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10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

6 January 1989

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister yesterday chaired the eighteenth meeting of the group reviewing the National Health Service. The group had before them papers HC67, 68, 69, and draft chapters of the White Paper contributed by the Secretaries of State for Wales, Northern Ireland and Scotland (letters of 20 December, 20 December and 21 December respectively).

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Mr. Wilson (Cabinet Office) and Professor Griffiths (No.10 Policy Unit).

NHS REVIEW: FPS - HEADS OF AGREEMENT (HC68)

The group first considered a joint paper by the Secretary of State for Health and the Chief Secretary about the Family Practitioner Service (FPS). In discussion, the following were the main points made:

a. The aim was to issue a consultation document at the same time as the White Paper, explaining how the Government expected indicative drug budgets to work in practice and inviting views. But considerable work was required and this timing might not be possible.

b. It was desirable that Family Practitioner Committees should determine the size of drug budgets in accordance with a formula as far as possible, but in practice there would need to be considerable flexibility to accommodate regional differences, including the problems of rural areas, and wide variations in prescribing patterns.

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c. The most satisfactory way of controlling GP numbers would be through action on remuneration. It could be argued that the proportion of average remuneration accounted for by capitation fees should be raised from 46% to 75% rather than the 60% proposed in paragraph 8.7 of HC67. On the other hand, even the figure of 60% would be controversial, and a substantial increase on what had been proposed in the White Paper on Primary Care. It was not realistic to go higher.

d. The way in which the Doctors' and Dentists' Review Bodies (DDRB) determined the pay of GPs was insensitive to the number of patients whom they treated. This needed to be put right. One approach would be to include the point in the White Paper, so that it could be referred to in future evidence to the DDRB and form a basis for possible later action. On the other hand, eventual abolition of the Basic Practice Allowance in some parts of the country would have a significant effect; and it was important not to make the White Paper too negative towards GPs.

The Prime Minister, summing up this part of the discussion, said that the group endorsed the proposals outlined in paper HC68. The Secretary of State for Health would consider further whether the White Paper should include a passage which could be referred to in future evidence to the DDRB. Any such passage would need to be drafted very carefully and given a positive flavour.

GP PRACTICE BUDGETS (HC69)

The group then considered a joint note by the Secrtary of State for Health and the Chief Secretary to the Treasury on GP Practice Budgets (HC69). In discussion, the following were the main points made:

a. There was a risk that GPs would not be able to exercise sufficient control over their budgets because decisions determining expenditure would be taken by hospital doctors. For instance, the costs of treatment could be significantly different from what the GP had expected if a consultant made an unexpected diagnosis. On the other hand, GPs would be able to protect themselves by placing fixed-price contracts with hospitals. There would also be some averaging of risks across all the patients belonging to the practice. More generally, the problem of controlling expenditure was not confined to GP budgets and could not be decisive.

b. There was general agreement on the need to provide incentives for GPs. It could however be argued that the particular proposals in HC67 might lead to impropriety if GPs were induced to divert patients' money to their own income. On the other hand, the arrangements for medical audit and for monitoring by FPCs would provide protection against impropriety The

risk of impropriety was not new: it applied in relation to capitation fees. The proposals in the White Paper were designed to allow GPs to plough money back into improving their practices (paragraph 3.18 of HC67). This was a desirable objective and it was important not to have controls which were too bureaucratic.

c. It was important that the scheme should deal with the problem of excessive referrals by GPs, as well as with prescribing costs. The combination of medical audit and tougher monitoring by FPCs was however designed to achieve this.

d. The system for negotiating practice budgets in paragraph 3.12 of HC67 was unacceptable. GP practices would never know what to expect from one year to the next. Moreover, there was a real risk that Regions would adopt different approaches to different GP practices and also that different Regions would follow different approaches (as had happened with nurses' pay); so that there would be no consistency. It was essential that a satisfactory, workable approach should be devised before the White Paper was published, which ensured consistency. A straightforward formula, based on the formula for allocations to District Health Authorities, might be appropriate. If need be, there might have to be a transitional period, starting with existing patterns but moving gradually to the new system.

e. The aim was to achieve maximum devolution of responsibility, subject only to administrative practicability. In England and Wales this pointed to budgets only for practices with at least 11,000 patients. But a smaller number might be possible for Scotland, at least in the light of experience.

