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DEPARTMENT OF HEALTH & SOCIAL SECURITY

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From the Secretary of State for Social Services

30 May 1986

The Rt Hon John MacGregor OBE MP
Chief Secretary to the Treasury

Dear John.

1986 PUBLIC EXPENDITURE SURVEY: HEALTH

This letter sets out my proposals for the health programme under the guidelines for the 1986 Survey. Detailed information will be contained in letters at official level.

A good record on health is clearly of crucial importance. To achieve it we need as a minimum to make the additional provision set out in the appendix to this letter.

The background is that our strategy for increasing the efficiency of the National Health Service is producing results. The cost-improvement programme launched in 1984-85 has produced cumulative cash savings of £105 million in 1984-85, £230 million in 1985-86 and £390 million in 1986-87. In addition there have been substantial increases in the number of patients treated within existing resources. Though savings are becoming more difficult to achieve and there are risks that they will be presented as cuts, I expect health authorities to continue with their cash-releasing programmes at a substantial level, giving a cumulative annual value of £820 million, or 7 per cent of their resources, by 1989-90. I also expect them to continue to increase the numbers of patients treated.

But this will not be enough to meet health needs. First, the justified demand for services has increased and will continue to increase because of the growing numbers of old people, new developments and opportunities in medicine and new problems such as AIDS and drug misuse. Second, the cash that we planned to use for service development has had to be used for increases in pay, mainly for Review Body awards. (Our own negotiated settlements have been below the level negotiated elsewhere within the public and private sectors.) As a result, in spite of increased numbers

of patients treated, we have not made enough headway in tackling the deficiencies of the Service, reflected most conspicuously in over-long waiting lists and waiting times. There is also the problem of providing adequate care for groups such as the mentally ill - highlighted, for example, in 'The Times' articles on schizophrenia. We have made progress in improving services in under-provided parts of the country, but this has led to heavy pressure for increased efficiency and service rationalisation in better-provided areas, especially but not only in London. This has been happening at a time when there is legitimate and widespread expectation that, as our economic policies bear fruit and consumer spending rises, the public will expect to benefit through improvements in health care. Present plans allow only increases in NHS spending over the Survey period of 0.3 per cent, 0.6 per cent and -0.5 per cent over forecast inflation.

What we need is an adequate and realistic baseline and targeted spending over the next two years to tackle key problems. This is the purpose of my proposals. I comment below on the main items.

It remains essential that we should provide extra resources for the increasing number of very old people. I have, however, reduced my bids to reflect the gradual slowing down in the rate of growth in the elderly population over the period. On pay, my bids cover the continuing costs of the 1986 Review Body awards. For the future, I am assuming that any increase in pay over the rate of inflation will be covered by increases in efficiency (ie the cost-improvement programme - though the money is, of course, then not available for services), but as this year has shown, it is not possible to predict in advance whether Review Body awards can be handled without additional provision in future years.

On waiting lists, experience shows that authorities can make real impact by a combination of better management and extra resources to remove bottlenecks (theatres, diagnostic services etc) and to invest in equipment to introduce new quicker forms of treatment (eg day case ophthalmic treatment using lasers). To make a major impact I propose we should spend £60 million on this over two years.

We also need to find ways of continuing to improve services in under-provided regions and districts without having to cut services in London and other cities, in particular Liverpool and Manchester. The RAWP review is most unlikely to justify stopping redistribution altogether, and if we simply halt the process there will be an outcry from the RAWP gainers, especially Trent, West Midlands, East Anglian, Oxford, Wessex and South Western. I propose instead that for the next two years, whilst the review is completed and its implications worked through, we should make funds available to losing Regions to help them tackle problems in the location and organisation of their acute services, for example, deferment of closures until planned developments are in operation and the development of new facilities such as day surgery.

Funds for these purposes would be made available to regions only against specific plans which would show how they would be used to improve standards of service.

The remainder of my bids are to enable the Service to respond to new needs which we cannot reasonably refuse to provide for; principally AIDS, drug misuse, the introduction of a breast cancer screening programme, more frequent cervical cancer screening, extra spending on supra-regional services such as heart and liver transplants, and new medical developments such as lithotripters to dissolve kidney stones. Finally, I want to make some additional funds available for community care, including help for authorities to build up services ahead of the run down and closure of the large mental illness and handicap hospitals, so tackling another area where we are open to serious criticism.

Spending carefully on these items will enable us to make quick improvements in the areas where we are particularly vulnerable and to bring in new treatments and preventive measures of a kind that people value very highly.

The practical consequences of holding to the baseline provision would be grave. The health service would be forced next year to reduce services by about 1 per cent - equivalent to about 100,000 in-patient cases - in the face of growing numbers of old people and of new pressures. Our committed policies for service improvement would be frustrated and new proposals - as in my bids - could not go ahead. Waiting lists would inevitably rise substantially and in many hospitals only emergency admissions might be possible. Cuts would have to fall disproportionately on under-provided regions and districts, who would be unable to open new hospitals now being built to put right service deficiencies and provide for growing populations.

Hospital and Community Health Services - Capital

I propose an increase of £50 million in 1987-88 to invest in more rapid progress in rationalising the NHS estate and providing new facilities which will produce revenue savings.

