10 DOWNING STREET

PRIME MINISTER

I am going to put a revised version of the minute below, incorporating comments from Stephen, Brian and Bernard, into your weekend box. But you may like to glance through it now as background to your meeting tonight with Mr. Fowler.

N.L.W.

NLW
29 May 1986

10 DOWNING STREET

Prime Minister

Worth thanking

Mr Fowler for his

help on the Perth

speech. He will

like that.

N.C.W.

29.5.86.

cc: Mr. Ingham
Professor Griffiths
Mr. Sherbourne

PRIME MINISTER

EDUCATION AND HEALTH

Besides unemployment, the two major domestic issues at the top of Government's priorities are education and health.

Education

Mr Baker is now busy at DES. You have begun the debate in Government on new initiatives. This needs to be resumed once Mr Baker has surveyed his empire. I suggest you call him in the second half of June to see what he is doing. Agree?

Health

Three headings here:-

- Presentation
- Management and efficiency
- Longer term

Presentation

At the Cabinet on 15 May it was agreed:-

> There should be a concerted effort, involving all members of the Cabinet, to ensure that the Government's achievements in providing additional resources for the NHS were presented as effectively as possible. There would need to be a strong local dimension to such an exercise. Other areas of Government achievements might benefit from such attention but the immediate concentration should be on the NHS. She would discuss how best to carry this forward with the Lord President, the Chancellor of the Duchy of Lancaster, the Secretary of State for Social Services and PMG.

I recommend that you have the meeting envisaged at a convenient time next week. Agree?

At the meeting you might raise the following points.

So far the Government has not persuaded people of the real improvements in NHS facilities. Your letter to Mr. Kinnock shows that there is a good story to tell. The numbers of beds, new hospitals, doctors, nurses, etc, are all up. But these "macro" statistics do not yet carry political credibility. Why? Perhaps because people are concerned about what is happening at <u>their</u> hospitals, about hip replacements in <u>their</u> town. We are not getting the good points of that story across. Instead, local difficulties are ruthlessly exploited, often with exaggeration and distortion, by political opponents, single interest groups, NHS trade unions, consultants etc.

So it is absolutely essential that DHSS (and the Scottish and Welsh Offices) concentrate their presentation effort at local level. Have they the organisation to do this? Should there be a special unit to mastermind an action plan? Can more be done to inform backbenchers?

All this assumes that all that is wrong is the presentation of policy, and that the policies themselves do not need development. Is this right?

<u>Management and Efficiency</u>

While there have been useful improvements, there is surely more to do to increase NHS efficiency through better value for money. Legislation is required to alter the cumbersome NHS organisation (regional health authorities, etc); difficult before the Election. In any event, we need to ensure that DHSS mobilises all its power to use existing machinery in the drive for efficiency. What should be done here?

Under both the headings Presentation and Management and Efficiency, Mr. Fowler will need extremely careful handling. You want to make him believe that initiatives agreed are a result of his own decision.

Longer Term

Present discontent about the NHS (and education) may be an expression of a more fundamental problem.

The public may be expressing a perfectly legitimate want for a higher standard of health care. In many countries this can be achieved by people spending more of their own money on private health provision. While possible to some extent in the UK (through BUPA, etc), an increase in the supply of private health facility is not really in prospect to the extent required. The only way that most peoples desire for better health care can be achieved is through the NHS; and that, once efficiency savings are made, means more public expenditure. So if the Government is to have a chance of keeping to its public expenditure levels we need to think more about getting private money into the Health (and education) Service.

A big issue here, but one that needs to be tackled. But you may want to leave it until after the Election.

N. L. WICKS

29 May 1986

1

PRIME MINISTER

THE NHS

The following emerged from a long "non-conversation" with Ken Stowe this afternoon. Throughout Ken Stowe asked me to emphasise that he hoped you would treat what he said with great discretion. He hopes Norman Fowler will explain the issues to you tonight and would not want you to divulge this pre-briefing.

