Part 19

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NHS Expenditure and Efficiency

NATIONAL HEALTH

Part 1: May 1979

Part 19: 20th Jan '89

FOLDER - Mock-ups for the NHS Review White Paper Cover

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~23.1.89~~							
~~31.1.89~~							
~~10.2.89~~							
~~15.2.89~~							
~~17.2.89~~							
21.2.89							
PT19 ENDS							

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PART 19 ends:-

AP to D/HEALTH. 21.2.89

PART 20. begins:-

NHS REVIEW - BMA COUNCIL RESOLUTIONS

2.3.89.

FILE KK

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

21 February 1989

Following my telephone call this morning, I am writing to confirm that there will be a meeting at No. 10 on Tuesday 21 March, 10.00 - 11.30 am, to discuss Community Care.

I am copying this letter to Michelle Cameron (Department of the Environment), Stuart Lord (Department of Social Security), Peter Wanless (Chief Secretary's Office), and to John Rider and Richard Wilson (Cabinet Office).

(MRS. AMANDA PONSONBY)

Mrs. Flora Goldhill,
Department of Health.

cc MJ
cc BS

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

20 February 1989

Dear Andy,

COMMUNITY CARE

Now that the NHS White Paper has been published the Prime Minister thinks it is important to make progress on the Government's response to Sir Roy Griffiths' Report on Community Care. She would therefore like to hold a meeting in mid-March to review the position reached with your Secretary of State and the Secretaries of State for the Environment, Social Security and the Chief Secretary. This office will be in touch to make the necessary arrangements.

I am copying this letter to Roger Bright (Department of the Environment), Gill Littlehales (Department of Social Security), Carys Evans (Chief Secretary's Office) and Trevor Woolley (Cabinet Office).

Yours,
Paul

Paul Gray

Andy McKeon Esq
Department of Health

MJ 2 DHH

cMr White Hall
P.U.

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

20 February 1989

Dear Andy,

NHS REVIEW: PUBLICATION OF THE WORKING PAPERS

Thank you for your letter of 17 February, enclosing the final version of the eight working papers, which the Prime Minister has seen. She has commented that all concerned have clearly worked very hard in order to have the working papers ready for publication tomorrow.

I am copying this letter to the Alex Allan (HM Treasury), Stephen Leach (Northern Ireland Office), David Crawley (Scottish Office), Stephen Catling (Lord President's Office), Nick Gibbons (Lord Privy Seal's Office), Carys Evans (Chief Secretary's office), Malcolm Buckler (HM Treasury), Sir Roy Griffiths (DoH), and to Richard Wilson (Cabinet Office).

Yours,
Paul

Paul Gray

Andy McKeon Esq
Department of Health.

6

PRIME MINISTER

NHS REVIEW: WORKING PAPERS

The eight detailed working papers to supplement the NHS Review White Paper are now being publicised on Monday. This has been brought forward from Tuesday, in order to avoid a clash with the Commons Debate on food. And it will ensure that the documents are out in advance of the Lords Debate on the NHS Review on Wednesday.

I am attaching the final versions of the working papers in case you wanted to glance through them over the weekend.

PAUL GRAY

17 February 1989

PM3AIX

0845A

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

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

CCPU.

Mr Paul Gray
Private Secretary
10 Downing Street
LONDON SW1

17 February 1989

Dear Paul

NHS REVIEW: PUBLICATION OF THE WORKING PAPERS

I am writing to let you know that arrangements have now been made for the publication of the eight working papers setting out how the main proposals in the NHS Review White Paper will be implemented. The papers are:

Working Paper 1 - Self-Governing Hospitals
Working Paper 2 - Funding and Contracts for Hopsital Services
Working Paper 3 - Practice Budgets for General Medical Practitioners
Working Paper 4 - Indicative Prescribing Budgets for General Medical Practitioners
Working Paper 5 - Capital Charges
Working Paper 6 - Medical Audit
Working Paper 7 - NHS Consultants: Appointments, Contracts and Distinction Awards
Working Paper 8 - Implications for Family Practitioner Committees

The papers will be issued on Monday 20 February and the Secretary of State will hold a press conference at 11.30am on that day. Five sets of the papers are being sent to Regional, District and Family Practitioner Chairmen in England; copies of papers 2, 3 and 4 are being sent to every General Medical Practitioners in England. Arrangements have been made for copies of the papers to be placed in the Vote Office and the Printed Paper Office before the press announcement. Members of the Ministerial Group will receive a personal set of the papers on Monday.

[redacted]R.

I am sending a copy of this letter to the Private Secretaries to the Chancellor of the Exchequer; to the Secretaries of State for Wales, Northern Ireland and Scotland; to the Lord President; to the Lord Privy Seal; to the Chief Secretary; to the Minister of State and Sir Roy Griffiths in this Department; and to Mr Whitehead at the No 10 Policy Unit and Mr Wilson at the Cabinet Office.

Yours

Andy

ANDY McKEON
Principal Private
Secretary

PM3AIW

CONFIDENTIAL

PRIME MINISTER

COMMUNITY CARE

Now that the NHS White Paper is out, I have been considering with Richard Wilson and Departments, the timetable and mechanisms for handling discussion of Community Care.

Ministers most concerned have been having some discussions. We have now persuaded them that there must be some early progress, and that we should be thinking in terms of a meeting with you in mid-March. Given the difficulties with this issue, I imagine you would want, in the first instance, to take a meeting just with the Ministers mostly concerned - Messrs. Clarke, Moore, Ridley and Major.

There is also the question of how to handle Roy Griffiths. I gather he is half expecting to be involved in any Ministerial group, in the same way as for the NHS Review. But, given the nature of his recommendations, Richard Wilson and I see major difficulties with this. One possibility would be for you to arrange to have a private word with Roy Griffiths after you have talked things through with the small Ministerial group. That would also provide an opportunity for you to get private reactions from Roy Griffiths on how the re-organisation of DOH, viz-a-viz the NHS, is proceeding.

Content:

- for us to arrange a Community Care meeting with Messrs. Clarke, Moore, Ridley and Major around mid-March?

Yes

- to fix up a private talk with Roy Griffiths in late-March/early April?

Possibly

PAUL GRAY

17 February 1989

CONFIDENTIAL

Note

Passed to PM's secretary to Andy McKeon (DoH), and agreed there was no need for any formal exchange of letters.

RRCG 16/2

PRIME MINISTER

NHS REVIEW: GP PRACTICE BUDGETS

You saw over the weekend a note from Ian Whitehead reporting on the difficulty he foresaw in persuading DOH to agree satisfactory drafting of the detailed working paper on GP Practice Budgets. I took this up with Kenneth Clarke's office, stressing that you would wish to see the draft document, and asking them to ensure that Ian Whitehead was closely involved in the drafting exercise.

Ian's further note attached reports on latest developments. He continues to feel that the draft of the key paragraph 4.5 is inadequate, and suggests a redraft.

You will want to consider whether to press this point with Kenneth Clarke. Ian's suggested redraft is rather closer to the wording of the White Paper, but I am not sure there is an enormous difference of substance. You will also want to bear in mind that:

- Ian has persuaded Kenneth Clarke to make a number of changes in other parts of the document;

- Kenneth Clarke took the decision on his present proposed wording after a long meeting at which Ian was present, where the opposing arguments were aired.

If you want to press Mr. Clarke on this I think it may therefore be necessary for you to have a word with him direct.

Are you content, reluctantly, to accept Mr. Clarke's wording? Yes

Or, do you want to press Ian's suggested alternative to him? no

RLCC.

PAUL GRAY
15 FEBRUARY 1989

[although the redraft is better - but there is a limit to what a Minister will change]

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CC 1. WHITEHEAD. 13(A-6)

PRIME MINISTER 15 February 1989

NHS REVIEW: DETAILED WORKING PAPERS

Fudging the Budget

Kenneth Clarke has redrafted the paragraph on GP budget setting (attached - para 4.5). It is shorter but the approach is much the same. It fails to address the potential for a huge bureaucracy at regional level.

What is being proposed?

The Regions will determine two amounts for each practice:

- a target budget for the practice, based on age-weighted capitation;

- actual expenditure for the previous year.

The RHA will then have the discretion to set the actual budget 'at a point between the two, taking account of local and social factors'.

The target budget and local factors are essential ingredients.

But why the need for actual expenditure?

Kenneth Clarke wants to encourage the inefficient GPs to participate in the practice budget. Over time, the Regions would then 'ratchet-down' the expenditure of the inefficient GPs. Also, he wants to avoid giving highly efficient GPs a sudden windfall. Efficient GPs would receive a budget slightly above their existing level of expenditure but somewhat

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below the target level.

Sub para 6.9 added "There are social and other local features which affect the use of hospital services, and these too will be reflected in the budget".

PHC 15/2

Why is this a problem?

We are moving away from one of the main principles of the Review, explicitly stated in the White Paper:

> **'The size of each practice's budget will depend primarily on the number of patients on the practice's list' (Para 6.4).**

While accepting that we must account for special local features - such as high morbidity rates - there is no justification for referring to actual levels of expenditure in the working papers.

Other incentives could be offered separately to inefficient GPs without breaking the main principles of the Review.

Proposed redraft of Para 4.5

'Each practice's share will be based on the number of patients on its list, weighted for the age and sex of its patients, adjusted by social and other local features which affect the use of hospital services in the area. The budget will be determined by using the District's capitation rates, adjusted for the specific needs of the local community. Budgets will not, however, underwrite high referral rates for which there is no demonstrable cause'.

Ian Whitehead

IAN WHITEHEAD

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SECTION 4: SETTING OF BUDGETS

4.1 Regions will have responsibility for allocations: to DHAs in respect of hospital and community services, to FPCs for expenditure on drugs and other primary care services; and to GP practice budgets. This will ensure that the allocation of funds to DHAs, FPCs and GPs are based on consistent principles and that no problem arises when patients registered with a practice are drawn from more than one district.

4.2 GP practices within the scheme will receive their budgets direct from the relevant RHA. Where patients are drawn from more than one Region, the Region within which the practice is located will take lead responsibility, negotiating an appropriate financial contribution from the other(s). The FPC will continue to hold the GPs' contracts and be responsible for monitoring expenditure against the budget. The Government expects FPCs to work closely with RHAs in agreeing budgets with participating practices. The Government recognises that GPs may need to look to other disciplines for skills associated with managing and controlling budgets. Accordingly, each practice's budget would include a fee set at a level which recognises the management and other costs associated with participation. The Government will discuss with the profession the size of the fee.

4.3 It is the Government's intention to move towards a weighted capitation approach to setting budgets in line with that proposed for RHAs and DHAs. Initially, however, budget setting will need to have regard to the different expenditure components contributing to the total budget. In addition, the overriding principle that budgets must sensitively reflect at the practice level the requirements of patients, for hospital and primary care services, of necessity points towards more detailed assessments than might be justified at DHA or RHA level. Once the practice budget scheme is bedded down, however, a simpler approach is anticipated.

Hospital services

4.4 Budgets must reflect the relative needs of patients for specific hospital services. The NHS Management Executive will discuss with the profession the factors, other than size of list,

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that need to be taken into account when agreeing the budget component in respect of hospital and community health services and the relative weights to be attached to them.

4.5 The approach to determining the hospital services component of the practice budget will be a comparison of the costs of the relevent services provided as a result of the practice's referral pattern in the previous year with the average for the District(s) taking account of the number, age, sex and health of the practice's patients. The actual budget will be set at a point between the two taking account of local and social factors. Budgets will not, however, underwrite high referral rates for which there is no demonstrable cause. Both Regions and GP practices will have access to the available information on the costs and use of services by practices.

Directly reimbursed expenses

4.6 Budgets will be based initially on the existing amounts the practice receives as directly reimbursed expenses in respect of practice staff and premises (cost-rent and improvement grants - paragraph 3.9), together with a pro-rata addition out of the additional cash allocated to the FPC in future for these purposes.

4.7 GPs currently receive direct payments for the cost of rent and rates. Where the GP is an owner occupier he would receive 'notional' rent based on the District Valuers' assessment of current market rents. GPs may also receive payments under the cost-rent scheme and improvement grants where they improve premises, including building new ones. These payments would be in place of notional rents. Over time, payments under the cost-rent scheme decline in real terms and become lower than notional rent. At this point, GPs may opt to receive notional rent instead of cost-rent. When a participating practice whose budget was initially based on cost-rent

payment opts for notional rent, budgets will be reduced to reflect the cessation of cost-rent payments. Notional rent will become payable separately by the FPC, as now.

Drugs

4.8 Working Paper 4 outlines the Government's proposals on indicative prescribing drug budgets for the generality of practices. It is proposed that indicative budgets be based on the Net Ingredient Cost (NIC) of prescriptions (basic list price). For GPs participating in the Practice Budget Scheme, the prescribing costs element of their global budgets will be found from within the overall drug budgets for RHAs. ~~The setting of drug budgets requires particularly careful analysis.~~ The drug component of practice budgets allocated by Regions will be in accordance with the principles outlined for indicative budgets.

4.9 FPCs will continue to be responsible for reimbursing pharmacists in respect of drugs dispensed. FPCs will need to invoice participating practices in respect of drugs prescribed by the practice and dispensed by retail pharmacists. Where the practice dispenses drugs for some patients, the costs of drugs will fall as a direct charge against the practice budget. When agreeing budgets, RHAs will need to take account of the average discounts received by dispensing doctors on the price of drugs purchased. Dispensing practice also incur VAT in respect of the cost of drugs dispensed and which is included in the costs currently reimbursed by FPCs to dispensing doctors. The drug component of practice budgets will need, therefore, also to include an allowance for VAT where appropriate.

MS76480

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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

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

Prime Minister (2)

POH(1)1694/1836

The Rt Hon Margaret Thatcher MP

14 FEBRUARY 1989

Dear Prime Minister.

HOSPITAL SOCIAL WORKERS IN SOUTHWARK

You asked me at a recent meeting what has happened on this subject since Tony Newton wrote to you on 20 November 1987. A constituent of yours (Dr A James) who worked at the Maudsley Hospital had originally raised the issue with you.

In September 1988 Southwark Social Services Department eventually published a consultative document outling proposals for a restructured Hospital Social Work Service. Those who responded (the Maudsley Hospital included) were critical of the evaluation of the current service and pointed out that uncertainty had made it even more difficult to staff the services, making life more difficult for those social workers who were left.

As a result the Director of Social Services in Southwark has decided not to proceed with the recommendations in the consultative paper and has undertaken to set up three further reviews. They continue to be indecisive therefore but I understand that following John Gummer's redetermination of their expenditure level the local authority will not be reducing its Social Services budget by as much as first intended and will protect "front line services".

Regular meetings between London Borough of Southwark Social Services Department representatives and local Health Authority Managers are continuing, and my officials are offering assistance to both parties in order to sort out difficulties.

We are therefore seeking to reduce the problems of the Maudsley. I am afraid however, that my people have not been able to identify any legal basis for a shift of money from Southwark to the Hospital to cover the loss of their experienced social workers.

Yours ever,

KENNETH CLARKE

PRIVY COUNCIL OFFICE
WHITEHALL. LONDON SW1A 2AT

14 February 1989

Dear Roger

MR TERRY DAVIS' TEN MINUTE RULE MOTION FOR WEDNESDAY 15 FEBRUARY

Thank you for your letter of 9 February setting out your proposals for handling Terry Davis' Ten Minute Rule Motion for Wednesday 15 February.

I agree that the Motion need not be opposed, that, in the event of a division, any colleagues present should abstain and that any resultant Bill should be blocked at Second Reading. We shall make the necessary arrangements to secure this.

I am copying this letter to the Prime Minister, members of L Committee, Sir Robin Butler and First Parliamentary Counsel.

Yours ever

JOHN

JOHN WAKEHAM

Roger Freeman Esq MP
PUSS/Health
Department of Health
Richmond House
Whitehall SW1

NAT HEALTH: EXP + EFF
PT 19

SRWBVA

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PRIME MINISTER

NHS REVIEW: DETAILED WORKING PAPERS

You will recall that Mr. Clarke will shortly be publishing the eight detailed working papers.

Ian Whitehead in the Policy Unit has been keeping in close touch with this exercise, and his note attached indicates that he thinks it is generally proceeding satisfactorily.

But there is one issue, the determination of GP practice budgets, on which he suggests you urge Kenneth Clarke to simplify the proposed procedure. Given the success of the launch so far, you will want to consider carefully whether to intervene personally over this point. The present drafting of the working paper represents something of a compromise between different interests and, although certainly not ideal, perhaps provides an acceptable starting point for the exercise.

Do you want to intervene to urge greater simplicity as Ian Whitehead recommends?

Or

Do you want Ian simply to continue to pursue this point at his level?

(PAUL GRAY)
10 February 1989

SECRET

MG5033P

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

From the Parliamentary Under Secretary of State for Health

The Rt Hon John Wakeham MP
Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1A 2AT

9th February 1989

Dear John,

PRIVATE MEMBER'S 10 MINUTE RULE MOTION: JUNIOR HOSPITAL DOCTORS (REGULATION OF HOURS) BILL

Introduction

1. You will have seen that Terry Davis is seeking leave to introduce a Ten Minute Rule Bill on 15 February 1989 to regulate the hours worked by junior hospital doctors. The Bill bears the same title as Lord Rea's Bill which received a Second Reading in the House of Lords on 25 January. We must assume that Terry Davis' intentions are the same ie with effect from 1 January 1992, to limit the hours a junior hospital doctor shall be required to work or be available for work to no more than 72 hours in any one working week averaged over a one-month period and to provide for the Secretary of State, by order, to reduce the hours further in stages to 60.

Background

2. Junior hospital doctors contract for a basic working week of 40 hours, or 10 basic units of medical time (UMTs). Hours over 40 are contracted at UMT rates which vary between 30 per cent and 38 per cent of the basic rate depending upon the grade of doctor. Average weekly contracted hours for all grades are approximately 85. Not all this time is spent working, as opposed to being available in hospital or at home should the need arise. Average hours spent actually working are 57, ranging from 46.4 in psychiatry to 66.9 in general surgery. The Doctors' and Dentists' Review Body has priced basic and additional UMT's so as to deliver what it judges to be a fair total salary having regard to average hours of work and duty.

3. Junior doctors' hours of duty fell from an average 91.3 in 1976 to 87.7 in 1982. A Government initiative in 1982 was a major factor in a further reduction of hours to an average of 85.7 in 1986. Despite this progress, a survey carried out by the Department of Health in 1987 identified a significant number of junior doctors whose commitments were undesirably heavy

and, in June 1988, the Government in agreement with the medical profession announced a new scheme whereby local professional working parties would be set up in each District Health Authority to advise on the elimination, wherever possible, of regular rota commitments which require a junior doctor to be on duty, on average, more than one night and weekend in 3 (equivalent, on average, to 84 hours of duty per week). This initiative is being carried forward in conjunction with a systematic review to assess the number of medical staff required in each Region to provide essential support for consultants in the acute specialties. Regional Health Authorities were asked for full reports by October 1989.

4. Meanwhile, the Government asked health authorities to submit urgent progress reports. These demonstrate that many reductions in rotas more onerous than 1 in 3 have been achieved or are planned and that efforts will continue to be made, wherever practicable, to seek further reductions. The Minister for Health will be discussing these reports shortly with representatives of the British Medical Association.

The Government's position

5. At a meeting on 9 January with representatives of the BMA, Kenneth Clarke and David Mellor agreed a joint statement with the profession which reflected a common concern about the excessive hours which some junior doctors work and the need to reduce them. Both sides further agreed that:

- this is a complex and long-standing issue to which the Government and the BMA agreed a solution must be found, although no simple solution is available;

- a key element in reducing junior doctors' hours is continued expansion of consultants to which both the Government and the profession are already committed;

- progress in reducing juniors' hours will depend on firm commitment to that end by all the parties concerned (the Department of Health, the profession, NHS Management, consultants and junior doctors themselves) at both national and local levels;

- the current initiative agreed jointly last June by the Health Departments and the profession was designed to reduce doctors' hours; and the urgent need now is for all the parties concerned at national, regional or local levels, to throw their weight behind the initiative in order to make it a success.

The Government's attitude to the Bill

6. During the Second Reading Debate on Lord Rea's Bill, the Government accepted that it would be sensible to work towards a target of an average week of duty of 72 hours; but confirmed our grave reservations about the effect of a statutory limitation:-

a. patterns of work should not be determined centrally. Rota commitments can only sensibly be worked out locally. These are influenced by specialty, training needs, local hospital service organisation, the needs of individual consultants and, most important of all, the need to ensure satisfactory medical cover for patients.

E.R.

b. To implement the Bill with conventional staffing patterns would require a substantial increase in the number of junior hospital doctors, particularly Senior House Officers. It is far from clear they could be recruited given that there were already difficulties in filling SHO posts.

c. Any increase in the number of junior doctors would run counter to the current efforts to reform the staffing structure. The main thrust of "Achieving a Balance", published in 1987, in agreement with professional and health authority interests, is to increase the number of consultants while limiting the number of junior doctors' posts to the number required to fill future career vacancies. It would be irresponsible for the Government to make firm plans for a maximum of 72 hours without a clear and agreed view in the medical profession on how this could be achieved.

7. Commenting on Lord Rea's Bill, the Prime Minister's office said "that there is no need for a decision yet on whether the Bill should be opposed if it reached the Second Reading Debate in the Commons. She (the Prime Minister) thinks that the Bill may be very charged if it gets to the Commons". We now need to decide whether to ensure that Terry Davis' Bill does not receive a Second Reading. For the reasons given in paragraph 6, we propose that we should invite the Whips to ensure that the Bill is objected to at Second Reading.

Conclusion

8. The Government is committed to reducing the long hours of work of some junior doctors. But for the reasons I have given above, we propose subject to your and colleagues' agreement, that any Bill resulting from the motion should not receive a Second Reading. Should the motion be opposed and a division take place, I suggest Ministers should abstain.

9. I am sending a copy of this letter to the Prime Minister and members of "L" Committee.

Yours ever
Roger.

ROGER FREEMAN

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PRIME MINISTER 8 February 1989

NHS REVIEW: DETAILED WORKING PAPERS

Ken Clarke plans to publish the eight detailed working papers shortly. But no date has been fixed.

The papers are good workmanlike documents, albeit turgid. They accurately reflect the proposals in the White Paper and they follow the more detailed conclusions of the ministerial group, with one notable exception.

My main concern lies with the determination of GP practice budgets. The working papers set out a far more complex and bureaucratic system than was proposed in the White Paper. The spirit of the policy is in danger of being thwarted by the letter of implementation.

What problems would emerge?

First, the proposed system is far too discretionary. In practice, budgets will probably be based on the previous years actual expenditure. Inefficient GPs will benefit from this allocation. And efficient GPs will see no advantage in applying for a budget.

Second, the system will be far too complex for many GPs to understand. And the lack of clarity will deter candidates.

Third, a large bureacracy will build up in the RHAs. Endless discussions will emerge between the RHA, FPCs and the GPs.

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What did we agree in the White Paper?

Para 6.7 of the White Paper states the following:

> "Each practice's share will be based on the number of patients on its list, weighted for the same population characteristics as are proposed in chapter 4 for allocations to Districts. There are social and other local features which affect the use of hospital services, and these too will be reflected in the budget."

Proposed mechanism for allocation (See Appendix)

The working papers propose the following mechanism for determining GP budgets:

First, the RHA will determine the 'Target Share' of a GP practice. This calculation will depend on the expected cost of hospital services by age, age profile of the practice, morbidity rates and mortality rates.

