753 MT.

Confidential Filing

Private Medical Care.

National Health.

May 1979.

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~22.5.79.~~							
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17.2.86.							

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TO BE RETAINED AS TOP ENCLOSURE

Cabinet / Cabinet Committee Documents

Reference	Date
H(79) 54 memorandum	13/09/1979
H(79) 10th meeting, minute 4	19/09/1979

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

Signed [signature] Date 30/9/2014

PREM Records Team

RLè. ECL

MR. WILLETTS cc Miss Robilliard

PRIVATE PROVISION OF NHS FACILITIES

The Prime Minister saw over the weekend your note about Community Psychiatric Centres. She commented that if one gets underway in her constituency she would like to go to see it.

Could you keep this in mind please and also let Joy Robilliard know the details so that she can also keep it in mind?

DAVID NORGROVE
17 February 1986

Prime Minister 2

DCV

14/2

MR NORGROVE 14 February 1986

PRIVATE PROVISION OF NHS FACILITIES

If this gets under way - I should like to go and see it

MS

The Prime Minister asked this morning if it was true that private provision was always more expensive than services directly provided by the NHS. The future of the Friern and Claybury mental hospitals near her own constituency provide an interesting case study.

Community Psychiatric Centres - a privately run health care organisation - are offering to design, build, staff and operate new psychiatric facilities under contract to the NHS. The service would be free to patients but it would not be provided by an NHS "direct labour organisation". Instead, the private sector would do the job - as happens already in Germany, France and the US.

Community Psychiatric Centres argue that they can undercut any internal NHS project because:

- They don't employ their staff under the restrictive Whitley agreements. Their nurses are actually paid more than the NHS, but they work 40 hours, not 37½ hours, and carry out a wider range of tasks. They also bank up extra nurses who are on call to work at peak times. They have fewer ancillaries than the NHS. Their consultants would, however, remain employed on NHS rates of pay - it is higher pay for doctors which often drives up private health care costs.

- The hospital is run cost-effectively. Only one in 20 patients gets a tray meal: the rest go to one canteen which is shared with the staff. The building avoids "staff traps" - private areas where staff can take a rest.

- Space is not wasted on administrative and clerical support. In one project they are launching in Birmingham, their building has 1,000 square feet for administrative and clerical services; the NHS plans involved 8,000 square feet.

An extra attraction of their plans is that they can get their facilities operational in about half the time it takes to set up a project within the NHS. The patients can therefore be moved out of the old Victorian mental hospitals more quickly. The institutions can then be sold off and the receipts become available to the NHS much more rapidly.

This project may interest the Prime Minister, because her own constituency is involved. It also contains a lesson for the NHS as a whole - the principle of competitive tendering doesn't just apply to ancillary services. A few bold NHS managers are already trying competitive tendering for hip replacement operations, for example. This is a trend to be encouraged.

David Willetts

DAVID WILLETTS

CONFIDENTIAL

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

G.T.N. 2915

From the Secretary of State for Social Services

Duty clerk
No 10 Downing Street.

28 May 1983

We spoke.

I attach a copy of a paper on cooperation between the NHS and the Private Sector which was prepared in this Department and put to one of our regular meetings with Regional Health Authority Chairmen and Members on 30 March 1983. The paper would ~~[illegible]~~ previously have

been seen by senior officers within the Regional Health Authorities and discussed at their own multidisciplinary meetings.

There has been no subsequent action on this paper, following the 30 March meeting, involving our Ministers.

In case you need me I can be contacted on 01-693 0927

Yours

Claire Foster

RHAC (83)6

CO-OPERATION BETWEEN THE NHS AND THE PRIVATE SECTOR AT DISTRICT LEVEL

INTRODUCTION

1. Although the private sector of health care is comparatively small, the benefits to the NHS of a partnership with it are disproportionate to its size. The development of private facilities draws on other sources of finance and increases total health care provision in the country and, in so doing, helps to bridge the gap between the demand for health care and its supply. The independent sector can relieve pressure on hard-pressed NHS services, either directly or by allowing the NHS to direct resources to other areas.

2. The NHS has always made some use of facilities in independent hospitals and nursing homes as a means of providing services to NHS patients. This paper suggests a number of practical ways in which constructive co-operation between the NHS and the independent sector could be further encouraged at district level. The list is not intended to be exhaustive, or to be equally relevant to all districts, but to stimulate discussion on how district health authorities might make more effective use of non-NHS facilities to meet the needs of their localities.

USE OF PRIVATE SECTOR RESOURCES BY NHS

Treatment of NHS patients

3. The NHS already uses the independent sector for the care and treatment of NHS patients on a contractual basis. Some 3,000 beds are occupied by NHS patients, mostly for long-stay, convalescent, post-operative and terminal care. About 24,000 in-patient admissions and 116,500 out-patient attendances take place annually. Health authorities were asked in HC(81)1 to make increased use of the independent sector "whenever it can contribute economically and effectively to the care of NHS patients".

4. The possibilities include:-

a) Short-term use - to overcome temporary difficulties in the provision of NHS services (e.g. to tackle a long waiting list; to maintain a level of service while NHS operating theatres or other facilities are closed for repair or building work).

Longer-term contracts - enabling more effective use to be made of total resources (e.g. provision of a specialised service where it is more economic to use existing spare capacity of an independent body than to develop an NHS facility; use of independent sector provision for elderly people - see below).

c) Amenity beds - being designated in private hospitals or nursing homes with which a health authority has contractual arrangements. The amenity bed charges would accrue to the authority and offset part of the cost of the contract.

Care of the elderly

5. Health authorities could assess the scope for contracting with nursing homes (where charges average between £135 to £200 a week) for the care of elderly NHS patients, so 'freeing' NHS acute beds and enabling unsatisfactory geriatric accommodation to be closed.

6. Health authorities could make use of available independent sector capital by arranging for private companies to provide facilities which the authorities would contract to use. (We know of one company with extensive experience of running nursing homes in Canada, which is interested in a development of this sort).

