme for NHS staff affected as a consequence of statutory or administrative change.

The Prime Minister was grateful to be informed of the Committee's decisions.

I am sending a copy of this letter to David Wright (Cabinet Office).

M. A. PATTISON

John Chilcot, Esq.,
Home Office.

DS

CONFIDENTIAL

PRIME MINISTER

H Committee has now settled terms to succeed Crombie, to be applied in the NHS reorganisation

MAP 19/2

PRIME MINISTER

In my minute of 24 January I gave a first report of the discussion at Home and Social Affairs Committee of the proposal of the Secretaries of State for Social Services and for Wales for a package of compensation and protection terms for staff affected by the forthcoming reorganisation of the National Health Service.

The Committee postponed taking decisions on the elements of the package at its earlier meeting to enable the Minister of State, Civil Service Department, to circulate a memorandum about the future of the Crombie Code. The Code was first introduced in the late 1940's to safeguard the interests of staff affected by nationalisation. It is now out-dated. It is complex and expensive to administer, and because it applied only to statutory reorganisations, it is anomalous in its effects. It would in the case of the NHS have been available in England but not in Scotland or Wales. The Committee have agreed that the Code should not be used in future, and that it should not be applied to the NHS reorganisation.

The Government cannot however announce the general abandonment of the Crombie Code without consultation with the CBI and the TUC, who were parties to its original adoption. The Minister of State, Civil Service Department and the Parliamentary Under-Secretary of State, Department of Employment, are giving further thought to this question. The Minister for Health will in the meantime have to discuss the position of staff affected by the reorganisation in the Standing Committee on the Health Services Bill. In defending the decision not to apply the Crombie Code he will need to rely as far as possible on the argument of equality of treatment for Health Service Employees in England, Scotland and Wales, but may also refer to the shortcomings of the Code. If pressed, he will have to say that the Government are reviewing the future of the Code more generally.

If the Crombie Code is not to be available, staff interest will focus on the other parts of the package. The Committee have now been able to reach agreement on a premature retirement scheme for offer to those in the NHS who are likely to lose their employment as a consequence of statutory or administrative change. Terms for premature retirement will be available for offer to staff who are aged 50 or over provided they have not less than 5 years reckonable service. The new scheme will not be discriminatory, ie it will apply to all grades of staff, and not just to Chief Officers, as did the 1974 scheme. It will provide the same enhancement of pension as the parallel local government scheme, and will be available at the discretion of the employing authority operating within guidelines.

/Agreement has also

CONFIDENTIAL

Agreement has also been reached on proposals for the protection of terms and conditions of service of staff who remain in NHS employment but who are obliged to accept poorer jobs than they have now. The necessary enabling powers to be taken in the Health Services Bill.

I am copying this minute to the Members of H Committee and to Sir Robert Armstrong.

WIW.

19 February 1980

with compliments

MINISTER OF STATE

CIVIL SERVICE DEPARTMENT
Whitehall London SW1A 2AZ

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National Health.

Civil Service Department
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Minister of State

John Chilcot Esq
Private Secretary to the
Home Secretary
Home Office
50 Queen Anne's Gate
LONDON SW1

15 February 1980

Dear John,

Not copied to No 10.

NHS REORGANISATION: COMPENSATION TERMS

The Secretary of State for Social Services sent my Minister of State a copy of his letter to the Home Secretary dated 15 February confirming his acceptance of the package of terms agreed by officials for a premature retirement scheme in connection with the NHS reorganisation.

The Minister of State is content.

I am copying this letter to the Private Secretaries of the members of H Committee and to Sir Robert Armstrong.

Yours sincerely
Gay Rogers.

G D ROGERS
Assistant Private Secretary

CONFIDENTIAL

Fire Nat Health DSG

25 January 1980

The Prime Minister was grateful for the Home Secretary's report of 24 January about H Committee's discussion of compensation and protection terms for staff affected by NHS reorganisation. She looks forward to hearing the outcome of the resumed discussion in due course.

I am sending a copy of this letter to Martin Vile (Cabinet Office),

M. A. PATTISON

John Chilcot, Esq.,
Home Office.

CONFIDENTIAL GB

CONFIDENTIAL

PRIME MINISTER

An interim report from Mr Whitelaw on the Health Service compensation discussion - you have already seen the minutes.

PRIME MINISTER

NATIONAL HEALTH SERVICE RE-ORGANISATION: COMPENSATION AND PROTECTION TERMS FOR STAFF

You asked me to report on the outcome of the discussion at Home and Social Affairs Committee of the proposal of the Secretaries of State for Social Services and for Wales, for a package of compensation and protection terms for staff affected by the forthcoming reorganisation of the National Health Service.

The Committee postponed taking decisions on the three elements of the package for two weeks, to enable the Minister of State, Civil Service Department, to circulate a memorandum about the future of the Crombie code. It was first introduced in the 1940s and has recently been under examination by an interdepartmental group of officials to see whether the time has come to change or abolish it. We need to reach a general view in the light of their study before deciding whether the code should be reactivated for use in the N.H.S. reorganisation and elsewhere in the public sector.