Second, the Target Share will then be compared with the practice's actual usage and cost of relevant hospital services in the most recent year ('Actual Usage').

Third, the RHA will determine the extent to which the patients in a GP practice use the private health sector.

Fourth, the RHA will then set the actual budget by balancing the above factors.

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CONCLUSION

Ken Clarke should be asked to simplify the budgetary process. As an absolute minimum, the budget should not depend on the previous year's actual expenditure. At best, it should equate to a simplified version of the so-called 'Target Share'.

Ian Whitehead

IAN WHITEHEAD

4.5 The starting point for setting the ~~particular~~ practice budget will be the basic allocations to those DHAs from whom the practice list is drawn:

(a) Regions will estimate the target share of the practice of the relevant Regional cash limit. This will be built up as follows:

- estimate the expected cost of the relevant hospital service by age band using activity data drawn from patient activity statistics and surveys such as the National Morbidity Survey in General Practice and information on the unit cost of services.

- these estimates would be weighted to reflect variations between Districts in the health of the local population (probably using Standardised Mortality Ratios as proxies).

- the resulting age specific (morbidity weighted) per capita cost estimates would be applied to age profile and size of the practice list to derive an estimate of the target share of the practice of the relevant Regional cash limit (excluding contingency reserves - see paragraph [ ]).

(b) Target shares will be compared with the practices' usage and cost of relevant hospital services in the most recent year available. In early years, while information systems are under development, RHAs will draw on information from Korner systems, from individual hospital departments like Pathology and Radiology, and from the practices themselves. The actual budget for the practice in respect of hospital services will take both into account. The extent to which the actual budget is above or below the target share will be determined by reference to any additional social and local factors - for example, the propensity of patients to use the private hospital sector rather than the NHS, the prevalence of elderly single adult households

lacking the support of informal carers - compared with the norms for the District. Budgets will not underwrite high rates of hospital use for which there is no demonstrable cause. Both Regions and GP practices will have the available information in a common form.

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

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

CC PM

Paul Gray Esq
No 10 Downing Street
LONDON SW1

31 January 1989

FA

Dear Paul

NHS REVIEW

I would be grateful if you and copy addressees could make a small amendment to the briefing for Cabinet Ministers which I circulated yesterday. The item on tax relief (the last point in para 2) should read:

- income tax relief on medical insurance premiums for those aged 60 and over, whether paid by then or, for example, by their families on their behalf.

I am copying this letter to the Private Secretaries of other Cabinet Ministers and to Trevor Woolley.

Yours

Andy

A J McKEON
Private Secretary

NHS Review

3.31 pm

The Secretary of State for Health (Mr. Kenneth Clarke): I would, with permission, like to make a statement about the National Health Service review. *[Interruption.]*

Mr. Speaker: Order. This is a statement for which the House has been waiting.

Mr. Clarke: Britain enjoys high and rising levels of health care and, at its best, our Health Service is as good as any in the world. I believe that the principles underlying the National Health Service still hold good today and will continue to guide it into the next century. The NHS is —and must remain—open to all, regardless of income, and financed mainly out of general taxation. If those principles remain unchanged, the Health Service itself, and the society in which it operates, are changing for the better.

We need constantly to improve and strengthen the NHS so that it can provide ever better care to those who rely on it. At the moment there are wide variations in performance across the country. We want to maintain the best of the Health Service, and bring the rest of it up to that very high standard. That is why the Government set out upon a fundamental review of the NHS last year. We have today published our conclusions in the White Paper entitled "Working for Patients". They build on and evolve from the improvements that the Government have already made to the service in the last 10 years. They reflect a change of pace rather than any fundamental change of direction.

All of our proposals share a common purpose—to make the Health Service a place where patients come first and where decisions are increasingly taken at a local level by those most directly involved in delivering and managing care.

The main proposals apply to all the United Kingdom, but there are separate chapters in the White Paper devoted to Wales, Scotland and Northern Ireland explaining how they will be applied in those countries. Implementation of the proposals will have to follow a process of discussion with many people in the service. We will be issuing in the course of the next week or two eight detailed— *[Interruption.]*

Mr. Dennis Skinner (Bolsover) *rose*——

Mr. Speaker: Order. The hon. Member for Bolsover (Mr. Skinner) must resume his seat. *[Interruption.]*

Mr. Doug Hoyle (Warrington, North): On a point of order, Mr. Speaker. Are you able to tell us what documents are being distributed to Conservative Members and why they are not being made available to Members on this side of the House?

Mr. Speaker: I know nothing of documents, other than the one which has just been handed to me.

Mr. Clarke: If I may help the House, I think that my right hon. and hon. Friends are reading documents that were placed in the Vote Office as I rose to make my statement. My right hon. and hon. Friends prefer to look at those sources for their information, not at information that comes to them in plain brown, sealed envelopes. *[Interruption.]*

Mr. Allan Roberts (Bootle): On a point of order, Mr. Speaker. No documents are available in the Vote Office. If Conservative Members have such documents, they have been given to them by Government sources. We have not got them. *[Interruption.]*

Mr. Speaker: Order. I think that I can now help the hon. Member for Bootle (Mr. Roberts). It appears that those documents are available in the Vote Office because certain hon. Members are now coming into the Chamber with them.

Mr. Roberts: Further to that point of order, Mr. Speaker. They are not the documents that Conservative Members have.

Mr. Clarke: I hope that the House will allow me to return to the proposals, instead of being obsessed with documents that accompany what we say.

In order to help the process of discussion with the many interested parties whom I have just described, we shall be issuing in the course of the next week or two eight further detailed working papers as the basis for those discussions.

Before I turn to the key proposals on management and the use of resources contained in the White Paper, I want to describe the kind of hospital service that I believe every patient has a right to expect. All hospitals should provide individual appointment times that can be relied upon. They should offer attractive waiting areas with proper facilities for patients and children. They should be able to provide proper counselling to those who need it and give clear and sensitive explanations of what is going on. In addition, patients should be able to pay for a number of optional extras, such as wider choice of meals, a bedside telephone, a television, or a single room. The best hospitals already provide this, and I want to see the whole service treating patients properly as people.

We will also ensure that patients are freer to choose and change their GP; and we shall give more encouragement to those GPs who, by offering the kind of service that people want, succeed in attracting more patients. To achieve that, we are proposing to increase the proportion of GPs' pay which comes from the number of patients on their lists from 46 per cent. to at least 60 per cent.

People look to their general practitioners to prescribe the medicines they need, and GPs must have the necessary flexibility to do so. But at present drug costs in some places are nearly twice as high per head of population as in others, even where the incidence of illness is much the same. The drugs bill is the largest single element of all spending on the family practitioner services. At £1·9 billion in 1987-88, it was more than the cost of the doctors who wrote the prescriptions. In each of the last five years, spending has risen by an average of 4 per cent. over and above the rate of inflation. Unnecessarily expensive prescribing is wasteful and takes up resources that should be used in other ways. Over-prescribing is not in the best interests of patients. We shall therefore introduce a new budgeting scheme whereby GP practices will receive indicative budgets for their prescribing costs. The scheme will be operated in a way that ensures downward pressure on the cost of prescribing without inhibiting the ability of doctors to provide necessary medicines for their patients.

At present, because of the way that hospitals are funded, GPs are not always able to offer their patients a full choice as to where they will be treated. We want to change this by giving GPs in large practices the

The Prime Minister: I refer the hon. Gentleman to the reply that I gave some moments ago.

Mr. Grant: Is the Prime Minister aware that the United Nations secretary-general has been compelled by the five permanent members of the Security Council, including Britain, to propose a reduction in the number of United Nations troops in Namibia from 7,500 to 4,650 during the transition to independence? Has she heard the views of President Mugabe of Zimbabwe, who has stated that the five permanent members of the Security Council have been fiddling with the moralities of resolution 435? In view of the fact that she will shortly be visiting Zimbabwe and that South Africa continues to support armed bandits and assassination gangs, will she review Britain's position in this matter and insist that the original numbers of troops be maintained?

The Prime Minister: I should have thought that the hon. Gentleman would wish to uphold a decision of the five permanent members of the Security Council. We shall honour it. The agreement was an excellent one and was obtained by the co-operation of those five members plus the co-operation of South Africa and Angola. I believe that we should do everything in our power to see that it is fulfilled. As far as this country is concerned, we pay our full subscription to United Nations peace-maintaining forces everywhere.

Mr. Tredinnick: Is my right hon. Friend aware that in recent Israeli raids on Palestinian camps in the Lebanon dogs with explosives tied to their bodies were used and that those dogs and their explosive charges were set off, resulting in the death of the dogs and of many Palestinians? Will she make representations to the Israeli Government deploring this practice?

The Prime Minister: I am not responsible in any way for what happened there. I have heard of no such incidents as those to which my hon. Friend refers. The first thing to do is to find the facts.

Dr. Owen: Is the Prime Minister aware that it is because she cannot bring herself to use the National Health Service that she does not understand the NHS and that the National Health Service is not safe in her hands because there is no place in her heart for it? Will she stop poisoning the moral and ethical basis of the National Health Service and the whole sense of vocation that doctors and nurses in that service have?

The Prime Minister: I could have expected that the right hon. Gentleman might take a totally different view, one taken by many people far to the left of him—*[Interruption.]*—who believe that those who can afford to pay for themselves should not take beds from others.

Mr. William Cash (Stafford): Irrespective of the fate of the Protection of Privacy Bill last Friday, is my right hon. Friend aware that this matter commands a great deal of public concern not only in this House but in the country at large, that it is a matter that the press itself must put right, and that if it does not do so the House will have to do so?

The Prime Minister: I believe that last Friday's Bill was very well debated, and I have not the slightest shadow of doubt that a similar measure will be debated either this coming Friday or the Friday after that. I am sure that the observations that were made will have been noted in the relevant quarters.

Q6. **Mr. Vaz:** To ask the Prime Minister if she will list her official engagements for Tuesday 31 January.

The Prime Minister: I refer the hon. Gentleman to the reply that I gave some moments ago.

Mr. Vaz: Will the Prime Minister take time out of her busy day to examine her shoes and, in so doing, will she reflect on the current state of the British footwear industry, which in the last 10 years of her reign has shown a dramatic increase in imports, resulting in many British firms being closed and employees being put on the dole, including Percival's in Leicester. Bearing in mind the fact that there is a penetration rate of 75 per cent. in terms of imports of ladies footwear, will she confirm that she supports the British footwear industry and is wearing shoes manufactured in Britain? Will she also outline her plans for protecting the industry against unfair competition?

The Prime Minister: In fact, the footwear industry is doing far better than it was a few years ago, because its designs are very much better, its prices are highly competitive, and right now, if the hon. Gentleman could see, I am wearing shoes from Marks and Spencer.

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opportunity to hold their own NHS budgets. They will be able to use these to purchase as they judge best certain types of hospital services for their patients. They will, in other words, be able to provide the hospitals they choose for their patients with the NHS funds required to finance the services the hospitals perform. These GP practice budgets will cover in-patients, out-patients and day care treatments, such as hip replacements and cataract removals. They will also cover prescribing costs and diagnostic tests, such as X-rays and pathology tests.

Large practices will be free to decide whether to join the scheme. It will, at first, only be open to practices with at least 11,000 patients—that is twice the national average. Over 1,000 United Kingdom practices could join, covering about one in four of the population. All of those practices could have their own NHS budgets of about £500,000 a year. Giving GPs the resources to finance services for their own patients will provide a real incentive to hospitals to improve the service they offer to those GPs. It will also enable GPs to provide a better service to patients by referring them, for example, to where waiting lists are shortest. I am quite sure that GPs will want to judge the quality of service at least as much as the cost of service when they decide where to refer their patients. We have important proposals on the quality of medical service to which I shall turn in due course.

But it will not just be through GP practice budgets that money will follow the patient to where work is done best. The principle will in future apply throughout the Health Service as a whole. As part of this new way of getting resources to hospitals, the present elaborate system, which we all know as the RAWP system, will come to an end. Over the past 12 years it has made an important contribution by helping to equalise the resources available to each region, but that task has now very largely been achieved. [HON. MEMBERS: "No."] Oh yes.

Mr. Graham Allen (Nottingham, North): Not in the right hon. and learned Gentleman's district. It is losing £8 million this year. The Secretary of State is changing the rules.

Mr. Speaker: Order. May I say to hon. Gentlemen who are making comments from a sedentary position that they do not improve their chances of being called to ask questions later.

Mr. Clarke: Over the past 12 years the RAWP system has made the contribution that I have described, but we are now in a position to replace it with an altogether more simple and fair system based on population numbers weighted for age and health, and the relative costs of providing services. The new method will be much quicker to compensate those regions which treat large numbers of patients from elsewhere in the country. We will move to a system that finances regions and districts on exactly the same system with a 3 per cent. addition for the Thames regions because of the inescapable extra problems of providing health care in the capital.

In future, the money required to treat patients will be able to cross administrative boundaries much more freely, so that those hospitals that best meet patients' needs get the funds to do so. All NHS hospitals will be able to offer their services to different health authorities and the private sector. All district health authorities will be able to provide finance for health services to whatever hospitals they choose, in other districts or in their own. As a result, we shall not in future have the frustrating situation that occasionally arises now whereby a good, efficient hospital that attracts more patients runs out of money and has to slow down its work or close wards. This new system will start in 1990 for regional health authorities and 1991 for districts.

But improving the hospital service is not just a matter of changing the way in which hospitals receive their funds. We also want to change the way in which they are run and managed. We want all hospitals to have more responsibility for their own affairs so that they can make the most of local commitment, energy and skills, and can get on with what they are best at, which is providing care.

Management can be strengthened throughout the whole Health Service. The better the management the better the care it can deliver. Financial accountability and value for money will be improved by transferring audit of the health authorities and other NHS bodies to the independent Audit Commission. The role of the National Audit Office will not be affected by this change. On management matters, it is nonsense that the Ministers of any Government should be directly involved in the detail of the day-to-day running of the whole NHS. We shall therefore set up a new NHS management executive, chaired by the new chief executive, Mr. Duncan Nichol, and responsible for all its operational decisions. It will be accountable to an NHS policy board chaired by the Secretary of State for Health who will determine policy and strategy for the Service.

The prime responsibility of health authorities will be to ensure that the population for which they are answerable has access to a full range of high quality, good value services. Their job will be to judge the quality of services, to choose the best mix of services for their resident population and to finance those services. They will no longer provide and run all their local services, which will be increasingly the role of the hospital and unit managers themselves. Authorities will need to be organised as more effective decision making and managerial bodies. We shall therefore be changing their composition to make them smaller and to include executive as well as non-executive members. The non-executive members will be appointed on the basis of the personal skills and expertise they can bring to the authority and not as representatives of interest groups. Although there will no doubt continue to be people who will combine being members of local health authorities with being local councillors, local authorities will lose their present right to appoint direct their own members to health authorities. At the same time, we shall also be strengthening the management of family practitioner committees along similar lines. We shall also make the FPCs accountable for the first time to regional health authorities to improve the links between planning for the hospital, community and family practitioner services.

We must devolve responsibility across the whole Health Service, but I believe that we can also go one stage further. The next logical step in the process of extending local responsibility is to allow individual hospitals to become self-governing. Let me make it absolutely clear that they will still be as much within the NHS as they are now. They will be no freer to leave the NHS as they are now. They will be no freer to leave the NHS than any unit has been throughout its 40-year history. They will, however, have far more freedom to take their own decisions on the matters that affect them most without detailed supervision

[Mr. Clarke]

by district, region and my Department. To be known as NHS hospital trusts, they will be free to negotiate with their own staff on rates of pay and, within limits, to borrow money. They will be able to offer agreed services for agreed resources throughout the NHS and, indeed, in the private sector, too. There will of course be safeguards to ensure that essential local services continue to be delivered locally. I believe that this new development will give patients more choice, produce a better quality service, build on the sense of pride in local hospitals, and encourage other hospitals to do even better in order to compete. I expect the first NHS hospital trusts to set up in April 1991.

In all these reforms we intend to concentrate on the quality of care just as much as the quantity and cost. I admire the progress that the medical profession is making in devising systems that doctors call "medical audit" to assess clinical performance and outcomes. We intend to work with the profession to ensure that good systems of medical audit are put in place in every hospital and GP practice as soon as is practicable. What matters for all patients is that high standards of medical performance are maintained and where possible improved, and such systems should secure that.

I turn finally to the matter of perhaps greatest public concern—waiting times. All the measures that I have so far outlined by making resources flow more directly to those parts of the service that deliver the best care, will help to cut the length of time that people sometimes have to wait for elective surgery. The waiting list initiative will continue, but we shall also introduce a number of other initiatives designed to have a more direct and immediate impact. First, we intend all GP practices to have the basic information systems they need to know where treatment is available quickest. Secondly, we shall introduce a new tax relief to make it easier for people aged 60 and over to make private provision for their health care. This will reduce the pressure on the NHS from the very age group most likely to require elective surgery, freeing resources for those who need it most.

Thirdly, we shall manage consultants' contracts more effectively so that the very best use is made of their time and expertise. We shall also reform the consultants' distinction award system to ensure that commitment to the service and involvement with the management of the NHS are included among the criteria for distinction awards. Fourthly, we shall increase the number of consultants by 100 over the next three years, over and above the increase in the number of consultants already planned. These additional consultants will be appointed in those specialties and in those districts in which waiting times are most worrying. Finance will be made available to cover the costs of the new appointments, and the supporting services for their work load. This will help us keep up the attack not only on waiting times, but on long hours worked by junior doctors.

Taken together, these proposals add up to the most formidable programme of reform in the history of the NHS. They are the latest step in our drive to build a stronger, more modern, more efficient Health Service. An NHS that is run better will be an NHS that can care better. The proposals will, of course, mean change, but change of the kind we need if we are to have a service that is fit for the future. I trust that all those who—like me—truly believe in a Health Service that offers high quality care to all our people will lend their support to these reforms, and I commend them to the House.

Mr. Robin Cook (Livingston): The Government set out on their review last winter, not, as the Secretary of State claimed, because they wanted to maintain the best in the NHS, but because the NHS was in a cash crisis. The rest of us thought that the crisis was that the NHS had too little cash. It is now evident that the authors of the White Paper always thought that the cash crisis was that the NHS cost too much. It is the prescription for a Health Service run by accountants for civil servants, written by people who will always put a healthy balance sheet before healthy patients.

Will the Secretary of State tell the House how many more bureaucrats the NHS will need to make this package work? Will he tell us how much time doctors will have to take off patient care to file their financial returns? Will he tell us how much more the monitoring, the pricing and the bargaining over every treatment will add to the cost of administration, and whether a single closed ward will reopen as a result of the White Paper?

The Secretary of State assures us that it has never entered his head to privatise the NHS. Will he confirm that his White Paper proposes that medical services will now go the way of ancillary services and be put out to competitive tendering? If he wants to reassure the House, will he tell us which medical lines he is not prepared to privatise?

The Secretary of State assures us that those hospitals that opt out of their local health authorities somehow will not have opted out of the Health Service. Will he confirm that they will trade on their own account, that they will charge for every treatment, that they will retain their profits and that in every important respect they will be identical to the private hospitals with which they are to compete. Is he aware that the nation will not be taken in again by the Government's trick of sizing up public assets for private sale under the pretence of greater economic efficiency?

The White Paper's only feeble pretence at consultation is that a proposal to opt out will be given "adequate publicity locally". I assure the Secretary of State that we will save him that trouble. We will ensure that every proposal to opt out is fully exposed for what it is—a staging post to opt in to the private sector. To enable us to get started now, does the Secretary of State have the courage to name those hospitals that he expects to opt out first in two years' time?

The Secretary of State claimed that his proposals for private practice give GPs more freedom. Is not the truth that they limit the freedom of GPs to decide what treatment their patients need and replace it with the freedom to decide what treatment they can afford? Under his scheme, every patient has a price tag. Does not the Secretary of State realise that for the first time GPs will have an incentive to turn away those patients with a high price tag. The elderly, the disabled and the chronically sick will now be told, "Sorry but you do not fit the business logic of this practice."

The Secretary of State was good enough to tell us that he believed that some GPs prescribe too much. Will he be good enough to tell the House which patients, in his medical opinion, get too many prescriptions and which patients will get fewer prescriptions under his scheme? He had the brass neck to claim that the White Paper will increase patients' choice. Why does he not admit that his

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scheme means that patients will go not to the hospitals that they want to go to, but to the hospitals where their GP has the cheapest bargain? That is not money following the patients; this is patients following the money.

The Secretary of State has confirmed that the Prime Minister has had her way. There is to be a subsidy out of taxation for private medicine. Will he confirm that in the whole White Paper that fatuous irrelevance is the only proposal for help for the medical care of the elderly? Does that not speak volumes for the Government's priorities? There is to be no relief for hard-pressed geriatric wards, but a new subsidy for private hospitals.

Why did not the Secretary of State take this opportunity to respond to the Griffiths report on community care which he has had for almost a year? Is it to be ignored again because the private sector cannot turn a fast buck out of the community care of the handicapped and the elderly?

The White Paper is the product of a review behind closed doors by closed minds. Junior ministers, we read, were consulted over dinner at No. 10. Junior doctors were not consulted. Nurses were not consulted. Patients were not consulted. The result is a series of proposals that will be as unworkable as they will be unpopular.

Now the nation has a chance to join in the debate. In that debate, we shall take every opportunity to hammer home the fact that the White Paper proves that the change that the NHS needs more than any other is a change of Government.

Mr. Clarke: The hon. Gentleman started with some extraordinary comments about the amount of cash that was accompanying the review and seemed to imply that there was none. He talked about the time that has elapsed since the review was first announced. During that time, over £2,000 million has been added to NHS budgets in the public spending round and nearly £1,000 million has been added to finance the nurses' regrading exercise. Next year we are contemplating spending a total of £20,000 million.

The Labour party has no proposals for health at the moment, except some half-baked proposal for an inspectorate put forward in one of its documents. If its policy remains that nothing needs to be changed but that somehow it would add more money to what we put in, I shall regard such an approach to health care as pathetic and quite inadequate to meet the demands facing the service, which needs money and new ideas, both of which it is getting from the Government.

The hon. Gentleman treats in a most derisive way what he refers to as the accountancy and financing aspects, about which he asked me various questions. Again, I find that astonishing. If the hon. Gentleman shares my belief that there is no reason why the public service should not be run with the same efficiency and consumer consciousness as the private sector—*[Interruption.]*—he cannot dismiss the value of modern management disciplines, financial accountability and consumer consciousness that we are seeking to build into the Health Service. *[Interruption.]*

Mr. Speaker: Order. The Secretary of State has been asked a series of questions. The hon. Member for Bradford, South (Mr. Cryer) stands very little chance of being called to put a question if he continues to behave as he is doing.

Mr. Clarke: The hon. Member for Livingston asked about what he describes as the proposal for hospitals to opt out of district health authority care. I repeat that there is no question, and there never has been, of those hospitals leaving the NHS. The only person who has ever suggested that is the hon. Gentleman, when he purported to be describing documents which at that stage he would not read out to the public to whom he was talking. That ridiculous argument can be set aside.

I have described self-governing hospitals as being free of the constraints of detailed control from district and regional authorities and central Government which hospitals are presently under. The hon. Gentleman obviously prefers a service in which everybody is answerable to a bureaucratic district health authority, and he does not like proposals to give greater freedom to those with responsibility for care nearer to the patient.

The hon. Gentleman talks about practice budgets which we will offer—again a detail that he left out before today—to those large general practices which want to take them because they see their attractions to themselves and their patients.

