PRIME MINISTER

David Willetts has sent in the attached paper on the National Health Service. As well as suggesting areas for reform, it contains some interesting information on variations in efficiency (as well as some horrifying statistics on the variation in fatality rates for different doctors).

You might like to have a look at this paper before the meeting on health tomorrow afternoon.

JRW

JOHN WHITTINGDALE

26.1.88

THE NATIONAL HEALTH SERVICE

A consensus is emerging, both within the Health Service and amongst commentators, about sensible ways to reform the NHS. John Moore is steering the debate in the right direction. We here at the CPS are doing our utmost to help. The reform programme has three main elements:

[i] we can still get more from our current levels of spending on the NHS, but this will mean reviewing the efficiency, competence and priorities of doctors;

[ii] we need to develop an internal market, with the best hospitals winning more 'customers' and more funding;

[iii] we need new mechanisms to bring extra private money into health care.

These three approaches are all considered below. (In addition, one silly idea - concentrating on health promotion - is assessed in Annex A). These reform ideas should be bearing fruit well before the next Election. But we also need to get from here to there; that is considered in the last section of the note.

Getting more and better work out of doctors

Some of the worst examples of waste in the NHS have been eliminated. They range from Guy's pruning their finance department as Ian McColl recommended to nurses not now using expensively sterilised swabs for wiping up spilt tea. To carry on getting more bang for the buck, we shall get into sensitive questions of doctors' clinical freedom. There are three distinct issues here: efficiency

competence

priorities

Some doctors are simply more efficient than others. At last we are beginning to get some basic information on how much the same operations cost in different hospitals. Ian McColl tells me that Guy's can do 600 heart operations for roughly the same cost as 200 heart operations in St Thomas's. Trent Region has found that cataract patients stay in one hospital for ten days and for two days in another. That means a gap of £800 in the cost of the same treatment because, on average, every day spent in a hospital bed costs £100. Derby General Hospital keeps hip replacement cases in for two weeks, as against three in the rest of the Region - a £700 saving. I attach further examples at Annexes B and C from work done by John Yates for

the West Midlands Region. Although the data need to be treated with caution, they do show wide disparities in lengths of stay and in number of operations between different medical teams (or 'firms').

Secondly, there is the question of medical competence. The variations in death-rate between different hospital doctors carrying out the same operation are enormous. I attach at Annex D another diagram from the West Midlands showing the different percentages of patients who die after being operated on for the same medical condition by different consultants in the West Midlands. Again, the data need cautious interpretation, but they appear to show that almost 10% of the consultants had no deaths during 1984. But the worst consultants had a 30% death-rate. This information is not meant to be seen by the layman. The row over publishing school exam results would be as nothing compared with the explosion we would get from the BMA if this material were published. But there are ways of discreetly getting district managers and GPs to act on it, and backing them up if they get into trouble.

Thirdly, we need to guide medical priorities. There is still wasteful heroic medicine aimed at an exotic article in The Lancet rather than alleviating human need. Many doctors believe that too much effort is put into painful treatment for those cancer patients who really don't have much hope anyway.

We need to open up these tricky issues. After all, none other than Sir Raymond Hoffenberg, President of the Royal College of Physicians, referred in a lecture last year to the "failure of most doctors to show a proper sense of responsibility towards the medical role in the generation of costs and the allocation of resources". If we do end up having to put any extra money into the health service, it must depend on acceptance that medical performance will need to be reviewed more closely than ever before. Maybe the Royal Colleges themselves should specifically be contracted to carry out clinical audits for NHS managers.

Opening up these questions also avoids the socialist fallacy of treating every problem as one great over-arching public spending issue. There are particular hospitals and doctors doing a good job who need to be rewarded, and others less good who need to be visited by an authoritative team from

the centre to help sort things out. The NHS convention is to allocate money on an essentially statistical basis - calculating how many people there are in an area and how ill they tend to be. That has no rewards or incentives for efficiency. Instead, money should go to the people who will use it most efficiently. For example, Price Waterhouse found that Sheffield Hospital carries out its heart operations at a lower price than Leicester. Now Trent Region will act on this information - directing more money for heart surgery to Sheffield. That is clearly a step towards an internal market.

The internal market

When the NHS was being set up, someone came up with this marvellous piece of doggerel about the doctor:

> "Servant of his patient when master of his fate,
>
> But master of his patient when servant of the State"

The idea of the internal market is again to make doctors servants of the patient because they need to win his custom (even though the patient is not paying directly). It is revealing that in a teaching hospital, the team of a consultant

together with his juniors is referred to as a "firm". There are competing small businesses trying to get out.

The use of the special waiting-list fund shows what the rudiments of an internal market might look like. Regions have been agreeing contracts with individual hospitals, fixing the number of operations they will do on top of a baseline agreed using the previous year's contracts. A price is fixed as well. An example from Birmingham is attached at Annex E. Progress in doing the extra work is agreed on a monthly basis. This sort of arrangement would have been inconceivable five years ago; it is encouraging evidence of what is already being achieved.

Bringing in private money

Imagine that there was a national car service, financed from taxation, which issued everyone with a free Austin Maestro. Poor people, who would not have had a car at all, or would have bought a Maestro anyway, would be happy. The rich would still have enough money to buy themselves a Rolls and they would leave the Maestro in the garage. But the middle-income earners, who in a free market would have bought themselves a Rover, would not be

able to afford one after paying all the extra tax to get a Maestro. Those are our natural supporters who lose out from the current system of financing health care. They are the people for whom we must devise new financing arrangements so that they can buy better care. John Moore is right when he argues that better management and greater efficiency are not enough on their own.

Two routes would help such people buy extras for themselves:

- letting patients opt out from the NHS by issuing them with vouchers so they can take some public money with them and buy a better service from the private sector

- bringing more private money into the NHS so that patients can spend their own money while still enjoying the basic free NHS care.

The voucher is a theoretically attractive proposition but we are not in a position to introduce one yet. The biggest single practical problem is the great gap in spending on different age-groups. The new public expenditure White Paper shows that on average the NHS spent:

- £190 on every person aged between 16 and 64
- £570 on people aged between 65 and 74
- £1,475 on people aged 75 and over.

If we simply gave everyone who wanted it a £500 voucher on leaving the NHS, all the fit squash players would opt out, costing us a lot of money spent on vouchers, and leaving the NHS with all the expensive cases anyway. So we need to do lots more work designing voucher schemes, with different values for different age-groups.

The other approach is to bring more private money into the NHS so that people can buy extras. There are enormous possibilites here which go way beyond simply putting a florist by the hospital entrance. Here are some examples:

[i] sponsorship by local companies of wards in local hospitals. Why not the Glaxo wing and the Marks & Spencer kidney unit? This helps involve local people. Moreover, no private company wants its name associated with a badly-run or slovenly authority.

[ii] joint projects with private health companies so that, say, a private wing is built on an NHS site with a 50/50 split between the NHS and the private company.

[iii] charging is difficult because after all the exemptions you end up without much money and at high political cost. But selling extras is different. Why not open NHS facilities on Saturdays to sell a health screening at £50 a go?

