PREM 19/1573

PART FOUR

MT

SECRET

CONFIDENTIAL FILING

NHS Expenditure and Efficiency

NATIONAL HEALTH

Pt 1: MAY 1979

Pt 4: SEPTEMBER 1984

PREM 19/1573

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~17.9.84~~							
~~25.9.84~~							
~~8.10.84~~							
~~30.10.84~~							
~~5.11.84~~							
~~8.11.84~~							
~~4.2.85~~							
~~6.2.85~~							
~~12.2.85~~							
~~18.2.85~~							
~~19.2.85~~							
~~21.2.85~~							
~~25.2.85~~							
~~4.3.85~~							
~~8.3.85~~							
~~13.3.85~~							
29.3.85							
ENDS							

PART 4 ends:-

R. Halstead (Beecham) to PM 29.3.85

PART 5 begins:-

FORB to Beecham Group. 1.4.85

Published Papers

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

1. The Health Service in England: Annual Report 1984
   HMSO [ISBN 0 11 321010 8]

2. House of Commons Hansard, 12 February 1985,
   Columns 169-176 "University Hospital of Wales"

3. House of Commons Hansard, 21 February 1985,
   Columns 1223-1233 "Limited List Prescribing"

Signed C Wayland Date 4 March 2014

PREM Records Team

PRIVATE & CONFIDENTIAL

RONALD HALSTEAD, C.B.E.
Chairman and Chief Executive

Beecham
Group p.l.c.
Beecham House Brentford
Middlesex TW8 9BD

RH.PVW

29th March 1985

The Rt. Hon. Margaret Thatcher, M.P.,
Prime Minister,
10 Downing Street, London SW1.

Dear Mrs Thatcher,

Further to my letter of 15th January, I enclose a copy of a letter I have written to Norman Fowler concerning the new target rate of 17% return on capital being imposed on the Pharmaceutical Industry.

I understand that the Limited List proposal will save the DHSS over £75 million and Beecham's share of this is, in fact, over 10%. In addition, the DHSS is proposing a 3% price reduction across all our products in order to reduce our return on capital in line with the reduction to the 17% target base. This new level of 17%, as I said in my letter of 15th January, is ridiculously low even by 1980 standards and with the increasing profitability of industry in general, it is well below the sort of levels which are now commonplace in British industry. Indeed, when the Public Accounts Committee reviewed the DHSS proposals on 19th March, they reversed their previous critical stance of the Pharmaceutical Industry and questioned the Permanent Secretary of the DHSS on the appropriateness of the projected levels and the effect on the Industry.

As I anticipated in my letter of 15th January, the profitability of British industry has thankfully now increased quite substantially since 1980 and I understand that the Review Board for Risk Contracts in the Defence Industry has now been increased from 17% to 20%.

There is a lot of concern in the Pharmaceutical Industry both here and in the USA, and I am sure that our American friends will once again (as in the 1970's) view with suspicion our commitment to industrial profitability and our attitudes to wealth creation. This could well affect their intention to invest in the U.K. as compared with other European countries.

As Chairman of the Industrial Development Advisory Board, I have had discussions with Norman Tebbit and both he and I are anxious to encourage inward investment and a more profitable industrial base in the U.K. We feel that this will be essential for job creation and our future economic viability.

Thank you for inviting me to lunch on 17th May and I look forward to seeing you on that occasion.

With very best wishes.

Yours sincerely,

Ron

P.S. I enclose a copy of an interesting article by Robert Heller on this matter.

MANAGEMENT: ROBERT HELLER

Why Mrs T is guilty of drug abuse

The Thatcher Government believes in market forces more passionately than most marketers — except (as with most marketers) when it dislikes the results. Take the drug industry: as fine and full an example of capitalist competition as you could hope to see. Spurred by the prospect of golden profits, the umpteen likes of Glaxo, Hoffmann-La Roche, ICI, Smith Kline, Beecham, Eli Lilly, etc., etc., strive furiously to be first with winners; weigh in with me-toos when they lose; and at all times bombard their market with messages and massages.

Their only sin, in the Government's eyes, is that they succeed too well. Not that the Inland Revenue agonises over having to collect its take from those abundant profits (Glaxo last year made £252m before tax, £165m after). The rub is that the Government resents its own contribution to that bounty, via the NHS. So it limits the marketing activity (only 9% of turnover on promotion); wants to limit what may be marketed (by restricting the drugs the NHS will buy); and limits the return on capital that companies may earn.

If that's a free market, Margaret Thatcher's a card-carrying Communist. The aim of this bizarrely unfree enterprise is to cut NHS drug costs — though a monopoly buyer who can't beat down the prices of fragmented suppliers must have the negotiating skills of, well, a civil servant. The limits are all pernicious, in practice and theory; but worst of all must be the proposal to restrict drug companies to something, in practice, between 17% and 18% return on capital employed, before tax.

Penalising the most successful is not exactly how supply-side economics are supposed to work. Returns on capital can be boosted in many ways: some virtuous, some vile. But increasing operating efficiency, the very essence of virtuous management, loses its attractions fairly fast if the net result is to force a price cut. Similarly, investment in new plant or new products must be vitiated if the ultimate return hits a ceiling — particularly one as low as 18%. This, note, at a time when one US multinational (not in drugs) won't even look at anything yielding under 45%; and when a British one (in drugs) has 30% as its aim.

That truth begs the question of whether, with returns on capital tethered down, companies will be able to finance new investment in any case. If Mrs T wants to study the results of restricting returns, there's an example far from dear to her heart: British steel. After the war, steel was the only industry subjected to permanent price control on the basis of return on capital. In 1956, the UK produced 20.7 million tons of steel; last year, output was 15.1 million — against 39.4 million for West Germany. British industry got cheap steel, all right, just as the NHS can enforce cheaper drugs. But the long-term result was totally disastrous — and not just for the steelmakers.

RONALD HALSTEAD, C.B.E.
Chairman and Chief Executive

Beecham
Group p.l.c.
Beecham House Brentford
Middlesex TW8 9BD

PRIVATE & CONFIDENTIAL

RH.PVW

29th March 1985

The Rt. Hon. Norman Fowler, M.P.,
Secretary of State for Social Services,
Department of Health & Social Security,
Alexander Fleming House,
Elephant and Castle, London SE1 6BY.

Dear Norman,

I am greatly concerned about the actions taken by your Department in recent times in negotiation with the Pharmaceutical Industry in general and with Beecham Pharmaceuticals in particular. You are well aware of the major contribution that the Industry and Beecham make to the British economy, yet your colleagues persist in taking arbitrary actions which are damaging to the Industry and to the climate for industrial investment in the U.K.

I am particularly concerned at their most recent actions in attempting to depress the profitability of the Pharmaceutical Industry. The target rate of return on capital of 17% which is now being imposed on Beecham Pharmaceuticals and on the Industry, in today's industrial circumstances, has no credibility. Even application of the Review Board for Government Contracts Profit Formula now makes a nonsense of your figure. Not only do your colleagues insist on its adoption, but they also insist on flouting procedure which is specifically laid down in the Pharmaceutical Price Regulation Scheme. You are aware that this is an agreement between your Department and the Industry, and yet your colleagues have chosen to virtually ignore its provisions.

The precipitous action which is now being taken to immediately reduce prices, backed with threats of laying orders in Parliament, is provocative and reminiscent of the actions of the Labour Government of the 1970's which did so much to undermine British industry. These actions were a prime cause of our industrial decline and British industry is only just starting to recover following the courageous action of the Prime Minister and Sir Geoffrey Howe in eliminating price, wage, dividend, and exchange controls after the election victory in 1979.

At the Annual Meeting of the Centre for Policy Studies on 4th March, Mrs. Thatcher and I both spoke about this period and on the importance of investing in our wealth creating industries. Indeed, she gave the following quote from her visit to the USA:

cont...

"Secondly, they said, Have you looked at the amount you are spending on the welfare state in Europe? Do you not think that you might be spending on the welfare state money which really should go to investing in industry and to job creation? You cannot have it all ways."

The various actions of your Department, if not corrected, will have a profound long-term effect on the Industry and therefore on the British economy. Already the bad faith and lack of confidence engendered has done immense damage to inward investment and has caused Beecham Pharmaceuticals to review its investment plans in this country. In recent years, Beecham Pharmaceuticals have invested over £110 million in this country and we are currently considering a major project costing over £40 million for Irvine in Scotland. This project will result in exports mainly to the U.S.A. of over £60 million per year. Following your actions, commercial judgment would indicate that the project should be transferred outside this country. However, I am concerned about the future of pharmaceuticals and our industrial base in this country and also for the provision of employment. The Irvine project will provide about 150 new long-term jobs and in the short term employ some 500 for the next two years. I am, therefore, sanctioning that this project will continue in Scotland, but my Board has resolved that unless a more favourable climate ensues, this will be the last major pharmaceutical investment Beecham will make in this country.

Your Minister is now demanding an immediate 3% price reduction from Beecham Pharmaceuticals. This is, of course, in addition to a loss of close to £8 million to Beecham arising from the imposed Limited Lists. I have been persuaded to accept this price reduction with great reluctance and misgiving, only because I do not wish to undermine discussion which must take place between Government and the Industry if a viable Industry is to survive and prosper. This is particularly demanding on Beecham as James Diamond, one of my Beecham colleagues, will be leading for the Industry. However, when the target return on capital is corrected, which cannot and must not be delayed, the Industry will certainly insist that the same procedure and its immediacy be adopted to increase prices.

The 3% price reduction will be implemented on 1st May. Because of the turbulence in the market-place predicted for next year, annual sales levels at 1st April 1985 will be utilised in arriving at the new prices.

I would welcome a discussion with you on these matters before too long and in the meantime I have sent copies of this letter to the Prime Minister and Norman Tebbit because of their interest.

With best wishes.

Yours Sincerely,

Ron

P.S. I enclose a copy of the speeches made at the Annual Meeting of the Centre for Policy Studies in case you haven't seen them.

JA

PCO

Spoke to SHFH & agreed his suggested course, explaining that the point to get across to the US Cos was the policy had been decided. It was important not to encourage them to think changes/substance could now be made.
MLH 14/3

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

Mark Addison Esq
Private Secretary
10 Downing Street

13 March 1985

Dear Mark,

You will wish to be aware of the request from the US Pharmaceutical Manufacturers Association that the Prime Minister should receive a deputation.

The background is as set out in the attached copy telegram. Briefly, the American companies feel that their extensive investments in the UK pharmaceutical industry have been ill-rewarded by the recent measures to limit the range of drugs prescribable under the NHS and the reduction in the profit earned on those which remain prescribable. Our Secretary of State and Mr Clarke received a deputation from the PMA in January, when their concerns, including the impact of these actions on inward investment, were discussed at length. Separately, Mr Clarke has seen representatives of several of the companies in membership with the PMA. All in all, therefore, the Association's members have had ample opportunity to express their misgivings and to suggest alternative policies and there was not thought to be a case for recommending that the Prime Minister should receive a deputation.

Action has therefore been taken along the lines of the recommendation in the final paragraph of the telegram.

I am copying this to Peter Ricketts (FCO).

Yours sincerely,

Stephen

S H F HICKEY
Private Secretary

Enc

GR 370

RESTRICTED

DISTRIBUTION SELECTORS
FILE COPY

RESTRICTED
FM WASHINGTON 280008Z FEB 85
TO PRIORITY F C O
TELEGRAM NUMBER 708 OF 27 FEBRUARY
INFO BTDO NEW YORK.

REQUEST FROM U.S. PHARMACEUTICAL MANUFACTURERS ASSOCIATION FOR A CALL ON THE PRIME MINISTER

1. THE PRESIDENT OF THE U.S. PHARMACEUTICAL MANUFACTURERS ASSOCIATION HAS WRITTEN TO ME ASKING IF A MEETING COULD BE ARRANGED BETWEEN THE PRIME MINISTER AND REPRESENTATIVE CHIEF EXECUTIVE OFFICERS OF MEMBER COMPANIES WITH INVESTMENTS IN BRITAIN (COPY OF LETTER FOLLOWS BY BAG). HE EXPRESSES CONCERN ABOUT RECENT D.H.S.S. ACTIONS - INCLUDING CHANGES IN THE USE OF GENERIC DRUGS BY THE NATIONAL HEALTH SERVICE, AND IN THE PHARMACEUTICAL PRICE REIMBURSEMENT SCHEME -- WHICH HE CLAIMS HAVE DIMINISHED HIS MEMBERS' CONFIDENCE IN BRITAIN AS A STABLE ENVIRONMENT FOR INVESTMENT. HE REFERS TO A MEETING WITH THE SECRETARY OF STATE FOR HEALTH AND SOCIAL SECURITY ON 15 JANUARY. THE ASSOCIATION HAVE (UNSPECIFIED) ALTERNATIVE IDEAS FOR SAVINGS WHICH THEY WOULD LIKE TO DISCUSS WITH THE PRIME MINISTER.

2. THE ASSOCIATION NUMBERS ALL THE MAJOR U.S. DRUG COMPANIES AMONG ITS MEMBERS. THEY HAVE TOLD US THAT IF THE PRIME MINISTER WERE TO AGREE TO RECEIVE THEM THEY WOULD PLAN TO SEND 3 OR 4 OF THE CHIEF EXECUTIVE OFFICERS OF MEMBER COMPANIES WITH MAJOR INVESTMENTS IN BRITAIN TO LONDON FOR THE MEETING. AFTER THE 15 JANUARY MEETING THEY HAD ASKED THE U.S. AMBASSADOR IN LONDON TO TRY TO ARRANGE A MEETING WITH THE PRIME MINISTER, BUT HE HAD TRIED TO POINT THEM IN THE DIRECTION OF OTHER MINISTERS.

COMMENT.

3. I WOULD NOT WISH TO ARGUE THAT THE THREAT TO OUR INWARD INVESTMENT INTERESTS OUTWEIGHTS THE NEED FOR ECONOMY IN THE NATIONAL HEALTH SERVICE. SO FAR AS WE ARE AWARE, THERE ARE NO INDICATIONS THAT CONCERN AMONG U.S. PHARMACEUTICAL MANUFACTURERS HAS SPREAD TO OTHER SECTORS, NOR DO THE PHARMACEUTICAL MANUFACTURERS THEMSELVES APPEAR TO BE RECONSIDERING EXISTING INVESTMENTS. NONETHELESS U.S. PHARMACEUTICAL COMPANIES ARE VERY IMPORTANT INVESTORS IN THE U.K., AND THEIR CONCERN IS CLEARLY GENUINE.

RESTRICTED

I RECOMMENDATION

RECOMMENDATION.

4. SINCE MR MOSSINGHOFF'S LETTER REFERS TO ALTERNATIVE FORMS OF SAVING, YOU MAY WISH ME TO REPLY THAT THE PRIME MINISTER FOUND THAT IDEA INTERESTING (ASSUMING SHE DOES), BUT WOULD WISH MR MOSSINGHOFF TO DISCUSS THESE IDEAS ~~ALSO~~ FIRST WITH MR FOWLER. DEPENDING ON THE OUTCOME, SHE WOULD CONSIDER MEETING THE DELEGATION.

WRIGHT

LIMITED

NAD
TRED
PROTOCOL D
NEWS D
PS
PS/LADY YOUNG
PS/PUS
SIR W HARDING
MR DAVID THOMAS

cc to:

MR. T. R. LONG.
DHSS. Rm 110 Russell Square

Mr. G. AUSTIN
IBB. D11. Rm 215
Kingsgate House
Vic St.

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

Andrew Turnbull Esq
Private Secretary
10 Downing Street

8 March 1985

Prime Minister:

This will be the issue of the early part of next week at least

Dear Andrew

HEALTH CHARGES

I attach a draft of the statement my Secretary of State will be making on Monday. The statement will cover private patient charges as well as prescription and dental charges. I also enclose a note on key facts.

I shall circulate a fuller briefing note as soon as possible.

Copies go to Janet Lewis-Jones (Lord President's office), Charles Marshall (Lord Privy Seal's office), Murdo MacLean (Chief Whip's office), Richard Broadbent (Chief Secretary's office), John Graham (Scottish Office), Colin Jones (Welsh Office) and Graham Sandiford (Northern Ireland Office).

Yours

Steve

S A Godber
Private Secretary

CONFIDENTIAL

DRAFT STATEMENT ON NHS CHARGES

With permission, Mr Speaker, I will make a statement on charges to be applied within the health service in the coming year.

The Government's detailed plans for spending in the coming year, published in January in the Public Expenditure White Paper, show that health service spending will rise to over £14½ billion next year, an increase of £670 million over this year. The great bulk of that extra spending will be paid for from public expenditure. But, as the plans made clear, the Government believes that there should be some increase in the proportion contributed by direct charges.

In the field of prescription charges, we are seeking an extra £20 million of income to help offset the increase in the drugs bill. At present some 72 per cent of prescriptions are dispensed free of charge and a further 6 per cent are covered by prepayment certificates. The elderly, those on low incomes, children, expectant and nursing mothers and people suffering from certain conditions do not pay any charges.

It has been suggested recently that we should narrow the range of exemptions rather than seeking other ways of reducing the drugs bill. But we believe it is right to protect those in need from the impact of charges and we do not, therefore, intend to make any change in the categories which are exempt from prescription charges. We have decided, however, that it is necessary to raise the basic prescription charge to £2. Even so, the charge will cover only some two-fifths of the cost of the average prescription.

There will also be equivalent increases in the cost of the prepayment certificates which can be purchased by those who require continuing and frequent medication. We have, however, decided to ease one aspect of the season ticket arrangements. In future, if a prepayment certificate is purchased by somebody who, within the next month becomes exempt, they will be able to receive a refund. This change will prevent some hard cases on which hon Members have made representations to me. I hope it will also, together with advertising which I intend to undertake, encourage more people to make use of the prepayment certificate facility.

In the field of dental treatment, the charges for specific treatments - crowns, inlays, bridges and dentures - will increase by 6 - 10 per cent. The maximum charge for any single course of treatment will increase by just 4½ per cent to £115. We have decided, however, to change the structure of charges for routine treatment such as fillings and extractions. At present patients pay the full cost of routine treatment up to a maximum of £14.50 but nothing thereafter. The effect of this can be that the greatest subsidy is given to people who neglect their teeth and seek treatment only when they need extensive intervention. We have therefore decided to relate the charge more closely to the cost of treatment. In future, patients will pay the full cost of routine treatment up to a maximum of £17 but they will also pay 40 per cent of any cost above that level. This new system will come into effect from 1 April.

The existing range of exemptions - for children, those on low incomes and expectant and nursing mothers - will continue. These exemptions account for some 45 per cent of all chargeable courses of treatment. Dental examinations will continue to be free of charge for all.

In the hospital service, the charges for private patients and overseas visitors will be increased by an average of just over 14 per cent although there will be variations for different types of charge and hospital. The increases are intended to ensure that the charges meet the full cost including all overheads some of which have not been fully allowed for in the past.

I am today laying the necessary Regulations before the House to implement all these changes which will come into effect on 1 April. A note providing full details of the changes is available for hon Members in the Vote Office.

Mr Speaker, the effect of the changes I have announced today will be to provide an additional £60 million of income towards the extra £670 million of health service spending we are planning for next year.

The result will be that the health service remains predominantly funded by general taxation - which accounts for some 85 per cent of expenditure. A further 10 per cent is derived from National Insurance contributions. Even after the changes I have announced, patient charges will account for only some 10.7 per cent of the cost of the family practitioner services. Charge income for the NHS as a whole will account for only some 3½ per cent of total spending. That is considerably less than the figure of 5 per cent which applied some twenty years ago.

It is, in my view, a reasonable contribution to seek from those who are using the services concerned, particularly as those in greatest need receive all treatment free of any charge.

NHS CHARGES : KEY POINTS

GENERAL

3.2% of total NHS cost in line with earlier years.

10.7% of FPS cost financed by charges - about the same as in 1973-74 and the plan for 1984-85.

Income England £460m out of £14½ billion NHS cost.

Contribution to extra spending

£39m after deduction of GOS income
[Increase £74m less £35m GOS = £39m]

Real terms increase £58m, price £16m
£600m extra spend on NHS, £100m on FPS

PRESCRIPTIONS

Charges Increase to £2 (£1.60) - 25%
Season ticket 4 month £11 (£8.50)
12 month £30.50 (£24)
Additional income £19m on top of £124m

Exemptions - 72% prescriptions free
No change 6% season ticket

- Pensioners
- Children
- Expectant & nursing mothers
- SB FIS low income.

Drug costs

- 2/5 ths of cost of average prescription covered by charges.
- Average cost per prescription static [indexing charge of £1.60 by RPI gives £1.70]

Season ticket Refunds now if holder exempt or dies in 1st month

Numbers dispensed (excluding dispensing doctors)

1979 - 305m
1983 - 315m
1984 - 320 (est)

PRIVATE PATIENTS

Changes 14% overall increase
total contribution £62m (£55m)

Defensive increase to recover full capital and admin. cost (+ 7½%) and increased costs of 6½%.

OVERSEAS VISITORS

Increases in line with private patients, estimated income £2¼m (£2m)

DENTAL - about 30 million courses of treatment costing £708m 1985-86.

Charges

Additional income in full year £49m (£35m in real terms) on top of £172m. Income 31.2% of cost.

Routine treatment : 100% charge up to £17 (£14.50) plus 40% of cost over £17 (new)

Crowns & dentures : £26 (£24) to £98 (£92)

Maximum charge : £115 (£110)

Average charge £18.30, increase of 23%

No charge for (no change)

- Check ups
- Children and those at school up to age 19
- Expectant and nursing mothers
- SB FIS Free milk/vitamins

HELP for those on low income (no change)

Defensive

Increase necessary to contain costs of services
Old system unfair on regular attenders
Taxpayer still meets nearly 70% of cost
46% of chargeable treatment given free
Those who pay pay on average some 60% of cost
Only 0.3% pay the maximum charge.

OPTICAL SERVICES

Changes 1984 Act; Low income & children remain eligible for subsidised glasses;

concession for poorly sighted to have GOS glasses at economic cost.

Opticians allowed to advertise.

Defensive

Free sight test available to all

Opticians must give prescription to patients who may 'shop around'.

Children's glasses must be dispensed by registered opticians

Freeing dispensing and introducing advertising increases choice and reduces cost of glasses.

PLE SH

cc: D. Wolfe

10 DOWNING STREET

From the Private Secretary

4 March, 1985

NHS SUPERVISORY BOARD FOR SCOTLAND

The Prime Minister has seen your Secretary of State's letter of 25 January to the Secretary of State for Social Services. While she is content with what is proposed, she has noted that the Health Services Policy Board in Scotland will be made up entirely of Ministers and civil servants. She has suggested that the Secretary of State might consider how to bring in management resources from the private sector.

I am copying this letter to Steve Godber (Department of Health and Social Security), Colin Jones (Welsh Office), Neil Ward (Northern Ireland Office), Richard Broadbent (Chief Secretary's Office) and to Richard Hatfield (Cabinet Office).

ANDREW TURNBULL

Edward Gowans, Esq.,
Scottish Office

CC MASTER

Pte
S/3abz

10 DOWNING STREET

From the Private Secretary

4 March 1985

Dear Sarah,

Mr Michael Morris MP came to see the Prime Minister today about the limited list of NHS drugs. Your Minister was also present.

Mr Morris said that he believed that the announcement by the Secretary of State for Social Services of the NHS limited list would cause considerable difficulties for the pharmaceutical industry, for the British Medical Association, and for patients. It was a radical departure from previous practice which had been introduced without adequate consultation. He recognised the need to reduce public expenditure on the NHS drugs bill but did not accept that this was the only way of achieving that objective. It was undesirable in itself since it would limit GPs clinical freedom; limit the availability to patients of drugs which they might need; and create uncertainty in the pharmaceutical industry which required confidence to undertake its massive research programme. Moreover, there were alternative and better ways to save money including such possibilities as encouraging pre-packed dispensing packets containing a fixed number of doses and encouraging GPs to reduce prescriptions. Indeed, DHSS would have been better advised to go to the industry with a proposal for a fixed percentage off prices than to adopt the limited list.

Mr Morris recognised however, that the decision on limited list had been taken and in this context proposed a number of measures to reduce what he saw as its deleterious impact. These were: the list should be implemented over a transitional period of eight weeks; there should be a "fall-back" mechanism for GPs along the lines of that for hospitals to enable branded drugs to be prescribed in special cases; the DHSS should talk to the BMA about "good prescribing practice" along the lines proposed in the Greenfield Report; DHSS should give guidance to the pharmaceutical companies on the application of the limited list principle to the compounds currently being researched; DHSS should confirm that there was to be no extension of the limited list into other categories of drug; and most important the pharmaceutical industry should be given a degree of confidence by adopting the American practice of enabling any patent to run from the day a drug was licenced.

Responding to Mr Morris's points the Prime Minister

said that with a drugs bill of £2 billion including the costs of dispensing prescriptions, DHSS Ministers were right in her view to take action. She found it difficult to believe that substantial savings could not be made by adopting better prescribing practice and in the absence of any evidence that the medical profession was prepared to do this itself there was a very strong case for a limited list with the appropriate safeguards. She recognised however the need for the pharmaceutical industry to retain a degree of certainty and in this context she was very sympathetic to the points made by Mr Morris about patent life. The Government took the protection of intellectual property extremely seriously and indeed this very point had been raised with her some time previously with her by Glaxo. Mr Morris could therefore be assured that this point was very much under consideration.

In view of the reference to intellectual property I am copying this letter to Andrew Lansley (DTI).

Yours ever,

Tim Flesher

Miss Sarah Bateman
Department of Health and Social Security

E.R.

Prime Minister,
Agree Policy Unit Comments?

Duty Clerk
pp AT 1/3.

Yes

MR TURNBULL

1 March 1985

NHS SUPERVISORY BOARD FOR SCOTLAND

George Younger wants to set up a Health Service Policy Board under John Mackay to strengthen Health Service management in Scotland. Unlike the formula which Roy Griffiths devised for England, there is no distinction between political supervision and executive management. But given the narrower Scottish scene, there is probably no point in trying, elaborately, to make such a distinction.

He envisages a Board consisting of politicians and Health Service bureaucrats. It is worth urging him to consider bringing in fresh blood from the private sector.

I recommend that the Prime Minister agrees to George Younger's proposal but suggest he considers looking to the private sector to strengthen the Board's managerial teeth.

David Willetts

DAVID WILLETTS

AR

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
ALEXANDER FLEMING HOUSE
ELEPHANT AND CASTLE LONDON SE1 6BY
TELEPHONE 01-407 5522 EXT

From the Minister for Health

David Barclay Esq
Private Secretary
10 Downing Street
LONDON SW1

Mr Fletcher

29.2.88

Dear David

MEETING ON LIMITED LIST

Please find enclosed a brief for the Prime Minister for her meeting with Michael Morris MP and Michael Latham MP, to discuss the Limited List. I understand that the meeting is now to be held on 4 March.

Sarah Bateman

SARAH BATEMAN
Private Secretary

LIMITING THE RANGE OF DRUGS AVAILABLE UNDER THE NHS - BRIEFING NOTE

What medicines will be affected by the list?

1. The medicines affected by the proposals fall into 2 main categories. First, there are the so-called "home remedies". These are for the treatment of minor ailments (cough and cold remedies, tonics, laxatives, analgesics, antacids and vitamins) and most of them are available over the counter at chemist shops. Secondly, there are the benxodiazepine tranquillisers and sedatives. A great deal of money can be saved in this area by not using the more expensive "brand named" products when suitable cheaper alternatives areavailable. A range of fully effective drugs will remain available under the NHS to meet all clinical needs. All drugs in other categories will continue to be prescribable at NHS expense. The limited list will affect less than 10% of drugs.

Why have a limited list?

2. Because

- the NHS drugs bill has increased ten-fold in the last fifteen years, a real increase of 5% a year;

- value for money in drug prescribing is just as important as elsewhere in the health service;

- no other country allows every drug to be prescribed at public expense under its health service;

- it saves public money while ensuring that all patients can get all necessary drugs.

How big is the drugs bill?

3. If the costs of dispensing prescriptions are included, the total cost is around £2000m a year for the UK.

Consultation

4. A provisional list was published for consultation on 8 November 1984. Comments were invited from all interested parties, to be received by 31 January.

More than 9,000 letters were received; and meetings were held with a number of organisations. In addition, the Chief Medical Officer set up a group of pharmaceutical experts. Taking account of all the representations, the Chief Medical Officer's advisers put forward a list of drugs, in the therapeutic categories affected, which they considered would meet all clinical needs at the lowest possible cost. The Secretary of State for Social Services has accepted this independent advice in full.

Implementation

5. The Secretary of State announced the final form of the limited list proposals on Thursday 21 February. The limited list will be implemented by amending the NHS (General Medical and Pharmaceutical Services) Regulations 1974, so that the prescribing and dispensing of "blacklisted" drugs (some 1,750 products) will not be permitted by general practitioners and retail pharmacists (to come into effect on 1 April). The amending regulations will be laid before Parliament in early March. They will be subject to negative resolution; it is anticipated that there will be a half-day debate on them in mid-March.

Details of the limited list proposals

6. Although GPs will not be able to issue NHS prescriptions for any "blacklisted" drugs, they will be able to issue a non-NHS prescription to NHS patients for "blacklisted" drugs to be used in the course of NHS treatment, if their patients wish it. They will not be able to charge a fee for such a prescription. But there should be no clinical need for any patient to buy medicines privately.

7. GPs will not be allowed to sell "blacklisted" drugs, except dispensing doctors who may supply them on a non-NHS prescription to their dispensing patients.

8. The amending regulations will provide the scope for certain drugs to be provided for certain types of patients. Currently, there is only one drug in this category - Clobazam for the treatment of epilepsy. Ministers were advised that Clobazam was necessary for the treatment of epilepsy, but not for its primary use as a tranquilliser. To have made Clobazam generally available would have cost many millions of pounds a year.

9. Health authorities are to be asked to bring hospital prescribing policy into line with the limited list proposals.

10. Dentists will not be covered by the amending regulations. The Secretary of State will amend the Dental Practitioners' Formulary (which contains the only drugs dentists may prescribe) with effect from 1 April.

11. There are some branded drugs on the list because the advice received was that in some cases there was no suitable generic drug available. It is hoped that generic equivalents will soon become available.

Savings from the limited list

12. Because the list will contain some relatively expensive branded products to start with, it will take a year or two for the savings initially estimated (£100m) to build up. As generic alternatives to these branded products become available they will replace them on the list and further savings will be made. The initial savings will be about £75m a year (UK).

Effect on the pharmaceutical industry

13. The UK will remain attractive to the pharmaceutical industry, in terms of both a site for research and production, and a market for drugs. Most other advanced countries are also trying to reduce their drugs bill. This country retains several advantages so far as inward investment is concerned, such as its excellent research and development base, sound economy, stable political environment and links with Europe and the Commonwealth.

Maintaining the list

14. The Health Departments will be setting up a professional committee to advise on a continuing basis on the contents of the list. This committee will be asked to consider whether new drugs coming on to the market fall within the scope of the limited list and if so whether they should be available at NHS expense (ie if a drug is essential to satisfy an unmet clinical need or if it satisfies a need more cheaply than anything on the existing list). It will also review the existing list on a regular basis to help ensure that it continues to give the best possible value for money.

Generic subsitution (Greenfield) - a more acceptable alternative?

15. No. The BMA is pushing generic substitution as something it would support and that could save far more than a limited list. In fact the BMA rejected the Greenfield Report's recommendation and put forward a much weaker and entirely

voluntary scheme as a basis for further discussions. There were so many conditions attached to this offer - which was only for more talks - that it was not worth pursuing. Compulsory generic substitution across the board could only save about £29m a year (England), since most drugs do not have generic equivalents. A voluntary scheme in the less important categories of drugs covered by the limited list proposals would be unlikely to save more than a few million pounds a year. Doctors are encouraged to prescribe generically now, but this has not curbed the growth of the drugs bill.

Michael Morris MP

16. Marketing Manager for Reckitt and Colman Group 1960-64. For the last 12 months, has been a consultant to Upjohn Ltd; has brought representatives of that company to see the Minister for Health on 2 occasions - first to seek assurances that it would be worthwhile to the company to set up a new R&D unit in the UK and secondly on the limited list proposals. Both Reckitt and Colman and Upjohn will be hit by the limited list, but neither will be hit as badly as it initially expected. Member of the PAC. Married to a GP. Has asked many PQs on the limited list.

Michael Latham MP

17. Member of the PAC. Does not seem to have a particular pharmaceutical interest, although has asked 19 PQs on the limited list and has recently written to health Ministers about the effect on small companies of the sales promotion allowance for the Pharmaceutical Price Regulation Scheme.

Annexes:

A - Statement of 21 Feb

B - White List

C - Black List

STATEMENT ON THE LIMITED LIST OF NHS DRUGS. THURSDAY 21 FEBRUARY 1985

(A)

With permission, Mr Speaker, I will make a Statement on the limited list of NHS drugs.

I told the House on 8 November that the Government intended to introduce a system under which a selected range of drugs would be available on the National Health Service in seven categories. These were:

- antacids;
- laxatives;
- analgesics for mild to moderate pain;
- cough and cold remedies;
- bitters and tonics;
- vitamins; and
- tranquillisers and sedatives.

I published at that time a provisional list of medicines which might be selected within each category. This was the basis for consultation which continued until the end of January. We made clear from the outset that our intention was to produce a list from which doctors would still be able to meet all the clinical needs of their patients. The Chief Medical Officers of the health departments wrote to all doctors individually to seek their views on the list. I am grateful to all the many doctors who responded and I hope they will recognise that their views have been taken into account. My Chief Medical Officer also brought together a group of independent experts practising in the relevant medical specialties, including three general practitioners and a pharmacist to assist him. That group has now unanimously recommended a list of medicines which they believe will meet all clinical needs. I have accepted their advice in full and I am most grateful for their help in this important task.

This extended list of medicines will contain some 100 different medicines, compared with 30 on the provisional list. Most of the medicines will be generic, or unbranded, products; but a number of proprietary medicines will be retained where the group concluded that they were necessary and where no generic preparation currently exists. I should emphasise that the quality of all the selected drugs is assured. They all conform to the very high standards we require of all medicines under the Medicines Act.

For the purposes of the Regulations which my rt hon Friend, the Secretary of State for Scotland, and I will introduce, it is necessary to list all the products which will no longer be prescribable on the National Health Service. The Regulations will also cover those products which the Advisory Committee on Borderline Substances have advised are not medicines and should not be prescribed by general practitioners. I am today publishing both the selected list of drugs and those no longer to be prescribable. Copies are available in the Vote Office.

I shall also today be giving the representatives of the medical and pharmaceutical professions the opportunity to comment on these Regulations as they affect the terms of their contracts with the health service.

Mr Speaker, I should like to mention three specific issues concerning the operation of the limited list which have been raised during the period of consultation.

The first is the question of the arrangements for reviewing the list itself. This was raised by, amongst others, the Royal College of Physicians. We fully accept that it is essential for independent professional advice to be available after April 1st on the need for changes to the list. I do not believe that complex machinery is required but I shall be very ready to discuss with the professional bodies concerned how the arrangements which have been used to formulate the extended list should be developed for the future.

Second, questions have been raised about the implications of the new arrangements for dispensing doctors - that is doctors predominantly in rural areas who themselves dispense drugs to their patients. For these doctors the Regulations will in effect retain the status quo. Dispensing doctors will still be able to supply any medicine to those of their patients for whom they already dispense although they will have to issue private prescriptions for medicines which are no longer available on the National Health Service. Concern has also been expressed about the position of retail pharmacists who now hold stocks of drugs which will no longer be available on the National Health Service. I am quite prepared to examine any relevant evidence that pharmacists may present on their stockholding of drugs.

Third, the question has been raised whether there should be some form of appeal mechanism for individual cases in which a doctor believes it is necessary to prescribe on the National Health Service a medicine which will no longer be available. Most concern was expressed by doctors who felt that there were serious omissions in the provisional list. My unanimous medical advice is that the selected list is now comprehensive and will make it unnecessary on clinical grounds for patients to use medicines not on the list. Nevertheless, let me say this: if, after examining the complete list and in the light of experience, the medical representative organisations still wish to propose that such a mechanism should be provided, my rt hon Friend and I will be ready to discuss it with them. I should make clear, however, that any mechanism would need to be very carefully controlled to ensure that it could only be used in genuinely exceptional circumstances.

Mr Speaker, during the period of consultation a number of alternative proposals have been advanced. Yet none of these offered the same prospect of achieving sensible savings in the NHS drugs bill without either harming the interests of patients or threatening the fundamental and legitimate interests of the pharmaceutical industry. The selected list which I am publishing today is likely to produce savings in the drugs bill of some £75 million now, rising to a higher figure in due course. I am therefore convinced that the approach we have adopted remains the right one in principle. I also believe that the selected list which I am publishing today will demonstrate that in practice the health service will continue to provide all medicines required to meet the clinical needs of patients. It is by making sensible savings of this kind that we are able to provide the health authorities with the increased resources which I have announced recently.

(B)

LIMITED LIST

OF

MEDICINAL PRODUCTS

IN CERTAIN CATEGORIES

AVAILABLE IN THE NHS

AFTER 1 APRIL 1985

GUIDANCE TO PRESCRIBERS AND PHARMACISTS

A definitive list of all medicines excluded from NHS prescription is provided separately, and this guidance should be read in conjunction with it.

NOTES

The restrictions on prescribing and dispensing at public expense which come into effect on 1 April 1985 are limited to the following therapeutic groups

Antacids
Laxatives
Analgesics used for mild or moderate pain
Cough and Cold remedies including

- Cough suppressants
- Expectorants, demulcents and compound preparations
- Mucolytics
- Inhalations
- Systemic and Topical Nasal Decongestants

Bitters and Tonics
Vitamins
Benzodiazepine Tranquillisers and Sedatives

This guidance sets out a list of names of preparations which continue to be available for prescription in each category.

Attention is drawn to the following additional points:-

1. Prescriptions should be written by the title used in this guidance note

2. Guidance is also given about medicines with overlapping actions or medicines in the same category but with different indications (eg benzodiazepines used in anaesthetics or for epilepsy)

3. In instances where a non-proprietary preparation is not at present available to fill a clinical need but a generic title is included in the list, prescribers should use this generic title. Pharmacists may supply an appropriate proprietary product until a non-proprietary preparation becomes available. Proprietary preparations are indicated in block capitals.

ANTACIDS

ALU-CAP(1)

Aluminium Hydroxide Tablets BP

Aluminium Hydroxide Mixture BP

GASTROCOTE TABLETS

GAVISCON INFANT

GAVISCON LIQUID

GAVISCON TABLETS

GELUSIL SUSPENSION

MAALOX SUSPENSION

Magnesium Hydroxide Mixture BP

Magnesium Trisilicate BP

Magnesium Trisilicate Tablets, Compound BP

Magnesium Trisilicate Mixture BP

MUCOGEL SUSPENSION

MUCAINE

TOPAL TABLETS

NOTES (1) The main use of ALU-CAP is for hyperphosphataemia in renal failure

(2) The following preparations which have been used as antacids and have other indications remain available:-

Calcium Carbonate Mixture, Compound, Paediatric BPC
Chalk Mixture, Paediatric BP
Sodium Bicarbonate Mixture, Paediatric BPC
Sodium Bicarbonate Tablets, Compound BP

LAXATIVES

Bulk Laxatives:

CELEVAC TABLETS
CELLUCON TABLETS
FYBOGEL
FYBOGEL ORANGE
ISOGEL
METAMUCIL
NORMACOL SPECIAL
REGULAN
VI-SIBLIN

Stimulant Laxatives:

Bisacodyl Tablets BP 5 mg
DORBANEX CAPSULES, LIQUID AND LIQUID FORTE
NORMAX
SENOKOT GRANULES
SENOKOT SYRUP
Senna Tablets BP

Faecal Softeners:

DIOCTYL PAEDIATRIC SYRUP
DIOCTYL SYRUP
DIOCTYL TABLETS

Osmotic Laxatives:

Lactulose Solution BP
Magnesium Sulphate BP
Magnesium Sulphate Mixture BP

Suppositories:

Bisacodyl Suppositories BP (all strengths)
Glycerol Suppositories BP (all sizes)

NOTES (1) All enemas remain prescribable.

(2) PICOLAX and X-PREP LIQUID remain available for bowel clearance before investigation or surgery.

ANALGESICS
For Mild to Moderate Pain

Aspirin Tablets BP (all strengths)
Aspirin Tablets, Dispersible BP
Aspirin Tablets, Dispersible, Paediatric BP
Aspirin and Codeine Tablets, Dispersible BP
CALPOL INFANT SUSPENSION
Codeine and Paracetamol Tablets (see note 1 below)
Codeine Phosphate Syrup BP
Codeine Phosphate Tablets BP (all strengths)
Dextropropoxyphene Capsules BP
Dextropropoxyphene and Paracetamol Tablets (see note 2 below)
Dihydrocodeine Elixir 10 mg in 5 ml
Dihydrocodeine Injection BP
Dihydrocodeine Tablets BP
Dihyrocodeine and Paracetamol Tablets (see note 3 below)
FEBRILIX ELIXIR
PALDESIC ELIXIR
Paracetamol Elixir, Paediatric BP
Paracetamol Tablets BP (all strengths)
PANADOL ELIXIR
PANALEVE ELIXIR
Pentazocine Lactate Injection BP
Pentazocine Suppositories 50 mg
Pentazocine Tablets BP
SALZONE SYRUP

NOTES:

1. Formula for Codeine and Paracetamol Tablets as in the Dental Practitioners' Formulary. (Codeine Phosphate 8 mg, paracetamol 500 mg).

2. Dextropropoxyphene and Paracetamol Tablets contain Dextropropoxyphene hydrochloride 32.5 mg and paracetamol 325 mg.

3. Formula for Dihydrocodeine and Paracetamol Tablets as in Dental Practitioners' Formulary (Dihydrocodeine tartrate 10 mg and paracetamol 500 mg).

4. The following remain available for use as previously:-

   a. Aspirin preparations specifically formulated and indicated for use in Rheumatic Disease

      Aloxiprin Tablets BP
      Benorylate Mixture BP
      Benorylate Tablets BP
      CAPRIN
      NU-SEALS ASPIRIN 300 mg and 600 mg
      TRILISATE

   b. Analgesic compounds specifically formulated and indicated for use in migraine

      MIDRID
      MIGRAVESS
      MIGRAVESS FORTE
      MIGRALEVE (Pink and Yellow)
      PARAMAX

   c. All non-steroidal anti-inflamatory preparations indicated for use in rheumatic disease. (NB non-steroidal anti-inflammatory preparations licensed only as minor analgesics will not be available, if in doubt please check with the definitive schedule of drugs not available.)

COUGH AND COLD REMEDIES

Cough Suppressants:

Codeine Linctus BP
Codeine Linctus, Diabetic BPC
Codeine Linctus, Paediatric BPC
Pholcodine Linctus BP
Pholcodine Linctus, Strong BP
PHOLCOMED DIABETIC LINCTUS
PAVACOL-D

Expectorants, Demulcents and Compound Preparations:

Ammonium Chloride Mixture BP
Simple Linctus BP
Simple Linctus, Paediatric BP

Systemic Nasal Decongestants:

SUDAFED ELIXIR
SUDAFED TABLETS

Inhalations:

Benzoin Tincture, Compound BP
Menthol and Eucalyptus Inhalation BP

Topical Nasal Decongestants:

Ephedrine Nasal Drops BPC 0.5% w/v
Ephedrine Nasal Drops BNF 1% w/v
Xylometazoline Hydrochloride nasal drops BP 0.05% w/v
Xylometazoline Hydrochloride nasal drops BP 0.1% w/v

NOTES:

1. Strong cough suppressants containing controlled drugs remain available for example:-

Diamorphine Linctus BPC
Methadone Linctus BP

2. Inhalation Mucolytics remain available.

AIRBRON
ALEVAIRE

BITTERS AND TONICS

Gentian Mixture, Acid BPC

Gentian Mixture, Alkaline BP

VITAMINS

Vitamin A Preparations:

Halibut Liver Oil Capsules BP
RO-A-VIT TABLETS
RO-A-VIT INJECTION
Vitamins A and D Capsules BPC

Vitamin B Preparations:

Hydroxocobalamin Injection BP 0.25 mg/ml
Hydroxocobalamin Injection BP 1 mg/ml
Nicotinamide Tablets BP (all strengths)
Pyridoxine Hydrochloride Tablets BP 10mg, 20mg, 50mg
Pyridoxine Injection BPC
Thiamine Hydrochloride Injection BP (all strengths)
Thiamine Hydrochloride Tablets BP (all strengths)
Vitamin B Tablets, Compound BPC
Vitamin B Tablets, Compound, Strong BPC
Vitamins B and C Injection BPC

Vitamin C Preparations:

Ascorbic Acid Injection BPC
Ascorbic Acid Tablets BP 25mg, 50mg, 100mg, 200mg, 500mg.

Vitamin D Preparations:

AT 10
Calciferol Injection BP
Calciferol Solution BP
Calciferol Tablets, High Strength BP
Calciferol Tablets, Strong BP 1973
ONE-ALPHA CAPSULES
ONE-ALPHA DROPS AND DROPS DILUENT
ROCALTROL CAPSULES
TACHYROL TABLETS

Vitamin E Preparations:

EPHYNAL TABLETS (All Strengths)
VITA-E GELS, VITA-E GELUCAPS, VITA-E SUCCINATE TABLETS

Vitamin K Preparations:

Phytomenadione Injection BP
Phytomenadione Tablets BP
SYNKAVIT INJECTION (all strengths)
SYNKAVIT TABLETS

Oral Multivitamin Preparations:

ABIDEC DROPS
DALIVIT DROPS
Vitamins Capsules BPC

NOTES:

1. Preparations such as KETOVITE and SUPPLEMENTARY VITAMIN TABLETS (COW AND GATE) which are required for patients on special diets remain available.

2. The following multivitamin injections remain available:-

   MULTIBIONTA
   PARENTROVITE
   PABRINEX
   SOLIVITO
   VITLIPID

3. Folic Acid Tablets BP and combinations of folic acid with iron remain available.

4. Preparations of Folinic acid and its salts remain available.

BENZODIAZEPINE SEDATIVES AND TRANQUILLISERS

Chlordiazepoxide Capsules BP, 5mg and 10mg
Chlordiazepoxide Hydrochloride Tablets BP, 5mg, 10mg and 25mg
Chlordiazepoxide Tablets BP, 5mg, 10mg and 25mg
Diazepam Elixir 2mg in 5ml
Diazepam Tablets BP 2mg, 5mg and 10mg
Lorazepam Tablets 1mg and 2.5mg
Nitrazepam Mixture 2.5mg in 5ml
Nitrazepam Tablets BP 5mg and 10mg
Oxazepam Tablets BP 10mg, 15mg and 30 mg
Temazepam Capsules 10mg and 20mg
Temazepam Elixir 10mg in 5ml
Triazolam Tablets 0.125mg and 0.25mg

NOTES

1. All Benzodiazepines prepared for parenteral or rectal administration and those licensed only as anti-convulsants eg clonazepam (RIVOTRIL) remain available.

