CONFIDENTIAL

Prime Minister

REVIEW OF COMMUNITY CARE

In December 1986, having consulted you and colleagues, Norman Fowler asked Sir Roy Griffiths to review the use of public funds to support community care, and advise on ways of improving effectiveness. I have received his report, and am circulating copies with this minute. Chapter 1 summarises his proposals.

The main issue facing Sir Roy was the disparate way in which public funds are currently committed to community care. Although the main statutory responsibilities, and much the greater part of the expenditure, rest with local authorities, social security entitlements for people in residential care have made a rapidly increasing and sizeable contribution, and some funds are available from NHS sources. Sir Roy has also had to grapple with the not always clear distinction between health and non-health care.

The current arrangements have prompted widespread criticism, from amongst others - the Audit Commission, the Social Services Committee and the Comptroller and Auditor General. Faced with how public funds could be managed to better effect Sir Roy has sought a solution that would concentrate responsibility at local level, while recognising multiple interests, and tighten accountability for plans and performance. He has concluded

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that, because of their primary existing role in this field, and the absence of more attractive alternatives, local social service authorities should be responsible for assessing the needs of people in their locality; taking a comprehensive view, in an enabling rather than a providing role, of the services that would most effectively respond to them; and arranging the delivery of suitable packages of care, through informal carers, voluntary and private bodies, and their own services. He proposes a central control and planning machinery, linked to the payment of specific grant, which he recommends should be used, amongst other things, to ensure that social service authorities make maximum use of the private and voluntary sectors, and improve consumer choice.

There is a great deal in the report with which I think we should all agree. The aims and objectives, from the point of view of effective management and delivery of policy, are entirely acceptable, and the package offers a valuable opportunity to bring expenditure on residential care within proper budgetary discipline.

We shall have to consider very carefully, however, the role he proposes should be given to local authorities. Although he sees this as enabling - in line with what Nicholas Ridley is seeking - I am far from sure that the arrangements which he proposes would ensure that local authorities dealt even-handedly with the private sector. There has been a welcome growth in private provision or residential care. We do not want to reverse that trend. And we need to do more work to turn Sir Roy's vision of a market for private non-residential care services into a reality.

More generally, we have to consider the reactions of our own supporters, many of whom are likely to be deeply sceptical of an enhanced role for local authorities. The available options will have, in my view, to be studied further.

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Other important and potentially controversial issues of substance include:

- changed social security entitlements for people in residential care;

- transfer of part of the Social Fund to local authorities;

- implications for the territorial departments.

We shall need to consider all the substantive issues collectively. Legislation would be required to implement the main changes. The resource and public expenditure implications need further analysis. Sir Roy had recognised that his proposals require further work. I am considering how this might best be organised to take account of departmental interests.

I have also received a report on residential care from a working party chaired by Lady Wagner, which was set up by the National Institute of Social Work, with Norman Fowler's support, in March 1986. That report is to be published by the Institute on 9 March. The proposals will need to be considered alongside those in Sir Roy Griffiths' report.

Against that background, I propose early publication of Sir Roy's report. Delay would stimulate speculation, and expectation of a more considered response than we shall be ready to make. I propose to make a short written statement on publication saying that the Government will be considering the proposals along with those in Lady Wagner's report; would take account of reactions; and would bring forward its own proposals in due course. A written answer to that effect is attached to this letter.

I hope it will be possible to publish on Wednesday 16 March. I have a number of Parliamentary questions asking about publication which have to be answered on 8 March. I propose to say in

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reply that I have received the report, and am arranging for it to be published on that date.

I invite agreement that:

- Sir Roy's report should be published and that I should say in answer to questions on 8 March that I have received the report, and that it will be published on 16 March;

- I should simultaneously make a statement as in the attached written answer;

- we should consider collectively the substantive issues, taking account of reactions, with the aim of reaching conclusions on a sensible and practical way forward.

Copies of this letter and the enclosures go to members of E(A) and Sir Robin Butler.

JM
29 February 1988

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DRAFT WRITTEN PQ ANNOUNCING PUBLICATION

Question: To ask the Secretary of State for Social Services when Sir Roy Griffiths' review of Community Care will be published, and if he will make a statement.

Suggested reply

Sir Roy Griffiths' report is being published today, and copies are being placed in the libraries of both Houses.

The report makes wide-ranging proposals affecting the responsibilities of local government; individuals' social security entitlements; central funding and control of community care services; and aspects of the Social Fund.

The Government will be considering the proposals, taking account of the report of the committee chaired by Lady Wagner on residential care, and of reactions to both reports; and will bring forward its own proposals in due course.