[iv] private pay beds could be considerably expanded. One of the reasons they are resented by some health workers is that although the health authority and the doctor make money from them, the nurses and ancillaries stay on basic NHS pay. If they are lucky, the doctor gives them a bottle of whisky at Christmas. If all the NHS employees who worked with private patients got a bonus at the end of each week, the opposition would start to melt away.

[v] companies can take on much more responsibility for the health of their employees - healthy workers are productive workers. At the moment the system of financing sickness pay works directly against that because all costs are met out of the overall national

insurance budget. Safe, low-sickness employees cross-subsidise the casual, high-sickness ones. We could abolish State financing of sickness pay and instead require companies to pay direct out of their own resources. That would give them a direct incentive to ensure that their employees stayed healthy.

Today's political problem: getting from here to there

After discovering during the Election campaign that he could exploit the cases of individual children waiting for hospital treatment, Neil Kinnock has appointed himself Shadow Minister for Health. Difficult though things are at the moment, the message will eventually get through that this approach is as ludicrous as holding you and David Young personally responsible whenever the Post Office fails to deliver a letter on time.

But there is another element to today's NHS problems which, however unpalatable, we cannot ignore. Sound and trustworthy people in the NHS - not the whiners and whingers - believe that this year's PESC settlement is tighter than ever. Indeed, it is widely believed that the figures are so tight that key people in the DHSS and the

Treasury may not have realised the implications of what they were agreeing until the detailed calculations were done for the regions and districts. Health service managers tried to keep a grip on their finances by closing wards before Christmas, until they got the extra £100million. The Regional Chairmen - experienced businessmen who are on our side - are reported to have estimated that they need an extra £150-£200m next year, or else they will have to close 6,000 beds in April - or more, if they delay. The nurses' pay settlement also looks likely to turn out expensive this year.

Of course, necessity is the mother of invention and of efficiency. We need tight budgets to force the NHS to change. One of the best ways to get more efficiency is to cut the number of NHS beds and get a quicker turnover of patients. That is why average length of stay in an NHS hospital is down from 9.4 days in 1978 to 7.3 in 1985. But if too many extra ward closures hit us in the Spring, Ministers and managers who ought to be leading and changing the NHS will instead find themselves fire-fighting.

It would be wrong to appear to surrender to blackmail, so we cannot anyway provide any extra

money until things quieten down a bit. Moreover, if there is to be more public money, it should not be a substitute for reform. Maybe the main themes in this note (which I believe are close to John Moore's own thinking), could be included in any announcement.

Meanwhile, we can gain support by inviting NHS managers and doctors to set out their own ideas for joint projects with the private sector. The best of them have a variety of useful and interesting proposals. Our CPS work on health care will be drawing on such sources of practical advice to give our ideas extra authority.

David Willetts

David Willetts

25th January, 1988

ANNEX A

HEALTH PROMOTION

One proposal is to set up targets for improvements in the nation's health as a means of demonstrating progress. This concentration on health prevention is wrong-headed. First, it smacks of the Nanny State. We would not dream of setting employment targets district by district to show how the economy was getting better. Nor can we take responsibility for people's individual health, which depends on a host of things which are (quite rightly), completely outside the Government's control.

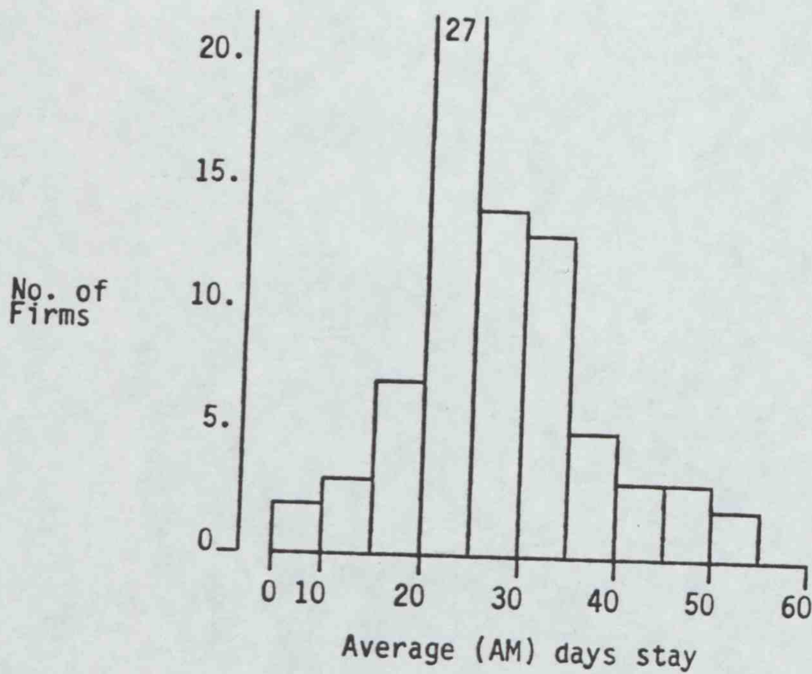
Secondly, if there is one lesson from the media horror-stories of the past few months it is that what really matters to people is classic, acute surgery. Even The Daily Mirror hasn't yet managed to generate a scare because old people need better chiropody services or breast-feeding mothers aren't taking enough vitamins. One of our major political mistakes over the past few years has been to direct extra money at the priority groups such as the mentally handicapped and the mentally disturbed. That is one of the reasons the major teaching hospitals specialising in acute medicine are under such pressure at the moment.

ANNEX B

ANALYSIS OF HAA DATA FOR TRAUMA AND ORTHOPAEDICS

1984 information for upto 79 firms

LENGTH OF STAY FOR FRACTURED NECK OF FEMUR



COMMENTS ON [I]
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Data source. [I]

Problems with calculation and/or source. [I]

What does it indicate? [I]

Evidence or support. [I]

Reservations. [I]

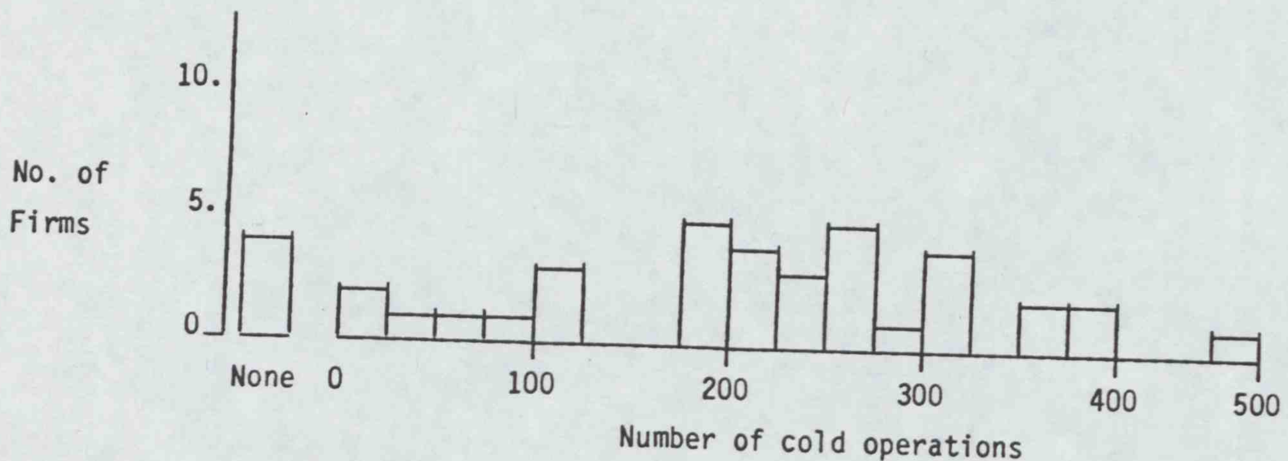
Ref. JMY/GI5

ANNEX C

ANALYSIS OF HAA DATA FOR OPHTHALMOLOGY

1984 information for 39 firms

COLD OPERATIONS



This histogram describes the number of patients who had at least one operation following a cold admission to hospital

