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14 September 1983
Policy Unit

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PRIME MINISTER

DHSS SEMINAR

The papers from the DHSS provide some useful information, but omit some equally useful information which would be more relevant to cost control. Options for controlling costs are not systematically presented. We suggest below only options which offer potentially large savings (£100 million or more).

2.4-2.6 Medical Advance. I am unsure about the assumption that medical advance should automatically entail extra expenditure. This is untrue in non-medical fields; computers save money; TV sets become less expensive. Medical advance ought to speed up diagnosis, improve accuracy of diagnosis and effectiveness of treatment, speed up recovery of patient - all money-savers - as well as require more expensive equipment and drugs. We should beware of accepting this assumption which often turns into an excuse for lack of proper cost control over drugs, research programmes, etc. After all, "over the past 5 years, despite more complex treatments, costs per case have fallen". Why should the process not continue?

2.7 "Private health insurance mainly helps with non-urgent surgery - it has not so far had any measurable impact on waiting lists for major NHS treatment." This is not really the point. Any reduction in pressure on the NHS must release resources for other patients. The rise in privately insured people from 2.4 million to 4.2 million in only 4 years must have helped to bring waiting lists down before the strike.

2.8 Between 1971 and 1981, the number of GPs increased by 15 per cent. With a near-static population, this represents a fall of 10½ per cent in average list size (Health Care, 2.37) and "a potential improvement in GP care", according to the DHSS. I doubt it. The real point is that over the same period, the proportion of family doctors in group practice rose from 58 per cent to 75 per cent (Health Care, 2.39). Every patient knows what that means: your doctor takes an extra day off every week and answers house calls only in extremis. A perfect specimen of Hutber's Law: "Improvement means Deterioration".

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The DHSS rightly argues (2.9) for tight control of the growth in the number of GPs. Better still, no growth.

2.10 Dentistry, Glasses and Drugs. DHSS rightly sees scope for savings. I have never understood why diagnosis should be free and glasses not.

2.12-2.15 Social Security - Work Incentives. We have got ourselves into an impasse. Increasing Child Benefit is the only way in the existing system to iron out the unemployment trap. But because Child Benefit is universal, increasing it significantly would be far too expensive (£500 million per extra £1; £7,000 million to "buy out" all the benefits in kind).

The DHSS does not mention another well-known fact, attested by all opinion polls: Child Benefit is the least popular benefit precisely because it is unselective. It's the only state goodie of which you will hear people say: "I don't see why I should receive it".

The only solution, I repeat, is a two-tier child support system. The universal basic tier would be at present Child Benefit levels, would not be indexed, and could even be frozen. The second tier would be paid to all unemployed families and working families now on FIS, and would be tapered out via means test, preferably at a gentler slope than the present FIS to reduce the effect on the poverty trap.

This would be providing "the greatest help to many of the poorest families in the country" (your letter to Brynmor John in May). It would not disturb existing Child Benefit and would offer a very large potential Exchequer saving on indexing basic Child Benefit.

The Elderly

3. The real problem here for the rest of this century is not the total number of pensioners, which is stable as a proportion of the working population. The difficulty is:

(a) The growing number of the very old. This is a problem for the NHS and the social services, not the pensions system.

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For the very old, we endorse the DHSS strategy in 3.7. We would add only the need to introduce some reliable system of inspection, if private-sector homes are to be encouraged as one answer for the small minority who cannot look after themselves.

(b) The earnings-related pension scheme. By the early 1990s, this will be already costing more than £1 billion a year. At maturity in the next century, it would be costing nearly £8 billion at present earnings levels; more than 20 per cent of the average man's income would be going on pension contributions.

We urge strongly that the earnings-related scheme be wound up as soon as possible. The DHSS suggests (3.12) two less radical alternatives:

Extending the role of the private sector by more contracting-out. This becomes fearsomely complicated, and even so, the DHSS admits that some NI contributions would have to go up.