The Prime Minister, summing up this part of the discussion, said that the proposals on GP practice budgets were as fundamental to the Reviews' conclusions as the proposals on self-governing hospitals and would be set out accordingly in the White Paper. It was however essential that the arrangements for determining the size of budgets should be revised, as indicated in discussion. The Secretary of State for Health would review this aspect of his proposals. The Secretary of State for Scotland would consider whether anything could be said in the White Paper about extending budgets to smaller practices in Scotland.

WHITE PAPER: FIRST DRAFT (HC67)

The group then turned to the first draft of the White Paper (HC67), circulated by the Secretary of State for Health.

Summing up preliminary discussion about the broad structure of the White Paper, the Prime Minister invited the Secretary of State for Health to arrange for the material to be reorganised so that it fell into four main parts.

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The first part would be to set out the Government's strategy for the NHS. This would be the key section which would cover all the important points, so that readers would know in essence what the Government was proposing and why, even if they read no further. It would include the topics in chapters 1 and 2 of the draft, but would go further as indicated in discussion below. The draft provided by the Secretary of State for Scotland struck the right sort of note, particularly in its first seven paragraphs. There would be no need for a separate foreword of the kind proposed in chapter 1. There could however be a short paragraph at the beginning signed either by the Secretary of State for Health or herself.

The remaining three parts would spell out the Government's proposals in more detail. Part two would deal with the proposals concerning hospitals. It would need to have an introductory section which explained the Government's overall approach and provided a framework for understanding the detailed material on hospitals, including managing the hospital service and self-governing hospitals. Part three would deal with the Family Practitioner Service and GPs, including practice budgets. Part four would bring together the remaining proposals.

Chapters 1 and 2

In discussion of chapters 1 and 2, the following were the main points made:

a. It was essential to use the right language in these and subsequent chapters. The drafting needed to show constant awareness that the NHS provided health care for individuals who contributed to the cost through their taxes and were entitled to expect considerate treatment and good value for money. It should avoid giving the impression of an impersonal approach: it was for instance more appropriate to talk about patients rather than customers, and about choice and value for money rather than competition and the market.

b. Similarly it was important not to use language which could be interpreted as running down the NHS. It would for instance be preferable to refer to improving the NHS or making it better rather than bringing it up to date. It was also important to draw attention in this first part of the White Paper to the benefits which the Government's proposals would bring to people who worked in the NHS.

c. In paragraph 1.2 it would be more accurate to refer to the NHS as being financed largely out of general taxation.

d. In paragraph 2.4 the last sentence about bringing the NHS up to date should be deleted.

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e. Another major theme of the White Paper which needed to be reflected in this opening section was the Government's wish to devolve responsibility. It had to be made clear that Ministers could not be expected to answer for every detail of the running of the NHS on the floor of the House. One central principle behind the Government's proposals was that the more responsibility and accountability could be delegated to people at the point where decisions were taken, the better would be the service which they provided and the more satisfying would be their jobs. Hitherto they had been too much constrained, and there were big differences in their performances. The Government wanted to put this right.

f. The language in paragraph 2.6 about talented people being 'given their head' and everyone being encouraged to 'give of their best' was not right. The Scottish Office draft provided a better model.

g. In paragraph 2.12 it would be better not to refer to "constraining" the rate of growth in drug costs. The point was that these costs had to be kept to reasonable proportions.

h. Paragraph 2.14 on waiting times ended lamely and needed to be more positive. In particular, the proposal for appointing more consultants ought to be mentioned. It was also an area which illustrated the patient's interest in good value for money.

i. In paragraph 2.15, the second sentence should be deleted. The paragraph needed to include a reference to making it easier for patients to change their GPs.

j. Whenever figures were quoted in these and subsequent paragraphs they should where possible be for the UK as a whole, and not just for England and Wales. The basis of the figures should always be made clear.

The Prime Minister, summing up this part of the discussion, said the group were agreed that chapters 1 and 2 of the present draft needed to be merged and substantially rewritten to reflect the points made in discussion, taking account of the first seven paragraphs of the Scottish draft and the material circulated by the Chancellor's private office on 4 January. It was essential to bring out the twin themes of, first, devolving responsibility and, second, the money following the patient, which lay behind the proposals for self-governing hospitals and GP practice budgets. Both were designed to lead to greater choice and value for money for patients who, as taxpayers, were providing huge sums for the NHS. These themes had to be developed clearly in language which was not impersonal. The Secretary of State for Health would arrange for this redrafting to be done.