The concept of the NHS Management Board

Ken Stowe believes that the concept of the Management Board, working inside the Department, is a useful and workable one; and he says that Roy Griffiths agrees. Before the establishment of the Board there were, said Ken, 9 different functions exercised by DHSS over the NHS (eg finance, distribution of resources, personnel, pay, capital development, procurement, estate management). These 9 functions had been distributed over 22 locations. But no official above an Assistant Secretary was responsible for any one. Responsibility had been diffuse and management vague. It was only at Permanent Secretary level where responsibilities were brought together. It was clearly impossible for the Permanent Secretary to coordinate each of the 9 functions, particularly as he had many other jobs to do. Hence the concept of the Management Board.

Since the Board was within the Department and the existing statutory framework, it could be presented as offering no threat to the role of Ministers, the Treasury, the Regional Health Authorities and other powerful interests within the NHS. But it enabled the responsibility for each of the 9 functions to be brought together under one of the 9 members of the Board.

Roy Griffiths had recommended that the Board should be drawn from three sources:

- Whitehall, where there was expertise in public finance etc,
- the Health Service, where there was expertise in hospital management,
- the private sector with expertise on efficiency management purchasing etc.

What has gone wrong?

Ken Stowe emphasised that the Management Board has considerable achievement to its credit over the last 18 months or so. But there have been increasing tensions between Victor Paige and Norman Fowler (who had in fact nominated him for the job). It was now clear that Victor Paige had not the faintest idea how a Government Department worked nor of the role and responsibility of Ministers. He wanted to pursue his own ideas, as his own ideas, in his own right rather than as an agent for his Ministers. He wanted to "decide" important policy issues himself rather than recommend them to Ministers who would "decide" them for Paige to implement. This misunderstanding about respective roles was evidenced in the following incidents:

1. There had been a row about membership of the Management Board: Paige had wanted 13 members but there were jobs for only 9.
2. Paige wanted to exert direct authority over the Regional Health Authority Chairmen on his own account, not as agent for the Secretary of State. This had led to tensions between them and the Management Board.
3. Paige had, without authority, given commitments about General Managers pay which would, in some cases, have led to a 40 per cent pay rise for former NHS administrators. Norman Fowler had told him that that was politically impossible and had, with great skill, negotiated the package of increases agreed, along with the Review Body increases, at the last Cabinet. The package had been

successfully welcomed by the General Managers without political fuss.

4. Paige had wanted to invite journalists to attend a Management Board meeting. Norman Fowler had vetoed this on the grounds that it was his job, not Paige's, to present publicly the NHS.

Ken Stowe said that underlying these conflicts was the basic issue "Who is in charge - the Chairman of the Management Board or the Secretary of State?" Ken believes that someone more sensitive to the ways of Government (like Robin Ibbs or John Sparrow) could have avoided the tensions and have worked through the existing machinery. Victor Paige did not have the capacity for that. With a Secretary of State behind them, the Management Board had a lot of power:

- it could distribute cash between the Regional Health Authorities;
- it could appoint a Regional or Area Authority Chairman;
- and it had a statutory power of direction over the authorities which though never used was a useful weapon of influence.

Crucial, however, was trust and confidence between the Chairman and Secretary of State.

Personalities

Ken Stowe held Norman Fowler in high esteem. His very considerable political skills had successfully piloted the Government in the last three years through the NHS minefield. But Norman was not good at getting through the business. There were inordinate delays in taking decisions. He could only deal with one thing at a time. Something which Victor Paige had found enormously frustrating.

As for Paige, Ken doubted whether, at 61, he was physically up to the strenuous job of stumping up and down the country

energising NHS management. Ken believed that he was now utterly played out and on the edge of a breakdown. There had been utter astonishment when a day or so ago he had (again) presented his resignation. This was particularly strange after the Department's "victory" at Cabinet when they had achieved, virtually, full implementation of the Review Body recommendations, extra money to pay for them and the General Managers' pay package.