Equipment

7. Difficulties in buying expensive items of equipment used in the diagnosis and treatment of patients could in some instances be eased:

a) In private sector premises - Several private hospitals and diagnostic centres have under used "high technology" equipment. NHS access could be on a time share cost per hour or cost per treatment basis .

b) In NHS premises - Independent sector capital might be used to provide expensive equipment for, say, a district general hospital on the basis of a leasing/rental agreement (or for joint use by a NHS and a private hospital).

Support Services

8. Many private hospitals have well equipped laboratories, some of which are underused. They could do laboratory investigations required in the diagnosis and treatment of NHS patients. At least one commercial organisation offering hospital laboratory services is keen to provide services to the NHS.

Staff accommodation

9. Health authorities might arrange for NHS staff accommodation to be provided by private companies. With new hospital developments this could involve new purpose-built housing units run on a commercial basis but with rents staff could afford. Existing staff quarters might be sold to private companies and also run on a commercial basis. Or the staff accommodation might be leased to the health authority, with or without private management.

USE OF NHS RESOURCES BY THE PRIVATE SECTOR

Equipment and supplies

10. Where a health authority has contracted with any person or body (including a voluntary organisation) for them to provide or assist in providing any services under the NHS Act 1977, the authority may, under Section 23 of the Act, make available - temporarily (including on loan) or permanently - "any facilities (including goods or materials, or the use of any premises and the use of any vehicle, plant or apparatus") provided for any NHS service, and "the services of persons ..... employed by the health authority in connection with it". The authority may do so on such terms as to payments as it considers appropriate. An advantage of co-ordinated purchasing is, of course, that there could be a beneficial effect on the prices charged to the NHS for contracted services.

Accommodation and services

11. Under Section 58 of the NHS Act 1977 (as amended by Section 10 of the Health Services Act 1980), health authorities can allow use of NHS "accommodation and services" for non-NHS purposes. Charges are for local determination and should normally cover the full cost, but a flexible approach may be adopted if this is of benefit to the NHS (e.g. for short-term arrangements where the health authority has spare capacity). An example of the ways in which Section 58 can be used is the provision of pathology and radiology services to private hospitals and nursing homes. Such arrangements offer a useful way of avoiding wasteful duplication of support services between the two sectors.

Disposal of NHS land and accommodation

12. Health authorities have been advised in the Land Transactions Handbook that there may be advantage to the NHS or that it may be in the public interest to allow surplus NHS property (land and accommodation) to be purchased by a body providing health services complementary to the services provided by the health authority. Any such priority sale would be by private treaty at a market value assessed by the District Valuer. The extent to which this guidance has resulted in sales to the independent sector is not known, though it is not thought to have resulted in many such transactions. The report of the inquiry into "underused" and surplus land published recently by HMSO points the way to increasing the availability of surplus NHS property for such purposes.

STAFF RESOURCES

Training

13. Health authorities were encouraged in HC(81)1 to explore with the independent sector ways in which they might co-operate in developing training and to consider joint training courses, seminars, and study days for staff at all levels. Some possibilities in relation to nurse training include:

a) a close nursing link could be developed between the independent hospital, the district school of nursing and/or the Regional Nurse Training Committee;

b) current proposals aimed at the professional development of newly-registered nurses could be implemented jointly by the district health authority and the independent hospital;

c) the two sectors could pool their expertise and facilities to provide "development" packages for the continuing education of their qualified staff.

Movement between sectors

14. There is advantage in the movement of trained staff between the public and private sectors; it should not be impeded by unnecessary restrictions. Representations have, however, been made by the independent sector that increasing difficulties are being experienced by their nursing staff who wish to return to the NHS. The Nurses and Midwives Whitley Council's agreement on re-appointment, for example, gives employing health authorities discretion to decide if credit may be given for service in independent sector hospitals when determining the commencing salary, but they are said often not to do so.

NHS PRIVATE PATIENT FACILITIES

15. There are 2,800 authorised "pay-beds" in the NHS from which health authorities in England obtain an income of £50 million a year. Of these 500 beds (including 250 for emergency admissions only) have been authorised since the dissolution of the Health Services Board. Although pay beds are not particular beds in a hospital, many hospitals do in fact set aside certain beds, often in a separate ward or wing, for the use of private in-patients. A number of these "private wings" offer a poor standard of decoration, furniture, and furnishings and several compare unfavourably with other in-patient accommodation at the hospital. This suggests that authorities are not spending pay-bed income on improving private patient facilities. The Health Service Commissioner has criticised the level of the (centrally determined) charges payable for some of these private patient beds as "unconscionable" in relation to the quality of the accommodation provided.

16. This suggests that consideration should be given to how standards can be improved - and income maximised. Possibilities which might be considered include:

a) Independent sector donations - The provident associations and other insurers might be encouraged to make donations to finance the upgrading of NHS private patient facilities for the benefit of their members generally. An attraction for them would be that NHS charges could be held below private "for-profit" hospital rates.

b) Independent sector management - Pay beds being managed for a fee by the independent sector, but remaining NHS beds for which the statutory charges would continue to apply.

c) Sale to the independent sector - A ward or wing being sold to the independent sector, which would run it outside the NHS but would have guaranteed access to the main hospital facilities.

CONCLUSION

17. Chairmen's views are invited on the suggestions made in this paper for increased co-operation between the public and private health care sectors. Chairmen may have other ideas for fostering co-operation. In addition, do Chairmen think that (i) Ministers could usefully table a paper on these lines when they meet DHA Chairmen shortly? (ii) that Regional Chairmen themselves might discuss these and similar suggestions with their own DHA Chairmen?

FEBRUARY 1983

NI7639 4 XXX 181

HATTERSLEY DELIVERS ULTIMATUM

SHADOW HOME SECRETARY MR ROY HATTERSLEY TODAY ISSUED AN ULTIMATUM TO MRS THATCHER TO PUBLISH A GOVERNMENT DOCUMENT ON THE NHS - WHICH HE SAID ''WILL DESTROY THE TORIES' CARING IMAGE.''