NAT HEALTH : Expenditure P1/2 . .

[Mr. Greville Janner]

because the matters raised in that written question are immensely important? The families of those commandos are still alive, and one of them wrote to me yesterday. They are extremely concerned. It is now clear that not only Waldheim, but his family, have been involved in those matters in a way that should be brought before the House in a statement, not in a written answer.

Mr. Wakeham: My right hon. Friend the Prime Minister has been forthcoming about the Government's attitude to these matters. I cannot promise a statement, but I shall refer the matter to my right hon. Friend.

National Health Service (Charges)

3.37 pm

The Minister for Health (Mr. Tony Newton): With permission, Mr. Speaker, I should like to make a statement about voucher values for spectacles, blood glucose testing strips, and NHS charges from 1 April 1988.

First spectacle voucher values: Help with the cost of spectacles through the NHS voucher scheme is available to children under 16, full-time students under 19, people on low incomes and those needing complex lenses. The current voucher values were set when the voucher scheme was introduced on 1 July 1986. We have decided to increase them from 1 April 1988 so that, for example, the lowest voucher value will rise by nearly 9 per cent. from £14·25 to £15·50 and the highest voucher value by 28 per cent. from £66 to £85. In the hospital eye service there will be small increases in the maximum charges, which limit the charges to those requiring expensive lenses but not entitled to vouchers, and no increase in the charge for contact lenses.

In setting the new values we have sought to repond to the representations of the Royal National Institute for the Blind by making particularly large increases in vouchers for the more complex spectacles. We also propose a number of other changes to assist with special needs, on which representations have been made. Over and above standard voucher values, there will be a new supplement in the hospital eye service of up to £4 for people prescribed photochromic lenses for clinical reasons and a new supplement of £30 for those whose particular facial characteristics entail specially made frames. There will also be a new supplement of £30 for children who need exceptionally small glasses, available through the general ophthalmic service and the hospital eye service.

These voucher scheme is at present available for contact lenses only if they are prescribed for clinical reasons by the hospital eye service. We propose to end this restriction and to give complete freedom of choice at to whether vouchers are used for spectacles or for contact lenses.

These changes will increase expenditure on the voucher scheme by about £7 million in 1988-89, to a total of more than £65 million.

Secondly, Blood Glucose Testing Strips for Diabetics. We announced last November our intention to bring about a further improvement in services for diabetics by making such strips available on general practitioner prescription, following the similar action we took last year in respect of disposable syringes for those who need to inject insulin.

Discussions have now been held with the suppliers of the strips, and I am pleased to be able to tell the House that they will be made available on prescription from 1 June this year. Diabetics are, of course, exempt from prescription charges and will therefore receive their supplies free of charge. The cost of this measure in 1988-89 will be around £8 million.

Thirdly, prescription charges. We propose to increase prescription charges broadly in line with the increased cost of medicines. The item charge will rise by 20p from £2.40 to £2.60, an increase of around 8 per cent. The four-monthly season ticket will increase by £1 to £13.50, and the annual season ticket by £2.50 to £37.50. We estimate that the increases will yield over £10 million in 1988-89.

Over three quarters of all items will, of course, continue to be dispensed free of charge under the wide-ranging exemption arrangements, which cover children, those on low incomes, and everyone over retirement age. The House will also be glad to know that we propose to extend the exemptions for young people to include those under the age of 19 while they remain in full-time education.

Fourthly, dental charges. As the House knows, we have already announced our intention to move from the present complex and anomalous system of charging for dental treatment to a straightforward system of proportiionate charging set at 75 per cent. of the cost, subject to a maximum of £150. This new arrangement will apply to all routine dental treatment and crowns from 1 April 1988, and the charges for dentures and bridges will be set as fixed cash amounts at or about the same 75 per cent. level.

We estimate that the changes will yield additional income of about £17 million in 1988-89. However, as many people now pay the full cost of the more limited courses of routine treatment, the cost of many such courses will, in fact, fall. For example, the charge for a scale and polish and two small fillings will come down from £14.20 to £10.65.

We are retaining all the current exemptions — for children, young people aged 16 and 17, students under 19, expectant and nursing mothers and people on low incomes —which mean that nearly half of all courses of dental treatment atract no charge at all. In addition, we intend to bring forward a Government amendment at the Report stage of the Health and Medicines Bill to end the anomaly whereby some young people of 16 and 17, while exempt from charges for treatment, Nevertheless have to pay for dentures and bridges. the effect, if the House agrees, will be to exempt them from all dental charges.