Next Steps

Ken believes (hopes?) that Norman Fowler will seek your approval to approach Roy Griffiths to become Chairman of the Management Board. It was essential that the Department should not run into the same problems with Griffiths. That required a very careful definition of the role of the new Chairman of the Management Board. (Ken thought that some evolution of the Management Board on the lines of the Manpower Services Commission might be possible, so as to give the Board more discretion. But this could not be decided before an early appointment of the new Chairman.)

What does Norman Fowler hope from this evening's meeting?

Ken Stowe doesn't know what Mr. Fowler will seek tonight. But he hopes that the following may emerge:

1. There will be agreement that Victor Paige should go quickly and cleanly, without recrimination on either side, and with an announcement next Monday or Tuesday.
2. Norman Fowler should be given authority to approach Roy Griffiths. (NB, the Civil Service Commissioners need to be squared if we are to avoid the sort of problems encountered with Levene's appointment).
3. The Press presentation of Paige's departure should be kept as low key as possible. Paige has apparently promised that he will not criticise if he is not criticised. (He has apparently written Norman Fowler a letter with a lot of muddled criticisms which, Ken

thinks, are easily answerable.)

4. Len Peach, Management Board member for personnel (ex-IBM) should be made Acting Chairman until Griffiths (or someone else) is appointed.

N.L.W.

N. L. WICKS

29 May 1986

JA1ATA

Read by PM.
PM saw NF alone.
She told me she had
spoken on the lines of KRS;
report. 1, 2, 3 above agreed.
4 not mentioned to me.
N.L.W
29.5

PRESENTATION OF THE NHS

There are three vital elements in any campaign to secure political credit for the 24 per cent increase in real NHS resoruces since 1979:

- to convince the public that the Government really does care about the NHS - ie. that it really is safe in your hands

- to square the national increase in resources with the public's experience locally

- to take on and beat the vested interests who, for a variety of reasons, saddle the Government with blame for each and evry NHS ill. {NB: Young and Rubicam tell me that their research shows that a campaign by you to require regional and district health authorities to account for their stewardship would pay dividends; it would demonstrate action and caring.}

But there is the overriding requirement: organisation.

It is relatively easy to mount a campaign by a Government Department to get over at national level particular facts of a certain point of view. That however is only one tier of the sort of campaign now required to remedy the public's perception of the NHS.

To achieve results in the peculiar circumstances of the NHS we need a three tier effort:

: national) corresponding to the NHS's
: regional or area) organisational hierarchy
: district or local)

At each level we need to devise a campaign which is relevant to that level but which:

- contributes to the "killing" of the notion that the NHS is dying from a thousand (Government) cuts

- takes credit for the additional spending within overall priorities

- puts the increased expenditure in the most positive light - eg new accomodation, facilities etc, so demonstrating the Government's commitment to the NHS;

- discredits pressure groups by swiftly and forcefully correcting misinformation and challenging local or regional administrations to account for any apparently wasteful use of resources.

None of this will happen unless the DHSS establishes a special unit, comprising both administrators and information officers, under the Secretary of State's chairmanship.

A precedent, the MOD's successful campaign against a resurgent CND in 1982/83, also included PPSs and myself.

This would be the campaign powerhouse. But one of its most important tasks would be to mobilise regional and local forces to discharge the responsibilities advocated above.

Such a unit would need to be complemented on the political net by CCO, a team of Backbenchers and supporters at regional and local level whose primary function should be to challenge every claim of Government "cuts" and through press, radio and television to call on regional and local administrators to account for their use of the overall increases in resources.

There would be something to be said for a Junior Minister being given direct day to day responsibility for running the campaign to ensure the immediate exploitation of opportunities and the instant rebuttal of falsehoods.

The aim should be to change the public's perception of the Government's stewardship of the NHS if possible by the recess and certainly no later than October - ie before the party conference.

I attach an outline plan of action at Annex I.

BERNARD INGHAM

29 May 1986

ANNEX I

OUTLINE PLAN OF ACTION

Objective

To convince the public that the Government:

- believes in the NHS;
- is spending more nationally, regionally and locally on it;
- that the service has improved; and
- that responsibility for the ever more efficient use of increased resources rests with local management.