2. Clobazam will be prescribable by special arrangement for patients with epilepsy only.

(C)

DHSS - PROPOSED LIST OF DRUGS AND OTHER SUBSTANCES NOT TO BE AVAILABLE AT NHS EXPENSE FROM 1 APRIL 1985

Abidec Capsules
Acid Gentian Mixture with Nux Vomica BPC
Acid Nux Vomica Mixture BPC
Acne Aid Bar
Actal Suspension
Actal Tablets
Actifed Brand Syrup
Actifed Compound Linctus
Actifed Expectorant
Actifed Linctus with Codeine
Actifed Tablets
Actonorm Powder
Actonorm Tablets
Actron Tablets
Adexolin Vitamin Drops
Adult Cough Balsam (Cupal)
Adult Meltus Cough & Catarrh Linctus
Adults Tonic Mixture (Thornton & Ross)
Afrazine Nasal Drops
Afrazine Nasal Spray
Afrazine Paediatric Nasal Drops
Agarol Emulsion
Agiolax Granules
Airball Breathe Easy Vapour Inhaler
AL Tablets
Alagbin Tablets
Alcin Tablets
Aletres Cordial (Potters)
Algipan Tablets
Alka-Mints
Alka-Seltzer Tablets
Alkaline Gentian Mixture with Nux Vomica BPC
Alkaline Nux Vomica Mixture BPC
Alket Powders
All Fours Cough Mixture (Harwood)
All Fours Mixture (Glynwed Wholesale Chemists)
All Fours Mixture (Roberts Laboratories)
Allbee with C Capsules
Allbee with C Elixir
Almazine Tablets 1 mg
Almazine Tablets 2.5 mg
Alorhen Pills
Alpine Tea
Alprazolam Tablets 0.25 mg
Alprazolam Tablets 0.5 mg
Alprazolam Tablets 1 mg
Altacaps
Altacite Plus Suspension
Altacite Plus Tablets
Altacite Suspension
Altacite Tablets
Aludrox Gel
Aludrox M H Suspension
Aludrox S A Suspension
Aludrox Suspension
Aludrox Tablets
Aluhyde Tablets
Aluminium Hydroxide & Silicone Suspension
Alupent Expectorant Mixture

Alupent Expectorant Tablets
Aluphos Gel
Aluphos Tablets
Alupram Tablets 10 mg
Alupram Tablets 2 mg
Alupram Tablets 5 mg
Aluzyme Tablet
Alzed Tablets
Amisyn Tablets
Ammonia and Ipecacuana Mixture BP
Anadin Analgesic Tablets
Anadin Tablets Soluble
Ancoloxin Tablets
Andrews Liver Salt (Diabetic Formula) Effervescent Powder
Andrews Liver Salts Effervescent Powder
Andursil Liquid
Andursil Tablets
Anestan Bronchial Tablets
Aneurone Mixture
Angiers Junior Aspirin Tablets
Anorvit Tablets
Antasil Liquid Suspension
Antasil Tablets
Antistin-Privine Nasal Drops
Antistin-Privine Nasal Spray
Antitussive Linctus (Cox)
Antoin Tablets
Antussin Liquid (Sterling Winthrop)
Anxon Capsules 15 mg
Anxon Capsules 30 mg
Anxon Capsules 45 mg
Aperient Tablets (Brome & Schimmer)
Aperient Tablets (Kerbina)
Apisate Delayed Release Tablets
Apodorm Tablets 2.5 mg
Apodorm Tablets 5 mg
APP Stomach Powder
APP Stomach Tablets
Arocin Capsules
Ascorbef Tablets
Ascorbic Acid BP & Hesperidin Capsules (Regent Laboratories)
Asilone Orange Tablets
Asilone Suspension
Asilone Tablets 250 mg
Askit Powders
Askit Tablets
Aspergum Chewing Gum Tablets 227 mg Aspirin/Tablet
Aspro Clear Tablets
Aspro Extra Strength Tablets 500 mg
Aspro Junior Tablets
Aspro Microfined Tablets
Asthma Tablets (Cathay)
Astroplast Analgesic Capsules
Atensine Tablets 10 mg
Atensine Tablets 2 mg
Atensine Tablets 5 mg
Ativan Tablets 1 mg
Ativan Tablets 2.5 mg
Atrixo
Aveeno Bar

Aveeno Bar Oilated
Ayrtons Macleans Formula Tablets
10 Day Slimmer Tablets
10 Hour Capsules

B Complex Capsules (Rodale)
B Complex Super Capsules (Rodale)
B Extra Tablets (British Chemotherapeutic Products)
Babezone Syrup
Baby Chest Rub Ointment (Cupal)
Babylix Syrup
Balm of Gilead (Robinsons)
Balm of Gilead Cough Mixture (Wicker Herbal Stores)
Balm of Gilead Liquid (Culpeper)
Balm of Gilead Mixture (Potters)
Barker's Liquid of Life Solution
Barker's Liquid of Life Tablets
Barkoff Cough Syrup
Bayer Aspirin Tablets 300 mg
BC500 with Iron Tablets
BC500
Becosym Forte Tablets
Becosym Syrup
Becosym Tablets
Becotab Tablets
Beechams Day-Nurse Syrup
Beechams Catarrh Capsules
Beechams Pills
Beechams Powder Tablet Form
Beechams Powders
Beechams Powders Mentholated
Beehive Balsam
Bekovit Tablets
Belladonna and Ephedrine Mixture, Paediatric, BPC
Bellocarb Tablets
Benadon Tablets 20 mg
Benadon Tablets 50 mg
Benafed Linctus
Benerva Compound Tablets
Benerva Injection 25mg/ml
Benerva Injection 100mg/ml
Benerva Tablets 10 mg
Benerva Tablets 100 mg
Benerva Tablets 25 mg
Benerva Tablets 3 mg
Benerva Tablets 300 mg
Benerva Tablets 50 mg
Bengue's Balsam
Benylin Day & Night Cold Treatment
Benylin Decongestant Linctus
Benylin Expectorant
Benylin Fortified Linctus
Benylin Mentholated Cough & Decongestant Linctus
Benylin Paediatric Solution
Benylin with Codeine
Benzedrex Inhaler
Benzoin Inhalation BP

Beogex Suppositories
Bepro Cough Syrup
Bile Beans Formula 1 Pill
Bioflavonoid C Capsules
Bio-Strath Drops
Bio-Strath Elixir
Biotin Tablets 50 microgram
Biovital Liquid
Biovital Tablets
Birley's Antacid Powder
Bis-mag Lozenge
Bis-peps (Tablets)
Bisma-Calna Cream
Bisma-Rex Powder
Bisma-Rex Tablets
Bismag Antacid Powder
Bismag Tablets
Bismuth Compound Lozenges BPC
Bismuth Dyspepsia Lozenge
Bismuth Pepsin and Pancreatin Tablets
Bismuth, Soda and Pepsin Mixture
Bisodol Antacid Powder
Bisodol Tablets
Bisolvon Ampoules
Bisolvon Capsules
Bisolvon Elixir
Bisolvon Tablets
Blackcurrant Cough Elixir (Thornton & Ross)
Blackcurrant Flavour Coldrex Powder
Blackcurrant Syrup Compound (Beben)
Blandax Suspension
Blavig Tablets
Blood Tonic Mixture (Thompsons)
Boldolaxine Tablets
Bonemeal Calfos, Vit A Ester, Vit D Tablets
Bonomint Chewing Gum
Bonomint Tablets
Booth's Cough & Catarrh Elixir
Boots Cold Relief Powder for Solution
Boots Compound Laxative Syrup of Figs
Boots Cough Relief for Adults
Boots Glycerin & Blackcurrant Soothing Cough Relief
Boots Health Salts
Boots Indigestion Plus Mixture
Boots Indigestion Powder
Boots Vapour Rub Ointment
Box's Balm of Gilead Cough Mixture
Bravit Capsules
Bravit Tablets
Breoprin Tablets 648 mg
Brewers Yeast Tablets (3M Health Care)
Brewers Yeast-Super B Tablets (Rodale)
Brewers Yeast Tablets (Phillips Yeast Products)
Bricanyl Compound Tablets
Bricanyl Expectorant
Brogans Cough Mixture
Brogans Cough Syrup
Bromazepam Tablets 1.5 mg
Bromazepam Tablets 3 mg

Bromazepam Tablets 6 mg
Bronalin Expectorant
Bronalin Paediatric Cough Syrup
Bronchial & Cough Mixture (Worthington Walter)
Bronchial Balsam (Cox)
Bronchial Catarrh Syrup (Rusco)
Bronchial Cough Mixture (Evans Medical)
Bronchial Emulsion (Three Flasks) (Thornton & Ross)
Bronchial Emulsion AS Extra Strong (Ayrton Saunders)
Bronchial Mixture (Rusco)
Bronchial Mixture Extra Strong (Cox)
Bronchial Mixture Sure Shield Brand
Bronchial Tablets (Leoren)
Bronchialis Mist Liquid (Industrial Pharmaceutical Services)
Bronchialis Mist Nig Double Strength (Phillip Harris Medical)
Bronchisan Childrens Cough Syrup
Bronchisan Cough Syrup
Broncholia Mixture
Bronchotone Solution
Bronkure Cough & Bronchitis Mixture (Jacksons)
Brontus Syrup
Brontus Syrup for Children
Brontussin Cough Suppressant Mixture
Brooklax Tablets
Brotizolam Tablets 0.125 mg
Brotizolam Tablets 0.25 mg
Bufferin Tablets
Buttercup Baby Cough Linctus
Buttercup Syrup

Cabdrivers Adult Linctus
Cabdrivers Diabetic Linctus
Cabdrivers Nasal Decongestant Tablets
Cafadol Tablets
Caffeine & Dextrose Tablets
Calcimax Syrup
Calcinate Tablets
Calcium Syrup (Berk Pharmaceuticals)
Calfornia Syrup of Figs
Calpol Six Plus Suspension
Calpol Tablets
Calsalettes Sugar Coated Tablets
Calsalettes Uncoated Tablets
Camfortix Linctus P1
Cantaflour
Capramin Tablets
Carbellon Tablets
Carisoma Compound Tablets
Carnation Instant Build-Up
Carrzone Powder
Carters Little Pills
Cascara Evacuant Liquid Mixture
Cascara Tablets BP
Castellan No 10 Cough Mixture
Catarrh & Bronchial Syrup (Thornton & Ross)
Catarrh Cough Syrup (Boots)
Catarrh Mixture (Herbal Laboratories)
Catarrh Syrup for Children (Boots)

Catarrh Tablets (Cathay)
Ce-Cobalin Syrup
Ceeyees Tablets
Celaton Rejuvenation Tablets
Celaton CH3 Strong & Calm Tablets
Celaton CH3 Triplus Tablets
Celaton CH3+ East & Vitality Tablets
Celaton Whole Wheat Germ Capsules
Celavit 1 Powder
Celavit 2 Powder
Celavit 3 Powder
Celevac Granules
Centrax Tablets 10 mg
Cephos Powders
Cephos Tablets
Charabs Tablets
Charvita Tablets
Cheroline Cough Linctus
Cherry Bark Cough Syrup Childrens (Loveridge)
Cherry Bark Linctus Adults (Loveridge)
Cherry Cough Balsam (Herbal Laboratories)
Cherry Cough Linctus (Savoury & Moore)
Cherry Cough Mixture (Rusco)
Cherry Flavoured Extract of Malt (Distillers)
Chest & Cough Tablet (Brome & Schimmer)
Chest & Cough Tablets (Kerbina)
Chest & Throat Tablets No 8,000 (English Grains)
Chest Pills (Broome & Schimmer)
Chest Tablets (Kerbina)
Chesty Cough Syrup (Scott & Bourne)
Chilblain Tablets
Child's Cherry Flavoured Linctus (Cupal)
Children's Blackcurrant Cough Syrup (Rusco)
Children's Cherry Cough Syrup (Thornton & Ross)
Children's Cough Linctus (Ransoms)
Children's Cough Mixture (Beecham)
Children's Cough Mixture (Loveridge)
Children's Cough Syrup (Ayrton Saunders)
Children's Cough Syrup (Cox)
Children's Cough Syrup (Evans Medical)
Children's Cough Syrup (Thornbers)
Children's Medicine Liquid (Hall's)
Children's Phensic Tablets
Children's Wild Cherry Cough Linctus (Evans Medical)
Chilvax Tablets

Chocolate Laxative Tablets (Isola)
Chocovite Tablets
Cidal
Cinnamon Essence Medicinal Mixture (Langdale's)
Cinnamon Tablets Medicinal (Langdale's)
Cinota Drops
Citrosan Powder in Sachets

Claradin Effervescent Tablets
Clarkes Blood Mixture
Cleansing Herb Dried (Potters)
Cleansing Herbs (Brome & Schimmer)
Cleansing Herbs Powder (Dorwest)

Clorazepate Dipotassium Capsules 15 mg
Clorazepate Dipotassium Capsules 7.5 mg
Clorazepate Dipotassium Tablets 15mg
Co-op Aspirin Tablets BP 300 mg
Co-op Bronchial Mixture
Co-op Halibut Liver Oil Capsules BP
Co-op Paracetamol Tablets BP 500 mg
Co-op Soluble Aspirin Tablets BP 300 mg
Cobalin H Injection 1000 mcg/ml
Cobalin H Injection 250 mcg/ml
Cobalin Injection 100 mcg/ml
Cobalin Injection 1000 mcg/ml
Cobalin Injection 250 mcg/ml
Cobalin Injection 500 mcg/ml
Cod Liver Oil & Creosote Capsules (10 Oval) (R P Scherer)
Cod Liver Oil & Creosote Capsules (5 Oval) (R P Scherer)
Cod Liver Oil Caps 10 Minims (Woodward)
Cod Liver Oil High Potency Capsules (R P Scherer)
Cod Liver Oil with Malt Extract & Hypophosphite Syrup (Distillers)
Cod Liver Oil 0.3 ml Capsules (R P Scherer)
Cod Liver Oil 0.6 ml Capsules (R P Scherer)
Codanin Analgesic Tablets
Codis Soluble Tablets
Codural Tablets
Cojene Tablets
Cold & Influenza Capsules (Regent)
Cold & Influenza Mixture (Boots)
Cold & Influenza Mixture (Davidson)
Cold & Influenza Mixture (Rusco)
Cold & Influenza Mixture (Thornton & Ross)
Cold Relief (Blackcurrant Flavour) Granular Powder (Boots)
Cold Relief Capsules (Scott & Bourne)
Cold Relief Tablets (Boots)
Cold Tablets (Roberts)
Coldrex Tablets
Colgard Emergency Essence (Lane Health Products)
Collins Elixir
Colocynth & Jalap Tablets Compound BPC 1963
Cologel Liquid
Complan
Comploment Continus Tablets
Compound Fig Elixir BP
Compound Rhubarb Oral Powder BP
Compound Rhubarb Tincture BP
Compound Syrup of Glycerophosphates BPC 1963
Compound Syrup of Hypophosphites BPC 1963
Comtrex Capsules
Comtrex Liquid
Comtrex Tablets
Concavit Capsules
Concavit Drops
Concavit Injection
Concavit Syrup
Congesteze Syrup
Congesteze Tablets
Congreves Balsamic Elixir
Constipation Herb Dried (Potters)

Constipation Herbs (Hall's)
Constipation Herbs (Mixed Herbs) (Brome & Schimmer)
Constipation Mixture No 105 (Potters)
Contact 400 Capsules
Copholco Cough Syrup
Corrective Tablets (Ayrton Saunders)
Correctol Tablets
Cosalgesic Tablets
Cosylan Syrup
Coterpin Syrup
Cough & Bronchitis Mixture (F C Davidson & Son)
Cough & Cold Mixture (Beecham)
Cough Balsam (Abernethy's)
Cough Balsam (Thornbers)
Cough Expectorant Elixir (Regent Laboratories)
Cough Linctus (Sanderson's)
Cough Linctus Alcoholic (Thomas Guest)
Cough Linctus for Children (Boots)
Cough Medicine for Infants & Children Solution (Boots)
Cough Mixture (Tingles)
Cough Mixture Adults (Thornton & Ross)
Cough Mixture Adults (Wicker Herbal Stores)
Cough Syrup Best (Diopharm)
Cough Tablets (Kerbina)
Covermark Removing Cream
Covonia Bronchial Balsam Linctus
Cox Pain Tablets
Crampex Tablets
Cream of Magnesia Tablets 300 mg
Cremaffin Emulsion
Creosote Bronchial Mixture (J M Loveridge)
Crookes One-a-Day Multivitamins with Iron
Crookes One-a-Day Multivitamins without Iron
Croupline Cough Syrup (Roberts)
Cupal Health Salts
Cytacon Liquid
Cytacon Tablets
Cytamen 1000 Injection
Cytamen 250 Injection

Dakin's Golden Vitamin Malt Syrup
Dalivit Capsules
Dalivit Syrup
Dalmane Capsules 15 mg
Dalmane Capsules 30 mg
Dansac Skin Lotion
Davenol Linctus
Daxaids Tablets
Day Nurse Capsules
Day-Vits Multivitamin & Mineral Tablets
Dayovite
De Witt's Analgesic Pills
De Witt's Antacid Powder
De Witt's Antacid Tablets
De Witt's Baby Cough Syrup
De Witt's Cough Syrup
De Witt's PL Pills
Deakin and Hughes Cough and Cold Healer Mixture

Deakin's Fever and Inflammation Remedy Mixture
Delax Emulsion
Delimon
Dentakit Toothache First Aid Kit
Derbac Soap
Dermacolour Cleansing Cream
Dermacolour Cleansing Lotion
Dermacolour Cleansing Milk
Desiccated Liver Tablets
Desiccated Liver USNF Tablets
Detox Tablets (Hursdrex)
Dextrogesic Tablets
DF 118 Elixir
DF 118 Injection
DF 118 Tablets
DGL 1 Suspension
DGL 2 Suspension
DGT 1 Tablets
DGT 2 Tablets
Diabetic Bronal Syrup
Dialar Forte Syrup 5 mg/5 ml
Dialar Syrup 2 mg/5 ml
Dialume Capsules 500 mg
Digesprin Antacid Tablet
Digestells Lozenges
Dijex Solution
Dijex Tablets
Dimotane Expectorant
Dimotane Expectorant DC
Dimotane with Codeine Elixir
Dimotane with Codeine Paediatric Elixir
Dimotapp Elixir
Dimotapp Elixir Paediatric
Dimotapp LA Tablets
Dimotapp P Tablets
Dimyril Linctus
Dinnefords Gripe Mixture
Diovol Suspension
Diovol Tablets
Disprin Tablets
Disprinex Tablets

Distalgesic Soluble Tablets
Distalgesic Tablets
Do-Do Linctus
Do-Do Tablets
Dolosan Tablets
Doloxene Capsules
Doloxene Compound Pulvules
Dolvan Tablets
Dormonoct Tablets 1 mg
Dr Brandreth's Pills
Dr D E Jongh's Cod Liver Oil with Malt Extract & Vitamins Fortified Syrup
Dr William's Pink Pills
Drastin Tablets
Dristan Decongestant Tablets with Antihistamine
Dristan Nasal Spray
Droxalin Tablets
Dry Cough Linctus (Scott & Borne)

Dual-Lax Extra Strong Tablets
Dual-Lax Tablets (Normal)
Dulca Tablets
Dulcodos Tablets
Dulcolax Suppositories
Dulcolax Tablets
Duo-Gastritis Mixture (Baldwin's)
Duphalac Syrup
Duralin Capsules Extra Strength
Duralin Tablets
Duttons Cough Mixture
Dynese Aqueous Suspension
Dynese Plus Aqueous Suspension
Dynese Tablets
D001 Capsules
D002 Capsules
D004 Capsules
D006 Capsules
D007 Capsules
D009 Capsules
D010 Capsules
D011 Capsules
D012 Capsules
D013 Capsules
D014 Capsules
D017 Capsules
D018 Capsules
D019 Capsules
D020 Capsules
D021 Capsules
D024 Capsules
D029 Capsules
D030 Capsules
D031 Capsules
D032 Capsules
D033 Capsules
D034 Capsules
D036 Capsules

Ecdilyn Syrup
Educol Tablets
Efamol Capsule
Effer-C Tablets
Effico Syrup
Eldermint Cough Mixture (Herbal Laboratories)
Elkamol Tablets
Endet Powders
Energen Starch Reduced Crispbread
Engran HP Tablet
Engran Tablet
Eno Fruit Salt (Powder)
EP Tablets
Equagesic Tablets
Eskornade Spansule Capsules
Eskornade Syrup
Eso-Col Cold Treatment Tablets
Euhypnos Capsules 10 mg
Euhypnos Elixir 10 mg/5 ml

Euhypnos Forte Capsules 20 mg
Evacalm Tablets 2 mg
Evacalm Tablets 5 mg
Evans Cough Balsam
Ex-Lax Chocolate Laxative Tablet
Ex-Lax Pills
Expectorant Cough Mixture (Beecham)
Expulin Cough Linctus
Expulin Paediatric Cough Linctus
Expulin Paediatric Decongestant
Extil Compound Linctus
Extravite Tablets
Extren Tablets
Exyphen Elixir
E001 Capsules
E015 Capsules
E018 Capsules
E021 Capsules
E031 Capsules
E032 Capsules

Fabrol Granules
Falcodyl Linctus
Fam Lax Tablets
Famel Expectorant
Famel Linctus
Famel Original Linctus
Family Cherry Flavoured Linctus (Cupal)
Family Herbal Pills
Father Pierre's Monastery Herbs
Fe-Cap C Capsules
Feac Tablets
Feen-a-Mint Tablets
Fefo-Vit Spansules
Femerital Tablets
Feminax Tablets
Fendamin Tablets
Fennings Adult Powders
Fennings Children's Cooling Powders
Fennings Little Healers Pills
Fennings Mixture
Fennings Soluble Junior Aspirin Tablets
Fenox Nasal Drops
Fenox Nasal Spray
Ferfolic SV Tablets
Ferfolic Tablets
Fergluvite Tablets
Ferraplex B Tablets
Ferrlecit Tablets/Dragees
Ferrocap Capsules
Ferrograd C Tablets
Ferrol Compound Mixture
Ferromyn B Elixir
Ferromyn B Tablets
Ferrous Gluconate Compound Tablets
Fesovit Spansules
Fibre Biscuits
Fine Fare Aspirin Tablets 300 mg
Fine Fare Hot Lemon Powders

Flar Capsules
Flavelix Syrup
Flora Margarine
Floradix Formula Liquid
Floradix Tablets
Floral Arbour Tablets (Cathay)
Flu-Rex Tablets
Flucaps
Flunitrazepam Tablets 1 mg
Fluralar Capsules 15 mg
Fluralar Capsules 30 mg
Flurazepam Capsules 15 mg
Flurazepam Capsules 30 mg
Flurazepam Hydrochloride Capsules 15 mg
Flurazepam Hydrochloride Capsules 30 mg
Folicin Tablets
Folped
Forceval Capsules
Forceval Junior Capsules
Forceval Protein Powder
Forprin Tablets

Fortagesic Tablets
Fortimel
Fortison Low Sodium
Fortral Capsules 50 mg
Fortral Injection
Fortral Suppositories
Fortral Tablets 25 mg
Fortral Tablets 50 mg
Fortris Solution

Fosfor Syrup
Franol Expectorant
Franolyn Sed Liquid
Frisium Capsules 10 mg
Frisium Capsules 20 mg
Frisium Capsules 5 mg
Fybranta Tablets
Fynnon Calcium Aspirin Tablets
Fynnon Salt

G Brand Linctus
Galfer - Vit Capsules
Galloway's Baby Cough Linctus
Galloway's Bronchial Expectorant
Galloway's Cough Syrup
Gamophen
Gastalar Tablets
Gastric Ulcer Tablets No 1001
Gastrils Pastilles
Gastritabs; Bismuth Heartburn Tablets
Gastrovite Tablets
Gatinar Syrup
Gaviscon Granules
Gelusil Lac Powder
Gelusil Tablets
Genasprin Tablets

Genatosan
Gentian & Rhubarb Mixture BPC
Georges Vapour Rub Ointment
Geriplex Capsules
Gevral Capsules
GF Brand Gluten-Free Maize Biscuits with Chocolate
GF Brand Gluten-Free Maize Biscuits with Hazel-Nut
GF Brand Gluten-Free Thin Wafer Bread
Givitol Capsules
Gladlax Tablets
Glemony Balsam (Baldwin's)
Glenco Elixir
Gluca-Seltzer Effervescent Powder
Glucodin
Glycerin Honey & Lemon Cough Mixture (Isola Manufacturing)
Glycerin Honey & Lemon Linctus (Boots)
Glycerin Honey & Lemon Linctus with Ipecacuanha (Boots)
Glycerin Lemon & Honey and Ipecac (Thomas Guest)
Glycerin Lemon & Honey Linctus (Rusco)
Glycerin Lemon & Honey Syrup (Cupal)
Glycerin Lemon & Honey Syrup (Thomas Guest)
Glycerin Lemon & Honey Syrup (Waterhouse)
Glycerin Lemon & Ipecac Cough Mixture (Isola Manufacturing)
Glykola Elixir
Glykola Infants Elixir
Golden Age Vitamin & Mineral Capsules
Golden Health Tablet (Kerbina)
Golden Health Tablets (Brome & Schimmer)
Gon Tablets
Gonfalcon Tablets
Grangewood Insomnia Tablets
Granogen
Granoton Emulsion
Gregovite C Tablets

GS Tablets
Guanor Expectorant

H-Pantoten Tablets
Hactos Chest & Cough Mixture (Thomas Hubert)
Halaurant Syrup
Halcion Tablets 0.125 mg
Halcion Tablets 0.25 mg
Haliborange Syrup
Halibut Liver Oil A & D Capsules (Rodale)
Halin Tablets
Halocaps Inhalant Capsules
Halycitrol Emulsion
Haymine Tablets
Hayphryn Nasal Spray
Health Salts (Wicker Herbal Stores)
Health Tonic Mixture (Hall's)
Heart Shape Indigestion Tablets
Hedex Plus Capsules
Hedex Selzer Granules
Hedex Soluble Granules
Hedex Tablets
Hemingways Catarrh Syrup

Hemoplex Injection
Hepacon B12 Injection
Hepacon Liver Extract Injection
Hepacon-Plex
Hepacon-B-Forte Injection
Hepanorm Tablets
Herbal Aperient Tablets (Cathay)
Herbal Aperient Tablets (Kerbina)
Herbal Bronchial Cough Tablets (English Grains)
Herbal Laxative Naturtabs
Herbal Pile Tablets
Herbal Quiet Nite Sleep Naturtabs
Herbal Syrup (Baldwin's)
Herbalene Herbs
Hi-g-ah Tea
Hi-pro Liver Tablets
Hill's Bronchial Balsam
Hill's Junior Balsam
Hip C Rose Hip Syrup
Histalix Expectorant
Honey & Molasses Cough Mixture (Lane Health Products)
Hot Lemon Cold Treatment (Scott & Bowne)
Hot Measure Solution (Reckitt & Colman)
Hypon Tablets

Iberet 500 Tablets
Iberol Tablets
ICC Analgesic Tablets
Iliadin Mini Nasal Drops
Iliadin Mini Paediatric Nasal Drops
Imarale Agba Suspension
Imarale Omode Suspension
Inabrin Tablets 200 mg
Indian Brandy Solution
Indigestion Mixture (Boots)
Indigestion Mixture (Thornton & Ross)
Indigestion Mixture (William Ransom)
Indigo Indigestion Lozenges
Influenza and Cold Mixture 2315 (Wright Layman & Umney)
Inhalit Liquid Inhalation
Iodised Vitamin Capsules
Ipsel Hygienic Babysalve
Irofol C
Iron & Brewers Yeast Tablets (3M Health Care)
Iron & Vitamin Tablets (F C Davidson)
Iron Formula Tablets (Rodale)
Iron Jelloids Tablets
Iron Tonic Tablets (Boots)
Ironorm Capsules
Ironorm Tonic
Ironplan Capsules
Ivy Tablets (Ayrton Saunders)
Iodo-Ephedrine Mixture

Jaap's Health Salts
Jacksons All Fours Cough Mixture
Jacksons Febrifuge
Jambomins Tablets

Jenners Suspension
Jenners Tablets
Junamac
Jung Junipah Tablets
Junior Aspirin Tablets 75 mg
Junior Cabdrivers Linctus
Junior Disprin Tablets
Junior Ex-Lax Chocolate Tablet
Junior Lemsip Powder
Junior Meltus Cough & Catarrh Linctus
Junior Mucron Liquid
Junior Tablets (Rodale)
Juno-Junipah Mineral Salts
Juvel Elixir
Juvel Tablets

Karvol Capsules
Kendales Adult Cough Syrup
Kendales Cherry Linctus
Kest Tablets
Ketazolam Capsules 15 mg
Ketazolam Capsules 30 mg
Ketazolam Capsules 45 mg
Keybells Linctus of Glycerine, Lemon & Ipecac
Kingo Cough Syrup
Koladex Tablets
Kolanticon Gel
Kolanticon Tablets
Kolanticon Wafers
Kolantyl Gel
Krauses Cough Linctus
Kruschen Salts
Kuralax Herbs

Labiton Kola Tonic
Laboprin Tablets
Lac Bismuth Mixture
Lacto Calamine
Laevoral
Lance B & C Tablets
Lane's Cut-a-Cough
Lane's Laxative Herb Tablets
Lane's Sage & Garlic Catarrh Remedy
Lantigen B
Laxaliver Pills
Laxatabs Leoren
Laxipurg Tablets
Laxoberal Elixir
Lederplex Capsules
Lederplex Liquid
Lejfibre Biscuit
Lem-Plus Hot Lemon Drink
Lemeze Cough Syrup
Lemon Eno Powder
Lemon Flavour Coldrex Powder Sachets
Lemon Flu-Cold Concentrated Syrup

Lemon Glycerine & Honey Cough Syrup Compound (Carter Bond)
Lemon Glycerine & Honey Lung Mixture (Whitehall Laboratories)
Lemon Glycerine & Ipecac Cough Syrup Compound (Carter Bond)
Lemon Juice, Glycerine & Honey A S Syrup (Ayrton Saunders)
Lemon Linctus 1-472
Lemsip Powder
Lendormin Tablets 0.125 mg
Lendormin Tablets 0.25 mg
Leoren Tonic Tablets
Levius Uncoated Controlled Release Tablets 500 mg
Lexotan Tablets 1.5 mg
Lexotan Tablets 3 mg
Lexotan Tablets 6 mg
Libraxin Tablets
Librium Capsules 10 mg
Librium Capsules 5 mg
Librium Tablets 10 mg
Librium Tablets 25 mg
Librium Tablets 5 mg
Lightning Cough Remedy Solution (Potters)
Limbitrol Capsules "10"
Limbitrol Capsules "5"
Linctified Expectorant
Linctified Expectorant Paediatric
Linctoid C
Linituss
Linoleic Acid - Naudicelle, Efamol, Evening Primrose Oil
Linus Vitamin C Powder
Lipoflavonoid Capsules
Lipotriad Capsules
Lipotriad Liquid
Liqufruta Blackcurrant Cough Medicine
Liqufruta Honey & Lemon Cough Medicine
Liqufruta Medica
Liqufruta Medica Garlic Flavoured Cough Medicine
Liquid Formula (Food Concentrate) (Rodale)
Liquid Paraffin & Phenolphthalein Emulsion BP
Liquid Paraffin Emulsion with Cascara BPC
Liver Herbs (Hall's)
Livibron Mixture
Loasid Tablets
Lobak Tablets
Lofthouse's Original Fisherman's Friend Honey Cough Syrup
Loprazolam Tablets 1 mg
Loramet Capsules 1.0 mg
Loramet Tablets 0.5 mg
Loramet Tablets 1 mg
Lormetazepam Capsules 1 mg
Lormetazepam Tablets 0.5 mg
Lormetazepam Tablets 1 mg
Lotussin Cough Syrup
Lung Balsam (Rusco)
Lysaldin

M & B Children's Cough Linctus
Maalox Concentrate Suspension
Maalox Plus Suspension
Maalox Plus Tablets

Maalox Tablets
Maalox TC Tablets
Mackenzies Smelling Salts
Maclean Indigestion Powder
Maclean Indigestion Tablets
Mainstay Pure Cod Liver Oil
Male Gland Double Strength Supplement Tablets
Male Sex Hormone Tablets (Diopharm)
Malinal Suspension 500 mg/ml
Malinal Tablets 500 mg
Malt Extract with Cod Liver Oil & Chemical Food BPC Syrup (Distillers)
Malt Extract with Cod Liver Oil BPC & Hypophosphites (Distillers)
Malt Extract with Cod Liver Oil BPC Soft Extract (Jeffreys Miller)
Malt Extract with Haemoglobin & Vitamins Syrup (Distillers)
Malt Extract with Halibut Liver-Oil Syrup (Distillers)
Mandarin Tablets
Manna Herbal Rheumapainaway Tablets
Matthew Cough Mixture
Maturaplus Tablets
Maximum Strength Anadin Analgesic Capsules
Maxivits Tablets
Medathlon Aspirin Tablets 300 mg
Medazepam Capsules 10 mg
Medazepam Capsules 5 mg
Medex Elixir
Medilax Tablets
Medipain Tablets
Medised Suspension
Medised Tablets
Meditus Syrup
Medocodene Tablets
Meggeson Dyspepsia Tablets
Melissin Syrup
Melo Brand Glycerin Lemon & Honey with Ipecac
Meloids Lozenges
Menthacol Liquid
Menthells Pellet/Pill
Menthol & Benzoin Inhalation BP
Menthol & Eucalyptus (M in P) Pastilles (Thomas Guest)
Menthol Inhalation
Mentholated Balsam (J M Loveridge)
Mentholated Balsam (Savoury & Moore)
Mentholated Balsam (Wright Layman & Umney)
Mentholated Balsam Mixture (Pilsworth Manufacturing)
Mentholatum Balm
Metatone Solution
Midro-Tea Powder
Milk of Magnesia Tablets
Mill-Par Suspension
Minadex Syrup
Minamino Syrup
Minivits Tablets
Modifast Nutritionally Complete Supplemented Fasting Formula
Mogadon Capsules 5 mg
Mogadon Tablets 5 mg
Moorland Indigestion Tablets
Morning Glory Tablets
Mrs Cullen's Lemsoothe Powder
Mrs Cullen's Powders

Mu-Cron Tablets
Mucodyne Capsules
Mucodyne Forte Syrup
Mucodyne Forte Tablets
Mucodyne Paediatric Syrup
Mucofalk Sachets
Mucogel Tablets
Mucolex Syrup
Mucolex Tablets
Mucron Liquid
Muflin Linctus
Multi Vitamin Tablets (English Grains)

Multivitamin Capsules (Regent Laboratories)
Multivitamin Tablets (Approved Prescription Services)
Multivitamin Tablets (Chemipharm)
Multivitamin Tablets (Evans Medical)
Multivitamin Tablets (UAC International)
Multivitamin with Mineral Capsules (Potters)
Multivitamin with Minerals Tablets (Chemipharm)
Multivite Pellets
Multone Tablets
My Baby Cough Syrup
Mycolactine Tablets
Mycolactine Tablets
Mylanta Liquid
Mylanta Tablets
Myolgin Tablets

N Tonic Syrup (Cupal)
N-300 Capsules
Napoloids Tablets
Napsalgesic Tablets
Natex 12A Tablets
Natural Bran
Natural Herb Laxative Tablet (Kerbina)
Natural Herb Laxative Tablets (Brome & Schimmer)
Natural Herb Tablet (Kerbina)
Natural Herb Tablets (Dorwest)
Natural Herb Tablets (Lane)
Naturavite Tablets
Neocytamen Injection 1000 mcg/ml
Neocytamen Injection 250 mcg/ml
Neoklenz Powder
Neophyrn Nasal Drops
Neophyrn Nasal Spray
Nethaprin Expectorant
Neuro Phosphates
Neurodyne Capsules
Neutradonna Powder
Neutradonna Sed Powder
Neutradonna Sed Tablets
Neutradonna Tablets
Neutragena Soap
Neutrolactis Tablets
New Formula Beechams Powders Capsules
New Life Herbs
New Life Tablets

Newton's Childrens Cough Treatment
Newton's Cough Mixture for Adults
Nezcaam Syrup
Nicobrevin
Nicorette
Night Nurse Cold Remedy
Nirolex Expectorant Linctus
Nitrados Tablets 5 mg
Nitrazepam Capsules 5 mg
Nivea
No 177 Tablets (Leoren)
Nobrium Capsules 10 mg
Nobrium Capsules 5 mg
Nocold Tablets
Noctamid Tablets 0.5 mg
Noctamid Tablets 1 mg

Noctesed Tablets
Noradran Bronchial Syrup
Noradran Syrup
Norgesic Tablets
Normacol Antispasmodic
Normacol Standard Granules
Normacol Standard Sugar Free Formular Granules
Normison Capsules 10 mg
Normison Capsules 20 mg
Norvits Syrup
Noscapine Linctus BP
Novasil Antacid Tablets
Novasil Anticid Viscous Suspension
Nulacin Tablets
Nurodol Tablets
Nurofen Tablets 200 mg
Nurse Sykes Powders
Nurse Sykes Bronchial Balsam
Nux Vomica Elixir BPC
Nylax Tablets

Oilatum Bar
Olbas Oil
Omeiri Iron Tonic Tablets
Omilcaf Suspension
Onadox 118 Tablets
One Gram C Capsule
Opas Powder
Opas Tablets
Opobyl Bailly Pills
Optimax Powder
Optimax Tablets
Orange & Halibut Vitamins (Kirby Warrick Pharmaceuticals)
Organidin Elixir
Organidin Solution
Organidin Tablets
Original Indigestion Tablets (Boots)
Orovite Elixir
Orovite Tablets
Orovite 7

Orthoxicol Syrup
Otrovine Nasal Drops 0.05%
Otrovine Nasal Drops 0.1%
Otrovine Nasal Spray 0.1%
Otrovine-Antistin Nasal Drops
Otrovine-Antistin Nasal Spray
Overnight Bedtime Cold Medicine
Owbridge's Cough Mixture
Oxanid Tablets 10 mg
Oxanid Tablets 15 mg
Oxanid Tablets 30 mg
Oxazepam Capsules 30 mg

Pacidal Tablets
Paedosed Syrup
Pain Relief Tablets (A N Cox)
Pain Relief Tablets (F C Davidson)
Panacron Tablets
Panadeine Forte Tablets
Panadeine Soluble Effervescent Tablets
Panadeine Tablets
Panadol Soluble Tablets
Panadol Tablets
Panasorb Tablets
Panets Tablets
Pango Pain Paracetamol Codeine Tablets Cupal
Papain Compound Tablets
Paprika Tablets (Kerbina)
Para-Seltzer Effervescent Tablets
Paracetamol & Caffeine Capsules
Paracetamol & Caffeine Tablets
Paracetamol DC Tablets
Paracetomal Tablets Soluble (Boots)
Paracets Tablets 500 mg
Paracodol Tablets
Paradeine R Tablets
Paragesic Effervescent Tablets
Parahypon Tablets
Parake Tablets
Paralgin Tablets
Paramol Tablets
Paranorm Cough Syrup
Pardale Tablets
Parenamps Intramuscular Injection
Pastilaids Pastilles
Pavacol Cough Syrup
Paxadon Tablets
Paynocil Tablets
PEM Linctus
Penetrol Inhalant
Pentazocine-Aspirin Compound Tablets
Peplax Peppermint Flavoured Laxative Tablets
Peppermint Indigestion Tablets (Boots)
Pepto-Bismol Suspension
Pernivit Tablets
Persomnia Tablets
Petrolagar Emulsion Plain
Petrolagar Emulsion with Phenolphthalein

PF Plus Tablets
Pharmacin Capsules
Pharmacin Effervescent Plus C Tablets
Pharmacin Effervescent Tablets 325 mg
Pharmaton Capsules
Pharmidone Tablets
Phenergan Compound Expectorant Linctus
Phenolphthalein Tablets BP
Phensedyl Cough Linctus
Phensic Tablets
Phensic 2 Tablets
Phillips Iron Tonic Tablets
Phillips Tonic Yeast Tablet
Pholcolix Syrup
Pholcomed Diabetic Forte Linctus
Pholcomed Expectorant Syrup
Pholcomed Forte Linctus
Pholcomed Linctus
Pholtex Syrup
Pholtussa Mixture
Phosferine Liquid
Phosferine Multi-Vitamin Liquid
Phosferine Tablets

Phyllosan Tablets
Physeptone Linctus
Pile Mixture (Ayrton Saunders)
Pile Tablets (Ayrton Saunders)
Pine Catarrh Drops Lozenges
Plenamin Super
Plenivite with Iron Tablets
Plurivite Tablets
Plurivite M Tablets
Plurivite Tablets
Polyalk Gel
Polyalk Tablets
Polycrol Forte Gel
Polycrol Forte Tablets
Polycrol Gel
Polycrol Tablets
Polyvite Capsules
Potaba +6 Capsules
Potaba +6 Tablets
Potassium Bromide & Nux Vomica Mixture BPC 1963
Power Plus Super Multivitamin and Mineral Capsules
Powerin Tablets
PP Tablets
PR Tablets
Prazepam Tablets 10 mg
PRD 200 Tablets 600 mg
Pregnadon Tablets
Pregnavite Forte F Tablets
Pregnavite Forte Tablets
Premit Tablets 20mg
Prenatal Dri-Kaps Capsules
Primes Premiums Tablets
Priory Cleansing Herbs Powder
Procol Capsules
Proctofibre Tablets

Prodexin Tablets
Proflex Tablets
Progesic Tablets
Propain Tablets
Pro-Plus He-Vite Elixir
Proteolised Liver Tablets
Pro-Vitamin A Capsules (Rodale)
Pru Sen Tablet Bar
Pulmo Bailly Liquid
Purgoids Tablets

Q-Panol Tablets
Quick Action Cough Cure (Brian C Spencer)
Quiet Life Tablets

Raspberry Tablets No B039
Rayglo Chest Rub Ointment
Reactivan Tablets

Red Catarrh Pastilles (Baldwin)
Redelan Effervescent Tablets
Redoxon Adult Multivitamin Tablets
Redoxon C Effervescent Tablets 1 g
Redoxon C Tablets 200 mg
Redoxon C Tablets 25 mg
Redoxon C Tablets 250 mg
Redoxon C Tablets 50 mg
Redoxon C Tablets 500 mg
Redoxon Childrens Multivitamin Tablets
Redoxon Effervescent Tablets 1 g
Reg-U-Lett Tablets
Regular Wate-On Tablets
Relanium Tablets 10 mg
Relanium Tablets 2 mg
Relanium Tablets 5 mg
Relcol Tablets
Remnos Tablets 10 mg
Remnos Tablets 5 mg
Rennie Tablets
Respaton
Rheumavit Tablets
Rhuaka Herbal Syrup
Rhuaka Tablets
Rhubarb & Soda Mixture BP
Rhubarb Compound Mixture BPC
Riddovydrin Liquid
Rinurel Linctus
Rinurel Tablets
Rite-Diet Gluten-Free Biscuits (chocolate chip cookies; half-coated chocolate biscuit; custard cream biscuit; Lincoln biscuit; shortcake biscuit; sultana biscuit; soya bran)
Rite-Diet Gluten-Free Canned Rich Fruit Cake
Robaxisal Forte Tablets
Roberts Aspirin & Caffine Tablets
Robitussin AC Liquid
Robitussin Liquid
Robitussin Syrup

ROC Total Sunblock Creams (light + deep tan)
Rock Salmon Cough Mixture
Rohypnol Tablets 1 mg
Roscorbic Effervescent Tablets
Roscorbic Tablets 200 mg
Roscorbic Tablets 25 mg
Roscorbic Tablets 50 mg
Rose Hip C-100 Capsules
Rose Hip C-200 Capsules
Rose Hip Tablets (English Grains)
Rose Hip Tablets (Potters)
Rose Hip Tablets (Roberts)
Rosmax Syrup
Roter Tablets
Rovigon
Rubelix Syrup
Rubraton B Elixir
Ruby Tonic Tablets (Jacksons)

Rum Cough Elixir
Rutin Plus Tablets (Gerard)

Safapryn Tablets
Safapryn-Co Tablets
Safflower Seed Oil
Sainsbury's Cold Powders with Blackcurrant
Sainsbury's Hot Lemon Powders
Sainsbury's Indigestion Tablets
Sainsbury's Junior Soluble Aspirin Tablets
Sainsbury's Paracetamol Tablets 500 mg
Sainsbury's Soluble Aspirin Tablets
Sainsubry's Aspirin Tablets 300 mg
Salzone Tablets 500 mg
Sanatogen Junior Vitamins Tablets
Sanatogen Multivitamins Plus Iron (Formula One) Tablets
Sanatogen Multivitamins Tablets
Sanatogen Nerve Tonic Powder
Sanatogen Selected Multivitamins Plus Iron (Formula Two) Tablets
Sanatogen Tonic
Sancos Co Compound Linctus
Sancos Syrup
Savant Tablets
Saxin
SBL Junior Cough Linctus
SBL Soothing Bronchial Linctus
Scott's Cod Liver Oil Capsules
Scott's Emulsion
Scotts Husky Biscuits
Seaweed Vitamin A Ester BP & Vitamin D BP Capsules (Regent Laboratories)
Sedazin Tablets 1 mg
Sedazin Tablets 2.5 mg
Senna Laxative Tablets (Boots)
Senna Tablets (Potters)
Sennokot Tablets
Senotabs Tablets
Serenid D Tablets 10 mg
Serenid D Tablets 15 mg
Serenid Forte Capsules 30 mg

Sertin Tablets
Setamol Soluble Tablets
Settlers Tablets
Seven Seas Cod Liver Oil
Seven Seas Formula 70 Multivitamin-Multimineral Capsules
Seven Seas Orange Syrup & Cold Liver Oil
Seven Seas Pure Cod Liver Oil Capsules
Seven Seas Start Right Cod Liver Oil for Babies
Sidros Tablets
Silk-Lax Tablets
Siloxyl Suspension
Siloxyl Tablets
Simple Soap
Sine-Off Tablets
Sinutab Tablets
Skin Glow Capsules
SMA Gold Cap Powder and Ready-to-Feed
SMA Powder and concentrated Liquid

Snufflebabe Vapour Rub
Solis Capsules 10 mg
Solis Capsules 2 mg
Solis Capsules 5 mg
Solmin (Tablets)
Solpadeine Forte Tablets
Solpadeine Tablets Effervescent
Solprin Tablets
Soluble Aspirin Tablets for Children (Boots)
Soluble Phensic Tablets
Somnite Suspension 2.5 mg/5 ml
Somnite Tablets 5 mg
Sorbitol
Sovol Liquid
Sovol Tablets
Soya Powder & Nicotinamide Tablets
Special Stomach Power (Halls)
SPHP Tablets
Squill Linctus Opiate BPC (Gees Linctus)
Squill Linctus Opiate, Paediatric, BP
Squire's Soonax Tablets
SR2310 Expectorant
Staffords Mild Aperient Tablets
Staffords Strong Aperient Tablets
Sterling Health Salts Effervescent
Sterling Indigestion Tablets
Sterling Paracetamol Tablets
Sterogyl Alcoholic Solution
Stomach Aids Tablets
Stomach Mixture (Herbal Laboratories)
Stomach Mixture H138 (Southon Laboratories)
Stomach Powder (Diopharm)
Stomach Tablets (Ulter)
Street's Cough Mixture
Strengthening Mixture (Hall's)
Stress B Supplement Tablets
Strychnine & Iron Mixture BPC 1963
Strychnine Mixture BPC 1963
Sudafed Co Tablets
Sudafed Expectorant

Sudafed SA Capsules
Sunerven Tablets

Super Plenamins Tablets
Super Wate-on Emulsion
Super Wate-on Tablets
Super Yeast + C Tablets
Superdrug Health Salts
Surbex-T Tablets
Surem Capsules 10 mg
Surem Capsules 5 mg
Surlax Laxative Tablets
Sweetex
Sylopal Suspension
Sylphen Tablets
Syn-Ergel
Syndol Tablets
Synflex Tablets 275 mg
Syrtussar Cough Syrup

T-Zone Decongestant Tablets

Tablets No B006
Tablets No B011
Tablets No B015
Tablets No B024
Tablets No B025
Tablets No B029
Tablets No B034
Tablets No B035
Tablets No B036
Tablets No B037
Tablets No B038
Tablets No B040
Tablets No B041
Tablets No B045
Tablets No B048
Tablets No B070
Tablets No 268A (Potters)
Tablets to Formula A10
Tablets to Formula A105
Tablets to Formula A11
Tablets to Formula A111
Tablets to Formula A114
Tablets to Formula B117
Tablets to Formula A120
Tablets to Formula B141
Tablets to Formula B143
Tablets to Formula A147
Tablets to Formula B148
Tablets to Formula B156
Tablets to Formula B157
Tablets to Formula A157
Tablets to Formula B158
Tablets to Formula A158
Tablets to Formula B160
Tablets to Formula A161
Tablets to Formula A162

Tablets to Formula B163
Tablets to Formula A164
Tablets to Formula A165
Tablets to Formula A166
Tablets to Formula A167
Tablets to Formula B169
Tablets to Formula A169
Tablets to Formula A175
Tablets to Formula B178
Tablets to Formula A18
Tablets to Formula B180
Tablets to Formula B181
Tablets to Formula B182
Tablets to Formula A19
Tablets to Formula B190
Tablets to Formula B193
Tablets to Formula A20
Tablets to Formula A202
Tablets to Formula A203
Tablets to Formula A213
Tablets to Formula A22
Tablets to Formula A23
Tablets to Formula A264
Tablets to Formula A266
Tablets to Formula A270
Tablets to Formula A271
Tablets to Formula A272
Tablets to Formula A273
Tablets to Formula A274
Tablets to Formula A275
Tablets to Formula A276
Tablets to Formula A277
Tablets to Formula A298
Tablets to Formula A301
Tablets to Formula A31
Tablets to Formula A316
Tablets to Formula A32
Tablets to Formula A33
Tablets to Formula A45
Tablets to Formula A51
Tablets to Formula A63
Tablets to Formula A67
Tablets to Formula A68
Tablets to Formula A69
Tablets to Formula A70
Tablets to Formula A71
Tablets to Formula BA6
Tablets to Formula B10
Tablets to Formula B102
Tablets to Formula B104
Tablets to Formula B118
Tablets to Formula B120
Tablets to Formula B122
Tablets to Formula B124
Tablets to Formula B128
Tablets to Formula B145
Tablets to Formula B15
Tablets to Formula B18
Tablets to Formula A183

Tablets to Formula A184
Tablets to Formula B19
Tablets to Formula A190
Tablets to Formula A195
Tablets to Formula B20
Tablets to Formula B207
Tablets to Formula B209
Tablets to Formula B21
Tablets to Formula B210
Tablets to Formula B211
Tablets to Formula B212
Tablets to Formula B213
Tablets to Formula B214
Tablets to Formula B215
Tablets to Formula B216
Tablets to Formula B217
Tablets to Formula B218
Tablets to Formula B22
Tablets to Formula A221
Tablets to Formula B222
Tablets to Formula B223
Tablets to Formula B224
Tablets to Formula B225
Tablets to Formula B227
Tablets to Formula B228
Tablets to Formula B231
Tablets to Formula B234
Tablets to Formula B235
Tablets to Formula B236
Tablets to Formula B243
Tablets to Formula A244
Tablets to Formula A245
Tablets to Formula A246
Tablets to Formula A247
Tablets to Formula A248
Tablets to Formula B248
Tablets to Formula A249
Tablets to Formula B25
Tablets to Formula A250
Tablets to Formula B250
Tablets to Formula B251
Tablets to Formula B252
Tablets to Formula B26
Tablets to Formula B29
Tablets to Formula B41
Tablets to Formula B48
Tablets to Formula B51
Tablets to Formula B56
Tablets to Formula B58
Tablets to Formula B64
Tablets to Formula B65
Tablets to Formula B66
Tablets to Formula B67
Tablets to Formula B68
Tablets to Formula B70
Tablets to Formula B71
Tablets to Formula B72
Tablets to Formula B73
Tablets to Formula B74

Tablets to Formula B75
Tablets to Formula B76
Tablets to Formula B77
Tablets to Formula B78
Tablets to Formula B79
Tablets to Formula B80
Tablets to Formula B81
Tablets to Formula B82
Tablets to Formula B83
Tablets to Formula B85
Tablets to Formula B86
Tablets to Formula B87
Tablets to Formula B90
Tablets to Formula B91
Tablets to Formula B93
Tablets to Formula B94
Tablets to Formula B96
Tablets to Formula B98
Tablets to Formula B100
Tancolin Childrens Cough Linctus
Tedral Expectorant
Tensium Tablets 10 mg
Tensium Tablets 2 mg
Tensium Tablets 5 mg
Tercoda Elixir
Tercolix Elixir
Terpalin Elixir
Terperoin Elixir
Terpoin Antitussive
Terrabron
Terramycin S F Capsules
Tetracyn S F Capsules
Three Noughts Cough Syrup
Throat Chest & Lung Drops Lozenges (Simpkin)
Titralac Tablets
Tixylix Cough Linctus
Tonatexa Mixture
Tonic Tablets (Thomas Guest)

Tonic Wines
Tonivitan A & D Syrup
Tonivitan B Syrup
Tonivitan Capsules
Top C Tablets
Topium Tablets 25 mg
Toptabs
Totavit D R Capsules
Totolin Paediatric Cough Syrup
Tramil Capsules
Trancoprin Tablets
Tranxene Capsules 15 mg
Tranxene Capsules 7.5 mg
Tranxene Tablets 15 mg
Trimtamyl Gluten-Free Bread Mix
Triocos Linctus
Triogesic Elixir
Triogesic Tablets
Triominic Syrup
Triominic Tablets

Triopaed Linctus
Triotussic Suspension
Triovit Tablets
Triple Action Cold Relief Tablets
Tropium Capsules 10 mg
Tropium Capsules 5 mg
Tropium Tablets 10 mg
Tropium Tablets 5 mg
Trufree Bread Mix
Trufree Pasta Mix
Trufree Plain Flour
Trufree Sweet Biscuit Mix
Tums Tablets
Tusana Linctus
Tussifans Syrup
Tussimed Liquid
Two - A - Day Iron Jelloids Tablets
Tysons Catarrh Syrup

Udenum Gastric Vitamin Powder
Ultracach Analgesic Capsules
Ultradal Antacid Stomach Tablets
Ultralief Tablets
Uncoated Tablets to Formula A323
Uncoated Tablets to Formula A325
Uniflu Tablets
Unigesic Capsules
Unigest Tablets
Unisomnia Tablets 5 mg
United Skin Care Programme (Uni-Derm; Uni-Salve; Uni-Wash)

Valium Capsules 2 mg
Valium Capsules 5 mg
Valium Syrup 2 mg/5 ml
Valium Tablets 10 mg
Valium Tablets 2 mg
Valium Tablets 5 mg
Valonorm Tonic Solution
Valrelease Capsules
Vanamil Tablets
Vapex Inhalant
Veganin Tablets
Veno's Adult Formula Cough Mixture
Veno's Cough Mixture
Veno's Honey & Lemon Cough Mixture
Veracolate Tablets
Verdiviton Elixir
Vervain Compound Tablets
Vervina Elixir
Vi-Daylin Syrup
Viamin A Ester Capsules
Vicks Coldcare Capsules
Vicks Cremacoat Syrup
Vicks Cremacoat Syrup with Doxylamine Succinate
Vicks Cremacoat Syrup with Guaiphenesin
Vicks Cremacoat Syrup with Paracetamol & Dextromethorphan
Vicks Daymed

Vicks Formula 44 Cough Mixture
Vicks Inhaler
Vicks Medinite
Vicks Pectorex Solution
Vicks Sinex Nasal Spray
Vicks Vapo-Lem Powder Sachets
Vicks Vapour Rub
Videnal Tablets

Vigour Aids Tablets
Vigranon B Complex Tablets
Vigranon B Syrup
Vikelp Coated Tablets
Vikonon Tablets
Visclair Tablet
Vita Diem Multi Vitamin Drops
Vita-Six Capsules

Vitalin Tablets
Vitamin & Iron Tonic (Epitone) Solution

Vitamin A & D Capsules BPC 1968 (Regent Laboratories)
Vitamin Mineral Capsules (Regent Laboratories)
Vitamin A Ester & Vitamin D2 Capsules (Regent Laboratories)
Vitamin A Ester Capsules (Regent Laboratories)
Vitamin A Ester Conc, Alpha Tocopherol Acetate Nat Capsules (Regent Laboratories)
Vitamin A 4500 Units & Vitamin D2 Capsules (Regent Laboratories)
Vitamin A 6000 Units & Vitamin D2 Capsules (Regent Laboratories)
Vitamin A, C & D Tablets (Approved Prescription Services)
Vitamin A, D & C Tablets (Regent Laboratories)
Vitamin B Complex Tablets (English Grains)
Vitamin B Complex with Brewer's Yeast Tablets (English Grains)
Vitamin B1 Dried Yeast Powder (Distillers)
Vitamin B1 Yeast Tablets (Distillers)
Vitamin B12 Tablets 0.01 mg
Vitamin B12 Tablets 0.025 mg
Vitamin B12 Tablets 0.05 mg
Vitamin B12 Tablets 0.10 mg
Vitamin B12 Tablets 0.25 mg
Vitamin B12 Tablets 0.5 mg
Vitamin B12 Tablets 25 mcg (Rodale)
Vitamin B12 Tablets 1 mg
Vitamin C Tablets Effervescent 1 gramme (Boots)
Vitamin Capsules (Regent Laboratories)
Vitamin Malt Extract with Orange Juice (Distillers)
Vitamin Tablets No B077
Vitamin Tablets No B081
Vitamin Tablets No B084
Vitaminised Iron & Yeast Tablets (Kirby Warrick Pharmaceuticals)
Vitanorm Malt Extract
Vitanorm Malt Extract Syrup
Vitasafe's CF Kaps Tablets
Vitasafe's WCF Kaps Tablets
Vitathone Chilblain Tablets
Vitatrop Tablets
Vitavel Powder for Syrup
Vitavel Solution
Vitepron Tablets
Vitorange Tablets

Vitrite Multi-Vitamin Syrup
Vykmin Fortified Capsules

W L Tablets
Wallachol Syrup
Wallachol Tablets
Wate-on Emulsion
Wate-On Tablets
Wate-on Tonic
Waterhouses All Fours
Wines
Woodwards Nursery Cream
Wrights Glucose with Vitamin D Powder
Wrights Vaporizing Fluid

Xanax Tablets 0.25 mg
Xanax Tablets 0.5 mg
Xanax Tablets 1.0 mg

Yeast & B12 Tablets (English Grains)
Yeast Plus Tablets (Thomas Guest)
Yeast-Vite Tablets

Zactirin Tablets
Zefringe Sachets
Zubes Expectorant Cough Syrup
Zubes Original Cough Mixture
Zyriton Expectorant Linctus

21 February 1985

CONFIDENTIAL JR

10 DOWNING STREET

From the Private Secretary

25 February 1985

Dear Steve,

LIMITED LIST OF NHS DRUGS

The Prime Minister has seen your Secretary of State's letter of 16 February to the Lord President, in which he set out proposals for a leaflet to explain the Government's decision on the limited list.

The Prime Minister is content with what is proposed, subject to the views of colleagues.

I am sending copies of this letter to Janet Lewis-Jones (Lord President's Office), John Graham (Scottish Office), Colin Jones (Welsh Office), Neil Ward (Northern Ireland Office) and Bernard Ingham at No. 10.

Yours ever,

David

(DAVID BARCLAY)

Steve Godber, Esq.,
Department of Health and Social Security.

CONFIDENTIAL

RG

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

Bernard Ingham Esq
Press Secretary
10 Downing Street

21 February 1985

Dear Bernard

My Secretary of State is making a statement on the limited list of NHS drugs this afternoon. I attach a copy of the final text. You and copy addressees might also find it useful to have copies of

(i) a background brief on the subject which is also being made available this afternoon in the Whips' office;

(ii) a speaking note on the current position.

My Secretary of State will also be writing to most Members of Parliament dealing with points which have come up during consultation.

Copies of this letter and attachments go to Private Secretaries to all Members of Cabinet.

Yours ever

Sheila McKeogh

pp S A Godber
Private Secretary

STATEMENT ON THE LIMITED LIST OF NHS DRUGS: THURSDAY 21 FEBRUARY 1985

With permission, Mr Speaker, I will make a Statement on the limited list of NHS drugs.

I told the House on 8 November that the Government intended to introduce a system under which a selected range of drugs would be available on the National Health Service in seven categories. These were:

- antacids;
- laxatives;
- analgesics for mild to moderate pain;
- cough and cold remedies;
- bitters and tonics;
- vitamins; and
- tranquillisers and sedatives.

I published at that time a provisional list of medicines which might be selected within each category. This was the basis for consultation which continued until the end of January. We made clear from the outset that our intention was to produce a list from which doctors would still be able to meet all the clinical needs of their patients. The Chief Medical Officers of the health departments wrote to all doctors individually to seek their views on the list. I am grateful to all the many doctors who responded and I hope they will recognise that their views have been taken into account. My Chief Medical Officer also brought together a group of independent experts practising in the relevant medical specialties, including three general practitioners and a pharmacist to assist him. That group has now unanimously recommended a list of medicines which they believe will meet all clinical needs. I have accepted their advice in full and I am most grateful for their help in this important task.

This extended list of medicines will contain some 100 different medicines, compared with 30 on the provisional list. Most of the medicines will be generic, or unbranded, products; but a number of proprietary medicines will be retained where the group concluded that they were necessary and where no generic preparation currently exists. I should emphasise that the quality of all the selected drugs is assured. They all conform to the very high standards we require of all medicines under the Medicines Act.