In view of the changes to social security benefits that will come into effect on 11 April, I should make it clear to the House that, for the purposes of exemption from prescription and dental charges, of entitlement to spectacle vouchers and of reimbursement of expenses incurred in travelling to hospital for treatment, receipt of income support or family credit will qualify beneficiaries in the same way as supplementary benefit or family income supplement do now. There will also continue to be arrangements for assisting other people on low incomes, based on the new social security framework. Regulations will be laid before the House in due course to establish a single consolidated scheme, which will be both simpler and speedier than at the present arrangements.

Lastly, charges for private patients and overseas visitors. Increases in the central list of charges for private patients, averaging about 6·5 per cent., have already been announced. Charges for overseas visitors will also be increased for 1988-89, by 8·1 per cent. on average for in-patients and 6·5 per cent for out-patients.

Details of the proposed new spectacles voucher values, the prescription and dental charges and the charges for overseas visitors are available in the Vote Office. Regulations giving them effect will be laid before the House shortly. Equivalent measures will be taken by my right hon. and learned Friend the Secretary of State for Scotland and my right hon. Friend the Secretary of State for Northern Ireland.

Mr. Robin Cook (Livingston): I should like to give an unqualified welcome to two items in the statement—for both of which the Opposition have pressed. The first is that blood glucose testing strips will be available on prescription. This will be welcomed in all quarters of the House. The second is the announcement that there will be an additional exemption of dental charges for 16 and 17-year-olds, an issue which, the Minister will agree, my hon. Friend the Member for Peckham (Ms. Harman) and her colleagues have been pressing in Committee.

I should like to give a qualified welcome to the announcement on vouchers for spectacles. It is qualified, first, because, as the Minister knows, we are in this difficulty about more complex spectacles only because the Government privatised the entire optical service and, secondly, because the increase in the lower voucher charge is about £1·25, which, the Minister will admit, is less than the likely increase in the price of spectacles from the imposition of VAT, which is calculated to cost another £2 or £3 per pair of spectacles. If the Government intend to accept that European decision, the least that the House might have expected was that they would protect the poorest purchasers of spectacles from its effect.

The Minister will appreciate that his statement will be judged by the fact that this is the tenth increase in prescription charges since the Government came to office. The Minister attempted to defend the increase by saying that it represented the increase in the cost of medicines. Is he aware that the prescription charge is now 13 times the prescription charge of 1979—an increase wildly in excess of the increase in the cost of medicines in the intervening period?

Is the Minister aware that last year the Pharmaceutical Services Negotiating Committee estimated that, after last year's increase, one third of the items available on prescription cost less than the face value of the prescription charge? Will the Minister confirm that, as a result of the increase, many drugs will be cheaper to obtain at the retail price than on an NHS prescription? Does he agree that the exemptions to which he referred do not include chronic conditions, such as cystic fibrosis, asthma, Parkinson's disease, multiple sclerosis and schizophrenia, and that it is wholly wrong that people who suffer from chronic conditions which require significant medication should have to pay for their presccription charges?

I remind the Minister of the statement of the chairman of the Pharmaceutical Services Negotiating Committee that 2,000 people forgo part of their prescriptions every week because they cannot afford the charges. Is that not what the Minister would have expected, as an advocate of the law of supply and demand? Is it not precisely the effect that he would have predicted—people responding to an increase in prices by taking up fewer treatments? Is it not entirely wrong that they should be priced out of the treatment that they need?

The Minister concluded by referring to the 6·5 per cent. increase in charges for pay beds. Will he admit that the Government's policy on pay beds has been a commercial disaster? Is he aware that since 1979 the Government have increased the number of pay beds by one fifth—in sharp contrast to the cut in the number of NHS beds—and that the number of patients in pay beds has gone down by one third, while the bad debts from private pay bed patients last year alone reached £800,000? Against that background, is it not entirely fanciful for the Minister to suggest that the NHS can generate income from an activity that is a net loss to the service?

On the subject of charges to patients, will the Minister comment on the recent practice in Merton and Sutton

Robin Cook]

district health authority, which has introduced charges for mentally handicapped patients for music and speech therapy? Will he say whether he regards it as reasonable that long-stay mentally handicapped patients should generate income for their own treatment?

The whole House will be aware of the background to the statement. There is a massive surplus revenue in the Treasury which the Chancellor intends to give away in tax handouts in a couple of weeks' time. The money is there to fund a decent Health Service without charging the sick another £10 million for their prescriptions. The increases are unnecessary, unjustified and undesirable. When the orders are tabled, the Opposition will demand a debate on them and an opportunity to vote against them.