Machinery

DHSS Ministerially-led task force involving Parliamentary Private Secretaries (representing party interest), also No 10 Press Secretary, COI and territorial departments, reporting to Prime Minister.

Ideas

Using available research, devise campaign which involves:

- standard national brief, including speaking note
- Ministerial speaking, radio, television campaign, drawing on wider resources of Government and Party
- regional speaking briefs relating national increase in resources to regional and local interests
- regionally based Backbench team (on lines of Tom King's which fought 1984 dock strike) with responsibility for replying promptly to local criticisms

- regional monitoring of media by DHSS regional information team (which already exists in COI offices) to ensure fast reaction to local criticisms and positive response to local pressure groups

- exposure of vested interests - eg single issue pressure groups and politically motivated campaigns - with aim of denigrating local achievements in order to secure more resources for their pet scheme

- talking up of morale in NHS; local management's identification with need to present NHS positively, urging them to shout their successes from the roof tops to the local media

- marshalling of local party resources to challenge local criticisms either factually or by calling on local management to justify its use of substantial real increase in resources

- organisation of eminent persons to put over general case of Government of increased resources, to expose the political game going on nationally, regionally and locally - to denigrate the Government's policies; and to fix responsibility for efficient use of increased resources on NHS management.

Mr Ingham

PRIME MINISTER

This note supplements Mr Wicks' minute on the presentational aspects of the NHS problem.

There are three vital elements in any campaign to secure political credit for the 24% increase in real NHS resources since 1979:

- to convince the public that the Government really does care about the NHS - ie that it really is safe in your hands

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29 May 1986

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29 May 1986

MR WICKS

cc Prof. Griffiths
Mr Ingham
Mr Norgrove
Mr Sherbourne

EDUCATION AND HEALTH

Brian Griffiths has asked me to comment on your draft note to the Prime Minister, as it largely covers health.

Presentation

You are right: it is the local story that matters rather than macro-statistics.

Improved local presentation and better management are closely related. If a local manager cannot promote a junior physiotherapist without clearance from the DHSS, why should he feel responsibility for, and hence pride in, local achievements? Local managers need much more freedom to operate within their fixed budgets.

Presentation is also linked with policy. The Government has not only to improve the presentation, but also to change the product. Even if the problem is just presentation, the best solution may not be to say that it is, because that looks condescending and complacent.

The attached note on NHS publicity - which I have discussed with Mr Tebbit at the Prime Minister's request - sets out some ideas on presentation and policy in rather more detail.

Management and Efficiency

I agree with your discussion here so far as it goes. But the problem is not so much new ideas for saving money - any competent DHSS official, or District Manager, could give you half a dozen examples of waste that could be eliminated. The problem is vigorous implementation and follow up.

That raises questions of organisation and personnel:

i. What exactly does the NHS Management Board do? What authority does it have? What is its output?

ii. Your minute doesn't mention appointments; but unless there is a strong sense of vigorous management from the centre, the morale of District and Regional Managers will carry on sinking.

The Long-Term Problem

It is not clear whether or not you endorse the statement that: "The only way that most people's desire for better health care can be achieved is through the NHS; and that, once efficiency savings are made, means more public expenditure". I do not accept it, but it vividly encapsulates the Government's dilemma in both education and health. As we become more affluent, we want more of both these crucial services. Yet in the UK more than in most other advanced countries, the only way to get more is via higher public expenditure, which

undermines the Government's macro-economic stance. People don't so much want more spending on the Health Service as more spending on health: the NHS is just the only vehicle around.

The solution is to enable people to top up with money of their own to buy extra above that provided by the state. This doesn't mean more Etons or their health equivalents whereby you opt out of the state system and start all over again. The articulate middle-classes should remain within the system. Direct-grant schools and their health equivalents need to be reinvented. No government will be able to satisfy the middle class appetite for more health care at an acceptable level of public expenditure. Unless some mechanism is provided within the NHS structure, the London suburbs will by the year 2000 be ringed with private health facilities and the London health service will have gone the way of ILEA.