HE SAID THE INTERNAL DOCUMENT, CO-OPERATION BETWEEN THE N.H.S. AND THE PRIVATE SECTOR, WAS LEAKED TO LABOUR PARTY OFFICIALS.

THE DOCUMENT, HE CLAIMED, PROPOSES:

::PUTTING ALL GERIATRIC CARE INTO THE PRIVATE SECTOR.

::PUTTING ELDERLY PEOPLE INTO PRIVATE HOMES.

::SELLING OFF WARDS AND HOSPITALS TO THE PRIVATE SECTOR.

:: ALLOWING THE PRIVATE SECTOR TO BUY SPECIALISED N.H.S. FACILITIES.

MR HATTERSLEY WARNED THAT UNLESS THE CONSERVATIVES PUBLISHED THE REPORT BY TUESDAY, LABOUR WOULD PRINT COPIES.

''IT IS GOING TO DESTROY THE CARING IMAGE OF THE TORIES,'' HE SAID AT ST GILES' HOSPITAL, PECKHAM, SOUTH LONDON, WHICH IS THREATENED WITH CLOSURE.

SHADOW HEALTH MINISTER MRS GWYNETH DUNWOODY SAID: ''WE WANT PEOPLE TO KNOW THAT FAR FROM BEING COMMITTED TO THE N.H.S., THE TORIES WANT TO SUBSIDISE THE PROFIT LEVELS OF THE PRIVATE SECTOR.

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281240 MAY 83

cjt

National Health DAVID ✓

You asked about this - a table of the charges is attached.

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

MS
25/9

Nick Sanders Esq
Private Secretary
10 Downing Street
London
S W 1

21 September 1979

Dear Nick,

You asked for a note on charges to private patients treated in NHS hospitals. I enclose a paper prepared by the Department.

Yours ever
Don.

D BRERETON
Private Secretary

encl

dao

CHARGES TO PRIVATE PATIENTS TREATED IN NHS HOSPITALS

Legislative position

1. The Secretary of State for Social Services is required by the NHS Act 1977 to set charges for private patients who are treated at NHS hospitals. Section 65 of the Act relates to in-patients (ie pay bed patients) and section 66 to out-patients.

a. Private resident patients (in-patients)

The provisions are for annual determination (from 1 April) of charges for different "classes" of hospitals. Charges must "have regard so far as is reasonably practical" to the total cost it is estimated will be incurred in the provision of services for resident patients in each class. A contribution for capital expenditure can be added.

b. Private non-resident patients (out-patients)

A very general provision allowing determination of different charges for different accommodation, services and circumstances.

Basis of charges

2. Within this legislative framework the method used in calculating charges for both resident and non resident patients is based on the principle of trying to recover the cost to the NHS of providing the service. We do not aim to make either a profit or a loss. The current method is to base charges on average cost of providing services in hospitals which are authorised to provide accommodation or services for private patients. The consultant charges patients separately (and without restriction) for out-patient and in-patient treatment (except under Section 65(1) - private patients of the hospital).

a. Resident patients

Hospitals are classified into six classes: long stay, psychiatric, non-teaching district, London teaching district, provincial teaching district and London Specialist Post-graduate teaching hospitals.

A charge per day is determined for each class. This is based on total in-patient costs for all services for all hospitals with pay beds in each of the classes. The average cost of an in-patient day in the immediately preceeding financial year is obtained by dividing total hospital expenditure in each class by total in-patient days. This figure is then revalued to estimated pay and price levels in the coming year. Additions are made for administration (2½% on each class, based on cost of BG, AHA and District Administration) and capital (based on a 3-year rolling average of capital expenditure in each class). There is a 10% surcharge for a single room and a lower rate where the patient is paying the consultant separately. (The attached Parliamentary answer describes the method of calculation in rather more detail).

b. Non-resident patients

Similar to resident patients. Hospitals are grouped (4 classes) and charges are based on the average cost of each out-patient procedure in each class. Additions are made for capital and administration. Some procedures (eg expensive courses of drugs) are left for local calculation.

Future charges

3. Pay bed charges become due for revision on 1 April 1980. (Private out-patient charges, though not statutorily required to be reviewed annually, are always revised at the same time). As part of the review DHSS will be looking at the method of calculating charges with a view to making improvements within the existing statutory basis. The aim will be to ensure that charges reflect actual costs as closely as is practicable. One point the Department will be looking at is the criticism by the Royal Commission on the NHS that the method of calculating the addition for capital bears "little relationship to the cost of providing a hospital bed in the private sector" and their recommendation that the charge should cover both interest and depreciation. The Department will be considering this and will be discussing with Treasury a new method for calculating this addition. Other refinements of the charging system which are being considered are:

For in-patients

More classes of hospitals, thus reducing the extent of "swings and roundabouts" within the present broad groupings;

Higher charges for very high cost procedures (at present the charge is an "all-in" one regardless of the particular treatment being given);
Higher charges for the first few days to reflect higher costs of medical/ nursing care for first part of a patient's stay.

<u>For out-patients</u>

More local calculation of charges by health authorities for very high cost procedures.

PRIVATE SECTOR CHARGES

NUFFIELD NURSING HOMES TRUST

4. The Nuffield Nursing Home Trust is the largest independent hospital group, and there are now 30 NNHT hospitals with a total of 1000 beds. Nuffield described their charging system as the "art of the possible": there are - they say - no end to the possible complexities but they have to draw the line at the point where the system would get too complicated and too expensive to administer. They recognise that there is a large element of swings and roundabouts.

5. Their starting point is the total costs of running the hospital plus "profit". Charges are calculated to recover this total sum. Individual charges are based so far as possible on calculated cost but there is also some adjustment to what "seems sensible" where fully accurate costing is impossible.