It is ludicrous to describe this as inhibiting the ability of a GP and the GP's patients to have choice in the service. The reverse will be the case. At present, if a GP tries to send his or her patients to a hospital to which they have not previously been committed, the effect is to pose a financial problem for the hospital because no funds come with the patients. We are providing for NHS money to move with the patients, with the patients' choice, and to be available to those general practices which have the ability to manage it.

Doctors seeking to increase their number of patients will, contrary to the hon. Gentleman's assertion, have just as much, if not more, regard for the quality of care which a hospital might provide to the patients and not just to the costs. Indeed, what we are suggesting gives greater incentives to enhance quality.

On prescription costs, the hon. Gentleman has the temerity to attack what we are proposing to exercise downward pressure on prescription costs. I have read some of the Labour party's published documents, including the party's so-called green paper—[HON. MEMBERS: "Answer."] I am answering the question. I am using the hon. Gentleman's own words to answer his criticism of what we are saying about prescribing costs. The hon. Gentleman said in that green paper:

> "It is not immediately apparent that the current high level of drug consumption is a considered measure of the need for medical treatment. Inappropriate prescription does not merely result in ineffective expense but, more seriously, can adversely affect patient care."

I agree with what the hon. Gentleman said. Why does he not bring forward proposals to deal with it and why does he attack the proposals that we have announced today dealing with the self-same problem?

The tax relief proposals will assist many elderly patients who pay for private practice throughout their lives and find the costs increase when they reach the stage of their lives when they most need elective surgery. In so far as we support those people who provide for their own elective surgery, it will reduce the pressure on the rest of the service and help other elderly patients who will be able to get quicker waiting times and more access to the services of the NHS.

[Mr. Clarke]

We look forward to the debate. We will be consulting. We have a policy which will be followed up by working papers and detailed discussions in the next few months with everybody interested in the subject to work up the implementation of these proposals. I hope that the hon. Gentleman will make a better contribution to that debate than he and his party have made so far—*[Interruption.]* The trouble with the hon. Gentleman is that, even when he gets accurate leaks, he does not bother to read them and he does not bother to interpret them correctly or understand them. He now has the real White Paper and will find that we are miles ahead of him and his party in suggesting improvements for a stronger NHS for the future.

Dame Jill Knight (Birmingham, Edgbaston): Anyone who has listened properly to my right hon. and learned Friend's comments this afternoon will be well aware that the National Health Service has a strong future and that the prime objective of the review is to improve patient services. So let us get away from the claptrap of the Opposition and talk about facts.

I invite my right hon. and learned Friend to comment further on the phrase "the money will follow the patients", as some doctors may feel that unless the money precedes the patients, the treatment may not be there to fund it and the effect on waiting lists will not be seen. Will he assure us that the present monumental waste and extravagance of the way in which alleged misdemeanours by hospital consultants are dealt with will be ended by the proposals in the review?

Mr. Clarke: As my hon. Friend says, these proposals look to the future of the NHS, whereas the Labour party is accustomed to looking to the past of the service. Our proposals are marked, above all else, with their concern to concentrate our efforts on patient care and introduce changes that benefit patients.

I talk about money following the patient, and my hon. Friend's correction is good. One is talking about the time when the right mix of services is being planned by a district health authority for the patients in that district; then it will make provision in advance for the necessary finance to provide the services, as will the GPs operating their own practice budgets.

What I mean by the phrase is that judgments will first be made about the quality of the service that can be provided in different places, about the satisfaction that patients will get from it, about the waiting times that they may encounter before their treatment, and then the budgets will ensure that the money goes to those parts of the service where the treatment is given best.

That is not the case at present. Some hospitals find that if they work too hard they run out of money. Hospitals that do not work hard or efficiently are quite well provided with finance because the formula gives them all that they require and they appear to be free of problems. That is not in the interests of the patients, and we want to encourage good performance.

As for the disciplining of those few consultants who get into difficulties with their authorities in the management of their contracts, we shall be strengthening the management of consultants' contracts and district health authorities will be acting as the agents for the regional health authorities in drawing up new job descriptions for consultants about the work they do.

We have a long-standing problem about the discipline of recalcitrant consultants. I am glad to say that we have reached some agreement with the representatives of the profession and, following a recent working party report, we intend to introduce proposals which will have some simpler local methods of dealing with minor problems and will speed up the present appalling process whereby serious disciplinary matters are handled in the service.

Mr. Frank Field (Birkenhead): Does the Secretary of State accept that in the long run the most significant statement he has made this afternoon concerns the tax funding of private health care for pensioners? Is he aware that, now that that principle has been established, it will be ever more difficult to prevent the concession being extended to other groups, and that once that stampede is on it will become impossible for him to maintain a line about the necessary funding for a common health service? Is that not why—for all those reasons—he opposed that reform right up to last Thursday's Cabinet meeting?

When considering reactions to his proposals, will the right hon. and learned Gentleman accept that, while it is important to listen to doctors, nurses and ancillary workers, the views of the customers—the patients—are crucial? If he accepts that form of political consumerism, will he monitor his proposed reforms and report to the House on whether the customer services have improved or have been cut as a result of today's package?

Mr. Clarke: The hon. Gentleman makes a curious choice. As I am aware of his interest in the NHS and his openness at least to new ideas and methods which might improve the flow of services to patients, I take it as a welcome sign that he asked not a solitary question about the NHS parts of the proposals and queried only the tax relief to the private sector.

I do not see the analogy between our tax relief proposal and other claims for tax relief with which over the years we have all become familiar. The Government have rejected the case for general tax relief for contributios to private health care. But the situation of those over the age of 60 is plainly different from that of analogous claims that are made elsewhere. People who have been insured throughout their lives find that the premiums rise steadily at the very time when they want to make most demands on the service for which they have been paying. It is also a clear example where the tax relief to those who will continue, out of their own pockets, to contribute towards their care will be of obvious and direct benefit to every patient in the NHS by relieving the pressures on elective surgery.

I do not believe that this proposal, once implemented, will ever be repealed by the Labour party—or I look forward to seeing how it will ever argue for the withdrawal of this help for elderly people paying for their private health care.

To answer the hon. Gentleman's question about the monitoring of the reforms, we shall begin by having detailed discussions on their implementation. There are huge details to discuss—on matters such as GP practice budgets, self-governing hospitals and drug budgets. But in all that we do we shall, of course, listen particularly to the views of the public and the patients. In dealing with the big

management and financial issues, we shall not forget—the point I made at the outset—the interests of patients who do not want to be kept hanging around waiting, who want to know what is going on and who want a patient and friendly service from the hospital. They and their GPs will have greater ability to choose that between various hospitals as a result of what we are proposing today.

Sir David Price (Eastleigh): Does my right hon. and learned Friend accept that his proposals to decentralise decision-making within the hospital service will be dependent on two factors? The first is an increase in the quality of medical audit and of real costing, and the second is a major improvement in the quality of middle and senior managers.

Mr. Clarke: My hon. Friend is perceptive, and what he says is undoubtedly the case. This will require a huge improvement in the financial information that is available within the service. It is astonishing that a service that consumes £26 billion is at present so devoid of basic information about the use of resources, about comparative costs and so on. That will be acquired.

It will also need the people necessary to carry it out and have the ability to make proper use of these systems, and by "people" I mean the consultants and medical staff, who must be just as involved and have just as leading a role in organising all this properly as their management colleagues with whom they will work.

Mr. Archie Kirkwood (Roxburgh and Berwickshire): Extra resources are of course needed in the NHS, but is the Secretary of State aware that these proposals could inflict potentially great damage on the fundamental principles of the NHS in future?

Does he not accept that leaving health care to the vagaries of competition in the free market is a very unsafe way to proceed when delivering health care? In relation to primary health care, how is he going to protect the income of rural general practitioners' services? In particular, what incentives will GPs have to look after the elderly and infirm?

With regard to hospitals, is the principle of RAWP being abandoned? Some of the discrepancies between regions have disappeared, but there are still major discrepancies between health districts up and down the country. Can the Secretary of State also say whether the patients' travel costs, which he calls administrative boundaries, will be refunded?

Returning to the question raised by the hon. Member for Birkenhead (Mr. Field) about tax relief for the elderly, is he aware that the *Daily Telegraph* of 16 January, so far from saying that no precedents are being established, said that the same scheme could apply in logic to the cost of private schooling? What does the Secretary of State say to that?

Mr. Clarke: First, I urge the hon. Gentleman to study closely what I accept is an extremely detailed and complicated document, with a great sweeping reform. I think that then he will see that the principles of the Service are in no way threatened, as he clams, and that there is no prospect of any patient dropping through the system without essential care or essential medicine, or anything else.

I agree that we shall have to look at the problems that might otherwise be caused for rural general practitioners if we increase the percentage of remuneration that comes from capitation. The document therefore also canvasses our other proposal, to vary the level of the so-called basic practice allowance in different parts of the country. A higher basic practice allowance will, in my opinion, be required in scattered rural areas such as that represented by the hon. Member for Roxburgh and Berwickshire (Mr. Kirkwood), and in the constituencies of many other right hon. and hon. Members.

With regard to the treatment of the elderly and infirm, no doubt the hon. Gentleman has in mind the prospect of some large practices going in for a practice budget. It has been suggested, I see, that somehow they will have some incentive not to take on the elderly or infirm patients. Like many other things that I have heard discussed in the past few days, we had thought of that over the past few months, and we have long ago covered the problem.

Mr. Frank Dobson (Holborn and St. Pancras): Answer the question.

Mr. Clarke: The hon. Member for Holborn and St. Pancras (Mr. Dobson) will have to study this reform, and the working papers that are coming forward. I will answer the question now. In putting together a general practice budget, one must have regard to the number of patients, the age of the patients, their comparative sickness, and any other features that affect the practice. If one has a high proportion of elderly patients, one gets paid more for elderly patients than for younger patients. Any practice that refuses to take elderly patients, for some eccentric reason, will simply find that it is not paid so much per head as if it is taking only younger patients. It is quite easy to put together a budget-negotiating process that makes it clear that there is no financial advantage for any GP to select his patients in that way.

I have described the abolition of the RAWP system, but the hon. Gentleman the Member for Roxburgh and Berwickshire again is quite right in saying that there are still considerable discrepancies, some of them between the English regions and some between the districts. We will therefore be moving towards the system that I have described, over a period of two years for regions and rather longer for districts. There will still be, within an ever-growing total, some further redistribution from the Thames regions to the provinces, before we get to the position that I have described in today's statement.

As between the districts, there will still need to be some movement towards a common, fair and level basis, but we shall phase that in steadily to avoid any sudden movements of funds between districts. We believe that now is the time to get rid of RAWP. We shall certainly ensure that none of the discrepancies of the past that were caused by RAWP, and the gaps between targets and sudden movements of funds, are brought back again by our new system.

Mr. Nicholas Winterton (Macclesfield): I wish to congratulate my right hon. and learned Friend on the dramatic programme of reform that he has outlined to the House this afternoon. I share his objective, as I am sure does the whole House, that we should get a better quality Health Service and better value for money.

Will my right hon. and learned Friend give me two assurances this afternoon—first, that the opting-out proposals for a number of hospitals will not make it more difficult to plan a comprehensive health care service in

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areas up and down the country? Secondly—the Secretary of State will be probed fully about this when he comes before the Select Committee—could he go further into detail about how practice budgets will reflect accurately the various breakdowns in the lists of patients, especially the elderly, the mentally ill and the disabled, and where demographic changes occur over time?

Mr. Clarke: I am grateful to my hon. Friend, who is a fair man, that now he is prepared to contemplate and look more closely at the details of the full proposals, in the light of his first comments upon them. I think they are both very valid.

I have certainly heard the points he has been making, and we anticipated them. The opting out of hospitals must not disrupt essential services in the area. One condition of self-governing status must be that the region requires that hospital to continue to provide local emergency and other services that must be provided locally. If there are to be changes in the patterns of service, some notice must be given to the districts and regions so that planning can take account of them. All that will be contained in the working documents available to the Select Committee and others.

Similarly, with practice budgets, I tried in a comparatively potted way, by my standards, to give a brief discription a few moments ago of how we were tackling them. We obviously need to ensure that, in putting together the right budget for a general practitioner or group of GPs, we accurately reflect the likely different needs and demands of patients of different ages and conditions.

I heard what my hon. Friend the Member for Macclesfield (Mr. Winterton) said this morning on the radio. I should have liked to reply to him then, but no doubt in the Select Committee and in discussions afterwards I shall be able to reassure him on that point.

Mr. Michael Foot (Blaenau Gwent): One of the major weaknesses in the Government's review, as it appears to people from outside, and no doubt one of the major causes of the many defects in the plans put before us today, arises from the absence of any consultation, or what could properly be called by that name, by the Government of the people who work in the Service. Will the right hon. and learned Gentleman now tell us whether he is proposing to have any genuine consultations with people working in the Service: with the nurses, the unions, the British Medical Association, and the presidents of the royal colleges? Are they to be consulted at all, in a way that enables them to make a radical alteration to the proposals that the Secretary of State brings forward, or are the Government proposing to continue with the same method that the Prime Minister used, of slamming the door in the face of the presidents of the royal colleges and not caring what the people who work in the Service have to say?

Mr. Clarke: The National Health Service has a rather poor track record in communicating with its own staff and the people who work in it. For that reason immediately after this statement we are having an exercise that will communicate with all our staff throughout the service, and we shall discuss with them the implications for them and their patients of what I am proposing. *[Interruption.]*

The reaction to that, as we can hear, is that any attempt to communicate in that way rather than through the agency of the trade unions, is bitterly attacked by the Opposition, who are consulting before they have a policy. I accept that that is the principle of the listening party.

I have been looking at Labour's consultation documents and I see that it is not putting forward a solitary idea. All they have come up with so far, rather than putting forward new ideas, is a half-baked idea of an inspectorate, which is the kind of thing one would expect the Labour party to come up with.

The Labour party's idea of consultation on health policy, as we all know, is to ring up NUPE, reversing the charges, and ask what they should be expected to say. We propose to run the Health Service in an altogether more constructive fashion.

Sir Peter Emery (Honiton): Will my right hon. and learned Friend bear in mind the fact that, in answering any attack on this scheme, he must emphasise the caring nature of any Government who will spend an extra £3,300 million on the Health Service in this period?

Will my right hon. and learned Friend answer two questions for me? In the amount of money that will be available to the large practices, will this allow them to use funds for the support of cottage hospitals in the country, to build up some of them in areas where they provide a major service for people?

Secondly, will my right hon. and learned Friend perhaps think again to overcome the appointment of consultants by means of a contract for life? The concept that any person today can from the moment he gets his first appointment believe that he holds the appointment for ever seems inequitable and wrong. For a consultant, surely, a four-year contract to begin with, then to be renewed, is something everyone would support.

Mr. Clarke: If a well-run general practice makes savings on its practice budget, for example, by making use of a new formulary and tightening up prescribing costs, it will be able to plough back those savings into local services. We will not claw savings back from successful practices. That would permit them, for example, to put the funds into cottage hospitals supported by local GPs as part of local general practice.

On consultants' contracts, we are not changing the basic nature of the contract, which is not quite as my hon. Friend described. A consultant is in theory open to dismissal at three months' notice. At the moment, that is subject to a right of appeal to the Secretary of State. As I told my hon. Friend the Member for Birmingham, Edgbaston (Dame J. Knight), we are reconsidering the position because of the ineffectiveness of that right of appeal and the length of time it has taken in the past. We think that we have reached agreement with the profession about it.

Rev. Martin Smyth (Belfast, South): I welcome the Secretary of State's statement, which has clarified some points which did not come across in the official leaks. For example, until today I was not aware that Northern Ireland was included in the review. Will there be a discussion with people in Northern Ireland akin to what is planned for England and Wales and, to a lesser extent, Scotland? The Secretary of State for Northern Ireland paid a fleeting visit to the Chamber earlier, but there is no one from Northern Ireland here now to answer such questions.

Will the National Health Service management executive and the National Health Service policy board

include representatives from Northern Ireland, or are they technically for England and Wales? The Minister said that efficient hospitals would not have to close wards because there was not enough money. Is that an open-ended commitment to general practitioners throughout the land to provide them with sufficient funds to treat their patients properly?

Mr. Clarke: I understand the hon. Member not fully appreciating the scope of the review before today, because he had to rely on the hon. Member for Livingston (Mr. Cook) to be the interpreter of most of the documents which were available. My right hon. Friend the Secretary of State for Northern Ireland has been closely involved in all this. The review will apply to Northern Ireland, but in a way which reflects the local service. One whole chapter, chapter 12, is about Northern Ireland and explains exactly what will happen. I am sure that my right hon. Friend will have discussions within Northern Ireland with all interested parties.

The policy board and the management executive relate to my responsibilities which are for the English Health Service and for England only. The position in Wales, Scotland and Northern Ireland is different in a number of important ways. My respective right hon. Friends will be responsible entirely for the way in which the principles of the policy are put into practice in their countries.

Mr. Roger Sims (Chislehurst): Is my right hon. Friend aware that his imaginative proposals, which are centred not on the clinicians or on the administrators but on the patients, are warmly welcomed on this side of the House, as they will be throughout the country? It must make sense that patients, GPs and administrators can choose where treatment is to take place on the basis of quality and cost. That can only be done if it is possible to compare costing in the Health Service with that in the private sector. At present, that is not practicable in many areas, because the information is not there. What steps is my right hon. and learned Friend taking to enable comparisons to be made?

Mr. Clarke: I agree with all the points which my hon. Friend has made. It is important that, when people are making a choice based on a combination of quality and cost, they should have the best information. The information should be properly comparable between one hospital and another within the Health Service and between the NHS hospital and the private sector provision. That would make it possible for a district health authority or a general practitioner to look to the private sector for part of the service and equally possible for the private sector to look to the NHS. The artificial divisions, and the daft political argument that has gone on about the respective merits of the public and private sectors, should be put behind us, and we should all work to the best effect for patient care.

We will have to develop systems for costing. That will include examining methods of reflecting various capital costs between one and the other, a well as the revenue costs incurred in particular services. This will involve a major management effort over the next couple of years before the system can get running.

Mr. Jack Ashley (Stoke-on-Trent, South): If the National Health Service is to be as good as the Minister says, why is he encouraging older people to take out private medical insurance? Surely they are wasting their money. If the NHS is not to be as good as he says, what will happen to the millions of people who cannot afford private medical insurance? Can he tell us also why he has misled the House of Commons about the future of the Health Service? Does he recognise that great institutions in Britain are driven by their objectives and that the noble objective of the National Health Service is the best possible treatment, which is to be replaced by the cheapest possible treatment? That is an act of political vandalism for which he will never be forgiven.

Mr. Clarke: As the hon. Gentleman puts it, we may be encouraging elderly people to go for private care but they do not need encouragement from the Government. It is an inevitable consequence of rising living standards that an ever-increasing proportion of the population want to consider making insurance provision for their own health care. I cannot for the life of me see why we should stand in their way. If we encourage it for those over the age of 60 it will benefit millions of other elderly people by reducing the pressure on elective surgery in the Health Service, thus reducing waiting lists and waiting times. That is the basis on which we are proceeding.

I accept entirely what the right hon. Gentleman described as the noble objective of the National Health Service. The growing silence and absence of people on the Opposition Benches is because they realise that they have been misled by their official spokesman into believing that that objective was under attack. No doubt most of the right hon. Gentleman's hon. Friends have gone to the Library to look through the document to try to discover how the hon. Member for Livingston (Mr. Cook) felt able to base his attack on the document by raising all over again his ridiculous hare that we were trying to privatise the service.

Sir Fergus Montgomery (Altrincham and Sale): Does my right hon. Friend agree that the provision of 100 new consultants must have an effect on waiting lists? Will he also confirm that these consultants will be given the necessary back-up staff they require?

Mr. Clarke: I am grateful to my hon. Friend. Over a period of three years there will be 100 extra consultants, with the necessary support care they require. The problem is not with the people. There are a little over 100 who will be qualified for appointment in that time. We need the actual men and women to be consultants. Then we need the operating theatre time, the beds, the nursing staff and so on. Finance will be available to provide the back-up which will enable the extra work to be done. The consultants will be appointed in key specialties such as general surgery and general medicine where waiting times are worst. The extra consultants will also have some impact on the problem of junior doctors' hours. It is not every junior doctor who works the long hours which we all know to be excessive. Junior doctors' hours tend to be worse in general surgery, general medicine and obstetrics.

Mr. Dafydd Wigley (Caernarfon): The statement is nonsense in Wales, where we do not have regional health authorities. We should have had our own statement. Can the Secretary of State clarify the position in large, scattered areas where virtually no medical practice comes up to the 11,000 threshold? They will miss out on the opportunities. Likewise, in valley communities, will this not lead to an amalgamation of practices and a lessening of choice for

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patients? As there are virtually no private beds in Wales, is it not appalling that paragraph 11.9 of the White Paper should give priority to an increase in private provision, which is deeply detestable to the thousands of doctors, nurses, paramedicals and auxiliaries who work in Wales and who have given a lifetime of service to the NHS? Can the Secretary of State give an assurance that any hospitals currently under threat of closure will have the threat removed until the full implications of the statement have worked through?

Mr. Clarke: My right hon. Friend the Secretary of State for Wales was also closely involved. There is a chapter on Wales, which the hon. Gentleman will have seen. Wales is of a size similar to an English region. That gives my right hon. Friend and the Welsh the advantage of having the centre of the service much closer to practical provision on the ground. The Welsh have been spared some of the remoteness which I hope we shall now overcome in England by devolving so much responsibility to lower levels of management nearer to the patient. I am delighted to hear that the hon. Gentleman wants to be sure that GP budgets are introduced in Wales. Any question of reducing the threshold for Welsh general practice will have to be addressed to my right hon. Friend the Secretary of State for Wales.

Mr. Jerry Hayes (Harlow): I warmly welcome my right hon. and learned Friend's revolutionary proposals for patients, within an evolutionary framework. But will he confirm that, when the GPs' budgeting scheme comes into force—including the scheme for prescriptions—no surgeries will close and no patients will be deterred from treatment or turned away because of a lack of resources?

Mr. Clarke: I can give an absolute assurance to that effect. As will be clear to my hon. Friend, now that he has the documents, the system will be very flexible. Those who start overspending can indeed be called to account, but there is no question of stopping the service.

For the past few days, my hon. Friend and I have had to put up with critics projecting the absurd vision of practices closing down in the middle of February until the next financial year, people being turned away from medical treatment and so forth. Anyone who want to know what will happen should study our proposals with care. Those who have tried to find criticisms of them have been on a wild goose chase.

Mr. Peter Shore (Bethnal Green and Stepney): The Secretary of State has already told us about the massive extension of medical auditing, accountancy and financial costs that his proposals will entail. Has he costed the proposals? If so, will he tell us what the cost will be, and whether he will make additional finance available to the Health Service or intends to meet the cost of his reforms from existing expenditure?

Mr. Clarke: "Medical audit" is a phrase that I do not like when it is applied to a system of quality control devised by the medical profession. Clinicians will consult each other about the outcome or success of procedures, comparing notes and advising each other on how to raise the standard. That is separate from financial auditing. We have always had financial auditing in the Health Service, and we are now strengthening that by giving it to the Audit Commission and making it independent from the health Departments. I am sure that the whole House wants good financial auditing and value-for-money studies in the Health Service, in the interests of taxpayers and patients.