There are a number of reservations in interpreting this data (quite apart from any concern about the accuracy and completeness of HAA). These are:-

1. Firms may be of different sizes (ie. comprising of one consultant and no juniors, one junior, or a number of juniors) and consist of doctors with different levels of training.

2. No weighting has been introduced to allow for differing contractual commitments. It may be that the firms with a small number of admissions are those where the consultant has a part-time contract with few sessions.

3. The data include information about all firms including those where consultants resign during the year, or commence during the year. It may also include data for locum consultants. The information for each firm is therefore not necessarily for a full year.

4. Transfers from another consultant within the hospital are not included. This might mean an underestimate of cases transferred to the firm but equally may be an overestimate because cases are transferred from one of the firms included here to another specialty.

Once the data has been thoroughly checked, it would seem reasonable to address particular attention to those firms which operate on less than (say) 200 cases per annum.

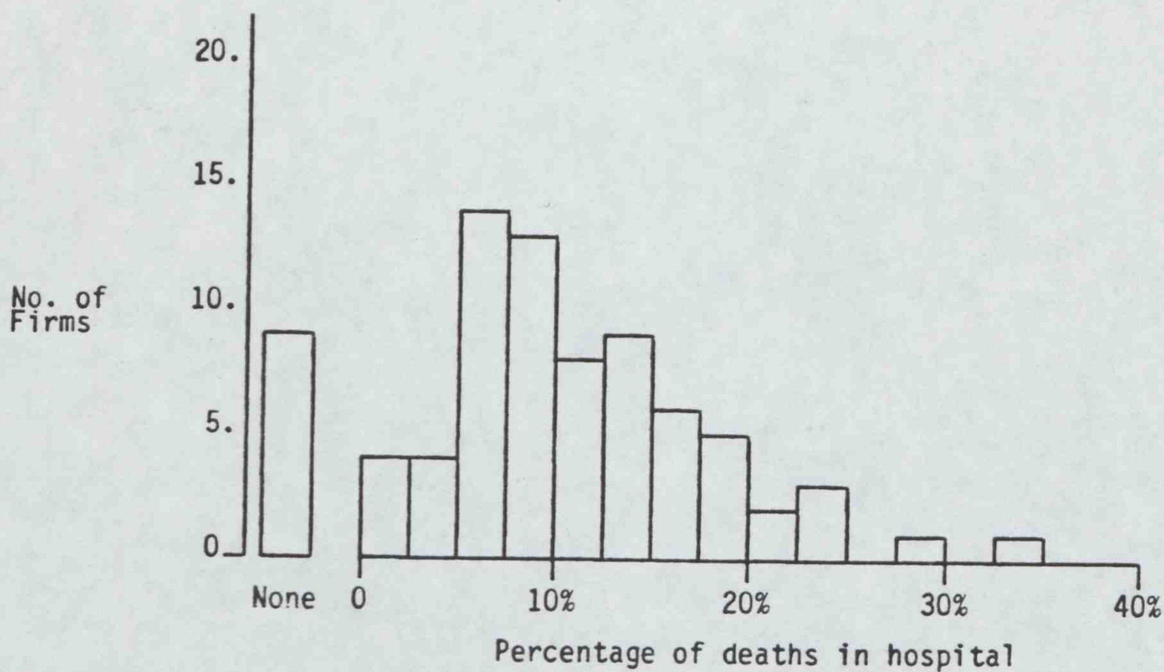
JMY/GI5

ANNEX D

ANALYSIS OF HAA DATA FOR TRAUMA AND ORTHOPAEDICS

1984 information for upto 79 firms

CASE FATALITY RATE FOR FRACTURED NECK OF FEMUR



COMMENTS ON [I]

Calculation. [I]

Data source. [I]

Problems with calculation and/or source. [I]

What does it indicate? [I]

Evidence or support. [I]

Reservations. [I]

Ref.JMY/GI5

ANNEX E

WEST MIDLANDS REGIONAL HEALTH AUTHORITY

WAITING LIST FUND 1987/88

CONTRACT FOR BID 1.3

DISTRICT: Bromsgrove SPECIALTY: Trauma and orthopaedics

Financial allocation for 1987/88	- £120,000 revenue, non-recurring. The fund is cash limited and any extra costs will require to be met by the District.
Start date	- 1 April 1987
Current workload	- 875 cold admissions (at Hill Top)
Additional throughput	- 150 cold admissions
Method	- Additional theatre lists at Hill Top Hospital. Some cases to be taken from the Woodlands Hospital waiting list.

The conditions regarding this contract are included in a covering letter from Mr Hands to each district general manager.

Prime Minister,

THE NATIONAL HEALTH SERVICE

Argument

True, the NHS budget is nearly twice the 1980/81 figure. True, there are thousands more doctors, tens of thousands more nurses, many more out-patient treatments and operations. True, there have been important improvements in efficiency.

Despite this impressive record, the Health Service is in crisis. A crisis of expectations. The Labour Party, certain unions, particularly NUPE, COHSE together with the willing complicity of the media, are all busy destabilising the Health Service because they see it as the only issue that presents an opportunity to mount any kind of effective opposition to you.

Night after night we see pictures of ill and dying people on the television. Pale children and paler babies with holes in the heart. Old people complaining about the waiting lists for such simple things as cataract operations. Senior consultants whingeing about resources.

These play awkwardly against your statements in the House even though they are, of course, true.

So long as the provision of national health care remains the sole responsibility of the government of the day it will always be vulnerable to this kind of dishonest lobbying.

Dishonest because it refuses to state the most important truth or ask the real question about the Health Service. The truth is that there has to be a limit on health spending. The real question is how should that limit be set and by whom?

The answer is simple. By the consumer. But to get to such a point is not simple at all, of course, and will take many years.

Meanwhile, the Left have made one major miscalculation. Because of the agitation they have mounted, more and more people have been brought to think about the health service. Ordinary people are very sensible. So they know perfectly well that people get ill, that people get old, that people die and that health spending designed to prevent or delay these inevitable events cannot be limitless. And more and more of them are beginning to accept that the principal question is where should the limit be set and by whom. At the same time, ordinary people, often far in front of the media and parliament, are more and more prepared to contemplate sensible and, if necessary, radical reforms of the methods for providing finance for the nation's health.