6. Patients pay a basic bed charge which includes all nursing, ancilliary staff, administrative, food, cleaning, heating and similar services. This charge is £2.00 per day higher for the first 5 days to reflect higher medical and nursing dependency during this period. On top of this they pay for services used eg use of operating theatre, physiotherapy, X-ray The operating theatre charge varies according to 'type' of operation (Major £40, intermediate £32, minor £13; this does not of course include consultant charges. It does include nursing services and normal dressings. There might be an extra charge if exceptional services were involved). There are scales of charges for different pathology and radiology tests.

7. The principles behind the NNHT system are very similar to those relating to NHS pay beds. The NNHT system is more sensitive to individual costs, but the fact that they are totally geared to charging and costing makes this a much easier task. It must also be one of their main priorities and justifying proportionately high administrative costs.

8. Some charges are the same throughout Nuffield, others vary (eg the bed charge is higher in Central London). In the provinces the bed charge at about £300 per week is close to the all-in pay bed charge for non-teaching district hospitals.

Other private hospitals

9. We do not have much information about how other private hospitals arrive at their charges. The charges at most private hospitals seem to be of the same general magnitude as pay bed charges, but some private hospitals are geared to providing treatment for "oil sheikhs" and the like, and their charges are much higher. (At October 1978 the charges at the London Clinic and the Wellington Hospital ranged up to about £1500 per week, as compared to £300-£450 in NHS pay beds. The private hospital charges are for accommodation etc only, whereas the pay bed charges are "all-in" bar the consultant's professional fee).

Thursday 6 April 1978
Written Answer
Tuesday 11 April 1978

PQ 2765/1977/78
Han Ref Vol 947
Col 383-6

PAY BED CHARGES

114 Mr Patrick Jenkin (C. Redbridge, Wanstead and Woodford)

To ask the Secretary of State for Social Services, if he will now set out the information and method upon which pay bed charges are based.

MR DAVID ENNALS

Section 65 of the National Health Service Act 1977 lays down the method to be followed in determining new pay bed charges operative from 1 April each year. Under Subsection (3) I have power to classify health service hospitals and determine the charges to be made within each class for the accommodation and services provided at a hospital falling within each class. In determining the charges I am required to have regard to the total cost which, by reference to the facts known to me at the time of the determination, it is estimated will be incurred during the year commencing 1 April in the provision for resident patients of services at hospitals within each class. I also have power to include such amounts as appear to me proper and reasonable by way of a contribution to expenditure properly attributable to capital account.

The method for calculating charges for 1978/79, summarised in the schedule below, is as follows:-

a. The in-patient costs in 1976/77 for each hospital with pay beds were averaged for each of the six different classes of hospital. These average costs were increased to take account of administrative costs at District and Board of Governors level (which were not included in the hospital costing returns), movements in NHS pay and prices during 1977/78, provision for inflation in 1978/79 and planned increases in the real level of expenditure on the service. This produced an average cost basis for each class (item 1. of the schedule).

b. An addition in respect of capital was calculated by reference to the average capital expenditure on hospital in-patient services for the years 1975/76 to 1978/79 (estimated) at 1978/79 prices. This expenditure is experssed as the cost per occupied bed per week at item 2. The full resulting amount of £20 per week was not included in the charges for long stay and psychiatric hospitals since most capital expenditure is outside these classes, which attract very few private patients.

c. Items 6.-9. of the schedule gives details of the adjustments made in accordance with Section 65(4) and (5) of the Act depending on whether the patient occupies a single room or other accommodation and whether he is paying the consultants separately for treatment. The daily charges are rounded to the nearest 10 pence.

[redacted]

N.B. - The latest charges came into effect on 1. April 1979

TABLE A

PRIVATE RESIDENT PATIENT CHARGES 1979/80 (1978/79 FIGURES IN BRACKETS)

Class of Hospital	Charges for patients not paying Consultant(s) Separately		Charges for patients paying consultant(s) Separately	
COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
	Single room	Other Accom	Single room	Other Accom
CLASS A. Long Stay Hospitals	31.20 (27.20)	28.50 (24.80)	29.80 (25.90)	27.10 (23.60)
CLASS B. Psychiatric Hospitals	19.10 (16.20)	17.50 (14.80)	18.30 (15.50)	16.60 (14.10)
CLASS C. Acute and other (N/T) Hospitals	52.50 (44.80)	47.90 (40.90)	50.30 (42.80)	45.70 (38.90)
CLASS D. London Teaching (other then A,B or C)	78.80 (69.30)	72.00 (63.60)	74.40 (65.30)	67.60 (59.40)
CLASS E. Provincial Teaching (other than A,B or C	61.60 (52.00)	56.30 (47.50)	58.20 (49.00)	52.90 (44.60)
CLASS F. London Postgraduate B G's	83.30 (70.70)	76.20 (64.70)	78.70 (66.60)	71.60 (60.60)

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TABLE B

PRIVATE NON-RESIDENT CHARGES 1979/80
(COMPARED WITH 1978/9)

		"London U/G TH District" £ (Class D)	"London BG" £ (Class F)	"Non London TH District" £ (Class E)	"Non Teaching District" £ (Classes A-C)	1978/79 CHARGES (+)
1.	General consultation	5.80	5.70	3.80	3.30	3.20
2.	Day cases	10.50	10.50	10.50	10.50	9.60
3.	Pathology	3.30	5.00	2.80	2.70	2.40
4.	Radiodiagnosis (* Per Work Units)	0.38	0.41	0.38	0.33	not comparable
5.	Radiotherapy	6.90	8.70	7.80	6.10	{3.20 {5.00
6.	Physiotherapy and Remedial Gymnastics — Single:	2.10	2.60	1.70	1.60	1.60
	Compound:	4.20	5.20	3.40	3.20	3.20
7.	Occupational Therapy	4.00	4.10	3.20	2.60	{1.60 {3.20
8.	Audiology — Session:	3.80	11.80	5.40	3.10	3.20
	Session + Instruction:	5.70	17.70	8.10	4.70	4.80
	Psychologists report:	7.60	23.60	10.80	6.20	6.40
9.	ECG	5.00	5.00	5.90	3.20	6.40
10.	EEG	14.90	14.90	12.70	13.60	6.40
11.	Electro-myography	10.00	10.00	9.30	8.40	6.40
12.	Use of operating theatre — Under 10 mins:	11.10	10.90	8.90	8.70	} 17.50
	10-30 mins:	22.00	21.60	17.50	17.20	
	over 30 mins:	32.90	32.30	26.20	25.70	