We made provision for some of the implementation costs in this year's public spending round. Provision has already been made in regional budgets for the introduction of financial management systems and so on, which, despite the attacks on them by Opposition Members, are desirable in themselves. If we were not reviewing the Health Service, we should still want Health Service management to take advantage of the best modern management techniques and to improve management information. It is shell-backed in the extreme for the Opposition to oppose advances in a great public service.

I can give the right hon. Gentleman an assurance that the cost of the proposals will not be met at the expense of plans for patient provision. There will be some cost up front, although eventually the savings made by cutting out waste will outweigh that and will benefit the service generally.

Dr. Alan Glyn (Windsor and Maidenhead): Having removed the difficulty of doctors using different areas, can my right hon. and learned Friend envisage a system in which the number of vacant beds is made available to doctors, so that instead of having to ring round and ask hospital after hospital whether there is a vacancy they will know immediately?

When will the self-governing hospitals come in? Is it possible to advance the date if a hospital wants to become independent before then?

Mr. Clarke: I agree entirely with my hon. Friend's first point. It is an excellent idea. I envisage that, as soon as possible, the microcomputer that every GP will have on his desk will provide, among other things, instant access to information about waiting lists within a wide area of his practice, so that he can advise patients about the shortest waiting times. In future, when he refers his patients, the hospital will pay for the extra patients, whereas in the past he would rather pay the hospital to keep it quiet, because it might receive patients for which no financial provision had been made.

We shall put the first self-governing hospitals into operation as quickly as we can, but for all the reasons that have been enumerated, including those mentioned by my hon. Friend the Member for Eastleigh (Sir D. Price), it will take a year or two before the first hospitals are capable of managing the process of self-government and making a success of it.

Mr. Jim Sillars (Glasgow, Govan): Will there be separate Scottish legislation to give effect to the document? Secondly, is the Secretary of State aware that he has now put the final nail into the lid of the coffin of the Tory party north of the border? It is transparently clear that the intention of the lady in Downing street is to fracture the national character of our Health Service and commercialise it, as a prelude to privatising it. We have never believed her claim that the National Health Service was safe in her private-patient hands. Is the Secretary of State aware that the fundamental gulf between the Scottish people and the English Tory party that governs us at present is that we do not consider the concept of market forces compatible with the medical ethic of providing care at the point of human need?

Mr. Clarke: We will probably not begin drafting legislation for any country until the summer, when the process of discussion will have advanced considerably. I am certainly not contemplating legislation in the present session of Parliament. When we draft the legislation we shall no doubt decide whether to have separate Bills for England, Scotland and the other countries or to have a single Bill for all of them.

I am rather vague about Scottish questions, because although the document contains a chapter dealing with them the system of governing the Health Service in Scotland is completely devolved. My right hon. and learned Friend the Secretary of State for Scotland is clearly best placed to answer questions about Scotland, and has already offered a debate in the Scottish Grand Committee.

I am astonished that the hon. Gentleman should think that opinion in Scotland will be so different from that in England. It would be absurd if we had a modern, more patient-conscious and efficient Health Service in England while the Scots preserved the Health Service as it was 40 years ago, with some modest changes. I know that my right hon. and learned Friend does not intend that, and that he will ensure that the Scottish Health Service, in a Scottish fashion, is made stronger, better and more responsive to patient needs.

Mr. Steve Norris (Epping Forest): I warmly welcome my right hon. and learned Friend's statement. May I remind him, however, of his comment that the better the management, the better would be the care? Many of us may be disappointed if he limits the management of consultants' contracts to giving district health authorities some sort of vague agency rights. Those of us with experience of managing the service at district level will look to him to ensure that consultants' contracts are held at that level by those who have to manage the consultants. Will he assure us that his effective management of consultants will include that provision?

Mr. Clarke: My hon. Friend has considerable experience of a district health authority himself, and I know that his views are shared by many people in such authorities. I ask him, however, to look closely at our proposals. Although the contract will be held with the region—it would be disruptive to change that for the sake of change—management of the contract will be devolved to the district, as the region's agent. In particular, the new provision for an up-to-date job description, to be reviewed each year, will close the gulf that sometimes now exists between local management and consultant.

Mrs. Audrey Wise (Preston): The Secretary of State failed to answer the point about lack of consultation. Will he now tell us plainly why the review had to take place behind closed doors? Could the reason have been a fear that evidence given publicly by those in the profession would get in the way of imposing this kind of change? Will the Secretary of State admit his determination to impose cash limits on general practice? Can he not imagine the shudder that will go through people when they realise that their treatment will be subject to the state of the practice budget?

Mr. Clarke: I hear what the hon. Lady says about consultation, but it seems to me that it is the duty of Government—and of a political party, come to that—to have a policy on how they propose to improve a great public service. Of course, having produced our policy, we are also producing a large amount of back-up material on which we will have the widest possible discussion with everyone interested, and we are starting discussions with our own staff straight away. We are engaging in much closer discussion with those who really work in the Service than I think has been tried by anyone before. The Labour Party's idea of consultation is to take a blank sheet of paper with no policy on it and to hold a series of silly meetings at which it asks whether anyone has a good idea. That is no way to form a policy.

I have already tried to explain—successfully to most people—that there is no prospect of patients' access to care being determined by the state of GPs budgets. In the extreme case of a practice that has consistently overspent by more than 5 per cent. for two years in succession, its budget will be taken away and it will be brought back into the general service. That will be a matter between the practice and the regional health authority. The patient will not notice any difference, except that, if the budget is operated properly, he will find that his GP can offer better choice and service, and hospitals will have an added incentive to provide better service.

Mr. John Greenway (Ryedale): Does not the clear and unambiguous support for the principle of a free Health Service available to all, outlined in my right hon. Friend the Prime Minister's foreword to the White Paper, constitute the most significant commitment to the National Health Service since it was formed 40 years ago? Is it not also right that the success of any service should be measured by the satisfaction of its customers and that, in putting patients first and creating a more coherent, responsive and effective National Health Service, the Government are right to say that we are working for the patient?

Mr. Clarke: The Labour party has been acting in this way for years. I am sure we all remember the 1983 election, which was largely fought by the right hon. Member for Birmingham, Sparkbrook (Mr. Hattersley) claiming that he had a secret document that said that the Government were about to privatise the Health Service. All that the hon. Member for Livingston (Mr. Cook) has done is to take that old gimmick out of its box, give it a whirl again and claim that it was possible to rerun the story on the strength of the leaked information he had received. We have not only repeatedly committed ourselves to the National Health Service—as we do today—but we have demonstrated that commitment by putting in more resources to enable the Service to treat 1·5 million more patients now than when the Government came to office. We have made it a better and more effective service for patients, and we propose to continue doing so.

Mrs. Rosie Barnes (Greenwich): Will the Secretary of State accept that, for the first time since the formation of the National Health Service, general practitioners will have financial incentives to limit how they treat their patients? There will be a restriction on prescribing and an incentive to refer fewer patients to hospital. Most importantly, there will be a strong disincentive for doctors to take on to their lists high-risk, high-cost patients such as the elderly, the chronically sick and the mentally ill. There is already evidence that, in the United States, where there are budget restrictions, such patients find it hard to persuade a GP to take them on. What would be acceptable

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grounds for budget practice GPs refusing patients? What right of appeal would the patients have, and to whom would those GPs be accountable if they refused?

Mr. Clarke: I do not understand why we should not offer incentives to GPs to make cost savings in their practices. At present there are wide discrepancies in costs between similar practices. Prescribing costs vary between different practices by as much as four times; the number of patients referred to hospital can vary by 20 times. If savings are made by GPs, they will not be clawed back by the Treasury but will be ploughed back into the practice to develop patient care in any way that the GP wants—for instance, in the form of new chairs for the waiting room or the support for a community hospital that my hon. Friend the Member for Honiton (Sir P. Emery) mentioned.

I thought that I had dealt several times with the argument that there will be incentives to take low-risk patients. That might be so if we paid the same rate for every patient, but we do not. By paying more for high-risk patients we have eliminated the risk—which I understand the hon. Member for Greenwich (Mrs. Barnes) fears—that there might be a disincentive to take high-risk patients. We always do our best to ensure that no such perverse incentives are built into health care systems.

When the hon. Member for Greenwich studies the report, she will find that much of what it recommends is astonishingly near to what the leader of her party, the right hon. Member for Plymouth, Devonport (Dr. Owen), advocated two or three years ago as an internal market in the Service. We have refined that idea to a much greater extent than anybody else and produced a good system, whereby cash follows patients. Immediately, the Social Democrats disown their interest in the internal market saying that it is a commercial system and dreaming up all sorts of fanciful risks that they say will lie behind it.

Mr. Derek Conway (Shrewsbury and Atcham): The fact that the NHS is treating more patients with more doctors and resources proves the Government's commitment to the NHS, not the Opposition's stolen lies. What will the proposals mean for rural areas such as Shropshire, which has a population of less than half a million but covers a land mass in excess of 25 per cent. of the west midlands? We should also like to opt out of the dead hand of regional control.

Mr. Clarke: I am familiar with the problems of Shropshire, not least because they are often pressed upon me by my hon. Friend the Member for Shrewsbury and Atcham (Mr. Conway)—*[Interruption.]* I think that my hon. Friend will acknowledge—even if the hon. Member for Holborn and St. Pancras (Mr. Dobson) is not instantly familiar with Shropshire—that the background to the problems in Shropshire is that we are opening, at considerable expense, a new district general hospital in Telford. Shropshire will have two district general hospitals, and would have had 20 small ones as well, had the service not been rationalised.

I know that my hon. Friend disapproves of how the region, and to some extent the district, have gone about rationalisation. Therefore, I am sure that he will welcome any proposals that give more local responsibility for such matters. Shropshire will want to take advantage of them as quickly as possible.

Dr. Lewis Moonie (Kirkcaldy): The Secretary of State's own GP will undoubtedly receive a large premium for looking after him after these these reforms are introduced, because he clearly has only a tenuous grasp on reality. The proposal is born of the eccentric mind of someone in the Adam Smith Institute who has no concept of what it is like to run a health service, as opposed to talking and thinking about one.

I wish to put three specific points to the Secretary of State.

Mr. Speaker: Order. One question, please.

Dr. Moonie: The three points are all part of the same question about how the service will be administered. The Secretary of State mentioned the patients' dependency as a factor for calculating costs. Is he aware that there is no way of measuring costs on an individual basis? He mentioned patient administration systems in hospitals. Is he aware that, as yet, no such system is fully effective? How long will it be until such a system is fully effective and capable of general introduction? Where shall we find computer staff to run it? The Health Service is already short of such staff.

Mr. Clarke: The hon. Gentleman talks about the need for clarity about how to measure different aspects and needs of patient care. As he knows, our English system of RAWP and the similar system in Scotland, SHARE, depend on a complicated formula that attempts to distribute resources on the basis of population, numbers, age and morbidity. It is easier——

Dr. Moonie: Reliable data do not exist—ask your officials.

Mr. Clarke: That is how it works. We shall discuss details afterwards. I am more familiar with RAWP than the hon. Member for Kirkcaldy (Dr. Moonie). Any distribution of funds involves such calculations. We must make the best calculations using modern methods. We have been developing patient administration systems and resource management information systems as rapidly as possible. They are required in the Health Service and I am sure that the hon. Gentleman will welcome their introduction. We have an ambitious timetable to introduce the necessary systems to implement the reforms. We shall need computer staff to do so, and I welcome the hon. Gentleman's recognition that the modern administration of a good large system is a good step—even if, at present, that is not remotely comprehended by his right hon. Friend, the leader of the Labour party.

Mr. Robert McCrindle (Brentwood and Ongar): If greater efficiency and better value for money are the watchwords of the White Paper, as they seem to be from my initial reading of it, is it not true that the health authorities appear to have escaped leniently? Does not my right hon. Friend agree that there is a case for the abolition of regional health authorities and for the absorption of some of their residual activities into the Department of Health. That would strengthen and exercise greater control over district health authorities. Is it not a fact that, rather than approaching it in that way, the White Paper appears to be strengthening the power of the regions?

Mr. Clarke: I would not take the powers of the regions back into the centre on any account. If we had to deal directly with 190 districts and 90 family practitioner

committees—without any regional authorities—it would be impossible to have any effective contact. We shall get the regional health authorities to concentrate on their real job, which is distributing funds locally, monitoring performance and laying our policy objectives. We shall stop the amount of detailed decision and supervision at regional level, which is no longer suitable for the Service.

Mr. Terry Davis (Birmingham, Hodge Hill): As some general practitioners refuse to give reasons for removing people from their list, how will the Secretary of State prevent a general practitioner from removing a patient from his list when the high risk has become high cost? If family doctors are trying to work within a budget, and even make savings, how can patients be sure that the doctors will do their best to arrange for the treatment needed by a patient, even if it means that the budget will be exceeded? Does not this development strike at the very heart of the relationship between doctors and patients?

Mr. Clarke: The doctor will be paid for a high-risk patient. Therefore, the financial incentive which the hon. Gentleman believes exists simply will not exist. With regard to the patient's satisfaction with his or her treatment and service, we propose to make it easier for the patient to choose for his or herself. If patients become dissatisfied with the service they are receiving from one doctor, we shall ensure that it will be easy to transfer from one doctor to another. That will give a greater incentive to general practitioners to ensure that the quality of the service and the way in which it is provided is the best possible for the patients in their care.

Mr. Henry Bellingham (Norfolk, North-West): Further to the question put by my hon. Friend the Member for Honiton (Sir P. Emery), I welcome the confirmation that cottage hospitals, which in Norfolk do so much for the care of the elderly, will still have a role to play. Does my right hon. and learned Friend agree that, increasingly, their future will be in the private sector, but with beds set aside for NHS patients?

Mr. Clarke: I believe that many cottage hospitals have an extremely important future. The last one I visited was Bealeys. It is an extremely small, well-run, GP hospital, which has a secure future in Bury. I know that there are many cottage hospitals in Norfolk, too.

The cottage hospitals will, of course, be able to continue as they are now. They will be given, anyway, greater responsibility for their affairs, because of the general devolving of responsibility about which we are talking. It is conceivable that some will find that self-governing status is suitable for them. Some hospitals are run by the GPs as independent hospitals. It is that variety of provision which is best. People in Norfolk know best how to provide for Norfolk. The combination of NHS and private care provided in Norfolk in their small hospitals will make it much easier for people in Norfolk to decide on their care.

Mr. Nigel Spearing (Newham, South): Does the Minister agree, from his constituency and family experience, that people especially the elderly, value district general hospitals and expect to go there—not further afield—when they are ill? Will not the right hon. and learned Gentleman's scheme encourage wider movement? Why should people from Newham have to go to Newmarket, people from Grantham to Gainsborough, or people from Finchley to Fulham? Is not such criss-cross market movement, even perhaps by motorway, completely incompatible with the wishes and the deep desires of the patients? How does he square that with the signed statement by the Prime Minister that the patient's needs will always be paramount? Does not that incongruity suggest that neither patients nor the Health Service are safe in her hands?

Mr. Clarke: I agree that patients look increasingly to local provisions, which is why we have had such a massive system of capital expenditure to improve local hospital provision throughout the country, and it is much less concentrated than it was. When confronted with the choice of either speedy treatment 30 miles down the road or a long wait for treatment in their local hospital, it will be for the patient and his or her GP to decide whether the inconvenience of travel is worth the speedier treatment. It would be perverse to deny patients that opportunity to choose. We are proposing that the patient should make the choice.

Mr. Robin Maxwell-Hyslop (Tiverton): Can my right hon. and learned Friend tell us about extra resources for patients who have come out of hospital—for instance, stroke patients—and need physiotherapy if they are to recover the faculties and functions they lost? My right hon. Friend will recall that Devon Members discussed this matter with him a couple of weeks ago. As there is less provision to keep patients in hospital long term—that seems to be a medical trend—the need for follow-up medical services and services ancillary to medicine simply are not being met at the moment. How does the very imaginative scheme that he has announced today compete with that admitted problem?

Mr. Clarke: Certainly, the services of the kind mentioned by my hon. Friend are every bit as important for the local community as services in the acute sectors of the hospital. I should make it clear that, when we talk about self-governing hospitals, what we are talking about in practice is the hospital together with the associated community health services, which we are used to seeing provided alongside hospital services, such as district midwifery and health visitor services, physiotherapists and other people providing service. We shall have to deal with the problem of stroke patients and others in Devon in our response to the Griffiths report on care in the community. We shall have to ensure that we are able to make the best and most sensible use of the resources available to carry on strengthening our community services.

Several Hon. Members *rose*——

Mr. Speaker: Order. I have an obligation to protect the subsequent business. I appreciate the importance of this statement. I will allow it to continue for a further five minutes. We shall then have had an hour and a half, which is a long time for a statement, but then we must move on.

Mr. Robert N. Wareing (Liverpool, West Derby): The Secretary of State began his speech by bemoaning the increasing cost of strokes to the National Health Service. Why does he not insist upon generic substitution for drugs in the Health Service, or even—better still—tackle the problem at source by taking the private monopoly drug companies into public ownership?

Mr. Clarke: I believe that general practioners should prescribe generic drugs when the remedy is as effective as

[Mr. Clarke]

a more expensive and branded alternative. We have been encouraging that. The last time that I was involved in an attempt to move in that direction, with a selected list, the Labour party made the foolish mistake of opposing it bitterly as a wicked attack on a doctor's freedom of choice. Having seen some of the hon. Gentleman's documents, I believe that his party is at least moving in the right direction on that subject. We shall not force generic substitution. We are constructing a system which will give every encouragement to general practitioners to make a sensible clinical judgment and go for the less expensive remedy when it is every bit as effective medically as the expensive alternative. We are tackling that all over again, and I look forward to the support of the hon. Gentleman and his right hon. and hon. Friends.

Mr. Tim Yeo (Suffolk, South): Does my right hon. and learned Friend agree that his proposals will be welcomed by everyone who has the future of the NHS at heart? Does my right hon. and learned Friend agree, too, that the fact that patients will be given more choice and power will provide the best possible spur to greater efficiency, effectiveness and consumer acceptability? Does he agree that the only person to whom his proposals must have come as a bitter disappointment is the hon. Member for Livingston (Mr. Cook) whose statements over the past few days have been shown to be so absurd that he no longer possesses any shred of credibility?

Mr. Clarke: I agree with my hon. Friend. I entirely endorse what he said. These proposals are for the benefit of the patient and every management or financial change of whatever complexity has underlying it the desire to ensure that the resources go to where they can best be used for patient care. The Labour party has no answer or equivalent to that. As my hon. Friend has said, I hope that the silly games that the Labour party has been playing in the past few days will be exposed for what they are.

Mrs. Alice Mahon (Halifax): Will the Minister confirm that his proposals will mean the end of national pay bargaining, and that one of the reasons for him meeting in secret was that he did not want to alert the staff to that fact? Is he aware of the disgust at the decision to kick out the only elected members of district health authorities, which is just one more example of the authoritarianism of this Government?

Mr. Clarke: I have long been advocating a much more flexible pay system for the National Health Service.

Mrs. Mahon: We know that.

Mr. Clarke: We have introduced more flexibility for some staff. We have asked the review body to consider allowing us to experiment with more local variations in the remuneration of nurses where there are local difficulties in recruiting them.

Of course, we keep our present structure of pay bargaining, but I make no apology for saying that I think our proposals will encourage more flexibility, and the self-governing hospitals in particular will take full advantage of it.

We are altering the nature of the district health authorities. It is nonsense that, at the moment, local government has the right to directly nominate representatives on the Health Service. Many of them do very valuable work but, at the other extreme, there are some who are merely there to bring local politics into the decision-making process of the Health Service. In some cases they have been exceedingly disruptive and people working in the Health Service—doctors and others—have to sit and listen to discussions of subjects which are only dimly related to the day-to-day problems with which they are dealing with in the hospitals.

Mr. Anthony Nelson (Chichester): In giving a strong welcome to these proposals, but questioning whether they go far enough, can I ask my right hon. and learned Friend to acknowledge that restructuring the system, replacing one allocation system by another or introducing budgetary independence does not in itself create net additional resources with which to satisfy the increasing demand for medical services of all kinds? Will he therefore keep an open mind about extending the tax relief that has been introduced for elderly people—which I very much welcome—not ruling out the possibility in the course of time of basic charges for hospital services?

Mr. Clarke: Plainly, we are injecting resources into the health system at the moment because we are reflecting rising demands for health care. Our proposals are not a substitute for more resources but are accompanying the extra resources which the Government are putting in from the taxpayer in order to make better use of the service. That is the way forward.

I do not agree with my hon. Friend on the general case for tax relief, largely for reasons which lie outside my direct province. I do not believe that the tax policy of the Government is to give tax relief for desirable forms of expenditure compared with others. We prefer a level of taxation which is low and gives the maximum individual choice to the taxpayer. However, the position of the retired, who often have contributed during their lifetime to health care, is different and it is defensible to say that to encourage, in the public interest, those people to continue in, or come into, private insurance is beneficial in effect for the general public.

Several Hon. Members *rose*——

Mr. Speaker: Order. May I say to those hon. Gentlemen and hon. Ladies who have not been called that I shall do my best to ensure that they are given some precedence when we subsequently debate this matter.

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PARLIAMENTARY STATEMENT ON THE NHS REVIEW

KENNETH CLARKE QC MP

Britain enjoys high and rising levels of Health Care and, at its best, our Health Service is as good as any in the world. I believe that the principles underlying the NHS still hold good today and they will continue to guide it into the next century. The NHS is - and must remain - open to all, regardless of income, and financed mainly out of general taxation.

But if those principles remain unchanged, the Health Service itself - and the society in which it operates - are changing for the better We need constantly to improve and strengthen the NHS so that it can provide ever better care to those who rely on it. At the moment there are wide variations in performance across the country. We want to maintain the best of the Health Service, and bring the rest of it up to that very high standard.

That is why the Government set out upon a fundamental review of the NHS last year. We have today published our conclusions in the White Paper entitled "Working for Patients". They build on and evolve from the improvements that the Government has already made to the Service in the last ten years. They reflect a change of pace rather than any fundamental change of direction. All of our proposals share a common purpose - to make the Health Service a place where patients come first and where decisions are increasingly taken at a local level by those most directly involved in delivering and managing care.

The main proposals apply to all the United Kingdom but there are separate chapters devoted to Wales, Scotland and Northern Ireland explaining how they will be applied in those countries. Implementation of the proposals will have to follow a process of discussion with many people in the serivce. We will be issuing in the course of the next week or two eight detailed working papers as the basis for those discussions.

Before I turn to the key proposals on management and the use of resources contained in the White Paper, I want to describe the kind of hospital service that I believe every patient has a right to expect. All hospitals should provide individual appointment times that can be relied upon. They should offer attractive waiting areas with proper facilities for patients and children. They should be able to provide proper counselling to those who need it and give clear and sensitive explanations of what is going on. In addition, patients should be able to pay for a number of optional extras such as a wider choice of meals, a bedside telephone, a television, or a single room. The best hospitals already provide this and I want to see the whole service treating patients properly as people.

We will also ensure that patients are freer to choose and change their GP. And we shall give more encouragement to those GPs who, by offering the kind of service that people want, succeed in attracting more patients. To achieve that, we are proposing to increase the proportion of GPs' pay which comes from the number of patients on their lists from 46% to at least 60%.