But they need a lead. Soon. If not, it is possible that sentiment will swing behind the agitators.

You are quite right to have said that there will be no more money for the Health Service in this budget and that there will be no formal enquiry. The government was elected to govern. Most people accept that making arrangements for the Health Service is entirely within that remit.

The failure of parliament and the media to reflect real public opinion on health and the role of government is illustrated in another, current issue - the Official Secrets Act. Despite the furore in the press, most people agree that it is not up to Shepherd but to the government to reform secrets legislation.

People like strong government. Even if some of them moan. It makes a frightening and uncertain world less daunting.

Proposals

1. We need to get far more information about consultants who are misbehaving. And from time to time to make it public. A task for the Health Communications Group. (See 4 below) Channel 4 transmitted a film ten days or so ago about opthalmic consultants in Wolverhampton. (I am arranging for a tape of the film to be made available to you with this note.) It was devastating and demonstrated that amongst them, at least, there is widespread failure to comply with their contracts with the NHS. This problem is certainly not unique to Wolverhampton.

2. Twice recently the government has appeared to give in to nurses and blood transfusion workers. This merely encourages more militancy. If the government is to give more money to the Health Service or to alter the methods of funding it, it must not be seen to be doing so under duress.

3. Groups of young, radical backbenchers need to be encouraged to publicly propose very radical solutions (that you have no intention of implementing) so as to increase your room for manoeuvre.

4. The government's communications on this issue are not good. So you are losing the initiative in the national debate and rendering introduction of the necessary reforms unnecessarily difficult. A major communications effort should be made.

I suggest you set up a small, secret, ad hoc Health Communications Group under John Moore. It could be Tim Bell, myself and, possibly, a medical professional. If one who can be trusted can be found. John Whittingdale should attend meetings so that he can keep you fully informed. The group would principally advise on the creation and co-ordination of government public relations on health. Tim suggested something along these lines to John Moore six months ago but it was shot down by DHSS officials who, presumably, feel that such a group would implicitly reflect badly on them. John Moore, I am sure, could solve this problem. Especially if the proposal was put to him and them tactfully.

The Left have already set up such an organisation. I enclose a copy of a Sunday Times article describing it at work. There is a front-page story in today's Mail describing the skilled way the Left is using disinformation on nurses and their choice of union. I also enclose a copy of it in case you haven't had it drawn to your attention.

The Health Communications Group would operate on the national debate as Tim and I did during the miners' strike. Tim can deal with the tabloids and I with the posh papers and both of us with the television channels all in the usual discrete way.

The tasks of the group would be:

(i) To draw criticism of the Health Service away from you onto John Moore and Tony Newton.

Almost every Health Worker, from senior consultant, via union leader to nurse, who is interviewed on television on this issue manages to bring you personally into the argument.

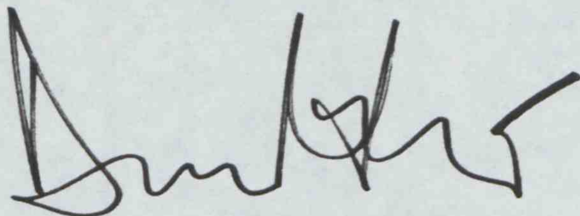
(ii) To ensure that the public are aware that there must, in their interest, be a limit to health spending.

(iii) To explain to the public that it is the government's long term aim to ensure that <u>all</u> people are able to spend, directly and indirectly through taxes, as much as <u>they</u> want on health care.

(iv) To maintain and enhance the present climate of national opinion that is coming to accept the need for reforms until you are ready to introduce them.

(v) To ensure that those reforms are properly explained to the people in ways that they will understand and accept.

Tim Bell is aware of the contents of this note.



<u>David Hart, 25th January 1987</u>.

Daily Mail
MONDAY, JANUARY 25, 1988
22p

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CENTR

Thousands rush to join work-on union

NURSES: WE DON'T WANT TO STRIKE

NURSES are showing their disgust at the Left-inspired campaign of industrial action by flocking to the no-strike Royal College of Nursing.

Figures from the college yesterday gave the lie to claims by the Left-wing unions NUPE and CoHSE that they have attracted hundreds of defectors.

By JOHN ILLMAN and NICK ASSINDER

In fact, the college's national processing centre in Cardiff recorded just four resignations last week while receiving more than 1,000 completed application forms.

And the union's regional offices in Scotland, where the TUC has called a 24-hour strike by all health staff, received more than 1,000 requests for the forms.

Compassion

The Royal College, which will not take strike action, is not affiliated to the TUC. Since 1976 it has more than trebled in size from 83,000 members to 267,000. Membership is restricted to enrolled and registered nurses, students and pupils. It does not represent auxiliaries, unlike NUPE, with 80,000 nurse members, and CoHSE with 120,000.

Describing itself as Britain's fastest-growing union, the college is planning a £100,000 advertising campaign in which it will bill itself as the 'gentle giant' of the union movement.

Senior nurses believe its success underlines the compassion and dedication which continue to characterise the profession.

The new members will further strengthen its hand in the bitter inter-union battle developing on the wards.

More nurses vote this week on whether to join several major London hospitals in a one-day strike on February 3. More than 1,500 London ambulancemen are also balloting over demands for protest demonstrations on that day.

And laboratory scientific officers at three of the city's hospitals, the Middlesex, Royal Free and University College, are also considering action.

Nurses will today present their evidence to the Government's pay review body.

Shortage of nurses has caused the closure of a children's cancer ward at Bart's in central London, prompting fears that admissions for life-saving treatment will be delayed.

Children with cancer will be treated on a general ward, but the total available beds will be cut from 40 to 20.

A Health Department committee will meet next week to discuss the need for more resources to treat young cancer sufferers.

And Social Services Secretary John Moore is to appeal to commerce and industry in a radical rethink over the way

Turn to Page 2, Col.1

The question NOT to ask Joan

Joan Collins . . . not showing her age

Scusi Signorina, how old are you?

By PETER ROSE

JOAN COLLINS flew into Britain from Italy last night at the centre of a bizarre mystery over her age.

The Dynasty star dismissed reports that she was stopped by an immigration official at Milan who claimed that her passport had been altered to take five years off her age.

Miss Collins, 54, admitted that there had been a dispute — but insisted that the row had concerned her publicist Jeffrey Lane's passport.'I was not involved in any row, she said.

'This sounds like a typically made-up Italian newspaper report. No one confronted me about the date of birth on my passport and I haven't changed it.'

But she refused to confirm her age. 'If you want to know it, look it up,' she snapped.