For the purposes of the Regulations which my rt hon Friend, the Secretary of State for Scotland, and I will introduce, it is necessary to list all the products which will no longer be prescribable on the National Health Service. The Regulations will also cover those products which the Advisory Committee on Borderline Substances have advised are not medicines and should not be prescribed by general practitioners. I am today publishing both the selected list of drugs and those no longer to be prescribable. Copies are available in the Vote Office.

I shall also today be giving the representatives of the medical and pharmaceutical professions the opportunity to comment on these Regulations as they affect the terms of their contracts with the health service.

Mr Speaker, I should like to mention three specific issues concerning the operation of the limited list which have been raised during the period of consultation.

The first is the question of the arrangements for reviewing the list itself. This was raised by, amongst others, the Royal College of Physicians. We fully accept that it is essential for independent professional advice to be available after April 1st on the need for changes to the list. I do not believe that complex machinery is required but I shall be very ready to discuss with the professional bodies concerned how the arrangements which have been used to formulate the extended list should be developed for the future.

Second, questions have been raised about the implications of the new arrangements for dispensing doctors - that is doctors predominantly in rural areas who themselves dispense drugs to their patients. For these doctors the Regulations will in effect retain the status quo. Dispensing doctors will still be able to supply any medicine to those of their patients for whom they already dispense although they will have to issue private prescriptions for medicines which are no longer available on the National Health Service. Concern has also been expressed about the position of retail pharmacists who now hold stocks of drugs which will no longer be available on the National Health Service. I am quite prepared to examine any relevant evidence that pharmacists may present on their stockholding of drugs.

Third, the question has been raised whether there should be some form of appeal mechanism for individual cases in which a doctor believes it is necessary to prescribe on the National Health Service a medicine which will no longer be available. Most concern was expressed by doctors who felt that there were serious omissions in the provisional list. My unanimous medical advice is that the selected list is now comprehensive and will make it unnecessary on clinical grounds for patients to use medicines not on the list. Nevertheless, let me say this: if, after examining the complete list and in the light of experience, the medical representative organisations still wish to propose that such a mechanism should be provided, my rt hon Friend and I will be ready to discuss it with them. I should make clear, however, that any mechanism would need to be very carefully controlled to ensure that it could only be used in genuinely exceptional circumstances.

Mr Speaker, during the period of consultation a number of alternative proposals have been advanced. Yet none of these offered the same prospect of achieving sensible savings in the NHS drugs bill without either harming the interests of patients or threatening the fundamental and legitimate interests of the pharmaceutical industry. The selected list which I am publishing today is likely to produce savings in the drugs bill of some £75 million now, rising to a higher figure in due course. I am therefore convinced that the approach we have adopted remains the right one in principle. I also believe that the selected list which I am publishing today will demonstrate that in practice the health service will continue to provide all medicines required to meet the clinical needs of patients. It is by making sensible savings of this kind that we are able to provide the health authorities with the increased resources which I have announced recently.

NATIONAL HEALTH SERVICE DRUGS LIST

The introduction of a limited list for some of the categories of drugs presently prescribable under the NHS will save money for the National Health Service that was previously spent unnecessarily. It is also carefully constructed, in the light of detailed advice from members of the medical profession, to ensure that the clinical needs of patients are fully safeguarded. So far from being an "attack" on NHS patients "the Government's plan is", in the words of The Times, "a modest overdue reform" (Editorial, 13 December 1984).

The proposals

The idea of a limited list was announced in Parliament on 8 November 1984. It was proposed that the list should take effect from 1 April 1985. When the announcement was made Ministers made it clear that they intended to consult members of the professions concerned and representatives of the drugs industry about the range of drugs in the categories affected which would be needed to meet the clinical needs of health service patients.

Seven categories of drugs are to be covered by the list proposals. They cover only around 10 per cent of the drugs bill. They are:

- antacids;
- laxatives;
- analgesics for mild to moderate pain;
- cough and cold remedies;
- bitters and tonics;
- vitamins; and
- tranquillisers and sedatives.

Consultation on the list

For illustrative purposes, and as a basis for consultation with the profession and the industry, the Government published a preliminary list in November 1984. The provisional status of that list was made clear to interested parties. A period for consultation was set aside lasting until 31 January 1985. However, the BMA and the representatives of the drugs industry swiftly rejected the idea of discussing amendments to the provisional list, despite their claims that the Government's proposals would damage patient care. The BMA Council even sought to prevent member doctors discussing the proposals with the DHSS; it urged doctors to "encourage" their patients to write to Members of Parliament. Seriously misleading advertising and poster campaigns were launched against the Government's plans.

There is therefore no basis for the claim that the Government has refused to consult on the list; the Government set aside twelve weeks specifically for consultations. Furthermore, the Chief Medical Officer at the DHSS, Dr Donald Acheson, was asked to take steps to ensure that within the context of the list the interests of NHS patients were fully safeguarded. Definition of the list is a matter for professional, not political, judgment. Dr Acheson therefore wrote individually to all doctors seeking their views on the list. He also assembled a group of independent experts from all the relevant medical specialties and the pharmaceutical professions to assist him in studying the drugs in the categories to be affected and in advising Ministers on the makeup of the list. The group included a General Practitioner, a Professor of Clinical Pharmacology, the Chairman of the Standing Medical Advisory Committee (also a General Practitioner), and specialists in child and geriatric care. The panel was asked to report by January 31st and to take into account comments submitted to the DHSS. They were assisted by constructive advice from many general practitioners who did not support the BMA's resolution not to communicate with the DHSS, as well as from the members of other relevant professions, from MPs, the public, and representatives of the pharmaceutical industry.

The Chief Medical Officer's Group has unanimously recommended a final list of medicines which it believes will meet all clinical needs. Ministers have accepted their advice in full. The Government is therefore confident that the list will contain all the medicines needed by the NHS to meet the clinical needs of patients.

The final list of medicines to be retained will contain some 100 different medicines, compared with 30 on the provisional list. The Chief Medical Officer's Group has extended the list in areas which include the laxatives, analgesics, and preparations for children about which most comment has been made during the period of consultation. Most of the medicines will be generic, or unbranded, products; but a number of proprietary medicines will be retained where the Group concluded that they were necessary, and that no generic version exists.

Saving Money for the health service

The limited list is in line with the Government's strategy for the Health Service as a whole - to eliminate waste and unnecessary expenditure so that more resources can be concentrated on direct patient care. The result of that strategy is that 650,000 more inpatients, ¼ million more day cases, and 2½ million more outpatient attendances were dealt with in 1983 than under Labour in 1978.

No-one can deny that there is scope for savings in the drugs bill. That bill costs the NHS nearly £1½ billion a year; it has been rising by an average of five per cent a year in real terms over recent years. In 1983 some 334 million prescriptions were dispensed through the Family Practitioner Service in England; current levels of prescribing are 40 per cent higher than they were 25 years ago. Over the same quarter of a century the range of medicines actually prescribed by GPs - as recorded in the Pricing Authority's master index of drugs - has doubled from less than 8,500 different items to some 17,000.

In the light of these increases and of the fact that education has consistently failed to persuade some doctors voluntarily to tighten up on slack and excessive prescribing practices, it is surely reasonable to seek the kind of limited savings from the drugs bill that are proposed.

It is certainly absurd for the Labour Party to criticise the proposals as being a threat to patients, or a move towards a "two-tier health service". In their 1983 Election Manifesto the Labour Party promised action as part of their strategy "to reduce inequalities in standards of health care" to "ensure that the drugs available are safe, effective, and economic" ("New Hope for Britain" para. 84).

No clear alternatives

Both the BMA and representatives of the drugs industry have suggested to the public that there might be alternative ways of producing the savings achievable through the limited list. Their proposals are neither consistent nor convincing.

The BMA has suggested a return to certain proposals of the Greenfield Report on prescribing which they previously had not accepted. Under these proposals for "generic substitution" it would be possible for a pharmacist to replace a brand name drug prescribed by a generic alternative, where such an alternative was available. This policy could apply in all categories of drugs, not simply in those limited categories covered by the Government's plans. The pharmaceutical industry would undoubtedly see such an idea as threatening research in areas of major therapeutic significance. Furthermore, the BMA would only accept generic substitution on a voluntary, or "opting-in", basis. In other words a doctor could indicate by a tick on a prescription that a substitute was acceptable. Self-evidently it is already open to doctors to prescribe a substitute themselves. Savings under this proposal could not therefore be significant; nor would doctors know what medicine their patients had actually received.

The pharmaceutical industry for their part have suggested a range of alternatives including reducing the number of people exempted from prescription charges, levying new charges in the health service, or squeezing the wholesalers responsible for distributing supplies of drugs throughout the country. Certainly none of these alternatives would affect the drugs industry; but it is not clear that they would be welcome to the public - or, for that matter, the BMA.

How the List will be implemented

The next Parliamentary step will be to lay regulations listing the drugs which will no longer be available on the NHS in the categories covered. Before that the professions will have a short period to make comments on the draft regulations. The regulations will have to list unavailable drugs because it is not possible to define the categories of drugs in legal terms; it is necessary to list all drugs which will not be available. The drugs unlisted in the regulations in the categories concerned will be the limited list. Copies of both the limited list and of the list of drugs to be unavailable will be available for members in the Vote Office.

Keeping the list up-to-date

The list will apply from 1 April. After that Ministers have made it clear that they will want to have a system in being for deciding whether new drugs should be added to the list. This was a recommendation made by the Royal College of Physicians when they offered their support for the principle of the list. Clearly advice on the value of new drugs has to be from the professions. Ministers will welcome talks with the professional bodies concerned on how simple machinery could be put in place to review the list for the future.

Special arrangements in rural areas

In rural areas in particular the practice of doctors being able to sell drugs directly to some patients is regarded as a valuable service. Patients who have difficulty in getting to a pharmacy or who live more than one mile from a pharmacy can apply to be dispensing patients and be provided with drugs by their doctors. Under the new regulations dispensing doctors will continue to be able to sell drugs which are no longer available under the NHS to dispensing patients. Dispensing patients will, if they wish, be able to buy non-listed drugs from their doctor in the same way as patients near a pharmacist will continue to be able to buy non-listed drugs over the counter.

An appeals system?

After three months of consultation and in the light of the unanimous opinion of the Chief Medical Officer's expert panel the best professional advice available to Ministers is that the limited list will cover all clinical needs. No patient need on clinical grounds use a medicine not on the list. However, the Secretary of State has made clear in his statement that should any professional organisation still wish to propose that arrangements might be made to permit the use of a non-listed drug on the NHS in exceptional individual cases he would be ready to discuss that possibility.

QUESTION AND ANSWER

WHY HAVE A LIMITED LIST?

In order to treat more patients with the resources available to the NHS we need to cut out waste and concentrate those resources more on direct patient care. The drugs bill accounts for around £1½ billion, around 10 per cent of health spending; value for money is as important in the drugs field as anywhere else. If we can provide the drugs needed to treat NHS patients just as effectively but more cheaply, that must be to the benefit of the Health Service. That is the purpose of the limited list.

HAS THE DRUGS BILL REALLY EXPANDED RECENTLY?

Recently the NHS drugs bill has increased by 5 per cent a year on average in real terms. The range of drugs available has doubled since 1960. The number of prescriptions issued annually has increased by 100 million in the last twenty-five years. There is no doubt that there has been a substantial increase in both prescribing and expenditure.

WHAT HAPPENS IN OTHER COUNTRIES?

No other country allows every drug to be prescribed at public expense; most apply restrictions across the board, not simply in the limited categories proposed by the Government. The Scandinavian countries have significantly lower prescribing levels than the UK. In West Germany, France, Italy and Spain Governments have also concluded that prescribing is excessive and have taken steps to contain the drugs bill.

WHY NOT LEAVE IT TO VOLUNTARY ACTION?

The medical profession accepts that present prescribing levels could be reduced; efforts have been made to encourage more rational prescribing. Education has been tried for many years - and the level of prescribing and expenditure on drugs has continued to climb. The Government spends £1 million a year on efforts to promote better prescribing, distributing several key publications free to all GPs. But the fact is that little result has been shown.

IS THIS NOT A "TWO-TIER" HEALTH SERVICE?

The Health Service is about answering the clinical needs of patients and treating what is wrong with them. The limited list of drugs will answer those needs. Access to treatment will not depend on means. It is not the responsibility of a taxpayer-supported Health Service to subsidise expenditure on unnecessarily expensive methods of treatment.

IS THIS NOT AN ATTACK ON DOCTORS' FREEDOM TO PRESCRIBE?

The first responsibility of doctors is to provide effective care for their patients and to give careful thought to what they prescribe. The essential question is whether freedom to prescribe any drug under the NHS is necessary for effective patient care. The limited list includes a range of drugs sufficient for all clinical needs. Doctors will still be free to prescribe any medicine if they and their patients wish. But the NHS will not be under a duty to pay for a more expensive medicine where a cheaper one will do.

WILL THE PROPOSALS THREATEN MEDICAL RESEARCH?

There is no reason why they should. Any new medicine offering real improvements in care could be added to the drugs on the list under the procedures proposed by the Secretary of State. Furthermore, any new drug could compete for the private market in the UK and the remaining 96 per cent of the world market. The limited list proposals specifically exclude the major therapeutic categories of drugs. There will not be even a marginal effect on research resources in those key areas.

WHY DID THE GOVERNMENT NOT CONSULT THE PROFESSIONS?

From the beginning the Government made clear its desire to consult. The composition of the list is self-evidently a matter for professional judgment. Twelve weeks were allowed for consultation; much invaluable advice was received by the CMO in that period. It was the BMA that elected not to discuss the details of the list with the Government.

WHY HAS THE LIST BEEN SO CHANGED? IS THIS A CLIMB-DOWN?

There is no question of a climb-down. It was made clear from the beginning that a provisional list was being issued for consultation and that professional advice would be taken on it. In response to that advice and to ensure the full protection of patients extra items have been added to the list. The list contains around 100 medicines, as opposed to 30 in the provisional list. But some 2000 products will be excluded from use under the NHS, thus maintaining the major proportion of savings for patients.

SPEAKING NOTE ON LIMITED LIST

The NHS drugs bill runs to around £1½ billion - almost ten per cent of spending on health. If sensible savings can be found in this area, just as in the rest of the health service, then money that otherwise would have been wasted can be put to good use for patient care.

That was why last November Norman Fowler suggested that in seven limited categories of drugs, covering just 10 per cent of the drugs bill - drugs like cough and cold remedies, vitamin pills, tonics, and tranquillisers - it would be possible to reduce the enormous range of products that can be prescribed free under the NHS without damaging patient care. In these categories of drugs - most of which can be bought across the chemists' counter - products of similar properties cost greatly differing amounts. In effect the NHS is paying for the brand-name of the medicine as much as for the generic substances inside.

The Government asked for the advice of the medical profession and the drugs industry on this plan. Nearly three months were set aside for consultation. Although they claimed that the plans would hurt patients, some organisations, like the BMA, refused to talk to the Government about them. Some of the drug companies were concerned that their profits at the expense of the NHS would be reduced. So a series of ads. and posters were produced which caused unnecessary concern to the public.

However, a large number of doctors did offer useful advice. Many professional organisations were in close touch with the Government. They saw no difficulty in accepting the principle of a limited list. Other countries restrict the range of drugs that are available at public expense. And the fact is that a limited list system is already operated in most British hospitals without any problems at all.

Norman Fowler asked the Chief Medical Officer at the DHSS, Dr Donald Acheson, to go through all the comments that were made in the three months of consultation. Dr Acheson wrote to every GP in the country. What he also did was to get together a team of eight top experts in the relevant professions, including GPs, to look at every drug on the market in the categories to be affected by the list. The final revised list is a professional list drawn up by professionals and commented on by professionals. The Government has accepted it in full.

So why the fuss? The clinical needs of NHS patients will be safeguarded. New drugs which offer clear benefits to patients can be added to the list. Norman Fowler has said that he will discuss suggestions for an appeals mechanism for dealing with any exceptional cases. The NHS will save tens of millions of pounds which otherwise would have been frittered away on buying expensive drugs which offered no extra benefits to patients.

So the NHS will benefit from this proposal. And the NHS patient can be confident that his illness will be treated no less effectively. Far from being an "attack" on the NHS the limited list plan is a sensible and modest step, taken in the public interest.

AS

AS 21/2

CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street, SW1P 3AG

Steve Godber Esq
Private Secretary to
Secretary of State
Department of Health and Social Security
Alexander Fleming House
Elephant andd Castle
London
SE1 6BY

21 February 1985

Dear Steve

LIMITED LIST

Thank you for sending me a copy of your letter of 19 September to Andrew Turnbull.

The Chief Secretary is content with the terms and timing of the proposed announcement.

Copies of this letter go to Andrew Turnbull, Janet Lewis-Jones, John Graham, Colin Jones, Graham Sandiford, Charles Marshall and Murdo Maclean

Yours sincerely

Richard Broadbent

R J BROADBENT

NAT HEALTH : EOP Pt 4

014/110

SECRET

6

NBPM 21/2

Treasury Chambers, Parliament Street, SW1P 3AG

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

21 February 1985

Dear Secretary of State

EXPENDITURE ON THE FAMILY PRACTITIONER SERVICES 1985-86

Thank you for your most helpful letter of 19 February.

I entirely appreciate the urgency of announcing the limited list, and in the light of your letter, I am content that you should do so this week.

I accept that given the uncertainties of FPS expenditure I was asking a lot of you in seeking a firm commitment on staying with your PES baseline. I therefore welcome the arrangements you offer on the second and third pages of your letter. In particular, I am prepared to agree to any savings from outturn falling below forecast being applied, if needed, to meet the shortfall on limited list - provided they are not required to meet increased spending elsewhere within the FPS.

I am glad to see your proposals for announcing the increases in prescription and dental charges. I am of course prepared to accept your political judgment on the timing of the dental charge increases. But I am concerned to be sure that the charging increases overall deliver at least the full savings agreed for 1985-86 in that year. I think it would be wrong to compound the problems on limited list with a shortfall here. Indeed I still think there are attractions in pushing up the dental charge increase to offset at least part of the savings foregone on limited list. I should be grateful for your response on these points - but this no longer need hold up your announcement on limited list.

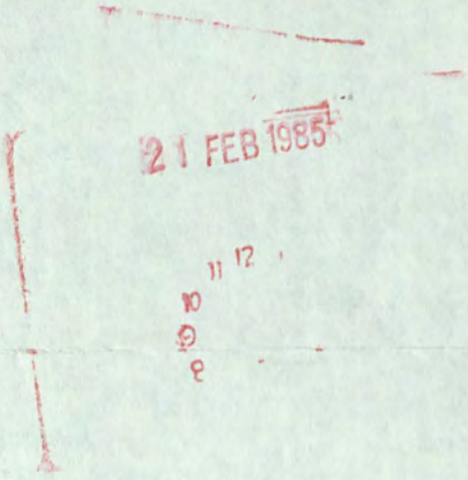
Copies of this letter go to the Prime Minister, Lord President, Secretaries of State for Scotland, Wales, Northern Ireland, Lord Privy Seal and the Chief Whip.

Yours sincerely

PETER REES

[Approved by the Chief Secretary]

NAT HEALTH : CCP Pt 4



CONFIDENTIAL

cc DW

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

Andrew Turnbull Esq
Private Secretary
10 Downing Street

19 February 1985

Have spoken to DHSS. Pse p.a.

DwB
20/2

Dear Andrew

LIMITED LIST

I enclose a draft of the statement on the limited list which my Secretary of State is now planning to make on Thursday. I shall be grateful for early comments.

Copies go to Janet Lewis-Jones (Lord President's office), Richard Broadbent (Chief Secretary's office), John Graham (Scottish Office), Colin Jones (Welsh Office), Graham Sandiford (Northern Ireland Office), Charles Marshall (Lord Privy Seal's office) and Murdo MacLean (Chief Whip's office).

Yours

S A Godber
Private Secretary

CONFIDENTIAL

DRAFT STATEMENT ON THE LIMITED LIST

With permission, Mr Speaker, I will make a Statement on the limited list of NHS drugs.

I told the House on 8 November that the Government intended to introduce a system under which the range of drugs available on the NHS would be limited in seven categories. These categories were:

- antacids;
- laxatives;
- analgesics for mild to moderate pain;
- cough and cold remedies;
- bitters and tonics
- vitamins; and
- tranquillisers and sedatives.

I published at that time a provisional list of medicines which would be retained within each category as a basis for consultation which continued until the end of January. I made clear from the outset that our intention was to produce a list from which doctors would still be able to meet all the clinical needs of their patients. My Chief Medical Officer wrote to all doctors individually to seek their views on the list and a great many specific comments were received. These have been taken into account. The Chief Medical Officer also brought together a group of independent experts active in all the relevant medical specialties and a representative of the pharmaceutical profession to assist him. That group has now unanimously recommended a list of medicines which they believe will meet all clinical needs. I have accepted their advice in full and I am most grateful for their help in this important task.

The final list of medicines to be retained will contain some 100 different medicines, compared with 30 on the provisional list. Most of the medicines will be generic, or unbranded, products; but a number of proprietary medicines will be retained for the time being where the group concluded that they were necessary and where no generic version currently exists. I should emphasise that the quality of all the retained drugs will be assured. They will be required to meet the same standards as we require of all other drugs.

For the purposes of the Regulations it is necessary to list all the products which are no longer to be available on the NHS. The Regulations will in fact cover some 2,000 different products because each manufacturer's version of any drug not to be available has to be listed. The Regulations will also include those products which the Advisory Committee on Borderline Substances have advised are not medicines and should not be prescribed by general practitioners. I am today publishing both the list of drugs to be retained and those not to be available. Copies are available for members in the Vote Office. In due course, the Dental Practitioner's Formulary will also be amended.

I am also publishing today a draft of the Regulations which determine the way the limited list is to operate. I shall be giving the medical and pharmaceutical professions' representatives an opportunity to comment on these Regulations as they affect the terms of their contracts with the health service.

Mr Speaker, I should like to mention three specific issues concerning the operation of the limited list which have been raised during the period of consultation. The first is the question of the arrangements for reviewing the list itself. I fully accept that it is essential for independent professional advice to be available after 1 April on the need for changes to the list. I do not believe that complicated or statutory machinery is required but I shall be very ready to discuss with the professional bodies concerned how the arrangements which have been used to formulate the final list should be modified for the future.

Second, concern has been expressed about the implications of the new arrangements for dispensing doctors and for retail pharmacists who now hold stocks of drugs which will no longer be available on the NHS. For dispensing doctors - that is doctors in rural areas who themselves dispense drugs to their patients - the Regulations will in effect retain the status quo: such doctors will continue to be able to supply any medicine to their patients, although they will have to sell privately medicines which are no longer available on the NHS. As far as stocks of medicines held by pharmacists are concerned, I am quite prepared to examine any evidence they may present on this as part of a general review of stockholding.

Third, the question has been raised whether there should be some form of appeal mechanism for individual cases in which a doctor believes it is necessary to prescribe a medicine which will no longer be available. I can understand why people may have wished to propose such a system if they felt that there were serious omissions in the provisional list on which we consulted. But I believe that the final list is now comprehensive and will obviate the need for any patient to use

medicines not on the list on clinical grounds. Nonetheless if, after examining the final list or after its introduction, the medical representative organisations wish to propose that such a mechanism should be provided, I shall be ready to discuss it with them. I should make clear, however, that any mechanism would need to be very carefully controlled to ensure that it could only be used in genuinely exceptional circumstances.

Mr Speaker, the period of consultation on my proposal has been remarkable for the range and force of the views expressed on both sides. A variety of alternative proposals have been advanced. Yet none of these offered the same prospect of achieving sensible savings in the NHS drugs bill without either harming the interests of patients or threatening the fundamental interests of the pharmaceutical industry. I am therefore satisfied that the limited list approach remains the right one in principle. I also believe that the final list which I am publishing today will demonstrate that in practice the health service will continue to provide all medicines required to meet the clinical needs of patients.

SECRET

cc DW AT 5

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Peter Rees QC MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON
SW1P 3AG

19 February 1985

AT to see nbpm 20/2

Dear Peter.

with AT?

EXPENDITURE ON THE FAMILY PRACTITIONER SERVICES 1985/86

Thank you for your letter of earlier today. I am grateful for your recognition that I have always done my best to honour my survey commitments.

I can respond positively to all the points you make in your letter but I think there is one other point that neither of us should lose sight of - the importance of actually achieving the savings that can now be secured from the limited list policy. If we are to achieve the savings described in my letter of 15 February, it is essential that the decisions on the limited list should be announced this week. If they are not, then it would become impossible to bring the scheme into operation on 1 April and as the consequence we will start to lose the savings I have identified at a rate of some £6 - 7 million a month. The reason the timetable is so tight is because the professions must be consulted (albeit very briefly) about the draft regulations that will be needed to implement the limited list, then the regulations must be made and laid and then time must be allowed for a debate in the House: all of this must be completed by mid-March if we are to stick to our target of bringing the new arrangement into operation on 1 April.

Turning to the points you raised in your letter, I can certainly confirm that I intend to keep to my commitment to raise prescription charges and dental charges to achieve the full-year savings which you mention. The basic prescription charge will be raised to £2 and changes in dental charges will be introduced to achieve a saving of £35 million a year. There is, of course, a political interaction between these increased charges and the limited list proposals and, given the rough ride we have been having on the limited list, I have

E.R.

concluded that we should not open up another flank with the dentists before the limited list policy is itself safely through. I would therefore want to leave the announcement on dental charges until later in March, with the changes coming into effect on 1 May. This may cause us to fall short of the savings we undertook to provide in 1985/86 although the outcome is uncertain because the unprecedented increase in charges may lead to a substantial fall in demand for treatment in the short term. The delay will not, of course, in any way reduce the volume of savings in subsequent years. Moreover, I think this timing is essential if we are to avoid still more serious problems in carrying through the policies on dental charges and the limited list.

The raising of the prescription charge to £2 will also attract criticism: but I agree with you that there is much to be said for ensuring that the Government's decisions on prescription charges are known at the same time as the House is debating the limited list proposals. With that in mind, I plan to announce the increase in prescription charges next week (I will be consulting colleagues separately about the precise timing) in time for the change to come into full effect on 1 April.

In response to your concern that expenditure on the FPS should not rise as a result of the reduced savings on the limited list, I can confirm that if monitoring later this year shows that FPS expenditure is rising above the PES line, and that this is the result of the decisions on the limited list, then we should consider together the scope for offsetting savings from within the health programme. If savings prove to be necessary, I shall do my very best to find them. But, as I indicated briefly in my letter of 15 February, I shall not be content simply to wait and see how the figures develop. Kenneth Clarke and I are taking firm action to follow up options for increasing savings on the FPS. But, like the action we have been taking this Winter, some of the action that lies ahead of us will again prove to be controversial. The measures in prospect include:

- pressures to bring in new generic drugs to replace some of the more expensive proprietary drugs we have had to retain on the limited list;

- pressing other ways to achieve more economical prescribing practices: the BMA's (belated) public recognition that there is scope for more economical prescribing gives us a real chance of making some improvement here;

- reducing the rate of increase in the number of dentists by introducing immigration controls: Kenneth Clarke has now secured the agreement of the Departments most closely concerned so that we can put proposals to H Committee shortly;

E.R.

- we are already seeking from the drug companies a £30 million a year reduction in the cost of the drugs they supply to the NHS.

We are therefore doing a great deal to constrain the bill for the Family Practitioner Service. Moreover, I am hopeful that the work which has been done by both your officials and mine to improve our forecasting techniques will mean that actual expenditure in 1985/86 does not rise above the levels that we have allowed for in the Public Expenditure Survey. Our latest forecasts for this year, for instance, suggest that we could see an outturn some £30 million below what we envisaged last Autumn; although it is clearly too early to know what this will mean for 1985/85.

In view of this fuller explanation, I hope you will now be able to agree that it is in the Government's interest that we should announce our decisions on the limited list policy this week; that I should continue to pursue the new initiatives that I have mentioned above; and that we should review the scene later in the year when we can see what is in fact happening on the ground following the major changes that we are now introducing (the limited list proposals themselves and the unprecedented (30 per cent) increase in dental charges). The alternative, of postponing an announcement on the limited list, would, as I have already explained, mean a substantial delay in introducing the limited list proposals and would mean forfeiting some of the savings which I believe we can and should achieve.

I am sending copies of this letter to the Prime Minister, Willie Whitelaw, George Younger, Nicholas Edwards, Douglas Hurd, John Biffen and John Wakeham.

Yours ever,

NORMAN FOWLER

Not Healthy NHS Expenditure & Efficiency Pt 4

004/110

CONFIDENTIAL

CDW

NBPM AT 19/2

Treasury Chambers, Parliament Street, SW1P 3AG

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

Mr Turnbull
To see
Toms 19/2

19 February 1985

Dear Secretary of State,

EXPENDITURE ON THE FAMILY PRACTITIONER SERVICES 1985-86 AND LIMITED LIST OF DRUGS

Thank you for your letter attached to me, and the copy of your letter to Willie Whitelaw, both dated 15 February.

I know that you regard yourself as being very much personally committed to achieving any savings you offer me during the Survey. If you are prepared to agree at this stage that you will somehow or other find within the health programme the necessary additional savings in 1985-86 to meet your agreed FPS PES figures, then I am prepared to proceed on the basis you suggest and will not press you to take policy action now to achieve the savings. I accept that you would be taking a risk here, particularly given the usual habit of the FPS to exceed provision. However, if you are not prepared to agree, then I must insist that your announcement be held back while we agree how the deficit should be made up. I simply cannot afford to rely on wishful thinking: and as we know from past experience, the Autumn is really too late to take effective action in-year. I am also surprised that you say nothing in your letter to Willie about announcing increases in prescription and dental charges. You agreed in the Survey to savings in 1985-86 of £13 million on prescription charges and £35 million on dental charges, in addition to the £92 million from the limited list. My understanding is that to achieve maximum savings, the new dental charges should have been announced by the end of January. Certainly the prescription and dental charge increase should be announced very quickly, which suggests they might sensibly be done together with, or close after, the limited list. Before agreeing to announcing the limited list, I should want to see your proposals on charges and be assured that the full savings will be achieved. At the risk of paining you, it seems to me that we may also have to consider much higher dental charges, as I originally proposed in the Survey, to offset the limited list shortfall.

CONFIDENTIAL

Copies go to George Younger, Nicholas Edwards and Douglas Hurd, and with copies of your letter to me, to the Prime Minister, Willie Whitelaw, John Biffen and John Wakeham.

Yours Sincerely,

Paul Lever

PP PETER REES
(approved by the Chief Secretary and signed in his absence)

MJ2ADL

bcc W Willetts

10 DOWNING STREET

From the Private Secretary

18 February 1985

Limited List of Drugs

The Prime Minister has seen your Secretary of State's letter of 15 February to the Lord President. Subject to agreement with the Treasury on the expenditure implications of the wider list, she is content with the revised proposals and that a statement should be made later this week. She is content also that the list should be revised periodically, that an exceptions procedure be discussed with the profession and that dispensing doctors should be allowed to provide black listed products privately. The Prime Minister hopes that the statement will avoid or at least limit any assurance to the drug industry that there will be no further extension of the limited list.

I am copying this letter to Janet Lewis-Jones (Lord President's Office), John Graham (Scottish Office), Colin Jones (Welsh Office), Jim Daniell (Northern Ireland Office), David Morris (Lord Privy Seal's Office), Murdo Maclean (Chief Whip's Office), Richard Broadbent (Chief Secretary's Office) and Richard Hatfield (Cabinet Office).

Andrew Turnbull

Steve Godber Esq
Department of Health and Social Security.

CONFIDENTIAL

CCBT CCO

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon The Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
68 Whitehall
LONDON
SW1A 2AT

16 February 1985

Prime Minister (2)

Dear Willie. A good idea, though the leaflet could be improved. DHSS 20/2

LIMITED LIST OF NHS DRUGS

I wrote to you on 15 February about my announcement of the final limited list and the Parliamentary arrangements for its introduction. I am writing now about how we should explain to the public what is involved.

After the limited list comes into effect on 1 April, a great many people will find themselves being given a different medicine from that which they have been used to. In many cases their doctors will explain the change carefully and sensibly but I think we have to do everything we can to help the process go as smoothly as possible. I shall therefore be producing leaflets - of which I attach a draft - explaining the change which can be available in every doctor's surgery and in every chemist's shop. That will help to deal with the change when it happens. But I think we also need to prepare the ground in advance. I therefore propose, subject to your agreement, to place advertisements in the national press as soon as the Regulations have been laid. The advertisements seek to explain simply how the limited list will operate - on lines similar to the leaflet.

I see this as important if we are to prepare for a smooth introduction for the list. It will also help to reassure the public following the misleading comment and advertising which we have seen in the last few months.

I shall, of course, be briefing our Parliamentary colleagues and the media separately to ensure that they are fully in touch with the details of the final limited list, and the arguments for sticking to our policy. I expect to be writing to colleagues directly after my statement so that they are able to deal with the further attacks which we must expect, particularly from the pharmaceutical industry.

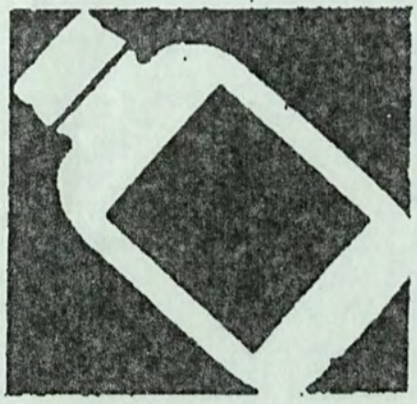
E.R.

I am copying this letter to George Younger, Nick Edwards, Douglas Hurd and to the Prime Minister's Chief Press Officer.

Yours

NORMAN FOWLER

NHS Medicine Changes



What it means to you

A CHANGE IN THE MEDICINES YOU CAN GET ON YOUR NHS PRESCRIPTION

. What is the change?

From 1 April 1985 you can no longer get some medicines on NHS prescription. ONLY the following medicines are affected:

- . Mild pain killers
- . Cough and cold remedies
- . Vitamins
- . Laxatives
- . Tonics
- . Indigestion remedies
- . Mild sedatives and tranquillisers

But you can still get fully effective medicines in each of these groups. And you can still get all the medicines in the other groups on NHS prescription, as before.

. What does the change mean?

There are very many medicines in each of the groups listed above. Many of these have exactly the same effect. Where this is the case, we have worked out which medicines represent the best value for money; and these are the only ones you can now get on NHS prescription.

You may have to change to a different medicine, but it will be just as good as the one you were using before.

. Can you get the medicines that are no longer on NHS prescription?

Yes. If you wish to continue using the same medicine and you can no longer get it on NHS prescription, you can buy it from your pharmacy. For some medicines you will need a non-NHS prescription from your doctor, before your pharmacy can sell them.

. Why has the change been made?

By limiting the range of medicines you can get in the groups listed above we can make a considerable money saving and still give just as good treatment as before. This money is needed to improve other parts of the NHS.

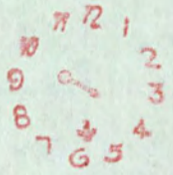
The medicine you get will be just as good as the one you were using before.

YOUR DOCTOR OR PHARMACIST WILL ADVISE YOU.

ISSUED BY THE UK HEALTH DEPARTMENTS

Nat Health; NHS Expenditure: Pt 4

20 FEB 1985



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 Peter Rees QC MP
Chief Secretary to the Treasury
Treasury Chambers
Parliament Street
London SW1

CHIEF SECRETARY	
REC.	18 FEB 1984
ACTION	Mr Raynes
COPY	PPS Mr Bailey
	Mr Watson
	Mr Scholar, Mr Mc Williams
	Mr Cropper, Mr Lord

Sir Peter Middleton
Mr Peet
Mr Gray

15 February 1985

Dear Peter

EXPENDITURE ON THE FAMILY PRACTITIONER SERVICES 1985/86

In the course of the Public Expenditure discussions last Autumn we agreed that we should look for savings of some £90m on our projected expenditure on the Family Practitioner Services in 1985/86, by limiting the range of drugs which may be prescribed at NHS expense. I am writing now to bring you up to date with the progress that has been made.

There has, as you know, been fierce criticism of our proposals from the drug industry and from some sectors of the medical profession. That criticism was to have been expected, and both Kenneth Clarke and I have made it plain that this opposition is no reason to deviate from the Government's agreed course of action. We have firmly resisted any suggestion that the Limited List proposals should be amended to suit the interest of the drug companies.

What we have not been able to resist, however, is the medical advice. As you may know the Chief Medical Officer here has chaired an advisory group with the remit of ensuring that limited list of drugs which will continue to be prescribable at NHS expense honours our pledge that patient care will not be harmed by the proposals. The Chief Medical Officer and his team agree that a very large

E.R.

number of drugs in the classes we wish to limit can indeed be safely "black listed": but they advise me that in the interest of the good care of patients, the limited list of permitted drugs will have to be somewhat larger than we had originally hoped. I do not think we can, or should, contradict or overrule this advice. If we attempted to do so, we would not only engage in difficult medical and ethical issues, but would also be seen to be ignoring the best advice available to us about patient care.

I have no alternative but to accept the Chief Medical Officer's advice and the financial implications that flow from it. Against the original projected saving of £90m, the Limited List would now generate an immediate saving of £55m. There is however scope for improving upon this. The CMO also advises me that if generic preparations can be manufactured to replace some of the more costly drugs, further substantial savings are likely. Kenneth Clarke and I are pursuing this urgently; the savings we can already identify from this will reach £15m a year in the course of the next two or three years, some of these additional savings will arise in 1985/86.

Given the vociferous opposition to the Limited List proposals, I think we have made much better progress than at one stage seemed possible. There are signs now that once the Government has made up its mind, and announced firmly the details of the way in which the new policy will work, the medical and pharmaceutical professions, and to a lesser extent the drug industry, will acquiesce in what we are doing, and, perhaps a little grudgingly, work with us to secure the savings that the scheme promises. I do not think we should underestimate this achievement: as you know we are scored in PES to achieve even further savings on the drugs bill in future years, and a good working relationship with the professions and with the industry will be essential if we are to retain any chance of securing those additional savings.

Although any forecast on a policy change of this sort must be somewhat speculative it seems likely on the basis I have outlined, that we may be up to £35m short of the savings for 1985/86 which we took into account in the Public Expenditure discussion last Autumn. I have, of course, considered whether there is any way in which the savings could be increased, either by further amending our own limited list proposals, or by taking additional action in some other field. As you know, this is an area that we combed very thoroughly last Autumn and although the matter has been looked at again, I cannot see how any additional ways of reducing expenditure beyond those already agreed. Even if additional approaches could be found, it might be tactically unwise to press ahead with them, given the degree of controversy that already surrounds our limited list proposals, the size of our intended increases in dental and prescription charges, and the further punishing blow we are dealing to the drug companies in seeking a £30m additional saving.

It is however too early to say whether or not this expected shortfall in savings will result in a net increase in the funds required for the Family Practitioner Services for 1985/86 or how large that

increase would be. Until the financial year has been under way for a few months, we will not know whether the forecast of expenditure made last year needs adjustment or not. The reaction of many people to our proposals has been to acknowledge that there is scope for more economical prescribing: the BMA have now publicly recognised that this scope exists. Indeed they have agreed to open discussions with me on it once the limited list argument is over. I intend to build on this to achieve an agreement with family doctors to restrain and monitor prescribing costs across the board. This should pay useful dividends, and add to the savings we are achieving, but we shall have to wait until later in the year before we can assess its effect. Similarly we will not know until later in the year the extent of the additional savings in 1985/86 from the availability of some generic drugs. I propose therefore that our officials should monitor progress on this during the Summer, and should report back in time for us to take stock in the early Autumn.

I am sending copies of this letter to George Younger, Nicholas Edwards and Douglas Hurd.

Yours ever-

NORMAN FOWLER

PP

CONFIDENTIAL

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Viscount Whitelaw CH MC MP
Lord President of the Council
68 Whitehall
LONDON
SW1

February 15 1985.

Dear Willie.

LIMITED LIST OF DRUGS

I am writing to let you know that I intend, subject to your and colleagues' views, to announce next week my final decisions on the limited list of drugs for NHS use on which consultations finished at the end of January.

Although we have experienced an active public campaign against the limited list proposal by the BMA and the pharmaceutical industry over the last few months, I think we have reached a satisfactory position as a result of the consultations. The key element in this was to ensure that the final list was professionally credible - that is, that it would enable all clinical needs to be met. To achieve this my Chief Medical Officer called together a group of eminent independent experts to advise him. The list of drugs they have proposed is longer than the provisional list we consulted on - about 100 medicines compared with 30. But it achieves a well-founded balance between meeting genuine criticisms of the original list and securing economies. I am certain we must be seen to have accepted this independent professional advice in its entirety. This inevitably means that the savings which we will achieve are smaller than originally envisaged although - at £75 million on a UK basis - still much greater than could have been achieved by the alternatives proposed by critics of the scheme. The savings should also rise by up to £20 million over the next 2-3 years. I have written separately to the Chief Secretary about this.

There are three other points which I will have to meet in my statement. First, it is clearly essential that we should have a continuing system for reviewing the content of the list so that drugs can be taken off or put on the list over time. I intend to announce my acceptance of that in principle and invite the professions to discuss the composition of the committee with me.

Secondly, I shall adopt a similar approach to the question of an appeals mechanism for individual cases, that is a system which would enable patients to be given drugs no longer available in very

E.B.

exceptional circumstances. (It is quite clear from discussions with colleagues that we have to be ready to meet for instance the case of an elderly patient who cannot adjust to a change of drug.) However I shall not go as far as fully to accept the case for having such a mechanism. The problem is that it will be impossible to have an effective policing arrangment in place by 1 April. If we allowed any interim period during which the only control was by self-regulation it would become impossible to introduce tighter controls later; there would then be no reason for the profession to accept any policing system we proposed. I intend, therefore, to affirm our view that the revised limited list is sufficient for all needs but to announce my willingness to discuss with the profession the need for and nature of an exceptional case procedure if they wish. I believe that this approach, together with my stance on a system for reviewing the list itself, will place the onus on the profession rather than the Government to enter into constructive discussions, which they have so far avoided. I am, of course, content for negotiations to take place separately in Scotland and for arrangements to be introduced earlier there if, as is likely, they can be settled more quickly.

Third, I agree with George Younger and Nick Edwards that we must enable dispensing doctors to provide black-listed products privately even though they are not available on the NHS. This has been a particular issue for them although it also arises in rural areas of England. There is, of course, a danger that dispensing doctors could exploit their position to sell black-listed drugs to their patients but that is, in my view, outweighed by the danger of creating a further row with the doctors and undermining our claim that all drugs will continue to be available either on private prescription or over the counter, if patients want them.

I believe that, by accepting the fuller revised list proposed by our professional advisers, we will disarm many of our critics. By also dealing with the other key issues as indicated above, I am sure we can carry our colleagues and much of the profession with us.

I think it important to make my announcement by an oral statement as soon as possible - preferably next Wednesday - in order to ensure that the Regulations can be debated before the scheme comes into effect on 1 April. The full limited list (of some 100 medicines), and the 'black list' (of some 2000 medicines) which formally has to be defined in Regulations, will be available at the time of my announcement. I will then have to allow a short period for consultation with the professions about the substance of the Regulations (not the list itself) because they involve changes in general practitioners' and pharmacists' contracts. I would aim to introduce the Regulations formally on 1 March with a view to having them debated as soon as possible thereafter.

I am copying this letter to the Prime Minister, George Younger, Nick Edwards, Douglas Hurd, John Biffen, John Wakeham and Peter Rees.

Yours ever.

NORMAN FOWLER

CONFIDENTIAL

Prime Minister -
agree Mr. Fowler's proposals, subject to Policy Unit comments?
Duty Clerk
AT
15/2/85.

PRIME MINISTER

DRUGS

Norman Fowler has fought a good campaign to save money on the exorbitant drugs bill against outrageous drug industry propaganda. We broadly agree with the proposals in his letter to Viscount Whitelaw.

We had originally hoped to save £100 million from limited list prescribing. The savings have fallen to £70 million because expert advice is that more brand-name drugs than expected are needed for a distinct medical reason. Challenging this expert advice would be unwise - some little old ladies are going to claim that the new drugs upset their bowels as it is. But the Chief Secretary will need to be satisfied that the DHSS expenditure figures will not be breached.

Although Norman Fowler does not mention it in his letter, I understand that in his Statement on Wednesday he wants to assure the drugs industry that we will not extend the limited list further. There is a political case for doing so as the drugs industry's real fear all along has been that this is the thin end of the wedge. But we have defended the proposals on general arguments of principle and we must not appear to undermine them now by restricting their application. Moreover, we need to avoid hostages to fortune which we may come to regret later. We might want to save more from the £1½ billion drugs budget which is still the soft underbelly of NHS expenditure. If there is to be any assurance at all, it needs to be drafted with great caution.

CONFIDENTIAL

I therefore recommend that you agree to Norman Fowler's proposals, subject to:

- Treasury agreement on the expenditure implications;

- avoiding or limiting any assurance of no further extension of the limited list.

David Willetts

DAVID WILLETTS

15 February, 1985

CONFIDENTIAL

Prime Minister (2)
To be aware of this story
AT 11/2

Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Swits fwrdd)
01-233 8545 (Llinell Union)

ODDI WRTH YSGRIFENNYDD
PREIFAT YSGRIFENNYDD
GWLADOL CYMRU

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 8545 (Direct Line)

FROM THE PRIVATE SECRETARY
TO THE SECRETARY OF STATE
FOR WALES

It is very long and

11th February 1985

Dear Andrew

... I enclose a copy of the statement on the University Hospital of Wales Cardiff which, with the agreement of the Leader of the House, my Secretary of State intends to make tomorrow afternoon. If you have any comments I would be grateful if they could be with me by close of play today.

/ I am copying this letter to David Hayhoe (Leader of the House of Commons) and (Lord Privy Seal), the Prime Minister's Chief Press Secretary, Murdo MacLean (Government Whip's Office), Richard Hatfield (Cabinet Office), Richard Mottram (Ministry of Defence), Stephen Godber (Department of Health and Social Security), Dinah Nichols (Department of Transport), Hugh Taylor (Home Office), Elizabeth Hodkinson (Department of Education and Science), David Beamish (Government Whip's Office, Lords), Mr Durant (Welsh Whip), Janet Lewis Jones (Lord President's Office), John Graham (Scottish Office), Richard Broadbent (Chief Secretary's Office), Jim Daniell (Northern Ireland Office), Viscount Long (Welsh Spokesman, Lords), Alex Galloway (Paymaster General's Office), Iain Jack (Lord Advocate's Department), John Ballard (Department of the Environment), and the Treasury Solicitor.

Yours ever

Paul Skellon

PAUL SKELLON

Andrew Turnbull Esq
10 Downing Street
LONDON SW1

In view of a number of misleading reports and unfounded allegations that have been published on the subject, I wish to make a statement about the defects at the University Hospital of Wales known as the Health Hospital.

The hospital was planned in the 1950's by The Board of Governors of the United Cardiff Hospitals. Messrs S W Milburn and Partners were appointed architects and Messrs W S Atkins and Partners engineers in 1961. F G Minter & Sons Ltd were appointed principal contractors for the main works in 1966.

The hospital was constructed between 1966 and 1972. Some faults - mainly arising from work carried out in the period 1966-1969, began to become apparent in December 1973, when the first piece of mosaic tile became detached and in 1974. In the meantime the hospital had been handed over to the Welsh Hospital Board in **October 1970** and became the responsibility of the new South Glamorgan Area Health Authority on reorganisation in 1974. The rights and liabilities of the Welsh Hospital Board passed to the Welsh Health and Technical Services Organisation (WHTSO) at the same time. The architect signed the final certificate of completion in November 1975.

The issue of this certificate was an event of crucial significance as it precluded claims against the contractors in contract or in tort in respect of defects patent at the time. At that stage, **WHTSO took no specific steps** to protect **its** legal position **and that of** the taxpayer against the contractors, the architects, or any other party.

In February 1977 a general property survey of the Heath complex by the South Glamorgan Health Authority led to concern at the condition of the mosaic cladding. WHTSO commissioned Ove Arup & Partners to carry out a survey to assess the extent of the problem and to produce recommendations. While that report was awaited the only legal action that was in hand was the defence by WHTSO of a claim by F G Minter Limited and subcontractors Drake & Scull Ltd who were seeking to recover finance charges under the terms of their building agreements. At that stage, the mosaic defects were considered to be defects in workmanship rather than design, and for this reason consideration was given to their inclusion as a counter-claim against Minters' finance charges claim. However, Counsel advised in July 1977 that such a counter-claim could not be sustained. No other legal action was taken prior to 1979 to protect the interests of the taxpayer.

Ove Arup's first report was received in November 1978, and having identified defects in the concrete during the course of their mosaic study they were further commissioned to carry out remedial and survey work on the concrete. The full extent of the mosaic defects having also now been clearly identified, WHTSO commissioned Bickerdike Allen Partners in January 1979 to advise them on the specification, supervision and execution of mosaic and related works. Their first report in April 1979 was addressed to these matters.

This report identified for the first time a possible claim against the architects (S W Milburn Partnership). The joint reference to Counsel was on 12 July 1979 when among other matters the question of

limitations was considered. Following that meeting with Counsel Bickerdike Allen prepared a further report which was received in November 1979 and was concerned with responsibilities and liabilities. Meanwhile, Counsel had been instructed in October to settle a draft writ and statement of claim against the Milburn Partnership, and in the instruction to Counsel the need for urgency was emphasised. Counsel settled notices of arbitration and an endorsement for the writ by telex on 17 December 1979 and the writ issued the same day.

At this point I must emphasise that despite allegations to the contrary, this writ was **not** out of time on the basis of the law as it then was. This provided that the 6-year limitation period ran from the date when damage was discovered or was reasonably discoverable by the plaintiff; and the relevant date for that purpose cited by Counsel in the Statement of Claim, was 18 December 1973. The law as to the limitation period **for a claim in negligence** was changed by the Pirelli decision of December 1982, but I repeat that at the time of issue of the writ it was in time **for the claim in negligence. It was in time, both before and after the Pirelli decision, for the claim in contract, where the limitation period was and is twelve years.**

I turn now to the outcome of the legal action, details of which were given on 6th February in an answer to my Hon Friend, the member for Cardiff Central. **I shall deal with** the allegation that there has been some kind of cover-up and the suggestion that in settling the action at about £300,000 the taxpayer has been negligently left with a liability for work costing £4m - or as is further alleged as much as

£8m. Let me say first that it has not been the usual practice under any Government to disclose full details of commercial settlements of this kind except to the Public Accounts Committee and in summary form in published accounts. In this case the total cost of remedial works of about £2.8m was attributable to structural defects other than the mosaic cladding. The Department's Accounting Officer reported to the PAC as long ago as 14 November 1983 Counsel's advice that legal action about this should not be pursued. He **had previously been** cross examined in some detail about this matter **by the PAC on 17th March 1982.** [and given full details of the amounts and the reasons for the decision.]

The settlement that was finally reached on the mosaics will be reflected in the summary of losses and compensation that forms part of the summary accounts of health authorities that are published every year **as a House of Commons paper,** and it was always the position that the Department's Accounting Officer would provide the PAC with any further information that it requires. There has therefore been no 'cover-up'; nor indeed could there have been. But in view of the outrageous statements that have been made on this subject in recent weeks, I have made available to the House, and my Permanent Secretary has passed to the PAC, a very great deal of material both about the settlement and about the events of the years that preceded it.

I turn now to the relationship between the Secretary of State and WHTSO. WHTSO is a Special Health Authority [established under S.11 of the 1977 NHS Act.] It is a body corporate with separate legal

identity; and it is entitled in the conduct of litigation to act "in all respects as if it were acting as a principal." It is thus a free standing body in this respect, and is not required to seek my approval to settlements of legal actions in which it may be engaged. It is perfectly normal for WHTSO and other Health Authorities to engage in litigation and to reach settlements without reference to Ministers and this has been the practice under successive Governments; but given the public and Parliamentary interest in this particular case and the particular terms of the non-disclosure clause I think it would have been better had I personally been informed, **particularly since one of my officials was a member of the WHTSO board.** I regret that this was not done; and I am sure that in these exceptional circumstances I was right to immediately arrange that the fullest information should be given to Parliament.

I will now deal with the suggestion that the cost of putting right the defects at the University Hospital of Wales may amount to as much as £8m. As my Hon Friend the Parliamentary Under Secretry said in Answer to a Question on 1 February this year, the total cost of the remedial work is expected to amount to a little under £4m. Of this, £2.7m has already been carried out and the remainder will be completed during the next two years. Once again the Accounting Officer has already given evidence on this matter to the PAC and the information was also given to the House in a Parliamentary Answer on 19 April 1982. A joint working party of the Welsh Office, WHTSO and the Health Authority agreed on the works that were necessary and did not accept all the recommendations of the Ove Arup report.

I regret that the Hon Member for Pontypool who has been responsible for most of the wilder allegations made did not at any stage communicate with me or attempt to check the facts with my Department.

I have had to answer this afternoon for events involving a hospital conceived in the 1940's, planned in the 1950's, largely built in the 1960's, before I entered the House and completed under a previous Conservative Government. I have had to report on the absence of any protective legal measures during the whole period of the last Labour Government, on the outcome of complex legal actions concluded under this Government and on measures to repair the damage that will be a burden on the Health Service for several years to come. I will accept such responsibility as is mine. I trust that others will **accept theirs as well.**

RESTRICTED

NO. Dec.

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

7 February 1985

N 13/2

Dear Lord Gowrie

I was rather surprised to receive, today, your letter of 6 February suggesting an amendment to the question I answered yesterday since it followed telephone confirmation from your office that there were no objections to the answer I proposed.

In the event since one of the defendants has threatened legal action I think it would be unwise to make a further statement highlighting the fact that it is not usual to disclose commercially confidential information. The statement could simply be used in the event of action being taken.

I am copying this letter to the Prime Minister, the Lord Chancellor, the Home Secretary, the Chancellor of the Exchequer, the Secretaries of State for Defence, Energy, Environment, Social Services, Scotland, Northern Ireland, Trade and Industry, the Lord Privy Seal and to Sir Robert Armstrong.

Yours Sincerely

Approved by the Secretary of State
and signed in his absence

The Lord Gowrie
Chancellor of the Duchy of Lancaster

NHS Expenditure : NAT. HEALTH
Pt 4.