Your note doesn't refer to the other big long-term issue, best called, I am afraid, the "contractorisation" of health services.

Most Health Authorities don't realise that they are actually carrying out two very different functions:

i. Disbursing public money so that the people in their District get a free health service.

ii. Running hospitals and employing the people in them so as directly to provide health care.

These functions can exist completely independently of each other. The Government's initiative on competitive tendering for ancillary services was a useful first step towards acknowledging that what matters is universal free basic health care, not the continued existence of an enormous direct labour organisation. But if it is such a good idea to invite competitive tenders for hospital catering, why don't we have competitive tenders for heart transplant operations? Competitive tenders for medical services need not just involve outside private organisations; public sector hospitals can compete with each other as well. St Thomas's and Guys should be able to compete for GP referrals on the basis of quality and cost. With some more Prime Ministerial pressure, I think there is a real prospect of progress in moving to an "internal market" in the Health Service. It builds on Health Service traditions. The first signs of movement are already there.

Conclusion

You will not be able to include all these thoughts in your note. The best way to reflect those you agree with might be to shorten the passages at the top of pages 2 and 3 and add more subjects and side headings, notably:

- What are the links between presentation and local management responsibility?

- What policy changes will improve health presentation?

- Are changes needed in DHSS organisation and personnel?

- How can we establish topping up mechanisms so people can buy that little bit extra - even if it is only an à la carte menu in hospital - within the Health Service?

- How can we encourage genuine competition between different public and private providers of health care?

David Willetts

DAVID WILLETTS

Mr. Wicks
No comment on your minute. & see my note on presentation, attached.

Mr. Ingham
Mr. Sherbourne
Professor Griffiths

cc: Mr. Norgrove

I want to put the minute below, or something like it, into the Prime Minister's box later this week. Have you any comments on it? Would each of you like to supplement it as follows:

- Mr. Ingham with a note on presentation;
- Mr. Sherbourne with one on the politics;
- Professor Griffiths with a Policy Unit note on organisation and efficiency initiatives?

Could I have comments/contributions by close on Thursday please?

N.L.W.

N. L. WICKS

27 May 1986

DRAFT MINUTE TO THE PRIME MINISTER

EDUCATION AND HEALTH

Besides unemployment, the two major domestic issues at the top of Government's priorities are education and health.

Education

Mr Baker is now busy at DES. You have begun the debate in Government on new initiatives. This needs to be resumed once Mr Baker has surveyed his empire. I suggest you call him in the second half of June to see what he is doing. Agree?

Health

Three headings here:-

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- Longer term

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> There should be a concerted effort, involving all members of the Cabinet, to ensure that the Government's achievements in providing additional resources for the NHS were presented as effectively as possible. There would need to be a strong local dimension to such an exercise. Other areas of Government achievements might benefit from such attention but the immediate concentration should be on the NHS. She would discuss how best to carry this forward with the Lord President, the Chancellor of the Duchy of Lancaster, the Secretary of State for Social Services and PMG."

I recommend that you have the meeting envisaged at a convenient time next week. Agree?

At the meeting you might raise the following points.

So far the Government has not persuaded people of the real improvements in NHS facilities. Your letter to Mr. Kinnock shows that there is a good story to tell. The numbers of beds, new hospitals, doctors, nurses, etc, are all up. But these "macro" statistics do not yet carry political credibility. Why? Perhaps because people are concerned about what is happening at their hospitals, about hip replacements in their town. We are not getting the good points of that story across. Instead, local difficulties are ruthlessly exploited,often with exaggeration and distortion, by political opponents, single interest groups, NHS trade unions, consultants etc.

So it is absolutely essential that DHSS (and the Scottish and Welsh Offices) concentrate their presentation effort at local level. Have they the organisation to do this? Should there be a special unit to mastermind an action plan? Can more be done to inform backbenchers?

All this assumes that all that is wrong is the presentation of policy, and that the policies themselves do not need development. Is this right?