On the public expenditure implications of the Government's proposals, the Prime Minister asked the Secretary of State for Health to consult bilaterally with

the Chief Secretary on the line to be taken, and to arrange for his officials to clear the relevant passages of the White Paper and all consultation documents with the Treasury.

Chapter 3

Summing up discussion of chapter 3, the Prime Minister said that the group had agreed the policy in this chapter subject to revision of the approach on funding in paragraph 3.12. They were content that expenditure on accidents and emergencies should not be included within practice budgets. The proposal in paragraph 3.10 for practices to be able to choose whether or not to include prescribing costs within their budgets had been overtaken by the new proposals for indicative drug budgets and would be amended. On paragraph 3.21 it was important to ensure that the timetable for introducing a substantial number of subjects by April 1991 was consistent with the proposals for Scotland: at present the Scottish text referred to 1991. More generally, the language of the drafting in this chapter could be improved: for instance, paragraph 3.4 was clumsy, and the reference to extending competition in paragraph 3.6 was inappropriate.

Chapter 4

In discussion of chapter 4, the following were the main points made:

a. It was very important to spell out clearly, right at the beginning of the section on the hospital service, that self-governing hospitals would remain within the NHS.

b. On paragraph 4.3 it was wrong to refer to 'pushing down' decision-taking since this implied resistance and an inferior position. The Government would 'delegate' and 'devolve' responsibility.

c. On paragraph 4.5 it should be made clear that people who were non-executive members would all be appointed in their own right and for the contribution which they would make in a personal capacity; and that there would be no representatives from any organisation or special interest group, whether from those listed in the text, from local authorities or from any other body.

d. On paragraph 4.7, the reference to a hospital 'generating income by selling its services' was inappropriate: 'earning its income from the services it performs' was better. The use of 'buyers' in the second sentence should be changed.

e. Paragraph 4.7 was incomplete without some reference to, and explanation of, core funding.

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f. The last sentence of paragraph 4.10 conveyed too negative an impression. There should be no possible implication that the Government had ever contemplated an arrangement in which people requiring urgent treatment might be turned away from a hospital.

g. The last sentence of paragraph 4.14, as drafted, might help perpetuate restrictive practices. It would be better if it read: "But subject to their contractual obligations Hospital Trusts will be free either to...."

h. Paragraph 4.17 should refer to the group's decision that self-governing hospitals would bid for an allocation of capital from within the annual financing limit.

i. The point in the last sentence of paragraph 4.20 was important and had to be made. But the drafting could be given a more positive flavour, for instance by explaining that the closure of old hospitals was often an unavoidable part of proposals designed to provide new hospitals and a better service for patients.

j. The first sentence of paragraph 4.22 gave the impression that Regional Health Authorities would have a directive role in relation to self-governing hospitals. It should be made clear that what was being described was an aspect of core-funding.

k. Paragraph 4.24 should convey the flavour that the Government expected many hospitals to be keen to win self-governing status. The initiative in identifying candidates would rest jointly with the Government and Regional Health Authorities. This should be made clear.

l. The logic of paragraph 4.25 was that where the roles of DHAs declined they might eventually be merged with FPCs. The paragraph should be drafted so as not to exclude this possibility. Keeping open the option of merger through natural evolution would give DHAs some hope of a continuing role and would reflect the views which had been expressed in earlier meetings of the group.

The Prime Minister, summing up this part of the discussion, said that the group had agreed the points made in discussion and invited the Secretary of State to arrange for them to be incorporated in revision of this part of the White Paper.

Chapter 5

In discussion of chapter 5, the group first considered the respective roles and responsibilities of the Secretary of State, the Department of Health, and managers within the NHS, as reflected in paragraph 5.2. Their discussion also covered paragraphs 9.8 and 9.9, about the central management

of the NHS. The Prime Minister, summing up this discussion, said that Ministers could not be expected to manage the NHS. The whole thrust of the Government's proposals was greater devolution of responsibility, and the implications had to be spelled out in the White Paper. The second sentence of paragraph 9.2 should be amended by deletion of 'fully' and 'and for the services which they finance'. The third sentence appeared to run contrary to the conclusions of the review. Ministers would have benchmarks for judging performance and would be able to ask the National Audit Commission to investigate particular matters; but neither they nor the Department should be involved in operational management, nor would they direct it. Subject to the normal arrangements for collective responsibility, the Policy Board, chaired by the Secretary of State, would be responsible for strategy on the NHS, its objectives, its finance and the monitoring of the Management Committee. The Management Committee, chaired by the chief executive, would be responsible for all operational matters, within the policy framework laid down by the Secretary of State. The Secretary of State should arrange for this approach to be brought out clearly in the White Paper.