Mr. Newton: I thank the hon. Gentleman for his welcoming words about some aspects of the statement. I readily note that in committee his hon. Friends raised the issue of 16 and 17-year-olds, and I am glad that we have been able to respond in the way that we have.

I believe that the hon. Gentleman's remarks about prescription charges are exaggerated, especially when one considers that last year's increase of 20p was followed by the largest increase in the number of prescriptions dispensed for some years. There is no serious evidence of the deterrent effect to which the hon. Gentleman referred.

With regard to exemptions, the hon. Gentleman will know that my predecessor made it clear that the Government did not think it right to reopen the general list of exemptions, but rather to focus especially on ensuring that effective arrangements were available to those on low incomes. We have consistently sought to do that.

I believe that the hon. Gentleman is labouring under some misapprehension with regard to pay beds. It should be clear to the House that such beds are pay beds only when they are occupied by a paying patient. It other times they are available to, and are used by, the NHS. I readily accept that not as much income has been made from such beds as we would like. Indeed, one of the aims of the Health and Medicines Bill is to increase the capacity of the Health Service to raise additional sums from such beds, for the benefit of NHS patients. I see nothing wrong or foolish about that.

I shall look into the point that the hon. Gentleman has raised about Merton and Sutton, which is new to me, and write to him if necessary.

With regard to the hon. Gentleman's comments about revenue available to the Treasury, it should be remembered that the background to this statement is an increase of no less than 43 per cent., in real terms, in expenditure since 1978-79 on our primary care services and plans for substantial additional real spending over the next two to three years.

Several Hon. Members *rose*——

Mr. Speaker: Order. I am bound to have regard to the fact that this is an Opposition day, on which there are two important debates, and some heavy business after that. I shall allow questions to go on until 20 minutes past 4. I am sure that we shall return to this matter, and therefore I ask hon. Members to ask one question rather than several.

Mr. Roger Sims (Chislehurst): Is my right hon. Friend aware that his statement will be warmly welcomed on the Conservative Benches, especially in respect of spectacles and diabetic prescriptions? Is he aware that, every day, people pay, and expect to pay, enormous sums of money for toothpaste, ointments and a whole range of proprietory medicaments for which no prescriptions are required? Does that not put into perspective the reaction to charges for those items for which prescriptions are required? Indeed, as my right hon. Friend said, prescriptions are paid for by only a quarter of those for whom they are written.

Mr. Newton: I am grateful to my hon. Friend for his comments. I agree that more than 75 per cent. of items are dispensed without charge, and indeed approaching half the population are exempt from prescription charges. I believe that that puts the matter into perspective.

Mr. Ronnie Fearn (Southport): We welcome the initiatives on eye-testing, dental charges and blood glucose testing about which we are keen. Will the Minister clarify what he means by the increase in prescription charges of 8·3 per cent., which is above the rate of inflation? The phrase "the cost of medicines" is rather bogus, because 20p is way above what the pharmaceutical people believe the increase should be. Will pharmacists be advised to give the people the right formula; in other words, will they be told that they should be using the cheapest, but best, forms of medicine?

Mr. Newton: We would always hope that that principle would apply. Equally, if pharmacists are aware that an item that has been prescribed is available without prescription at a lower price, it is entirely reasonable to draw that to their customers' attention. Prescription charges are, necessarily, an averaging process, and I do not make any great apology for that.

It is true that the increase in prescription charges is greater than the general rate of inflation, but the price of medicines — partly because of advances — is rising somewhat faster, and the increase is in line with the rise in the cost of medicines.

Mr. Jerry Hayes (Harlow): I warmly welcome my right hon. Friend's enlightened statement on charges. However, will he accept that while the increase in the value of the spectacles voucher is also welcome it will not be of much benefit if, in a few months' time, he announces the abolition of the free eyesight check, because that will simply deter many people from getting their eyesight checked in the first place?

Mr. Newton: My hon. Friend and I discussed this matter at some length in Committee. I made the point then that nearly three quarters of those entitled to spectacle vouchers spend sums well in excess of £10 over and above the value of the spectacle voucher when purchasing their spectacles. As far as we can judge, they do that voluntarily, and that must cast some doubts on my hon. Friend's proposition about the alleged deterrent effect of our sight testing proposals.

Mr. Max Madden (Bradford, West): As my hon. Friend the Member for Livingston (Mr. Cook) said, there is a general welcome for parts of the Minister's statement. However, many members of the public will be extremely angry that the Minister has seen fit to increase prescription charges for the 13th time since the Government came into office, when the Chancellor of the Exchequer is sitting on a mountain of money. Does the Minister not recognise

that on this occasion he could have announced that there would be no increase in prescription charges? That would have been very welcome at a time when the vast majority of people want to make Budget day National Health Service day. Will the right hon. Gentleman give a clear undertaking that, as he has found it impossible to halt the increase in prescription charges, he has no intention of increasing any NHS charges for the remainder of the year?