People look to their GPs to prescribe the medicines they need, and GPs must have the necessary flexibility to do so. But at present, drug costs in some places are nearly twice as high per head of population as in others, even where the incidence of illness is much the same. The drugs bill is the largest single element of all spending on the family practitioner services. At £1.9 billion in 1987-88, it was more than the cost of the doctors who wrote the prescriptions. In each of the last five years, spending has risen by an average of 4% over and above the rate of inflation. Unnecessarily expensive prescribing is wasteful and takes up resources that should be used in other ways. Over - prescribing is not in the best interests of patients. We shall therefore introduce a new budgeting scheme whereby GP practices will receive indicative budgets for their prescribing costs. The scheme will be operated in a way that ensures downward pressure on the cost of prescribing without inhibiting the ability of doctors to provide necessary medicines for their patients.

At present, because of the way that hospitals are funded, GPs are not always ableto offer their patients a full choice as to where they will be treated. We want to change this by giving GPs in large practices the opportunity to hold their own NHS budgets. They will be able to use these to purchase as they judge best certain types of hospital services for their patients. They will, in other words, be able to provide the hospitals they choose for their patients with the NHS funds required to finance the services the hospitals perform.

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These GP practice budgets will cover in-patients, out-patients and day care treatments - for instance hip replacements and cataract removals. They will also cover prescribing costs and diagnostic tests - such as X-rays and pathology tests. Large practices will be free to decide whether to join the scheme or not. It will at first only be open to practices with at least 11,000 patients - that is twice the national average. Over 1,000 UK practices could join, covering about 1 in 4 of the population. All of those practices could have their own NHS budgets of about £1/2 million a year. Giving GPs the resources to finance services for their own patients will provide a real incentive to hospitals to improve the service they offer to those GP's. It will also enable GPs to provide a better service to patients for example by referring them to where waiting lists are shortest. And I am quite sure that GP's will want to judge the quality of service at least as much as the cost of services when they decide where to refer their patients. We have important proposals on the quality of medical service to which I shall turn later.

But it will not just be through GP practice budgets that money will follow the patient to where work is done best. The principle will apply throughout the Health Service as a whole. As part of this new way of getting resources to hospitals, the present elaborate system known as RAWP will come to an end. Over the last 12 years it has made an important contribution by helping to equalise the resources available to each Region, but that task has now very largely been achieved. Now we are in a position to replace it with an altogether more simple and fair system based on population numbers weighted for

age and health, and the relative costs of providing services. It will be much quicker to compensate those regions which treat large numbers of patients from elsewhere in the country. We will move to a system which finances Regions and Districts on exactly the same system with a 3% addition for the Thames Regions because of the inescapable extra problems of providing health care in the capital.

In future, the money required to treat patients will be able to cross administrative boundaries more freely, so that those hospitals which best meet patients' needs get the funds to do so. All NHS hospitals will be able to offer their services to different health authorities and the private sector. All District Health Authorities will be able to provide finance for health services to whatever hospitals they choose in other Districts or their own. As a result, we will not in future have the frustrating situation whereby a good, efficient hospital that attracts more patients runs out of money and has to slow down its work or close wards. This new system will start in 1990 for Regional Health Authorities, and 1991 for districts.

But improving the hospital service is not just a matter of changing the way in which hospitals receive their funds. We also want to change the way in which they are run and managed. We want all hospitals to have more responsibility for their own affairs so that they can make the most of local commitment, energy and skills, and can get on with what they are best at - providing care.

Management can be strengthened throughout the whole Health Service, The better the management the better the care it can deliver. Financial accountability and value for money will be improved by transferring audit of the health authorities and other NHS bodies to the independent Audit Commission. The role of the National Audit Office will not be affected by this change. On management matters, it is a nonsense that the Ministers of any Government should be directly involved in the detail of the day-to-day running of the whole NHS. We shall therefore set up a new NHS Management Executive, chaired by the new Chief Executive, Mr Duncan Nichol and responsible for all operational decisions. It will be accountable to an NHS Policy Board chaired by the Secretary of State for Health who will determine policy and strategy for the Service.

The prime responsibility of Health Authorities will be to ensure that the population for which they are answerable has access to a full range of high quality, good value services. Their job will be to judge the quality of services, to choose the best mix of services for their resident population and to finance those services. They will no longer provide and run all their local services which will be increasingly the role of the hospital and unit managers themselves. Authorities will need to be organised as more effective decision making and managerial bodies. We shall therefore be changing their composition to make them smaller and to include executive and non-executive members. The non-executive members will be appointed on the basis of the personal skills and expertise they can bring to the authority and not as representatives of interest groups. Although there will no doubt continue to be people who will combine being members of local health authorities with being local

councillors, local authorities will lose their present right to appoint direct their own members. At the same time, we shall also be strengthening the management of FPCs along similar lines. We will also make them accountable for the first time to Regional Health Authorities so as to improve the links between planning for the hospital, community and family practitioner services.

We must devolve responsibility across the whole Health Service. But I believe that we can also go one stage further. The next logical step in the process of extending local responsibility is to allow individual hospitals to become self-governing. Let me make it absolutely clear that they will still be as much within the NHS as they are now. They will be no freer to leave the NHS than any unit has been throughout its forty year history. They will have far more freedom to take their own decisions on the matters that affect them most without detailed supervision by District, Region and my Department. Known as NHS Hospital Trusts, they will be free to negotiate with their own staff on rates of pay, and within limits to borrow money. They will be able to offer agreed services for agreed resources throughout the NHS, and indeed in the Private Sector too. There will of course be safeguards to ensure that essential local services continue to be delivered locally. I believe that this new development will give patients more choice, produce a better quality service, build on the sense of pride in to local hospitals, and encourage other hospitals to do even better in order to compete. I expect the first NHS Hospital Trusts to set up in April 1991.

Mr Speaker, in all these reforms we intend to concentrate on the quality of care as much as quantity and cost. I admire the progress with which the medical profession is devising systems which doctors call "medical audit" to assess clinical performance and outcomes. We intend to work with the profession to ensure that good systems of medical audit are put in place in every hospital and GP practice as soon as is practicable. What matters for all patients, is that high standards of medical performance are maintained and where possible improved and such systems should secure that.

I turn finally to the area of perhaps greatest public concern - waiting times. All the measures I have so far outlined by making resources flow more directly to those parts of the service that deliver the best care, will help to cut the length of time that people sometimes have to wait for elective surgery. The Waiting List initiative will continue but we shall also introduce a number of other initiatives designed to have a more direct and immediate impact. First, we intend all GP practices to have the basic information systems they need to know where treatment is available quickest. Second, we shall introduce a new tax relief to make it easier for people aged 60 and over to make private provision for their health care. This will reduce the pressure on the NHS from the very age group most likely to require elective surgery, freeing up resources for those who need it most. Third, we shall manage consultants' contracts more effectively so that the very best use is made of their time and expertise. We will also reform the Distinction Award system, to ensure that commitment to the service and involvement with the management of the NHS are included among the criteria for awards. And fourth, we shall increase the number

of consultants by 100 over the next three years over and above the increase in the number of consultants already planned. These additional consultants will be appointed in those specialties and in those Districts where waiting times are most worrying. Finance will be made available to cover the costs of the new appointments, and the supporting services for their workload. This will help us keep up the attack not only on waiting times, but also on long hours worked by junior doctors.

Taken together, these proposals add up to the most formidable programme of reform in the history of the NHS. They are the latest step in our drive to build a stronger, more modern, more efficient Health Service. For an NHS that is run better will be an NHS that can care better. They will of course mean change, but change of the kind we need if we are to have a service that is fit for the future. I trust that all those who - like me - truly believe in a Health Service which offers high quality care to all our people, will lend their support to these reforms, and I commend them to the House.

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

cc P.M.

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

Prime Minister
The final version.
RRCG
30 January 1989

COVERING SECRET

Paul Gray Esq
10 Downing Street
LONDON SW1

Dear Paul

WHITE PAPER "WORKING FOR PATIENTS"

I attach a confidential final revise of the White Paper "Working for Patients" which is to be published at 3.30pm tomorrow. My Secretary of State will be making a Statement in the House at that time.

I am copying this letter and enclosure to the Private Secretaries, to members of the Cabinet, and also to Trevor Woolley at the Cabinet Office.

Yours
Andy

A J McKEON

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

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

CONFIDENTIAL

Paul Gray Esq
10 Downing Street
LONDON SW1

30 January 1989

Dear Paul

NHS REVIEW: STATEMENT TO HOUSE

I enclose a draft of the Statement which my Secretary of State proposes to give to the House tomorrow. I should be grateful to have any comments as early as possible tomorrow morning.

I am sending copies of this letter and attachment to Private Secretaries of other members of the Ministerial Group and to Richard Wilson (Cabinet Office).

Yours

Andy

A J McKEON
Private Secretary

0642A

DRAFT PARLIAMENTARY STATEMENT

Britain enjoys high and rising levels of Health Care and, at its best, our Health Service is as good as any in the world. I believe that the principles underlying the NHS still hold as good today as they ever have and they will continue to guide it into the next century. The NHS is - and must remain - open to all, regardless of income, and financed mainly out of general taxation.

But if those principles remain unchanged, the Health Service itself - and the society in which it operates - are changing for the better. We need constantly to improve and strengthen the NHS so that it can provide ever better care to those who rely on it. At the moment there are wide variations in performance across the country. We want to take the best of the Health Service, and bring the rest of it up to that very high standard.

That is why the Government set out upon a fundamental review of the NHS last year. We have today published our conclusions in the White Paper entitled "Working for Patients". They build on and evolve from the improvements that the Government has already made to the Service in the last ten years. They reflect a change of pace rather than any change of direction. All of our proposals share a common purpose - to make the Health Service a place where patients come first and where decisions are increasingly taken at a local level by those most directly involved in delivering and managing care.

The main proposals apply to all the United Kingdom but there are separate chapters devoted to Wales, Scotland and Northern Ireland explaining how they will be applied in those countries. Implementation of the proposals will have to follow a process of discussion with many people in the serivce. We will be issuing in the course of the next week or two eight detailed working papers as the basis for those discussions.

Before I turn to the key proposals on management and the use of resources contained in the White Paper, I want to describe the kind of hospital service that I believe every patient has a right to expect. I intend to ensure that all hospitals will provide individual appointment times that can be relied upon. They should offer attractive waiting areas with proper facilities for patients and children. They should be able to provide proper counselling to those who need it and give clear and sensitive explanations of what is going on. In addition, patients should be able to pay for a number of optional extras such as a wider choice of meals, a bedside telephone, a television, or a single room. The best hospitals already provide this and I intend to ensure that the whole service treats patients properly as people.

We will also ensure that patients are freer to choose and change their GP. And we shall give more encouragement to those GPs who, by offering the kind of service that people want, succeed in attracting more patients. To achieve that, we are proposing to increase the proportion of GPs' pay which comes from the number of patients on their lists from 46% to at least 60%.

People look to their GPs to prescribe the medicines they need, and GPs must have the necessary flexibility to do so. But at present, drug costs in some places are nearly twice as high per head of population as in others. The drugs bill is the largest single element of all spending on the family practitioner services. At £1.9 billion in 1987-88, it was more than the cost of the doctors who wrote the prescriptions. In each of the last five years, spending has risen by an average of 4% above the rate of inflation. Unnecessarily expensive prescribing is wasteful and takes up resources that should be used in other ways. Over - prescribing is not in the best interests of patients. We shall therefore introduce a new budgeting scheme whereby GP practices will receive indicative budgets for their prescribing costs. The scheme will be operated in a way that ensures downward pressure on the cost of prescribing without inhibiting the ability of doctors to provide necessary medicines for their patients.

At present, because of the way that hospitals are funded, GPs are not always ableto offer their patients a full choice as to where they will be treated. We want to change this by giving GPs in large practices the opportunity to hold their own NHS budgets. They will be able to use these to purchase as they judge best certain types of hospital services for their patients. They will, in other words, be able to provide the hospitals they choose with the NHS funds required to finance their work.

These GP practice budgets will cover in-patients, out-patients and day care treatments - for instance hip replacements and cataract removals. They will also cover prescribing costs and diagnostic tests - such as X-rays and pathology tests. Large practices will be free to decide whether to join the scheme or not. It will at first only be open to practices with at least 11,000 patients - that is twice the national average. Over 1,000 UK practices could join, covering about 1 in 4 of the population. All of those practices could have their own NHS budgets of about £1/2 million a year. Giving GPs the resources to finance services for their own patients will provide a real incentive to hospitals to improve the service they offer to those GP's. It will also enable GPs to provide a better service to patients for example by referring them to where waiting lists are shortest. And I am quite sure that GP's will want to judge the quality of service at least as much as the cost of services when they decide where to refer their patients. We have important proposals on the quality of medical service to which I shall turn later.

But it will not just be through GP practice budgets that money will follow the patient to where work is done best. The principle will apply throughout the Health Service as a whole. As part of this new way of getting resources to hospitals, the present elaborate system known as RAWP will come to an end. Over the last 12 years it has made an important contribution by helping to equalise the resources available to each Region, but that task has now very largely been achieved. Now we are in a position to replace it with an altogether more simple and fair system based on population numbers weighted for

age and health, and the relative costs of providing services. It will be much quicker to compensate those regions which treat large numbers of patients from elsewhere in the country. We will move to a system which finances Regions and Districts on exactly the same system with a 3% addition for the Thames Regions because of the inescapable extra problems of providing health care in the capital in particular.

In future, the money required to treat patients will be able to cross administrative boundaries more freely, so that those hospitals which best meet patients' needs get the funds to do so. All NHS hospitals will be able to offer their services to different health authorities and the private sector. All District Health Authorities will be able to provide finance for health services to whatever hospitals they choose in other Districts or their own. As a result, we will not in future have the frustrating situation whereby a good, efficient hospital that attracts more patients runs out of money and has to slow down its work or close wards. This new system will start in 1990 for Regional Health Authorities, and 1991 for districts.

But improving the hospital service is not just a matter of changing the way in which hospitals receive their funds. We also want to change the way in which they are run and managed. We want all hospitals to have more responsibility for their own affairs so that they can make the most of local commitment, energy and skills, and can get on with what they are best at - providing care.

Management can be strengthened throughout the whole Health Service, The better the management the better the care it can deliver. Financial accountability and value for money will be improved by transferring audit of the NHS to the independent Audit Commission. On management matters, it is a nonsense that the Ministers of any Government should be directly involved in the detail of the day-to-day running of the whole NHS. We shall therefore set up a new NHS Management Executive, chaired by the new Chief Executive, Mr Duncan Nicholl and responsible for all operational decisions. It will be accountable to an NHS Policy Board chaired by the Secretary of State for Health who will determine policy and strategy for the Service.

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councillors, local authorities will lose their present right to appoint direct their own members. At the same time, we shall also be strengthening the management of FPCs along similar lines. We will also make them accountable for the first time to Regional Health Authorities so as to improve the links between planning for the hospital, community and family practitioner services.

We must devolve responsibility across the whole Health Service. But I believe that we can also go one stage further. The next logical step in the process of extending local responsibility is to allow individual hospitals to become self-governing. Let me make it absolutely clear that they will still be as much within the NHS as they are now. They will be no freer to leave the NHS than any unit has been throughout its forty year history. They will have far more freedom to take their own decisions on the matters that affect them most without detailed supervision by District, Region and my Department. Known as NHS Hospital Trusts, they will be free to negotiate with their own staff on rates of pay, and within limits to borrow capital. They will be able to offer agreed services for agreed resources throughout the NHS and the Private Sector. There will of course be safeguards to ensure that essential local services continue to be delivered locally. I believe that this new development will give patients more choice, produce a better quality service, build on the sense of pride in to local hospitals, and encourage other hospitals to do even better in order to compete. I expect the first NHS Hospital Trusts to set up in April 1991.

Mr Speaker, in all these reforms we intend to concentrate on the quality of care as much as quantity and cost. I admire the progress with which the medical profession is devising systems which doctors call "medical audit" to assess clinical performance and outcomes. We intend to work with the profession to ensure that good systems of medical audit are put in place in every hospital and GP practice as soon as is practicable. What matters for all patients, is that high standards of medical performance are maintained and where possible improved and such systems should secure that.

I turn finally to the area of perhaps greatest public concern - waiting times. All the measures I have so far outlined by making resources flow more directly to those parts of the service that deliver the best care, will help to cut the length of time that people sometimes have to wait for elective surgery. The Waiting List initiative will continue but we shall also introduce a number of other initiatives designed to have a more direct and immediate impact. First, we intend all GP practices to have the basic information systems they need to know where treatment is available quickest. Second, we shall introduce a new tax relief to make it easier for retired people to make private provision for health care. This will reduce the pressure on the NHS from the very age group most likely to require elective surgery, freeing up resources for those who need it most. Third, we shall manage consultants' contracts more effectively so that the very best use is made of their time and expertise. We will also introduce new incentives to reward those consultants who become more involved with the management of the NHS. And fourth, we shall increase the number

of consultants by 100 over the next three years. Those consultants will be appointed in those specialties and in those Districts where waiting times are most worrying. Extra finance will be available to cover the costs of the new appointments, and the supporting services for their workload. This will help us keep up the attack not only on waiting times, but also on long hours worked by junior doctors.

Taken together, these proposals add up to the most formidable programme of reform in the history of the NHS. They are the latest step in our drive to build a stronger, more modern, more efficient Health Service. For an NHS that is run better will be an NHS that can care better. They will of course mean change, but change of the kind we need if we are to have a service that is fit for the future. I trust that all those who - like me - truly believe in a Health Service which offers high quality care to all our people, will lend their support to these reforms, and I commend them to the House.

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

CC PM.

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

CONFIDENTIAL

Paul Gray Esq
No 10 Downing Street
LONDON SW1

30 January 1989

NHS REVIEW

I attach briefing on the Review White Paper for Cabinet Ministers as requested at last week's Cabinet meeting.

I am copying this letter and attachment to the Private Secretaries of other Cabinet Ministers and to Trevor Woolley.

Julie McAuslan FOR

A J McKEON
Private Secretary

NHS REVIEW WHITE PAPER

Background and Summary

1. The Government's White Paper on the NHS, "Working for Patients", was published on 31 January 1989 following a year-long review of the NHS.

2. The White Paper concentrates on the hospital and family doctor service. It proposes a series of measures to improve the quality and efficiency of services. In particular:

- power and responsibility will be delegated much more to the local level, including greater flexibility in setting pay and conditions and over the use of capital;

- the role of the centre will be clarified by the establishment of a Management Executive with responsibility for NHS operations which will be accountable to a Policy Board chaired by the Secretary of State for Health;

- Regional and District Health Authorities (RHAs and DHAs) will be slimmed down and reconstituted. Local authorities will no longer have a right to appoint DHA members;

- hospitals will be able to apply for self-governing status, while remaining in the NHS. They will be known as NHS Hospital Trusts and will have considerable freedom over their use of resources;

- new funding arrangements will ensure that resources are channelled to those hospitals which attract most patients. Health authorities will be encouraged to buy the best service they can for their population whether from their own hospitals, other health authorities' hospitals, NHS Hospital Trusts or the private sector;

- hospital consultants will be expected to take more responsibility for their use of resources, and they will have fuller job descriptions. The system of distinction rewards will be revised;

- 100 new consultant posts will be created over the next 3 years in specialties with the longest waiting times;

- GPs in large practices will be able to opt to have their own budgets for buying a range of services direct from hospitals;

- indicative drug budgets for GPs will be introduced to put downward pressure on prescribing costs;

- the management of Family Practitioner Committees (FPCs) will be improved. They will become accountable to RHAs;

- what doctors call "medical audit" - quality control by peer review - will be extended to cover all hospitals and GP practices;

- the Audit Commission will assume responsibility for auditing the accounts of health authorities and other NHS bodies, and will undertake wide-ranging value for money studies;

- retired people will be able to claim tax relief on private health insurance.

Key facts on the NHS (UK base)

3. - the number of doctors and dentist increased from 42,000 in 1978 to 48,000 in 1987, an increase of over 14 per cent;

- the number of nursing and midwifery staff grew from 444,000 to 514,000 during the same period, an increase of 16 per cent;

- total gross expenditure on the NHS has increased from £8 billion in 1978-79 to £26 billion in 1989-90, an increase of 40 per cent after allowing for general inflation;

- the NHS now treats over one and a half million more inpatients a year than in 1978, bringing the total to nearly 8 million.

Points to make

4. - this is the most fundamental review of the NHS in its 40 year history. The Government is keeping all that is best in the NHS whilst strengthening it to meet the challenges of the 1990s;

- the Government remains committed to the underlying principles of the NHS that is open to all, regardless of income, and financed mainly funded out of general taxation;

- the Government has put patients first. More local flexibility and competition in the provision of services means more choice and better quality services. Hospitals will have major incentives to attract more patients by improving services;

- this will reduce waiting lists further. As a result of earlier Government initiatives, half of all waiting list patients are already admitted to hospital within five weeks or less;

- hospitals will be freer to respond to local needs. NHS Hospital Trusts are not a step on the road towards privatisation - they will remain an integral part of the NHS;

- the role of GPs will be enhanced and patients who are not satisfied with the service will be able to change GPs more easily;

- staff working in the NHS will have stronger incentives to improve performance, greater control over their resources and greater freedom to innovate and respond to patient preferences.

Points to watch

5. - Action on Griffiths' report on community care?

The NHS review has focused closely on the funding and management of health services - hospitals and family doctors in particular. The interaction of health and social care in the field of community care needs further study. That work is well in hand.

- Won't cash-limited drug budgets harm patients?

No. Patients will continue to get the drugs that they need but, by encouraging more effective and economic prescribing, the Government wants to release more resources for other areas of patient care.

- Will the introduction of contracts restrict GPs freedom of referral?

This is not the Government's intention. By improving the information that is available to GPs and encouraging more contact between GPs and hospitals, the Government wants to enhance the role of GPs as gatekeepers to the hospital service.

- NHS Review White Paper a bureaucrat's delight?

No. The Government's aim is to produce a more effective and responsive service, by redistributing staff to the hospital level where possible and strengthening key functions.

- Isn't the White Paper preparing the NHS for the Private Sector?

The White Paper makes it plain that the Government remains committed to a public sector service that is available to all, regardless of income, and financed mainly out of general taxation. NHS Hospital Trusts will remain an integral part of the NHS.

- Will higher regional costs still be reflected in the allocation of resources?

Yes. The Thames Regions will receive a slightly higher funding than the rest - some 3 per cent higher per head of population - to reflect the higher costs of and demands on services in the capital in particular.

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PRIME MINISTER

NHS WHITE PAPER

I attach:

Flag A - Draft of Kenneth Clarke's statement tomorrow.

Flag B - Briefing on the NHS Review prepared by members of Cabinet.

Flag C - The final version of the White Paper.

Do you want to feed in any comments on the statement?

PRCG.

Paul Gray

30 January 1989

It is very long.

27/1/89

STATEMENT FROM KENNETH CLARKE, SECRETARY OF STATE FOR HEALTH.

Giving highly coloured accounts of so-called leaked documents is no way for a responsible politician to behave. Robin Cook and Harriet Harman really ought to stop larking around if they want to be taken seriously. Scare stories about privatizing the NHS are very old hat, and have been parrotted by the Opposition for almost as long as anyone can remember. The real White Paper will be published on Tuesday when we will be able to have a proper debate, based on the full facts.

PA – NOTS

STATEMENT FROM KENNETH CLARKE, SECRETARY OF STATE FOR HEALTH

"For the last ten years, it has been standard practice to claim that we are on the point of privatizing the National Health Service. That has never been true, and is no more true today.

"Let me make it absolutely plain - we have no plans whatever to encourage hospitals to leave the NHS. For Robin Cook to imply we have, is the most irresponsible scare-mongering.