NOTE Classes: Class A long Stay Hospital. Class B Psychiatric Hospitals. Class C Acute and other (NT) hospitals. Class D London Teaching (other than A, B or C). Class E Provicial Teaching (other than A, B or C) Class F London Postgraduate BCs.

* Work unit values for all procedures are listed in HM(73)29. There is a minimum charge for all procedures of 20 units or less and charges for procedures or combinations of procedures with unit values in excess of 20 are calculated according to the charges per unit value shown at item 4 above.

\+ In 1978/79 there was a single charge covering all types of hospitals. The basis of some of the charges was also revised to reflect more accurately actual costs.

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

2

POA/2711/20

The Rt Hon Michael Jopling MP
Government Chief Whip
12 Downing Street
London SW1

Prime Minister
I understand you enquired about the legislation time-table for the Health Bill.
This note explains.
31 August 1979

Dear Michael,

HEALTH SERVICE (MISCELLANEOUS PROVISIONS) BILL

In your Private Secretary's letter dated 15 August to the Home Office referring to Gerry Vaughan's letter, dated 2 August, to members of Home Affairs Committee about the borrowing limit of the General Practice Finance Corporation it says that you understand that Royal Assent would not be required for the Health Service (Miscellaneous Provisions) Bill until November 1980. I hope that this is not correct.

As Gerry Vaughan explained in his letter, we intend that this bill will deal primarily with the Government's proposals on private medical practice. In the consultations on these proposals, with the medical profession and other interests, we have said that we want to introduce legislation as soon as possible after the summer recess. The proposals were circulated in correspondence to Home Affairs Committee before consultations began. There are two main reasons for urgency - first that the Health Services Board is continuing to put out recommendations for phasing out pay beds which, under current legislation, I am obliged to implement; and secondly that the Board itself comes up for reappointment in January 1980 and it would be very embarrassing for us if the Bill was not by then well on the way to completing its passage through Parliament. (Ideally this measure should be on the Statute Book before the date for reappointment.) Consultations on the proposals have been cut short so that we can work to this timetable and we will be putting their final proposals next month to Home Affairs Committee. I realise that the timetable we have in mind is extremely tight but we are driven to it.

I take your point about the desirability of avoiding a separate one-clause Bill dealing with the General Practice Finance Corporation's borrowing. There should be no need to press for this provided the Health Service (Miscellaneous Provisions) Bill can be enacted in line with the timetable I have outlined, which would enable

E.R.

us to deal with the borrowing limit before the Corporation effectively ceases to function. But it is essential for us to move quickly on both these issues and I do not see how we could live with the consequences of allowing the Health Services Board to continue to phase out pay beds in NHS hospitals.

I am copying this letter to the other recipients of this correspondence.

Yours ever

Peter

cc Miss Spencer
Mr Wormald
Mr Cashman
Mr C.H. Wilson
Mr R.P.S. Hughes

Nat. Health Subject filed as Nat. Health: June 1979 1945
Report of Royal Commission on NHS

NOTE OF A MEETING BETWEEN THE PRIME MINISTER AND PROFESSOR SIR ALEC MERRISON, CHAIRMAN OF THE ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE, WITH THE SECRETARY OF STATE FOR SOCIAL SERVICES AT 10 DOWNING STREET AT 1945 ON 29 AUGUST

The Prime Minister said that the Secretary of State was already putting in hand some of the organisational changes recommended by the Royal Commission. One of her concerns was in the Report's recommendations on private medicine. There was a risk that it would be impossible to keep the best doctors in some areas if pay beds were eliminated. Sir Alec Merrison said that the pay beds issue had been a red herring. It was unfortunate that one political party had adopted it as a symbolic issue. The Prime Minister agreed that the issue was a red herring if the Government chose not to cut out pay beds.

The Prime Minister expressed her surprise at some individual recommendations, for instance the support for comprehensive fluoridation. She had once been in favour, but had recently found the case against argued convincingly. Mr. Jenkin said that the recent United States court case had been wrong. There was now encouraging progress in this country; Warwickshire had recently decided to adopt fluoridation. The Prime Minister commented that fluoridation retarded decay but did not prevent it. Sir Alec Merrison said that this was not strictly true. The Birmingham experiment, where figures covered a long period, had demonstrated the benefits. The Commission had recommended a clear commitment. Mr. Jenkin said that this was in line with Government policy.

The Prime Minister said that her major concerns on the Commission's Report were over finance and accountability. She saw a need for much more money coming into the health service from private sources. She drew attention to the health systems of France, Germany and New Zealand. If tax could be reduced the people would be prepared to pay for more services themselves. It was on this basis that she still favoured a voucher system for education. Many expensive new techniques were now being developed in health care: if all were to be introduced through the NHS, its claim on public spending would get completely out of control. However, the current system often left the individual with a lack of choice: he had to accept the nearest facilities. She had noted the Commission's argument that much of the existing finance was used in ineffective ways. Sir Alec Merrison said that he had never believed in pouring in funds as a means of improving performance in any sphere. But he wished to

/ emphasise

emphasise that the great achievement of the NHS lay in its primary services within the Community, and not in expensive curative medicine in hospitals. Indeed much of the achievement was in the number of people kept out of hospital. He pointed out that the treatment for a single brain-damaged child who might die young could well cost £¼million. This kind of case unbalanced the finance. The current condition of the NHS would not be dramatically improved across the board even if an enormous cash injection were available. Mr. Jenkin commented that there had been an enormous cash injection in 1974, largely in pay for nurses and ancillary staff. This proved the point. The Prime Minister asked if the NHS made the right use of nurses. In the United States, nurses were reserved solely for professional purposes. Sir Alec Merrison said that the Commission had not looked at the use of staff in detail. He felt that nurses were effectively used, but there was considerable manpower waste elsewhere. The NHS employed 5% of the national work force.