Mr. Newton: We have made it clear that we have no plans of the kind that the hon. Gentleman adumbrated in the latter part of his remarks.

Prescription charges need to be considered against the background of the cost of drugs. These charges still raise a good deal less than 10 per cent. of the total cost of drugs, which has been increasing very rapidly. It is not an unreasonable policy to increase charges at least in line with the rise in the price of drugs.

Mr. Robert McCrindle (Brentwood and Ongar): Will my right hon. Friend accept that some of us who make no secret of our wish for additional funding for the National Health Service will nevertheless find it possible to accept the increase in prescription charges that he has announced? Whereas there are some things that only Governments can do — for example, authorising the building of new hospitals and meeting increased payments to nurses—there are some ways in which we can help ourselves. Therefore, for those of us able to afford it the additional 20p on prescription charges it is quite acceptable.

Mr. Newton: I am most grateful to my hon. Friend for his supportive remarks.

Mr. Harry Ewing (Falkirk, East): Opposition Members are concerned with those who cannot meet the additional 20p. The Minister said that his right hon. and learned Friend the Secretary of State for Scotland would make a similar announcement. Will that take into account the remarks of the Secretary of State in his commentary on public expenditure in Scotland the week before last, in which he showed clearly that Scotland still has the largest number of deaths from heart disease and cancer in the United Kingdom? Does the Minister honestly believe that increasing prescription charges will do anything to solve that very serious problem?

Mr. Newton: The generality of our plans for he primary health care services—which go much wider, although in some ways they are related to today's announcement—is directed at improving preventive measures, the early detection of ill health and early action to stop it getting worse. That entails the sort of moves that we plan for the development of general medical services, to which some of the proposals that I have announced will contribute.

Mr. Peter Thurnham (Bolton, North-East): Does my right hon. Friend agree that his proposals provide a welcome opportunity for diabetics to look after their own health more effectively and so improve the quality of their lives?

Mr. Newton: One of the purposes of last year's move on syringes and this year's move on blood glucose testing strips is to encourage diabetics to have more regular contact with their general practitioners, many of whom now run diabetic clinics. We are anxious to encourage that, and I am sure that that is in the general long-term interest of good health care for diabetics in this country.

Mr. Dafydd Wigley (Caernarfon): If the Minister is serious about preventing worsening health, surely he must think again about the charges for eye testing. May I press him for clarification on what he said about the transition from supplementary benefit to income support and family credit? Will there be any groups that could lose on benefit and be sustained by the guarantee that has been given by the Government? If that is the case, will that guarantee also operate on passporting for prescriptions?

Mr. Newton: There are two separate points. One concerns the move from supplementary benefit to income support and from family income supplement to family credit, where passporting will have the same effect as the transition itself. Of course, many more families will be in receipt of family credit than are currently in receipt of family income supplement. On the law-income scheme above those levels, the effect is more complicated. That is partly because it is extremely complex now and the scheme does not work very well. As I said in my statement, we shall try to bring forward a simpler and speedier scheme. It would be right for the hon. Gentleman to look at the details of that when my hon. Friends are able to bring it forward.

Dr. Michael Clark (Rochford): Is my right hon. Friend aware that the cost of the blood-testing strips was a burden on a considerable number of diabetic patients and that they will greatly welcome his statement? Will the availability of blood-testing strips on prescription apply to all strips, or just to a proprietary few? If the blood-testing strips are improved by advancing medical technology, will my right hon. Friend consider allowing those to be available on prescription without any delay?

Mr. Newton: I shall consider the point raised by my hon. Friend in the latter part of his question.

Mr. Robert N. Wareing (Liverpool, West Derby): Does the Minister agree that it is totally immoral to increase the tax on the sick, including those with multiple sclerosis and asthmatic diseases, just a fortnight before the Chancellor is planning a decrease in taxes on the very rich and often able-bodied people? When the Minister talked about an increase of 43 per cent. in real terms in spending on the NHS, is that in terms of the retail prices index, or of the actual cost to the NHS?

Mr. Newton: The figure is related, not to the NHS as whole, but to the family practitioner services, which are the primary focus of the statement. I do not agree with the hon. Gentleman's moral strictures. Indeed, they are absurd, when about half the population are exempt from prescription charges, over three quarters of all items dispensed are dispensed free, when there are expensive exemptions on medical grounds and when there are important season ticket arrangements, which help many of those who need regular prescriptions.