The faithful publicist also poured cold water on the reports. 'The dispute involved my passport and was quickly sorted out. I have two passports and had taken the wrong one.' Italian newspapers said that

Turn to Page 2, Col. 2

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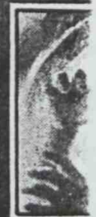

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INSIDE: Weather 2, Keith Waterhouse 8, World Wide 10, Femail 12, Diary 17, TV 20-21, Entertainment 22, Letters 24, Double Casino 26, City 30

Health unions want winter of discontent

by Jon Craig and Christine Toomey

NURSES' unions are hastily co-ordinating national strike action after being caught on the hop last week by members' votes for a stoppage.

Labour party left-wingers and trade unions want to turn the health service dispute into a new "winter of discontent".

They are desperate to mobilise support in the party and the TUC, and want to persuade Neil Kinnock and Norman Willis to pledge their wholehearted backing for industrial action.

The TUC-affiliated Nupe and Cohse unions and the moderate Royal College of Nursing were surprised by the wave of industrial protest that swept through London hospitals last week. Nupe and Cohse are now trying to organise national strike action; the non-striking RCN is trying to stop members walking off wards next month.

The action in the capital followed a 24-hour strike by 38 Nupe members in Manchester three weeks ago, protesting against proposals to cut special duty payments.

Encourged by the Manchester strike, the most militant of the nursing unions, Nupe, ordered its 18 full-time officials in London to organise meetings of nurses at every hospital in the capital to test support for a strike. The officials were to report to a regional committee next week.

But they were taken aback when nurses — first at Charing Cross hospital, then at three east London hospitals — voted immediately to hold strike ballots.

Nurses' anger over low pay and staff shortages was fuelled by a government offer last month to increase London weighting by just £50 a year.

At Charing Cross, the mood last week was one of frustration. Nurses believed a strike was the only way left to win more funding for the National Health Service.

"Our anger has reached such a pitch that we feel we have to do something to save the health service," said Sue, 19, a student nurse and Cohse member. "This is not just a strike over nurses' pay. It is about low morale and the critical state of the NHS. I don't think we will lose public sympathy."

Members of the Royal Collége of Nursing face disciplinary action if they go on strike. But two such nurses, who did not want their full names published, said they would either defy the strike ban themselves, or support others who did.

Jane, 24, said: "We have had the sympathy of the public for a long time now, but sympathy has got us nowhere."

Lynne, 21, said she would not be prepared to strike. "But I would wholeheartedly support any nurse who does."

By Tuesday night, eight hospitals were poised to strike. By the end of the week, the threat of a one-day walk-out had spread nationwide. Yesterday there were demonstrations in Oxford and Wolverhampton and nurses in York voted to strike in a dispute over shift changes.

Nurses in Leeds, Sheffield, Burnley, Manchester and Cornwall will vote this week on industrial action. "We're also getting pressure from Cheltenham, Bristol and Exeter," said Ty Taylor, a Cohse regional organiser.

The decision by London nurses to target February 3 for strikes was no coincidence. It came after the London Health Emergency, a left-wing pressure group set up by the former Greater London Council and now funded by Labour boroughs, called for a day of action.

Realising that they had underestimated the strength of feeling among their members, Chris Humphreys and Godfrey Eastwood, the senior Nupe officials in London, seized on the propaganda value of nurses leading an NHS crusade.

To help the strike spread, they telephoned newspaper, television and radio newsdesks.

The result was that Wednesday evening's news bulletins broadcast interviews with nurses at University College hospital, London, and on Thursday, Eastwood invited the cameras to film a meeting at St Ann's hospital, Tottenham.

With a cause to fight at last, far-left political activists jostled to give the nurses support. Socialist Workers party activists picketed a meeting of anti-strike nurses in Bloomsbury on Wednesday evening.

Then Militant supporters holding elected posts in Nupe and Cohse were ordered to press for a one-day strike in every hospital throughout the country.

This week, at a meeting of the TUC general council, John Macreadie, the Militant deputy general secretary of the CPSA, the civil service union, will call for a one-day general strike in support of the health workers.

Among nurses opposed to a strike, there is resentment at the left's interference. The RCN, the biggest nursing union with 268,000 members, says its members are being intimidated.

"There is a lot of manipulation of our members by other unions and extreme left-wingers within Cohse and Nupe," said Andrew Barton, a senior staff nurse at Middlesex hospital in London and secretary of the college's Bloomsbury branch.

Focus Special, pages 9-12

Bronco is our school answer to Crazy Joe

by Bruce Kemble Education Correspondent

Duncan Baxter

BRYN MORGAN, a London headmaster, is winning a reputation as Britain's answer to "Crazy Joe" Clark, the American high school principal who impressed the White House with his war on crime.

Clark, 47, received worldwide publicity this month when television showed him wielding a baseball bat and haranguing students through a loud-hailer in an effort to combat classroom violence.

Morgan, 52, nicknamed "Bronco Bryn" by his pupils ... bat, Bronco Bryn often uses bluff. "I take out my pocket tape-recorder and it looks like a walkie-talkie. Intruders think I am summoning help and they run away," he said.

And he searches for intruders from his study with binoculars. "You've got to be vigilant," he says. Clark agrees: "Never relax. Order can descend into chaos in the twinkling of an eye."

Morgan said last week: "Both of us concentrate on getting the children into lessons. You cannot teach them if they are not here. And we both believe in tough talking when it is necessary.

"I have sometimes called in ...

Freeze kills but spring is in the air

by Tim Rayment

THE DEATH toll from Britain's sudden cold spell rose to 10 yesterday. As snow continued to fall in many parts of the country, the latest victims — a driver and passenger who died after their car skidded off an icy road in Derbyshire — were named.

Darren Woolham, 18, and Anthony Walsh, 17, both of Long Eaton, are thought to have drowned when their car landed on its roof in a 2ft-deep dyke.

In Northern Ireland, a father-of-five died when his Datsun hit a tree during heavy snow in County Down. The bad weather has claimed at least seven other lives: three from Walsall, two in Yorkshire, one in Mid-Glamorgan, and another in Northampton.

... mated, and now the female sits on three or four young in their nest above Charles Clinkard, a local shoe shop. "She's in the 'C' of Charles," Margaret Fisher, the assistant manager, said.

In Clapham, south London, Dante Quattromini has blossom on the apple tree in his garden. "Apple blossom in January?" queried Mike Read, botanical officer for the Fauna and Flora Preservation Society. "That's outrageous. It shouldn't happen until April."

Long-eared bats are flying in Kent, hazels are coming into flower, and roses, cowslips and primroses are already blooming. Experts are not sure if the bats have yet to hibernate, and think it is still 1987, or have hibernated and are appearing early for 1988. Normally they would spend January hanging upside down in cool places,

Prime Minister[2]

I disagree with this analysis.

N.C.W
25.2 -Jan.

8 Douro Place
London W8 5PH
Tel. 01-937-5177

Dear Nigel,

A further note, based on reading the weekend press, including Bernard's leader!

Also attached Telegraph Gallup Poll,

Yours,

David.

P.S. FOR INFORMATION. POLICY MAY HAVE BY NOW TAKEN ACCOUNT OF THESE IDEAS.

P.P.S. YES, I AM AN OPTIMIST.