Reverting to the question of private medicine, Professor Merrison said that he strongly favoured the Prime Minister's twin efforts to switch charges to expenditure from income, and from the public sector to the private sector, through the economy. But he did not believe that there was much scope in either direction in the NHS. The state was obliged to protect the young, the old and special groups such as the mentally handicapped. These were expensive in themselves. For a number of other groups, private medical insurance was beginning to be a perk. Speaking as one who almost lived on perks, he strongly disapproved of this. Private health should not become simply a fringe benefit. Mr. Jenkin commented that the Treasury were taking a tough line on the Conservative Manifesto commitment to reconsider tax exemption for health insurance subscriptions.

Sir Alec Merrison commented that perks were inherently unsatisfactory, and were largely designed to evade wider national policies. Within the Commission, there had been a range of views on private medicine. One member only had been wholly against. Personally he distrusted monopolies, especially state ones. The NHS had worked. To date, no Government had found it necessary to take drastic measures to encourage private medicine owing to failures in the NHS. But private medicine must survive in effective forms. This offered rival standards against which

/ to check

to check NHS performance. He saw the possibilities for private medicine as limited but of great importance. The NHS existed on such an extraordinary scale, and with such complex functions. But, he commented, he had never been in hospital as a resident patient. This was true of many people. It was a delusion to judge NHS performance by intensive hospital care, whilst disregarding its basic community functions. The Commission was convinced that this was better than was to be found in any other country.

Mr. Jenkin said that the Report's main weakness was that it took insufficient account of the local authority role in the basic community function. Sir Alec Merrison conceded that the Report was flabby on this. It had been a point of argument. A number of members, not only those strongly championing local authorities, had wanted a local authority take-over at the NHS local level. Mr. Jenkin commented that his officials were totally hostile to any suggestion of changing the basis of NHS financing. It was difficult even to get them to consider this. Sir Alec Merrison said that insurance arrangements could only work for the fringe areas of the service. Mr. Jenkin compared the percentage of health care costs made by the tax payer in the United States (60%), and the UK (nearly 100%), with France and Germany in between: he wanted to bring the UK figure down to somewhere between 75% and 95%, with a small amount of acute care funded separately. His intention was that medical service as a whole would have more resources in this way. The Prime Minister said that she and many others liked to be able to choose who would treat them or their dependants. Sir Alec Merrison said that most NHS clients could only rely on their GP's advice. This issue merged into the one of medical career structures. Young staff had to start their work somewhere and if all patients could demand the most experienced doctors there would be major problems.

The Prime Minister said that she was alarmed at the sheer wastage of drugs, not only through patients taking unnecessary drugs, but through over-subscription of drugs which were never used. Mr. Jenkin agreed that initiatives had to be found to encourage sparing prescription. If doctors, individually or by area, could be given a target budget, in the knowledge that if they saved within this budget the funds could be released for other uses in their areas, there might be risks of too much corner cutting, but it was worth a try. He had given a pre-election

/ commitment

commitment on the annualisation arrangements. He was now having great difficulty with the Treasury over the carry-over of unspent funds and he needed support on this. The Treasury feared a loss of control over aggregate spending. They also feared that this would lead to over spenders being free to draw down from the following year's funds. The Prime Minister said that the Treasury were nervous of losing the benefit of underspends on capital account, but this should matter less on the current expenditure.

The Prime Minister inquired about progress on the Health Bill. Mr. Jenkin said that his problem would be Parliamentary priority. The Chief Whip was now forecasting completion by November 1980. Mr. Jenkin required this by April 1980 and needed support.

The Prime Minister said that the Commission found the NHS lacking leadership at all levels. This was a fierce indictment. Sir Alec Merrison said that this was not spelt out in the Report, although he had drawn it to her attention. Within hospitals, leadership had disappeared for a variety of reasons. Sir Derek Rayner had told him that administrators in the largest hospitals earned less than managers in the smallest Marks and Spencer stores. Mr. Jenkin said that the health service structure did not allow the promotion and rewarding of able young administrators for these key jobs.

Sir Alec Merrison said that the hospital level required the active involvement of lay people. At district level there was none. Mr. Jenkin said that this need was widely recognised. His Department could move fast. At present, the committee structure was overwhelming. It would be massively reduced through the pruning of one tier of administration. He pointed out that the Government's working definition of Quangos had excluded health authorities. The Royal Commission's Report had also been very sound on problems of function management, where each trade or specialism retained its own hierachy. The exercises of putting right local leadership and lay involvement were linked. In single district areas this could be done quickly. In two-tier areas, the administration would first have to be sorted out. The real problem was the proposed devolution of Parliamentary accountability. He recognised the Royal Commission's dislike of the Secretary of State's accountability for every detail. He had to have an effective filter built into the system.

/ / Unlike

Unlike the education system, he did not have accountable local authorities or a University Grants Commission to take some responsibility. Sir Alec Merrison commented that the NHS involved larger units, and much more emotional subject matter, than the education system. Mr. Jenkin said that he required the absolute backing of his colleagues when he found it necessary to say that a particular matter was for the District Health Authority, and that he would not interfere, but accept responsibility for the broad policy not the detail. With backing he could do this. His first ever sacking of an area health authority had had an electric effect elsewhere. One of his predecessors should have done it earlier. The Prime Minister commented that she had been much impressed by his speed of response.