In discussion of the rest of chapter 5, the following were the main points made:

a. The heading to paragraph 5.7 - leaner and fitter regions - should only be used if it were true that there would be a net reduction in the size of RHAs. The group had earlier agreed that there should be.

b. The opening of paragraph 5.19 with its reference to regional information strategies was obscure. It should be shortened to read: "The Government remains committed to introducing modern information systems to support.."

c. Paragraph 5.24 should be included. But 'market' should be deleted from the first sentence. The second sentence should be amended to read: "...national pay spine, to reward individual performance and to take account of market conditions".

The Prime Minister, summing up this part of the discussion, said that the group invited the Secretary of State to revise the chapter in the light of these points.

Chapter 6

In discussion of chapter 6, the following were the main points made:

a. Paragraph 6.7 should make it clear that the results of audits should be available to management, and that there could be joint inquiries, as agreed earlier.

b. It should be possible for consultants to contract to provide the NHS with a smaller proportion of their time than nine-elevenths, say five-elevenths. The

point could be met by amending the first sentence of paragraph 6.13 to read "...their use of resources and the extent of their services".

The Prime Minister, summing up this part of the discussion, said that the group accepted the minor modification of its earlier proposals indicated in the last indent of paragraph 6.20, namely that distinction awards should still be payable, but not pensionable, within three years of a consultants' retirement. The Secretary of State was invited to revise the text to reflect the points made in discussion.

Chapter 7

In discussion on chapter 7, the following were the main points made:

a. The graph should be dropped.

b. The reference to "some two per cent" in paragraph 7.8 should be "three per cent" as agreed earlier.

c. In the penultimate sentence of paragraph 7.13 the reference should be to changes managed "over a transitional period".

d. The first sentence of paragraph 7.16 should be deleted, as should 'where necessary' in the second sentence. Both could be taken to suggest that there had been some doubt about immediate access for those needing urgent treatment.

e. The proposals in paragraph 7.18 for core services to be funded on an annually negotiated contract could lead to the perpetuation of existing inefficiencies. There had to be some basis or formula for determining core funding, other than by reference to existing expenditure: the proposals would otherwise work to the disadvantage of good, efficient hospitals. On the other hand, the whole concept of DHAs buying health care involved the concept of shopping around and of negotiating the price at which core services were provided.

f. Paragraph 7.31 on waiting-times should be expanded and strengthened, if possible. Paragraph 7.32 on the appointment of more consultants should include a reference to the position of junior hospital doctors.

The Prime Minister, summing up this part of the discussion, invited the Secretary of State to consider further the passage in paragraph 7.18 on the funding of core services, with a view to including some indication of the criteria by which funding would be determined. More generally, the Secretary of State was invited to revise the chapter in the light of discussion.

Chapter 8

In discussion on chapter 8, the following were the main points made:

a. Paragraph 8.4 should make it clear that Family Practitioner Committees will have access to the results of medical audits of GPs. This would have to be built into their contracts.

b. Paragraph 8.5 should if possible give credit to GPs as a profession for the contribution they had made to the introduction of medical audit.

c. The heading 'Competition' before paragraph 8.6 should read 'Patient Choice'. The reference to competition in paragraph 8.6 should be rephrased in terms of better value for money.

d. Paragraph 8.8 was needlessly dismissive of the contribution which some older doctors made to the NHS, and needed substantial modification and revision. The first and second sentences could be omitted, as could the second of the two steps which it was proposed the Government should take.

e. The heading 'Patients as consumers' before paragraph 8.9 should be deleted.

f. The last four lines of paragraph 8.11 should be deleted.

g. On paragraph 8.18 it would be better not to change the name of FPCs to Family Practitioner Authorities.

The Prime Minister, summing up this part of the discussion, invited the Secretary of State to revise the text in the light of the points made. The group also agreed that the White Paper should include an incentive for FPCs to reduce drug bills, by allowing them to plough back 50 per cent of savings into local services.

Chapter 9

The group had already discussed paragraphs 9.8 and 9.9. Summing up discussion of the rest of the chapter, the Prime Minister said that the proposal in paragraph 9.6 to allow local authorities to be consulted by RHAs as part of the normal appointments procedure for DHAs should not be made in the White Paper. The group considered that it should be kept in reserve as a concession to be offered during the passage of legislation.