NHS STRATEGY

THE GOVERNMENT'S STRATEGY TO DEAL WITH THE REAL PROBLEMS OF THE NHS APPEARS TO BE BASED ON A LOGICAL FALLACY WHICH LEADS TO WISHFUL THINKING. THE FALLACY IS CALLED NON-SEQUITOR.

THE FOLLOWING STATEMENTS, WHEN ALLIED TO THE IMPLIED STATEMENT IN BRACKETS, ARE ALL FALLACIOUS:

THERE ARE MORE DOCTORS AND NURSES IN THE NHS THAN IN 1979...(SO THE NHS PROVISION OF HEALTH CARE IS SATISFACTORY)

WE ARE SPENDING MORE MONEY, IN REAL TERMS, ON THE NHS THAN IN 1979. (SO THE PROVISION OF HEALTH CARE IS SATISFACTORY)

THE NUMBER OF OPERATIONS BEING CARRIED OUT, AND THE NUMBER OF PATIENTS TREATED, ARE MUCH HIGHER THAN IN 1979. (SO THE PROVISION OF HEALTH CARE IS SATISFACTORY)

TRY THE NEXT ONE OUT, AND THE POINT BECOMES OBVIOUS:

THE AMOUNT OF MONEY BEING SPENT ON AIDS IS VASTLY GREATER THAN IN 1979. (SO AIDS IS LESS OF A PROBLEM THAN IT WAS THEN)

SINCE THE GOVERNMENT'S ANSWER TO THE PROBLEMS CAUSED BY THE EFFICIENCY SQUEEZE IS BASED ON A FALLACY, IT LEADS INEVITABLY TO WISHFUL THINKING. WISHFUL THINKING THAT THE PRIVATE SECTOR WILL SOMEHOW EXPAND, DESPITE THE TAX PENALTIES. WISHFUL THINKING THAT MORE SQUEEZE WILL MEAN MORE EFFICIENCY, WHEN IT CAN HAVE THE OPPOSITE EFFECT. WISHFUL THINKING THAT THE REPETITION OF THE ABOVE FALLACIES WILL CONVINCE THE PUBLIC THAT THE NHS IS OK.(SEE THE ATTACHED ARTICLE IN THE TELEGRAPH BASED ON A WEEK OLD POLL WHICH WOULD PROBABLY BE WORSE TODAY!)

AND, MOST IMPORTANT, WISHFUL THINKING THAT THE STRIKES AND DISRUPTIONS WILL TURN THE PUBLIC BACK IN FAVOUR OF THE GOVERNMENT. OH, OF COURSE, THERE MAY BE A TEMPORARY BLIP OF IRRITATION WITH STRIKERS, PARTICULARLY NURSES. BUT THE NURSES WILL BE ON TV, AND THEY ALL SOUND REASONABLE AND LOOK NICE. MY GUESS IS THAT THEY WILL GAIN SUPPORT, NOT THE GOVERNMENT. AFTER ALL, HEATH DIDN'T BENEFIT FROM CHAOS IN 1973, AND CALLAGHAN DIDN'T BENEFIT FROM THE WINTER OF DISCONTENT. WHY SHOULD IT BE DIFFERENT NOW, PARTICULARLY WHEN THE PUBLIC, PER GALLUP, THINK THE NHS ISN'T SAFE WITH THIS GOVERNMENT. AREN'T THE NURSES TRYING TO MAKE THE NHS SAFE FOR US, AND THE US IS THE 90% OF PEOPLE NOT ON PRIVATE HEALTH INSURANCE.

PM from David Willetts

NATIONAL HEALTH SERVICE

MORE THAN 90% OF THE POPULATION RELY EXLUSIVELY ON THE NHS FOR THEIR HEALTH CARE. IT IS PROBABLE THAT WELL OVER 90% OF THE PEOPLE ADVISING THE PRIME MINISTER RELY ON PRIVATE HEALTH INSURANCE. THERE IS A NEAR CERTAINTLY THAT SOME FORM OF BIAS MUST ENTER INTO THE ADVICE GIVEN TO THE PRIME MINISTER.

MOREOVER, THE NHS HAS THE WORST MANAGEMENT INFORMATION AVAILABLE OF ANY LARGE ORGANIZATION IN THE U.K. IT IS THEREFORE EASY, WHEN THERE IS NO PROPER BALANCE SHEET OR TRADING ACCOUNT, TO PRESENT RANDOM FACTS TO PLEASE THE LISTENER, AND TO SUPPRESS RANDOM FACTS WHICH MIGHT DISPLEASE THE LISTENER. POWER CORRUPTS THE INFLOW OF INFORMATION.

IN AGREEING THE NHS PUBLIC EXPENDITURE TARGETS FOR 1987/8, NORMAN FOWLER MAY WELL HAVE GUESSED THAT HE WOULDN'T BE THE MINISTER RESPONSIBLE BY THE YEAR END: SO WHY NOT ACT TOUGH AND LEAVE SOMEONE ELSE TO PICK UP THE PROBLEMS? AND WHEN JOHN MOORE ARRIVED AT DHSS, WOULD HE HAVE ENHANCED HIS POLITICAL FUTURE BY ASKING FOR MORE MONEY IF HE THOUGHT IT WAS NEEDED?

THE NHS HAS BEEN SQUEEZED, PARTLY BY NOT FULLY FUNDING PAY AWARDS. THERE COMES A YEAR IN ANY SQUEEZE WHEN THE EASY SAVINGS HAVE BEEN MADE. IN A NORMAL ORGANIZATION THAT EMERGES BEFORE DAMAGING DECISIONS ARE MADE BASED ONLY ON THE SHORTEST-TERM CASH FLOW. BUT NOT IN THE NHS BECAUSE THERE IS NO SATISFACTORY INFORMATION FOR MANAGEMENT. SO SILLY THINGS ARE DONE TO KEEP UNREASONABLE PROMISES ON FINANCE.

THERE HAS BEEN ONE FUNDAMENTAL MISJUDGEMENT ABOUT THE TIME SCALE FOR IMPROVED EFFICIENCY RESULTING FROM THE NEW MANAGEMENT STRUCTURE. THE MAJOR SAVINGS ARE STILL TWO YEARS AWAY, WHEN A FULLY FLEDGED COSTING SYSTEM ENABLES COMPARISONS TO PROVOKE BETTER PRACTICE THROUGHOUT THE NHS.

THERE ARE TWO ISSUES FOR THE PRESENT MOMENT.

1. THE PRIVATE PROVISION OF ACUTE PATIENT CARE SERVICES, I.E. THE CARE WHICH CAN BE INSURED FOR WITH BUPA ET AL., AND WHICH IS PROVIDED "FREE" BY THE NHS.

2. THE PRESENT PROBLEMS IN THE NHS, WHICH ARE LARGELY VISIBLE IN ACUTE PATIENT CARE SHORTAGES, AND WHICH THE MEDIA ARE REFERRING TO AS THE "CRISIS IN THE NHS".

(THE MORE SERIOUS PROBLEM OF LONG TERM FINANCING OF CARE FOR A GROWING POPULATION OF ELDERLY PEOPLE IS A PROBLEM FOR THE NEXT CENTURY, AND CAN BE LEFT FOR TODAY!