Mr. Derek Conway (Shrewsbury and Atcham): My right hon. Friend's £8 million announcement on glucose strips is as welcome as the statement last year on free syringes for diabetics. It will help to make their lives more liveable. So that we are not awash with crocodile tears when the orders are laid before the House, will my right hon. Friend reiterate that 75 per cent. of prescriptions are free, and that when the Labour party was propped up in power by the Liberals there was a charge, or as the Opposition put it, a tax, on sickness under that regime?

Mr. Newton: Yes. I can readily agree with my hon. friend.

Mr. Kevin Barron (Rother Valley): Will the Minister accept that the deterrent effect of charges on primary health care is likely only to put pressure on the acute services, which are already under-funded? Will he accept that the future of health care will look very grim until we stop charging for primary health care and do something about getting the nation's health into proper repair?

Mr. Newton: The whole programme put forward in the Government's White Paper on primary care and the generality of the measures being debated currently on the Health and Medicines Bill are designed to achieve precisely the significant further improvement in the primary care service that the hon. Gentleman wishes to see. We obviously disagree about whether it will bring about improvement, but my judgment is that it will, and the proof of the pudding will be in the eating.

Mr. Chris Butler (Warrington, South): My right hon. Friend will be aware that general practitioners and pharmacists often do not recommend to their patients that they can buy over the counter more cheaply than they can obtain some things on prescription. Will he consider encouraging pharmacists to issue a receipt showing the cost of the drugs dispensed to patients, so that they are able to make the decision themselves, and, in other cases, to enable them to adjudge the great value for money that they receive from the massive cost of the drugs that can be dispensed?

Mr. Newton: That is an interesting suggestion and I shall consider it. I would hesitate to go snap on it at the moment, in view of the possible administrative costs entailed.

Mr. Martin Redmond (Don Valley): Bearing in mind that a vast number of people are caught in the poverty trap and cannot afford today's prescription charges, what provision does the Minister intend to make to ensure that they receive adequate medicine free?

Mr. Newton: I have already referred to the Government's intention to bring forward proposals for a simpler and quicker low-income scheme for those above the direct passporting from income support or family credit, as it will be. We share the aim of avoiding the difficulty to which the hon. Gentleman referred, and I am hopeful that our proposals will do just that.

Mr. John Marshall (Hendon, South): Does my right hon. Friend agree that much of the indignation from Opposition Members is bogus and synthetic, as the increase is less than the cost of a bar of chocolate, and as Labour Governments have promised to abolish the prescription charge but have failed to do so? Is my right hon. Friend aware that many Conservative Members would contribute to a season ticket for the cure of verbal diarrhoea for the Leader of the Opposition?

Mr. Newton: I do not think that I would care to go down precisely the track advocated by my hon. Friend in the last part of his remarks. However, I endorse the first part of his question and would add that I am advised—this is against the background of the wide range of exemptions—that the average spending in this country on alcohol is now £8 per adult per week.

Mr. Barry Jones (Alyn and Deeside): Is it not unjust to put up prescription charges when the Government are putting through Parliament a measure such as the poll tax? Does the Minister know that under that tax as envisaged his grace the Duke of Westminster will be £7,000 per annum better of? Is it not unjust to announce higher prescription charges when the duke will not have any problem in paying the higher charges?

Mr. Newton: I have enough problems of my own, without getting into the poll tax.

Mr. Rhodri Morgan (Cardiff, West): I welcome what the Minister said about blood strips for diabetics, but how does he justify the increase in prescription charges for others who are chronically sick? This is perhaps one thing in life that I share with the Parliamentary Under-Secretary of State for Health and Social Security, who is sitting alongside the Minister. Many British holidaymakers have found that if they forget their inhalers they can obtain them more cheaply over the counter in France than they would in this country, with all the benefits of the NHS. With the latest increase in prescription charges, will the Minister tell the House how many countries in the EEC sell items such as asthma inhalers over the counter at a cost lower than they can be obtained on prescription in this country?

Mr. Newton: I am afraid that I cannot give the hon. Gentleman the information he seeks. However, I have said already that the prescription charge scheme is almost inescapably an averaging arrangement, and that implies that some people will receive their drugs more cheaply than they could in other ways, but others may find that they are a shade more expensive. I accept that.

