NHS Review

3.31 pm

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[Mr. Clarke]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[Mr. Clarke]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Speaker: Order. One question, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Several Hon. Members *rose*—

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

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

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

[Mr. Clarke]

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

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

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

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

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

Mrs. Mahon: We know that.

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

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

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

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

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

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

Several Hon. Members *rose*——

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

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PARLIAMENTARY STATEMENT ON THE NHS REVIEW

KENNETH CLARKE QC MP

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONFIDENTIAL

Paul Gray Esq
10 Downing Street
LONDON SW1

30 January 1989

Dear Paul

NHS REVIEW: STATEMENT TO HOUSE

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

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

Yours

Andy

A J McKEON
Private Secretary

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DRAFT PARLIAMENTARY STATEMENT

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

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

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

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

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

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

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

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