The Committee also decided that officials of the Departments concerned should be asked to examine in greater detail the other two elements in the package, (a) provision for voluntary early retirement, and (b) the protection of terms and conditions of service for those adversely affected on transfer to a new job; and that they should report to Ministers before our next discussion in Home and Social Affairs Committee.

CONFIDENTIAL

I am copying this minute to the Secretary of State for Social Services, the Secretary of State for Wales, the Minister of State, Civil Service Department, and Sir Robert Armstrong.

24 January 1980

spoke to H.O.
DHSS
Cab.

Home Secretary will minute PM after the discussion
MP 22/1.

PRIME MINISTER

H Committee will tomorrow consider compensation and protection terms for staff affected by the National Health Service reorganisation.

The attached paper from Mr Jenkin and Mr Edwards seems somewhat inadequate. There is no real attempt to quantify the cost of the proposed measures. You may not think expenditure decisions should be on the basis that "the main effect of the package will be on the timing of the planned savings in management costs and the speed at which those savings can be diverted to patient care".

Mr Jenkin is proposing a repeat of the powers available to his predecessor in 1974. He wants to amend the Health Service Bill for this purpose.

I understand that the CSD will be strongly resisting blanket use of these powers. It obviously makes sense to use the Health Service Bill as a vehicle to confer the necessary powers on the Secretaries of State, but a much clearer picture of costs should perhaps be required before Messrs Jenkin and Edwards are allowed to apply those terms.

Would you like Mr Whitelaw to report the outcome of this discussion to you before further action is taken?

MP

Yes please
MS.

21 January 1980

PART 1 ends:-

DHSS to MAP ~~+atts~~ 7.12.79

PART 2 begins:-

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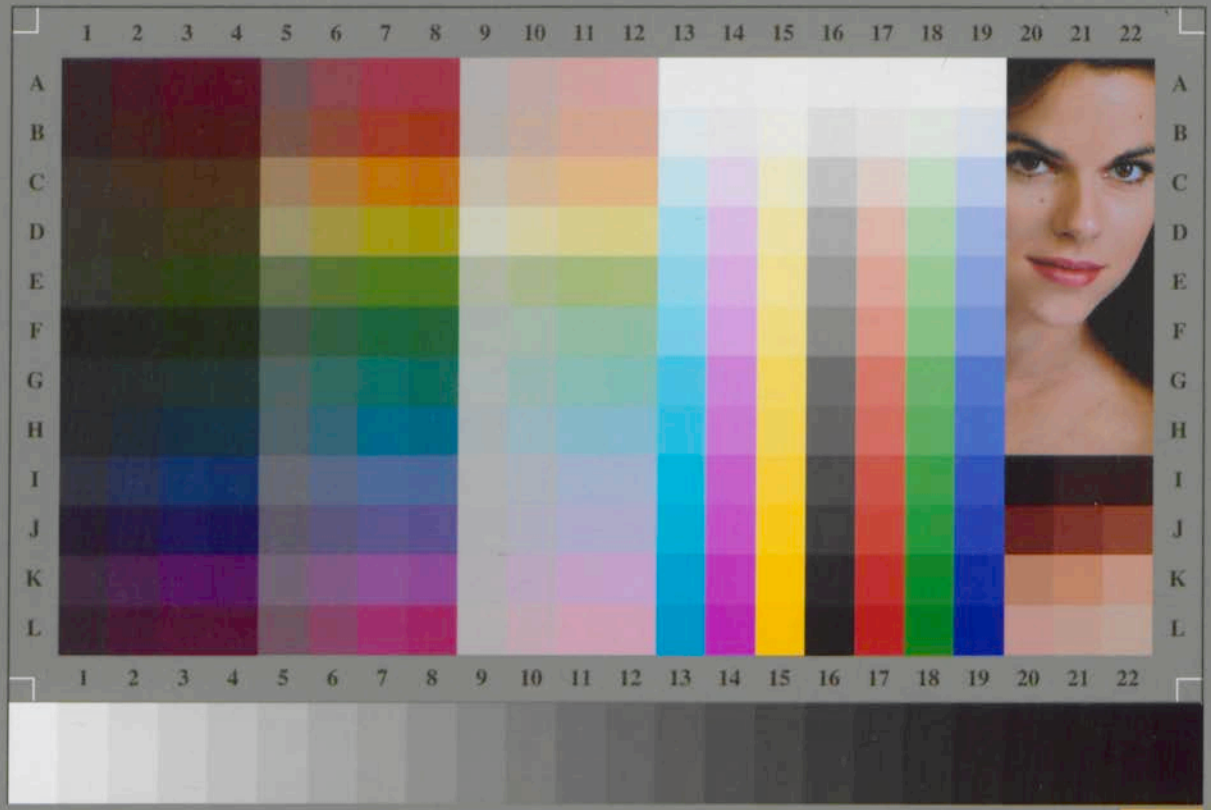

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