In conclusion, the Prime Minister said that she had been disturbed by the financial issues raised in the Report, but that the Government was in agreement with much else in it. There was some contradiction between the realism that the NHS could not do all that people might like, but the expectation that what was necessary would have to be funded from tax. The Commission's answer to this was to squeeze the administration. Sir Alec said that they were not speaking of much more money: they had not found a crisis: they wanted to see better use of money. Mr. Jenkin said that the crisis, if any, lay in the low respect for the system by its employees. Sir Alec Merrison commented that last winter's experiences, with volunteers improving the atmosphere in hospitals, had produced important lessons. He hoped that union leaders had learned them. Mr. Jenkin said that all reports indicated that TUC leaders were desperate to avoid disruption this winter in basic services which hit ordinary people. The Prime Minister said that the problem was one of too many employees. She still preferred to pay better for a top quality service.

30 August 1979

SM

Natural Health

MR WOLFSON

You asked the question: here is the DHSS answer

NJS

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

Nick Sanders Esq
Private Secretary
10 Downing Street
LONDON SW1

16 August 1979

Dear Nick

SHORTAGE OF DOCTORS AND NURSES

We spoke over the telephone and I agreed to let you have a note on how the development of private health schemes might affect the NHS if there were national or regional shortages of doctors and nurses.

Nationally, manpower supply could sustain a moderate and well timed increase in private sector activity though there could be some localised problems in anaesthetics and pathology where we are short of doctors. The regional picture is variable. In London and some other large cities there will be enough doctors but the nursing manpower supply already constrains the NHS. Elsewhere nursing will not be a constraint but doctor supply might limit the rate of expansion. While the Union view that development of private health schemes will not add to total health resources available has substance, Ministers consider that a moderate increase could be supported without detriment to the NHS, although sensitive points will be watched.

The willingness of trade union negotiators to include private health insurance as part of pay deals is welcome and this should help to ease the burden on some parts of the NHS.

Yours sincerely,

Robert Woollcombe-Adams

R WOOLLCOMBE-ADAMS
Private Secretary

file

DS

National Health

19 June 1979

The Prime Minister has seen your letter of 15 June, responding to my enquiry about your Secretary of State's intentions on the Health Services Board. She is pleased to note the proposals for abolition which are now under consideration.

M.A. PATTISON

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

PRIME MINISTER 2.
CC Govt Trading (Quangos) May 79

You asked what Mr Jenkin intended to do about the Health Services Board. You will see that he has abolition in hand.

18/VI.

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

15 June 1979

Tim Lankester Esq
Private Secretary
10 Downing Street
LONDON
SW1

Dear Tim,

I promised to let you know, in the context of the review of "Quangos", the position in relation to the Health Services Board. I attach a copy of a letter which my Secretary of State has sent today to the Home Secretary, setting out the arrangement proposed for consulting on the legislation to be introduced on private medical practice in hospitals. You will see from paragraph 2 of the proposed consultation letter that part of the proposals is to abolish the Health Services Board, leaving local management to determine the limit to which NHS facilities can be made available to other than NHS patients. We envisage that legislation will be introduced as soon as possible after the Summer Recess.

Good

Yours sincerely

D Brereton
Private Secretary

ENC.

YDS

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

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

June 1979

Dear Willie,

PRIVATE PRACTICE

I am now ready to start consultations on the Government's plans to introduce legislation on private medical practice in hospitals, and I enclose a copy of the consultative letter which we have in mind to send to health authorities, the major health professional bodies, the private sector organisations, the TUC and NHS Whitley Council Staff Side. I am proposing two stages of consultation, the present one on the contents of legislation and a second stage on the details to be set out in regulations or promulgated administratively. This is necessary because of the urgency of introducing legislation on which nevertheless we are committed to consultation.

You will see that I am looking for legislation as soon as possible after the Summer Recess and I shall be seeking the agreement of colleagues to this after completion of the first round of consultation. I must give advance warning that a timetable motion may be necessary but I will be making the case for this when my proposals are firm.

I now need to issue the letter quickly both to allow as much time for consideration as possible and because I would like it to reach the British Medical Association before their Annual Representative Meeting next week. I propose to issue the letter with a press notice and to place it in the House unless I hear that colleagues have reservations.

I am copying this to the other members of H Committee and Sir John Hunt.

Yours ever

Patrick

AB

DRAFT CONSULTATION LETTER ON PRIVATE PRACTICE

1. The Government have been considering how best to put into practice their policy referred to in the manifesto of freeing NHS private hospital practice from the enforced reductions of the Health Services Act and of encouraging co-operation rather than confrontation between the public sector and the private sector of medicine. The method must be consistent with the main principles that:

(a) people who wish to do so should be free to make arrangements for their private medical treatment.

(b) there should be the maximum delegation to local health authorities of responsibility in respect of services in that locality.

(c) central government should only intervene when necessary; such decisions should be taken by Ministers answerable to Parliament.

The Government intends to introduce legislation as soon as possible after the Summer Recess. The purpose of this letter is to set out the main lines it is expected to follow. Later on you will be consulted about the detailed arrangements mentioned below, some of which would be set out in Regulations; others would be the subject of Departmental guidance.

<u>private practice in NHS hospitals</u>

2. The chief purpose will be to restore the Secretary of State's discretion to allow NHS hospital facilities to be made available for private patients. The Health Services Board with its function of phasing out NHS private facilities will be abolished and the arrangements (never in fact implemented) for some residual private practice in specialised cases will not be needed. However the Government does not think it would be acceptable that there should be no ceiling on private practice within the NHS. There will therefore be provision for determining the limits to which NHS facilities can be made available to other than NHS patients. The Government propose that this function should be exercised by local management. Legislative provision will be retained that services for private patients should not prejudice services for NHS patients.