Reducing some of the benefits. This would be just as controversial as abolishing the scheme - in some ways more so, since we could be depicted as betraying a promise. And it would save less than a third of the total public expenditure.

Total abolition would not be unprecedented. We did the same with the pre-1975 scheme. So long as the entitlements already earned are preserved, that would be no breach of faith. By abolishing it, we would be nipping the scheme in the bud before it had built up a constituency of beneficiaries.

There is also a strong philosophical argument against it. We accept it as the duty of the state to provide an adequate safety net, but it is not the state's task to rig up a network of hammocks strung at different heights. Building up a pension entitlement related to previous earnings is emphatically a job for the private sector.

And surely most people would relish the prospect of lower NI deductions. I wonder if DHSS is fully aware how fiercely these are already resented.

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3.15 Pension Age. Why change the pension age? There is no popular pressure for it. And whichever way you move, it is likely to cost more, not less, and to arouse resentment.

I return to my palliative: now that Supplementary Benefit is drawn automatically by men over 60 who have been out of work for a year, why not dignify Supplementary Benefit with a new name - interim retirement benefit? These men are not really on the labour market and should not be counted among the unemployed, but we do not want to enlarge the population receiving pensions as of right (IRB would, of course, be withdrawn if the recipient finds a job).

Mental Illness and Handicap - the Disabled

4.1-4.8 There seems little scope for saving here. Indeed, every available extra penny should be spent in these fields. Even the possibility of more "contracting-out" of benefits looks more trouble than it is worth.

We should be reducing the rate of general hospital building in view of the huge programme undertaken since Enoch's days at Health. But these savings ought to be more than swallowed up by rebuilding our psychiatric hospitals, and by building smaller homes for the very old and frail.

The Unemployed

5.2-5.3 Benefit Structure. Unifying the administration of UB and SB would obviously save money. In the long run, this raises the question: do we really need a Department of Employment? But with 3 million unemployed, this is scarcely a topical question. Meanwhile, we clearly ought to computerise UB on the DHSS computers, despite opposition from DEm.

5.4-5.7 Benefit Expenditure. The gap between UB and earnings is now wider than it has been since the 1950s (Green Book, page 31). If UB continues to be strictly price-indexed, and earnings continue to rise faster than prices, that gap will slowly widen. There is therefore no reason to risk the political obloquy of deliberately failing to price-protect UB, particularly if SB continues to be indexed.

If SB is strictly price-indexed and real incomes continue to rise, then the gap between in-work and out-of-work income will rise there too, at least for single men and married couples without children. The incentive problem is the dependants' allowances. They can be dealt with only by paying a single rate to needy parents, regardless of whether they are in or out of work; ie: a two-tier child support system (see above, 2.12-2.15).

5.8 Capping/Wage Stop. We have already concluded that this would, on balance, be counter-productive since, for the most part, it would not affect the workshy who are more likely to be young and single.

The simple answer is to abolish UB for the under-18s (those not living at home would be entitled to SB). This would save about £100 million.

General Financial Issues

6.1-6.3 Taxation or Contributions? I am sure that the contributory principle, by providing some test of entitlement, does continue to provide some constraint on expenditure. It is not our aim to increase taxation.

6.4 Tax Credits. It might be possible to devise a tax credits system that was politically acceptable and did not involve extra expense. But nobody seriously suggests that tax credits would materially reduce expenditure. Tax credits are therefore not relevant to our present dilemma.

6.5-6.6 Health Expenditure. The DHSS is, I think, a little defeatist and defensive here.

(a) Manpower control can have dramatic effects. The only sector of the NHS which has hitherto attempted to impose any pressure on manpower has been Ancillary, where a bonus scheme has operated.

Look at the results. Ancillary Staff is the only category of NHS staff whose numbers have not increased by leaps and bounds over the past 10 years.

As with GPs, much of the increase in numbers of clinical staff has been absorbed by a shorter working week.

Administrative and clerical staff have merely increased in line with the growth of bureaucracy.