RESTRICTED

CABINET OFFICE

From the Chancellor of the Duchy of Lancaster

Lord Gowrie

MANAGEMENT AND PERSONNEL OFFICE
Great George Street
London SW1P 3AL
Telephone 01-233 8610

The Rt Hon Nicholas Edwards MP
Secretary of State for Wales
Welsh Office
Gwydyr House
Whitehall
LONDON SW1A 2ER

N 6/2

6 February 1985

Dear Nicholas,

Thank you for sending me a copy of your letter to Nicholas Ridley about the University Hospital of Wales case.

I entirely understand why you judge that you need to give the details of this particular settlement, and I would not want to quarrel with that judgement. But I can imagine that there will be other cases in which the public interest will lie in more limited disclosure to Parliament of the kind originally envisaged in the WHTSO settlement. I wonder therefore whether your answer might perhaps bring out more clearly that this is an exceptional case, and without prejudice to practice in subsequent cases.

If you agree, this might be done by changing the third paragraph to read:

> " I have carefully considered whether these arrangements meet the requirements of Parliamentary accountability. Although it is not usual to disclose commercially confidential information of this kind, I have decided that the special circumstances of this case and the exceptional public interest it has aroused, call for full disclosure of the details to Parliament. I have asked the parties ....."

I am copying this letter to the Prime Minister, the Lord Chancellor, the Home Secretary, the Chancellor of the Exchequer, the Secretaries of State for Defence, Energy, Environment, Social Services, Scotland, Northern Ireland, Trade and Industry and Transport, the Lord Privy Seal and to Sir Robert Armstrong.

Yours,

GOWRIE

NAT
HEALTH
Expenditure
pt 4

DEPARTMENT OF TRADE AND INDUSTRY
1-19 VICTORIA STREET
LONDON SW1H 0ET 5422
TELEPHONE DIRECT LINE 01-215
SWITCHBOARD 01-215 7877

JF

Secretary of State for Trade and Industry

6 February 1985

The Rt Hon Nicholas Edwards
Welsh Office
Gwydyr House
Whitehall
LONDON
SW1A 2ER

Dear Nick.

DEFECTS AT THE UNIVERSITY HOSPITAL OF WALES : CONFIDENTIALITY OF OUT OF COURT SETTLEMENT

You copied to me your letter of 1 February to the Secretary of State for Transport about the disclosure of the details of an out of court settlement between the Welsh Health Technical Services Organisation and defendants.

2 The circumstances of this case are not such as to jeopardize the procedure my Department follows in answer to PQs about the employment of consultants and advisors, for example in privatisation schemes; when details of individual contracts are refused. I am therefore content with your proposal.

3 I am copying this to the Prime Minister, Lord Chancellor, Home Secretary, Chancellor of the Exchequer, Secretaries of State for Energy, Defence, Scotland, Environment, Social Services, Transport, Northern Ireland, the Chancellor of the Duchy of Lancaster, the Lord Privy Seal and to Sir Robert Armstrong.

Yours ever
Norman

NORMAN TEBBIT

JH2AGJ

NAT. HEALTH : Expenditure & Efficiency

A4.

TF

Y SW[redacted]FA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switsfwrdd)
01-233 8545 (Llinell Union)

ODDI WRTH YSGRIFENNYDD
PREIFAT YSGRIFENNYDD
GWLADOL CYMRU

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 8545 (Direct Line)

FROM THE PRIVATE SECRETARY
TO THE SECRETARY OF STATE
FOR WALES

4 February 1985

Dear Private Secretary

DEFECTS AT THE UNIVERSITY HOSPITAL OF WALES
CONFIDENTIALITY OF OUT OF COURT SETTLEMENT

Attached.

My Secretary of State's letter of 1 February has also been copied to the Secretaries of State for Trade and Industry and Northern Ireland.

/ Copies of this go to the Prime Minister, Lord Chancellor, Home Secretary, Chancellor of the Exchequer, Secretaries of State for Energy, Defence, Scotland, Environment, Social Services, Trade and Industry, Northern Ireland, Lord Privy Seal, Chancellor of the Duchy of Lancaster and Sir Robert Armstrong.

Yours sincerely

K L DALLIMORE

Private Secretary to
The Rt Hon Nicholas Ridley MP
Secretary of State for Transport

RESTRICTED

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

1 February 1985

From Secretary of State

DEFECTS AT UNIVERSITY HOSPITAL OF WALES
CONFIDENTIALITY OF OUT-OF-COURT SETTLEMENT

I am writing to inform you, and the other colleagues to whom I am copying this letter, that in view of the public concern about the cost of remedying defects at the University Hospital of Wales in Cardiff, I have given very serious consideration to the need in the public interest to disclose to the House, in response to an arranged question, the details of an out-of-court settlement entered into by the Welsh Health Technical Services Organisation (a Special Health Authority) and three defendants. Having taken the advice of my officials following their consultations with your Department, as well as the Cabinet Office, Ministry of Defence, DHSS, SHHD and PSA, I am sure there is no real alternative open to me but to make such a disclosure.

I am conscious that your Department settles some of its disputes with contractors by agreement out-of-court, and that those agreements often involve an undertaking to maintain commercial confidence subject to the requirements of accountability. I understand, however, that in respect of an agreement concerning the Midlands Link you have announced the global figure of a settlement in response to pressure, without disclosing the separate contributions of several parties.

In the case which now confronts me, the settlement is for £305,000 involving three defendants, only one of whom contributed a substantial amount. Simply to disclose the global amount is, therefore, not going to stand, since two parties would almost certainly disclose their small contributions. The case has other features which I believe your officials agree make the circumstances different from those which are usual in your cases. The agreement is, for instance, with a Special Health Authority (WHTSO) which is not required to submit the terms of its agreements to the Welsh Office, and the public concern in Wales over the defects in its

/largest hospital ...

The Rt Hon Nicholas Ridley MP
Secretary of State for Transport
2 Marsham Street
London
SW1P 3EB

largest hospital and the net cost of remedying them is such that I can well sustain the argument that in the particular circumstances of this case it is in the public interest that I should disclose the terms of the settlement.

I should add that further good reasons for taking this view are that the details are with the PAC who, of course, have discretion to disclose, and that the overall total is discoverable in published accounts. There is, therefore, really no merit in resisting disclosure.

I believe these special circumstances are such that disclosure in this case ought not to jeopardise the procedures you now follow. Unless you feel strongly to the contrary I therefore propose to proceed with disclosure. I intend to arrange a question for reply no later than 7 February since my Department is First Order for questions on Monday, 11 February.

... I enclose a copy of the text.

/ I am copying this to the Prime Minister, Lord Chancellor, Home Secretary, Chancellor of the Exchequer, Secretaries of State for Energy, Defence, Scotland, Environment, Social Services, Lord Privy Seal, Chancellor of the Duchy of Lancaster and Sir Roberts Armstrong.

Yours sincerely

Approved by the Secretary of State
and signed in his absence

SUGGESTED PQ

To ask the Secretary of State for Wales if he will seek the agreement of the parties to publication of the terms of the settlement reached in respect of defects in the construction of the University Hospital of Wales, Cardiff.

SUGGESTED REPLY

The defects in question arose from construction between 1966 and 1969 and were of two main catergories, mosaic cladding and structural defects. Counsel advised the Welsh Health Techical Services Organisation (WHTSO) against pursuing a claim for the recovery of the cost of remedial measures in respect of the structural defects. The Public Accounts Committee was informed of this on 14 November 1983: a summary of the main features of Counsel's advice had been given to them in March 1982. They were told that action was continuing in respect of the mosaics.

Having taken further advice from Counsel WHTSO signed an agreement with the architects, the consulting engineers and the liquidators of the building contractors on 24 November 1983 primarily concerned with the mosaic cladding but also in full and final settlement of all claims in respect of all defects in the building known at that time. The agreement stipulated that it should remain confidential to the parties saving that WHTSO could disclose the terms in full to the Welsh Office, and envisaged subsequent disclosure in confidence to the Public Accounts Committee. This has been done.

I have asked the parties to the settlement to agree to wider publication of its terms. One party has objected. However, I have decided that in the public interest details of the settlement should be made available to the House. Accordingly I have placed in the Library a copy of the agreement, together with copies of the related Counsel's Opinion and the previous Counsel's Opinion to which I have referred.

CRNO.

1) Mr Fletcher: to see
2) please p.a.

DMB
4/1

Prime Minister 4)

To be aware.

SP

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

DMB
31/1

Miss Janet Lewis-Jones
Private Secretary to the
Lord President

31 January 1985

Dear Janet

This is to let you know for information that a letter from my Secretary of State is going out to all MPs today explaining the current position on the limited list of drugs, and I enclose a copy.

I am copying this to Private Secretaries to Members of the Cabinet and the Paymaster General.

Yours sincerely

Elizabeth

ELIZABETH MOTHERSILL
Private Secretary

Enc

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

To all Members of Parliament 30 January 1985

Dear Colleague.

LIMITED LIST OF DRUGS

I wrote to you shortly before Christmas giving a full explanation of the Government's proposal to restrict the range of drugs used by the NHS in certain categories. You will also now be receiving replies to individual letters you have written to me and my ministerial colleagues. As the level of propaganda being put round against the proposal continues to be high, and its contents frankly misleading, I felt you might find it helpful to know the current position.

The period of consultation on the limited list is now ending. During that period we have benefited from the constructive comments of many doctors on the contents of the list. The Government's Chief Medical Officer, Dr Donald Acheson, has also been considering what additional drugs should be included in the list compared with the provisional list we published. In doing so he has been helped by an eminent group of independent doctors (see enclosed list) from all the relevant specialties. Once their work is completed we will be able to bring forward the final list with the certainty that it will leave sufficient medicines available on the NHS to meet all the clinical needs of patients.

As far as Parliament is concerned the next step will be to introduce regulations listing the drugs which will no longer be available on the NHS in the categories we are dealing with. This is necessary because it is not possible to define categories of drugs in legal terms; we have to list all drugs which will not be available. But the effect will be the same - to leave a simpler and manageable limited list of drugs in the categories concerned so that doctors and pharmacists know what is available. I should just add that the categories covered by the limited list account for only about 10 per cent of the drugs used in the NHS - and they are nearly all the simpler drugs which do not in any case require a prescription and are freely available over the counter from chemists.

F.R.

Once the list is in operation - after 1 April this year - we will want to have a system for deciding whether new drugs should be added to the list. We will need to have the best professional advice then, as we have had in formulating the original list. The need for such a system was a point which the Royal College of Physicians highlighted in offering their support for the idea of the list. I shall be announcing shortly how I intend to ensure that we have the right professional advice on a continuing basis.

As far as the principle of the scheme is concerned, the Government remains firmly of the view that it is a sensible way of getting better value for money from the drugs bill without harming the interests of patients.

We certainly do not believe that it threatens the health of the research-based pharmaceutical industry - despite the very overstated response of the ABPI. You might be interested to see the enclosed commentary on their current advertising campaign which shows that their claims need to be treated with considerable caution. You may find it useful in responding to constituents who have approached you on the subject.

Yours ever Norman Fowler.

NORMAN FOWLER

LIMITED LIST OF DRUGS: EXPERT ADVISERS

The following experts have been assisting the Chief Medical Officer in considering what medicines need to be included in the limited list to ensure that it provides for all clinical needs.

Professor Alasdair Breckenridge	Professor of Clinical Pharmacology, Liverpool
Professor David Morrell	Professor of General Practice, London
Dr John Tomlinson	General Practitioner, Hampshire
Dr Duncan Colin Jones	Consultant Physician, Portsmouth
Professor Eric Stroud	Professor of Child Health, London
Professor Malcolm Hodkinson	Professor of Geriatric Medicine, London
Mr David Coleman	Retail Pharmacist, Norwich
Professor Malcolm Lader	Professor of Clinical Psychopharmacology, Institute of Psychiatry, University of London

In addition, Dr Stuart Carne, as Chairman of the Secretary of State's Standing Medical Advisory Committee, has attended the Chief Medical Officer's meetings on the composition of the list.

FACTS ABOUT THE NHS DRUGS BILL

The Association of the British Pharmaceutical Industry (ABPI) has recently been buying full pages in the national press for an advertisement headed "You've heard the fallacies about the NHS drugs bill. Now here are the facts".

There is a clear implication that the "fallacies" quoted in the advert are a part of the Government's case for introducing a limited list of NHS medicines in some less essential categories of drugs, and that the ABPI's "facts" rebut and destroy that case. There is however another, and real, fact that you might like to consider: the ABPI only succeeds in refuting claims the Government has never made. Where it seeks to dispose of points that are central to the limited list its "facts" are largely wrong, misleading, or irrelevant.

WHAT THE ABPI SAY

1. "FALLACY: The NHS medicines bill is rapidly escalating and running out of control.

FACT: Over the past 20 years the medicine bill, as a proportion of total NHS expenditure, has remained almost constant. It is still under 10 per cent of NHS costs."

2. "FALLACY: There are as many as 17,000 products available on the NHS TWICE as many as 25 years ago.

FACT: When Government Ministers refer to 17,000 products they are talking about product licences, the number of which have in fact halved not doubled since 1971. Doctors prescribe almost entirely from a range of just over 2,000 products listed in the Monthly Index of Medical Specialties (MIMS)."

3. "FALLACY: Doctors' prescribing in the UK is excessive.

FACT: Doctors in this country write on average 6.5 prescriptions per patient a year. Doctors in comparable developed countries - such as Germany, France, Italy and Spain - write almost twice as many prescriptions for each patient."

THE GOVERNMENT'S COMMENTS

1. COMMENT: In recent years the NHS drugs bill has been increasing at about 5 per cent a year in real terms. The past 20 years have been a period of continuous expansion in NHS services: new hospitals, more front-line staff, new and expensive life-saving and enhancing operations. NHS expenditure has increased rapidly to pay for these developments and the drugs bill might have been expected to consume a decreasing rather than increasing proportion of the total.

2. COMMENT: Ministers have said that doctors prescribe from a range of about 17,000 drugs, twice as many as 25 years ago. This is true and has nothing to do with product licences (which have indeed declined since more stringent requirements were introduced). The figures are from the Prescription Pricing Authority's master drug index, which lists all the drugs actually prescribed. MIMS, produced for the drugs industry, is no more than a list of branded products and while it might show what the drug industry wants doctors to use, it is in fact far from being a comprehensive guide to what doctors actually prescribe. Generic drugs, which account for over 20 per cent of NHS prescriptions, are not even mentioned.

3. COMMENT: The Governments of Germany, France, Italy and Spain believe prescribing in their countries to be excessive and have taken steps to contain the drugs bill. There are also developed countries with lower prescribing levels than the UK, including particularly the Scandinavian countries with their "model" health care systems. In the UK the medical profession itself accepts that current levels could be reduced and has agreed to co-operate with the Government in encouraging more rational and economic prescribing.

4. "FALLACY: Medicine prices in this country are too high and are unfair to the taxpayer.

FACT: Medicine prices in this country are competitive with those in other major manufacturing nations - and have been subject to government regulation since 1957. Per head, Britain spends on medicines about half the amount recorded in Germany, France, America or Japan. The average cost to the taxpayer of an NHS prescription is just over £4. The average cost of treating an NHS patient in hospital is around £550 a week."

5. "FALLACY: Pharmaceutical companies make excessive profits.

FACT: Pharmaceutical companies, on average, earn a real return on historic capital of 17-18 per cent on sales to the NHS - the same as the average profit for manufacturing industry as a whole."

6. "FALLACY: The pharmaceutical companies are mainly multi-national, and make little contribution to the nation's economy.

FACT: Pharmaceutical exports from the UK by multi-national research based companies exceed imports by some £650 million a year - a considerable benefit to British taxpayers and the national economy."

4. COMMENT: International comparisons of medicines prices are notoriously difficult. While some countries without effective control systems have higher prices, others have lower prices. Neither the cost of medicines per head of population, nor the difference between the cost of medicines and of hospital treatment is directly relevant to the question of whether prices are reasonable.

What is important is the value which the NHS gets from the money it spends. The Government is asking health authorities to control spending more effectively and cut out waste. It also believes we can get better value from the money we are spending on drugs.

5. COMMENT: The return quoted is the companies' own declaration of their profits. After taking into account expenditure which the Government does not feel should be a charge on NHS business - excessive promotional expenditure for instance - the profit is several percentage points higher.

6. COMMENT: Ministers have on many occasions congratulated the industry on its export achievement. Take for instance Norman Fowler's comments in a speech shortly before Christmas:

> "The record of the pharmaceutical industry in this country really is remarkable. As sponsor of the industry I am very proud of that. I am proud not only because of what the industry has contributed to the country's economy. Not only because the industry's record in research and innovation makes it a world leader. I am also proud of what your industry's achievements have meant in human terms - in terms of more and better treatment and care for patients suffering from all kinds of illness."

7. "FALLACY: Pharmaceutical companies are not producing any really worthwhile new products.

FACT: In the last 25 years there have been major new products for the treatment of, for example, asthma, epilepsy, heart disease, ulcers, virus diseases, high blood pressure, Parkinson's disease, leukaemia in children, some other cancers and mental illnesses. Furthermore new drugs have played a major role in saving the lives of patients needing heart, kidney and liver transplants."

8. "FALLACY: The Government's proposals will save taxpayers £100 million.

FACT: Costs arising from the measures - unemployment benefits to former pharmaceutical company employees, re-employment costs, lost exports, could cost taxpayers more than the community will gain. In practical terms the only 'savings' to the taxpayer would come from the pockets of the sick, the elderly and the unemployed, who on occasions would have to pay directly for the medicines they need."

7. COMMENT: In announcing its limited list proposals the Government stressed the enormous therapeutic advances of the last quarter of a century. It recognises the need for continuing research in major and life-saving areas such as those mentioned by the ABPI. None of these areas is affected in any way by the Government's proposals. What is more, the NHS contributes heavily to research activities of the industry through the price it pays for drugs. At present some £200 million a year of R and D expenditure is accepted as a cost against sales of drugs to the NHS.

8. COMMENT: Savings will be real, substantial, and immediate. They will mean that the NHS has a smaller drugs bill to meet. That will make it easier to meet the urgent pressures we face for extra spending in other parts of the health service. The limited list will affect only 10 per cent of the UK drugs market and less than half a per cent of the world market. It is nonsense to imply that the industry faces the prospect of serious harm. Moreover it is grossly irresponsible of the pharmaceutical industry to try to persuade the poor or the elderly that they will be unable to get the medicines they need. The limited list will be settled only after eminent independent experts have agreed on its contents. Nobody who is old or poor will have to pay anything to get the drugs they need.

NHS Expenditure

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

→ cc DW
for urgent advice

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

25 January 1985

Dear Norman,

NHS SUPERVISORY BOARD

The Griffiths Report did not apply to Scotland but last summer I issued a consultation paper on a programme for developing general management in the NHS in Scotland. The paper outlined as part of the new arrangements the possibility of a Supervisory Board to strengthen the central organisation in dealing with major management issues. I have now considered this proposition in greater detail following responses to the consultation paper.

I have concluded that the best way to take matters forward is to set up what I intend to name a Health Services Policy Board under John MacKay's Chairmanship, as Minister for Health and Social Work in the Scottish Office. The Board will comprise the Chairman of the Scottish Health Board Chairmen (Mr John Gibb), the Chairman of the Scottish Health Services Planning Council (Dr W K Davidson), the Chief Scientist (Professor Pat Forrest), officers of the Scottish Home and Health Department and, as appropriate, the Under Secretary responsible for the Social Work Services Group. It will be underpinned by the Health Services Policy Group, which is chaired by the Secretary of the Scottish Home and Health Department.

The remit of the Health Services Policy Board will cover advice to the Secretary of State on policy decisions required for the Health Service in Scotland and on the efficient management of the Health Service; assessment of the performance of the service in implementing agreed policy; and the identification of management action required to improve performance and increase management efficiency. I shall be making an announcement about this in due course.

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

Yours ever,

George

file

ECL

Ronald HALSTEAD

30/1

The BEECHAM GROUP

1 4/2

2 11/2

3 19/2

4 26/2

5 5/3

6 12/3

7 18/3

8 26/3

10 DOWNING STREET

From the Private Secretary

17 January 1985

I enclose a copy of a letter to the Prime Minister from the Chairman of the Beecham Group plc, about the return on capital in the pharmaceutical industry, and the limited list proposals.

I should be grateful if you would arrange for a draft reply to be prepared for the Prime Minister's signature, to reach this office by Wednesday 30 January. You will note that Mr Halstead has marked his letter "Private and Confidential" - could you please ensure that it is handled accordingly.

(David Barclay)

Steve Godber Esq
Department of Health and Social Security

SH

GR

10 DOWNING STREET

THE PRIME MINISTER

Dear Mr. Halstead,

Many thanks for your letter of 15 January. It was good to see you on Sunday.

I have read with great care your letter and memorandum, and have taken careful note of what you say about the pharmaceutical industry, and the proposals of the DHSS. You will understand that I cannot say any more than that!

Yours sincerely

Margaret Thatcher

Ronald Halstead, Esq., C.B.E.

Ack'd on 16/1

Beecham
Group p.l.c.
Beecham House Brentford
Middlesex TW8 9BD

RONALD HALSTEAD, C.B.E.
Chairman and Chief Executive

PRIVATE & CONFIDENTIAL

RH/PVW

15th January 1985

The Rt. Hon. Mrs. Margaret Thatcher, M.P.,
Prime Minister,
10 Downing Street,
London SW1.

Dear Mrs Thatcher,

Thank you very much for inviting me to lunch on Sunday. It was a most enjoyable occasion and I was delighted to have the opportunity of visiting Chequers.

I should like to confirm to you the points I made concerning the profitability of industry in general and the pharmaceutical industry in particular. As we have discussed on a number of occasions, one of the major problems of British industry in competing internationally has been the low return on capital stemming from the years of price control regimes in the 1960's and 1970's. This affected cash flow, innovation, investment and productivity and has been a major cause of our loss of share in world trade of manufactures and the change from a surplus to a significant deficit in our manufacturing trade balance.

One of the few areas where we have succeeded in maintaining a strong international market position has been the pharmaceutical industry. This was not subject to the full rigours of the Price Commission since it was dealt with separately in the 1970's under its agreements with the DHSS. As a consequence, the profitability of the industry was not seriously undermined and it was able to maintain its competitive position in the world. Indeed, its record has been a very good one and is a case study example of how British science and technology can be exploited by British companies in world markets. In 1984 its exports were £1200 million and it had a balance of payments surplus of £600 million. It also carried out 10% of the world's research and development in pharmaceuticals even though the U.K. has only 4% of the world market.

cont...

I was, therefore, greatly concerned after reading the House of Commons Public Accounts Committee Reports on the "Dispensing of Drugs in the National Health Service" (1982/83 and 1983/84). The general view appeared to be that because the pharmaceutical industry's return on capital had risen from 21% (historic cost basis) in 1978 (5% above the industry average) to 23% (historic cost basis) by 1980 whilst the profitability of industry elsewhere had declined, the return on capital of the pharmaceutical industry should be reduced. The fact that the return on capital of British industry had been depressed by price control and was generally far too low was not even mentioned. Indeed, as a result of compulsory price reductions the rate for the pharmaceutical industry as a whole was reduced from 25% to 21% in 1984 with the target rate for individual companies somewhat below the 21% figure. The 21% return on capital which is the new average for the whole industry included an allowance for the so-called "grey area". This is the procedure whereby for a limited period of time a successful company can enjoy an individual return on capital greater than its target, resulting from successful new product introductions and improved productivity programmes. I understand that proposals are now in hand to reduce the average for the industry as a whole to approaching 17%. I find this hard to believe for two reasons:-

a) As I said at our CPS dinner in Downing Street, the much welcomed removal of price controls, etc., in 1979 has enabled British industry generally to progressively improve its profitability and investment. Although it still has some way to go in its return on capital, this should improve steadily leading to more investment and better international competitiveness.

b) In the international markets in which we operate, successful companies have a return on capital at the rate of 25-35%. The more successful ones are at the top end of this range. This not only applies to pharmaceuticals, but also to our competitors in the consumer goods industry. Also, in the USA the return on capital of a number of American pharmaceutical companies with whom we compete is substantially higher than the rest of American industry.

In view of all this, I feel it is important to review the 1984 return on capital targets with a view to increasing them back to the 25% level, and I am horrified that we are even considering reducing them below the 21% level!

I have not dealt with the present proposals for a restricted drug list since I feel that the return on capital is the critical issue facing the British pharmaceutical industry in its ability to compete internationally. However, there are potential pitfalls in the restricted list proposals and I think it is important for the industry and the DHSS to work closely together to prevent any unnecessary backlash if the proposals are implemented on 1st April 1985. I asked my pharmaceutical colleagues in Beecham to give me a memorandum on the industry case and also indicate how they would save the £100 million that Norman is looking for. I enclose a copy of this memorandum and I hope that the notes will be of help to you.

With very best wishes.

Yours Sincerely,

Ron

NOTES ON D.H.S.S. PROPOSALS OF NOVEMBER, 1984

HISTORICAL

Two years ago, because of the country's recession, Industry asked to cut prices by 2½% and then freeze prices. This was contrary to PPRS but Industry reluctantly agreed - effective August 1983. Immediately followed by further restrictions including fall of R.O.C. for Industry from 25% to 21% - estimated to reduce drug bill by £100m p.a.

ASSURANCES

8th December 1983. Mr. Clarke gave assurance that the Government rejected generic substitution. Also stated that Government accepted all other recommendations of the Greenfield Report including rejection of limited lists.

Mr. Jenkins gave Industry his categoric assurance that Government policy excluded concept of limited list in his speech at the ABPI Dinner on April 2nd 1981.

P.R.

Industry has over the last decade operated on the basis of maintaining a low profile as being consistent with an industry in the health care field and preferred to negotiate with its main customer without the misleading pressures of public debate. Further, the Industry considered such PR as an unnecessary expense.

However the DHSS in its cavalier handling of the Industry forced the Industry to defend itself to the public, to the medical profession and to politicians.

NEW D.H.S.S. PROPOSALS

In two parts

1) limited lists

2) reduce profitability by cut in ROC.

1) Statements by Mr. Fowler and Mr. Clarke flawed on many counts - must have been badly advised.

a) Statement in House by Mr. Fowler on 8th November that 17,000 medicines are available for prescribing by UK general practitioners. Claimed that this was excessive when compared to medicine available in other countries. Mr. Fowler's advisers failed to tell him that this 17,000 includes 6,000 homeopathic medicines and, because of the UK licensing system, each separate presentation of a medicine requires a separate licence. Thus Mr. Fowler was quoting the number of licences - not the number of medicines. In fact, MIMS (the doctors' handbook on prescribing) contains less than 3,000 medicines and there are only 1,300 drug substances used in the UK - a very similar number to that available in most other countries.

b) Statement by Mr. Fowler that in the last 25 years the number of prescriptions has increased by 100 million per annum. In the last 25 years

(i) contraceptives have been added by Government to the prescription list - this has resulted in over 10 million scripts.

(ii) There has been a change in procedure for dispensing doctors (10% of G.P.s) whereby their dispensing is now included in the script count - accounts for 10 million scripts.

(iii) Over the last four years, hospital policy has moved outpatient scripts from Hospitals to Family Practitioners. No accurate

assessment of effect but believed to be about 30 million scripts.

(iv) The number of people over 65 in 1982 was 8.3 million compared with 6.0 million in 1958. On the basis of the difference in prescription rate for retired people to younger people, this has resulted in an increase in prescriptions of 24 million.

(v) The population has increased by 4.2 million since 1958, equivalent to increased script level of 28.5 million on basis of 6.8 script per head in 1982.

In addition in the last 25 years there has been increase in the standard of health care, the quality of life and life expectancy.

c) Value for money -
View appears to be that - whatever the magnitude of the drug bill - it is too high. Compared to most developed countries the cost of medicine in the UK on a per head basis is very moderate reflecting reasonable drug prices and responsible prescribing by doctors.

In France, often quoted as the cheap drug country, the cost of medicine per head of the population is 60% higher than UK. Germany is 80%, Japan 100%.

d) "Limited lists universal throughout Europe" -
Limited lists used in other European countries vary and are different from that proposed for the UK. Recent report on the use of a negative list introduced in Germany indicates that at best it had a neutral effect, but it probably had the effect of increasing the total cost of medicine in Germany.

e) Proposed limited lists are generic substitution, although at this time in a limited area of medicine. Where applied not only is it generic substitution, the lists actually further limit the generics which may be substituted. Complete violation of undertaking of 1983.

Likely effects if proposed limited lists introduced -

a. Estimated that over 10 million people will note the change - half of them will be significantly affected - estimated that some 80 - 90 million current scripts at risk (total scripts in UK per annum - about 400 million).

People most affected will be elderly.

b. Because of the procedures and restrictions which apply to Dispensing Doctors (10% of all G.P.s), will not be practical for Dispensing Doctors to issue private scripts. If they do, they cannot fill the script themselves and the patient will require to travel a significant distance (could be several miles) to find a chemist to dispense the script. Will tend to occur in rural areas - Conservative constituencies.

c. Private scripts will cost the patients up to 50% more than the current cost to the N.H.S.

Average script costs NHS £4.4 including dispensing fee. Cost of a comparable private script £5.20 to the patient. Cost of medicine dispensed O.T.C. - minimum of £6 to the patient.

d. Effect on chemists

- in poor areas - marked reduction in income
- in rich areas - substantial increase in income.

e. Quality of medication will suffer.

Comparable medicine offered on restricted lists is NOT comparable and will certainly not be accepted either by patients or doctors as comparable. The two laxatives initially offered on the restricted list (as selected by the DHSS advisers) are totally unacceptable in modern medicine in this country. Methyl cellulose granules are unpalatable and in any case are more expensive than some branded laxatives which are excluded. Glycerol suppositories may be good French medicine, but are generally unacceptable to the British public. Similar

situations arise in every classification of medicine when limited lists are proposed.

f. There is a confusion between so-called peripheral medicine (e.g. cough and cold remedies etc.) and serious medicine (e.g. mild analgesics and tranquilisers). The attack on the latter is based on medical prejudice in certain DHSS circles but the view of the Medicines Commission was not sought. Most of this listed serious medicine is P.O.M. - prescription only medicine - (although not exclusively so). This serious medicine must be removed from restrictive lists.

2) REDUCED PROFITABILITY

a) Introduction of limited lists will significantly reduce the profitability of the Industry.

b) The British Research-based Companies in the Industry have presented two papers, one in September 1983, the other one year later, to the DHSS. Both papers presented substantive arguments that the Industry's profitability should be between 25% - 35% return on historic capital.

c) The DHSS and the Public Accounts Committee quote the results of the Review Board for Government Contracts as a basis for assessing the fair level of profitability for pharmaceuticals. Study of the Review Board's report certainly shows that it is inappropriate for the pharmaceutical industry as the comparison is by devious means, related to the average return for all industry (excluding North Sea oil). We argue that the Pharmaceutical Industry should be compared with successful industry. The Review Board data indicate a R.O.C. of 16.9% for so-called Risk Defence Contracts (Risk is defined as Contracts which are not cost plus) and this is the figure quoted by DHSS for pharmaceuticals.

The British Companies are presenting data to show that updating the Review Boards data would raise this 16.9% to over 20% and there is no case for the DHSS to reduce the present figure of 21% used in the current A.F.R. (Annual Financial Return under PPRS).

d) The DHSS have implied that not only do they wish to reduce the R.O.C. to close to 16.9%, they wish to impose immediate price reductions - these reductions would be on a scale such that the successful companies have the largest price cuts. An average of 2½% has been quoted (i.e. £40m in a full year) but it could range up to 5% or even 10% in some cases.

ALTERNATIVES

The Industry have made a number of suggestions on alternative ways to save money on medicine.

A. Reduce distribution cost by £35 million. The Industry would collect this money for the DHSS and actually pay it monthly or quarterly to the DHSS.

B. If contraceptives were excluded from NHS medicines, the Medicine Bill would be reduced by £40 million. An alternative or half-way position would be to impose prescription charges on contraceptives - this would raise £20 million p.a.

C. Reduce Sales Promotion to 8% in 1986 - would save £15m p.a.

D. Reduce prescription exemption level (including season tickets) from 80% to 70% i.e. level in 1980 - save £70 million p.a.

E. Limit on Scrip size to a maximum of one month's supply.

LIKELY EFFECTS

1. Substantial adverse public reaction after 1 April. In the surgery the doctor will blame the DHSS and the Government for his inability to prescribe patients established medicine.

2. DHSS activities over the last two years have introduced lack of stability within the pharmaceutical industry. This environment cannot be conducive to expansion of a successful British industry.

3. Investment in R & D must be curtailed, simply because of lack of resource. Research in certain areas of medicine, e.g. analgesia, will virtually cease.

4. An R.O.C. below 21% will inhibit capital investment as return inadequate to fund investment.

5. Export markets will be adversely affected

   - if UK prices are reduced - many overseas prices for products sourced from UK will be reduced.
   - market restrictions introduced in UK likely to be emulated overseas.
   - exports of £1 billion at risk.

6. UK market represents 4% of World Pharmaceutical Market
   UK supplies 8% of World Pharmaceutical Market
   UK carries out ca. 10% of World Pharmaceutical R & D.

JBD/pvj
10.1.85

Secret until 3pm 8/11/84

→ a Press Office Question

File

→ DW

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

David Barclay Esq
Private Secretary
10 Downing Street
LONDON

8 November 1984

Dear David,

RESTRICTIONS ON NHS PRESCRIBING

Following consultation with colleagues, my Secretary of State intends to announce during this afternoon's health debate measures to help restrain growth in the cost to the NHS of certain kinds of drugs.

At present, doctors can - unlike those in most other countries - prescribe any drugs they choose at public expense. The new measures will mean that, for two kinds of drugs, the NHS will in future provide only the cheaper generic alternatives, which will be specified in a 'limited list'. (This should no longer be referred to as a 'grey list' as in earlier correspondence.)

The first group affected are 'household remedies' for minor conditions like coughs and colds, most of which can be brought over the counter without a prescription. The second are tranquilizers and sedatives, where a great many closely - similar brand-name products are prescribed which could be replaced, with no adverse effects for patients, by cheaper generic alternatives.

The proposals do not affect doctors' freedom to prescribe, or patients' rights to request any drug they choose; doctors will still be able to prescribe privately any drug not available under prescription. The medical profession will be consulted on which drugs in the groups concerned should continue to be available.

Attached is a note of key points explaining the changes and the reasons for them, for use as speaking notes if required, together with a list of the brand leaders in the two groups, a copy of the consultation letter and the relevant extract from my Secretary of State's speech.

Copies of this letter and attachments go to Colin Jones (Welsh Office), John Graham (Scottish Office), John Lyon (Norther Ireland Office), Richard Broadbent (Chief Secretary's Office), Elizabeth Hodkinson (DES), Mrs Janet Lewis-Jones (Lord President's Office), Richard Stoate (Lord Chancellor's Office), Charles Marshall (Lord Privy Seal's Office) and Russell Yates (Lord Elton's Office).

Yours sincerely,

Ellen

ELLEN ROBERTS

RESTRICTIONS ON NHS PRESCRIBING

Key points

DRUGS BILL

1. The drugs bill is now £1,400 million a year for FPS in England alone; over the past decade it has grown on average 5 per cent a year in real terms - faster than the economy or NHS resources can support. It must be contained to protect and enable vital NHS developments. Persuasion and education have been tried by every government since the 1950s. They help restrain growth but more positive action is needed. The number of prescriptions issued each year has increased by 100 million in the last twenty-five years and the average cost of the drugs on each prescription has increased fifteen-fold.

2. The number of different drugs prescribed by GPs has risen from under 8,500 to over 17,000 in the last twenty years. We must ask ourselves whether they are all necessary. No other country makes the same unlimited range of products available within its health service. In the Scandinavian countries, so often quoted as examples of good practice in health matters, fewer than 2,500 drugs are available for prescription at public expense. We have at least 18,000. Does the NHS really need to provide so many, particularly when a lot of them are very similar: the "me too" drugs designed to get round patent rights?

OTHERS DO IT

3. Our EEC partners, the major Commonwealth countries, the Nordic group, even eastern European countries all have restrictions on the drugs that will be reimbursed under national health or insurance schemes. We are the only country of any significance that allows doctors to prescribe any drug they choose at public expense; and the only one that supplies 70 per cent of them totally free of charge and the remaining 30 per cent at considerably less than half their true cost. Is there anything unique about doctors or patients in the UK that requires us to continue with a system that other countries including some far richer than ours have discovered they cannot afford? Regrettably, but undoubtedly, not.

HOME REMEDIES

4. The NHS spends £120 million a year on drugs for minor conditions that will clear up by themselves in at most a few days if left alone. These drugs do not cure, they alleviate symptons and minor discomforts. Most people already go to the chemist and buy them over the counter rather than trouble their doctor. Some of these drugs are even available in supermarkets. They are safe, effective, and useful. But they are hardly a matter of life or death. If people want them they will be available from their chemists, almost all without prescription. Reasonable quantities often cost less than the NHS prescription charge.

PRESCRIBING HABITS

5. We hope doctors will think very carefully about whether these less important drugs are necessary for their patients, and whether their provision would be a justifiable use of scarce NHS resources. If they are necessary, then doctors will be able to prescribe from a range of cheap and effective generic drugs. They and their patients will also have the choice of private prescriptions for any drug, whether available through the NHS or not.

SEDATIVES AND TRANQUILLISERS

6. £40 million are spent each year on proprietary sedatives and tranquillisers. Many doctors believe that the volume of prescribing is far higher than is clinically necessary, and there is no question that it has resulted in a bewildering variety of expensive branded products with essentially similar characteristics. I am advised that in normal clinical practice a very small number of generic drugs can replace all the proprietary products now available without any adverse effects for patients and at a considerable saving to the NHS.

THE "ME TOO" SYNDROME

7. The 'home remedies' are obviously the first to be tackled in the attempt to contain the NHS drugs bill. The only surprise is that we have continued to pay for them for so long. The sedatives and tranquillisers have been singled out for action because they contain large numbers of closely related drugs which the manufacturers spend large amounts on developing and promoting and for which we pay high

prices without significantly greater benefits for patients. In future the NHS will supply only a small number of generic tranquillisers which are of proven value and adequate for normal clinical needs. Any manufacturer who wants the business will be able to compete for a share of it on the normal criteria of price, quality and availability.

IS THIS JUST THE FIRST STEP TOWARDS GENERIC SUBSTITUTION FOR ALL DRUGS?

8. No. We have already said that we do not favour wholesale generic substitution. That would place an unjustifiable restriction on doctors' ability to meet the clinical needs of their patients within the coverage of the NHS and would undermine the innovative work of the pharmaceutical industry in this country. But I believe there is a clear distinction between the groups of drugs on which we are acting - drugs which are either of limited importance or are in a group with closely similar effects - and the more important and life-saving drugs where important innovation and research is now being done and will need to be done in the future. What we are doing is to take a sensible and limited step in order to ensure that the health service is using its limited resources wisely.

WHAT ABOUT SPECIAL CASES OR PARTICULAR DRUGS?

9. My advice is that the range of products in these groups which we will be keeping available on the NHS is sufficient to meet all the normal clinical needs for which they are appropriate. But we are consulting the professions precisely to make sure that we do not by accident exclude particular products which are essential to the clinical needs of patients with particular conditions.

CONSTRAINT ON THE CLINICAL FREEDOM OF DOCTORS TO PRESCRIBE?

10. Doctors will continue to be free to prescribe any medicine which is licensed as safe and effective. But, for those drugs which are no longer to be available on the NHS, the prescription will have to be made and dispensed privately.

NOTES FOR EDITORS

Among the proprietary drugs in each of the categories affected by the limited list proposals are:

Tonics	Metatone	Minor analgesics:	Distalgesic
	Effico		Solpadeine
	Labiton		Para Hypon
	Fosfor Tonic		Lobak
	Neuro Phosphate		Equagesic
	Minamino		Calpol
Cough Remedies:	Actifed	Vitamins:	Orovite
	Benylin		BC 500
	Phensedyl		Multivite
	Benylin Codeine		Compliment
	Mucodyne		Gevral
	Dimotapp		Allbee
Antacids:	Asilone	Tranquillisers and Sedatives:	Mogadon
	Altacite Plus		Ativan
	Mucaine		Dalmane
	Polycrol		Tranxene
	Nulacin		Valium
	Maalox		Halcion
Laxatives:	Dorbanex		
	Fybogel		
	Iso-gel		
	Duphalac		
	Normacol		
	Regulan		

These drugs are listed for illustrative purposes only, as being those whose names are most likely to be known to the public.

From:-

To:		From:-
	Central Committee for Hospital Medical Services	CMO
	General Medical Services Committee	"
	Hospital Junior Staffs Committee	"
	Community Medicine Consultative Committee	"
	Joint Consultants Committee	"
	Royal College of General Practitioners	"
	Dental Faculty, RCS	CDO
	Medicines Commission	Mr Hale
	[British Pharmacopoeia Commission	CP]

Dear

LIMITING THE RANGE OF DRUGS PRESCRIBABLE UNDER THE NHS

The Secretary of State [for Social Services] today announced in Parliament the Government's intention to limit from 1 April 1985 the range of drugs available for prescription on the NHS. I am writing to explain the proposals and, on the Secretary of State's behalf, to invite your comments on them.

The number and cost of prescriptions issued under the NHS has increased very substantially in recent years. In 1983 some 334 million prescriptions were dispensed through the Family Practitioner Service in England at a cost of almost £1400 million. This is about 100 million more prescriptions a year than were issued 25 years ago, and the range of drugs prescribed has doubled in the same period from less than 8500 different items to more than 17000.

Many of these increases are fully justified and reflect the enormous therapeutic advances made during the last quarter of a century, but expenditure on the present scale can be maintained only at the expense of other parts of the health service. It is now necessary to consider carefully whether all the drugs being prescribed need to be provided by the NHS and whether there are areas in which sensible economies can be made in the drugs bill without detriment to patients.

The Government has concluded that there are two areas in which it would be right to take action. First, the NHS spends £120 million a year on medicines prescribed mainly for the relief of symptoms caused by minor and self-limiting ailments that do not normally call for medical intervention. Most patients already buy these simple remedies, which include tonics, cough and cold remedies, antacids, laxatives, analgesics for the relief of mild to moderate pain and low dose vitamin preparations over the counter from pharmacies rather than trouble their doctors. A substantial proportion are also obtainable from other retailers, ~~[while one of the prescription only medicines]~~. In reasonable quantities the cost of these drugs is usually less than the prescription charge.

The Government believes it has more important uses for the money it spends on these drugs. It therefore intends to introduce regulations to withdraw most of them from NHS prescription and supply. An adequate range of cheap and effective generic drugs will remain available for those cases where doctors feel that the clinical needs of individual patients genuinely require such medication. Patients who are prescribed generic drugs remaining available will receive them on the same terms as at present; that is for the standard prescription charge or, if they are exempt from charges, absolutely free.

Secondly, the NHS spends £40 million a year on benzodiazepine sedatives and tranquillisers. This group of drugs has expanded dramatically in recent years and includes a large number of expensive proprietory products with essentially similar characteristics and with no significant advantage in normal clinical practice over the small number of generic benzodiazepines. There is also a widespread feeling in the medical profession that prescribing levels for the benzodiazepines are ~~[still]~~ far higher than is clinically justified.

SECRET

The new Regulations will therefore limit the range of benzodiazepine tranquillisers and sedatives available under the NHS to a small number of generic drugs which between them will provide appropriate alternatives to all the proprietory products now available. The Government urges all doctors to review their prescribing habits for this important therapeutic group and invites the medical profession as a whole to consider how it can help achieve the lower levels of prescribing that are generally recognised as being desirable.

The Regulations will relate to the prescribing and dispensing of medicines in the family practitioner services, but the Government will be asking health authorities to apply the same limitations to the use of drugs in hospitals. In all cases it will be open to medical and dental practitioners to issue private prescriptions to NHS patients for drugs no longer available through the NHS.

The Government is committed to the principle of this scheme in order to contain the ever rising drug bill but, as the Secretary of State made clear, it is now our intention to consult carefully with the medical, dental and pharmaceutical professions on the details of its implementation. I attach a provisional list of the drugs it is proposed to leave prescribable under the NHS in each of the therapeutic groups affected and would welcome your views.

The Secretary of State has decided to allow until 31 January 1985 for consultation and I would be grateful for any written comments you wish to make by that date.

Should you require additional information or clarification on any aspects of the scheme please do not hesitate to contact me.

Extract from Secretary of State's speech - 8 November 1984

up in surplus residential accommodation and land can surely be released and ploughed back into developments for patients in the future.

The process of competitive tendering is already producing major savings. There have, as a result of competition, been considerable reductions in the cost of contracts that have stayed in-house - savings of over £100,000 in the case of one domestic contract and of another £100,000 for a laundry contract. So far thirty-four health service contracts let to private contractors will be producing total savings of over £18 million over the next three years. Three individual hospitals have saved over £½ million on cleaning contracts; in one case a reduction of two-thirds on previous costs. And one health authority will be saving £1.4 million a year. All that money is now available for patient care. All that money would be lost to patients if Labour could ever carry out their Conference resolution to end all competition and to ban private contractors.

So value for money is a central objective - value for the taxpayers, but above all value for the patient.

Let me make it clear that the concept of value for money applies to all areas of the health service and - as I said at Brighton four weeks ago - I do not exempt the drugs bill from this process.

It seems to me that at present there are two proper causes of concern. First, there is the cost to the NHS of the drugs bill which now totals nearly £1,400 million: compared with about £250 million ten years ago. And second, there is the concern that we the public are demanding more drugs each year - the result being that doctors are now issuing

more prescriptions each year than they did twenty-five years ago; and prescriptions covering over 17,000 different products, double the range used twenty five years ago.

It is of course true that many of the increases are fully justified. They reflect the enormous medical and pharmaceutical advances made in the last quarter of a century. But that is not true of all the drugs now being prescribed under the National Health Service.

The clearest example is the wide range of branded medicines which are prescribed for minor conditions - like coughs and colds. In most cases these conditions will remedy themselves without medical intervention and the medicines are prescribed for relieving the symptons. By any standards these are the less important drugs. Most of them can be bought over the counter from the local chemist without the need to consult a doctor or obtain a prescription. Many people already buy them in this way. Nevertheless, these branded medicines - tonics, cough and cold remedies, tablets for indigestion or headaches and low dose vitamin pills - are currently costing the health service £120 million a year.

A second group are the tranquillisers and sedatives - some of the branded sleeping pills come into this category. The use of those drugs has expanded dramatically in recent years - many doctors would say too far. Many different brand name products have been introduced which have essentially similar properties and the cost to the NHS is now £40 million a year.

We have already made clear that we do not intend to move over to a policy of indiscriminate generic substitution which would both limit the freedom of the medical profession and have a serious effect on the research-based pharmaceutical industry in Britain. I see no reason, however, why in the two groups I have set out the NHS should not limit itself to providing only the cheaper generic alternatives which are available.

In other words, the patient can still obtain these kind of medicines on prescription from his doctor under the health service, but they will be the cheaper generic alternative. If the patient still wishes to go for a particular brand name then he will have the alternative of buying it over the counter from his local chemist or else asking his doctor to prescribe it privately. This is the kind of system that applies in many other countries already.

Clearly I will need to consult with the professions and the industry on this to ensure that we do not accidentally exclude from NHS use a drug which is essential to the treatment of a particular condition. But I thought it right to tell the House of the outline of these proposals in advance. I shall be issuing a consultation letter later today and my rt hon Friend, the Minister for Health, will be taking the consultation process forward. He will also be opening discussions with the pharmaceutical industry on the implications of the Report of the Review Board on Government Contracts for the Pharmaceutical Price Regulation Scheme. Again our aim will be to contain the costs falling on the NHS.

016/106

SECRET

cc DW

4

Treasury Chambers, Parliament Street, SW1P 3AG

Steve Godber Esq
Private Secretary to
Secretary of State
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
London
SE1 6BY

8 November 1984

NBPR

Dear Steve

RESTRICTIONS ON NHS PRESCRIBING

Thank you for sending me a copy of your letter of ~~7~~ Attached. November to Colin Jones. As I told you by telephone, the Chief Secretary was content with Mr Fowler's decision to announce the "grey list" proposals in today's debate.

The Chief Secretary noted that there was to be a period of consultation on the proposals, and that there might be room for adjustment of the list. This may be inevitable. But he would like to stress the importance of achieving the promised savings from the grey list of £90 million a year. Any adjustments which might be made must not be such as to reduce these savings.

Copies of this letter go to Andrew Turnbull, Janet Lewis-Jones, John Graham, Colin Jones, Graham Sandiford and Richard Hatfield.

Yours sincerely

Richard Broadbent

R J BROADBENT
Private Secretary

SECRET

SECRET

010

cc DW
cc BI
3

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

C L Jones Esq
Private Secretary to
The Rt Hon Nicholas Edwards MP
Secretary of State for Wales
Welsh Office
Gwydyr House
Whitehall
LONDON
SW1A 2ER

7 November 1984

WBP

Dear Colin

RESTRICTIONS ON NHS PRESCRIBING

My Secretary of State, together with Mr Kenneth Clarke, met Mr Edwards, Mr Wyn Roberts and Mr John MacKay yesterday to discuss the 'Grey List' proposal outlined in Mr Fowler's letter of 1 November to Lord Whitelaw.

attached

They agreed that the proposal would require careful presentation and that it would be important to make clear that there was to be a period of consultation during which professional interests would be able to offer views on the range of products which were to remain available on the NHS. It was accepted that there was some room for adjustment of the list but it would be necessary, in the end, to rest on the fact that drugs which were not available on the NHS could, if doctors and patients wished, still be prescribed privately. This was an important safeguard in diffusing any criticism from the medical profession on the grounds of clinical freedom.

As far as the pharmaceutical industry was concerned, the meeting recognised that some companies would be significantly affected although they would be free to continue to seek private prescriptions or to enter the generic market.

In the light of discussion, it was agreed that there would be advantage in making an announcement in advance of the Autumn Statement on public spending. My Secretary of State will therefore issue a consultation letter to interested parties tomorrow and make reference to this in his speech during the debate on the address.

I am copying this letter to Andrew Turnbull (10 Downing Street), Janet Lewis-Jones (Lord Whitelaw's office), John Graham (Scottish Office), Graham Sandiford (Northern Ireland Office), Richard Broadbent (Chief Secretary's office) and Richard Hatfield (Sir Robert Armstrong's office).

Yours Steve

S A Godber
Private Secretary

SECRET

SECRET

008/106

CC DW 2
CC B1

Treasury Chambers, Parliament Street, SW1P 3AG

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

6 November 1984

Dear Norman

RESTRICTIONS ON NHS PRESCRIBING

Thank you for sending me a copy of your letter of 1 November - with AT to Willie Whitelaw. I welcome your proposals.

I am, however, a little concerned at your proposal to make an announcement this week ahead of the Autumn Statement. I am glad that you intend to present the measures in a positive light and on their own merits, irrespective of savings - but the fact is that savings of about £90 million a year will result, and these are directly relevant to the Autumn Statement and the public expenditure situation generally. It seems to me, therefore, that it would be better to time your announcement to coincide with the Autumn Statement.

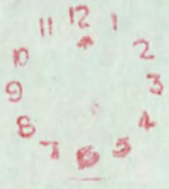
If you feel strongly that there would be merit in an announcement this week notwithstanding the above arguments, I would not wish to press the case for delay. But if it would not make much practical difference, I think an announcement next week would be preferable.

I am copying this letter to the Prime Minister, Members of MISC 106 the Secretaries of State for Wales and Northern Ireland and Sir Robert Armstrong.

Yours ever Peter

PETER REES

SECRET



SECRET

NBPM
AT 5/11

Copy 1 of 10

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

5 November 1984

Dear Secretary of State

Thank you for sending me a copy of your letter of 1 November to Willie Whitelaw about the projected measures for reducing expenditure on the family practitioner services. ✓ with AT.

In my letter of 24 October I expressed support for the draft H Committee paper circulated with your letter of 16 October and I am surprised to learn that you now intend to proceed without consulting colleagues in this way. The widening of your proposals to embrace control on the prescribing of hypnotics and tranquilisers introduces a much more controversial dimension. I have taken the trouble to re-read the papers and I am aware of the extreme sensitivity of the issue.

I accept the need to progress quickly but I really would like to know a little more about how this controversial issue is to be presented. A little time spent now in consulting colleagues more widely would be very worthwhile.

I am copying this to the Prime Minister, Members of MISC 106, Douglas Hurd and Sir Robert Armstrong.

Yours sincerely,

Ch Jones

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

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

SECRET

Prime Minister
To note. Mr Fowler has announced today. AT 8/11

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 The Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1A 2AT

1st November 1984

Dear Willie,

RESTRICTIONS ON NHS PRESCRIBING

I explained to colleagues at MISC 106 that I intended to bring forward in the near future a so-called "grey list" as a means of making savings in the NHS drugs bill. I have agreed with other Health Ministers how the scheme should work in order to achieve the savings I then envisaged of £60 million. But, as I explained in my letter of 25 October, the extra savings which we have agreed I should make following the MISC 106 discussions, can I believe be best achieved by extending the grey list concept. If we are to put the scheme into effect in time to achieve these savings, I shall need to announce the proposals as soon as possible after the Queen's Speech so that we have time to undertake consultations with the professions concerned before laying the regulations to bring it into effect. The purpose of this letter is to confirm to you and colleagues what I shall be announcing.

At present, doctors in the NHS (both general practitioners and hospital doctors) can prescribe any substance which they feel will be beneficial to their patients and, under their terms of service, pharmacists are required to dispense those prescriptions if at all possible. The clinical freedom implied by this is in many areas important. But I believe that at the extremes it simply leads to unnecessary expense. My intention is to restrict freedom to prescribe in three separate areas:

(i) those medicines which are of limited therapeutic value and used for essentially self-limiting conditions. This category would comprise tonics, cough remedies, antacids, laxatives, pain killers and vitamins. Almost all the drugs in these categories are available over the counter without prescription and it seems to me entirely reasonable that people should in future simply buy them direct from their chemists. There are a very small number

E.R.

of instances in which there may be sound medical grounds for prescribing them and I would retain a limited number of generic (ie non-brand name) drugs which doctors could prescribe if necessary;

(ii) substances which are not generally recognised as medicines at all. I have an Advisory Committee on borderline substances which advises on substances which should not be prescribed by doctors under the NHS. My proposals would give its recommendations statutory force. This would mean that doctors could no longer prescribe substances such as alcoholic beverages, cosmetics, special foods, dietary supplements and anti-smoking preparations (eg nicorette) on the NHS;

(iii) finally, to achieve the extra savings required I have decided to take action on hypnotics (sleeping tablets), sedatives and tranquillisers. These are, in the view of my medical advisers, widely over-prescribed and include some well-known and expensive proprietary drugs (such as valium and mogadon). I do not intend to stop drugs in these classes being prescribed on the NHS but I shall only allow the drugs to be prescribed under their generic name. This will have the effect that the NHS will only pay for the cheapest available brand of any given drug in this group.