"To the best of my recollection, the words 'opt out' have never even appeared in any draft of the White Paper. Rather than ferreting around in this ridiculous manner, he ought to wait until next Tuesday when we will have a full discussion in Parliament on the Government's actual, detailed plans."

25th January 1989

A089/222

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cc B Hoskyns

10a-b

PRIME MINISTER

DRAFT WHITE PAPER ON THE REFORM OF THE NATIONAL HEALTH SERVICE
C(89) 2 and E(A)(89) 2:
Memorandum by the Secretary of State for Health

DECISIONS

1. The purpose of this item is to secure formal Cabinet approval of the proposals in the White Paper and agreement that it should be published on 31 January.

2. You may wish to begin with a few general comments about the proposals, on the lines suggested below, and then to invite the Secretary of State for Health to introduce the White Paper.

3. In the discussion which follows you may wish to make the point that the Cabinet is being invited to endorse the substance of the proposals: the Secretary of State must retain discretion to polish it provided that he does not change the sense. You may also wish to check that there are adequate arrangements for co-ordinating public presentation with the Secretaries of State for Wales, Scotland and Northern Ireland, backed up by agreed briefing.

OPENING REMARKS

4. In opening the discussion you may wish to draw on the following:

i. The central theme of the reforms is the need to provide a better Health Service for patients: raising the performance of all hospitals and GP practices to the level of the best. It is particularly important to bring about first, a greater devolution of responsibility throughout the NHS, so that so far as possible those who provide the service can take the decisions; and second, to allow the

money to follow the patient, so that the resources go to the hospitals which do the work.

ii. The proposals for self-governing hospitals and for GP practice budgets are major, fundamental reforms. Both are designed to lead to greater choice and value for money for patients who, as taxpayers, are providing huge sums for the NHS. There is no question of the hospitals 'opting out' of the NHS.

iii. Another key theme is to get the public and private sector working together. A healthy and growing private sector adds to the choice for patients. The proposal for tax relief for the elderly is important in this context and will be welcomed.

iv. Finally, there will be an important drive to sharpen up the accountability and efficiency of NHS management. The aim is to take out the political element in District Health Authorities and to streamline the system so that there is a proper chain of command running from the bottom to the top, with the Audit Commission providing more effective audit arrangements. On the professional side, there will be much greater use of medical audit and better arrangements for consultants.

HANDLING

5. After the Secretary of State has introduced the White Paper, you may wish to give members of the Cabinet who are not on E(A) a chance to comment. This includes the Secretary of State for Social Security (who was involved in the early months of the Review), the Secretary of State for Foreign and Commonwealth Affairs, the Home Secretary, the Secretary of State for Defence and the Secretary of State for Education and Science.

HRB

ROBIN BUTLER

Cabinet Office
25 January 1989

cst.ps/7jm25.1/drfts

CONFIDENTIAL

cc PUS

Prime Minister
To note these loose ends. I hope it will be possible to resolve them without involving you

AT 25/1

Treasury Chambers, Parliament Street, SW1P 3AG

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

25th January 1989

Dear Ken,

NHS REVIEW: DRAFT WHITE PAPER

On re-reading the complete draft of the White Paper, we have noticed that the proposals you and I agreed in relation to the FPS, described in HC 68 and subsequently endorsed by the Ministerial Group, are not fully reflected in the draft. I am sorry to raise a point of substance at such a late stage, but as you will appreciate it is a matter of some importance.

Chapter 7 of the White Paper does not make clear that drug budgets will be cash limited at regional level. This is clearly important. Nor does it make clear that the increased capitation element of GPs' remuneration will be at the expense of basic practice allowance, which will become subject to geographical variation, including abolition in some areas. I realise that the final sentence of 7.3 could be taken to imply this, at least partially. But it is a very oblique reference and certainly does not imply abolition of BPA for some GPs. Since these matters are currently being discussed between your department and the GMSC, it is surely essential to have a clear statement of the Government's intentions so that those concerned know precisely where they stand. Otherwise, there are bound to be accusations of bad faith when you do introduce the proposal.

In order to remedy these deficiencies, the following changes need to be made.

Para 7.3 - insert a new sentence at the end:

"Basic practice allowance will form a reduced proportion of remuneration, and its level will vary according to the location of the practice; in some cases, it will be reduced to zero."

Para 7.16 - first sentence to start as follows:

"Each year the provision made for FPS drug costs will be divided into separate cash-limited allocations for the 14 health regions, and RHAs will set ...".

I am sending copies of this letter to the Prime Minister, Malcolm Rifkind, Peter Walker, Tom King, David Mellor, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson (Cabinet Office) and Mr Whitehead (Policy Unit).

Yours Ever, John

JOHN MAJOR

SECRET - CMO

9 SUBJECT cc Mailer

9A → UNTIL 31-12-89

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DA.

cc SO
CST
M/Health
Roy Griffiths
FERB
PermSec./Health
R. Wilson
G. Monger
I. Whitehead

D. Nichol
HMT
Wales
NIO

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

24 January 1989

Dear Andy,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister chaired today the twenty-first meeting of the group reviewing the National Health Service. The group had before it a note by the Secretary of State for Health 'NHS review: central management of the NHS'.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present were the Secretary of State for Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Sir Christopher France, Mr. Wilson and Mr. Monger (Cabinet Office), Mr. Whitehead (No.10 Policy Unit) and Mr. Duncan Nichol (Chief Executive, National Health Service Management Board).

In discussion of the paper by the Secretary of State for Health the following were the main points made:

(a) The Department of Health appeared to have a large number of staff involved in NHS management. It was doubtful whether this involvement on such a scale was appropriate. The functions and number of this staff should be reviewed. Of the 8,900 staff employed by the Department, nearly 6,000 were to be transferred to Special Health Authorities and the Audit Commission, or were in areas being considered for Next Steps Agencies; and a proportion of the 3,000 staff at Headquarters were involved on work which it seemed right to retain in the Department including public health, licensing and regulation of pharmaceuticals and personal social services. Nevertheless, many of the Headquarters staff could be said to be involved in NHS management work. The Department of Health would need to examine their functions to see what savings could be made.

(b) NHS procurement work now done by Departmental staff was an obvious example of work which might be better undertaken by the NHS direct. The Health Authorities and self-governing hospitals should be responsible for their

own purchasing policies. But there were also advantages in maintaining a central buying function to exploit the NHS's strength as a very large buyer, where authorities and hospitals themselves wished it to continue to be available. An outside businessman was in charge of the Department's procurement work and had already produced considerable savings for the NHS.

(c) Another example of work which needed to be reviewed critically was personnel work. This covered mainly central negotiations on pay through the Whitley Council machinery. It was common ground that centralised pay bargaining in the NHS should be broken up in the interests of greater flexibility. This was an area where the Department aimed to make savings. The Secretary of State was already taking action to give the Chief Executive a direct role in pay negotiations.

(d) Relations between the Secretary of State, the Management Executive, especially the Chief Executive, and the regions needed clearer definition. If the Chief Executive was to be responsible for all operational matters in the NHS, he needed to have the powers to enable him to discharge this: otherwise he would be in a position of responsibility without power. The power to appoint and dismiss Regional General Managers, for instance, seemed fundamental. At the same time, it could be argued that the system would work in practice. The pay received by the Regional General Managers would depend on the Chief Executive's assessment of their performance. If a Region proved unresponsive to the wishes of the Chief Executive, he could appeal to the Secretary of State, who had the power of appointment and dismissal over Regional Chairmen. The Secretary of State therefore had the powers necessary to ensure that the system worked, and was determined to exercise them so as to achieve that. To go further and give the Chief Executive the explicit power to appoint General Managers would be inconsistent with having separate Regional Health Authorities and cut across the devolution of responsibility rightly emphasised in the White Paper.

(e) There needed to be a clear statement of the functions and powers of the Management Executive. They should be established clearly before the composition of the Executive was decided. The Department had conducted in 1983 a major review of the management structure and the chain of command down the line, but its conclusions had never been implemented. That analysis should now be reconsidered and brought up to date.

(f) A clear statement of responsibilities would also be needed for Scotland. The Scottish Office was working along the same broad lines as the Department of Health. The recent decision to appoint a Chief Executive for the NHS in Scotland would make it easier than hitherto for Ministers there to distance themselves from management matters.

(g) There were major disadvantages in more far-reaching structural changes such as the establishment of an English Health Authority or a Health Service Corporation. They would be seen as forming another layer of bureaucracy and might in practice become lobbies for more spending on health.

(h) There were numerous examples of waste in the NHS. One area which needed attention was policy on stocks. Maintaining stocks was expensive and there was much to be said for reducing and in some cases even eliminating stocks held by the NHS as opposed to its suppliers. Some progress had already been made in this direction. Another area needing attention was that of employment of nurses. The NHS at present hardly attempted to provide proper management of nurses, partly because the Royal College of Nursing had always insisted that it could be undertaken only by trained nurses, who might not have the necessary aptitudes. Greater use of general management for nursing services needed to be considered. But improvements in this area, and other areas where NHS management was deficient, should result from the new competitive pressures arising from the Government's reforms as a whole.

The Prime Minister, summing up the discussion, said that the group accepted the case against more far-reaching structural changes like the establishment of an English Health Authority or a Health Service Corporation. They accepted that there should be a Management Executive, located in the Department, but with a separate and defined status under the Secretary of State for Health.

All central operational and management work on the NHS carried out in the Department should be brought under the Management Executive, as the Secretary of State proposed. This central management structure should however be kept small and effective, in accordance with the White Paper objective of maximum devolution of decision-taking, and not be allowed to become a large bureaucracy. The Secretary of State for Health had said in the discussion that he would continue his scrutiny of the size of the Department and in particular hoped to make further reductions in the number of staff involved with NHS management matters. This objective should be pursued.

A lot more work was needed on the detail of the new arrangements and how they could work in practice. A written statement for the purpose should be prepared. It would need to cover the relationship between the Secretary of State and the Chief Executive, including what powers would be delegated to the latter,what powers the Secretary of State would retain and what the position would be in grey areas, for instance where the Chief Executive was only able to act with the consent or support of the Secretary of State. The note would also need to define clearly the powers, responsibilities and functions of the Chief Executive - and of the Management Executive - in relation to the Policy Board, the Department,

the Regional health authorities and the NHS below them including self-governing hospitals, bearing in mind the importance of maximum delegation throughout. The arrangements would need to include the setting of budgets, monitoring, the use of medical audit and financial audit and sanctions for non-performance. Consideration would also need to be given to membership of the Management Executive in the light of conclusions reached on these matters, which where necessary could include Departmental officials.

A review should now be undertaken to prepare an agreed written statement on these lines, drawing on the analysis done in 1983 as appropriate. The work could probably be better done in house, perhaps drawing on the expertise of one or two good managers from within the NHS, but the Department would be able to use outside management consultants if it wished. The work should be completed in not more than three months and the proposed outcome should be reported back to herself and other members of the Ministerial group. A similar statement would need to be prepared for Scotland.

I am sending copies of this letter to the private secretaries to Ministers on the group, to Sir Robin Butler and Sir Christopher France and to the other officials present at the meeting.

Yours,

(PAUL GRAY)

Andy McKeon, Esq.,
Department of Health.

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CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street, SW1P 3AG

MBRM
RRC6
28/1

The Rt Hon Malcolm Rifkind QC MP
Secretary of State for Scotland
Scottish Office
Dover House
Whitehall
London
SW1A 2AU

24th January 1989

Dear Malcolm,

NHS REVIEW: CHIEF EXECUTIVE OF THE NHS FOR SCOTLAND

Thank you for your letter of 19 January at flag A/18. I am content with your proposed amendment to paragraph 17 of your chapter of the draft white paper. I also agree that the new post should be at grade 3.

However, my agreement is without prejudice to my consideration of your proposals to retain in addition the existing two health grade 3 posts. I shall respond to that when my officials have seen the details.

I am copying this letter to the Prime Minister, the Chancellor, Peter Walker, Tom King, David Mellor, Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No. 10 Policy Unit and to Sir Robin Butler and Mr Wilson in the Cabinet Office.

Yours Ever,
John

JOHN MAJOR

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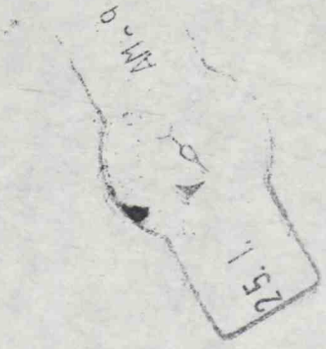
Efficiency Pt 19



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PRIME MINISTER

23 January 1989

NHS REVIEW: THIRD DRAFT

I have two comments on the White Paper after a cursory review of the draft, just received.

Para 3.2 Self-Governing Hospitals

> 'The Government anticipates that major acute hospitals will be the most suitable candidates for its proposals but, in due course, other hospitals may also come within their scope.'

This paragraph still gives the clear impression that smaller hospitals should not bother applying for self-governing status. These negative signals will deter the small entrepreneurial hospitals.

As in the 'pop' version of the White Paper, this - and any other - reference to this limitation should be removed.

Para 6.7 GP Practice Budgets

It would be helpful to repeat a sentence from para 10.9 of the Scottish Chapter in para 6.7:

> 'Smaller practices (in Scotland) will, however, be able to group together if they wish to do so in order to opt for GP practice budgets.'

Ian Whitehead

IAN WHITEHEAD

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RA MIS.

Note 6

Spoke DoH and gave PM's views at X. DoH advised it was too late to change Y. Also told DoH to ensure no apostrophe for 1990's!

PRIME MINISTER

MOCK-UPS FOR THE NHS REVIEW WHITE PAPER COVER

I have been pressing the Department of Health for some days to let you have a sight of the proposed White Paper cover. They have now provided three versions, as attached.

PACG 26/1

I gather that DoH did not like Version 1, but have not yet really considered 2 and 3. My immediate view is that Version 2, with the bolder lettering for the title, is much to be preferred.

The common feature for all three variants is the logo and slogan at the bottom, which is being used on all the promotional material. I am told it is now too late to alter this.

Do you have a preference between the layout of Versions 2 and 3?

PACG.

PAUL GRAY
23 January 1989

DS3AFU

X | Agree - general lay-out of 2

Y | But what does Caring for the 1990's mean??!! Don't we care now? And it is not the years but the patients we care for.

SECRET

5

PRIME MINISTER

MEETING OF E(A): 24 JANUARY

The meeting is for E(A) to consider the draft NHS Review White Paper prepared by the Review Group. You saw the papers over the weekend, namely:

Flag A - White Paper draft (which, for logistical reasons, does not yet include all the comments you and others gave towards the end of last week);

Flag B - Richard Wilson's steering brief.

The E(A) meeting is to be followed by the meeting of the Review Group alone to consider NHS Central Management. So I imagine you will want to bring the E(A) discussion to a fairly prompt end.

The papers for the subsequent meeting of the Review Group are in a separate folder.

Also at Flag C are some detailed drafting comments from the Policy Unit.

PAUL GRAY
23 January 1989

DS3AFW

4

PRIME MINISTER

NHS REVIEW: CENTRAL MANAGEMENT

This meeting will start when the E(A) discussion of the draft White Paper is over.

Those attending are members of tne NHS Review Group, plus Sir Chris France and Mr Duncan Nichol (NHS Chief Executive-designate). Peter Walker and Tom King are not planning to attend the meeting (or that of E(A)), although Peter Walker is looking at the papers overnight to check if there are any major points he wishes to feed in.

The papers are:

Flag A - Ken Clarke's paper responding to the remit you gave him on Friday;

Flag B - Cabinet Office briefing, comprising a covering note by Robin Butler and a more detailed brief by Richard Wilson;

Flag C - a further note by Robin Butler, providing a striking insight into the potential bureaucracy in the NHS;

Flag D - a Policy Unit brief.

PAUL GRAY
23 January 1989

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PRIME MINISTER

NHS WHITE PAPER

I have seen your Private Secretary's letter of 20 January and am quite content with the two amendments you suggest to the Welsh Chapter.

I have also seen Kenneth Clarke's memorandum to you of 23 January about the central management of the NHS. The management of the NHS in Wales is of course described in paragraph 4 of the Welsh Chapter, where we say that the management arrangements have 'proved their worth and will continue'. I assume that nothing in Kenneth's paper will mean that these arrangements in Wales will now need to be reviewed.

I am copying this minute to the Chancellor of the Exchequer, Secretary of State for Health, Secretary of State for Scotland, Secretary of State for Northern Ireland, Chief Secretary, Minister of State for Health, Sir Roy Griffiths, Professor Griffiths, Mr Whitehead and Mr Wilson.

Keith Davies

PW
Dictated by the
Secretary of State and
Signed in his absence.

RA (Agreed by PM).

PRIME MINISTER

You agreed to do a foreword for the NHS Review White Paper.

Following this morning's video recording we have had the message typed up as you delivered it.

Content to sign the attached?

Sarah Charman

Sarah Charman
Press Office

January 23 1989

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

The National Health Service at its best is without equal. Time and again, the nation has seen just how much we owe to those who work in it.

A skilled and dedicated staff - backed by enormously increased resources - have coped superbly with the growing demands of modern medicine and increasing numbers of patients. There is a great deal of which we can all feel very proud.

The National Health Service will continue to be available to all, regardless of income, and to be financed mainly out of general taxation.

But major tasks now face us: to bring all parts of the National Health Service up to the very high standard of the best, while maintaining the principles on which it was founded; and to prepare for the needs of the future.

We aim to extend patient choice, to delegate responsibility to where the services are provided and to secure the best value for money.

All the proposals in this White Paper put the needs of patients first.

They apply to the whole of the United Kingdom but there are separate chapters on Scotland, Wales and Northern Ireland to cater for their special circumstances.

We believe that a National Health Service that is run better, will be a National Health Service that can care better.

Taken together, the proposals represent the most far-reaching reform of the National Health Service in its forty year history.

They offer new opportunities, and pose new challenges, for everyone concerned with the running of the Service.

I am confident that all who work in it will grasp these opportunities to provide even <u>better</u> health care for the millions and millions of people who rely on the National Health Service.

The patient's needs will always be paramount.

January 1989

RESTRICTED

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

23 January 1989

NHS REVIEW

Just to confirm, as I told you on the telephone earlier today, that the Prime Minister would be grateful if Mr Duncan Nichol could attend tomorrow's meeting. She feels that the White Paper should be sponsored by the four Secretaries of State concerned.

Dominic Morris

Mrs Flora Goldhill
Department of Health.

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3a-5

PRIME MINISTER

23 January 1989

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

In the short-run, Ken Clarke's preference for a Management Executive, with a separate and defined status under the Secretary of State (Option 2) is reasonable, but I have two main concerns:

1 Lack of a Clear Definition of Roles

The Policy Board will have a very high profile at the centre. On the plus side, the Board will operate as a buffer between Ken Clarke and the day-to-day operations of the health service. But there is a significant danger that the Board will become far too powerful. The Management Executive would simply become the cashier for the NHS. And the health service would then be run by a team of bureaucratic policy advisers. Back to square one. This must be avoided at all cost.

During the meeting, Ken Clarke should be asked to address four specific points:

Who will be represented on the Policy Board? How will it operate?

How will the relationship between the Secretary of State, Policy Board and the Management Executive work in practice?

What will be the specific division of responsibilities between the Board and the Executive?

Will the Management Executive be responsible for

SECRET

setting clear targets and performance bonuses for key regional staff?

2 The Role of the Department

The future role of Department officials is still unclear. This is mirrored by the sketchy details on the operation and make-up of the Policy Board.

Ken Clarke will need to spell out the future responsibilities and reporting lines in the Department.

If the majority of staff become accountable to the new Policy Board, the Management Executive will suffer from atrophy. And the central management of the NHS will continue as before.

Will the Department be slimmed down? Or will the number of senior officials be expanded to support the workings of the Policy Board and the Management Executive?

Will most of the officials report to the Management Executive? Or will a lion's share be accountable to the new Policy Board?

Ian Whitehead

IAN WHITEHEAD

Ref. A089/195

PRIME MINISTER

Bureaucracy in the NHS

My neighbour, Anthony Lester QC, was appearing last week in proceedings to remove a consultant from the NHS. He told me that the complaints against the consultant concerned had been going on for some 15 years without effective action being taken. The cost was astronomical.

I asked him to write a note about the bureaucracy involved. --- It is attached. He tells me that he does not think that the Department of Health could gainsay any of it.

F.E.R.B.

ROBIN BUTLER

23 January 1989

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LONDON EC4Y 7BH

THE REMOVAL OF INCOMPETENT AND DEFAULTING DOCTORS FROM THE NHS

1. For reasons summarised below, in my view, the present arrangements for removing incompetent or defaulting doctors from the NHS are unwieldy, cumbersome, inefficient and in urgent need of radical reform.

2. Medical practitioners in the NHS now have included in their contracts of employment detailed and complicated terms and conditions of service (the Red Book) as well as general conditions of service agreed by the Whitley Councils for the Health Service (the Blue Book). In addition there are Ministerial circulars which overlap with the Red Book and the Blue Book: eg HC(81)5 Health Service Complaints Procedure, HC(82)13 Prevention of Harm to Patients resulting from Physical or Mental Disability of Hospital etc Staff; and HM(61)112 Disciplinary Proceedings in cases relating to Hospital etc Staff.

3. The procedures in these various documents are complex and cumbersome. They do not fit well with each other. They require a High Court Judge (or at least a QC) to make sense of them. Even then they do not make much sense in the modern world.

4. It is widely believed by Health Authorities and senior medical practitioners that a consultant or hospital practitioner is virtually unsackable. This belief is well founded in practice because time and again Health Authorities have found themselves defeated by the complexity of the procedures and the unwillingness of doctors to give evidence against each other when the Authorities have tried to remove an incompetent or defaulting member of the profession. Years pass and hundreds of thousands of pounds are wasted in trying to tackle the problem.

5. Quite apart from the over-complicated disciplinary procedures and ministerial circulars dealing with action short of dismissal, the final appeal procedure to the Secretary of State (para 190 of the Red Book) is extremely elaborate. Five senior members of the medical profession sit at Hannibal House, together with a shorthand writer, and three or four other officials to hear the practitioner appeal against his or her dismissal. At this stage it is open to the BMA to persuade the professional committee to advise the Secretary of State not to confirm the dismissal but to send it back for exhaustion of the internal disciplinary procedures. I understand that this happened in one case after the Health Authority had spent some £300,000 trying to dismiss a senior consultant from their employment.

6. I do not see any good reason for treating hospital doctors more favourably than company directors, yet that is the

present position. In my view unfair dismissal and wrongful dismissal protection should be sufficient.

7. No doubt the existing situation is the result of antique collective agreements negotiated at the birth of the NHS, and the considerable power of the medical profession in resisting change. However, it is not in the best interests of a safe and efficient health service, nor ultimately of a competent and healthy medical profession. If the system cannot be radically improved by voluntary agreement, in my view, it should be tackled by legislation - for the sake of patients, nurses, Health Authorities, the taxpayer and doctors.

Anthony Lester

20th January 1989

ANTHONY LESTER, QC

2 Hare Court
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London EC4

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P 03345

PRIME MINISTER

NHS REVIEW

CENTRAL MANAGEMENT OF THE NHS

[Note by the Secretary of State for Health]

DECISIONS

1. You asked for this meeting to discuss the central management of the NHS, after Mr Clarke's minute on the subject last week.