1. THE PROVISION OF BUPA TYPE SERVICES.

THE GOVERNMENT DOES, I BELIEVE, ACCEPT THAT A GROWING STANDARD OF LIVING WILL GENERATE A MORE THAN PROPORTIONAL DEMAND FOR GROWING HEALTH CARE SERVICES. IN THE CONTEXT OF THIS NATURAL HUMAN DESIRE, THE GOVERNMENT HAS TWO TOTALLY CONFLICTING POLICIES:

A. THE GOVERNMENT WANTS ADDITIONAL HEALTH CARE TO BE PROVIDED IN THE PRIVATE SECTOR, NOT BY ADDED PUBLIC EXPENDITURE. IT BELIEVES THE MARKET WILL GIVE BETTER VALUE FOR MONEY, AND THAT PEOPLE SHOULD BE FREE TO CHOOSE THEIR STANDARD OF HEALTH PROVISION ABOVE THE BASIC PROVIDED BY THE STATE.

B. HOWEVER, THOSE WHO OPT TO PROVIDE THEIR OWN HEALTH CARE HAVE TO PAY A PENAL TAX ON THAT PROVISION, BY PAYING FOR THE PARTS OF THE NHS WHICH THEY DO NOT USE. IF THE BUPA SERVICES OF THE NHS COST, SAY, £400 PER AVERAGE FAMILY, THOSE WHO CONTRACT WITH BUPA HAVE TO PAY THAT £400 AND, SAY, A BUPA CHARGE OF £600. VAT OF 66%!

THE POLICIES AND OBJECTIVES SHOULD BE COMPARED TO THE SALE OF COUNCIL HOUSES. IT IS AS IF YOU FAVOURED THE EXPANSION OF PRIVATE HOUSING, BUT INSISTED THAT PEOPLE WHO MOVED FROM OR BOUGHT A COUNCIL HOUSE WOULD HAVE TO CONTINUE TO PAY THEIR COUNCIL RENT WHILE PAYING THEIR OWN MORTGAGE AS WELL! OF COURSE, SOME PEOPLE WOULD STILL HAVE BOUGHT COUNCIL HOUSES, BUT NOT VERY MANY. YET WE NEED TO HAVE MANY PEOPLE GOING PRIVATE IF WE ARE TO AVOID THE NEED FOR A SUBSTANTIAL LONG-TERM INCREASE IN PUBLIC EXPENDITURE ON THE NHS. BUT OUR TAXATION AND "BENEFIT ASSESSMENT" POLICIES PREVENT THIS.

THE ANSWER IS SIMPLE: WE MUST USE TAX POLICIES TO ENCOURAGE PRIVATE HEALTH EXPANSION, OR IT WON'T HAPPEN. AND THE IDEAL OF A VOUCHER SYSTEM IS NOT A PRESENT OPTION, FOR IT DEPENDS ON A VALID COSTING SYSTEM IN THE NHS, AND A VALID COSTING SYSTEM IS PRESENTLY NOT AVAILABLE. INDEED, ITS ABSENCE IS THE MAIN REASON FOR THE INEFFICIENCY OF THE NHS. SUCH A SYSTEM IS BEING DEVELOPED, BUT WILL NOT BE EFFECTIVE FOR SOME YEARS. SO WHATEVER THE DIFFICULTIES OF TAX INCENTIVES, TO INDIVIDUALS AND COMPANIES, FOR PRIVATE HEALTH PROVISION, THERE IS NO OTHER SOLUTION ON OFFER IN THE NEAR FUTURE. INCIDENTALLY, IT WOULD BE EASY TO TRANSFER TAX INCENTIVES INTO A VOUCHER SYSTEM IF ONE BECAME AVAILABLE.

IN ANY CASE, WHATEVER THE TAX TREATMENT, THE GROWTH OF PRIVATE HEALTH INSURANCE WILL PROBABLY BE SLOW, AND IN THE NEXT FEW YEARS THE NHS MUST BE ABLE TO PROVIDE WHAT THE PUBLIC PERCEIVE AS A REASONABLE MINIMUM. THE POLITICAL CONSEQUENCES OF IT NOT DOING SO ARE SURELY NOT ACCEPTABLE.

2. THE PRESENT "CRISIS"IN THE NHS.

TO DEAL WITH THIS ONE MUST FIRST ANALYSE HOW IT CAME ABOUT. THE NHS IS THE MOST DIFFICULT ORGANIZATION IN WHICH TO SEEK OPERATIONAL EFFICIENCIES. THE REASON IS THAT IT IS HUGE, HAS VIRTUALLY NO MANAGEMENT INFORMATION ON COSTS, AND SUFFERS FROM A VERY UNSATISFACTORY CHAIN OF COMMAND LEADING UP TO THE HEALTH MINISTER. THERE HAD TO COME A TIME WHEN PRESSURES FOR EFFICIENCY WERE NOT MATCHED BY APPROPRIATE ACHIEVABLE SAVINGS: BUT THE REPORTING STRUCTURE HID THE RESULTING PROBLEMS FROM THE MINISTERS, UNTIL THEY APPEARED IN THE MEDIA. MINISTERS, NOT WANTING TO BE WET, PRESSED FOR ECONOMIES, BUT WERE NOT CLOSE ENOUGH TO THE OPERATIONS AREA TO ENSURE THAT THEY WERE ACHIEVED. NEGOTIATIONS BETWEEN A RETIRING OR INCOMING HEALTH MINISTER AND THE CHIEF SECRETARY COULD TAKE PLACE QUITE OBLIVIOUS OF CERTAIN REALITIES. HENCE THE BLOOD DONOR SERVICE AND NURSES SPECIAL PAYMENT PROBLEMS.

THE FACT IS THAT GREATER EFFICIENCY IN THE NHS WILL, IF THE RIGHT COURSE IS NOW FOLLOWED, COME THROUGH IN TWO TO THREE YEARS TIME. THE PRESENT SOLUTION IS PAINFUL.

1. MORE MONEY WILL HAVE TO BE FOUND FOR THIS YEAR AND THE NEXT TWO YEARS. THE ONLY QUESTION IS WHETHER KINNOCK, BIFFEN OR THE GOVERNMENT WILL GET THE CREDIT FOR THE EXTRA PROVISION! THAT DEPENDS ON WHAT IS DONE NOW, BUT NO EXTRA PROVISION WILL RESULT IN THE PRESENT DAILY DIET OF NHS HORROR STORIES, AND I DON'T THINK THAT IS ACCEPTABLE.

2. MAXIMUM EFFORT MUST BE PUT INTO USING THE NEW MANAGEMENT INFORMATION WHICH IS STARTING TO APPEAR IN THE HOSPITALS. PUBLICITY IS THE BEST WEAPON TO PROMOTE EFFICIENT USE OF RESOURCES, AND THE WHOLE BUREAUCRATIC MACHINE WILL BE AGAINST PUBLICITY. (AS THE LEFT WING DON'T WANT SCHOOL EXAM RESULTS PUBLISHED.)