I believe we have a good case in logic for these changes: they will help us to control expenditure on the drugs bill; they will prevent the NHS spending considerable sums of money on almost worthless products; they will prevent the NHS from having to pay unnecessary high prices for essentially the same product (particularly within the field of hypnotics). I think the measure can therefore be presented in a positive light and not primarily as a savings measure; but this adds to the importance of my making an early announcement. I have in mind a statement during the course of next week or during the debate on the Queen's Speech.

The reception from the medical profession will be mixed: some doctors are likely to welcome the scheme but others will oppose it as representing a restriction on their clinical freedom. The drug industry will certainly be hostile, particularly the two or three foreign-owned companies which are heavily dependant on the market for hypnotics. The effect on the industry as a whole, however, will depend on the extent to which proprietary brands currently prescribed are replaced by cheaper generic drugs supplied under the NHS or by drugs bought privately.

Despite these problems, I think that with careful handling we can have the best of the argument and can demonstrate that the effect will be to allow the NHS to concentrate on the more important areas of ill-health and treatment.

I am copying this letter to the Prime Minister, members of MISC 106, Nicholas Edwards and Douglas Hurd and to Sir Robert Armstrong.

Yours ever

NORMAN FOWLER

File

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

Andrew Turnbull Esq
Private Secretary
10 Downing Street

30 October 1984

Dear Andrew

THE HEALTH SERVICE IN ENGLAND
ANNUAL REPORT 1984

My Secretary of State reported last month, and the Prime Minister welcomed, his intention to publish the first of a new series of annual reports on the health service in England. The report is being published tomorrow and I enclose three copies of the report for your use together with copies of the Press Notice which we will be issuing with it.

The purpose of the report is to illustrate the improvements in the performance of the health service in recent years and to outline the policy achievements and objectives which the Government is pursuing in each area of the service. A central aim of the document is to focus attention on the outputs achieved by the service - essentially the numbers of patients treated and the services provided - rather than simply the resources put into it. As the report shows, the health service has in fact made real progress in these terms.

My Secretary of State hopes that his colleagues will find the report a useful reference point in explaining the Government's record on the health service. I am therefore sending copies of the report to Private Secretaries in the Departments listed below.

Yours

Steve

S A Godber
Private Secretary

Annex

Copies of Report distributed to Private Offices of Departments listed below:

	No of copies
MAFF	1
Defence	1
Education and Science	2
Employment	2
Energy	1
Environment	2
FCO	1
Home Office	3
Law Officers' Department	1
Lord Advocate's Department	1
Lord Chancellor's Department	1
Lord President of the Council	1
Lord Privy Seal	1
Northern Ireland Office	5
Scottish Office	5
Trade and Industry	1
Transport	1
Treasury	5
Welsh Office	5
	40

File

Department of Health
and Social Security

PRESS RELEASE

Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone 01-407 5522

84/343

31 October 1984

THE HEALTH SERVICE IN ENGLAND

Norman Fowler, Secretary of State for Social Services, has today (Wednesday) published an annual Report on the Health Service in England. This report looks at the developments in the last five years and some of the longer-term trends over the last decade.

In his foreword to the report Mr Fowler said:

> "The Government has shown that it is committed to sustaining the Health Service as the backbone of health care in this country. We are determined to make sure that the record of improvements continues in future."
>
> "I want to see a Health Service more responsive to those who use and pay for it."
>
> "There is no doubt that there have been real advances in recent years, with more and better services to more patients than ever before. Health Service staff can take great pride and credit in their performance in the face of increasng pressure for services. The Service will continue to face major challenges in the future, for example, in meeting the health needs of the growing numbers of old people, in providing the new and better forms of treatment made possible by medical and technical advances, and in responding to the health implications of social problems such as drug misuse. To meet these challenges the Health Service must change and develop, as it has in the past; but in particular it must look to get improved value from the money provided by the taxpayer so as to give the best possible services to patients from the resources available. That is the biggest challenge of all."

Chapter one highlights main points in the report and records that, for example:-

* the money available to the Health Service in England has doubled since 1978/79 - to nearly £13 billion cash in 1983/84, with the Health Service receiving high priority in public expenditure (paragraph 1.13);

* more patients have been treated than ever before - in-patient cases rose by 12 per cent between 1978 and 1983: people are spending less time in hospital and advances in treatment mean that more is done to help them (paragraph 1.3);

* professional staffing has increased - with, for example, over 13 per cent more consultants in 1983 than in 1978 in the acute hospital services and supporting specialties, and 25 per cent more in geriatric medicine; nursing staff in mental illness and mental handicap services have increased substantially (paragraphs 1.5, 1.9);

* striking reductions in the rate of perinatal mortality - down by about a third over this period to 10.3 deaths per 1,000 births in 1983 (paragraph 1.7);

* substantial progress is being made in improving services for old people, and mentally ill or handicapped people, away from concentration on long-stay hospital care and towards more care in the community; community care has been encouraged including trebling of the cash available for "Joint Finance" and launching of a special Care in the Community initiative (paragraph 1.10);

* the hospital building programme has increased so that spending in 1983/84 was 23 per cent more in real terms than in 1978/79; 35 new schemes in excess of £5 million each will be completed between 1980 and 1984 and over 70 other major schemes are in planning or construction (paragraph 1.5);

* the management of the NHS is being improved, including improving accountability of health authorities, and more recently, implementing the Griffiths Inquiry to get better management (paragraph 1.26).

Later chapters of the report describe main developments in:-

* Prevention and Health Education;
* Primary Health Care;
* Services for Elderly People, Mentally Ill and Mentally Handicapped People and People with Physical or Sensory Handicaps (the Priority Groups);
* Acute Hospital Services;
* Maternity and Child Health Services;
* Health Building and Estate Management;
* Health Service Management;

This report is the first of a planned series of annual reports to show the development of the Health Service.

CONFIDENTIAL

E.R.

(2)

PRIME MINISTER AT 8/10

8 October 1984

THE HEALTH SERVICE

The more we spend the less popular we become. There is no gratitude from the producers' cartel of COHSE (and NUPE, GMU) and the doctors despite our protestations and £15,000 million of spending.

So far we have used the language of better management and efficiency to counter the attacks. That language lacks warmth and newsworthiness and in a way gives credence to the endless stream of newspaper articles and TV broadcasts about cuts. Sometimes we confuse the message by claiming credit for yet more spending; well orchestrated "cuts" campaigners ensure that the message falls on deaf ears.

What can we do?

We have to split the producers from the patients. The Government should act as the patients' representative and expose the ways in which the producers are misusing or misdirecting cash, are playing politics with our health and deliberately organising a campaign against the Government.

This can be done through speeches. Each local MP should take an interest in how his local hospital works and should ask the difficult questions:

CONFIDENTIAL

- Why is a ward closing down when the hospital has millions of pounds of money tied up in unused stocks?

- Why is so much expensive overtime worked?

- Why is the drug bill so high?

- Why have ancillary services not been put to the test of the market place?

- Why are waiting lists so long? Why can't people be re-routed to shorter queues in neighbouring hospitals? etc.

Whilst this counter-blast is being organised the DHSS should seize the initiative. It should pledge itself to achieve certain higher standards in hospitals through the application of better management. We can announce new initiatives to:

a) Shorten waiting lists (just cutting out the dead and the duplicates could cut the total by about 20 per cent). Routing to the shortest queue could cut effective waiting times.

b) Setting out a charter of the patient's rights for consultative information from the doctor and a better complaints procedure.

As suggested by Michael McNair-Wilson

E.R.

The contracting-out initiative must be pushed through. The recent salmonella scare was handled wrongly: it was an opportunity to show how we need higher standards of cleanliness which requires more elbow grease (perhaps by private operators) rather than more cash.

We should even up the duties, remuneration and hours worked by well paid consultants vis a vis the more numerous (and potentially more powerful) junior doctors. The consultants will object but under Labour they would lose all access to lucrative private practice from their NHS base: not an enticing alternative. How many people really want to be treated by a young doctor in his 99th hour of the working week?

The Politics of Change

We have to mobilise the patients, stressing we believe in a free hospital service but are unhappy with standards of care per pound of their money spent.

We will never win over COHSE et al. But we can hope for support from nurses and junior doctors and we can win them over if, for example, some of the savings of privatisation are seen to be reapplied within the Health Service.

CONFIDENTIAL

Stepping Stones

We cannot, and should not, try to introduce hotel charges or consultancy fees for NHS work.

We could encourage more private services - gifts, journals, food retailing - within NHS hospitals with the companies paying rentals to the health authorities. This revenue could be ploughed back into medical uses.

Couldn't we encourage BUPA and medical companies to set up private treatment centres for specific problems? Chiropody and teeth are the model. Why not private local X-ray and limb fracture centres for those who want speed and are prepared to pay? There is now a private clinic for sports injuries for professionals.

Conclusion

We need fast and politically adept action. We have to expose the vicious "cuts" campaign, split up to the political forces within health, address ourselves to real patient need. We need to squeeze the cosy unionised producers' cartel through patient power. We can win over the patient who also doubles up as the voter.

JOHN REDWOOD

CONFIDENTIAL

NAT HEALTH
Expenditure

CCNO

NORTHERN IRELAND OFFICE
WHITEHALL
LONDON SW1A 2AZ

NBPM

AT 2cl9

SECRETARY OF STATE
FOR
NORTHERN IRELAND

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

25th September 1984

Dear Secretary of State,

NHS ANNUAL REPORT

You sent me a copy of your minute of 14 September to the Prime Minister.

I endorse your desire to publicise developments in the health service in recent years and believe that the annual report will demonstrate the Government's continuing commitment to these important public services.

The Department of Health and Social Services here is under a statutory obligation to publish periodic reports covering essentially similar ground. In addition the Department publishes at regular intervals Regional Strategic Plans for the Health and Personal Social Services which contain analyses of service development. The most recent of these appeared in December 1983.

I am copying this letter to the Prime Minister, Willie Whitelaw, Nigel Lawson, George Younger, Nicholas Edwards and Sir Robert Armstrong.

Yours Sincerely

N J Ward.

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

ssd

National Health Pt 4

Expenditure

RAMADO

hle

cc:
DAVID WILLETTS, P.O

10 DOWNING STREET

From the Private Secretary

17 September, 1984

THE NATIONAL HEALTH SERVICE: ANNUAL REPORT

The Prime Minister has seen your Secretary of State's minute of 14 September to which was attached a draft of the National Health Service Annual Report. She warmly welcomes his efforts to publicise the Government's record on the National Health Service and was most grateful for the work which has gone into the preparation of the Report.

She proposes to make use of the material in the Report in speeches, interviews and Question time and hopes other Ministers will do the same.

I am sending a copy of this letter to Janet Lewis-Jones (Lord President's Office), David Peretz (HM Treasury), John Graham (Scottish Office), Colin Jones (Welsh Office), Graham Sandiford (Northern Ireland Office) and to Richard Hatfield (Cabinet Office).

(Andrew Turnbull)

S. Godber, Esq.,
Department of Health and Social Security

10 DOWNING STREET

Prime Minister ①

Agree

(i) you congratulate Mr Fowler on efforts to present Government case on NHS? Yes

(ii) we put suggestions for improvements to draft to DHSS?

We will fillet the material for Speeches and Questions

AT

14/9

I think it would be best to leave our message at congratulations. The department really has made a superb effort & it is very helpful to

MR TURNBULL 14 September 1984

THE NATIONAL HEALTH SERVICE: ANNUAL REPORT

Norman Fowler has written to the Prime Minister attaching a draft annual report on health services in England. It is intended to be the first in a series. He wants to publish it shortly before the Party Conference. The Prime Minister could congratulate him on looking for new ways of getting across the positive message on the health service, copying this to colleagues.

The document is too long. The only bits which most people will bother to read are the foreword and the first chapter, which the Prime Minister may wish to glance at if she has time. The first chapter gets over some good themes - improved productivity and better services to patients. It is a bit thin on responsiveness to consumers (paragraph 24) and contracting-out (the last part of paragraph 26). We would like the DHSS to make rather more of the need to create economic pressures to lower costs and satisfy the patient.

The DHSS think that they have need to keep the other factual material to back up the bold assertions in the opening section, and it is a useful store of juicy facts for speeches. The later chapters could be reorganised by bringing the Consumer and Management to the fore as chapters

2 and 3, and ending with the Estate which is not very eye-catching.

The report deliberately avoids announcing any new policies - these are being kept for the Green Paper on Family Practitioners. So there is little we would quarrel with, though colleagues may wish to pick up some points of detail.

The whole thing is unfortunately weighed down with leaden bureaucratic prose. The opening sections in particular need to be punchier and zippier as the language is not right for general consumption.

David Willetts

DAVID WILLETTS

PRIME MINISTER

NHS ANNUAL REPORT

I have thought for some time that we should do more to publicise developments in the health service in England in recent years. The debate on health tends to be almost exclusively in terms of what the Government is spending on the health service. I believe we should tell the public what the service is doing with these resources in terms of the services actually provided. Here there is also a good story to tell.

We began this with our publication in early 1983 of 'Health Care and Its Costs' and I think it worthwhile to develop the messages put over, for the first time, in that publication and set out the important progress we have made since. The achievements need, however, to be balanced against the challenges the health service still faces in terms of rising demands for more and better services and, most importantly, in terms of making the best use of available resources. We can take the opportunity here of writing up the wide range of action the Government is taking to improve the management of the NHS for the benefit of patients.

I propose to do this by introducing a new series of reports on the health services in England. The first such report - of which I enclose a draft copy - takes a look over the last five years in particular rather than concentrating simply on the last twelve months. It will set the scene for subsequent reports - which I expect to publish annually.

I intend to publish the report at the beginning of October. To keep to that timetable I would accordingly be very glad to have any comments which you and colleagues might have by Friday 21 September.

E.R.

Copies of this minute and the draft report go to Willie Whitelaw, Nigel Lawson, George Younger, Nicholas Edwards, Douglas Hurd and Sir Robert Armstrong.

14 September 1984

N F

THE HEALTH SERVICES IN ENGLAND

ANNUAL REPORT 1984

Foreword

The National Health Service helps nearly all of us at some time in our lives. For many it means no more, most of the time, than an occasional visit to our family doctor or dentist. But for others it is a life-saver and for some it provides the main support for the whole of their lives. At any time, for example, there are on average over a quarter of a million patients resident in hospitals in England; every day about half that number attend hospital out-patient clinics for specialist advice, and about two-thirds of a million consult their family doctors ~~each day~~.

Despite the vast numbers, the Health Service is by far the most personal of our public services and is inevitably judged very much by the direct experience people have of the individual treatment, care and attention they receive.

But it is also one of the biggest businesses in England and the largest of our public services. It employs over a million people and now spends £13½ billion annually. It works through over 300 different authorities to provide services in every part of the country. Like any business undertaking it ought to account for what it does. It is my responsibility to account to Parliament for the Health Service but I believe my responsibility goes wider, and that the public, both as taxpayers and patients, should have more information about the Service. That is why I have decided to publish this report on the Health Service in England so as to set out what the Service has achieved in recent years, and the challenges ahead. I want to see a Health Service more responsive to those who use and pay for it and I hope that this report and those which will succeed it - which may well differ in form and content from year to year - will in turn help to keep the public informed.

The first report looks back over the last five or ten years to show how the Service in England has developed. There is no doubt that there have been real advances in recent years, with more and better services to more patients than ever before. Health Service staff can take great pride and credit in their performance in the face of increasing pressure for services. The Service will continue to face major challenges in the future, for example, in meeting the health needs of the growing numbers of old people, in providing the new and better forms of treatment made possible by medical and technical advances, and in responding to the health implications of social problems such as drug misuse. To meet these challenges the Health Service must change and develop, as it has in the past; but in particular it must look to get improved value from the money provided by the taxpayer so as to give the best possible services to patients from the resources available. That is the biggest challenge of all.

The health of our society depends also on how we as individuals face up to the challenge to take better care of our own health - particularly through a better balanced diet, taking regular exercise, not smoking and keeping alcohol consumption down to a sensible level. More healthy ways of living will not, of course, eliminate the need for health services but will help significantly to reduce unnecessary ill-health and preventable deaths.

The Government has shown that it is committed to sustaining the Health Service as the backbone of health care in this country. We are determined to make sure that the record of improvements continues in the future. I hope this Report will help people to understand the purpose and nature of the developments taking place in the Service and to see how they relate to those which their own local health authorities propose from time to time in their own communities.

THE HEALTH SERVICE IN ENGLAND

CONTENTS

CHAPTER 1

HEALTH SERVICE ACHIEVEMENTS, CHALLENGES AND RESOURCES

ACHIEVEMENTS

1. The Health Service is a vast and complex organisation. Yet its objective can be stated extremely simply: to help the individual stay healthy and to provide effective and appropriate treatment and care where necessary.

2. Assessment of final outcomes of health care - either in terms of the well being of individuals or the health of society at large - is notoriously difficult. However there is no doubt that the Health Service is providing more services and with real improvements in their quality and distribution. Progress is also being made towards better patterns of service and new forms of treatment are being provided more generally across the country. The record for each main sector of the health service is described in succeeding chapters of this report. The main points are summarised here.

3. NHS hospitals are treating more patients than ever before. Figure 1 illustrates the trends 1973-83. Table 1 shows that, comparing 1978 with 1983, the number of in-patient cases increased by nearly 650,000 and out-patient attendances by over 2½ million. These increases were much bigger than in the previous five years.

Figure 1 to go in here.

Figure
NHS Hospital Activities 1973-1983

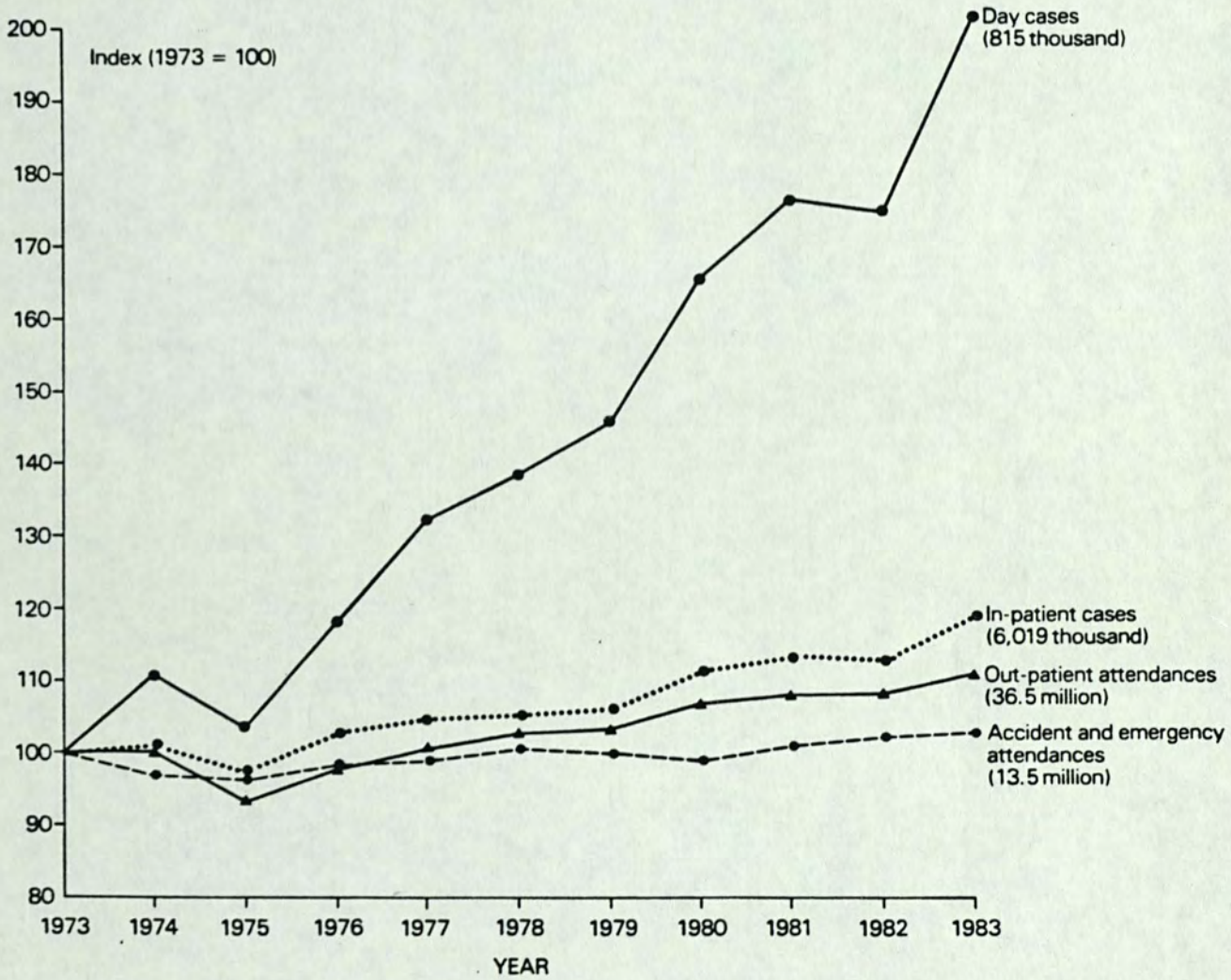


TABLE 1

Increases in NHS hospital activity 1973-1983 England

	Increase between 1973 and 1978		Increase between 1978 and 1983	
	thousands	percentage	thousands	percentage
In-patient cases	238	4.6%	649	12.1%
Day Cases	154	37.6%	252	44.9%
Out-patient attendances	632	1.9%	2,567	7.6%

Note. 1983 figures are provisional.

If all the main types of output - eg hospital in-patient cases, hospital day cases, out-patient and accident and emergency attendances and the community health services - are weighted for their average costs, the overall increase in output between 1978 and 1983 was 12.7% or about 2.4% a year on average. This increase is very much larger than the rise in the five years to 1978 (7.7%).

4. The figures in Table 1 cover all hospital services - acute, maternity, and those for the 'priority groups' - elderly people, mentally ill people and those with physical or mental handicaps. Significant improvements are being made in each of these services and in primary health care.

5. In the acute hospital services (excluding maternity) an extra 450,000 patients - nearly 11% more - were treated in 1983 than in 1978, an increase in the number of patients per available bed (throughput) of nearly 14%. Underlying this improved performance were developments in professional staffing and facilities and in medical and surgical practice. Consultant medical staffing in the acute specialties increased by nearly 12% in whole time equivalent (wte) terms between 1978 and 1983. Though the total number of acute beds fell by about 9,000 in those years, in the five years 1980-84 some 11,000 new beds, the majority in the acute sector, will have opened and, amongst other facilities, 169 new operating theatres forming part of 35 new major schemes costing between £5m and £20m will have been completed, reversing the decline in capital spending in the late 1970s. Over 70 other major schemes, each costing £5m or more, with a total value in excess of £840m, are now in planning or construction.

6. Advances have also been made in the availability of newer forms of diagnosis and treatment; for example, since 1978 there has been:

- a 50% increase in new patients treated for end stage renal failure;

- more than double the number of coronary artery bypass grafts;

- wider use of scanners and ultrasound instead of invasive (x-ray) investigative techniques.

7. In the maternity services there has been a dramatic improvement in perinatal mortality rates - by over a quarter in 4 years to 10.3 deaths per 1000 births in 1983. This has been due to a variety of causes including greater awareness of the factors making for a safe pregnancy and the good health of the newborn, better facilities and staffing (an increase of 12% in consultants since 1978), and improved midwifery and nursing ante-natal care. Much more emphasis is now being given to making these services more responsive to the individual needs and wishes of mothers and their families.

8. In the services for the priority groups progress is being made in improving the pattern of service, away from concentration on long stay hospital care and towards more care in the community - either at home or in more local facilities. For example, in mental illness hospitals and units the number of daily occupied beds fell by over 11% (8,800) between 1978 and 1983; for mental handicap beds the fall was 14% (6,400).

9. More patients in the priority groups are making use of day care facilities - over 5 million regular attendances in 1983 compared with about 4½ million in 1978. The quality of care for those remaining in long stay hospitals has benefited from improvements in medical and nursing staffing; for example the wte number of consultants in geriatric medicine increased over this period by 25% and in mental illness by 17%. Nurse staffing improved in all these areas by between 14 and 17%. Two new specialist units for patients with spinal cord injury or disease have been opened since in 1984.

10. District nurse staffing increased by 9.6% between 1978 and 1982 and the number of old people (aged 65 and over) ~~first~~ treated by District Nurses rose by nearly a quarter between 1978 and 1983, to 1½ million. The money health authorities have to assist local authorities (Joint Finance) in jointly planned ventures to promote community care has been increased to £99.5m in 1984/85 - nearly treble the amount in 1978/79 - and a special Care in the Community programme has been launched. These developments reflect the commitment to improve the quality of life of those being cared for in the community as well as those in institutional care.

11. The primary health care services have been strengthened by increases in medical and dental practitioners (12% between 1978 and 1983). The average family doctors list size fell by 9% and changes in practice organisation are helping the development of ~~the~~ primary health care teams. Community health services have improved through more nurses and health visitors and better training and patterns of working; more people are being nursed and visited at home. Extra finance has been provided to assist improvement of primary care in inner cities.

12. In the field of health education and prevention, there have been welcome reductions in the numbers of smokers and in cigarette consumption. Acceptance rates for immunisations against infectious diseases have improved.

RESOURCES

13. These and other improvements would not have been possible without real growth in the resources available to the NHS. On all the relevant measures the increases over the last five years (1978/79 to 1983/84) have been substantial. The figures are in Table 2. They show that:

- cash has doubled from £6½ billion to nearly £13 billion;

- in terms of economic cost - ie cash adjusted for general inflation - this means an increase of nearly 17%; this figure measures the real cost to the taxpayer and hence reflects the relative priority the Government attaches to the health service; by comparison public expenditure generally grew by just over 7% in economic terms;

- in terms of input volume - what money can buy for the NHS - this means an increase of over 7%; this lower figure reflects the fact that the cost of the goods and services used by the NHS rose faster than general inflation over this period.

TABLE 2

INCREASE IN NATIONAL HEALTH SERVICE EXPENDITURE 1978-79 to 1983-84, IN CASH. ECONOMIC COST, AND VOLUME. ENGLAND. £m. gross

	1. Cash	2. Economic Cost (at 1983-84 prices measured by the GDP Deflator)	3. Volume (1983-84 prices) measured by the NHS pay and prices deflator)
1978-79	6,455	11,075	12,063
1983-84	12,919	12,919	12,919
Increases in £m	6,464	1,844	856
Percentage increases	100.0	16.6	7.1

14. These increases have been sufficient to meet the additional pressures on the hospital and community health services of population changes and to finance the rising demand on the family practitioner services as well as to provide for capital expenditure in 1983/84 23% higher in real terms than the level to which it had fallen in 1978/79. [The original allocations to health authorities for 1984/85 for hospital and community health services envisaged growth in real resources of some 1% as well as significant additional increases in output from ~~the~~ better management. ~~of resources~~. NHS pay settlements were in the event somewhat higher than anticipated. The Government provided additional funds to meet about | %| of these extra costs and health authorities are covering the remainder of about |£ m| from the cost improvement programmes of £100m they have identified for 1984/85. Overall there will still be both a real growth in resources allocated and over and above that, further gains in output from authorities' cost improvement programmes.]* [DN this passage dependent on announcement of decisions on final outcome of NHS pay round.]

15. Progress continues to be made also in achieving a fairer share of resources across the country towards the objective of providing equal opportunity of access to health care for people at equal risk. There are still disparities between the 14 Regional Health

Authorities in their funding levels but in 1979/80 the gap between worst and best was 22%. In 1984/85 it is 14%. In 1979/80 the worst funded Region was some 9% below target; in 1984/85 no Region is more than 5% below. The long term resource assumptions given to RHAs in 1983 are based on RHAs moving steadily closer to their targets over the next 10 years so that by 1993/94 a broad equity should have been achieved. Figure | | illustrates the progress made in recent years, region by region. |DN. Figure to go in here is appended|

CHALLENGES

16. The achievements of the Health Service in terms of providing more and better services to patients and making better use of available resources have received less recognition than they should and reflect great credit on all the staff working in the Service. But it is in the nature of health care that needs do not remain static. They are affected by demographic and social changes and advances in medical science. Needs will always be running ahead of what can be generally available and the pattern and organisation of care will always be evolving as the scope for further improvement is recognised.

17. Nor has the progress made in recent years been even across the board. There remains too much variation in standards of service and provision. Broad national measures of activity and improvements mask these differences and variations and hide local deficiencies and shortages. Much is still to be done to bring standards in all areas to the level of the best now being achieved and to make the most cost effective use of available resources.

18. The Health Service as a whole will continue to face growing <u>demographic pressures</u> as the numbers of old people, especially those over 75, continue to rise. This will affect not only the acute services and services specifically for the elderly but also physical or mental handicap and mental illness services as the proportion of people with physical and mental disabilities increases with age.

19. <u>Social changes</u> in terms of personal lifestyle, for example the long term trends towards increased drinking and the more recent rapid rise in drug misuse, are causing increasing demands on health

services and challenges to health education and prevention. They emphasise the general importance of continuing to develop means of promoting good health and preventing illness to improve the quality of life and reduce the demands on health services through avoidable disease and disability.

20. For the acute services the challenge will be to sustain and build on the improvements in the use of resources already made, to make advances in treatment more widely available, and to achieve the right balance between the introduction of new and often initially expensive treatments and strengthening existing services without preempting the resources needed to improve services for the priority groups. There is general concern that waiting lists, and more importantly waiting times, should be reduced.

21. For the priority groups there are major challenges ahead for health and local authorities, working with voluntary bodies, in planning and carrying through the continued contraction of inappropriate long stay provision and the complementary expansion of community care; the development of district based services for the mentally ill; extending services for disabled people, including new equipment to meet their particular needs; and, above all, in meeting the growing needs of elderly people across a wide range of health and social services.

22. For maternity and child health services there are particular challenges to extend recent improvements to all social classes and areas of the country, calling for an imaginative and understanding approach as well as building up services where they are weakest. More effective integration and development of child health services and increased take up of immunisation are needed.

23. The primary health care services are a major factor in the clinical and financial effectiveness of the NHS. The inherent strength of the family practitioner services must be sustained and ways found of improving the planning and development of these services within the NHS as a whole without prejudice to the independent contractor status of practitioners. The Government intends to publish a Green Paper on these issues later in 1984. Improving primary health care in inner cities must remain a high priority for early progress. The preventive role of primary care services needs to be strengthened.

24. The public's satisfaction with the Health Service depends very much on how they feel about the way the Service treats them as individuals. The challenge of making the Service as sensitive as it should be to the needs and wishes of consumers, both individually and collectively, has not yet been adequately met and the need to do so must be more widely recognised, as recently re-emphasised by the Griffiths Report.(1) It is a challenge to everyone in the Service in their dealings with patients.

25. As regards resources, in its 1984 White Paper on Public Expenditure the Government underlined its commitment to the NHS by showing a cash increase for the three years 1984/85 - 1986/87 of 17% for the NHS (as compared with 10% for public expenditure programmes as a whole |and extra cash has been made available this year to meet | | of the extra cost of pay awards above the level allowed for in cash limits.| This should allow room for continued steady and sustained growth in services through increased resources from the taxpayer. How much growth will, however, depend on how efficiently and effectively resources are used. Getting the best out of resources in terms of maximising the services to patients is, and will continue to be, a fundamental challenge for the Service and for Ministers in providing strategic direction and leadership.

26. The Government recognises the prime importance of this challenge and of meeting it successfully in the interests of consumers and taxpayers alike. It has already taken a series of major steps to that end. These include.

: Improving the structure and management of the Service. The authority structure has been simplified and shorter, clearer lines of accountability established by abolishing the Area tier and giving health authority status to Family Practitioner Committees. Action is now underway to implement the main recommendations of the Griffiths Inquiry,(1) including the appointment of general managers at Regional, District and unit level by the end of 1985 and, on a slower timescale, the introduction of management budgeting within Districts. General managers will draw together responsibility for planning, implementation and control of performance in one individual who will take personal responsibility for securing action at

(1) NHS Management Inquiry Report. Chairman Mr Roy Griffiths. Published by DHSS, October 198

each level; they must provide the drive and leadership necessary to improve the management performance of health authorities in the interests of better patient care.

: Encouraging the <u>better utilisation of manpower</u> - representing over 70% of health authorities' current costs. Total NHS numbers increased between 1978 and 1983 (see Table 3 below). The increase in employed staff (5.7%)[1] was considerably less than between 1973 and 1978 (about 14%)[1] though hospital activities - as shown in table 1 - increased faster in the later than the earlier period and faster than the rate of increase in staff. The number of staff providing direct patient care increased by more than 8% between 1978 and 1983, as compared with a growth of 1% in those providing support services. This is in line with the Government's policy to concentrate resources on services to patients. Between 1980/81 and 1984/85 health authorities are required to reduce the proportion of expenditure on management costs by a tenth to 4.61%. Indications are that this will be achieved. As part of the continued drive to improve the utilisation of manpower, in September 1983 manpower targets were settled with health authorities providing for a reduction overall of about 4,800 staff (0.5%) by March 1984. Authorities overreached their targets as staff were reduced by 11,400. Revised planning arrangements now require health authorities to produce integrated plans showing how finance, manpower and the NHS estate are being used together to meet service objectives, and with the aim that services should expand faster than manpower. In the light of service plans submitted in 1984 Ministers decided that plans for 1984/85 could be achieved within the same national manpower target for March 1985 as that set for 1984. The regional targets which have been set are consistent with that figure.

: Improving the <u>accountability of health authorities</u> for the way they manage and plan the huge resources for which they are responsible. Annual reviews of performance are now held between Ministers and each Regional Health Authority. These are repeated between each Region and its District Health Authorities and are being extended down to unit level

---

(1) these percentages take account of the reductions in working hours of nurses and some other groups.

Districts. The outcome of these reviews is made public. Similar reviews will be conducted between the DHSS and Family Practitioner Committees after they achieve their new status in April 1985.

: As part of the new planning arrangements, from 1984 onwards health authorities are required to carry through substantial and sustained cost improvement programmes. No specific targets have been set but the Regional Health Authorities identified current expenditure savings of about 1% (some £100m) in 1984/85. Authorities are expected to build on this beginning in subsequent years. It will be a prime challenge, especially to the new general managers, to see that these programmes are sustained and resources used more effectively in improving patient care.

: Positive contributions towards achievement of cost improvement programmes should flow from the implementation in the NHS of 'Rayner scrutinies, competitive tendering for 'hotel' services, and a much more positive and, where appropriate, commercial approach to managing the massive NHS estate. Scrutinies - conducted by NHS officers - examine particular activities to see whether they represent value for money. They have so far identified considerable possible savings - perhaps £170m on residential accommodation. The potential of the scrutiny approach must be exploited. Competitive tendering for 'hotel' services has already shown that there is scope for considerable savings, either through more efficient in-house services or the use of commercial services of equivalent standard if cheaper. Hotel services cost about £1 billion a year but in 1982/83 less than 2% were contracted out. The NHS estate covers nearly 50,000 acres and includes some 2,000 hospitals. About 10% of expenditure on the hospital and community health service goes on its maintenance. Action has been taken in the light of the Davies Report[1] to make more effective use of the estate consistent with the needs of the service and to identify and dispose of surplus property. At constant price levels, for example, sales have gone up by two and a half times since 1978/79 and were worth over £30m to the Service in 1983/84.

---

(1) Report of the Inquiry into Underused and Surplus Property in the NHS. DHSS 1982. Chairman Mr Ceri Davies.

27. These developments - described more fully in chapters | | indicate the Government's commitment to improve the use of resources in the NHS and the extent to which significant benefits have already been achieved or are in sight. But they can only mark the beginning of what has to be a continuing and challenging objective which the Government is determined to pursue.

TABLE 3

NHS EMPLOYED STAFF BY MAIN STAFF GROUP

England whole-time equivalent

Directly Employed Staff (1)	Sept 1978	Sept 1983	% increase
Nursing & Midwifery (2)(3)	374,400	397,100	6.1
Medical & Dental (4)	35,900	40,200	11.9
Ancillary	172,200	166,200	- 3.5
Administrative & Clerical	100,300	110,000	9.6
Professional & Technical	57,200	68,700	20.0
Maintenance	19,900	20,800	4.9
Works	5,600	6,000	7.0
Ambulance (inc. officers)	17,500	18,400	5.0
ALL STAFF (directly employed) (5)	783,000	827,400	5.7
General Medical & Dental Practitioners	33,000	~~31,000~~ 37,000	~~-1114.8~~ 11.8

(1) Includes staff at the Dental Estimates Board and Prescription Pricing Authority.

(2) Adjusted to account for reduction in working hours in 1980 (from 40 to 37½ hours per week).

(3) Includes agency staff and health visitor students.

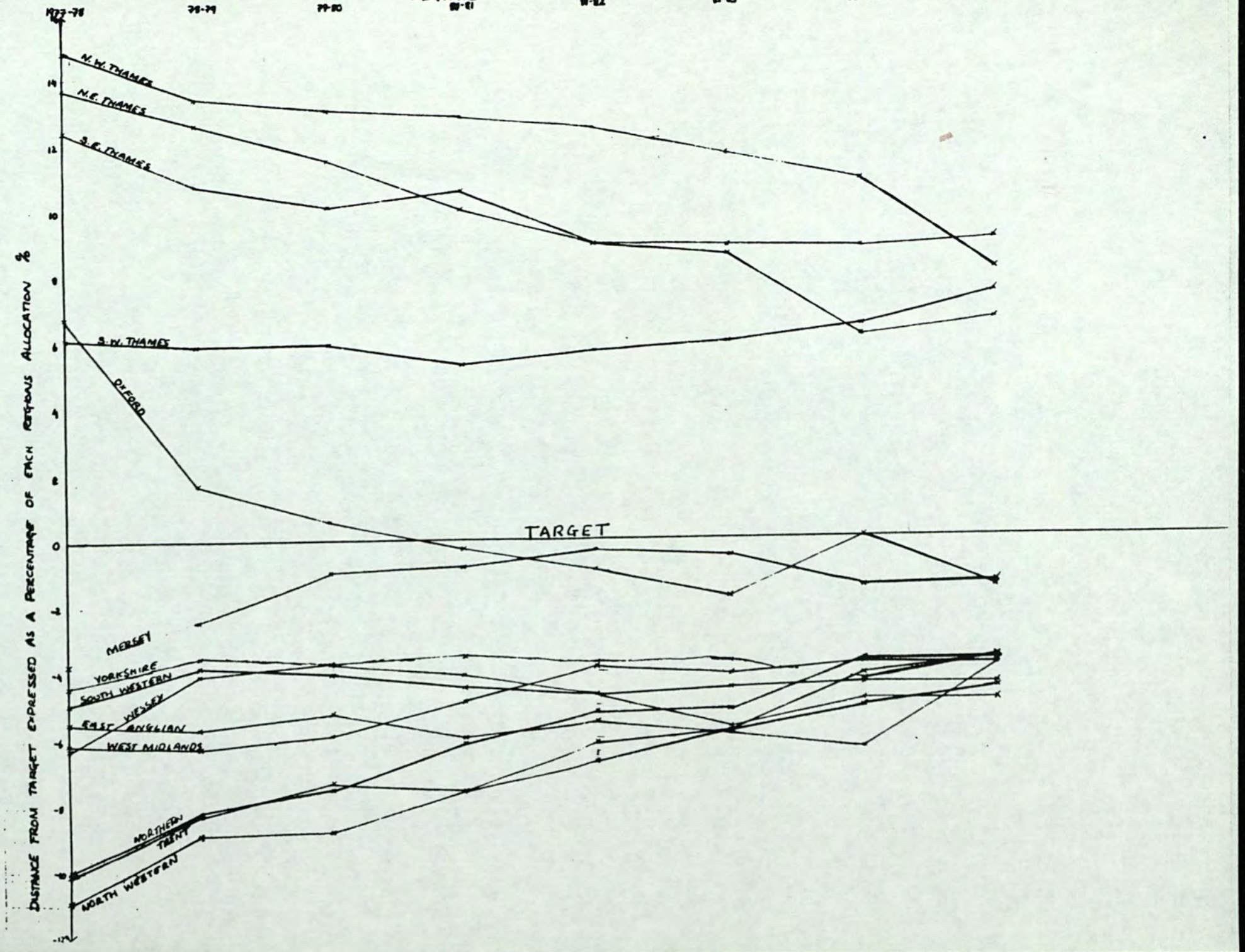
(4) Includes locums. Excludes hospital practitioners, clinical assistants, general medical practitioners participating in Hospital Staff Funds and occasional sessional staff in the Community Health Services.

(5) Excludes Medical trainees and Dental assistants.

~~SRTC~~
~~August 1984~~

NHS 1973-78 - [illegible] 5.7% 1978-83

REGIONS DISTANCES FROM RAWP REVENUE TARGETS



JW

NEW CHAPTER
12.9.84

HEALTH BUILDING AND ESTATE MANAGEMENT

1. The NHS estate consists of some 50,000 acres of land and 2,000 or so hospitals and numerous other premises. It is vital that this vast resource is put to the best use to support the practice of modern medicine and the delivery of health care. Its upkeep, modernisation and renewal require the investment of very substantial sums of money, about 10% of expenditure on the hospital and community health service.

2. Capital expenditure in the NHS grew in the early 1970s but fell sharply in 1977/78 to about one third less in real terms than in 1973/74. In recent years there has been a steady recovery and by 1983/84 the real level of investment was 23 per cent higher than in 1978/79 - in cash terms about £745m as compared with £365m. Figure [ ] shows year by year expenditure since 1970/71.

N.H.S. CAPITAL SPENDING

Figure

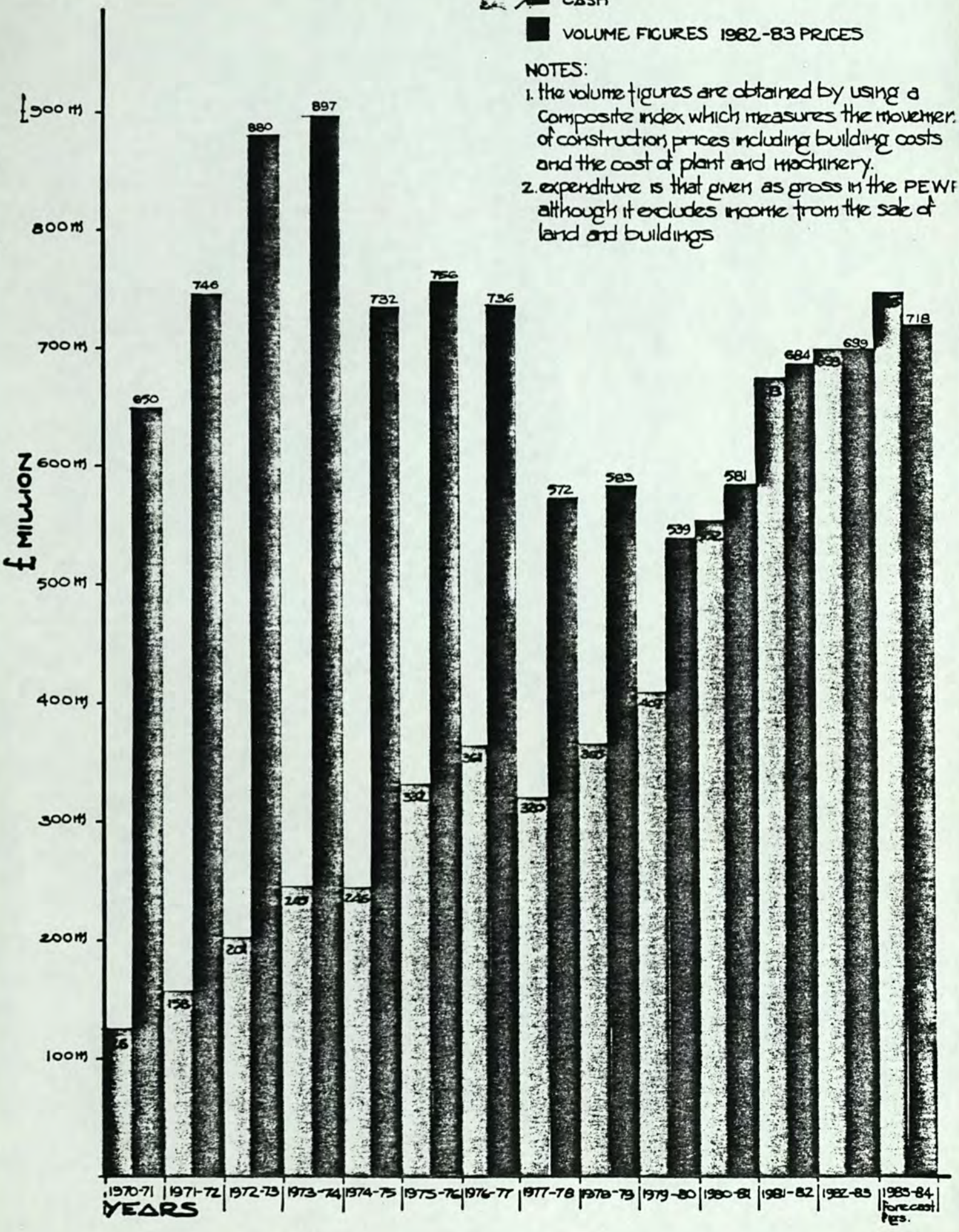
KEY:

CASH

VOLUME FIGURES 1982-83 PRICES

NOTES:

1. the volume figures are obtained by using a composite index which measures the movement of construction prices including building costs and the cost of plant and machinery.
2. expenditure is that given as gross in the PEWP although it excludes income from the sale of land and buildings



3. This increased expenditure has produced real and substantial benefits. In the five years 1980-1984 35 major hospital schemes, each between £5 million and £20 million in value, will have been completed in addition to very many smaller schemes. Figure [ ] ~~and / /~~ illustrates the progress being made. The major schemes alone will have provided over 11,000 new hospital beds and other facilities including 169 new operating theatres, 105 X-ray rooms, ~~and~~ 23 Accident and Emergency Departments and 22 outpatient departments. Figure [ ] ~~illustrates~~ shows the growth in the number of new facilities completed ~~year by year~~.

~~TABLE~~ [ ]

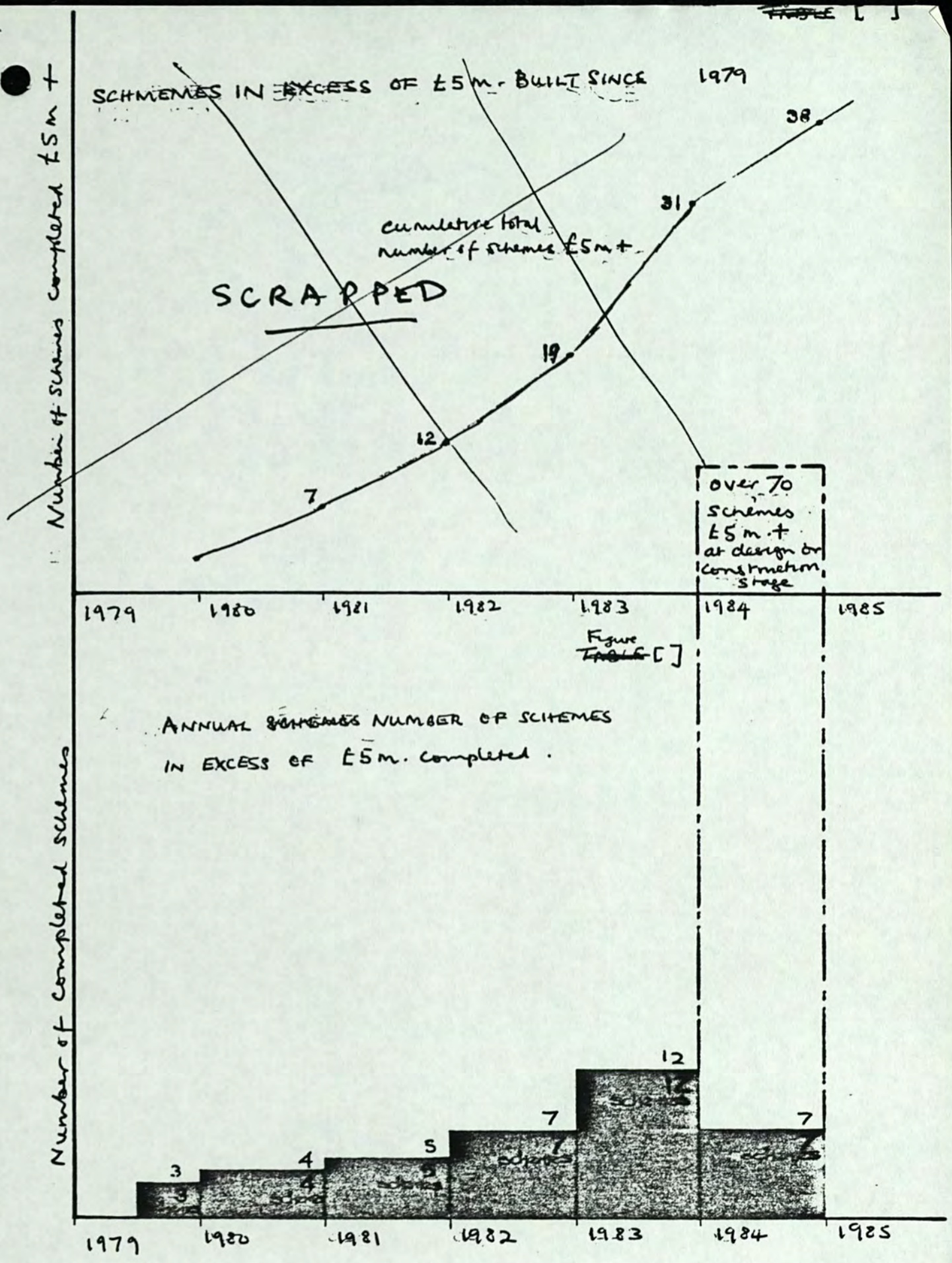


Figure ~~TABLE~~ [ ]

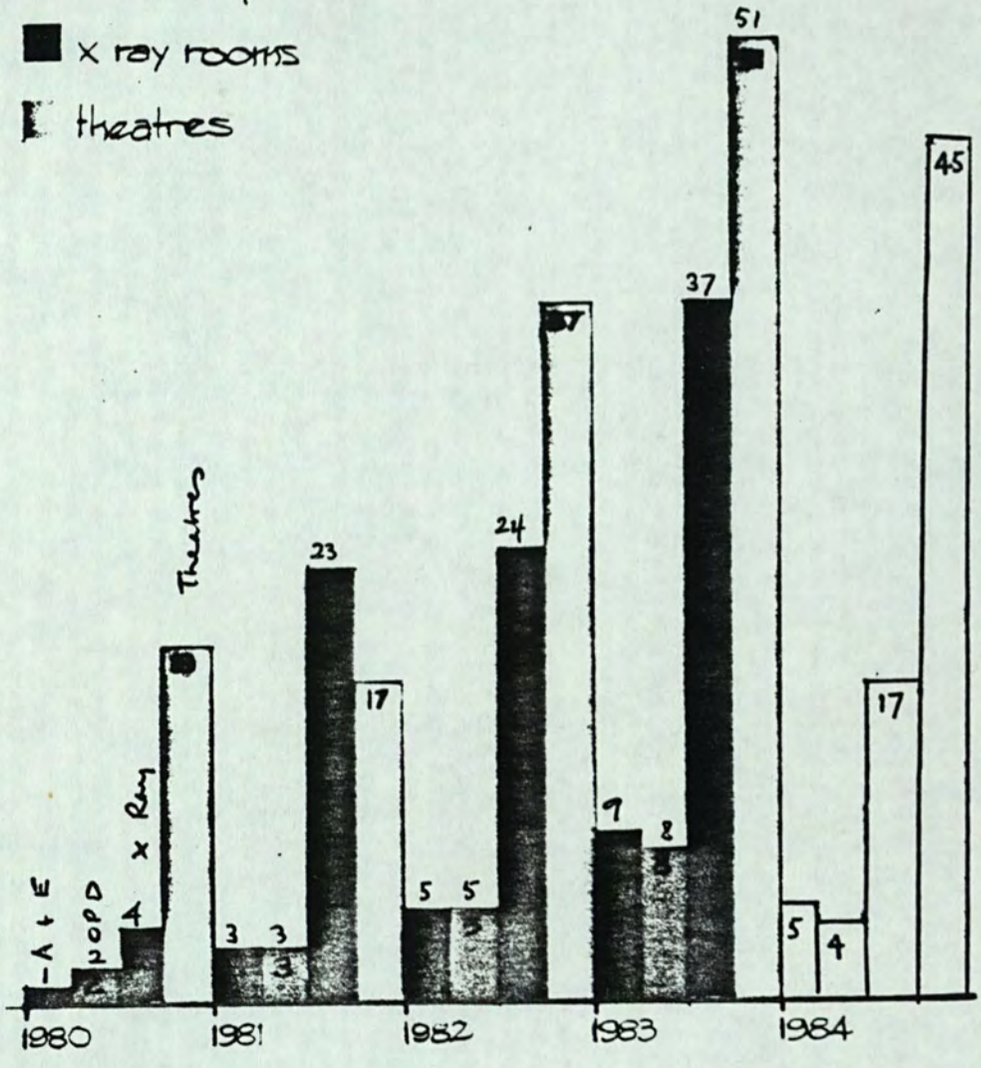
ANNUAL ~~SCHEMES~~ NUMBER OF SCHEMES IN EXCESS OF £5m. completed.