2. In his paper Mr Clarke sketches out four broad options. The first would be to continue with the present arrangements (option 1): he rules this out. You may wish to concentrate on the remainder:

i. option 2: a Management Executive within the Department of Health. This is Mr Clarke's preferred option;

ii. option 3: a legally separate Management Executive which would be known as the English Health Authority. The Regional and District Health Authorities would become answerable to it, while presumably remaining separate statutory entities;

iii. option 4: a Health Service Corporation. This would be a public corporation exercising direct management control over the industry. The degree of independence retained by the regional and district boards would have to be decided: there would be a number of possible models.

3. In addition to deciding which of these options should be pursued, you may wish to reach a view on the following:

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i. greater devolution of Departmental functions. It seems clear that the Department of Health has a significant number of staff involved in operational matters. Whichever option is adopted, you may wish to commission an exercise to see how far their work can be slimmed down, as part of the process of greater devolution to local units;

ii. chairmen of Regional Health Authorities. The White Paper refers to a clear and effective chain of management command running from Districts through Regions to the Chief Executive and from there to the Secretary of State (paragraph 2.6). You will wish to consider whether it is compatible with this chain of command to have the chairmen of Regional Health Authorities reporting to the Secretary of State.

iii. accountability to Parliament. Mr Clarke's minute accepts that there should be a new basis for Ministerial accountability to Parliament but seems to indicate in paragraphs 13 and 14 that it should not be introduced until the proposed legislation is implemented. You may wish to explore his thinking on this and ask him to draw up guidelines on how the new arrangements are to work, for use when the White Paper is issued, so that the same practice is followed for Scotland, Wales and Northern Ireland.

4. Finally, depending on what decisions are taken, you will wish to ask the Secretary of State to arrange for the White Paper to be amended accordingly and to report to Cabinet on Thursday on what has been agreed, if it affects the substance of the proposals.

MAIN ISSUES

What has already been agreed

5. Practically you might find it useful to begin by reminding the group of the points about central management which have already been agreed, namely:

i. Policy Board and Management Executive. There is to be a Policy Board, chaired by the Secretary of State, to determine the strategy, objectives and finance of the NHS and to set objectives for the Management Executive which it will monitor. The Management Executive will deal with all operational matters within the strategy and objectives set by the Policy Board (paragraph 2.5 of the White Paper);

ii. Maximum devolution. There is to be a clear and effective chain of command running through the NHS, with "as much power and responsibility as possible delegated to local level" (paragraph 1.9 of the White Paper);

iii. Ministerial accountability to Parliament. There is to be a new basis for Ministerial accountability to Parliament (paragraph 13 of Mr Clarke's paper) and it is to be made clear that Ministers will not be answerable in Parliament for day-to-day operation (minutes of meeting on 17 January);

iv. the Government should change the present arrangements in the Department of Health, which are based on a Management Board which is essentially part of the Department (paragraph 3 of Mr Clarke's minute).

6. The central question therefore is what new arrangements should be adopted which will best implement the Government's reforms and in particular what degree of formal separation there should be between strategy and operational management. At present there seems to be no clear dividing line in the NHS between politics or policy on the one hand and operations on the other; and no clear demarcation of responsibilities or line of command. These defects show themselves in the structure by for example:

i. many members of the present Management Board appear to be officials of the Department of Health;

ii. substantial numbers of Departmental staff appear to be engaged in NHS management. The annex to Mr Clarke's paper shows that 633 staff are directly engaged on support for the

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Management Board, and substantial numbers of other staff also appear to be intimately involved in the work of the NHS;

iii. as Mr Clarke's paper shows, the regional Chairmen are mainly political figures, with a direct line to the Secretary of State.

Option 2: Management Executive within the Department

7. Mr Clarke argues that he should retain the Management Executive within his Department, taking steps outlined in paragraph 8 of his paper to give it an "enhanced role" and to "mark out its new status clearly". In particular, all staff in his Department working on operational and management matters would come under the Management Executive, and the Chief Executive would have his own budget for the operation of the Executive. You will wish to consider whether those measures would be enough to establish a clear, separate structure for the operational management of the NHS, given the political and other pressures on the Secretary of State and the policy part of his Department to intervene. Particular points to explore include:

i. membership of the Management Executive. It is not clear whether officials of the Department would be members of the Management Executive, sitting as a board, and if so how many.

ii. Next Steps Agency. Mr Clarke mentions the possibility of making the Executive, with its staff, a Next Steps Agency (paragraph 8, fifth indent).

iii. Regional Chairmen would still have direct access to the Secretary of State, over the head of the Chief Executive. Might this tend to undermine the Chief Executive's position?

iv. Some senior officials of the Department would offer Mr Clarke advice on both policy and on operational and management matters (paragraph 9). It is not clear how many, or what he has in mind.

8. Underlying these points is the question of the Chief Executive's power in practice to oversee the management of the NHS. If he is to be accountable for the management of the NHS, as the White Paper indicates (paragraphs 2.4 to 2.6), he ought to have the power to discharge this responsibility. It is not however clear from the paper what powers he would have in practice, for instance over the appointment and dismissal of managers in the NHS, over the allocation of funds, the setting and monitoring of budgets, and the giving of instructions: in short, all the matters which would be normal features of a clear and effective chain of command. If the formal legal powers are to remain with the Secretary of State, the position of the Chief Executive will be weaker than if he had formal legal powers in his own right. You may wish to explore what formal powers the Chief Executive will have.

Option 3: An English Health Authority

9. This option is not spelled out in detail in the paper but would entail setting up a new Health Authority, comprising the Management Executive, separate from the Department. The Regional Health Authorities would report to it but would presumably remain separate statutory bodies. Departmental staff engaged in NHS management would presumably transfer to it. You may wish to explore the arguments, including the following:

i. Special Health Authority. The implication appears to be that the body might be created as a special health authority under existing legal powers. You may wish to check this. If so, it would have the advantage of being a well understood process, and might arguably be the first steps down the road of making the NHS a separate commercial body without at this stage arousing too many susceptibilities.

ii. An extra link in the chain. Mr Clarke says that this would be an extra link in the chain of command between the centre and the regions. It is not clear whether this would in practice be more so than if the Executive was a Next Steps Agency inside his Department.

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iii. A pressure group for more money. Mr Clarke's main concern is that this Authority would become a lobby for more resources, despite the fact that it would clearly be a subordinate agency. You will wish to judge how serious a threat this would be. If it is serious, it points to a solution which keeps the Executive within the Department of Health.

Option 4: A Public Corporation

10. This option would mark the clearest distinction of any of the options between the Department and the NHS, and between policy and management. It would not necessarily involve centralisation. The legislation could regulate the relationships between the centre and the units to ensure that there was a proper degree of delegation. You will wish to consider these benefits against the practical problems which Mr Clarke is likely to raise.

i. Parliament might not welcome the explicit loss of Ministerial accountability which it would involve. The task of getting the other reforms through Parliament would be complicated;

ii. The Health Authority Chairmen, whose co-operation would be necessary in the short term to the implementation of the reforms, might also be antagonised;

iii. Establishment of a separate Corporation might lead to fears of privatisation;

iv. A separate Corporation might become a lobby for greater health spending.

Departmental Involvement in Management

11. Whatever option is adopted, you may wish to ask for an exercise to be carried out to review the number of staff in the Department of Health involved in operational management, given the Government policy of maximum delegation to the local level. Annexes 1 and 2 to Mr Clarke's paper indicate that the number of

staff employed by the Department is 8857. Of these, 4582 are to be transferred to Special Health Authorities or the Audit Commission, and another 1409 are possible candidates for Next Step Agencies. This still leaves nearly 3000 dealing with either policy or operational management of the NHS. It is not clear from the Annexes how this number breaks down between the two functions. There are 633 staff clearly identified in operational areas such as estate and property management, procurement and information technology; but there are significant numbers of other staff also involved in management who cannot be identified from the table. You may wish to ask Mr Clarke what the number is, and what plans he has for reviewing their work.

Accountability

12. Finally, Mr Clarke's paper agrees that there should be 'a new basis for Ministerial accountability to Parliament' but seems to indicate that it should not be introduced until legislation is implemented (paragraphs 13 and 14). You will wish to explore the arguments. There will need to be agreed guidelines for the new arrangements, for all the Ministers concerned, perhaps on the lines attached.

R T J WILSON
Cabinet Office
23 January 1989

NHS REVIEW: ACCOUNTABILITY

i. The Secretary of State will continue to be answerable to Parliament, not only for the huge sums of money spent on the NHS as indicated in paragraph 2.4, but also for the matters dealt with by the Policy Board and for the functions dealt with by his Department which lie outside the NHS (eg public health).

ii. If the Secretary of State is asked by a Member of Parliament about an operational matter, his normal course will be to refer it to the Chief Executive or, in appropriate cases, the relevant Regional or District Health Authority for a reply. The Chief Executive will be available to appear before Select Committees or to meet MPs on operational issues, where necessary. In the last resort, if the MP is still not satisfied, particularly on a major issue such as a hospital closure, it will still be open to the Secretary of State to reply; but this will not be the normal routine.

iii. In exceptional cases, where for instance an operational issue may be symptomatic of a more general national problem, the Secretary of State may respond to pressure in Parliament by asking for a report from the Chief Executive, discussing it with him and publishing the report together with an account of the action being taken to deal with the problem.

cc Paul Gray
John Whittingdale

ROMOLA CHRISTOPHERSON

NEW STATESMAN ON NHS

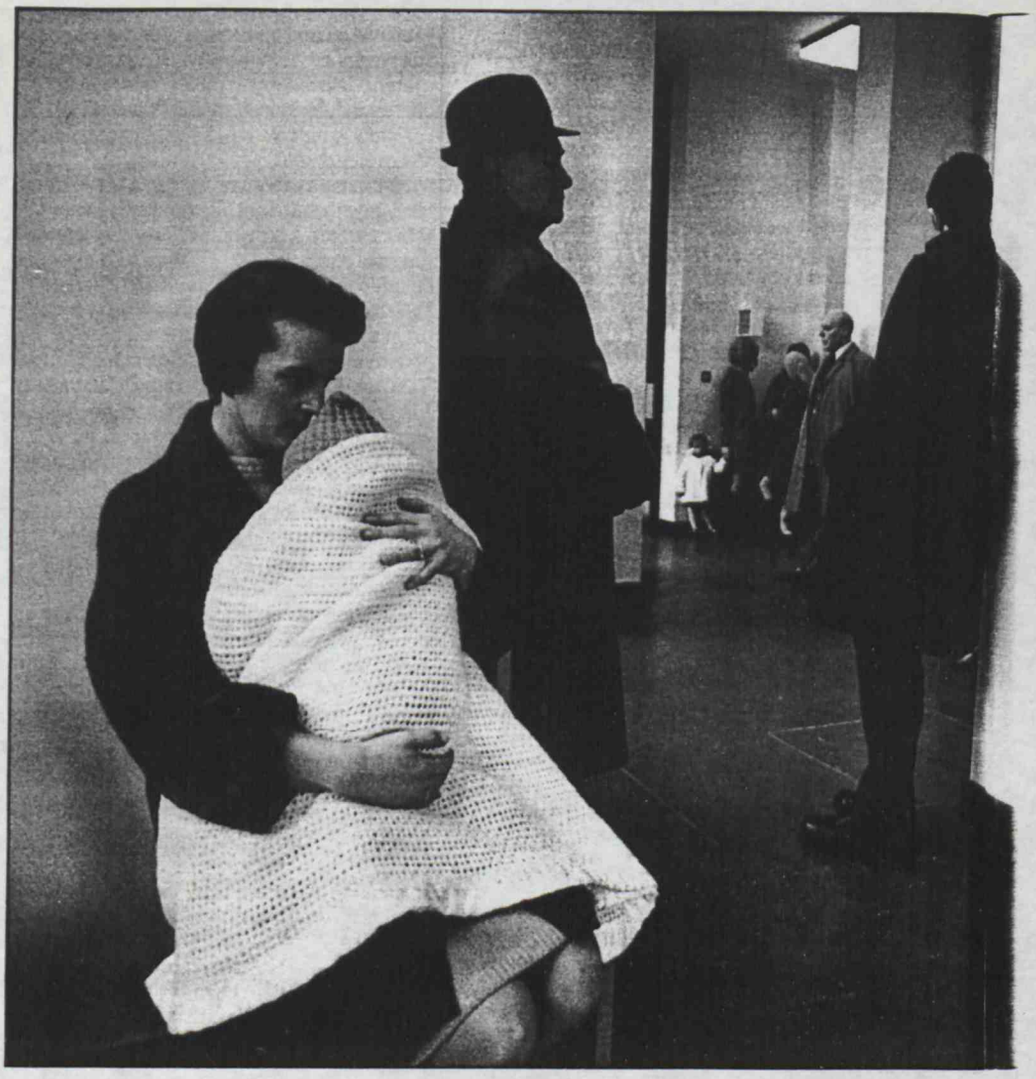
Please see attached article on NHS in the current issue of the New Stateman. The highlighting is mine.

The Secretary of State and his Supporters can have a lot of fun with this in the Commons on January 31.

BERNARD INGHAM
January 23, 1989

Waiting in line

What people loathe about the NHS is its impersonality. Jolyon Jenkins looks at the prospects for a post-Fordist health service



On 28 November last year, 18 month old James fell against a park swing, and hurt himself so badly that he found it difficult to walk. His father, Bill, took him to the GP's surgery that evening. The doctor diagnosed "superficial bruising". But 24 hours later, James was no better, so the GP arranged for him to be X-rayed the next day at the Whittington hospital in north London.

The appointment was for 11.30 am, and Bill and James arrived five minutes early. "We waited first of all in one crowded room, then another," Bill recalls. "Eventually we were seen by a paediatrician at 1.20 pm. He decided to take X-rays; they were back an hour later. We had to see the paediatrician again. He diagnosed a fracture in James's leg, and summoned an orthopaedic registrar. We waited some more.

"James was getting hungry, but we couldn't get any food because we were worried about missing the registrar. At 4.00 we were told he was on his way. Half an hour later we bumped into the paediatrician, but it wasn't until 5.15 that an orthopaedic doctor arrived. He decided that James should be put in a toe-to-thigh plaster cast. That was done by 5.45. Then it was back to the X-ray department and then on to the registrar again. We were out of the hospital by 6.30. The whole thing had taken seven hours, and James hadn't eaten since breakfast."

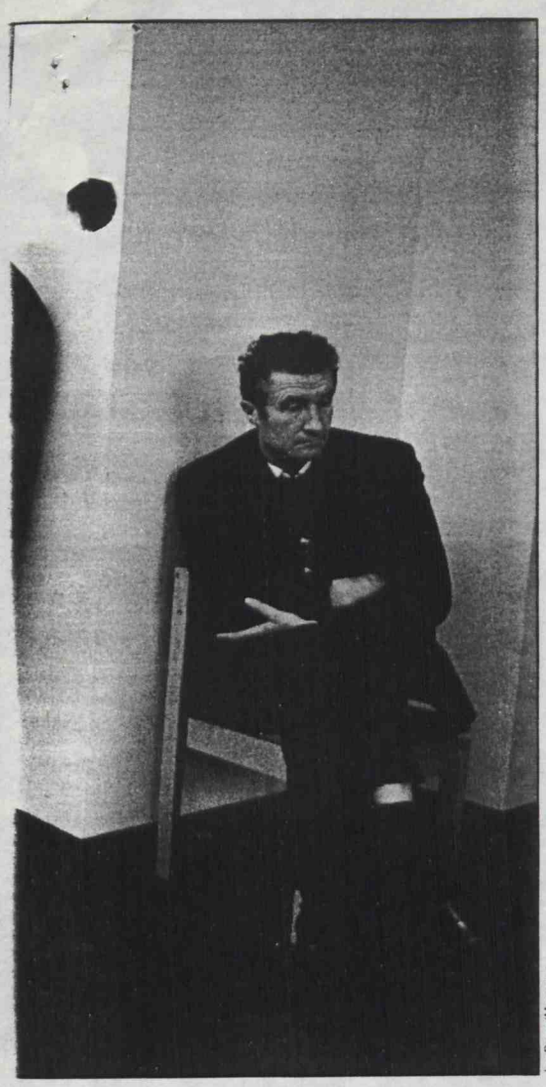
As hospital horror stories go, it's fairly mild—just another brush with the hard-pressed health service. But it's one of the most ignored aspects of health care: how do ordinary people feel about the NHS? There's no evidence that the health service review, despite all the modish talk of "choice" and "consumers", is even asking that basic question.

Opinion polls always show great support for the NHS in principle, but when you look at how users feel about their own treatment a more complex picture emerges. One such survey was published last year by Social and Community Planning Research and the Royal Institute of Public Administration. One of the researchers, Tessa Brooks, summarises some of the findings: "People were increasingly unhappy as they went through the system. They were at their most satisfied using GPs. They were fairly tolerant using Accident and Emergency Services—they understood that waiting times just had to be endured—but they became less satisfied with outpatient departments and inpatient departments. I think that was based on a knowledge that they were block-booked: that there were procedures that were geared not to their needs but to those of the system."

People are amazingly stoical. At GPs' surgeries, of those who were kept waiting more than 45 minutes, only 14 per cent said it had caused them problems. But they are most irritated when they have kept an appointment and the doctor seems to be breaking it. At outpatients' surgeries they resent *their* time being wasted: nearly half agreed that "no one seems to care that patients also have busy lives".

Take the case (not part of the survey) of Leonora, a 37-year-old woman who suffers from diabetes and has been going to St James's Hospital in south London since 1980. "I started to notice that when I arrived for an early appointment, at, say nine o'clock, there were already vast numbers of people in the waiting room. Outbreaks of belligerence and aggression were quite common, and nurses were often brought in to deal with complaints. Sometimes people who complained about waiting for three hours were grudgingly moved up the queue—to loud comments from the rest of us!

"It slowly dawned on me that people were seen in the order they arrived, regardless of their appointment times, and that everybody had sussed that out. So I worked out an alternative system of rolling up at 12.45, regardless of my appointment time. Then the system changed two years ago so that people really were seen in appointment order. There was mayhem at first and even more aggro as people got used to the new order, but after that it went very smoothly and now you don't ever need to wait more than



Ian Berry/Magnum

It dawned on me that people were seen in the order they arrived, regardless of appointment times

15 minutes. But it only happened because a doctor wrote and installed his own computerised appointment program with a very fierce recall system if you didn't turn up."

It's hard to believe, in the era of Sir Roy Griffiths, streamlining and consumerism, that such things depend on clued-up individual doctors. But they do. At St Thomas's eye department, it's possible to wait three hours. One patient says, in some fury: "When I suggested they saw patients according to their appointment times, they said this had been under discussion for some time but no decision had been taken. Why it needs a committee to decide something as simple as this I fail to grasp."

What we seem to be seeing is increasing dissatisfaction with a health service that operates, at least in the hospital sector, on "Fordist" principles of mass production. People want efficiency—efficient use of *their* time. They don't automatically want efficient use of *doctors'* time. Nor do they necessarily want "choice". Tessa Brooks comments: "We assumed that people would want more choice in health care, and that was not borne out by the survey. The average person is very happy to abdicate the decision-making process to the doctor: what they want is a sense of being involved, which has to do with being given information and being treated intelligently."

The two objectives don't necessarily conflict. In 1987, the National Audit Office published its findings into how operating theatres were being used. During weekdays, operating theatres were empty for nearly half the time, largely because sessions were cancelled at the last moment. There was very little advance planning about, for example, how many beds would be available for patients coming out of the theatre. This is not only inefficient, but extraordinarily annoying for patients. If there's one thing worse than a production line system, it's a production line system that doesn't work.

The right's answer to this is that market forces should even out mismatches between, say, the number of beds, the number of nurses, and the availability of operating theatres. Hospitals which opt out will be able to spend their money more effectively than district and regional bureaucrats ever could. And if they concentrate on particular sorts of treatment—hip replacements is the normal example—they will become more efficient and provide a better service to the customer.

Well, maybe. In purely medical terms, hospitals that specialise in certain sorts of operation, *do* get better at those operations. In America there are surgeons who deal only with slipped discs, and very good at it they are too. In this country, Peterborough general hospital has a unit that specialises in repairing old people's fractured hips. It has achieved significantly better results than other hospitals. The price, of course, is greater use of the Fordist ethos that everybody dislikes so much. Specialisation may save time and money for *hospitals* but do precisely the reverse for *patients*.

Moving towards a more responsive health service may mean changing the way we think. The Social Services Select Committee last year produced a report on NHS underfunding. Under the heading "Underutilisation and inefficiencies", the report quoted junior hospital staff at NE Thames, who spoke of "inefficient use of medical time as doctors spend increasing amounts of time cancelling admissions, consoling patients and re-arranging admissions." But perhaps this is only inefficient if you think of the NHS as a production line. After all, what's so bad about doctors consoling patients?

There are other fundamental difficulties. The NHS often hides serious conflicts and disagreements about what it's supposed to be doing. Professor Gilbert Smith at Hull University, for example, has studied the way psychogeriatric care is organised. "We found there was a major disjunction between the views of the old people's relatives and those of health professionals. The latter saw it as a medical problem—a disease—to be treated; the relatives wanted the solution to whatever it was they saw as the problems in their lives. That could be their jobs, their partners, their children or their sex relations, which all get disrupted when you've got a crazy old person about. If we could get our home situation right, they said, then we'd be quite capable of looking after granny.

"Everybody sees the issue in terms of the problems *they* have: so for health professionals the issue was whether there were enough places in psychogeriatric hospitals. They would make concessions to other views: for example, they had a relatives' support group to 'support the supporters'. But in practice, the support group attempted to sell the medics' perspective to the relatives." No amount of opting out and free markets is likely to solve that.

In the end, a post-Fordist NHS is likely to come about—whether we want it or not—from changing technology. It may soon no longer be necessary to wait a fortnight for your results to come back from a distant pathology laboratory. A survey last year, funded by the World Health Organisation, reported that: "In the future, many diagnostic kits will probably be offered to the general public. Tests for sexually transmitted diseases and hepatitis may be offered in the next five years. Certain screening tests for cancer could also be marketed in the next ten years. Genetic screening kits are also being developed for home use, especially by US companies, who plan to develop and market tests for common diseases with a genetic basis, such as diabetes."

A recent study by the National Association of Health Authorities adds: "In the longer term, there is no reason why diagnostic kits should not become available for self-use for other purposes, including tests for inherited diseases such as Huntingdon's chorea and Parkinson's disease." In other areas, too, post-Fordist "flexible specialisation" is coming. As the NAHA study says: "Boundaries between medical specialisations are becoming blurred as new techniques are made more widely available. For example, investigation for treatment of gastric ulcer may be undertaken by a physician, surgeon or radiologist using the same techniques. Another example is gall-bladder stones which could be treated by a physician using drugs, a surgeon using open surgery, or by a radiologist using endoscopic techniques under radiological control."

Perhaps some of this can be accommodated in the government's proposals, if GPs are given the freedom to buy new equipment that will give patients the quick results they want.

But on the present showing we're not ready for this brave new world. Technological post-Fordism solves some problems by creating others. Who will pay for those handy across-the-counter pathology tests? We can be sure the government won't want to. When you can test yourself for HIV, who will counsel you if you find you have the virus? When computers are moved out of intensive care units into the home to monitor the health of old people (one of the forecasts of the WHO group) who will monitor the computers? Without deliberate government intervention, health care for the average citizen is on course to get worse rather than better. ●

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Ref. A089/196

PRIME MINISTER

NHS Review: Central Management of the NHS

I attach a brief by Mr Wilson. I should like to emphasise these points.