3. The new arrangements will allow early changes in the present level of authorisations where circumstances justify them. But they do not necessarily mean that authorisations withdrawn under the previous Government will be restored. New private sector facilities have been provided and the pattern of demand for NHS provision has altered. In any case many of the authorisations were withdrawn on the basis that they were not being used. The Government expects that for the time being authorisation will remain at about their present level in most places.

4. Although the Secretary of State will delegate responsibility for authorising NHS facilities, he will retain residual control. The main purpose of this will be so that he can settle disputed cases. The Government propose a small non-statutory committee to advise the Secretary of State on private practice generally and from whom he could obtain advice on individual cases of this kind. The details of the arrangements for referring to the Secretary of State are one of the subjects for later consultation.

Private practice in private sector hospitals

5. Private hospitals and nursing homes are registered by AHAs on behalf of the Secretary of State under the Nursing Homes Act, 1975. At present new acute hospitals are notified to the Health Services Board and the larger ones need the Board's authorisation. The Government believe that the registration system to maintain standards of accommodation and staffing has in general worked well, although they are prepared to take the opportunity to make minor amendments to the Act and they intend new Regulations in due course.

6. As a basis for the co-operative development of hospital facilities for private practice at local level, the Government propose provision for advance notification to AHAs of all significant private hospital developments at the planning stage. This will be followed by local consultation whose objective will be to ensure the orderly and effective development of health services in the locality. Where there is local agreement this will usually be a sufficient basis for a development to proceed. If there is disagreement the matter will be referred to the Secretary of State for a decision. It is proposed that, initially at least, the very largest developments and any containing certain highly specialised facilities should invariably be referred to the Secretary of State before final decisions are taken.

LWS.

7. The method of consultation will need to be worked out locally, and may differ from place to place. In localities where a range of private facilities is proposed it will be desirable to arrange for joint discussion of the whole future pattern, including the authorised level of NHS facilities. Elsewhere a simpler approach can be expected to suffice.

8. The legislation will need to give the Secretary of State power to reject or impose conditions on private developments. The intention is that this power which would not be delegated, would be exercised rarely. The new legislation will probably include a broad definition of the developments to which the residual control of the Secretary of State would apply and the criteria he would use for approval. The details of the procedure could be set out in Regulations, and these will be the subject of later consultation.

Co-operation between the NHS and the private sector and the balance between them

9. The Government look not only for a fresh approach of consultation between AHAs and the private sector in the planning field as set out above but for development of joint schemes to the benefit of both parties. This could indeed increased use of contractual arrangements, in both directions, and there are potential benefits from joint provision of services, sharing of some staff and possibly collaboration in research. The Government also believes that there is scope for considerable expansion of the private sector's contribution to staff training. Most of this can be undertaken without legislative provision but the Secretary of State will need power to assist private hospitals to provide services and to take part in collaborative projects with them. The setting up of such contracts and schemes would remain a matter for the local NHS authority to work out with the private sector as part of their planning within the resources allocated to them.

10. The Government's view is that it will be of benefit to the NHS for private practice facilities normally to be available to the extent that consultant staff and patients wish to use them. Such patients contribute resources which will allow local NHS hospitals to provide facilities and amenities not otherwise possible. The Government believe however that private patients should not be judged by different standards of medical priority from NHS patients, nor should they be given a higher standard of care. The arrangements for private practice

in NHS hospitals must operate, and be seen to operate, fairly. The Government will be discussing with representatives of the medical profession ways in which this can be achieved, including the possible extension of common waiting lists beyond the categories already covered by them. However it is not yet clear to the Government whether the extension of common waiting lists is a practicable proposition and they propose that the local discussions on this, initiated by the previous Government, should continue.

11. The private hospital sector has become stronger in recent years, providing facilities in many towns throughout the country. Where there are such private facilities it is to be expected that NHS beds will be used mainly for cases requiring the special facilities of a district general hospital, and for emergencies. But although the Government wish to encourage private provision they do not propose to lay down a rigid pattern from the centre, since it is best for each locality to decide what NHS provision and what independent provision to plan for.

Comments

12. This letter sets out the Government's main approach and their intentions for legislation. Any comments on the legislative aspects are needed by the end of July. Comments on the detail of the arrangements should be held back until the second round of consultations.

Natural Health

Prime Minister

To note

cc the Lobby
The Times

Copy circulated as Natural Health: Doctors and Dentists Pay May 1974.

PRIME MINISTER

I had an excellent and friendly meeting with the leaders of the medical profession on Monday evening. Two points arose, of which I think you ought to be aware.

2. The BMA was on the point of dropping another letter onto your doormat, urging a swift decision on the Doctors and Dentists Review Body Report. I dissuaded them from doing this by assuring them that we had the matter under urgent investigation. They pointed out that the understanding between the profession and successive Governments has been that Governments would do their best to publish the Report with their decision within 3 weeks of their receiving the Report from the Review Body. Of course, the BMA recognise that for this purpose they cannot count the period prior to the Election, and indeed they accepted that the three weeks should run from 8 May, the date when effectively I took over this Department. I had hoped that we would have been able to announce our conclusions before the House rises for the Whitsun Recess, but I entirely understand the reasons that prompted you to delay a decision to next week. You will understand however, that I would be in some embarrassment if we could not reach a conclusion by the end of next week.

It will be on the agenda for E Committee next Thursday.

3. The other point concerns our commitment to facilitate the wider use of private medical care. I have deliberately held my peace in the face of the provocative statements by COHSE and NUPE, since I take the view that it is sensible to make public pronouncements when one has something positive and constructive to say. We are, of course, working on plans which will achieve our objective, and you may like to know that the doctors last night made some suggestions which I hope may help to defuse the union position, while meeting the central purpose which we have set ourselves. In the meantime, I would not regard it as helpful

We had to postpone the meeting because the Treasury paper on pay was not ready.

to answer provocation with provocation, and I feel sure that this will have your support.

I am copying this minute to Willie Whitelaw, Geoffrey Howe, Jim Prior, George Younger and Nicholas Edwards.

P.J.

22 May 1979