Mr. Tony Banks (Newham, North-West): Will the Minister tell the House why the price of medicines has gone up so much? He announced an 8 per cent. increase in prescription charges, which is twice the rate of inflation, and he said that that was because of the increase in the price of medicines. Is that not indicative of the excessive profits being made by the pharmaceutical industry? Is it not true that if he took steps to prevent that industry from creaming off money from British taxpayers he would have more money at his disposal to devote to primary health care?

Mr. Newton: I have to say that, following the introduction of the new pharmaceutical price regulations scheme, I do not think that the hon. Gentleman's perception would be shared by the industry. Great sums of money are invested in drugs, but the cost of producing them does rise. We are anxious to keep costs under maximum control, but the price has risen by 8 per cent. and that is the background against which I have made the announcement.

Mr. Dennis Skinner (Bolsover): Does not the Minister's argument contain a curious logic? He said that when prescription charges are increased it will not be a deterrent to the sick who have to purchase various commodities. However, he uses the alternative argument—as his right hon. and hon. Friends will on Budget day—of saying that there is a deterrent for those in the higher income bracket who have to pay tax on 60p in the pound and that we should remove that deterrent so that they will work harder. The truth is that that curious logic has meant that the Minister has had to make this statement today so that

it is not made on Budget day, because the Government do not want the Budget to look really bad by increasing prescription charges while giving high rate taxpayers probably hundreds and hundreds of pounds per week.

Mr. Newton: I do not see any connection between the two lines of argument. The Government's taxation policies have contributed to the substantial increase in economic resources that are enabling us to sustain the services that we are discussing today. I do not believe that a charge of £2·60, levied, at most, on only half the population, will have a deterrent effect when people are ill, as the hon. Gentleman suggested.

Following are the charges:

Optical voucher values and charges from 1 April 1988

		New values £	*Percentage increase*
(1) Single vision spectacles			
Voucher type	A £14·25	15·50	8·8
	B £22·00	25·50	15·9
	C £33·00	42·00	27·3
(2) Bifocal spectacles			
Voucher type	D £27·00	29·50	9·3
	E £42·00	50·00	19·0
	F £66·00	85·00	28·8
(HES only)	G £66·00	85·00	28·8
(3) Amounts added to voucher value for clinically necessary:			
Prisms £3 per lens (single vision)		3·50	16·7
£4 per lens (bifocal)		4·50	12·5
Tints £3 per pair (single vision)		3·50	16·7
£4 per pair (bifocal)		4·50	12·5
(4) Complex lens vouchers for those not entitled to standard vouchers:			
Single vision	£2·00	3·00	50
Bifocal	£14·00	17·00	21
(5) Hospital Eye Service Maximum Charges:			
Single vision	£29·00	32·00	10
Complex lenses	£50·00	52·00	4
Contact lenses: charge per lens	£25·00	25·00	—
New Supplements			
Supplement for children needing very small glasses		30·00	—
Hospital Eye Service only:			
(a) Supplement for people needing specially-made frames		30·00	—
(b) Supplements for people prescribed photocromic lenses for clinical reasons:			
(i) single vision		3·00	—
(ii) complex lenses		4·00	—

Prescription charges from 1 April 1988

Charges proposed	*Present charge* £	*New charge* £	*Percentage increase*
Charge per item	2·40	2·60	8·3
Season tickets:			
4 monthly	12·50	13·50	8·0
Annual	35·00	37·50	7·1

Dental charges from 1 April 1988

	Present charge £	*New charge* £	*Percentage increase*
Dentures			
Metal based dentures having:			
1-3 teeth	50	64	28
4-8	42	69	33
more than 8 teeth	55	71	29
Synthetic resin based dentures having:			
1-3 teeth	26	26	—
4-8 teeth	28	34	21
more than 8 teeth	30	40	33
Maximum charges for more than one synthetic resin denture			
Synthetic resin based full upper and full lower dentures	47	59	26
Any other combination of synthetic resin based dentures	47	62	32
Bridges			
An acid-etched retained bridge	50	65	30
Any other bridge	50	150	200
Crowns			
High gold alloy	63	[1]51 to 55	−19 to −13
Other alloy	33	[1]26 to 42	−22 to +27

[1] Charges will vary depending on type of crown and materials used.