2. First, the Secretary of State's paper directs your attention to question whether the Management Executive should be a non-statutory body within the Department (option two), a separate statutory authority (option three) or a public corporation (option four). He recommends option two, and you may well agree with this. But this is not the only or most important question. The main question is the layers of bureaucracy between Management Executive and the operational end of the health service. These layers of bureaucracy exist both in the department and in the regions and districts. They arise at both levels, because the departments place regulations and requirements on the regions and districts which they have to employ people to respond to. (I have provided you separately with an illustration of the bureaucracy in the area of dismissals.) If you want this removed, it will not be done simply by establishing a new relationship between the Management Executive and the Secretary of State. It will require a specific scrutiny of the role of officials in the Department, the regions and the districts and insistence that they be reduced perhaps with a numerical target. (You will remember that there is to be a scrutiny of the role of the medical divisions next year.)

2. Second, if we were setting up the Management Executive as

an agency under Next Steps, the Chief Executive would be given a written framework setting out the responsibilities delegated to him over, eg, recruitment, promotion, pay and approvals of capital expenditure. Should not a similar definition be given to the responsibilities of the Chief Executive of the Management Executive?

F.R.B.

ROBIN BUTLER

23 January 1989

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SECRET

PRIME MINISTER

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

I attach the detailed paper on the central management of the NHS for which you asked.

2. You will see from the paper that I am well content with the title of Management Executive that you suggested.

3. I make only one general point. It is that whatever we decide on central management and accountability should be consistent for the United Kingdom as a whole.

4. I am copying this minute and the paper to the Chancellor, the Secretaries of State for Wales, Scotland, Northern Ireland, the Chief Secretary, the Minister for Health, Sir Robin Butler, Mr Wilson (Cabinet Office) and Mr Whitehead (Policy Unit)

23 January 1989

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SECRET

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

Note by the Secretary of State for Health

I attach summary notes setting out:

- the functions, structure and management of the Department of Health (DH) (Annex 1)
- staff numbers in DH (Annex 2)
- the management of the NHS by the Management Board (Annex 3)

2. We have three broad objectives:

first, to put in place an effective chain of command to implement and carry forward our proposed reforms.

second to make clear the distinction between policy advice and operational responsibilities at the centre and the relationship between the managerial chain of command and the Department.

third, to ensure that the Government are only answerable in Parliament for those matters for which they can sensibly be held to account.

Future arrangements for central management of NHS

3. There is a range of options. They begin with the present arrangements then move progressively further from that. In order they are:

1. Management Board (MB), as now

   The MB has a distinct role within the Department, but is essentially part of it. We are agreed we must move beyond this.

2. Management Executive (ME), with a separate and defined status under the Secretary of State for Health

   This would put the ME on a quite different basis from the MB and, for the reasons set out below, is my preferred option.

3. English Health Authority (EHA), a body with separate legal status.

   A new body, between the Secretary of State and the NHS with a Chairman as well as a Chief Executive. Unlike now, Regional Health Authorities (RHAs) would be statutorily responsible to the EHA, rather than the Secretary of State. The simplest model would be a health authority model.

4. Health Service Corporation (HSC), a public corporation with separate legal status.

   The HSC would operate like a nationalised industry,

with direct management control. It could be a unitary model or a devolved model. With a unitary model, the NHS would become a single unified organisation with central, regional and local boards. But the regional and local boards would have no separate legal identity as health authorities have now. With a devolved model, regional and local boards could become more independent bodies. So the Northern Region for example could develop its own character, rather like the NHS has developed its own character in Scotland, Wales and Northern Ireland.

4. Starting with the far end of the spectrum, a Health Service Corporation as in Option 4 would provide a clear separation of the Government from the management of the NHS. The unitary model would provide a streamlined, direct chain of command. The devolved model would provide a visible buffer between the centre and local management, enabling the latter to get on with its job.

5. But I am not aware of any precedent for a public corporation running a public service funded almost entirely (97%) from taxation (81%) and National Insurance contributions (16%) and with virtually no independent income of its own. Even those nationalised industries that have been grant aided have had profit and loss accounts to which they have taken their income from charges or trading. Detailed accountability to Parliament would certainly be much less than now - but to an extent which we would not find easy to defend. We would also have to deal with allegations that the public corporation was a first step to privatisation. And, most important of all, an independent public corporation with a high profile Chairman and funded through taxation would become a powerful, and very visible, lobby for extra resources.

6. Unlike the public corporation model, the English Health Authority envisaged by option 3 would be recognisably in the NHS mould by building on the existing NHS structure. It would provide a separation between the Government and the management of the NHS, though not as sharply as option 4. It would provide an extra link in the chain of command between the centre and regions which matched that between regions and districts.

7. This option still presents us with two of the significant obstacles which apply to option 4, a public corporation. First the EHA would not be part of central government. The Accounting Officer would have to be in DH, as he would be if we went for option 4. And inevitably, the temptation for the EHA would always be to attribute failings to the lack of resources or other constraints imposed by Government. Of course, we would maintain some disciplines through contractual obligations and direct lines of accountability to me from the EHA and its senior management. But the EHA would come under permanent pressure from many of the health authorities below it to become a powerful and visible lobby for more resources. That indeed would be seen as its only quality by people in the NHS who would otherwise look on it as another layer of bureaucracy between them and Ministers. Second, if we are to adopt this option, or option 4, we should have to look again at the arrangements in Scotland, Wales and Northern Ireland.

8. Having reexamined the case for options 3 and 4, I have concluded that option 2, a Management Executive, is to be preferred. Annex 1 explains how the Management Board operates within the Department of Health. As my minute of 18 January made clear, I fully recognise both the enhanced role we see for the new ME which will replace the Management Board and the need for us to mark out its new status clearly. I

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propose a number of important steps to achieve this:

First, all central operational and management work on the NHS would come under the ME.

Second, staff working for the ME would have a clearly defined responsibility to the ME. If necessary, this could be incorporated in letters of appointment. I also expect that in future a greater proportion of ME staff will be seconded from the NHS.

Third, all operational and management work on the family practitioner services, including negotiations with the contractor professions, will in future be the responsibility of the ME. The Chief Executive will become Accounting Officer for this block of work too. My officials are discussing with the Treasury the implications of this for the present Vote structure.

Fourth, as I said in my minute of 18 January, the Chief Executive will report to me direct on all NHS operational and management matters.

Fifth, the Chief Executive will have his own budget for the operation of the ME. The precise accounting arrangements, which could draw on the Next Steps Agency model, would need to be worked out.

Sixth, as I have also already said, the Chief Executive will take a prominent role in dealing with Select Committees.

Finally, I envisage that the ME will operate on the basis of policy and resource directives issued by the Policy Board which I chair.

9. Taken together, these steps will both underline and underpin the new and separate status of the ME. They will not however - nor should they - lead to a situation where policy and strategy on the one hand and operations and management on the other become artificially separated. The ME will not be excluded from offering me policy advice; and of course the Chief Executive will be on the Policy Board. Similarly, I will not expect the Department to frame its policy advice without taking account of operational and management factors. And some senior officials will need to offer me advice on both fronts. The crucial point is that it will be clear where the advice comes from, the Department or the ME. It will be like advice on fiscal matters to the Chancellor, some of which comes from the Treasury's Fiscal Policy Division and some from the Inland Revenue

The Secretary of State, the ME and the RHAs

10. There are two lines of communication now between the centre and regions. One is between the Secretary of State and the Chairman, who are appointed by him. The other is between the Chief Executive and the Regional General Managers. This is less messy and more practical than it sounds. The line to Chairman from me is essentially political; the management line is from the Chief Executive to the Regional General Managers. The same arrangement applies between Regions and Districts. If a Regional General Manager spots any different emphasis between the messages he is getting from the Chief Executive and his Chairman it is quickly sorted out in practice.

11. In future the management line will be reinforced by my intention (mentioned in my minute of 18 January) that Regional General Managers will be accountable to the Chief Executive who will set objectives for them. I intend that the Chief Executive will be responsible for monitoring the

performance of Regional General Managers against objectives set for Regions by the ME.

12. It is important, however, that we retain the separate links to Chairmen who, as I have said, regard themselves as charged with the delivery of Government policy in their Regions. This will help us considerably in carrying through our reforms. But it may be even more important in achieving our aims on accountability. Regional Chairmen, as Chairmen of public authorities, have a personal position and standing of their own. This enables them to act as political firebreaks, in resolving or halting issues so that they do not automatically reach Ministers and Parliament.

Accountability

13. My approach to the Management Executive will enable us to establish a new basis for Ministerial accountability to Parliament. Operational and management matters will be for NHS Management rather than Ministers. National management issues will be for the ME to handle and more detailed issues for Regions, Districts and local management to handle as appropriate. I envisage that, when our legislation is implemented, we should normally refer Members who write or ask Questions to the relevant level of the NHS.

14. I do not expect us to get to our final goal overnight. We must move towards it steadily, as part of the implementation of our reforms. It would not be helpful in carrying through our proposed legislation if we were to appear to present Parliament with a fait accompli which meant an immediate and major shift in the present conventions on accountability. In any event I would not want health authorities as at present constituted before our legislative changes to be given this opportunity to attack the Government when pressed on their local problems.

15. I should reiterate the point that we can only change Parliamentary expectations on accountability if we maintain a common line in all four countries. Otherwise my position, and that of the Prime Minister, would not be tenable.

DH 23 January 1989

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ANNEX 1

THE DEPARTMENT OF HEALTH

Functions

The Department has two main functions:-

a. to inform, advise and serve the Secretary of State and other Ministers across the whole range of their responsibilities for health and personal social services, including:

i. supporting Ministers in their, and the Department's duty of informing and accounting to Parliament.

ii. developing policy in response to the requirements of the Secretary of State and of Parliament, consulting the relevant statutory authorities and others as appropriate.

iii. co-ordination and close collaboration with the Cabinet Office, Treasury and other Government departments in carrying forward the business of the Government as a whole.

b. to support the Secretary of State in the implementation of the legislation for which he is responsible, including the efficient and effective delivery of services costing £23 billion in 1989/90 and employing directly and indirectly over a million people.

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Services

2. The services in England for which the Secretary of State is responsible can be grouped broadly as follows:-

a. Hospital and Community Health Services, delivered through the agency of 14 Regional Health Authorities, 191 District Health Authorities and 10 Special Health Authorities governing the London post-graduate teaching hospitals, the Health Education Authority and the Disablement Services Authority and managed by the NHS Management Board.

b. Family Practitioner Services: Services are provided on the Secretary of State's behalf by 62,000 independent contractors. Their contracts are negotiated centrally by the Department with representatives of the professions concerned; and are administered locally by 90 Family Practitioner Committees which were established in 1985 as separate bodies directly accountable to the Secretary of State.

c. Personal Social Services: the Social Services departments of local authorities are required by statute to act under the general guidance of the Secretary of State who, in addition, possesses certain specific powers (eg of formal

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inquiry, inspection and action in default) and responsibilities (eg in relation to social work training) but not the same measure of resource allocation and performance monitoring as for the health services

d. an extensive range of wider health and social responsibilities some of which derive from specific statutes and others from his general statutory duty to safeguard public health. They include direct executive responsibilities for Special Hospitals, public and environmental health measures, public health laboratories, health education and preventive health measures, relations with the private health sector, licensing medicines, evaluating health care equipment, sponsoring the pharmaceutical and medical equipment industries, grants to voluntary bodies, sponsoring research, monitoring the professions' self regulation and international work.

Structure and Management

3. Support to the Secretary of State for the two main functions is provided at Headquarters. Management developments have been based on the following specific guidelines:-

i. No work should be done in the Department that could be done more cost-effectively outside it.

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ii. Work should be delegated to the lowest competent level, subject to monitoring by higher management;

iii. There should be clear lines of accountability at all levels; and

iv. Managers at all levels should be held accountable for performance against agreed objectives.

Where the Department has responsibility for the implementation of policy, directly or indirectly, management bodies dedicated to the particular service have been established some with external advice. By contrast, the Department maintains responsibility of the integrated formulation of policy over the whole field of the Secretary of State's responsibility for health and personal social services, in liaison with the relevant statutory authorities. The Department is developing new management information systems to reflect the varying communications needs of the main businesses.

4. Most recently possible candidates as Next Steps Agencies have been identified with a view to improving the efficiency and effectiveness of delivery of services to customers when it has seemed inappropriate to delegate responsibility for delivery outside the Department.

5. The analysis of DH Headquarters staff numbers at Annex [2] illustrates this trend: Medicines Division (227 staff) is about to become a self-financing Agency within the Department; the Special Hospitals (3,220 in the hospitals themselves) are due to become a Special Health Authority within the NHS this year; NHS Statutory Audit (220) will be transferred to the Audit Commission; the Disablement Services Authority (1,080) is already a Special Health Authority, though for the moment mainly staffed by DH officials; the Dental Reference Service (62) is being transferred to a Special Health Authority and NHS Superannuation (800), Youth Treatment Centres (190) and the Social Services Inspectorate (192) are possible candidates for Next Steps Agencies. Thus the size of the DH is in the process of being more than halved; and a further 1,400 staff are already being transferred or are being examined for transfer into different forms of Agency.

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ANNEX 2

DEPARTMENT OF HEALTH

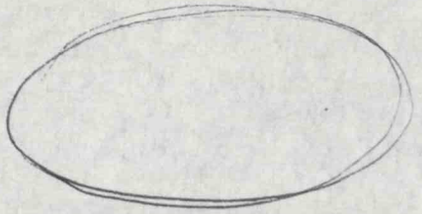
Approximate Staff Numbers, January 1989

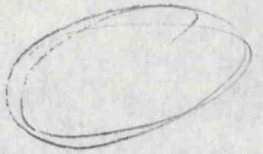
A. HEADQUARTERS (London based)

			Total
(i)	NHSMB support		
	(a) Information, Performance Indicators, Planning, IT	64	
	(b) Health Authority Finance, Financial Management, Management Services, Income Generation	82	
	(c) Regional Liaison	87	
	(d) Health Building	103	
	(e) Procurement	157	
	(f) Personnel	115	
	(g) Estate and Property Management	25	
		633	633
(ii)	Family Practitioner Services		166
(iii)	Health & Personal Social Services Policy		353
(iv)	Medicines Division (Licensing & regulation of pharmaceuticals) (NOTE 1)		227
(v)	Professional Groups (including administrative support)		
	(a) Medical	234	
	(b) Dentists	10	
	(c) Nurses	65	
	(d) Social Services Inspectorate HQ (NOTE 2)	66	
	(e) Analytical and statistical	266	
	(f) Legal	28	
		669	669
(vi)	Finance and internal audit		139
(vii)	Personnel Management and Central Account		203
(viii)	Private Offices and Information Division		83
(ix)	Office Services (typing, messengers, security etc)		420
	Total		2893

NOTE 1: About to become a self-financing Agency within the Department with externally recruited director.

NOTE 2: These are HQ numbers; see B5(a) for the field force.





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			Total
B.	DEPARTMENT OF HEALTH SERVICES		
	(i) Special Hospitals (NOTE 3)	3220	
	(ii) NHS Superannuation (NOTE 4)	800	
	(iii) Youth Treatment Centres (NOTE 4)	190	
	(iv) NHS Statutory Audit (NOTE 5)	220	
	(v) Miscellaneous services (outside London)		
	(a) Social Services Inspectorate (NOTE 4)	126	
	(b) Dental Reference Service (NOTE 6)	62	
	(c) Regional Medical Service	219	
	(d) Mental Health Act Commission and Review Tribunals	47	
		4884	4884
C.	DISABLEMENT SERVICES AUTHORITY (NOTE 7)		1080
	GRAND TOTAL A. Headquarters	2893	
	B. DH Services	4884	
	C. DSA	1080	
		8857	8857

NOTE 3: Planned to become a Special Health Authority within the NHS during 1989

NOTE 4: Possible candidates for Next Steps Agencies

NOTE 5: To be transferred to the Audit Commission on 1.4.91

NOTE 6: To be transferred to the Dental Estimates Board (an SHA) on 1.9.89.

NOTE 7: Became a Special Health Authority in July 1987 tasked with arranging full transfer to the NHS by 1.4.91. Included in the Department only because the Authority is, for the present, staffed mainly by DH officials.

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ANNEX 3

THE MANAGEMENT OF THE NHS BY THE MANAGEMENT BOARD

The NHS Management Board (MB) currently manages the NHS through a series of formal systems and informal relationships. Ministers are heavily involved in many of these systems and relationships. The following notes describe the main elements.

2. The MB's Director of Finance leads the Department's work on establishing the financial needs of the NHS in PES. Once Ministers have agreed the outcome, the Finance Director advises Ministers on the allocations to individual Regions and other health authorities, and is responsible for the release of funds to individual authorities, for monitoring expenditure against cash limits and for ensuring delivery of the cash limit by the NHS as a whole. The MB's Director of Financial Management monitors the income and expenditure position of RHAs and their Districts in order to ensure that the NHS spends at a level which can be afforded.

3. Health authorities are required to draw up short term programmes (ie annual operating plans) before every financial year. These show what services they intend to provide (including new developments), what manpower will be employed and how they will be funded. The STPs must be framed to respond to policy guide-lines from the Department eg as to the development of particular services. The STPs must also contain proposals for

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cost improvement and income generation. These STPs are vetted for ambition, coherence and soundness by the revelant MB Directors (Planning, Financial Management, Operations and Personnel), before approval. Implementation is monitored by the MB.

4. The performance of each RHA is thoroughly reviewed every year. The MB examines, inter alia, the execution of a series of special tasks agreed with the RHA at the previous year's review (the Action Plan); the RHA's financial position; and its achievement of a range of policy or other objectives eg the improvement of vaccination rates, the implementation of energy conservation measures,the better use of beds the reduction of waiting times. Having carried out their review, the MB Directors then support a Minister to who carries out Ministerial Review, at which the key issues are thrased out with the RHA Chairman.

5. Capital investment in the NHS is controlled through the requirement on RHAs to submit major building schemes for approval - schemes of over £10m have to go to the Treasury, - and through the monitoring of RHA performance on schemes (eg time and cost over-run).

6. RHAs are obliged to submit disputed hospital closures for Ministerial decision. Such closures often cause political

difficulties and considerable work for the health authorities, Ministers and officials.

7. The pay and conditions of NHS staff are tightly controlled through their central determination by Ministers, whether on the advice of Review Bodies or Whitley Councils.

8. RHAs, and DHA Chairmen, are appointed by Ministers. Ministers now enjoy very close relations with Regional Chairmen. Ministers meet them regularly; frequently consult them on policy and management issues; and expect (and receive) considerable personal loyalty in carrying out Ministers' policies.

9. The MB Chief Executive and his fellow Directors enjoy good relations with Chairmen and very close relations with Regional General Managers. The Chief Executive has established himself as "professional" head of general managers in the NHS, and spends much time and effort encouraging the development of management skills and raising management standards in the NHS. Through hundreds of visits and speaking engagements he has become highly visible to the NHS managers. The MB's functional directors (eg Financial Management, Personnel) also act as professional heads of their functions in the NHS.

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10. Paragraph 2-7 above describe some of the formal, regular systems by which Ministers and the MB manage the NHS. In addition, of course, the MB is in frequent touch with Regions and Districts over particular problems or issues. The requirement to answer in Parliament for what happens in the NHS inevitably pulls up, to Departmental level, many issues which would not otherwise require our involvement.

0606A

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

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

CONFIDENTIAL

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
LONDON
SW1P 3AG

23 January 1989

Dear John,

NHS REVIEW: DRAFT WHITE PAPER

Thank you for your letter of 19 January.

Taking your suggested amendments in turn:

- paragraph 2.23: accepted;

- paragraph 2.28: accepted;

- paragraph 3.14: I am unhappy with this suggestion, which raises a wholly new proposition going beyond the terms of HC65. I am of course prepared to discuss the basis on which self-governing hospitals should manage their finances, although I do not believe they should be placed under constraints, or set targets, which do not apply to NHS hospitals generally. On the understanding that this is the underlying intention, I have amended the preceding indent to clarify this point. The words you suggest would also tend to signal that self-governing hospitals might not, after all, remain within the NHS;

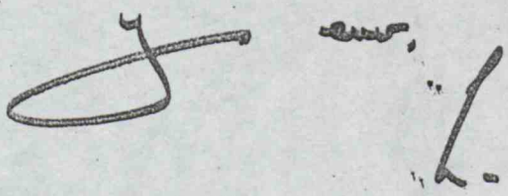
- paragraph 3.15: accepted (although I have turned the wording round to make it sound more positive);

- paragraph 6.9: I accept that this proposal has not previously been discused, and I have deleted it. But I have also removed the implication that the prescribing costs element of a practice budget would necessarily be the same as an indicative budget under the general drug budget scheme. I should like to give further thought to this. We may need to discuss further as the detail is developed;

E[illegible].

- paragraph 7.21: I have dealt with this in my minute of 19 January to the Prime Minister.

I am copying this letter to the recipients of yours.



KENNETH CLARKE

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1 of 6

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Treasury Chambers, Parliament Street, SW1P 3AG

NBPM
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Andy McKeon Esq
Principal Private Secretary
to the Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1

23 January 1989

Dear Andy,

NHS REVIEW:WHITE PAPER SUMMARIES

We spoke earlier today with PRC ? about the two NHS review summaries enclosed with your letter of 20 January and I relayed the Chief Secretary's comments to you. For the record these are detailed below.

DRAFT POP VERSION OF WHITE PAPER

First paragraph, line 6: delete 'compared with' and insert 'has now risen to'.

Under "The Way Ahead" second indent, redraft first sentence to read '..popular hospitals which treat more patients will receive more money'.

Amend fifth indent, first sentence to read. ' ... over the next three years over and above the increase previously planned'.

The Chief Secretary also suggests inserting a new final indent which reads as follows:

'There will be more rigorous audit of quality of treatment and value for money. Arrangements for medical audit will be extended throughout the NHS. And the Audit Commission will take over the audit of health authorities and other NHS bodies'.

Under the heading "Timetable for Change", the Chief Secretary would like to amend the fourth sentence to read:

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'By 1991, and subject to the approval of Parliament, the first NHS Hospital Trusts will be up and running ..."

The Chief Secretary would like to include a final paragraph entitled "The best use of resources". This would read as follows;

'These reforms will also improve the value that people get for the £35 a week the average family pays for the NHS. Managers will be freed to get on with the job of managing. And doctors will be made more accountable for the resources they use.'

Finally the Chief Secretary thinks that the 'pop' version should include a paragraph along the lines of paragraph 16 in the staff version.

SUMMARY OF NHS REVIEW WHITE PAPER - FOR NHS STAFF

In paragraph 3 the Chief Secretary suggests adding a new fourth sentence. 'It now totals £35 per family, per week.'

The Chief Secretary is firmly of the view that the fourth indent of paragraph 9 should mention the other half of the consultants package; namely enforcement of contracts and the new approach to merit awards

Paragraph 9 should end with the sentence 'Some of these proposals will require the approval of Parliament.'

In the penultimate paragraph on self governing hospitals, the Chief Secretary would like to redraft the second sentence to read:

'And they will have freedom (within limits) to borrow money'.

Finally, the Chief Secretary thinks that the last sentence of paragraph 16 should be revised to read:

"The Government therefore proposes to allow tax relief on private medical insurance premiums for retired people, whether paid by them or, for example, by their families on their behalf.

I am copying this letter to Paul Gray (No.10) and Richard Wilson (Cabinet Office)

Yours,

Pete

PETER WANLESS
Assistant Private Secretary

PART 18 ends:-

Dept Health to PS Jan 89

PART 19 begins:-

PS/CST to PS/SS. Health 23-1-89

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