3. MOVES MUST BE MADE TO ENABLE MORE PRIVATE PROVISION AS DISCUSSED ABOVE, THOUGH THIS CAN ONLY HAVE AN EFFECT AT THE MARGIN.

2 FURTHER POINTS:

THE EXTRA COST OF PROVISION FOR THE HIGH PROFILE PART OF THE NHS WILL NOT, EVEN TAKING IT AT ITS WORST, WRECK THE GOVERNMENT'S ECONOMIC STRATEGY. INDEED, THE LATEST PRIVATE FORECASTS SUGGEST THAT THERE IS ROOM FOR BOTH TAX CUTS AND NHS INCREASES. I WOULD SUGGEST THAT RADICAL TAX REFORMS, PARTICULARLY AT THE TOP END, WILL ONLY BE POLITICALLY ACCEPTABLE IN THE LIGHT OF NHS INCREASES. WITH INCREASING PROSPERITY, ONLY A PUBLIC PERCEPTION THAT THE NHS IS NOT SAFE WITH THIS GOVERNMENT COULD WRECK THE ECONOMIC STRATEGY, BY POSING THREATS TO THE GOVERNMENT ITSELF.

THERE IS AN ARGUMENT THAT THE NHS ONLY NEEDS MORE MONEY BECAUSE IT IS INEFFICIENT. THIS SEEMS DANGEROUS GROUND, FOR WHO IS RESPONSIBLE? WE'VE HAD 8 YEARS, AND A MANAGEMENT REFORM. DID WE WASTE THOSE YEARS, AND GET IT ALL WRONG?

Mr faxed to Chequers
LO. 23.1.88.

8 Douro Place
London W8 5PH
Tel. 01-937-5177

Saturday A.M.

Dear Prime Minister,

The position seems to be getting steadily worse, so I am writing this urgent note as next week may be too late.

Yours ever,

David (Wolfson).

NATIONAL HEALTH SERVICE

LISTENING TO RADIO LBC, NOT BBC, I HEARD THE COMMENTATOR SAY, (IN A REASONABLE AND FRIENDLY VOICE),

"OF COURSE, MRS. THATCHER CAN REPEAT HER VERSION OF 'CRISIS, WHAT CRISIS?' AS OFTEN AS SHE LIKES, BUT WE ALL KNOW THAT THERE IS A CRISIS IN THE HEALTH SERVICE". THE TONE OF VOICE WAS MATTER-OF-FACT: SHE KNEW NO LISTENER DISAGREED WITH HER. AND SHE WAS RIGHT.

I BELIEVE THAT WELL OVER 90% OF THE POPULATION NOW ARE CERTAIN, NOT JUST BEYOND REASONABLE DOUBT BUT BEYOND ANY DOUBT, THAT THERE IS A CRISIS IN THE NHS. WHEN YOU DENY, EXPLICITLY OR IMPLICITLY, THAT THERE IS A CRISIS, YOU DON'T CHANGE THEIR PERCEPTIONS OF THE NHS BY QUOTING STATISTICS ABOUT CHANGES SINCE 1979. YOU NOW ONLY DAMAGE THEIR PERCEPTION OF YOUR CREDIBILITY AND COMPETENCE. FOR THEY WANT, AS YOU SO RIGHTLY PERCEIVED, A GOVERNMENT WITH WHOM "THE NHS IS SAFE". IF THE HEADS OF THE ROYAL COLLEGES, THE NURSES, THE DOCTORS, THE AMBULANCEMEN, THE MEDIA, NEIL KINNOCK, JOHN BIFFIN, JILL KNIGHT, ET AL ARE TELLING THEM THE HEALTH SERVICE IS AT RISK, AND THEY ARE, THEN THE CONCLUSION IS OBVIOUS.

I BELIEVE YOU ARE NOW MORE AT RISK THAN WITH THE FALKLANDS OR WESTLAND. IN BOTH THOSE CRISES YOU WERE ABLE TO LOOK AT THE FACTS AND FORMULATE A STRATEGY TO DEAL WITH THE FACTS. YOU ARE NOW UNABLE TO FORMULATE A STRATEGY TO DEAL WITH A CRISIS WHICH YOU MAINTAIN DOES NOT EXIST.

I HAVE BEEN WORRIED ABOUT THE NHS SINCE THE SUMMER, AND FORESAW THE SERIOUSNESS OF THE INTERVENTION OF THE ROYAL COLLEGES. AS THE AMERICANS SAY, IT CHANGED THE GAME. I ADVISED THEN THAT THEY SHOULD BE "EMBRACED" AS A MEANS OF GETTING IMMEDIATE REMEDIAL ACTION, AND OPENING UP THE DEBATE ABOUT THE FUTURE OF HEALTH PROVISION AND FUNDING. THAT OPPORTUNITY HAS BEEN VIRTUALLY REJECTED. BUT THE REQUEST FOR A MEETING BY THE ROYAL COLLEGE OF NURSING COULD BE A REINSTATEMENT OF THIS LIFELINE. THERE IS A WAY OUT AND IT ONLY REQUIRES A LITTLE THOUGHT AS TO HOW TO PRESENT IT.

BUT IF YOU GO ON PANORAMA WITHOUT A STRATEGY TO DEAL WITH THE CRISIS, WITHOUT OF COURSE USING THAT WORD TO DESCRIBE IT, I FEAR THE WORST. YOU WILL INEVITABLY BE FORCED TO DENY THAT THERE IS A CRISIS, SOMETHING YOU HAVE JUST ABOUT AVOIDED SO FAR. YOU WILL PROBABLY BE FORCED TO DENY THE POSSIBILITY OF FURTHER FUNDING, WHICH YOU HAVE AGAIN JUST AVOIDED SO FAR. IT WILL BE A QUESTION OF "SAUVE QUI PEUT", AND I READ GEOFFREY HOWE'S SPEECH TODAY AS PUTTING HIMSELF IN A GOOD POSITION TO AUTHORISE AN "INQUIRY INTO THE NHS", AND SOME INTERIM FUNDING WHILE THE STUDY GOES ON.

I MAY, OF COURSE, BE WRONG: BUT I BELIEVE THAT THIS ADVICE IS THE MOST CRITICAL AND BEST I HAVE EVER OFFERED OR I WOULDN'T BE WRITING IT AT 2 A.M ON SATURDAY MORNING! AND IT REQUIRES ACTION ON SUNDAY, OR PANORAMA WILL ARRIVE BEFORE YOU HAVE FORMULATED A WAY TO DEAL WITH THE NHS WHICH WILL CALM THE FEARS OF THE GENERAL PUBLIC. MAKE NO MISTAKE, THE NHS IS VERY HIGH ON THEIR LIST OF EMOTIONAL PRIORITIES. AND THEY NOW FEAR IT IS NOT SAFE WITH YOU. ONLY ACTION, NOT P.M'S QUESTIONS STATISTICS, WILL REMOVE THAT FEAR.

COPY OF TEXT

8 Douro Place
London
W8

Saturday am

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Yours ever,

David (Wolfson)

8 Douro Place
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