Centrally Administered Health and Personal Social Services

This programme covers a wide range of over one hundred central HPSS budgets and the administrative costs of the Family Practitioner Services. Most fall within a single cash limit. There are urgent needs for new developments on AIDS services, teenage smoking, coronary heart disease, children under five, intermediate treatment, child abuse and drug misuse, all of which occasion national concern, and which require between £24 million and £27 million in the various Survey years. I have nonetheless decided that these will have to be funded through economies, improved efficiency and reviews of priority within the cash limited programme.

What I cannot do, however, is to absorb also the demand-led elements of expenditure on EC Medical Costs and Welfare Food where increased requirements of some £8 million, £16 million and £22 million have been identified, and I have no alternative but to seek increased provision of these amounts.

Family Practitioner Services

We have met and have corresponded recently about issues affecting the provision for the Family Practitioner Services (FPS). In particular we have discussed the problems associated with finding measures to meet the balance of commitments arising from previous Surveys. Our officials have agreed what that balance is and it is included in the bids set out in the Appendix. The figures include the knock-on effect of the DDRB settlement and other pay in 1986-87.

The bids I am making over and above the carried over commitments from earlier Surveys and the DDRB effect are modest for 1987-88 (£27 million) and 1988-89 (£29 million). They comprise the increase in the profit level allowed in the Pharmaceutical Price Regulation Scheme - for which you already have details - and small service development bids which are largely to allow for the supply of blood testing strips for the improved control of diabetes and extension of the high risk groups for Hepatitis B vaccination. The higher bid in 1989-90 is mainly to finance th year-on-year growth of the FPS, eg more doctors, dentists, prescriptions, which has not under the PES rules been allowed for in the baseline.

I cannot, of course, contain the demand-led requirements of the FPS within the existing provision without specific savings measures. As we agreed, our officials have been in touch about the scope for savings. They have looked at a number of possibilities most of which we have considered in previous Surveys; most have considerable practical or political difficulties. I have myself looked carefully at the possibilities of further savings from the FPS; there are some but they are limited in scope. My officials will let yours have the full details but as things stand I can see prospects of saving only about £30 million in each of the years. This includes the amount I expect to raise from the proposed changed role of the General Practice Finance Corporation to fund the PPRS profit increase.

One of my outstanding commitments was on prescription charges and on which I need to raise £10 million over and above the amount necessary to keep in line with the cost of the service. (This £10 million is included both in the £66 million outstanding commitments in the Appendix to this letter, and in the £30 million savings mentioned in the previous paragraph.) This is likely to require an increase in the charge from £2.20 to £2.60 from 1 April 1987. I do not need to spell out the political difficulties of such an increase - it would be a considerable lead on inflation. Indeed the present level of the prescription charge means that nearly a third of prescriptions paid for have a cost which is lower than the charge. In the dental service we recover, on average, two-thirds of the cost of a chargeable treatment. I shall be exploring possible changes to the structure of prescription charges and dental charges to see whether a more acceptable way of raising the additional income is available.

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After taking account of savings which seem likely to be achieved we are left with a gap of £113 million in 1987-88. This is largely accounted for by the knock-on effect of the DDRB award and by the "unallocated" saving of £40 million related to an assessment of the possible outcome of the Consultative Document on primary health care. However, the Consultative Document has only just now been published and the consultative period now extends to the end of this year. Given the time that I shall need to consider the outcome of the consultations and - as important - the time needed to negotiate and implement changes, it would be unrealistic for you and me to plan for cost savings in 1987-88.

You and I have been much concerned about applying proper disciplines to spending on the FPS and both our Departments have put a great deal of effort into improving forecasting. I am sure you are as glad as I am that we are reaping the rewards of that work. Improved accuracy in the last Survey has put us - fo the first time - in the position where I do not need to bid for additional provision to cover increased demand.

I recognise that the total of my bids is substantial. Some of this is inescapable such as the knock-through of pay, but the essence of what I am proposing is a limited amount of additional resources targeted on specific areas like waiting lists. I believe that that would have very real benefits in demonstrating our commitment to the health service.

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

Yours ever

Norman

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Appendix of Bids

£ million

	1987-88	1988-89	1989-90
Survey Baseline	15937	16617	17032
Hospital and Community Health Services: Current			
1. Restoring lead over inflation to meet pressure from growing number of elderly people	10	33	171
2. Consequences of 1986 Review Body Awards	153	159	165
Service Priorities			
3. Waiting lists	30	30	-
4. London/RAWP	25	25	-
5. AIDS	10	20	30
6. Breast cancer screening	10	20	30
7. Cervical cancer screening	15	16	16
8. Supra-regional services	4	7	11
9. Community care	20	20	20
Total HCHS Current	277	330	443
Hospital and Community Health Services: Capital			
10. Rationalisation of estate and new facilities to produce revenue savings	50		
Total HCHS Capital	50		
Centrally Administered Health and Personal Social Services			
11. Welfare food	5½	8	10
12. EC medical costs	2	8	12
Total CA HPSS	8	16	22

Family Practitioner Services (Contractors)			
13. Re-assessment of FPS items discussed in earlier Surveys	66	127*	128*
14. Inflation in 1989-90 (0.5%)	-	-	14
15. 1986 DDRB award and other pay consequences	50	51	53
16. Demand not in baseline	-	-	151
Service Priorities			
17. Blood test strips for diabetics	8	8	9
18. Pharmaceutical Price Regulation Scheme - profit level	15	20	14
19. Hepatitis B vaccine	4	-	-
Total FPS (Contractors)	143	206	369
Total Additional Bids	478	552	834

* Final figure to be settled in the light of the outcome of discussion on the Consultative Document


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