Management and Efficiency

While there have been useful improvements, there is surely more to do to increase NHS efficiency through better value for money. Presumably you do not want to alter the cumbersome NHS organisation (area health authorities, etc) before the Election. So you need to ensure that DHSS mobilises all its power to use existing machinery in the drive for efficiency. What should be done here?

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Longer Term

Present discontent about the NHS may be an expression of a more fundamental problem. The public may be expressing a perfectly legitimate want for a higher standard of health care. In many countries this can be achieved by people spending more of their own money on private health provision. While possible to some extent in the UK (through BUPA, etc), an increase in the supply of private health facility is not really in prospect to the extent required. The only way that most peoples desire for better health care can be achieved is through the NHS; and that, once efficiency savings are made, means more public expenditure. So if the Government is to have a chance of keeping to its public expenditure levels we need to think more about getting private money into the Health Service. A big issue here, but one that needs to be tackled. But you may want to leave it until after the Election.

EL3BEA

DRAFT MINUTE TO THE PRIME MINISTER

cc Mr Ingham
Mr Griffiths
Mr Ingham

EDUCATION AND HEALTH

The two major domestic issues, besides unemployment at the top of Government's priorities are education and health.

Education

Mr Baker is now busy at DES. You have begun the debate in Government on new initiatives. This needs to be resumed once Mr Baker has surveyed his patch. I suggest you call him in in the second half of June to see what he is doing. Agree?

So action on education is in hand. The other problem is health.

Health

This has three aspects:-

- Presentation
- Management and efficiency
- Longer term

Presentation

At the Cabinet on 15 May it was agreed:-

"There should be a concerted effort, involving all members of the Cabinet, to ensure that the Government's achievements in providing additional resources for the NHS were presented as effectively as possible. There would not be a strong local dimension to such an exercise. Other areas of Government achievements might benefit from such attention but the immediate concentration should be on the NHS. She would discuss how best to carry this forward with the Lord President, the Chancellor of the Duchy of Lancaster, the Secretary of State for Social Services and PMG."

(check that this sentence is correct)

I recommend that you have the meeting envisaged at a convenient time next week. Agree?

Cabinet's discussion reflected the view that the Government has not so far persuaded people of the real improvements in a HS facility. That is why we have not a good story to tell. As your letter to Mr Kinnock demonstrates, the "macro" statistics -

numbers of beds, new hospitals, doctors, nurses, etc, are good but these macro statistics do not appear to carry political credibility. Why? Perhaps because they inevitably conceal difficulties at the local level, hospital closures (often of old inefficient hospitals) local shortages, etc. These are ruthlessly exploited, often with exaggeration and distortion at local level, by political opponents, single interest groups, NHS trade unions, and consultants etc.

So it is absolutely essential that DHSS (and the Scottish Office) concentrate their presentation effort at local level. Have they the organisation to do this? Should there be a special unit to mastermind an action plan? Can more be done to inform backbenchers?

All this assumes that all that is wrong is the presentation policies not the policies themselves. Is this right? (NB: the Health Ministers no doubt argue for extra money.) What are the possibilities for new policies?

Management and Efficiency

While there have been useful improvements, the drive for increased efficiency has not really taken off. What can be done here? Presumably you do not want to alter cumbersome NHS organisation (area health authorities, etc) before the election. That means making sure that HQ (Alexander Fleming House) use all its power to vitalise existing machinery. What

shall we do here? Are personnel changes needed?

How should they be accomplished?

Mr Fowler will need extremely careful handling. Ideally, we want him to think that any changes are as a result of his own initiative.

Longer Term

Many of the presentation and political problems with the NHS arise because it is funded to such a large extent by the taxpayers. This inevitably causes us a problem when we try to keep down public expenditure. It may well be that the public want a higher standard health facility. In many countries this can be achieved by people spending more of their money on private health provision. While theoretically available in the UK (through BUPA, etc), an increase in the supply of private health facility is not really in prospect to the extent required. So if we are to have a chance of holding our public expenditure policy, we need to think more about getting private money into the health services. But you may want to leave that until after the election.