			Percentage
Other treatment	Full cost up to £17: 40 per cent. of cost above £17	75 per cent. of cost	−25 to about +50 depending on cost
Maximum charge for course of treatment	£115	£150	30

Daily charges for services provided for overseas visitors as in-patients as at 1 April 1988

	Class of hospital in which services are provided	*Single room* £	*Shared accommodation* £
Class A	Long-stay hospitals	93	84
Class B	Psychiatric hospitals	85	77
Class C1	Mainly acute and other hospitals in non-teaching districts	149	136
Class C2	Acute and other hospitals in non-teaching districts	170	154
Class D	Hospitals in London teaching districts (other than hospitals in Classes A and B)	231	210
Class E	Hospitals in provincial teaching districts (other than hospitals in Classes A and B)	185	168
Class F	London Postgraduate Teaching Hospitals managed by Special Health Authorities except the Hospitals for Sick Children and the National Heart and Chest Hospitals	253	230
Class G	The Hospitals for Sick Children and the National Heart and Chest Hospitals	392	357

Charges for services provided for overseas visitors otherwise than as in-patients as at 1 April 1988

Services provided	*Hospital class A to E* £	*Hospital class F and G* £
1. For a patient on each attendance at a hospital other than attendances directly associated with the procedures listed in paragraphs 4-12 following.	14·50	21·50
Day Cases[1]		
2. Charges per day exclusive of charges for procedures listed in paragraphs 4-12 following.	28·50	29·50
Day Patients[2]		
3. Charges per day exclusive of charges for procedures listed in paragraphs 4-12 following.	34·00	35·00
Pathology		
4. For each request.	7·50	15·00
Radiodiagnosis, Nuclear Medicine and Ultrasound		
5. (i) For each procedure listed in Appendix D (charge per Korner unit value).	6·50 per unit for the first 6 units, 1·00 per unit thereafter	9·00 per unit for the first 6 units, 1·25 per unit thereafter
(ii) CT Scanning. For all scans	96·00	115·00
Radiotherapy		
6. For treatment in any one day	18·00	45·00
Physiotherapy and Remedial Gymnastics		
7. Per attendance	5·50	11·50
Occupational Therapy		
8. For treatment in any one day	8·50	10·00
Other Diagnostic Procedures		
9. (i) Audiometry	5·00	5·00
(ii) Electrocardiography. For each testing session.	9·50	17·50
(iii) Electroencephalography. For each testing session	38·50	83·50
(iv) Electromyography. For each testing session	24·00	50·50
Use of Operating Theatre Facilities		
10. Operating theatre facilities booked as required:		
(i) For less than 10 minutes	22·50	28·00
(ii) For 10 minutes to 30 minutes	44·00	56·00
(iii) For more than 30 minutes	67·00	84·00
Dialysis		
11. For haemodialysis or intermittent peritoneal dialysis:		
(i) With training or routine at a hospital per session	111·00	111·00
(ii) Routine, at home—per session	70·50	70·50
(iii) Minimal Care Unit—per session	90·50	90·50
For continuous ambulatory peritoneal dialysis (including continuous cycling peritoneal dialysis)—per day.	33·50	33·50
Supply of Drugs and Medicines		
12. For the supply of a drug or medicine which is designed to eliminate, prevent the replication of, or in any way inhibit the mode of action of any Human Immunodeficiency Virus — for each quantity sufficient for one day's treatment.	14·50	14·50

[1] For the purpose of this item a day case is a patient who attends as a non-resident patient for investigation, treatment or operation and who occupies a bed without staying overnight.

[2] For the purpose of this item a day patient is someone who attends regularly for a course of treatment without necessarily occupying a bed or staying overnight.

SECRET

10.

PRIME MINISTER

THE NHS CRISIS: A PRIORITIES APPROACH

The NHS already operates a system of priorities. Accidents, emergencies and dangerous acute conditions will all receive immediate treatment. But this is not widely known. Press coverage, shroud-waving consultants, management failures, the mal-distribution of resources have all combined to give the impression that the NHS is in a state of chaos in which people in urgent need of life-saving care do not receive it. This is a key influence on public opinion. If a patient who needs a new hip thinks that he and a heart patient are being kept waiting (and dying) because of a mean-spirited Government, he will be angry. But if he realises that he is waiting so that heart patients can be treated promptly, he will be pacified.

Making priorities explicit leads to a proposal to tackle the waiting list problem by giving guaranteed maximum waiting times for certain treatments. If a patient's District Health Authority had not given him treatment when that time expired, he would receive a voucher for full-cost treatment at any hospital, NHS or private, in the country. Categories would therefore be expressed in terms of the waiting time guarantee as follows:

(i) Treatments requiring immediate assistance: this might include accidents, emergency admissions, coronary thrombosis, deep-vein thrombosis, pulmonary embolism, strokes (of various types), perforated ulcers, acute pancreatitis, meningitis and other infectious diseases, etc., etc.

(ii) Conditions requiring treatment within three weeks: e.g. all malignant disease, cancer of the colon, breast, stomach; etc., life-threatening diseases, e.g. investigation of haematuria; many