Figure

EXAMPLES OF NUMBERS OF FACILITIES COMPLETED IN SCHEMES OF £5M+ 1980-84

KEY:

- A and E depts
- O.P.D. depts
- X ray rooms
- theatres



New schemes are spread over all Regions of the country and although some of them, as at Milton Keynes, will provide hospital care for new communities, most have replaced old and outdated hospital. This modernisation and replacement of the estate continues and over 70 major schemes, each costing over £5 million and with a total value in excess of £840 million are now at the stages of planning, design and construction to follow those already completed.

4. There is emerging evidence to suggest that the new, well designed, compact hospitals which are now coming into operation all over the country not only provide a greatly improved environment and facilities but also are more economical to run than the hospitals they replace. A challenge for the future will be to achieve the optimum balance of spending on maintenance and upgrading of existing buildings and spending on new buildings. Better value for money in expenditure on new hospitals is being achieved through increasing use of national standardised design data, in particular the Nucleus system developed by the DHSS. Not only does this system reduce design and planning and expected construction costs but it also largely eliminates escalating costs and late completion which have often been problems in the past. The first twelve Nucleus hospitals completed have shown an average saving on the capital costs of a conventional one-off design of £1.27 or 10.8 per cent. In other words, for about the same volume of expenditure, an extra hospital was built as compared with conventional design.

5. Progress continues to be made also in allocating capital resources to Regions on ~~the basis of relative health care need~~ a more equitable basis. As with current expenditure ~~allocations~~, health authorities have been moving gradually towards each regions "target" allocation of resources, based on its projected population weighted to take account of that populations health care needs. The 'worst' Region in 1979/80 was 14 per cent below its target and in 1984/85 no Region will be more than 6 per cent below.

6. Increasing efforts have been made by the DHSS and in the NHS to improve the efficiency of the estate in which the Health Service is provided. A computerised management information system (WIMS)

is being developed to manipulate the data needed for cost effective running of the estate. This computerised system is the first of its kind in the world and has already been adopted by the majority of Health Districts in England, Scotland, Wales and Northern Ireland, as well as being sold here and overseas for both commercial and health work.

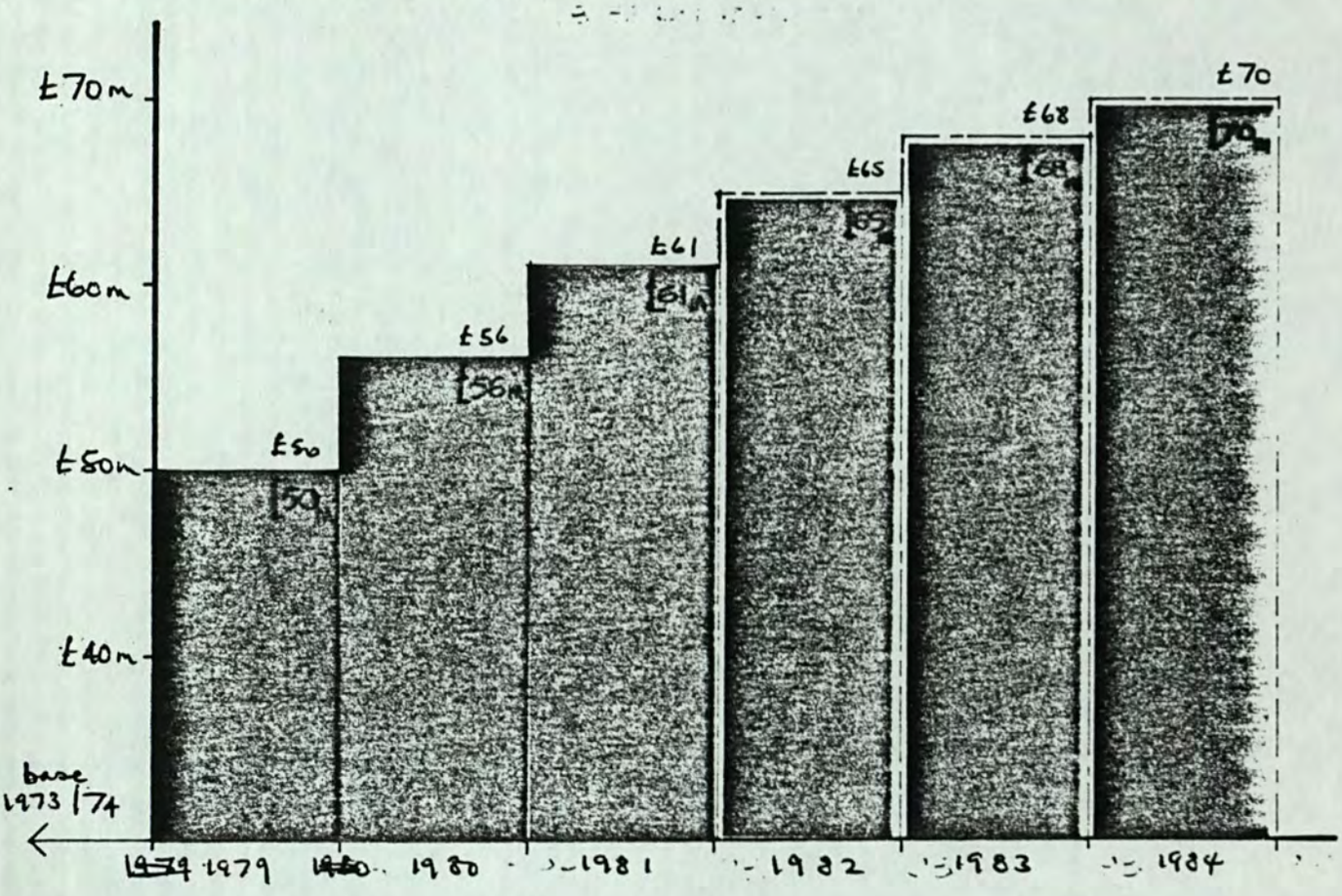
7. The Report of the Enquiry into Underused and Surpous Property in the NHS (the Davies Report) published in 1982 laid particular stress on the need to keep the size of the estate consistent with the needs of the service and to dispose of land which is demonstrably surplus to requirements. The Government's decision on the report were ~~published~~ announced in November 1983 (HC(33)22). Health authorities were instructed to survey and value their estates and review functional suitability, and to bring in a system of notional rents. A National Property Advisory Group has been set up to monitor progress and to advise on estate matters. Health Authorities have a particular incentive to dispose of surplus land, since proceeds from such sales are retained by them as a supplement to their capital allocations. And from August this year the Town and Country Planning Act 1984 allows Health Authorities to maximise the value of surplus land by obtaining planning permission for its development. Over the past siz years the size of the NHS estate has slowly but steadily diminished without detriment to the service provided. At the same time the NHS had benefited financially, with ~~over~~ about £3~~B~~ million being received in 1983/84 - about 2½ times the amount in 1978/79 in real terms.

8. Advantage has been taken of developing technologies to reduce the costs of running the NHS estate. For example, the cumulative effect of the work on energy conservation for existing buildings carried out in previous years is currently saving the NHS over £70m this year and there are many possibilities for large energy savings still to be tapped in the future. Figure [ ] shows the growth in savings in recent years. Two major studies have also been undertaken to demonstrate how energy demand can be reduced in new buildings. The first assumed using ~~in~~ a combination of existing techniques and technologies and ~~it~~ demonstrated that over 50 per cent of the normal energy demand of a hospital could be saved. The second

study which has just been completed and which uses more advanced techniques has shown that the energy demand can be reduced by over 65 per cent. The studies will lead to two hospitals being built by selected Health Authorities to demonstrate and confirm how these savings can be achieved. This research work has attracted a substantial grant from the EEC which considers that such is its importance that it should have a European application.

Figure -

ANNUAL SAVINGS FROM FUEL AND ENERGY CONSERVATION MEASURES (81/82 price levels)



9. As this account shows the Government has given a high priority to regenerating the capital building programme. This is already showing benefits for both patients and staff and increased value for money. And the substantial volume of design and building in hand will help increasingly to spread these improvements to other areas at present managing with less satisfactory provision often unsuited to the modern needs of the service. The Government also intends to secure that, in the words of the Griffiths Inquiry, the estate is regarded as 'an active contributor to overall NHS resources'. The steps it has already taken are designed to bring about a much more positive and, where appropriate, commercial orientation to the handling of the estate, including capital investment. Building schemes must now, for example, all be subject to investment option appraisals, and proposals for schemes fully integrated with financial, service and manpower planning. Improving the management of the estate in order to obtain better value for money in terms of better services for patients within available resources will continue to be a major objective.

PREVENTION AND HEALTH PROMOTION

The Changing Pattern of Disease and Ill Health

1. Infectious diseases used to be a major cause for concern. But the picture today is very different. Diphtheria, poliomyelitis and tuberculosis have been almost eliminated. Measles and whooping cough have been greatly reduced. Thanks to new drugs, immunisation programmes and other factors, mortality and morbidity from infectious diseases has reduced dramatically. But the statistics also sound a cautionary note - prevention measures cannot be relaxed. In the USA for example measles has been virtually eliminated. There is room for improvement, and increased uptake of major immunisation programmes is a key aim of health policy.

2. Nevertheless the success of the infectious diseases campaigns contrasts sharply with the failure in controlling today's major causes of death - heart disease, cancer and stroke - accounting for 68% of all mortality in England in 1983. During the productive years (15-64) the most important single cause of death in men is ischaemic heart disease ('coronaries'), in women it is cancer, with breast cancer the most prevalent. Cancer, particularly lung cancer, is also a major killer among men under 65. Cerebrovascular diseases (including strokes) are numerically important in both sexes, causing 12% of all deaths in 1983. Figure [ ] shows selected causes of death in England for 1983.
[DN figure appended to be inserted here]

3. An important feature of these 'modern' diseases is their link with the lifestyle of the individual. In 1981 some 100,000 deaths in the United Kingdom were attributable to smoking (chiefly from lung cancer, bronchitis and obstructive lung disease 90% - 63,000 - of which could be attributed to smoking - and from coronary heart disease of which about 20% - 36,000 - could be so attributed). The nature of the relationship between the harmless enjoyment of alcohol by the great majority and the harmful misuse of it by a minority is a matter of debate. But the number of deaths from alcohol related causes has continued a long

term rise, in line with the pattern of increased drinking. There were double the number of deaths in 1982 as compared with 1973. The numbers of admissions to mental hospitals has increased by nearly 50% since 1973. /Figure / / illustrates the admission trends for alcohol related disease./

DN Not attached

4. On a smaller scale but growing rapidly the health problems related to other changes in social behaviour, for example, the advent of solvent misuse; the growing incidence of sexually transmitted diseases - 1983 was the first year in which the total number of new cases exceeded £½m in England; and in particular the rise in drug misuse. The number of addicts in the United Kingdom notified by medical practitioners in 1983 was 5,850, an increase of 42% over 1982. Of these, heroin, alone or with other drugs, accounted for all the increase in notifications of new addicts. The true prevalence of addiction or other serious misuse of drugs is not clear. Research has suggested that in some urban areas the number of notified addicts may represent only a fifth of the total. What is clear is that the problem is persistent and growing.

5. The changing patterns of disease have altered the relative responsibilities of the individual on the one hand and the Government and health agencies on the other. There was relatively little that individuals could do to reduce their chances of contracting some of the major diseases of the past. But to-day there is much that they can do to reduce the chances of ill-health and self-inflicted harm. There are still important tasks for Government and the health services. But one of these is to help individuals to understand how the lifestyle they adopt may affect their health, and how they can help to minimise the risks to health.

Smoking

6. Smoking remains the major avoidable cause of death and disease. But there are encouraging signs:

- the prevalence of cigarette smoking in the adult population fell from 42% in 1976 to 35% in 1982 (for men the figures were 46% to 38% and women 38% to 33%). Smokers were then for the first time in a minority in every socio-economic group.

- cigarette consumption also fell by 20% over the period 1976 to 1982.

TABLE

Prevalence of cigarette smoking by sex: 1976-82

Persons aged 16 and over — Great Britain

	Percentage smoking cigarettes	
	Men	Women
1976	46	38
1978	45	37
1980	42	37
1982	38	33

Source: General Household Survey

7. Government actions which have contributed to these trends include a series of voluntary agreements with the tobacco industry. These have reduced the volume of poster and cinema advertising, ensured greater universality and prominence for the Government's health warning, and secured further reductions in tar yields of cigarettes. They have also produced a good deal of money for research on the effects of tobacco product modification.

8. However the Government is particularly concerned about the levels of smoking in children, and has:-

- published guidelines drawn up with retail bodies, aimed at encouraging shopkeepers to comply with the law regarding illegal sale of cigarettes to children under 16:

- issued to schools a leaflet drawing teachers' attention to facts about smoking among chidren:

- sponsored further research into why teenagers smoke.

A further survey of children's smoking habits will be carried out later this year.

Drinking

9. Drinking Sensibly, the discussion document published in the United Kingdom Health Departments' Prevention and Health series in 1981 identified several ingredients in a prevention strategy. It emphasised that health and local authorities can do a great deal to ensure that professional staff respond to demands from problem drinkers, preferably at an early stage, as part of their normal duties, using the existing range of local facilities. There is evidence of real improvements in co-operation at local level. DHSS is helping by providing pump-priming funds for a number of experimental innovative projects for local services and assisting in the establishment of a major new voluntary body, 'Aclohol Concern', the National Agency on Alcohol Misuse. 'Alcohol Concern' will be well placed to work on prevention and services in consultation with the Health Education Council, health and local authorities and local councils on alcoholism.

10. More information on the nature of problem drinking is needed, and the DHSS has engaged the Office of Population Censuses and Surveys to conduct surveys of women and drinking, adolescent drinking, and drinking habits in selected regions. The DHSS has also commissioned research into the economic costs of alcohol misuse and a project which aims to produce a 'manual' of practical and innovative prevention strategies for the local level.

Healthier Eating

11. An important report on diet and cardiovascular disease was published in July 1984, by a Panel of the Chief Medical Officer's Committee on Medical Aspects of Food Policy (COMA). This advised that a reduction in the amount of fat eating could help to reduce

cardiovascular disease. If people want to reduce their fat intake, for example, relevant and intelligible labelling information is essential. The question of fat labelling is now under discussion with the food and drinks industry. Meanwhile the DHSS has asked the Health Education Council and the British Nutrition Foundation jointly to produce practical dietary advice based on the Panel's scientific report.

Drug Misuse

12. The problems of drug misuse are particularly complex. The Government is tackling them in several ways. Recent action to reduce the supply of drugs from abroad includes a substantial increase in Customs' specialist investigation resources. A wide range of action initiated by the Home Secretary includes the addition, from 1 April 1984, of dipipanone (diconal) to the most strictly controlled category of prescribed drugs, and increased use of his statutory powers for dealing with doctors found to have prescribed irresponsibly. Chief Constables are giving high priority to dealing with drug traffickers and the deterrent effects of the law are being strengthened. The Government has welcomed the Advisory Council on the Misuse of Drugs' report on Prevention which was published in June 1984. An inter-Departmental Ministerial Group has been set up to develop strategy and consider further action. The Advisory Council reaffirmed recommendations in their report on Treatment and Rehabilitation published in 1982 which may help to prevent the recruitment of new misusers. Action already taken includes providing £7 million 'pump-priming' money for a wide spread of additional services under a central initiative and the issue of a circular asking health authorities to review the scale of the problem in their areas and to report their findings, together with plans for tackling the problem. The circular attaches the highest priority to improving services for drug misusers and calls for early and urgent action.

13. A report is expected shortly from a Medical Working Group set up by the Secretary of State to prepare guidelines for doctors on the treatment of drug misuse, and to consider the feasibility of the extension of current licensing restrictions on

prescribing to other opioid drugs. The report's recommendations should point the way to significant reductions in the availability of prescribed drugs on the black market.

14. Many agencies and individuals must play a part in discouraging drug misuse and helping drug misusers to overcome ther problems. To create a wider understanding of what is involved training and research opportunities have been increased. Studies funded by DHSS cover ways of estimating the prevalence of drug misuse and information on the work of projects run by voluntary organisations to help drug misusers. Studies of drug taking by young people in inner London and on why addicts relapse are in hand. This range of research could have important implications for the efffective organisation of services, for the help individuals can give, and for the prevention of drug misuse.

Solvent misuse

15. Action is also being taken to curb the incidence of solvent misuse. The Government has funded a post at the National Children's Bureau to collate and disseminate good practice, and has helped with the preparation of training materials for professionals and leaflets for parents, teachers etc. Research has been commissioned and guidelines on voluntary restraint on retail sales issued. The Home Office has issued guidance to the police and announced support in principle for the creation of an offence in England and Wales of knowingly selling substances to under-16s when they are likely to be inhaled to achieve intoxication.

Accident Prevention

16. The DHSS is sponsoring a project, based on 15 accident and emergency departments, studying the severity of injuries from road accidents one year before and one year after the seat belt legislation. In this and in other ways help is given to the Department of Transport in assessing the effects of seat belt

wearing. The DHSS also gives financial help to the Medical Commission on Accident Prevention which promotes research into accident prevention generally.

Preventive Medicine - Immunisation and Vaccination

17. There has been a gradual increase in acceptance rates for immunisation overall since 1978 (see Table / /). High acceptance rates have been achieved for a number of important diseases including poliomyelitis (84%), diphtheria (84%) and tetanus (84%). Efforts are continuing to increase these levels.

TABLE

rates for England (% uptake)

By end of	Whooping Cough	Measles	Diphtheria	Tetanus	Polio	Rubella
1978	31	48	78	79	78	74
1979	34	51	80	80	80	78
1980	41	53	81	81	81	84
1981	46	55	83	83	82	84
1982	53	58	84	84	84	83
1983*	59	60	84	84	84	84

* Provisional

Note

Figures show levels of uptake by second birthday except for rubella where figures represent uptake at 14th birthday.

18. The Government has taken special action in relation to two programmes:-

Rubella. A 3 year campaign was launched in November 1983 to increase the uptake amongst schoolgirls between the ages of 10 and 14 and adult women of childbearing age who are found not to be immune to rubella, with the aim of eliminating the congenital rubella syndrome. Target uptake levels for these groups have been set at 95% and 90% respectively. The campaign is spearheaded by the National Rubella Council,

patron H.R.H. the Princess of Wales, and which consists of representatives of the United Kingdom Health Departments, the Health Education Council and eleven voluntary bodies.

Measles. The uptake level for measles was only 60% in 1983. The Government announced an initiative in July 1984 aimed at 90% take up by 1990 as a first step towards elimination of this disease.

19. There are other childhood diseases where uptake of immunisation needs to be considerably improved. For example, the recent improvements in uptake of immunisation for whooping cough need to be sustained so that the uptake level in 1983 of 59% can be raised to reach and exceed the previous peak level of 79% in 1972 and 1973.

20. The safety of some vaccines is sometimes in question. The independent expert advice available to Government is that the benefits of immunisation far outweigh the small risks of adverse reactions. Health authorities and family doctors were issued in April 1984 with the most recent information on vaccines commonly used, including contra-indications to immunisation.

Cervical Cytology

21. The aim of the cervical screening programme is to reduce mortality from cancer of the cervix by ensuring that women at risk from this disease are screened at regular intervals in order to identify the early signs of the disease while it is still at the pre-invasive stage. The existing policy on the age and frequency at which women should be screened has been simplified and revised guidance issued to the NHS. Whilst highest priority remains with the over 35s and those who have been pregnant on 3 or more occasions, women who are or who have been sexually active should be screened on first presentation for contraceptive advice, or on first request for a smear, and thereafter at ages 20, 25 and 30 and not at intervening ages. The new

arrangements should result in a more effective screening programme within existing resources provided that unnecessary repeat smears are not taken.

Special Needs

22. The ~~Department~~ DHSS receives advice from a working group on Asian Health Care and has supported two initiatives to help meet the health needs of the Asian community. From 1981 to 1983 the Stop Rickets Campaign was carried out in conjunction with Save the Children Fund (SCF) and local authorities. This involved community leaders and the Asian media in a range of health education activities to provide the Asian community with information on steps they could take to avoid rickets. In /September/ 1984 the ~~D~~department, again in conjunction with SCF, launched the Asian Mother and Baby Campaign to help Asian mothers to make better use of the maternity services, and to ensure that professional staff in the health service are aware of the needs of these mothers. As part of this campaign linkworkers are being used from the Asian community to help bridge language and cultural barriers. The Department gives support to a number of voluntary organisations concerned with the health needs of ethnic minorities: the Centre for Ethnic Minority Health Studies, the Sickle Cell Society, and the Organisation for Sickle Cell Anaemia Research. Further consideration is being given to the need for central guidance on meeting needs in this field.

Health Education Council

23. The Government directly funds the Health Education Council to provide health education at national level. Since 1979/80 money for the Council has increased by 39% in real terms to £9.135m in 1984/5. The Council mounts campaigns, produces health education material and engages in a range of research and evaluation work. Current activity strongly supports Government action on smoking and drinking:-

- the Council regard smoking as its single highest priority and spent £700,000 in the first part of 1984 on an antismoking campaign directed at young people;

- in 1983 the HEC published a guide to sensible drinking That's the Limit to help people appreciate the relative strengths of various drinks, and to discourage harmful drinking habits. Programmes on 'preventing alcoholism' are planned for selected regions.

The Council is also undertaking work on preparaton for parenthood, dental health, and coronary heart disease. Each programme includes baseline studies, evaluation of the impact of compaigns as they progress, and final assessments of the success of campaigns. In this way, future work builds on the experience of the past.

Health Authorities and Prevention

24. The Health Education Council also works closely with health educators in the NHS in order to seek maximum effectiveness through combined national and local effort. More NHS authorities now have their own health education service staffed by Health Education Officers whose numbers have risen from around 350 in 1978 to well over 400 in 1983. They work with other health professionals, community groups, local employers and others to determine the most suitable local programmes. In their 10 year strategic planning outlines RHAs generally are planning to increase the resources available for health education and preventive measures, for example the introduction of health checks for the middle aged population to identify those at risk of heart disease and help them to reduce that risk.

Family Doctors and Prevention

25. There has been a welcome growth of interest and activity amongst family doctors in preventive health and health education, a trend encouraged by the development of the primary health care

team (see chapter --). The Royal College of General Practitioners has stimulated GPs to adopt a more active approach to prevention and health promotion with a series of excellent reports on prevention in general practice. More GPs are now developing age/sex registers of the populations they serve, as a means of identifying people potentially at risk of various diseases, and ~~of introducing people potentially at risk of various diseases, and~~ of introducing screening programmes for cervical cytology, arterial disease and other conditions or of following up specific groups of patients.

While much of the initiative has come from the profession themselves, the Government has been able to support them. Recent projects have included pound for pound support to GPs wishing to install micro-computers in almost 150 practices, and the installation of computers in each Region to assist with cervical cytology screening.

Public Health Laboratory Service

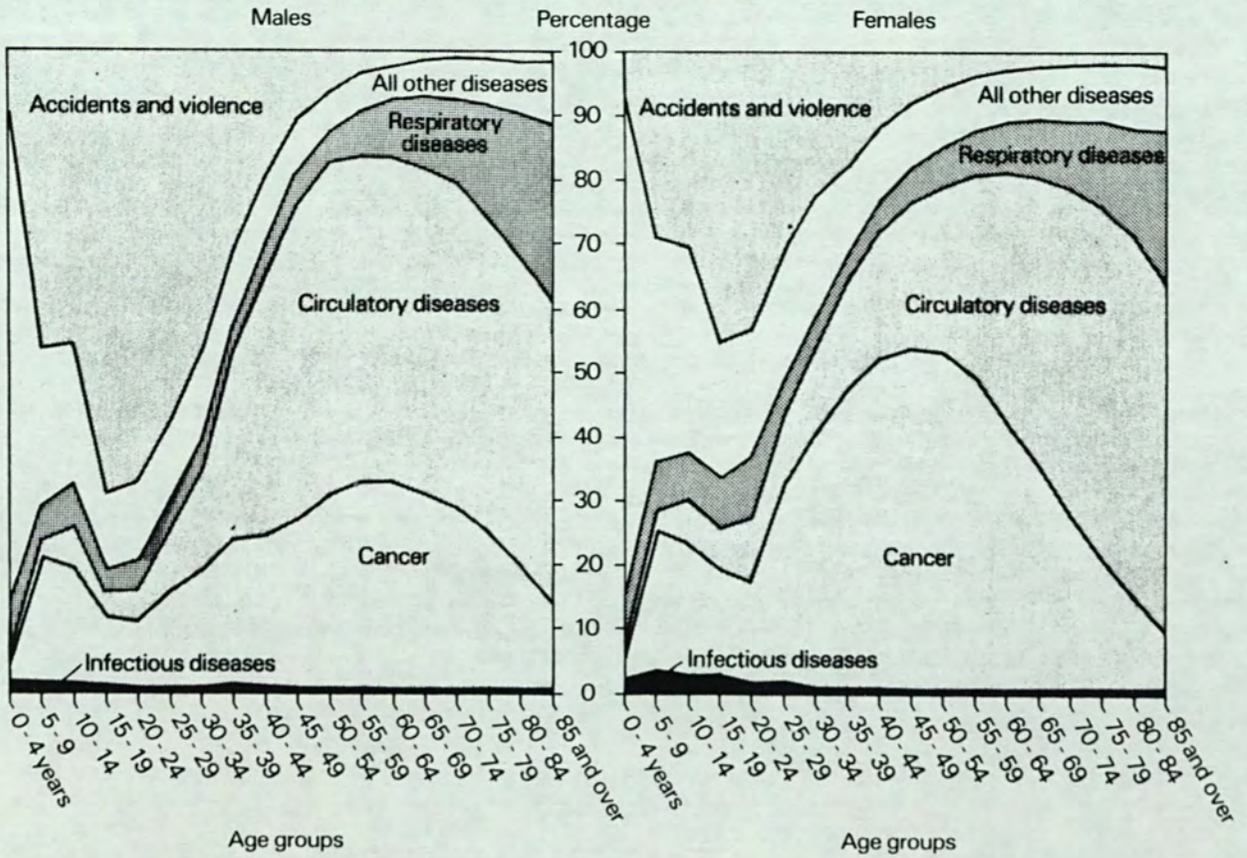
26. The work of the Public Health Laboratory Service is closely allied to NHS prevention work. It provides a microbiological service for the diagnosis, control and prevention of communicable disease; the production of biological materials and the issue of reagents; the giving of advice: the undertaking of a wide range of research; and the development of applications of biotechnology, mainly in the health field. A new Central Public Laboratory at Colindale will be completed shortly at an estimated total cost of £24.1m. At the Centre for Applied Microbiology and Research at Porton Down a new Production Centre is currently being built at an estimated cost of £5.1m.

Conclusion

27. This is only a brief and selective survey of some developments in preventive health and health education. /A more detailed account will be contained in the CMO's Annual Report for 1983 on the state of the Public Health./ The main challenges in

the immediate years ahead will certainly continue to be in finding effective and acceptable ways for the Government and health bodies to change the social climate so as to promote healthier - and indeed more responsible - life styles. There are major potential benefits here - to society as a whole, to the individual and to the health service with the prospect of diverting to other use the very large resources which currently go on treating avoidable and unnecessary disease.

Figure
Selected causes of death: by sex and age, 1983 England



[1] Includes heart attacks and strokes

12-9-84

Chapter -

PRIMARY HEALTH CARE

A Green Paper

1. The Government proposes to publish later this year (1984) a Green Paper designed to stimulate debate within the health professions, the health service and more widely about the development of primary health care services, their organisation and financing. This report accordingly provides only a brief account of recent trends in these services, leaving the important and substantive issues for their future to be developed in the Green Paper.

General

2. The first and most frequent contact people have with the health services is through their use of the primary health care services - the family practitioner services (family doctors, dentists, pharmacists and opticians) and the community health services provided by health authorities (nurses, health visitors, midwives and doctors). These services carry out a huge workload in the diagnosis and treatment of illness, in helping people to avoid illness and to improve their physical and mental health, and in providing alleviation, support and comfort ~~where there is no medical cure~~. Only in a minority of cases is it necessary for patients to be referred to the hospital and specialist services. For example there are about 190 million consultations a year with family doctors - 90% of all NHS medical consultations - but only about 10% of patients are referred to hospital. In addition the primary care services meet the 'after care' needs of patients discharged from hospital - a growing task with the trend increasingly towards early discharge. Continuity of care is one of the main characteristics of ~~primary health care~~ these services.

The Primary Health Care Team

3. The family doctor services are provided by self employed general practitioners contracting with the family practitioner committee to provide NHS services. Community health services are provided mainly by doctors and nurses employed by local health authorities. Historically, the two services have developed separately, with the community health services providing the preventive and health education services which at the time were not provided by the generality of family doctors. In recent years however there has been growing professional recognition of the need for team work, so as to improve the effectiveness of the totality of services available, and to exploit fully the scope for managing more illness in the community than hitherto.

4. Increasingly, younger doctors entering general practice expect to work closely with the community health staff and to develop the preventive more anticipatory care side of their practice. This is one reflection of the improved vocational training of doctors before entering general practice, which became mandatory in 1982. Over 80% of health visitors and district nurses are now working in close co-operation with family doctors; and this collaboration is increasingly extending to midwives, school nurses and community psychiatric nurses. These developments represent a practical reflection of the endorsement by the Harding Report[1] of the health care team concept, providing a comprehensive and integrated service to the community. Strong and effective primary health care services provided by such teams are a key requisite for the successful implementation of the Government's objectives for prevention and health promotion and the development of community care.

---

(1) Report of the Joint Working Group of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee. Published by DHSS May 1981.

Improvements in general medical practice

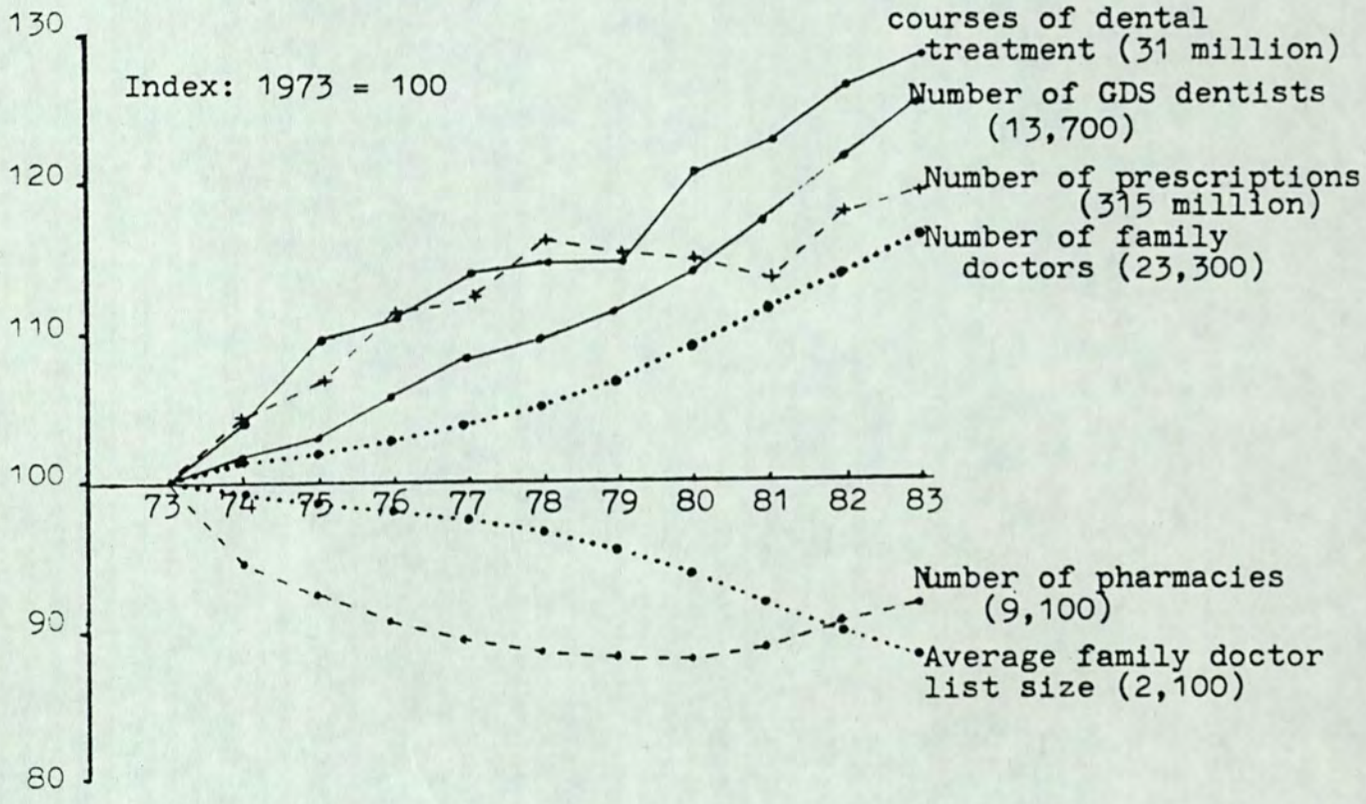
5. The structure of general practice has changed with a steady increase ~~fostered by successive Governments~~, in the proportion of family doctors in group practice (now 76%) who are generally better able to provide a comprehensive service than doctors working alone. More doctors are now working from new or substantially modified premises designed to assist team working and more than a quarter work from health centres where community health services are also based. They are increasingly supported by their own ancillary staff where the numbers have increased by 27% in the last five years. These and other developments have helped to improve the attraction and standing of general practice, and more and better ~~qualified~~ trained doctors are seeking to enter. The number of unrestricted principals in practice rose by 11% between 1978 and 1983 (to 23,254) with a reduction in average list sizes (to 2,110) and a fairer distribution of doctors across the country. Figure / / illustrates the trends over a longer period. More general practitioners are reviewing their own performance and comparing it with others eg on prescribing. The Royal College of General Practitioners, which has done much to raise standards in general practice, has pioneered a system of in-depth peer review to assist doctors with professional audit.

6. These developments have strengthened the capacity of the family doctor service to meet the demands placed upon it for example by the growing numbers of very elderly people. The expansion of the service has meant higher costs - the gross cost of the family doctor services in 1983/84 was £862 million, an increase of nearly 127% in cash terms since 1978/79 and 33% in economic cost terms.

(DN Figure / / to go in here)

FIGURE

FAMILY PRACTITIONER SERVICES 1973-1983 (excluding General Ophthalmic Services)
Figures for 1983 are given in brackets



Improvements in community health services

7. Expansion of the numbers of family doctors has been accompanied ~~also~~ by improvements in the community health services. The numbers of whole time equivalent health visitors and district nurses have risen by 2.7% and 9.6% respectively between 1978 and 1982, (after adjustment for the reduction in working hours in 1981).[2] Nearly half a million more people were visited in their own homes by these staff in 1983 than in 1978. Expenditure on community health services increased from 1978/79 by £357m to £728m in 1982/83, an increase in input volume terms of 10.6%.

8. Health authorities have made considerable effort to improve the quality and quantity of care provided in the community. Many now provide a 24 hour district nursing service, MacMillan nursing service to patients suffering from cancer and a variety of specialist nurses eg mastectomy and stoma care nurses to provide advice and assistance to members of primary health care teams and their patients. Some authorities are providing intensive home nursing to allow patients to be cared for at home who would otherwise need hospital care and one such 'hospital at home' scheme is being evaluated as part of the DHSS research programme. Systems to improve communication and direct personal contact between hospital nurses and community nurses are becoming commonplace. Increasingly, post basic and continuing education for all nurses working in the field is organised on a joint basis, wherever possible bringing together both hospital and community nurses. District nurse training has been extended and is now mandatory for such posts.

9. The remedial professions of physiotherapy, occupational therapy and speech therapy are making an increasingly important contribution to community health services. Policies with regard

---

(2) The actual number of health visitors (including health visitor field work teachers, TB visitors and combined duty posts) was 8,700 in 1978 and 9,500 in 1982. For District Nurses 1978 figures are estimated on the basis of the trend between 1975 and 1982. Data for years pre- and post-1980 are not directly comparable due to a change in staffing returns from 1980.

to mentally handicapped and mentally ill people and the implementation of the Education Act 1981 have underlined the importance of developing community based services and of close co-operation with local authority social services and education departments.

10. The contribution of the community health services to the care of elderly people, people with mental illness or physical handicap are discussed ~~further~~ in chapter / / and the care of children in chapter / /.

Family Planning Services

11. Planned childbirth undoubtedly contributes to better maternal and child health and to a stable and secure family life. The Government remains committed to the provision of family planning services for all those who wish to make use of them. Currently about 3.5m people use NHS family planning services. While more than half choose to obtain them from their family doctors, many continue to attend the family planning clinics provided by health authorities.

Recent Initiatives

Inner Cities

12. The Government has made an extra £9m available over 3 years, starting in 1983, to help raise the standards of primary health care services in inner cities to those already generally available elsewhere. Deficiencies in these services were shown by the Acheson Report(3) which pointed out that many GPs were elderly or worked single handed, practised in cramped or unsuitable premises, and that community health services staff faced heavy workloads in difficult circumstances, with consequent

---

(3) Primary Health Care in Inner London - Report of a Study Group commissioned by the London Health Planning Consortium. Published by DHSS May 1981.

high staff turnover. In those conditions it was hard for the team approach to develop and bring to inner cities some of the improvements being made elsewhere.

13. So far the extra £9m has been spent on new payments to encourage more group practices by general practitioners in inner cities; enhanced improvement grants for inner city surgery premises; help for inner health authorities who face extra costs in training health visitors and district nurses; and funding selected health authorities to engage in co-operative projects with local authorities designed to improve primary care in inner cities. In 1983/84 over 200 projects, costing £1.2m were funded in this way, covering a wide range of topics including extra help for the terminally ill, incontinence and home laundry services, and health education projects.

14. While the problems of inner city services cannot be resolved quickly, these measures will bring real improvements to some services in inner cities and offer the opportunity for experimentation and initiatives. Further progress may be achieved in two ways. Firstly the Government will continue to look for means of improving these services and concentrating help where it is most needed in partnership with health and local authorities, and health care professions. Secondly it expects the new separate status of Family Practitioner Committees (described in Chapter X) will prove helpful. It has already been proposed that the Committees should have a stronger role in monitoring the standards of premises. It is now hoped that they will be able to co-operate more fully with health authorities and the family practitioner professions with the objective of improving primary health care services, both in the inner cities and elsewhere.

Deputising Services

15. The extent to which doctors employ deputising services to provide services for them at night and weekends has caused recent concern. In 1983 the Government asked Family Practitioner Committees (~~FPCs~~) to satisfy themselves that where deputising

services operate they do so satisfactorily. Arrangements concerning the use of deputising services were subsequently revised and, in each area where the services operate, Committees ~~FPCs~~ have been asked to establish a Deputising Sub-Committee to ensure that they are satisfactory and are kept under review. The Sub-Committees include both doctors and lay people.

Pharmaceutical Services

16. Figure / / shows trends in the development of pharmaceutical services. The number of pharmacies dispensing NHS prescriptions increased over the period 1978 to 1983 from 8,761 to 9,057 ending a lengthy period of decline. An OPCS study on access to primary care suggested that more than 90% of people feel that they have reasonably easy access to a pharmacy. There is, however, some unevenness of distribution with some areas apparently under- or over-provided. In rural areas general medical practitioners may, under some circumstances, dispense as well as prescribe so as to provide a service to patients who might otherwise find difficulty in getting to a pharmacy. Since April 1983 significant changes in dispensing arrangements in rural areas have been regulated by a new national body, the Rural Dispensing Committee, so as to secure that changes serve the best interests of patients.

17. The number of prescriptions dispensed grew between 1978 and 1983 by about 1% ~~W~~ (from 307 million to 311 million). The proportion of prescriptions for patients not required to pay charges has increased - in 1983 78% as against 63% in 1978. The gross cost of pharmaceutical services rose by 104% in cash terms between 1978/79 and 1983/84 (from £699m to £1430m); in economic cost terms by 20%, representing about 47% of the total gross cost of Family Practitioner Services.

18. Pharmacists have long been a source of direct advice on minor ailments. Many of the six million visits made to pharmacists every day result in the purchase of appropriate self-medication as a result of advice from the pharmacist. There may be scope for further use of pharmaceutical knowledge,

particularly in the provision of advice about medicines and in health education generally. This, and other aspects of the pharmacists' work, are currently being considered by the inquiry set up by the Nuffield Foundation, due to report in 1985, and will be discussed in the forthcoming Green Paper.

General Dental Services

19. Figure / / shows trends in the development of general dental services. The numbers of general dental practitioners contracting to provide NHS dental services has been rising by about 360 a year and reached 13,585 principals in 1983 as against 11,796 in 1978, an increase of 15%. The number of courses of treatment in 1983 was around 30 million compared with about 27 million in 1978. Expansion in the number of dentists has helped to improve access to treatment. Since 1979 health authorities have been able to provide emergency dental services at weekends and on bank holidays. There are now 52 emergency dental schemes in operation; local practitioners provide the services. Both these developments mean better services for patients, reflected also in the higher cost of services. The current gross cost of general dental services in 1983/84 was about £584m a cash increase of 110% over 1978/79, equal to growth of about 23% in economic cost terms. About 45% of chargeable dental treatment is free because no charges are made to children and other priority groups. Check ups, repairs of dentures and emergency services are free to everyone.

20. The work of general dental practitioners continues to be supplemented by the community dental services, which may now provide services for handicapped adults who find it difficult to use the general dental services, as well as the screening of schoolchildren required by law and the treatment of school and pre-school children, and expectant and nursing mothers.

21. Objectives for improvement in services include achieving a better distribution and utilisation of dental manpower, expanding the preventive role of the general dental practitioner and

promoting greater continuity of care, particularly for children. A pilot study for paying general dental practitioners on a capitation fee rather than item of service basis for treating children has been started.

22. There are however already welcome and striking indications of reductions in dental decay amongst children. Preliminary results of the OPCS 1983 Children's Dental Health Survey show, for example, that the proportion of five year olds in England and Wales with some known decay experience has decreased from 71% in 1973 to 48% in 1983. The average number of teeth with known decay experience in five year olds has decreased from 3.4 teeth in 1973 to 1.7 teeth in 1983. Improvements were found in all age groups from five to fifteen and were apparent in all regions. Factors at work here include the now widespread use of fluoridated toothpaste, the fall in sucrose consumption together with improvements in infant feeding patterns and greater public awareness of the need to maintain dental health. Recent studies have also consistently shown a significant additional reduction in dental decay amongst children living in the fluoridated areas. However whether or not to fluoridate is a matter for health and water authorities locally and at present only about 10% of the population receive fluoridated water. ~~/DN ?is this England./~~

General Ophthalmic Services

23. The General Ophthalmic Service (GOS) comprises arrangements for the testing of sight and the supply of optical appliances (glasses). Trends in this service are shown in Fig / /. The testing of sight is carried out by either Ophthalmic Opticians (86% of tests), or Ophthalmic Medical Practitioners (14%). The number of sight tests has grown almost continuously since the start of the NHS. Between 1978 and 1983, for example, there was an increase of nearly 15% from 7.8 million to 9.0 million. The number of Ophthalmic Opticians and Ophthalmic Medical Practitioners have increased between 1978 and 1983 by 421 (8%).

Sight tests are provided without charge to the patient. The cost of this service rose from £29m in 1978/79 to £73m in 1983/84, in cash terms 152% and 48% in economic cost terms.

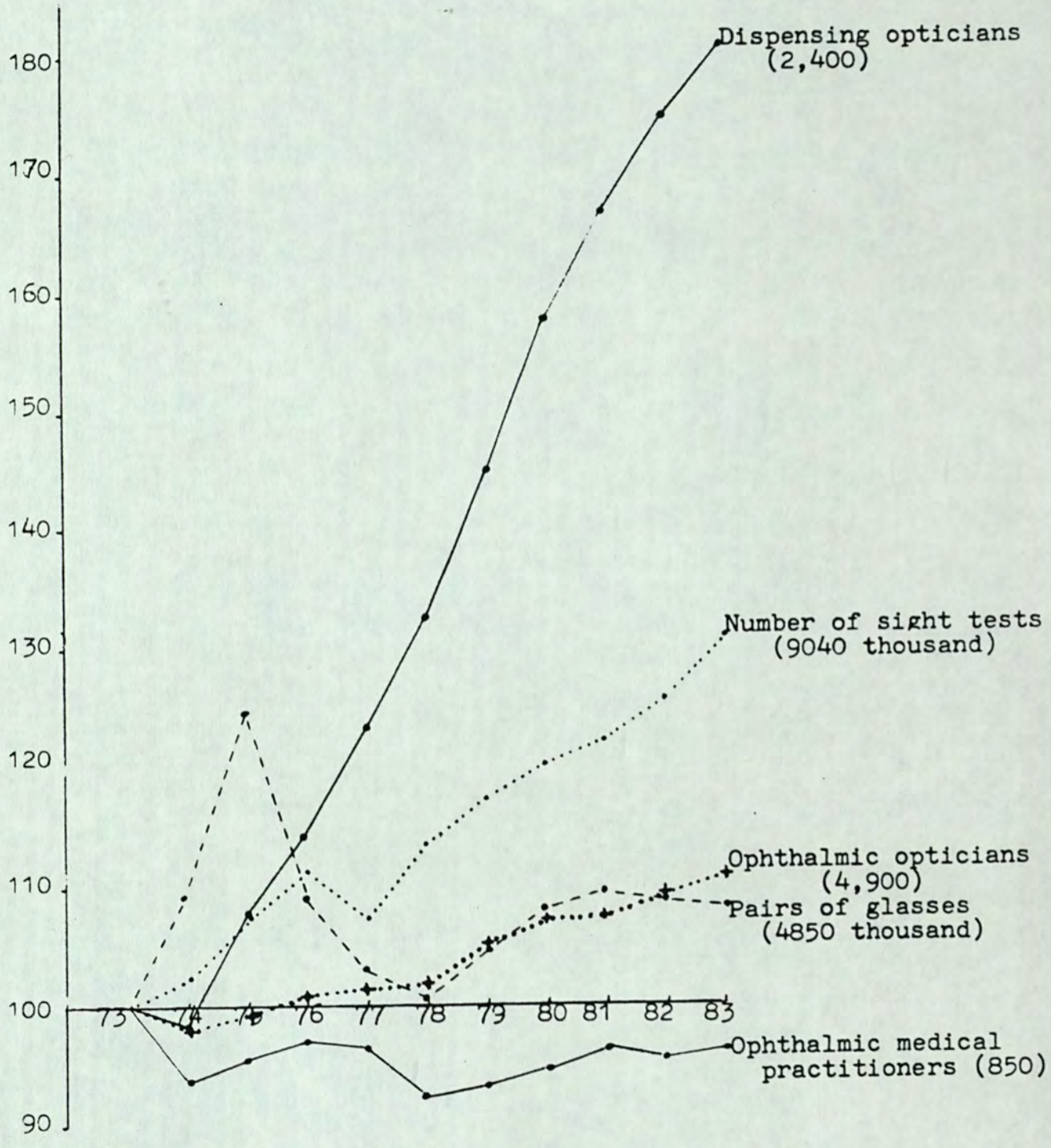
24. The issue of a prescription for new glasses can lead to a fully private transaction or to a dispensing under the GOS of either lenses alone or frame and lenses. In 1983 4.7 million dispensings of NHS lenses took place - an increase of 7% over 1978. The gross cost of dispensing rose from £46m in 1978/79 to £89m in 1983/84, in cash terms 93% or 14% in economic cost terms. Children and those in receipt of certain benefits get glasses free. Others on low incomes can get glasses free or at a reduced charge. In 1983 over 1 million adults received free or reduced cost glasses and 428,000 children free glasses.

25. Those paying charges for their GOS glasses have been charged much of the cost of their provision. In ~~1984/~~ 1983/4 the average difference between patients' charges and the cost of provision was around £5. The NHS range of frames has remained largely unchanged since the inception of the service. The Government decided that the private sector could provide most people with a better service at comparable cost. Legislation was enacted in 1984 with the aim of increasing competition within the private sector by relaxing the restrictions on who can sell glasses and on advertising by opticians. The legislation allows the GOS arrangements for supply of appliances to be terminated and for financial grants for or towards the cost of glasses to be made to children and those on low incomes. The Government intend to end general supply of appliances in March 1985. For an interim period supply will continue for children, those on low incomes and those requiring certain less usual lenses. These arrangements will in due course be replaced by financial grants for children and those on low incomes so as to extend to them he advantages of buying privately. Free sight tests will continue to be available under the NHS.

/Figure to go in here showing GOS trends/.

FIGURE - 4

FAMILY PRACTITIONER SERVICES 1973-1983 - GENERAL OPHTHALMIC SERVICES
Figures for 1983 are given in brackets

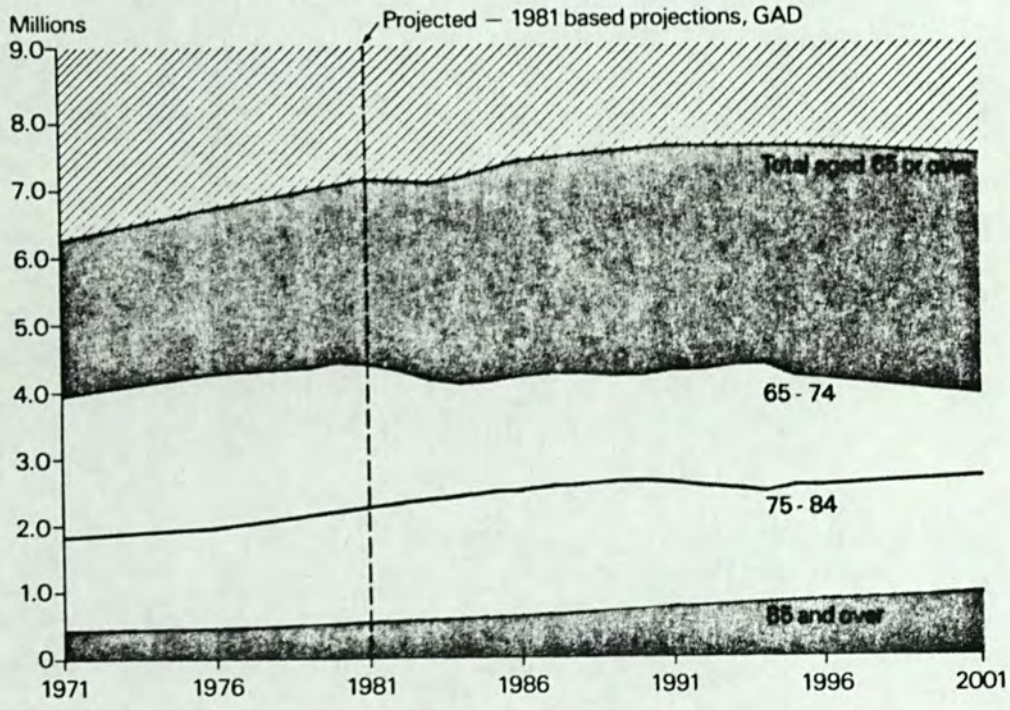


PRIORITY GROUPS

1. The Government reaffirmed in Care in Action the priority to be given to care of elderly people, and people who are mentally ill or handicapped, or suffering from physical or sensory handicap.

2. The growth in numbers of people surviving to a very old age is a key factor affecting the services for these groups. Figure 1 shows the trends. The number of people aged 75 and over is expected to increase by over one-fifth (22%) between 1978 and 1986 from 2.56m to 3.12m and to 3.33 million by 1991. These increases come on top of the substantial growth over the last 30 years in the proportion aged 65 and over - from about 11% in 1951 to about 15% in 1981 (7.1 million). The total number aged 65 and over is forecast to peak in the early 1990s at around 7.6m.

Figure
Elderly people: by age group — England



Sources: 1971 - 1980 OPCS final population estimated
1981 - 2001 GAD 1981 based population projection

3. ~~The incidence and duration of many types of illness both physical and mental increases with a~~ge. People aged 65 and over consult their family doctors more often and have three times more home visits than the average. About 40% of all current expenditure on primary care and hospital services goes on services for those aged 65 and over, who represent about 15% of the population, and nearly one quarter goes on people who are 75 or over, who form only about 6% of the population (1981 estimates). ~~Figure / / shows the estimated breakdown by age group~~s.

4. Apart from the demands made by old people on the acute services and services for the elderly, the growth in the numbers of very old people is having an increasing impact on mental illness services as the prevalence of psychiatric disorders increases with age. Mentally handicapped people are living longer and with increasing age come additional problems requiring special care.

5. Later sections of this chapter explain how the health services are responding to these challenges and also to the needs of mentally ill or handicapped people and people with physical handicaps in younger age groups.

COMMUNITY CARE

6. In relation in particular to the care of old people, and people with mental illness or handicap, there is a common thrust towards community care and away from reliance on the large and often remote institutions in which traditional services were concentrated. This reflects the desire of most people for the more normal life and ordinary networks of social relationships which can more readily be provided when people are supported, according to their individual needs, in their own homes or in small units firmly located in their own local community.

7. These preferences have been increasingly recognised in the growth of domiciliary and day care services, in the shortening of the periods for which people requiring acute treatments stay in hospital, and in the build-up of alternatives to long-stay hospital care for those whose needs as individuals can better be met elsewhere. In the personal social services provided by local authorities and voluntary organisations similar trends are reflected, for example, in the reduction in the number of children's homes and the more extensive use of fostering as an alternative form of care. The new patterns of service are concerned with quality of life and not just with location of care or treatment. This fundamental alteration in the balance of services requires major changes of attitudes, training, organisation and finance, and seeks to underpin the long-standing role of families, voluntary groups and the community at large. There are many risks to be reckoned with and problems to be overcome, but there is no doubt of the widespread support for the general thrust of community care policies among public authorities, the professions and the public at large.

Joint Finance

8. The Government has encouraged these developments by greatly increasing the sums allocated to health authorities for use as joint finance; that is, in aiding the development of local authorities' schemes in accordance with plans drawn up jointly

with those authorities, in ways likely to make a greater contribution to the total care of patients than if used for health services in the normal way. The total available for joint finance in 1978/79 was £34.5m: in 1984/85 it is £99.5m an increase in input volume terms of over 50% since 1978/79, and it can now be used to assist housing and education services as well as personal social services.

Care in the Community Programme

9. There are still far too many people in long-stay hospitals who could live more independently if other forms of care were available. To reduce these numbers the Government introduced in 1983 the Care in the Community programme under which health authorities are able to transfer their resources for as long as they are needed to pay for the alternative care provided. In addition a programme of pilot projects is being centrally funded at a cost of £16m over 4 years to serve as demonstrations of what it is possible to achieve. By mid 1984, projects had been approved costing £8m and providing for the movement of some 500 people from hospital over 3 years. This programme should encourage transfers on a much larger scale using local funding under the Community Care programme.