If there had been no increase in staff between 1971 and 1981, the saving would have been some £1,500 million.

(b) Pay. We are given no evidence that present pay levels in the NHS are insufficient to recruit and retain sufficient staff of the right quality. NHS pay levels have risen rather faster than other pay levels over the past decade.

(c) Income from Charges. See 2.10.

(d) Private Sector. The DHSS says that there would be £65 million deadweight if tax relief were extended to all health insurance. But if we merely extended to individual policies the present relief on corporate schemes for those earning below £8,500 p.a., the deadweight would be negligible. It is also time we raised the ceiling to £10,000 p.a. to include skilled manual workers. Over the next decade, with only modest fiscal encouragement, we might still expect to see a growing contribution from the private sector, up from its present £350 million a year (3 per cent of NHS spending) to perhaps £700 million (6 per cent of NHS spending).

Government Statements and Commitments

The DHSS rightly lists the most important statements by leading Government Ministers. But I think it is important to distinguish between hard commitments and what might best be called situation reports.

Commitments cannot honourably be fudged or dodged except on grounds of national emergency. Our commitments are: not to introduce charges for hospital stay, or visits to the doctor; to maintain exemptions from prescription charges; the price protection of pensions and linked long-term benefits; the annual payment of the Christmas bonus; and to restore the abatement of invalidity pension.

With Sit Reps, it is both possible and right to say: "When we were last asked the question, we truthfully replied that we had no plans for change, but we gave no pledge. We now believe that it is right to make a change". The principal examples here are Earnings-related Pensions and Child Benefit.

Savings. I therefore suggest that we can look for savings in an altogether more optimistic frame of mind, without injuring standards of care and without reducing - and probably by increasing - the total amount of money spent on health by the British people.

	£ million (1983 prices)
Possible savings by 1993 (approximate)	
HEALTH - Family Practitioner Services	
Pharmaceutical) cost-related	200
Optical) charges, but keep	100
Dental) exemptions	100
Medical (freeze number of GPs)	150
	£550
- Hospital Services	
Pay and Manpower control (1% saving on pay bill)	500
Supplies Purchasing - 20% savings	200
"Hotel" services - 20% savings on contracting-out or renegotiated in-house contracts	200
Administrative bureaucracy reductions	100
	£1,000

DHSS expects NHS expenditure to rise by £1,430 million between 1983 and 1993 (Green Book, page 3). The above savings would hold expenditure steady at present real levels.

SOCIAL SECURITY	
Abolition of earnings-related NI scheme	1,000
Abolition of unemployment benefit for under-18s	100
Unification of UB and SB administration	100
Freezing of Child Benefit for upper-income groups (assuming that only one half of all parents have Child Benefit indexed against 5% p.a. inflation)	2,500
	£3,700

DHSS expects Social Security expenditure to rise by £3,700 million between 1983 and 1993. Again, the above savings would hold expenditure steady at present real levels - without hurting the poor or breaching our commitments.

We must protect our flank against the Alliance. David Owen at Salford proclaims his intention to combine an energetic Thatcherite economic policy with a "tender-hearted" approach to the social services. We must therefore make it clear that our policies will:

1. Fully protect the sick, the elderly and the poor.

2. Maintain a high-quality hosptial and GP service free at the point of use.

3. Rebuild the "snake-pits" and workhouses, just as we have rebuilt the district general hospitals, so that, in 10 years' time, Britain's public health and social services will have been comprehensively modernised to the highest standards.

FERDINAND MOUNT fm

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MR. MOUNT cc: Mr. Scholar

I attach two copies of "annotated agenda" for the Seminar on Medium and Long Term Policy Issues in DHSS Programmes" which is to be held this Friday. The Policy Unit will want to provide a briefing note for the Prime Minister for this seminar, and I hope that you may be able to provide this by Wednesday evening in order to give the Prime Minister good time to study it.

B.E.R. BUTLER

12 September, 1983