Informal Carers

10. In 1984 the Government set aside £10.5m over 3 years to fund a programme - "Helping the Community to Care" - principally aimed at assisting volunteers, families, neighbours and other informal carers looking after elderly or handicapped people in the community to act more effectively and with greater confidence. They also conducted a major development project in 1983/84 to highlight the problems faced by the informal carers - particularly relatives-and to draw attention to their needs for support. Statutory authorities are increasingly taking account of the need to sustain informal carers both by support services in the home and by making hospital and residential care available on a short-term basis to provide respite.

Voluntary Bodies

11. Voluntary organisations complement and supplement services directly provided by health authorities and social services departments. In addition to grants from those authorities to voluntary organisations active in their area, DHSS has increased its grants to the voluntary sector from £7½m in 1978/79 to £23m in 1983/84, a rise in real terms of 81 per cent. Apart from grants designed to support specific policies, such as the drug misuse initiative (Chapter / / paras --), DHSS grants are directed mainly at ~~strengthening~~ enhancing the planning and management capacity of the voluntary sector at nationa level. Strengthening the voluntary sector is vital to the success of the community care approach.

Joint Planning

12. Joint planning locally involving all relevant statutory authorities and voluntary bodies, and taking account of the potential contribution and the needs of informal carers, is the key to balanced development of community services and the transfer of patients and resources from the long stay hospitals. Health and local authorities have a statutory duty to co-operate and to set up formal consultative machinery (the Joint Consultative Committees - JCCs) to that end. Since 1983 the JCCs have been able to include members appointed by voluntary bodies. Joint Finance and the Care in the Community Initiative have acted as a spur to joint planning and action. In 1984 the Secretary of State, the Local Authority Associations and the National Association of Health Authorities established a joint working group to consider how the current arrangements could be further improved.

CARE OF ELDERLY PEOPLE

13. The growing numbers of very elderly people present a major challenge to the health and social services in meeting their needs and in helping them to retain their independence for as

long as possible where they wish to do so. This section, along with paragraphs / / on provision of services for elderly people with psychiatric disorders, explains what is being done.

14. The objectives set by Care in Action were:

to strengthen the primary and community care services together with neighbourhood and voluntary support to enable people to continue to live at home;

to encourage an active approach to treatment and rehabilitation to enable elderly people in hospital to return to the community wherever possible;

to maintain capacity in the general actue sector to deal with the increasing numbers of elderly people needing acute medical or surgical treatment;

to maintain an adequate provision for the minority of people requiring long term care in hospital or residential homes.

Strengthening the Community Care Services

15. About 95% of the over 65s and 87% of the over 75s live in the community (including sheltered housing). Enabling people to live a home for longer means developments in support services - such a community nursing, home helps and day care facilties. The estimated expansion (9.6%) of District Nursing staff between 1978 and 1982 has already been noted /para /. Over the period 1978-1983 the number of people aged 65 and over first treated by District Nurses rose by nearly one quarter (23.5%) to over 1½ million, more than keeping pace with the rise in the number of old people.

16. NHS chiropody services are predominantly community based and mainly help elderly people. There has been a long standing shortage of chiropodists in the NHS but training opportunities have been expanded in recent years. Staffing and services provided have increased as shown in Table / /.

TABLE / /

	1978	1983	% increase
No. of WTE NHS salaried and sessional chiropodists	1913	/2190/*	14.5
No. of Persons Treated (thousands)			
Over 65	1274	1472	15.5
Total	1393	1634	17.3

*1982 figure.

17. Local authority social services departments have despite the difficult financial climate expanded most services for non-residential care. Gross expenditure on non-residential services mainly for the elderly rose in input volume terms by 5% between 1978/79 and 1982/83 (from £206m to £371m). This includes a contribution from Joint Finance, about 40% of which is spent on services for the elderly. Table / / illustrates changes in provision.

TABLE / /

PERSONAL SOCIAL SERVICES AND NON-RESIDENTIAL CARE FOR THE ELDERLY

	as at 30 September		% increase
	1978	1983	
Home Helps and Organisers (wte)	46670	51670[1]	+ 10.7
Social Work Group[2] (wte)	22160	23570[1]	+ 6.3
	as at 31 March		%increase
	1979	1983	
Places in day centres for the elderly[3]	18890	21070	+ 11.5
Meals served in home and elsewhere[4] (thousands)	40949	40854	- 0.2

17. Health and local authorities are helping in a variety of ways to provide more support for the informal 'carers' looking after elderly people by providing short term relief in residential homes and hospitals, by care attendant schemes and day/night sitting services. In 1982/83 two thirds of admissions to local authority residential homes were for short term care, 16% more than in 1978/79.

Hospital Rehabilitation and Treatment Services

18. The trends in non-acute provision for elderly people are shown in Figure / / and Table / /

---

(1) Estimates

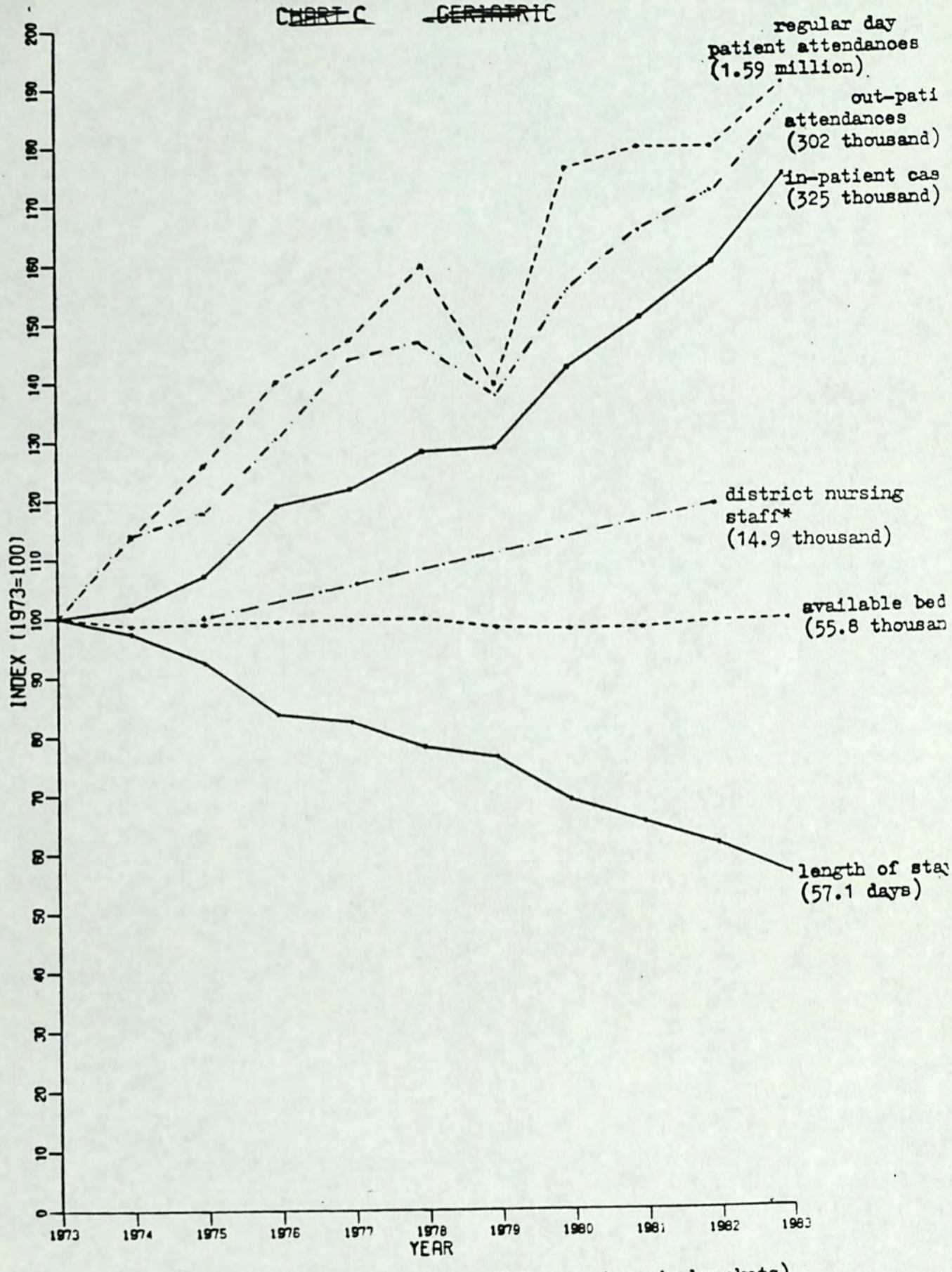
(2) includes community workers, trainee social workers and social work welfare assistants. No breakdown is available of the time social workers spend with the elderly or other client groups.

(3) excludes places in mixed centres and residential homes.

(4) includes meals for physically handicapped.

Health Services for Elderly People 1973 - 83

~~CHART C~~ ~~GERIATRIC~~



(Provisional figures for 1983 are given in brackets)

* This is the estimated trend in district nursing staff numbers for the period 1975 to 1982 as a whole (ie 1975 = 100 and the actual figure for 1982 is given in brackets). Year on year movements for district nursing staff are not available on a consistent basis over this period.

TABLE / /

CHANGES IN HOSPITAL SERVICES FOR THE ELDERLY (GERIATRICS) 1973-83

	Change between 1973 and 1978		Change between 1978 and 1983	
	number	percentage	number	percentage
In-patient cases (thousands)	+ 52	+ 28.0	+ 87	+ 36.5
In-patient throughput (cases per available bed)	+ 0.9	+ 27.3	+ 1.6	+ 38.1
In-patient average duration of stay (days)	- 22.3	- 21.9	- 22.2	- 28.0
Out-patient attendances (thousand)	+ 75	+ 45.7	+ 63	+ 26.2
Regular day patient attendances (thousand)	+ 499	+ 59.5	+ 257	+ 19.3

Increasing numbers of old people are being cared for, and for shorter periods, as facilities are used more intensively. Costs per in-patient day in geriatric hospitals are rising reflecting this and the increasing dependency of some patients. Many more people, some of whom would otherwise require hospital admission, are receiving treatment in out-patient departments or are regular day patients, though the rate of increase in these numbers has slowed in recent years.

19. The specialty of geriatric medicine continues to be developed to meet the needs of elderly people and the number of medical staff in the specialty has increased:

	1978 wte	1983 wte	% change
Consultants	330	413	+ 25
Other medical staff	1055	1282	+ 21.5

The numbers of nursing staff working in departments of geriatric medicine is estimated to have increased by 17% between 1978 and 1982.(1)

---

(1) Staff numbers are not available on a consistent basis for these years. 17% is an estimate of the trend 1978-82, adjusted

20. Co-operation between hospitals and community health services has become increasingly important with the trend towards shorter hospital stay. A number of 'home from hospital' and other 'settling in' schemes already exist. Extra funds have been provided to further develop these types of scheme over the next 2 to 3 years as part of the Government's £10.5m programme Helping the Community to Care, (para -- above).

Acute Hospital Services for the Elderly

21. Over a quarter of all acute admissions are aged 65 or over and they take up about 45% of all occupied beds. Trends generally in the acute sector are considered in /Chapter /. It is clear that the elderly, and especially the very elderly, are getting an increased share of resources in the acute sector, and in virtually all specialties or diagnostic groups which include the elderly rates of activity for the over 75s are increasing faster than other age groups. This reflects the increasing ability to offer treatments to this older age group as well as increased demographic pressure. Though the evidence suggests that the general acute sector is maintaining its capacity to offer acute services to elderly people, pressure will continue eg for hip replacements. This makes it all the more important that the full range of rehabilitative skills present in departments of geriatric medicine is available to elderly patients in acute beds.

Long Term Hospital and Residential Care

22. The increasing availability in departments of geriatric medicine of well equipped beds for the acute care and rehabilitation of elderly people is expected to lead to a progressive reduction in the need for long term hospital care. Some long stay beds will still be needed for patients whose pace of recovery is very slow and for those who are unlikely to recover sufficiently to be discharged. Provision will also be

---

for reduction in hours of work.

needed for short-stay admissions for some elderly people so as to provide a break for families and other carers. The aim is for long-stay beds to be in small homely local units, close to family and friends.

23. For those elderly people not needing continually available hospital medical care but who do need long term nursing care and DHSS has introduced the concept of nurse managed homes in the NHS. One experimental nursing home opened in 1983. Two more are expected to open in 1984. They should be able to provide a more homely atmosphere than is usually possible in conventional long-stay geriatric wards. Some health authorities are already planning to set up units on similar lines.

24. The number of elderly people in residential homes has increased by about 12½% between 1979 and 1983, and the number of places in local authority homes by about 1½%. Local authority gross expenditure on residential care for the elderly grew from £315m in 1978/79 to £555m in 1982/83 (3% in input volume terms), though there has been a fall in the number of residents supported by local authorities, reflecting partly wider use of supplementary benefit to finance provision in the private and voluntary sectors. Table / / gives figures.

TABLE

	as at 31 March		change between 1979 and 1983	
	1979	1983	number	%
No of residents (65+) in all homes	152900	172200	+19300	+12.6
(in local authority homes)	(102100)	103600	+ 1500	+ 1.5
No of residents supported by local authorities in voluntary and private homes	15000	11900	+ 3100	-20.7

25. New systems of registration and inspection of voluntary and private residential care homes are being introduced following legislation in 1983. Fresh guidelines have been prepared covering standards of accommodation and management. New arrangements are

also being made for regulating private nursing homes, including a code of practice. These developments reflect the concern to protect and improve the quality of life for elderly people.

26. A substantial contribution to improving standards continues to be made by the Health Advisory Service whose largely professional teams, working where appropriate with members of the DHSS Social Work Service, carry out visits and give impartial advice to authorities and the Secretary of State. Since 1979 there have been over 60 reports dealing with services for the elderly. Reports on visits made after 1 January 1985 will be published.

PHYSICALLY HANDICAPPED AND SENSORILY IMPAIRED PEOPLE

27. Care in Action identified four objectives

to relieve pressure on caring relatives;

to improve the arrangements for caring for younger disabled people separately from elderly people;

to help those with hearing impairments to make the best use of the improved range of hearing aids;

to improve co-operation between authorities so that visually handicapped people are aware of the help available.

Helping Caring Relatives

28. The expansion of community nursing services (para) and home help (para) provision (para) is assisting here. Short term relief to carers is also available through the disabled person going into hospital or residential care. The growing desire for a more independent life has emphasised the need for the kind of assistance not usually available outside the family to help with ordinary but necessary tasks such as helping a disabled person to get up and dressed. To meet these needs the DHSS has encouraged

the growth of care attendant schemes. Some are run by local authorities and some by voluntary bodies, usually with funding from statutory sources. Two of the most well known are Crossroads and the Leonard Cheshire Foundation's family support schemes, both assisted financially by DHSS. Crosssroads now has some 500 care attendants operating in more than 70 schemes throughout the United Kingdom. The Cheshire Foundation's schemes provide personal help for physically disabled and mentally handicapped people at homes: there are 20 such schemes with more planned. Care attendants enable disabled people to exercise choice in where they live and to lead more interesting and stimulating lives. Help is tailored around the needs of the disabled person who is able as a result to exercise much more choice about where and how to live.

Younger Disabled People

29. Much disablement, both physically and sensory, is a result of ageing. But there are also many younger disabled people. Long term places in hospital or residential homes for a minority remain necessary but the emphasis more and more on helping them to live as full a life as possible in the community with appropriate support - home nursing, home helps, remedial therapy, and aids to daily living (appliances, wheelchairs etc). Those who still need the specialised facilities of hospitals need surroundings where they can live as normally as possible. Progress continues to be made on the movement of younger disabled people from wards mainly for elderly or psychiatric patients. In 1978 about 2275 people were inappropriately accommodated but by 1983 the number had decreased to about 1660.

30. The number of younger disabled units in hospitals remains steady, providing about 1700 beds but the provision is being used more intensively, reflecting in part increased use for short stay patients. The number of discharges and deaths in 1983 (6239) represented a doubling of the number of patients treated per available bed since 1978. A similar pattern is seen in local

authority provision where 79% of all admissions to residential homes were for short stay - an increase of nearly a quarter over 1978.

31. The specialist supra-regional services, providing treatment and rehabilitation for patients with spinal cord injuries or disease, have been strengthened. The original spinal unit at Stoke Mandeville Hospital was replaced in 1983 using appeal funds. The Government has financed two new units opened in 1984, at the Royal National Orthopaedic Hospital, Stanmore, and the Odstock Hospital, Salisbury, bringing the number of such units to eight.

Artificial Limb and Appliance Service

32. The DHSS provides a range of services direct to disabled people through 30 artificial limb and appliance centres and sub-centres, including artificial limbs, wheelchairs, motor cars and invalid three-wheelers (trikes).

33. The Government has set up a working party to review the service provided by these centres, with the following terms of reference.

> "To review and report on the adequacy, quality and management of the various services received by patients in artificial limb and appliance centres in England, and on the respective roles of the staff of the centres, the NHS and manufacturers, having regard to the need to promote efficiency and cost effectiveness".

The working party is expected to report in the first half of 1985.

34. Meanwhile the Service continues to meet the needs of some 63,000 amputees, and in 1983/84 over 23,000 new and replacement limbs were issued. Some 80 per cent of limb patients are elderly, and the proportion is increasing slowly within a broadly constant

total. A study of the problems faced by amputees and their views on the services provided for them was carried out for the DHSS in 1983.*

35. Although the majority of wheelchair patients are elderly the demand for wheelchairs is growing much more rapidly than the elderly population as awareness of the wheelchair service increases. In 1983/4 146,000 wheelchairs were issued, nearly twice the number in 1978/79, bringing the total fleet to nearly 380,000.

36. The major change in personal transport for disabled people flowed from the introduction of the Mobility Allowance in 1976. Since then no cars or trikes have been issued to new civilian drivers and the availability of the Allowance has widened the range of disabled people receiving assistance and offered people more choice. The introduction in 1983 of the War Pensioners Mobility Supplement is leading to a run down of their special vehicles scheme as more War Pensioners take advantage of the cash allowance.

Voluntary Help

37. Many voluntary bodies are active in assisting disabled people, and DHSS assistance to them has grown from £1.4m in 1978/79 to £3.42m in 1983/84. Families with severely disabled children can apply for help from the Family Fund set up in 1973 and adminstered on the Government's behalf by the Joseph Rowntree Memorial Trust. The amounts paid to families through the Fund have almost doubled in the last 4 years from £2.5m in 1979 to £4.8m in 1983.

---

* Artificial Limbs and their Users: report of a survey among patients of the artificial limb service. (Study by Research Surveys of Great Britian Ltd).

Hearing Impairment

38. It has been estimated recently that more than 4 million people in Great Britian have significant hearing loss. About one child in a thousand is born with severe hearing loss so the first priority is prevention. This includes genetic counselling, better antenatal and perinatal care, and treatment of upper respiratory and other infections. It also includes vaccination against german measles (rubella) as deafness in infants can be rubella related.

39. It is not always possible to prevent deafness which makes it important that any impairment is discovered as early as possible. Emphasis continues to be placed on the need to screen children at an early age, around 8/9 months, so that action can be taken quickly to diagnose, assess and treat any child in whom a hearing loss is suspected. With Government funds, new equipment has been developed which is opening up the prospect of effective tests on babies before they leave hospital.

40. The range of NHS hearing aids, including behind the ear high powered aids, available free on loan is now extensive and should meet the needs of all but a few people for whom health authorities may purchase commercial aids. The numbers issued increased by nearly 10% from 1978 to over 450,000 in 1982. The number of ENT consultants in England, who prescribe hearing aids, increased from 316 in 1978 to 336 in 1983 (6.2%). The number of physiological measurement technicians (audiology) in post in England in 1982 was 799 compared with / / in 1978. /DN. no 1983 figures?/.

41. The Government has provided special funds to set up the new profession of hearing therapist. These are mainly concerned with the rehabilitation of adults suffering from acquired deafness and there are now around 50 in post in England.

42. Again the voluntary sector continues to make a major contribution, with DHSS assistance. The Government has recently also given specific grants to a scheme to increase public

awareness of hearing impairment and to develop new visual display units (VISTEL) for use via telephone systems. Several grants have been made to the recently formed Council for Advancement of Communications with Deaf People.

Visual Handicap

43. In 1984, the numbers of registered blind and partially sighted people in England were 111,729 and 58,003 respectively. However, these figures are almost certainly an understatement since many visually handicapped people choose not to register. Of those who are registered more than 50% are aged 75 or over, and many have other disabilities.

44. There is a strong and well established tradition of voluntary provision for visually handicapped people which pre-dates the statutory services. The DHSS supports this continuing tradition through grants to organisations of and for the visually handicapped.

45. Services provided by social services may include social work support, the provision of aids and adaptations, advice on rehabilitation, job training and employment services, training in the use of Braille, Moon and other communication skills, training in mobility and daily living skills, and help with recreational activities. Such services are often provided by voluntary organisations on an agency basis for the local authorities.

46. Concern that developments in help for visually handicapped people might not have kept pace with those for other groups led the DHSS to undertake a fact finding exercise during 1983. This involved discussions with health and social services staff and representatives of voluntary organisations in different parts of the country. The information gathered should help to provide a more objective picture of what is happening. Meanwhile, there are indications that the discussions are already having a beneficial effect on co-ordination of effort between health, social services and voluntary agencies. A review is in hand of the procedures for

admission of visually handicapped people to local authority registers of the blind and partially sighted, involving consultation with medical, social services and other interests.

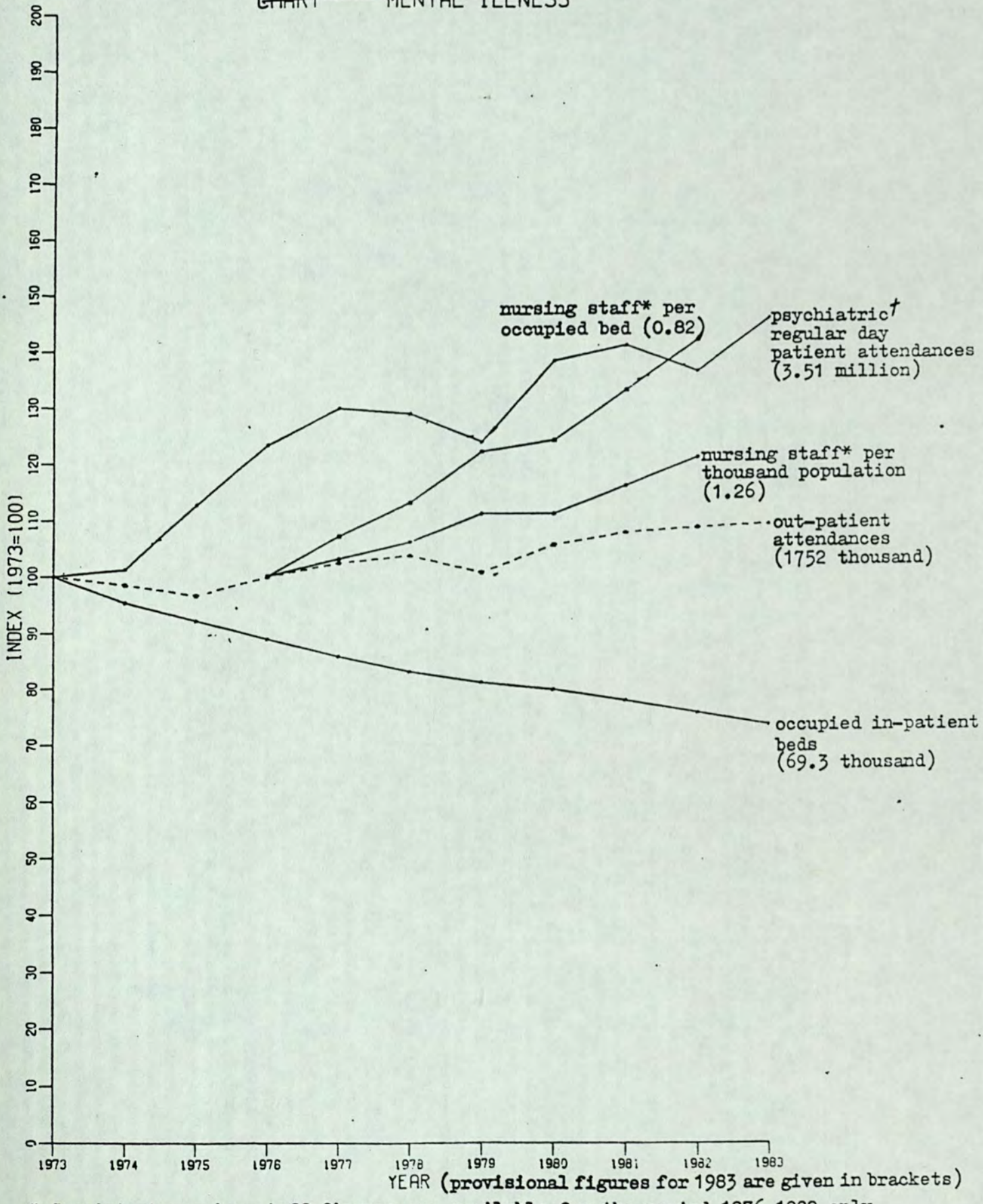
MENTAL ILLNESS

47. Advances in the treatment of mental illness have in recent years brought great benefits to patients. The number of beds occupied by mentally ill people fell over the decade 1973-1983 by over one fifth (nearly 25,000) and the proportion of patients admitted who are discharged within a month rose by 16% to 58%. This reflects more effective assessment, treatment and rehabilitation during the acute phase of illness. Much mental illness can now be treated successfully without admission to hospital. The trends in hospital services are illustrated in the Figure / / and Table.

Figure [ ]

Hospital Services for Mentally Ill People 1973-83

~~CHART~~ ~~MENTAL ILLNESS~~



* Consistent nursing staff figures are available for the period 1976–1982 only (ie 1976 = 100 and figures for 1982 are given in brackets)

† The 1983 figure is made up of 3.22 million attendances by the mentally ill and 0.29 million attendances by the mentally handicapped. Separate figures are not available before 1979.

TABLE

HOSPITAL SERVICES FOR MENTALLY ILL PEOPLE

	Change between 1973 and 1978		Change between 1978 and 1983	
	thousand	percentage	thousand	percentage
Average daily number of occupied beds	- 16.0	- 17.0	- 8.8	- 11.3
Number of out-patient attendances	+ 58	+ 3.6	+ 91	+ 5.5
Number of psychiatric[1] regular day patient attendances	+ 691	+ 28.7	+ 414	+ 13.4

The costs per in-patient day in hospitals for the mentally ill rose over 12% in input volume terms from 1978 to 1982/83 (£31).

48. These improvements, and the change in social attitudes which they have helped to bring about, have made the old pattern of health services based on long-term care in large isolated hospitals increasingly inappropriate. The aim is rather to enable people with mental illness to have access to the services they need with the minimum of formality and delay and without losing touch with their normal lives. Care in Action identified the main tasks as :

to build up local psychiatric services in districts that still had little local provision;

to make suitable provision in every district for the increasing number of elderly people with psychiatric disorders, and to ensure that each district has a ~~constant~~ consultant psychiatrist with a special interest in elderly people:

to make satisfactory arrangements for the closure of badly placed large hospitals for mental illness;

---

(1) includes attendances by the mentally handicapped. Separate figures for the mentally ill and mentally handicapped are not available for 1973 and 1978.

for local authority social service departments, working with voluntary bodies and health authorities, to provide essential residential and day care facilities and other support and rehabilitation services.

49. The need was also recognised for some patients to have more secure accommodation than would otherwise be provided within the new pattern of service; and more generally to improve the quality of life, particularly for those remaining in institutional care for long periods.

Whilst the pace varies from place to place, as does the baseline of provision, encouraging progress is being made towards each of these objectives, as outlined below.

Provision of District Based Service

50. Most of the single specialty mental hospitals can contribute to the provision of a good service in their own districts. The aim is to provide psychiatric services in districts previously reliant on other district's hospitals, sometimes a long way away; and hence also to reduce the catchment areas of the remaining specialist hospitals to their own districts. The number of general hospitals with in-patient provision for psychiatric patients has grown from 130 in 1978 to 145 in 1982 so that by 1982 only 13 districts had no psychiatric beds of their own and most of these districts had plans for opening a psychiatric unit. This compares with 25 Districts with no psychiatric beds in 1978. Building up the comprehensive district service needed is a slower process. However the proportion of in-patient admissions to units other than the large specialist hospitals rose from 39% in 1978 to 44% in 1983. Expansion of medical staffing is assisting the development of services - see table / /.

TABLE

MENTAL ILLNESS. HOSPITAL MEDICAL STAFFING. WTE

	1978	1983	% change
Consultants[1]			
Child/Adolescent Psychiatry	228	284	+ 25
Adult Psychiatry	947	1085	+ 15
Other Doctors			
Child Adolescent Psychiatry	115	130	+ 13
Adult Psychiatry	1844	2184	+ 18
Consultants[1] per 100,000 population	2.5	2.9	+ 16

on average each district now has between 5 and 6 consultant psychiatrists working with adults, and between 1 and 2 child psychiatrists. Many adult psychiatrists combine their general work serving a particular locality with specialist work for the district as a whole eg in the psychiatry of old age, or drug or alcohol dependency. Some extend their commitment to their locality by links with primary health care teams.

51. Since 1978 nursing staff in mental illness have increased by 15%, after adjustment for reduced hours of work, to 58,800 in 1982. These improvements are reflected in the change in the ratio of nursing staff per 100,000 population from 111 to 126 (14%); the increase in community psychiatric nurses within this total has been particularly sharp, from 971 in 1978 to 1728 in 1982, in keeping with the emphasis on caring for patients within the community wherever possible. The proportion of qualified staff needs to be increased and in many places this will be a high priority for the next few years. Strengthening the number and training of community psychiatric nurses has a particular importance.

52. Though numerically still small, the number of clinical psychologists in the NHS is expanding - numbers rose by 30%, after adjustment for change in hours, from 1978 to 1200 wte in 1982.

---

(1) including mental illness, child and adolescent psychiatry and forensic psychotherapy.

The w.t.e. number of qualified physiotherapists and occupational therapists working in mental illness hospitals and units increased by 35% to 1138. Support staff also increased, helping to provide improved rehabilitation services.

Provision for elderly people with psychiatric disorders

53. About 25% of all referrals to psychiatric departments are aged 65 and over. These include patients with disorders such as depression and confusional states which may be reversible and dementias which usually are not. It has been estimated that in England about ½ million people over 65 suffer from moderate or severe dementia, about a quarter of whom are 85 or over, many living at home. With growing numbers of very elderly the demands on health services can be expected to increase significantly.

54. The report of the Health Advisory Service (HAS) "The Rising Tide" published in 1982 gave guidance on the service developments required to meet their particular needs - eg more assessment beds and small local units for long stay care, strong medical leadership, more systematic support for the 'front line' carers in families and in residential homes. To assist health and local authorities to respond to these needs the Government announced a special initiative in 1983 under which an extra £6m was made available. Schemes in 29 Districts have been approved for funding under this initiative to develop services in 'demonstration districts', giving a lead to other districts. About half of all districts now have a consultant psychiatrist with special responsibility for elderly people and the HAS has been able to report that considerable improvements in services are being made. This will remain a high priority area for development.

55. The DHSS is supporting 3 experimental residential care schemes embracing a variety of social and health care patterns. The psychiatry of old age is a major concern in the DHSS's research strategy.

Closure of badly placed hospitals

56. The inherited hospital network in many places bears little relationship to current needs and opportunities. It is a major management and professional challenge to get the right balance between hospital in-patient and other care, and a rational distribution of remaining hospital beds. All 14 Regions are grappling with the planning, consultation, resource allocation, and staff training involved. By the end of the decade, the remaining hospitals should be playing their part in a reasonably comprehensive local service, and sometimes a more specialist service as well, in their own Districts. Staff and other resources redeployed from redundant hospital services will have helped to fill the gaps that now exist in their own or other Districts. The funds saved as the old institutional services shrink are to be earmarked for the new community mental health service. For example, nearly all the psychiatric beds in Devon used to be in 3 hospitals near Exeter. One of these will close in 1986 and the services and money saved redeployed to provide local community orientated care in all the three districts concerned.

Local Authority and Voluntary Services

57. The strategy of increasing reliance on community care for mentally ill people is critically dependent on joint planning to secure appropriate local authority social services and voluntary provision to complement NHS services. Local authorities have expanded facilities for both residential and day care as shown in table / /. Gross expenditure on these services rose from £15m in 1978/79 to £32.4m in 1982/83 - 25.6% in input volume terms.

TABLE

LOCAL AUTHORITY PROVISION FOR MENTALLY ILL PEOPLE

	as at 31 March 1979		Change between 1979 and 1983	
	1979	1983	number	%
No of places in all residential homes for the mentally ill	5607	6540	+ 933	+ 16.6
(In local authority homes)	(3592)	(4173)	+ 581	+ 16.2
No of places in day centres (excludes places in mixed centres and residential homes)	4622	5159	+ 537	+ 11.6

58. Unstaffed group homes, places provided by housing associations or local housing authorities, and unsponsored private accommodation, exist on at least the same scale and are not accounted for in the table. Voluntary bodies including local mind groups, the Mental After-Care Association and the Richmond Fellowship are important providers of residential care. Social security payments have been instrumental in opening up of choices in accommodation for those without an earned income of their own; and can be of great help in the context of a wider system in which there is adequate information about available choices and suitable back-up services, including day-time occupation. It will be important to maintain a close watch on standards of care and costs.

59. There is still a substantial shortfall in centres, workshops etc providing day care. The DHSS is making a three year grant to the British Institute of Industrial Therapy to help develop employment and training opportunities, to provide in the community more of the opportunities now available in many large hospitals. Five rehabilitation demonstration services are helping to set the pace in rehabilitation.

60. It is not possible to say what proportion of social work time is devoted to people with mental illness. Their contribution is however of major importance both in the community and in hospital, and the Mental Health Act 1983 is designed, among other

things, to improve social work expertise in this area. As noted in Table / / the numbers of social workers expanded by 6.4% between 1978 and 1983.

61. Local authorities have also been assisted by the special arrangements under the 'Care in the Community' Programme whereby health authorities can give them financial help to enable people to be discharged from hospital.

62. Joint Finance is helping to support the growing variety of local and often voluntary initiatives, using the skills and interests of many people. These are chronicled by the DHSS funded Good Practices in Mental Health project, which encourages local analysis of good practice and maintains information about them centrally.

Quality of Life

63. Facts and figures do not provide an adequate measure of improvements in the quality of service though the changes which can be measured point towards progress in a much needed improvement. The Health Advisory Service has helped to highlight where improvements are necessary, to advise on how they can be made and to spread good practice. The changes introduced by the Mental Health Act 1983 and the setting up of the Mental Health Act Commission are in different ways helping to ensure the quality of life through the protection of patients' rights, and securing good accountable professional practice in their treatment. The Commission is well advanced with its preparation of a Code of Practice. The Government welcomes the current study of Community Mental Health services by the Social Services Committee of the House of Commons.

Care of Patients Requiring Additional Security

64. After a slow start the important national programme of regional secure units is now well under way. Six permanent units are open, and two more are due to open by the end of the year.

Three further units and a multi-site scheme are under construction, and four are at a planning stage. About 300 beds are available now in interim units, and over 900 beds in other types of secure provision in NHS hospitals.

65. The Secretary of State is directly responsible for the four special hospitals - Broadmoor in Berkshire, Rampton in Nottinghamshire, and Moss Side and Park Lane near Liverpool - which provide treatment in conditions of special security for those patients detained under the Mental Health Act with "dangerous, violent or criminal propensities". The important and challenging work of the special hospitals is a key part of the developing area of forensic psychiatry. The hospitals now offer a full therapeutic programme of treatment and care for each patient by multi-disciplinary clinical care teams. The old overcrowding has been eliminated, and the hospital fabric is being substantially improved. The completely new hospital at Park Lane was opened in September 1984. The first main stage of the complete redevelopment of Broadmoor Hospital has begun.

MENTAL HANDICAP

66. Care in Action reaffirmed that the aims for health and local authorities should be:-

(a) to provide a locally based service that enables people to live with their families where possible, or failing that, in a local community setting;

(b) to develop the capabilities of each individual so that he or she can live as independent a life as possible;

(c) to support those looking after mentally handicapped people at home by providing day services and short-term residential care for training, relief and holiday purpsoes.

67. These aims reflected the consensus of opinion that mentally handicapped people are generally more suitably cared for in the community and in particular that large and often isolated mental handicap hospitals are no place for children to grow up in. Ideas are still being developed on the nature and role of health service units for some mentally handicapped adults who have clear medical and nursing needs which cannot be met outside such units. As with services for mentally ill people, the period of transition to the new patterns of services presents a major challenge in terms of shifting resources, in training staff, and in securing the co-operation of all those involved. Substantial progress is being made, as outlined below.

Community Care

68. Local authority provision of both day and residential facilities have been expanded over the last five years as shown in Table / /. Their gross expenditure increased from £87.8m in 1978/79 to £193.1m in 1982/83 an increase in input volume terms of28.4%, including Joint Finance.

TABLE

LOCAL AUTHORITY FACILITIES FOR MENTALLY HANDICAPPED PEOPLE

	as at 31 March		Change between 1979 and 1983	
	1979	1983	number	%
No of places in ~~Audit~~ Adult Training Centres (including social education units)	42061	46558	+ 4497	+ 10.7
No of places in Local Authority Homes and registered voluntary and private residential homes	15156	18781	+ 3625	+ 23.9
(in local authority homes)	(11381)	(13735)	+ 2354	+ 20.7

Where residential places are funded through social security entitlements they are often not recorded in local authority returns so the figures in the table understate total provision.

The range of sheltered employment opportunities is being extended through an increasing, though still small, number of sheltered industrial groups in ordinary firms - about 700 places in 1984.

69. The discharge of patients from inappropriate hospital provision has been assisted by the Care in the Community initiative (para above). Under the special centrally funded arrangements 13 schemes have been selected to start, of which 7 relate to mentally handicapped people, and about the same number will be selected to start next year.

70. Grants to the important voluntary sector have also been continued, especially through grants to MENCAP (£0.2m pa for 3 years 1983/84 - 1985/86) which now has some 450 local societies. People caring for mentally handicapped dependants should benefit from a new Government funded MENCAP/Open University course on coping with mental handicap.

71. The quality of care in the community is also being enhanced through improved training of professional caring staff. A new syllabus for mental handicap nursing, with more emphasis on offering care in the community, was introduced in 1982. Active consideration is being given to ways of increasing co-operation in social work and nurse training following professional reports* in 1982 and 1983.

The Pattern of Hospital Care

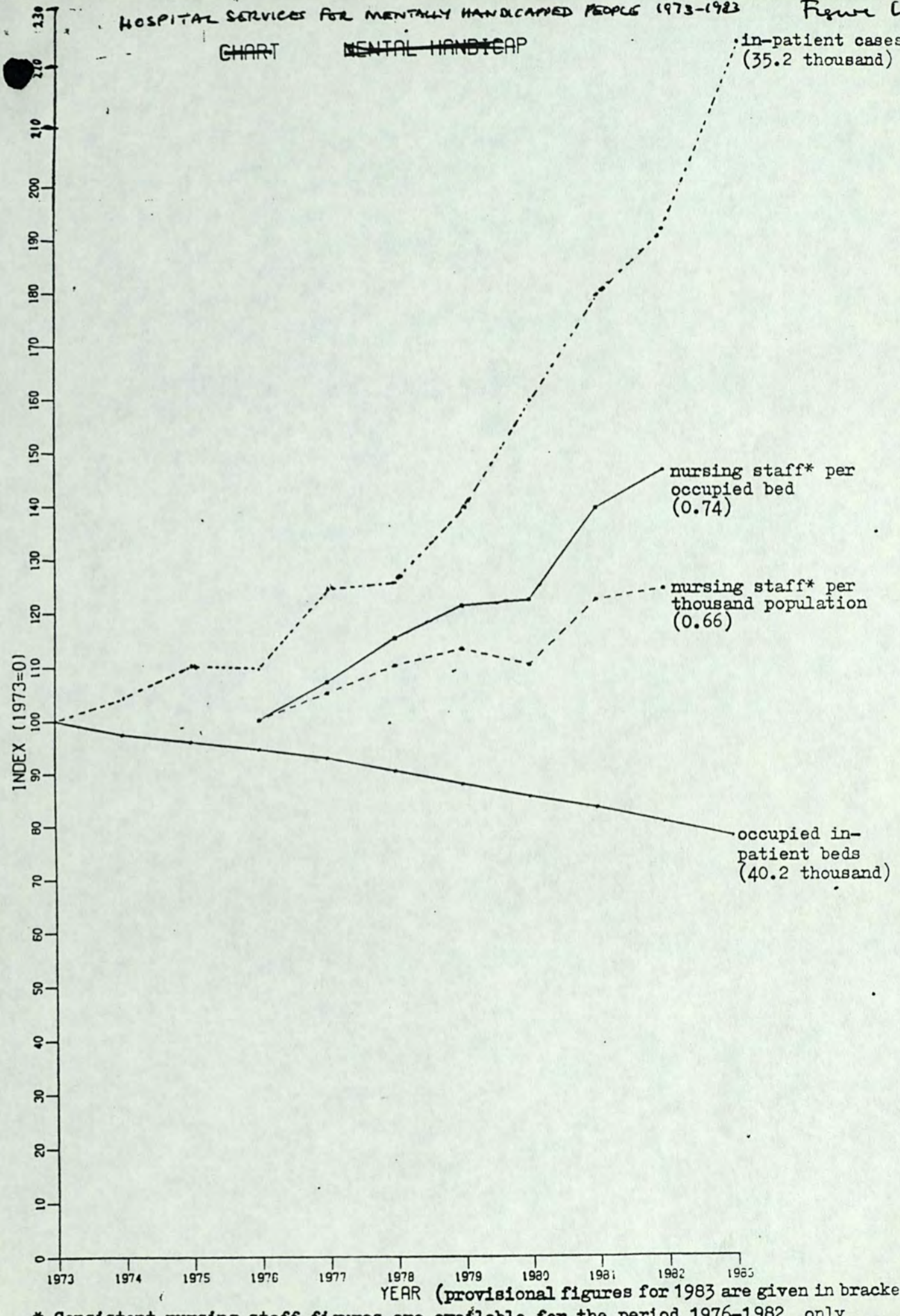
72. The number of mentally handicapped people in NHS hospitals and units has been steadily reducing for many years. Over the decade 1973-1983 the average number of occupied beds fell by more than one fifth (11,500) to 40,200. Regular day patient attendances have, on the other hand, been rising. ~~and~~ Figure / / and Table / / show the trends.

---

* Reports of the Joint Working Group set up by the Central Council for Education and Training in Social Work and General Nursing Councils in 1981 at Health Ministers' invitation.

HOSPITAL SERVICES FOR MENTALLY HANDICAPPED PEOPLE 1973-1983 Figure [ ]

~~CHART~~ ~~MENTAL HANDICAP~~



* Consistent nursing staff figures are available for the period 1976-1982 only (ie 1976 = 100 and figures for 1982 are given in brackets)

TABLE

HOSPITAL SERVICES FOR MENTALLY HANDICAPPED PEOPLE 1973-83

	Change between 1973 and 1978		Change between 1978 and 1983	
	thousand	percentage	thousand	percentage
Average daily number of occupied beds	- 5.1	- 9.8	- 6.4	- 13.8
In-patient cases discharges and deaths	+ 3.2	+ 26.4	+ 12.4	+ 77

73. Medical and nurse staff numbers have increased, as shown in table / /.

MENTAL HANDICAP . HOSPITAL MEDICAL AND NURSE STAFFING . WTE

TABLE

	1978	1983	% change
Consultants ~~WTE~~	135	145	+ 7.2
Other Medical Staff	156	210	+ 35
Nursing Staff(1) in Mental Handicap	27100	30800	+ 14
Nursing Staff per occupied bed	0.582	0.741	+ 27

As noted in para / / there has also been increases in the number of psychologists. The number of w.t.e. physiotherapists & occupational therapists working in mental handicap hospitals & units rose by 44% from 1978 to 330 in 1982.

74. The increased numbers of staff are having to deal with a progressively older and more handicapped hospital population. However there is in turn more information now available on the services neded, for example, the report of a Departmental Study Team published in 1984 on the needs of severely and multiply handicapped people. Both health and local authorities have also been helped through the advice of the National Development Team for Mentally Handicapped People, and through its published biennial reports.

---

(1) 1978 figures adjusted for change of hours; includes nursing staff in mental handicap hospitals and mental handicap work in other hospitals, and community mental handicap nurses.

Mentally Handicapped Children

75. The recognition that large mental handicap hospitals provided the wrong environment for mentally handicapped children led in 1980 to the launch of the Children's Initiative. The numbers of children in mental handicap hospitals and units has subsequently been reduced - by over one-third. In 1983 there were only 1,250 (provisional) as compared with 2,421 in 1980 before the initiative. This has required careful planning between health and local authorities, assisted by an extra £10m of central funds for projects to bring children out of hospital. Of the children still in hospital in 1983 many were in NHS units in the community or short-term hospital care so real and substantial progress in ending the care of these children in long-stay hospitals has been achieved.

PRIORITY GROUPS - CONCLUSIONS

76. Overall the record shows that steady progress has been made in improving the standards of care and developing more appropriate patterns of service. But there is still a long way to go. Progress has not been even throughout the country and the pressures on services also vary considerably. There are formidable challenges ahead. The changes in the patterns of care which must be accomplished can only be brought about through careful forward planning and close collaboration between authorities. The Government proposes to continue to regard the care of these groups as a priority and to ensure that authorities are developing services accordingly. Ministers will in particular:

scrutinise carefully the 10 year Strategic plans which RHAs will be submitting in 1985 ~~so~~ not only to see that their priorities are being observed but also that plans are realistically drawn, soundly based, and robust enough to stand up to the uncertainties of changing circumstances;

continue to use the annual Ministerially led Regional Review mechanism (see Chapter X) to monitor progress in the management and planning of services for the priority groups;

in conjunction with the NHS, develop a wide range of performance indicators (see Chapter X, para --) for health authorities in respect of services for people who are elderly, mentally ill or mentally handicapped. These will be published in 1985;

continue to support the work of the HAS and the National Development Team for Mentally Handicapped People. Implementation of the proposed changes in the role of the Social Work Service to give it a more inspectorial function should also help to maintain and raise standards and promote effective, appropriate changes in services.

12.9.84

CHAPTER

ACUTE HOPSPITAL SERVICES

Background

1. The acute hospital services have to meet the needs of patients for an enormous variety of diagnostic and treatment procedures. In the NHS these services are generally defined as including all medical and surgical specialties other than obstetrics, geriatrics, gp maternity services and services for younger disabled people and the specialties of mental illness and mental handicap. All the acute specialties make heavy demands on the clinical diagnostic support services, particularly pathology and radiology.

Demand for Services

2. There continues to be a sustained pressure on services. A principal factor is the growing number of elderly people. Over one-quarter of all acute patients admissions are people aged 65 or over and because they tend to have longer lengths of stay they take up some 45% of all occupied beds. The other major factor is medical advance, which has meant that for all age groups there are new forms of treatment, some for conditions previously regarded as untreatable, giving rise and ~~which lead~~ on to public expectations that they will become quickly and generally available.

Expenditure

3. The proportion of expenditure on the acute hospital services, as compared with the hospital and community health services generally, has remained relatively stable in recent years at around 46 to 47%. In input volume terms it is estimted to have grown by an average of 0.6% per year between 1978/79 and 1983/83 - less than half the annual growth for hospital services for the

priority groups. The average gross cost per case treated in acute hospitals(1) fell in input volume terms by 5.2% from 1978/79 to 1982/83, to about £700 per case.

Services Provided

4. The volume of in-patient services provided has expanded significantly faster than resources. Falling case costs and shorter stay are helping to ensure that more people than ever before can be treated as in-patients. Many more are now treated as day patients without admission.

5. The trends in activity over a ten year period are shown in Figure | | and summarised in Table | | below. They show that generally activities over the last 5 years have grown more than in the preceding period and that more intensive use has been made of acute sector beds.

TABLE

Changes in the acute sector 1973–83

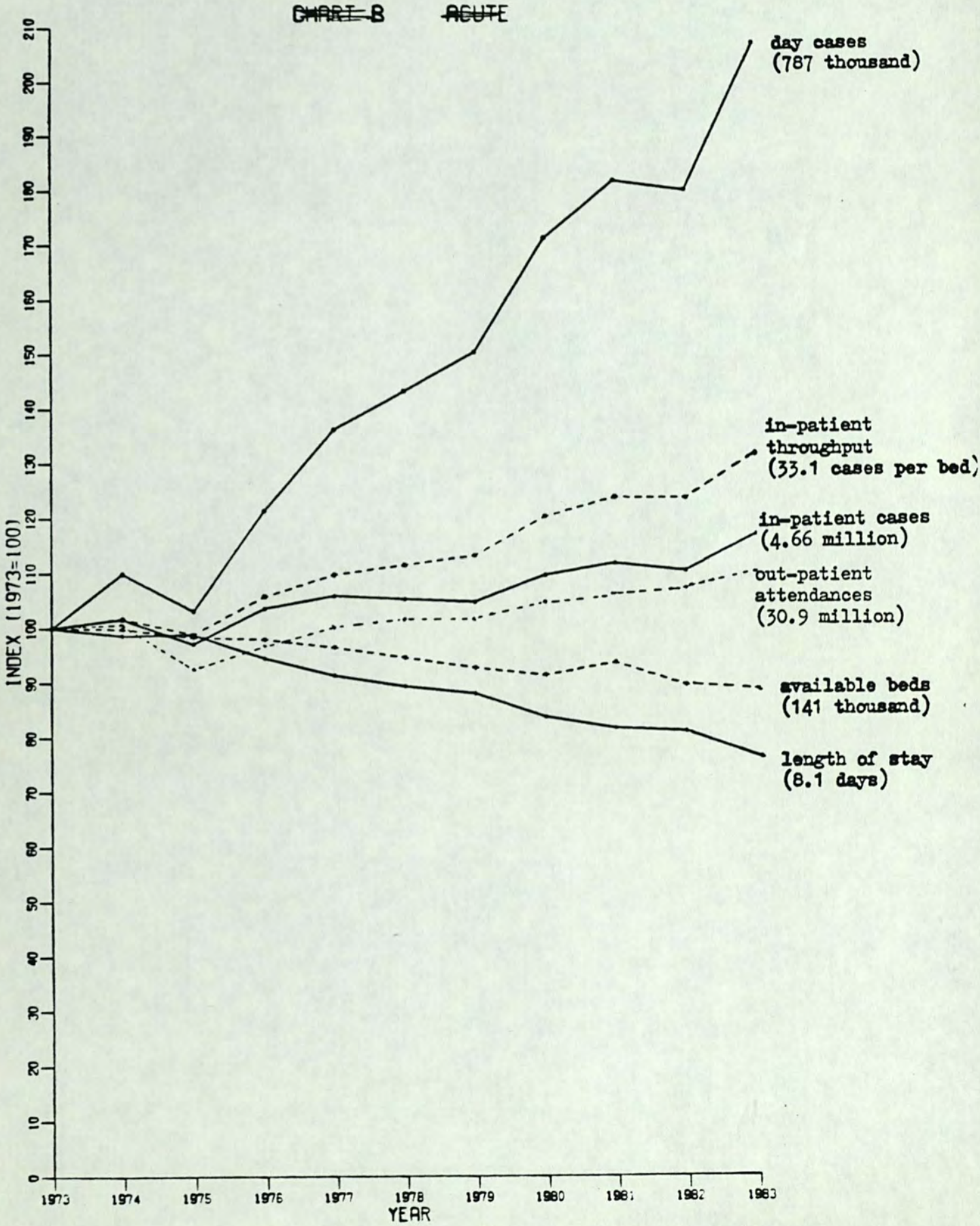
	Change between 1973 and 1978		Change between 1978 and 1983	
	number	%	number	%
In-patient cases (thousand)	+ 209	+ 5.2	+ 454	+ 10.8
In-patient throughput (cases per available bed)	+ 2.8	+ 11.1	+ 5.2	+ 13.8
In-patient average duration of stay (days)	- 1.2	- 11.3	- 1.3	- 13.8
Day cases (thousands)	+ 163	+ 43.1	+ 244	+ 44.9
Out-patient attendances (thousand)	+ 489	+ 1.8	+2,462	+ 8.7

---

(1) This includes hospitals classified as acute, mainly acute and partly acute. The cost per case figures reflect costs for non-acute as well as acute cases in these hospitals though the latter predominate. The activity figures in Table | | reflect work in the acute specialties only, as defined in para | | above.

Acute Hospital Services 1973 - 1983

~~CHART B~~ ~~ACUTE~~



(Provisional figures for 1983 are given in brackets)

6. These increases in patients treated have been achieved over a period when the available daily number of in-patient beds in the NHS acute sector has been reduced by about 9,000 to 140,500. The capacity of the Service to treat more patients in fewer beds reflects a variety of factors including strengthening of professional staffing see Table | |, and improvements in facilities as well as advances in medical and surgical treatment.

TABLE

ACUTE HOSPITAL SERVICES - MEDICAL STAFFING WTE

	1978	1983	% change
Specialties providing direct care to acute patients (1)			
Consultants	4787	5348	+ 11.7
Others	12124	13383	+ 10.4
Support Specialties (2)			
Consultants	3355	3872	+ 15.4
Others	3468	4095	+ 18.1

Nursing staff have also increased but separate figures for acute specialties are not available.

Improvements in facilities

7. In a growing number of areas improvements in the performance of the acute sector are part of the benefits flowing from increased capital expenditure. These are described separately in chapters | |.

Improvements in treatment

8. In recent years there have been many changes in medicine and surgery. Anaesthetic and Surgical techniques have improved generally; coupled with early mobilisation and active rehabilitation they have led to better clinical management and

---

(1) includes all medical and surgical specialties (excluding obstetrics and gynaecology plus Accident and Emergency and Ophthalmology)

(2) radiology and radiotherapy, pathology and anaesthetics; some pathology work is also in support of geriatric or psychiatric medicine.

use of resources, including reductions in lengths of stay. Many specific improvements have also either reduced short term discomfort for patients or improved their quality of life in the longer term. Examples include:

* increase in one year kidney graft survival from 60 per cent to 80 per cent and the reduced length of stay in hospital for transplant patients brought about by the use of Cyclosporin; similar improvements have been made in liver and heart transplants;

* the improved use of endoscopic techniques which can be carried out under local anaesthetics as out-patient or day patient procedures in gastro-enterology, urology and gynaecology;

* the advent of H_2 - antagonist drugs for treatment of peptic ulcers means fewer patients now need surgery;

* the use of lasers which are quicker, cheaper and less traumatic than normal eye surgery and can be used to treat diabetic retinopathy and senile macular degeneration which are otherwise untreatable;

* the introduction of standard strength (100 units/ml) insulin which should both reduce accidents and, because a smaller volume is required, be less painful for those requiring large doses.

Priority Developments

9. Progress in introducing new techniques has and will continue to be determined by a mix of factors - not simply competing priorities for cash but also the availability of suitable trained manpower and establishing safety and reliability. There have however been significant advances in key areas to which the Government has attached particular priority. These include:

: Renal Services

The number of patients being treated for end stage renal failure rose from 4493 in 1978 to 7479 in 1982, an increase of 66% since 1978. Over the same period the number of new renal patients accepted for treatment rose from 906 to 1376, an increase of 52%; this is equivalent to a rate of 30 new patients per million population. Nevertheless renal services need to be expanded yet further, and the Government intends to ensure this by agreeing with RHAs target numbers of new renal patients to be accepted for treatment within each Region.

For most renal patients the preferred method of treatment is by kidney transplant. This enables patients to resume a near normal lifestyle; is the most cost-effective form of treatment; and releases dialysis facilities for use by other patients. The number of kidney transplant operations rose by 16% from 790 in 1978 to 919 in 1983. Further expansion depends on the availability of donor organs. The Government launched a campaign in February 1984 to increase public awareness of the benefits of transplantation and to promote the organ donor card scheme. Initial results have been most encouraging, over nine million new donor cards were distributed during the first three months of the campaign and the number of kidney transplants performed was about 40% up on the equivalent period in 1983.

: Coronary Artery Bypass grafts

Coronary artery bypass grafting is now accepted as part of NHS cardiac surgical provision. The number of grafts performed in the United Kingdom rose by 112% from 3191 in 1978 to 6766 in 1982, but the Government's view is that further increases are required and an expansion of provision has been defined as a priority. [DN. England figures not separately identified.]

: Total Hip Replacements

Hip joint replacement operations are now regarded as a standard treatment for many cases of osteoarthritis and other arthritic diseases which affect that joint. The estimated number of operations (arthroplasties) rose steadily from 28,090 in 1978 to 34,780 in 1981, although there was a fall to 33,730 in 1982 when the industrial action reduced the amount of "cold" surgery which could be done. Demand for this operation, which has an important role to play in keeping elderly people mobile, is high and Ministers have stressed the need for Regions to ~~develop~~ give priority to services for joint replacements.

: Bone Marrow Transplants (BMT)

Bone Marrow Transplantation is used in the treatment of some haematological disorders and particularly of the leukaemias, with possible potential in the treatment of some other conditions.

Ministers want to see an expansion of facilities and an additional £500,000 has been made available in 1984/85 and 1985/86 for six London hospitals to enable them to do more BMT work whilst facilities outside London are developed. Regional Health Authorities have been asked to pay special attention to the development of BMT facilities in their ten year strategic plans now being drawn up.

Supra Regional Services

10. Some highly specialised services, to be economically viable or clinically effective, need organising for a population substantially larger than any one region. New arrangements were introduced in 1983 for the funding of these services. These arrangements (described in HN(83)36) include the designation of appropriate services and supra regional centres for their provision, and the central allocation of earmarked funds to the health authorities responsible for their management. A Supra Regional Services Advisory Group has been set up to advise Ministers on the services meeting the criteria for supra regional designation, the centres best fitted for their provision, and the levels of funding for each centre. So far five services have been designated as supra regional; spinal services, (8 centres); services for the treatment of children under 16 who suffer end stage renal failure (8 centres); services for the management of chorion-carcinoma (2 centres); the National Poisons Information Service (1 centre); and neonatal and infant cardiac surgery (9 centres).

Other Developments

11. Heart Transplants: the Government is currently evaluating the costs and benefits of heart transplantations and will be receiving at the end of this year the final expert evaluation it commissioned on the transplant programmes at Harefield and Papworth hospitals (which it has supported financially since 1981). There were 54 such operations in 1983 as against 3 in 1979.

12. Cancer Services: an authoritative report by the Standing Medical Advisory Committee's Sub Committee on Cancer [has recently been] [will shortly be] published. It offers practical guidance on the organisation of acute cancer services with a view to making the most effective use of resources for patient care.

13. Blood Products: construction of the building to house the new blood products production unit at the Blood Products Laboratory, Elstree is expected to be finished in 1984. Subsequent equipping and commissioning in 1985 will complete this major investment aimed at making England and Wales self sufficient in blood products. Considerable savings are expected on products currently imported.

14. Amublance Services: potential benefits to patients suffering from heart attacks or serious injuries have been demonstrated by the use of advanced techniques for resuscitation by ambulance crews. A national training package is now available for all health authorities planning to introduce these techniques or to extend existing training of ambulance staff.

Waiting Lists

15. The acute hospital sector is and will continue to be a dynamic and changing scene. It has achieved much in recent years in providing more treatment over a wider range and using facilities more intensively. But the demand for services ~~remains~~ stays strong ~~high~~ and increasing, and as new treatments are developed, so they in turn stimulate further demand. Despite the significant improvements in performance waiting lists remain high, particularly in some areas and some specialties. Until the industrial action in 1982, waiting lists had been falling from a peak in March 1979. The most recent figures show that the downward trend has been resumed. ~~and~~ Waiting lists may well overstate demand - probably by more than 10% - through including people who do not at a given time require treatment - nevertheless at present levels they remain a source of concern to Government, and underline the need for the improvement in the performance of the acute services to be sustained.

Co-operation with the independent hospital sector

Acute Hospital Services

16. The Government believes that a strong private acute hospital sector can add significantly to the total health care resources available and to NHS revenue; can relieve pressures on the NHS; and that collaboration between the NHS and the private sector can help to optimise the use of the resourcs available to the benefit of NHS and private patients.

17. The early 1980s saw a substantial increase in the number of people covered by private health insurance so that just under 8% of the population of the UK now has such cover. This growth was accompanied by an expansion of the number of independent acute hospitals which had a total of nearly 7,700 beds in England at the end of 1982. The NHS also treats a significant number of private patients - 81,000 in-patients and 213,000 day and out-patient attendances in 1982. Private patients brought the NHS an estimated £55.5 million in 1983/84.

18. Collaboration between the NHS and the private acute sector is increasing. For example, the British United Provident Association is providing a lithotripter (which breaks up kidney stones without surgery) at St Thomas' Hospital, with 75% of its time being available for NHS patients. There are a number of other cases where high technology equipment, such as scanners, installed in private hospitals, is used by NHS patients. And several Districts are contracting to treat NHS patients in private hospitals to reduce their waiting list, or because they have theatres or beds out of use due to upgrading work. Conversely the independent sector has contractual arrangements with the NHS in many places for the provision of pathology, radiology and diagnostic services.

Other hospital services

19. Collaboration with the independent sector is not confined to the acute sector. There is a long tradition of providing convalescent care, and care for the elderly and mentally handicapped people in the independent sector. There has been a growing and constructive partnership in the provision of care for the dying. The voluntary sector has brought an innovative, imaginative and flexible approach whilst by its financial support the NHS can contribute a longer-term stability to the services provided. Support is given in a variety of ways - contractual arrangements for hospice beds, grants or agreements to fund home care teams after initial periods of funding by voluntary bodies. In this way the particular needs of the terminally ill can be met and the best balance of care for the patient and their family provided through a growing partnership between local authorities and the voluntary sector.

20. There are now about 100 hospice-type establishments, of which some two-thirds have home care services. Many receive support from the NHS. In addition, there are about 20 hospital support/symptom control teams attached to NHS hospitals.

12.9.84.

CHAPTER

MATERNITY AND CHILD HEALTH SERVICES

MATERNITY SERVICES

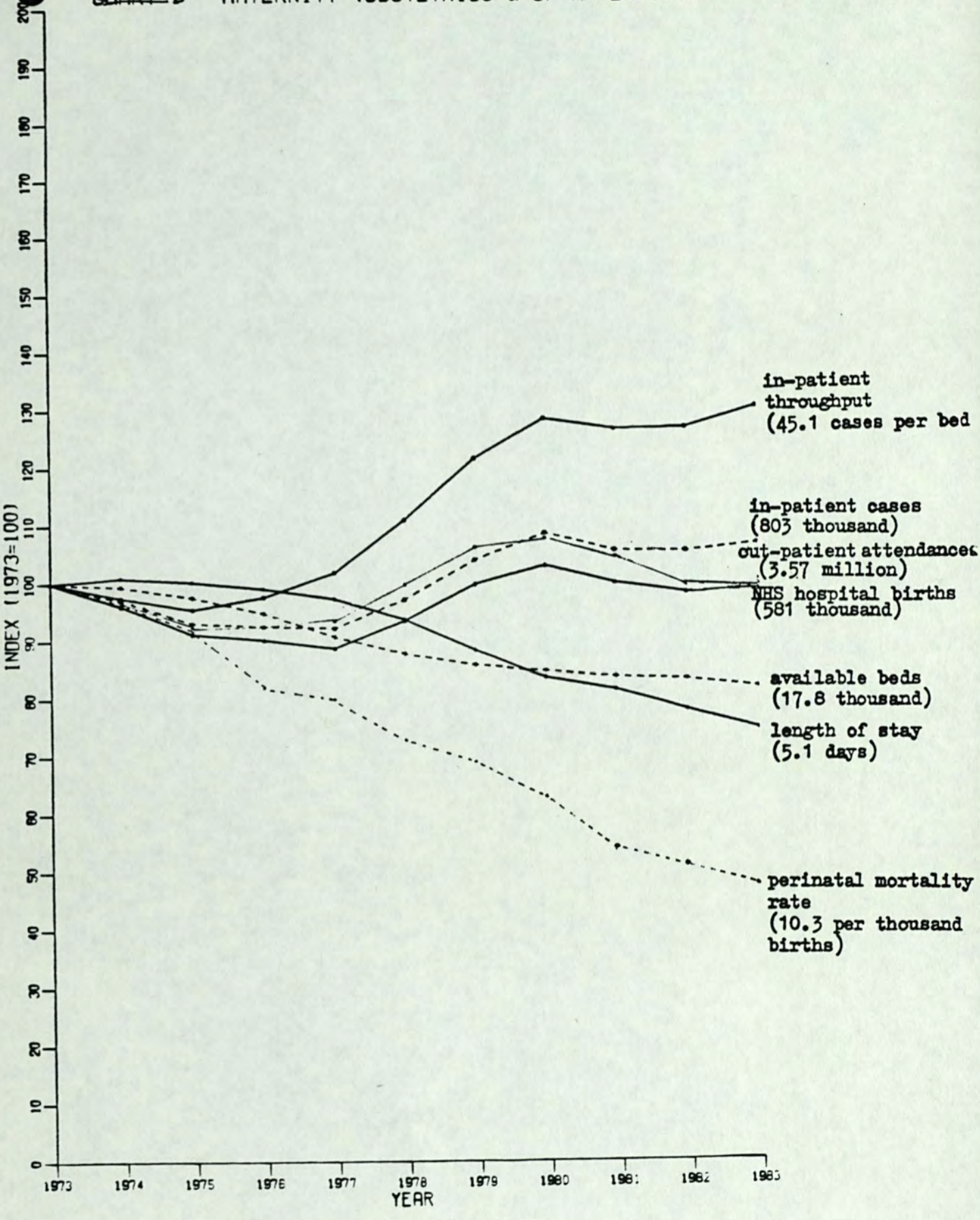
1. The number of births per year fell from 828 thousand in 1964 to 537,000 in 1977; increases were then recorded each year to 1980 (618,000). Since then there has again been some decline to 590,000 in 1982. The 1981 based projections are for a steady increase over the decade 1983 to 1993 (711,000) followed by a fall to about659,000 by 2001.

2. The improvement of maternity and neonatal services continues to be a Government priority, as reaffirmed in Care in Action. The Social Services Select Committee Report on Perinatal and Neonatal Mortality, ~~which was~~ published in 1980, pointed out the problems that were facing these services. The majority of the Committee's recommendations were referred to health authorities for consideration and action. The Social Services Committee published its follow up report in July 1984, and the Government is currently considering its further recommendations. However most health authorities have reviewed their maternity and neonatal services and taken steps to improve them.

3. Real and substantial improvements are being made. There has been a striking reduction in perinatal mortality over the past few years: it has dropped in England by over a quarter in 4 years, from 15.4 deaths per 1,000 births in 1978 to 10.3 in 1983. The drop between 1980 and 1981 represented the largest percentage fall (13%) since perinatal mortality statistics were first collected in 1928. The improvement in perinatal mortality has been accompanied by a continuing reduction in the length of stay of mothers. Table | | and Figure | | shows the main changes in hospital maternity ~~activities~~ services between 1973 and 1983.

FIGURE [ ]

~~CHART D~~ MATERNITY (OBSTETRICS & GP MATERNITY) SERVICES



(Provisional figures for 1983 are given in brackets)

TABLE

HOSPITAL MATERNITY SERVICES

	Changes between 1973–1978		Changes between 1978–1983	
	number	percentage	number	percentage
No of NHS Hospital births (thousands)	- 40	- 6.8	+ 30	+ 5.4
No of in-patient cases (thousands)	- 24	- 3.1	+ 72	+ 9.8
No of in-patient cases per NHS hospital birth(1)	+ 0.05	+ 3.9	+ 0.05	+ 3.8
In-patient average stay (days)	- 0.4	- 5.9	- 1.3	- 20.3
In-patient cases per available bed (throughput)	+ 3.7	+ 10.7	+ 6.8	+ 17.8
Out-patent attendances (thousands)	+ 11	+ 0.3	- 56	- 1.5

(1) Reflects changes in the number of ante-natal admissions to hospital births

~~[ACTIVITIES GRAPH HERE]~~

4. The fall in perinatal mortality reflects a variety of factors including improved standards of care, made possible partly by a greater awareness of the factors likely to contribute to a safe pregnancy and the good health of new born babies, and also by improved staffing (see Table | |) and facilities. Nevertheless there is no room for complacency. Perinatal mortality rates have fallen in other countries also and within England there are significant differences between social classes, and between different areas, which need to be reduced.

TABLE

MATERNITY SERVICES - STAFFING WTE

	1978	1983	% change
Consultants in Obstetrics and Gynaecology	578	650	+ 12
Other doctors	1756	1925	+ 9.6
	1978	1982	% change
Qualified Midwives (1)			
- hospital	12800	13000 (2)	+ 1.9
- community	2800	3500 (2)	+ 17

Maternity Services Advisory Committee

5. In improving services, health authorities have had the benefits of the first two reports of the Maternity Services Advisory Committee, set up by the Secretary of State in 1981 to advise on matters relating to the maternity and neonatal services. So far, the Committee has issued reports on Antenatal care and on Care during Childbirth. The third report will be on postnatal care of the mother and the new born child. As well as giving advice on good practice the Committee recommended in its first report the setting up in each District of a Maternity Services Liaison Committee, including hospital and comunity based professional and lay members, to coordinate the whole spectrum of maternity services. The Government attaches much importance to these committees and especially to the presence of a consumer voice. It has asked all health authorities who have not already set up Committees to consider doing so, and will be seeking reports on their work.

---

(1) adjusted for changes in working hours.
(2) 1982 figures

The needs of mothers

6. Maternity services, particularly those based in big hospitals, face particular problems. While a mother is not "ill" during normal pregnancy and childbirth, complications may occur at any stage of pregnancy that can present a risk to the mother or child. The maternity care that is now available means that many mothers may safety have children who in earlier eras would have become gravely ill or might have died during pregnancy or as a result of childbirth. Preoccupation with routine checks designed to reduce the risks of pregnancy to a minimum, and the fact that what is routine to professionals may cause anxiety to lay people, has meant that some maternity services, particularly antenatal clinics, have been much criticised for failing to treat mothers as individuals, each of whom have personal and individual needs. Much is now being done to "humanise" maternity care and professional staff are increasingly aware of the importance of good communication and the development of trust between them and mothers. The ~~Department~~ DHSS has warmly endorsed the advice on good practice in this area, which the Maternity Services Advisory Committee have produced, and have been encouraged by the response to it by midwives and doctors. If mothers-to-be are not content with the form or style of care they receive, particularly at antenatal clinics, a consequent reluctance to make proper use of these services can only increase the dangers to both child and mother.

Neonatal care

7. Developments in neonatal intensive care have clearly been one factor which has helped to improve the survival prospects of all babies born alive and to reduce the neonatal mortality rate. It is now possible in many cases to keep alive babies born from 26-28 weeks gestation and over. Survival from as early as 24 weeks gestation has been achieved in a few cases. However, comparatively few babies are born at such early ages of gestation in each maternity unit, so that long-term intensive care facilities, required when the baby is likely to need to be in hospital for several weeks, have been concentrated in selected Regional centres. The organisation of neonatal services is being reviewed by the Maternity Services Advisory Committee.

Perinatal Screening

8. Over the past 10 years there have been rapid developments in perinatal screening techniques. Amniocentesis has become more widely available within the health service. This screening test is offered to pregnant women at risk of having a foetus with a chromosomal abnormality, normally women over 35 who have had a previous affected pregnancy, and to those women who on the basis of preliminary serum screening are at increased risk of carrying a foetus with an open neural tube defect.

9. Research on new forms of prenatal screening and the further development of a number of diagnostic techniques has proceeded rapidly during the past 5 years. Most notable among these advances are: (i) the development of DNA based "gene probe" methods to identify specific genetically determined conditions, (ii) the use of high resolution ultrasound scanning, (iii) the development of the techniques of fetoscopy and of chorion biopsy. With these methods it is now possible to detect a very wide range of conditions in the foetus which could not have been identified 5 years ago. For a few conditions treatment of the foetus in utero may be possible; in other cases where treatment is possible arrangements can be made for the baby to be delivered in a hospital with the best facilities for treatment after birth.

Infertility Services

10. In recent years there has been some development of infertility services in the NHS including artificial insemination by donor and in vitro fertilisation. In 1982, because of public concern about the uncontrolled development of infertility techniques which could involve the creation of human embryos, the Government set up the Inquiry into Human Fertilisation and Embryology chaired by Dame Mary Warnock. The Inquiry published its report in July 1984. The report identifies many issues which require subsequent public discussion and debate. Future policy on these issues and further development of infertility services within the NHS will be considered in the light of that debate and the comments Ministers have asked for on the Inquiry's report.

Voluntary Bodies

11. The work of voluntary bodies contributes significantly, directly and indirectly, to raising standards of maternity care and increasing public and professional awareness of the professional and personal issues involved in childbirth. The Government welcomes their work and provides financial support to several national organisations, including the Maternity Alliance, the National Childbirth Trust and the Stillbirth and Neonatal Deaths Society.

The Future

12. The objective must be to continue the improvement in standards of maternity care and in particular to reduce the still significant differences in perinatal mortality rates between social classes and different parts of the country. Health authorities will also need to take account of the upward trend in birth numbers expected over the next decade. The DHSS will be reviewing RHAs intentions in their 10 year strategic plans to be put forward in 1985.

CHILD HEALTH SERVICES

13. These include the specialist hospital based services, the community health services including the School Health Service and those provided by family doctors. Family doctors are working increasingly with community health staff in primary health care teams (see chapter --). The child health services have a strong preventive as well as curative role.

Community Health Services

14. Care in Action emphasised the need to improve the uptake of community based child health services. Some progress has been made. The total number of home visits to the under-5s made by health visitors rose from 7.6 million in 1979 to 8.4 million visits in 1983, an increase of 10%. The proportion of children aged 6 and under attending clinics also rose progressively from 42% in 1978 to 47% in 1981/2 although there was a fall back to

45% in 1983. The number of child health clinic sessions also increased - by 6% between 1978 and 1983 when 366,000 clinics were held.

15. Immunisation and Vaccination continue to be key elements in the strategy for preventive medicine. Progress and objectives in this field are recorded in paragraph | |.

School Health Service

16. The decrease in the numbers of schoolchildren over the past few years has been reflected in the numbers of children examined by school doctors and nurses but the level of service has been broadly maintained. In 1983 just under 1 million children (12½% of the 5-16 population) received full medical examinations and over 4½ million (60% of the 5-16 population) were seen by the school nurse during child health surveillance programmes of whom 5% were referred for medical examination.

Children with Special Educational Needs

17. The Education Act 1981 introduced from 1983 a requirement for detailed individual assessments of children with special educational needs instead of only categorising them by type of handicap. (A child with a special educational need is one who, because of a learning difficulty, is unable to benefit fully from ordinary school, or pre-school facilities, unless special provision is made for him or her). Health authorities now have a duty to advise local education authorities if they think a child might experience learning difficulties (after discussing this option with parents) and must also tell parents of any voluntary organisation which they think could provide help. The written advice provided by health professionals is available to parents who can discuss health aspects of the LEA's statement of special educational need with appropriate health staff. A statement must, where appropriate, include details of the child's health requirements~~, and health authorities are involved in the provision of such services~~.

Services for Sick Children

18. Most illness in children is dealt with by treatment in their own home, from their family doctor with help from the community nursing services and attendances at hospital out-patient departments as necessary, or attendance at hospital on a day care basis.

19. When a child is admitted to hospital the aims are to have unrestricted visiting with overnight accommodation for parents with very young children. Early discharge should be assisted by appropriate arrangements with the community health and family doctor services. Within a general hospital children's beds should be in or linked with a children's department with a consultant paediatrician having a general concern for the arrangements for children.

20. Some measure of the improvements in hospital paediatric services and progress towards these objectives is shown in Tables | | and | |.

TABLE

HOSPITAL PAEDIATRIC SERVICES(1)

	Changes between 1973 and 1978		Changes between 1978 and 1983	
	number	%	number	%
In-patient Cases (thousands)	+ 29	+ 12.7	+ 59	+ 23.1
In-patient Average Duration of Stay (days)	- 1.6	- 22.5	- 1.4	- 25.5
Number of day case attendances (thousands)	+ 5	+ 42	+ 2	+ 12

TABLE

HOSPITAL PAEDIATRICS MEDICAL STAFFING(2)

	1978	1983	% change
Consultants (wte)	420	519	+ 24
Other doctors (wte)	1135	1362	+ 20

(1) includes patients under the care of consultant paediatricians only

(2) including paediatrics, paediatric neurology and paediatric surgery.

21. Between 1978 and 1982 the proportion of children admitted as in-patients treated by consultant paediatricians rose from 32% to 38%. A survey in 1983 showed that 72% of wards admitting children are for children only and that 49% of all wards admitting children allowed unrestricted visiting. Only 14% restricted visiting to less than 10 hours a day; in 1975 the proportion of wards imposing such restrictions was 49%. There is no reason, however, why all hospitals should not have unrestricted visiting of children by parents, and the ~~Department~~ DHSS will be monitoring closely in the next year the action taken by authorities who need to improve their position.

The future

22. An efficient and effective system for regularly assessing the health of children is essential to their proper development. These services are provided in various ways at present, but it is the Government's expectation that increasingly this work will be carried out in a general practice setting by family doctors, and other members of the health care team, for children on the doctors' lists.

12·9·84
CHAPTER

THE CONSUMER

1. Health services are provided for people, and generally depend on the patient's active cooperation. Thus, while judgements need to be made by professionals with the competence to make them, people want to know what treatment is being proposed for them and why, and what, if any, risks and alternatives there may be. They also need to be able to exercise their right to forego what is being offered, to make informed decisions where choices are available, and generally to maintain their dignity and rights as competent individuals. The public also wants to be able to express collective views about the provision of health services and the priorities these reflect; and to feel that due weight is given to these views before decisions are taken at all levels of the service.

2. The achievement of these objectives in practice does however represent a major challenge. Complex moral, social and legal issues can arise, for example over the treatment and care of people who are vulnerable because of old age, mental illness or mental handicap, or over the treatment of children. The law may set the parameters for professional conduct, but it is not generally possible to shape professional attitudes and practices of individuals by diktat, though education, peer influences and social pressures can have strong influence. In practice on many matters the public does not have a united view about what it wants from the health service or how it should be provided - opinion reflects rather the different values and interests of health service consumers, and bodies who speak for them.

3. The Government does, however, firmly support the objectives of making the NHS more sensitive to the needs and wishes of consumers both individually and collectively. It has given expression to this support in a variety of ways.

4. The Government established in 1981 the Maternity Services Advisory Committee which has helped to develop awareness amongst health authorities and professionals of the importance of the views and wishes of women using maternity services. It has also continued to give considerable financial support to major national bodies such as MIND, MENCAP, Age Concern, the National Association for the Welfare of Children in Hospitals, Leagues of Hospital Friends

and the Patients Association, whose work plays an important part in championing the rights and representing the views of groups of health service consumers including those least able to make their own opinions and needs known.

5. Action has been taken to safeguard the rights of the individual patients with mental illness, in particular through the setting up of the new Mental Health Act Commission and new consent to treatment procedures. The Government has also continued to support the work of the Health Advisory Service and the Development Team for Mentally Handicapped People both of which have over the years done much to reflect the views and aspirations of consumers and their rights as individuals.

6. Nearly 36 million people attend outpatients departments in England each year and a significant source of patient dissatisfaction arises from the time spent waiting to be seen. Following a study by the DHSS Operational Research Unit in 1982 a new method of devising appointment and monitoring systems for outpatient clinics has been developed and will be made widely available to health authorities.

7. Health authorities themselves seek to reflect patients' wishes in planning and delivering services. Some have undertaken local surveys of consumer views. Many participate in training and other initiatives aimed at improving services from the patients' point of view. For example, authorities are currently reviewing the organisation of non-emergency ambulance services, particularly so as to improve scheduling of journeys.

8. Community Health Councils (CHCs) were set up in 1974 as independent statutory bodies with a duty to "represent the interest in the health service of the public in their districts". CHCs have statutory rights to information and consultation and provide the public with an independent means of monitoring the provision of services and influencing their development. They get direct expressions of public views, for example through public meetings or by undertaking or sponsoring surveys to assess consumer satisfaction and attitudes. CHCs make considerable use of the model questionnaire developed by the King's Fund for this purpose. Legislation in 1983 gave CHCs the same rights and duties in relation to Family Practitioner Committees as they have in relation to ~~DHAs,~~

District Health Authorities,
which should help to strengthen the consumer voice in the arrangements for family practitioner services. CHCs also advise individuals on how best to make suggestions for improving services or lodge complaints. They can act as a 'patients' friend' in the course of a complaint against a health authority or concerning the family practitioner services.

9. The Government is also glad to see the increasing interest of general consumer bodies such as the National Consumer Council (NCC) and the Consumers Association. It publicly welcomed the publication in 1983 of 'Patients Rights' by the NCC and 'A Patients Guide to the NHS' jointly by the Consumers Association and the Patients Association, and drew them to the attention of health authorities.

Hospital complaints procedures

10. The guidance to health authorities (HC(81)5) on health service complaints procedure emphasised that the responsibility for establishing effective communications with patients rests with nurses, doctors and other health care staff, that the professions concerned accept this, and that a conscious and continuing effort is needed to achieve it. It is clear that where effective communications are established many of the worries and frustrations which give rise to patient dissatisfaction can be avoided and that both patients and staff benefit as a result. Where complaints do arise the Government has made it clear that it wants prompt, thorough and open investigation and effective steps taken to eliminate any weaknesses identified.

10. In 1981 the Government introduced an alternative to the Courts for the review of complaints about clinical judgement. The first two years of these new arrangements have been encouraging. During 1983 the health authorities' regional medical officers dealt with 184 clinical complaints which had failed to be resolved at the local ~~clinical complaints which had failed to be resolved at the local level~~ (about 3% of all written complaints). In 82 of these, independent consultants were asked to undertake a full review of the complaint. Fifty-nine reviews were completed during the year.

In about half, action was recommended for improvement in services. The 1981 guidance asked health authorities to keep the volume and nature of complaints under review so as to identify any trends which could enable improvements to be made.

12. Health authorities receive remarkably few written complaints in relation to the number of patients treated. In 1982 there were about 16,200 complaints about hospital services in England, compared with about 6 million stays in hospital and 50 million outpatient visits a year. The relatively small number suggests that many problems are satisfactorily sorted out - as they should be - orally at ward level. Table [ ] below shows recent tr ends in the number of written complaints.

TABLE

WRITTEN COMPLAINTS RELATING TO HOSPITAL SERVICES (ENGLAND)

Year ending 31. [illegible]	1976		1977		1978*		1981		1982	
TYPE OF COMPLAINT	No	%	No	%	No	%	No	%	No	%
Wholly or partly clinical	6,432	43.2	6,708	44.4	6,498	44.1	6,368	42.7	7,005	43.2
Other	8,450	56.8	8,404	55.6	8,227	55.9	8,550	57.3	9,213	56.8
Total number of written complaints	14,882		15,112		14,725		14,918		16,218	
WRITTEN COMPLAINTS PER 1,000 DISCHARGES OR DEATHS		2.83		2.84		2.75		2.59		2.84

* figures not collected in 1979 and 1980.

13. Patients dissatisfied with the handling of their complaints by health authorities may have them investigated by the independent Health Service Commissioner (HSC) if they are within his jurisdiction. Only a tiny fraction of complaints are in fact investigated by the HSC - 1,178 completed investigations over the last decade. The HSC in his ~~last~~ Annual Report for 1983/84 notes with approval that the DHSS and health authorities have always responded positively

to the proposals he has made about changes in procedures to eliminate weaknesses exposed by his investigations. The annual reports of his activities provide useful indicators of those aspects of the NHS which fall short of the reasonable expectation of patients. Table 5 below, drawn from ~~the HSC's published~~ his 1983/84 report ~~for 1983/84~~, analyses the complaints investigated for the period 1977/78 - 1983/84.

TABLE 5

Analysis of grievances 1977/78–1983/84

Year	Total number of grievances	Nursing	Medical	Administration	Failure in Service	Handling of complaint
1977/78	355	111 31%	99 28%	56 16%	28 8%	61 17%
1978/79	446	147 33%	91 20%	61 14%	31 7%	116 26%
1979/80	344	114 33%	97 28%	50 15%	16 5%	67 19%
1980/81	399	125 31%	94 23%	79 20%	27 7%	74 19%
1981/82	407	107 26%	136 33%	73 18%	26 6%	65 16%
1982/83	368	103 28%	101 27%	59 16%	36 10%	69 19%
1983/84	350	136 39%	61 17%	101 29%	15 4%	37 11%
Totals	**2669**	**843 32%**	**679 25%**	**479 18%**	**179 7%**	**489 18%**

14. The spread of grievances through the various broad headings indicates the room for improvement across the whole spectrum of the patients' experience of the hospital and community services both in their professional and non-professional aspects. It leaves no room for complacency, notwithstanding the relatively small volume of complaints made, and it points up the need for health authorities to give systematic and continuing attention to obtaining the experience and perception of patients and the community about the services provided. The recent NHS Management Inquiry laid much stress on this need and for health authorities to respond directly to this information in the planning and management of services. The Government endorses this judgement. Developing effective means through CHCs and in other ways represents a major challenge for health authorities for the future.

Family Practitioner Services

14. Patients contacts with the NHS are, however, much more frequently with the Family Practitioner Services and in particular their family doctors - there are about 190 million contacts between patients and their doctors every year as compared with 50 million outpatient visits and 6 million hospital in-patient episodes. Consumer surveys in the past have suggested that the public appears to be reasonably satisfied with the care they receive from their doctors. A major study published in 1981 on access to primary health care concluded that the newer forms of practice organisation were no hindrance to accessibility.

15. The number of formal complaints considered by the separate statutory procedures for complaints against doctors, dentists, chemists and opticians in these services is relatively small (approximately 1,300 in 1983). The procedures are designed to ensure that a complaint is always fairly and systematically considered but some complainants find them complex and daunting. The DHSS issued a leaflet earlier this year (1984) setting out in plain English how complaints should be pursued.

16. More generally the Government consider that Family Practitioner Committees need to do more to provide advice and assistance to the public, for example by making more readily available information about how, where and when family practitioner services can be made available; and in ensuring that all patients who wish to avail themselves of services are able to do so. It wishes to see Committees become more responsive to the communities they serve and will be pursuing these objectives with them.

17. The Government welcomes the development in family doctor practices of patient participation groups. While there are still only a few of these, numbers are growing. They are a welcome example of constructive cooperation between patients and doctors at local level in order to improve consumer satisfaction.

JMc

MANAGEMENT OF THE NHS - A MANAGEMENT DEVELOPMENT PROGRAMME

1. The Government's overriding concern is, as stated in HC(84)13*, to see that the NHS provides the best possible service to patients within available resources. There is no conflict between the Government's commitment to sustain and improve the service which people receive from the NHS and the emphasis it has given to the organisation and management of the NHS. Better management leads to better services; poor management is a major disservice to those who seek and depend on ~~the health services~~ them.

2. The NHS is the country's largest single enterprise and possibly its most complex. The challenge of making it run more efficiently and effectively is a massive one. The Government's determination to do so has found expression through a series of different and separate initiatives. But overall they add up to a wide ranging programme which is already showing significant benefits and, more importantly, is laying down a firm basis for the future.

3. The drive for better direction and management in the NHS has been directed towards:

- getting the structure of health authorities right;

- getting the management within authorities right;

- seeing that managers have the information they need to do the job, and the training to use it;

- securing that national policies are translated into effective appropriate local management action and plans;

- improving the accountability of the NHS to the Secretary of State and in turn his own accountability to Parliament and the taxpayer;

- ensuring that management gives the systematic search for better value for money much higher priority than previously.

* HC(84)13 Health Services Management. Implementation of the NHS Management Inquiry Report 1983 (Griffiths Report) June 1984

Getting the Structure of health authorities right

4. This was tackled first. The aim was to bring the local managing authority closer to those actually directing and managing services day by day and to shorten and clarify lines of communication locally. The first step was taken in 1982 when the 90 Area Health Authorities (AHAs - responsible for 208 districts) were replaced by 192 district authorities. The second step, now completed by the Health and Social Security Act 1984, ends the unsatisfactory split accountability of FPCs - to DHAs for administrative management and to the Secretary of State for arranging the provision of services - by making the FPCs wholly accountable direct to the Secretary of State. The abolition of AHAs reduced the total number of chief officers by over 200, contributing towards the drive to reduce management costs. At the same time unit management within districts was strengthened and professional advisory machinery simplified.

Getting the Management within authorities right

5. The Government has accepted the main recommendations of the Griffiths Inquiry which reported to the Secretary of State in October 1983. The Inquiry recommended a wide range of management action for health authorities. To carry out these and their other responsibilities effectively the Inquiry underlined the need to define and develop the general management function, drawing together responsibility for planning, implementation, and control of performance, and to vest this management function in one identifiable person at each level within the NHS who would take personal responsibility for securing action. HC(84)13 set out a timetable for the following 18 months for the appointment of general managers, first at Regional, then at District and finally unit level eg in the major hospitals.

6. Linked to these developments will be changes with the DHSS itself on the lines recommended by the Inquiry Team. The top level Health Services Supervisory Board has already been established, under the chairmanship of the Secretary of State, to assist him in the setting of policies for health services. The appointment to the new post, within the Department, of Chairman of the NHS Management Board recommended by the Inquiry, is being actively pursued.

7. The appointment of general managers will not in any way alter the need for a multi disciplinary approach to management in the NHS. Professional chief officers will continue to be directly accountable, and have a right of access, to their

authority on the provision and quality of professional advice. However, the objective is to secure that the necessary multi-professional process of management leads always to effective and timely management action. This has not happened consistently and sufficiently in the past and it will be the job of the general manager to secure that it does in future. The introduction of the general managers is intended also to enable more matters of day to day management to be settled by officers and to leave health authorities themselves more time to settle the general direction within which their officers should work.

8. Any additional costs arising through the appointment of general managers will be offset within the existing provision for management and not reduce the resources available for patient care.

Information and Training

9. A complex enterprise like the NHS cannot manage its affairs properly without the right information. Too often the information available to NHS management has been incomplete, inaccurate, or out of date, or has not in practice been the kind ~~of information which~~ management needed.

10. The information needs of the NHS have been comprehensively reviewed through the Steering Group on Health Services Information, chaired by Mrs Edith Korner, which began its work in 1980. The work of the Group is now largely completed. Six reports covering patient activity, manpower, ~~and~~ patient transport services, community health services, finance and miscellaneous services have now been published. [DN. to check before publication]. Many improvements in the data collected about patient treatment and the deployment of money and manpower are recommended.

11. The Secretary of State and RHA Chairmen have agreed to implement the Korner recommendations. Their wide-ranging and complex nature means that this will take three to four years and require much planning, preparation and exploitation of information technology.

12. The Government has also sponsored research and trials in measuring the costs of clinical practice and in developing budgeting for clincial work. The objectives are to provide a means for involving clinicians more fully in managing the resources they use and to create incentives for improving the cost effectiveness of clinical management. This means providing information to link clinical activity with resource use and cost. The Griffiths Inquiry gave a major boost to this development by recommending the introduction in each district of management budgeting involving the identification of user budget holders (principally clinicians). As a start four demonstration projects have

been set up with the help of management consultants. Budgets will be built up on planned clinical workload and the costs of carrying it out. This enables the budgetary process to be linked in to district plans and programmes, and performance to be reviewed later against budgets and planned workload. There is potential here for a major breakthrough in local health service management.

13. Health authorities are being advised to implement "Korner recommendations with systems capable of supporting management budgeting. By April 1987 districts should be able to provide the information needed for ~~management budgeting~~ this.

14. The ability of NHS management to analyse its own performance is also being strengthened through the introduction of performance indicators. These provide selective indicators covering clinical activity, manpower, finance and estate management at district or hospital level and enable managers to compare their position with those of other districts and hospitals. The first national package of indicators was published in September 1983 (with HN(83)25, Health Service Management - Performance Indicators). A revised and expanded package is envisaged for 1985 based on the work of the Joint NHS/DHSS Group on Performance Indicators. The new package should significantly enhance the value of the indicators as a means of assessing relative performance and standards of service.

15. Better information and better means of using it will not be effective unless managers, including clinicians, have the necessary skills. The Griffiths Inquiry stressed in particular the need to increase the opportunities for management training of clinicians to fit them for the enhanced managerial responsibilities it recommended they should have. The NHS Training Authority has already set up seminars for the Chairmen and members of NHS authorities on Griffiths implementation; a training programme for new general managers is under consideration and project teams have been set up on the introduction of improved information systems based on "Korner work and the general use of information technology in the NHS.

Turning national policies into effective local action

16. The Government has sought to bring about the maximum possible delegation of responsibility to health authorities locally, as recommended by the Griffiths Inquiry. But the NHS remains a national service in which national policies and priorities are set for service development. Means of securing their implementation consistent with the objectives of delegation are necessary.

17. Planning is the key here. In the past planning arrangements have been over elaborate and the outcomes in practice disappointing.

Revised and simplified arrangements came fully into operation early in 1984 with the issue of HC(84)2 - Resource Distribution for 1984/85, Service Priorities, Manpower and Planning. This required Regional Health Authorities to prepare outline long term strategies in 1984 on the basis of which District authorities will prepare long term plans. From these each Regional authority will produce its ten year strategic plan in 1985. Though varying in detail the outline strategies broadly reflect national policies for the different services and priority groups. Examination of the quantified long term plans in 1985 will be a key feature of the on-going accountability of health authorities through the regional review arrangements (para -) Regional authorities were also asked to submit routinely, starting in 1984, summary reports of the main proposals in Districts' short term (two year) programmes, and to show how, in a quantified way, finance, manpower and the NHS estate were being used together to achieve service objectives. These proposals were taken into account in setting the Regional manpower targets from 1985 (see para[ ] below).

Accountability

18. The Committee on Public Accounts argued in their 1981 report that there needed to be a greater accountability to Parliament for the NHS. In response to these arguments and in line with its own determination to make the maximum delegation to health authorities combined with effective accountability, the Government has introduced a new review system. The key feature is an annual meeting between Ministers and the Chairman and chief officers of each Regional Health Authority at which the Authority is held to account for the ways in which resources are used in their Region, for the efficiency with which services are delivered, and for their plans for future development. In turn the Regional authorities hold their constituent District authorities to account. The outcome of these meetings are recorded in an agreed action plan. Copies of the Regions' action plans are deposited in the Library and made available to F-P-C-s, C-H-Cs- & local authorities.
of the House of Commons, District action plans are discussed at open ~~health authorities~~ meetings of health authorities, and ~~both Regional and District action plans~~ are ~~made~~ available locally ~~to Committees and Local Authorities~~. Follow up is monitored through successive meetings and other means. The Griffiths Inquiry strongly endorsed this approach and advocated its extension within districts so as to provide for the systematic review of performance at ~~the~~ unit level. This recommendation has been accepted and ~~District~~ unit reviews are already underway in many regions. [Similar arrangements are being ~~made~~ considered for FPCs].

19. Two full rounds of Regional reviews have been completed and the second round of District reviews is nearing completion. The subject matter varies in detail from Region to Region depending on what the main regional or local problems are. Common themes have included performance and efficiency, planning, services for the priority groups and manpower. The emphasis in the review is on doing and not simply saying and they are already producing very worthwhile results. They have for example helped to give a strong push to the development of the 'Care in the Community Initiative' (para - above). The reviews have directly stimulated a good deal more planning ~~activity~~ for services for the priority groups, leading to a welcome levelling up in this respect between regions. They have also provided the opportunity to press specific issues, eg perinatal mortality, health education, renal services, where appropriate and for the general follow up of action on major national initiatives such as implementation of Ministerial decisions on the Inquiry Team on Estate Management in the NHS.

20. The Review meetings themselves concentrate on the most important priorities but the review mechanism ensures that a much wider range of matters are examined between the Department and the RHAs before the formal meetings and taken up in action plans. The plans are getting progressively more specific in their requirements which in turn sharpens up the subsequent monitoring process.

21. There is no doubt that the Review process has been widely welcomed within the Service and it is having a significant and beneficial effect on the management of the NHS. It should increasingly do so particularly as progress is made in carrying through the Government's decisions on the NHS Management Inquiry.

Better value for money

22. Securing between value for money is a fundamental task of NHS management. This has not been adequately recognised and acted upon in the past even though NHS has in fact achieved considerable improvements in performance in the last few years, keeping costs in check and providing a substantially increased volume of service. But every large organisation must be constantly and consciously seeking to make better use of its resources. Specific efficiency targets for health authorities were set in the three years 1981/82 ~~and were achieved~~ - 1983/4.

23. Cost improvement programmes: from 1984 onwards these targets have been replaced by a requirement for health authorities to carry through substantial and sustained cost improvement programmes, ie specific and quantified changes

but RHAs to make better use of resources as currently deployed, eg to treat more people or treat them better or to acheive resource savings which can be redeployed more effectively elsewhere. No specific targets have been set. Health Authorities have in their short term programmes (para - above) identified savings in 1984/85 of around £100 million or about one per cent of their current expenditure and Ministers expect this useful beginning to be built on in future years.

24. Manpower control : the NHS is very manpower intensive - with over 800,000 employees and over 70 per cent of health authority current expenditure taken up by staff costs. Making the best use of manpower and ensuring that the total numbers are kept under effective control is accordingly essential to securing value for money. In the past there have been weaknesses in manpower planning and control with the result that increases, however necessary, have not been subject to sufficiently rigorous scrutiny.

25 In line with its manifesto commitment, the Government asked health authorities in 1981 to reduce their management costs by 10 per cent, to 4.61 per cent, by 1985. Indications are that this will be achieved. Whilst administrative and clerical staff have expanded in recent years (see table 3)* much of this has been at the operational level - medical secretaries and ward clerical staff freeing doctors and nurses from clerical duties . The proportion of professional staff, doctors and nurses, and others directly involved in patient care has increased, ~~but not as much as hospital activity measures~~ and hospital activities have increased faster still (table 1 above).*

26 As noted in [para]* in order to encourage the better use of manpower, in 1983 the Government for the first time set specific Regional manpower targets within an overall manpower ceiling. The reduction in staff was more than achieved and the same national ceiling has been set for 1985. The progress will be monitored during 1984/85 to ensure that plans and targets are achieved. Future manpower requirements will continue, as in 1984, to be assessed as part of the normal planning cycle when the annual Regional Summaries of Districts' two year programmes are considered, so as to secure that manpower plans are properly related to service objectives and use of resource generally, and can be seen in relation also to the cost improvement programmes identified by authorities.

27 Other approaches : the Government and the NHS are acting together in a number of other ways to get improved value for money and hence to contribute to cost improvement programmes. These include:

* DN. These are references to material in the chapter 'Achievements, Challenges & Resources.'

: NHS 'Rayner' scrutinies

: competitive tendering

: purchasing

: audit

: estate management (see chapter [ ])

28. NHS Scrutinies The system of special scrutinies within Government begun under the direction of Lord Rayner has been successfully extended to the NHS. Scrutinies examine particular activites to see whether they represent value for money, and if they are needed, how they could be made more efficient and effecitve. They are conducted by NHS officers reporting to RHA Chairmen who report to the Secretary of State. Seven scrutinies in the NHS have been completed; five have been published so far. In the case of three - non-emergency ambulances, other transport, recruitment advertising - RHAs have been requested to take action. The report on residential accommodation is the subject of consultation and action on the report on central stores policy waits on completion of a central review by the NHS Supply Council.

29. Implementation of the transport scrutiny may have the potential of saving £15 million a year by improving management of the activity, and the advertising scrutiny up to £7 million by more effecitve arrangements for national advertising, and £1 million by local improvements. The scrutiny on residential accommodation estimates that sales of property of at least £170 million may be achievable. These are savings for the future and not proven yet. Nevertheless there are prospects for releasing significant resources to improve for patient care and consideration is being given to launching a further round of NHS scrutinies.

30. Competitive tendering in 1982/83 the NHS in England spent almost a billion pounds - more than eight per cent of its total expenditure - on 'hotel' services - cleaning, catering, laundry and linen.

31. In September 1983 all health authorities in England were asked to draw up programmes for testing the cost-effectiveness of these services by submitting them to competitive tender, including in-house tenders. Authorities will be expected to award the contract to whichever bidder can do the work to the standard required for the lowest price, whether this is the in-house service or a contractor.

30. The Government believe that very worthwhile improvement in value for money in these services should be obtained from tendering. In 1982/83 less than two per cent of these services were contracted out. Studies of the use of contractors in cleaning Ministry of Defence hospitals suggest that savings in the NHS could be up to 20 per cent. This is confirmed by experience in which 12 recent NHS contracts have led to annual savings of £1½ million.

31. Although specific programmes have only been requested for domestic, catering and laundry services, health authorities are expected to consider competitive tendering for other services, in addition to engineering, equipment and building maintenance where extensive use is already made of contractors.

32. Purchasing : The NHS is one of the country's biggest purchasers. The supplies bill for the hospital and community health services in 1982/83 was nearly £1½ billion - 12 per cent of NHS expenditure. The Health Service Supply Council was set up in 1980 to maximise efficiency in the supplies expenditure. It has concentrated in areas most likely to produce early economies. Potential savings identified through co-ordinated purchasing of the products in question - ranging from ambulances to disposable syringes - exceed £60 million out of an annual spend of about £1 billion. So far savings are running at £10 million a year so there is still substantial scope for further progress. The evaluation programme run by the DHSS for the NHS identifies best value for money for buying items of medical equipment and may be expanded to cover other important purchases.

33. In 1983 the Council launched a computer based Supplies Information System for the NHS. It has already been adopted by 50 authorities and the target is full implementation by early 1985. National objectives and timescales have been introduced to improve supplies services in specific areas, eg stock turnover. The Council is working with Regional Health Authorities to turn these into Regional targets and is developing appropriate performance indicators.

34. The substantial savings which will be achieved through more efficient purchasing will be available for improving patient care.

35. Audit : The Government has also taken steps to raise the professional standards and scope of NHS audit and to equip it better to help management secure value for money. The recommendations of the Working Group on NHS Audit (1983) chaired by

Mr Patrick Salmon were mainly to that end. The action taken on them should help ~~further~~ to promote improvements in NHS audit. Recent NHS investigations by DHSS auditors aimed at promoting better value for money have included reviews of the deployment of nursing staff and the use and staffing of operating theatres. The NHS's own internal audit is being strengthened. In addition the resources and experiences of the private sector are being drawn on - a number of private firms of accountants are now acting as external auditors of some health authorities and internal auditors of others and are further contributing towards the goal of increased value for money in the NHS.

Summary

38. As this account makes clear the Government has been pursuing a wide ranging programme of action to improve management performance and accountability both in the NHS and the DHSS. Its various initiatives are at different stages of development. Some are already paying dividends in terms of resources saved or released for improving patient care. The Government considers that there is much scope for further sustained improvements, especially through bringing together planning, budgetary and performance review processes at local level, and the involvement of clinicians in resource management. The introduction of the general management function will be an essential key to implementing these and other developments. Many of these are still at early stages. But the evidence is that within the NHS there is now increasing understanding of, and assent to, the need to manage better all the resources available - people, land, buildings, and so on - and that this duty is a central and ongoing obligation of managers at all levels. The Government is encouraged by these signs and believes that NHS management will become increasingly more able to rise to the challenges ahead.

Nat Health: Expenditure

10 DOWNING STREET

From the Private Secretary

7 September 1984

Thank you for consulting us about the possibility that a photograph of the Prime Minister might be included on the front cover of the forthcoming DHSS Annual Report.

I have shown the "mock-up" which you enclosed to the Prime Minister, who would be quite content for the photograph of her to be used in this way.

DAVID BARCLAY

Steve Godber, Esq.,
Department of Health and Social Security.

E. R.

PRIME MINISTER w/end box

The DHSS will be publishing their Annual Report on the Health Service at the beginning of next month, and they would like to include a photograph of your visit to East Surrey Hospital on the front cover. The photograph would be part of a montage, and I attach a mock-up which shows roughly how it would look.

Would you be content for DHSS to use the photograph in this way?

Yes NS

DHSS

5 September, 1984.

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

David Barclay Esq
10 Downing St

4 September 1984

Dear David

I mentioned that we are trying to finalise the cover for the Annual Report on the NHS to be published at the beginning of next month. The attached is one option which we think works quite well. But you thought it would be sensible to check with the Prime Minister whether she would be happy for her picture to be used.

It would be most helpful to have a quick reaction as we will need to finalise the design quite soon and I would like to be able to put a final choice to my Secretary of State as soon as he gets back from holiday.

Yours Norman

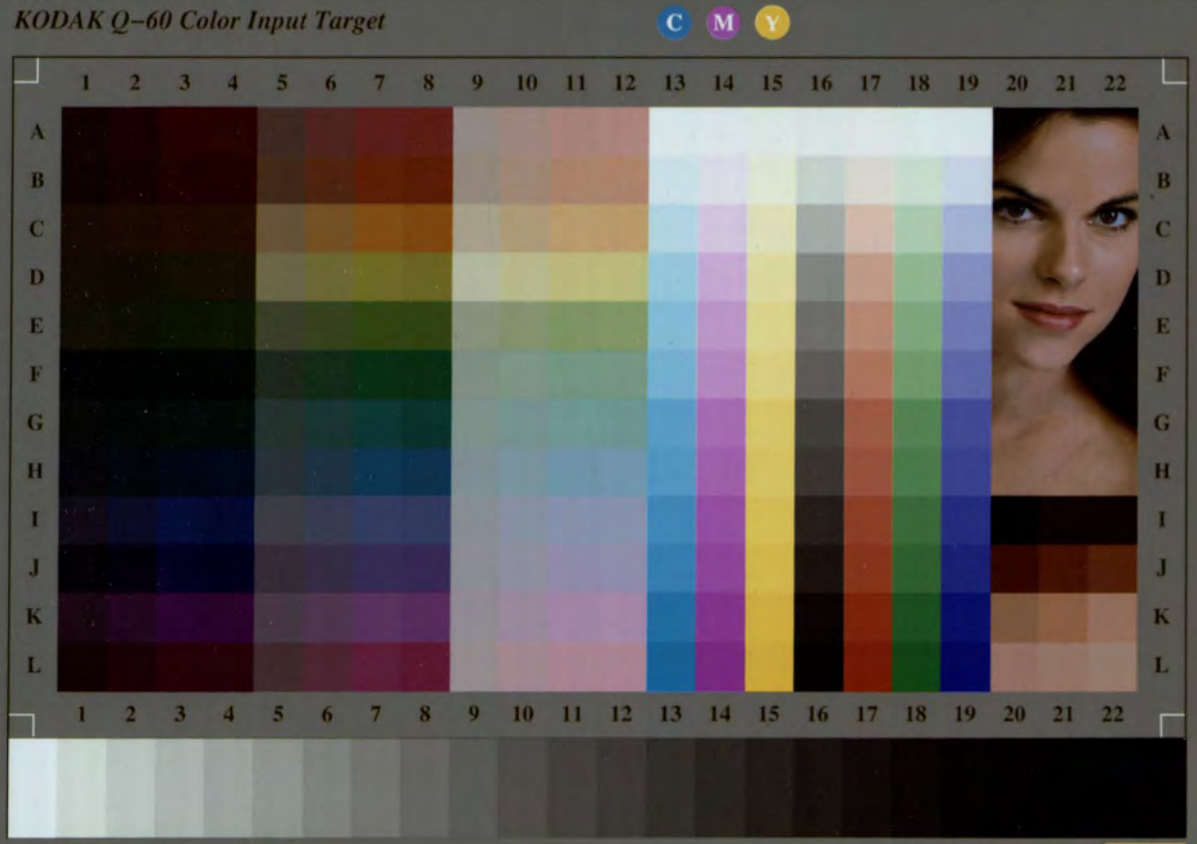
S.A. Norman

PART 3 ends:-

SS/Wales to SS/DHSS 24/8/84

PART 4 begins:-

DHSS to DB 4/9/84


KODAK Q-60 Color Input Target
C M Y
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22
A B C D E F G H I J K L
IT8.7/2-1993
2007:03
FTP://FTP.KODAK.COM/GASTDS/Q60DATA
Q-60R2 Target for
KODAK
Professional Papers
Kodak