Chapter 10

Summing up discussion of this chapter, the Prime Minister said that the group were agreed that the White

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Paper should include the proposals agreed earlier for giving tax relief in respect of private health insurance taken out by, or on behalf of, people over the age of 60. The earlier proposals in relation to company health insurance schemes would not however be pursued. The Treasury would monitor the growth of company schemes, in case action was needed at a later date.

SCOTLAND, WALES AND NORTHERN IRELAND

Summing up discussion, the Prime Minister said that there should be separate chapters on each of the territories. The first seven paragraphs of the Scottish chapter were excellent but the Secretary of State would wish to reconsider later passages, in particular in paragraphs 8 to 10 and paragraph 15, in the light of the discussion at the meeting. She was very concerned that the chapter on Wales should give a more positive slant to the introduction of self-governing hospitals and GP practice budgets, for example by introducing a planned timetable; and the rationale for these important developments should be brought in line with the rest of the White Paper. (I have elaborated her concerns more fully in my letter of 3 January). The Prime Minister invited the three Secretaries of State to send revised texts of their chapters to the Secretary of State for Health who would have overall responsibility for preparing a complete new text of the White Paper, reflecting the discussion.

NEXT STEPS

Concluding the meeting, the Prime Minister invited the Secretary of State for Health to circulate the revised text of the White Paper to the group on Thursday, 12 January, for discussion at its meeting on Tuesday, 17 January. Thereafter, the proposals would be considered by E(A) at the meeting arranged for Tuesday, 24 January, and by Cabinet on Thursday, 26 January. The aim would be publication on Tuesday, 31 January.

I am copying this letter to the private secretaries to Ministers on the group, to Sir Robin Butler and to the others present.

PAUL GRAY

Andrew J. McKeon, Esq.,
Department of Health

d. The system for negotiating practice budgets in paragraph 3.12 of HC67 was unacceptable. GP practices would never know what to expect from one year to the next. Moreover, there was a real risk that Regions would adopt different approaches to different GP practices and also that different Regions would follow different approaches (as had happened with nurses' pay); so that there would be no consistency. It was essential that a satisfactory, workable approach should be devised before the White Paper was published, which ensured consistency. A straightforward formula, based on ~~that~~ the formula for allocations to District Health Authorities, might be appropriate. If need be, there might have to be a transitional period, starting with existing patterns but moving gradually to the ~~desired~~ new ~~allocations~~ system.

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impersonal approach: it was for instance more appropriate to talk about patients rather than customers, and about choice and value for money rather than competition and the market.

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c. In paragraph 1.2 it would be more accurate to refer to the NHS as being financed largely out of general taxation.

d. In paragraph 2.4 the last sentence about bringing the NHS up to date should be deleted.

e. Another major theme of the White Paper which needed to be reflected in this opening section was the Government's wish to devolve responsibility. It had to be made clear that Ministers could not be expected to answer for every detail of the running of the NHS on the floor of the House. One central principle behind the Government's proposals was that the more responsibility and accountability could be delegated to people at the point where decisions were taken, the better would be the service which they provided and the more satisfying would be their jobs. Hitherto they had been too much constrained, and there were big differences in their performances. The Government wanted to put this right.

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h. Paragraph 2.14 on waiting times ended lamely and needed to be more positive. In particular, the proposal for appointing more consultants ought to be mentioned. It was also an area which illustrated the patient's interest in good value for money.

i. In paragraph 2.15, the second sentence should be deleted. The paragraph needed to include a reference to making it easier for patients to change their GPs.

j. Whenever figures were quoted in these and subsequent paragraphs they should where possible be for the UK as a whole, and not just for England and Wales. The basis of the figures should always be made clear.

The Prime Minister, summing up this part of the discussion, said the group were agreed that chapters 1 and 2 of the present draft needed to be merged and substantially rewritten to reflect the points made in discussion, taking account of the first seven paragraphs of the Scottish draft and the material circulated by the Chancellor's private office on 4 January. It was essential to bring out the twin themes of, first, devolving responsibility and, second, the money following the patient, which lay behind the proposals for self-governing hospitals and GP practice budgets. Both were designed to lead to greater choice and value for money for patients who, as taxpayers, were providing huge sums for the NHS. These themes had to be developed clearly in language which was not impersonal. The Secretary of State for Health would arrange for this redrafting to be done.

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to be taken, and to arrange for his officials to clear the relevant passages of the White Paper and all consultation documents with the Treasury.

Chapter 3

Summing up discussion of chapter 3, the Prime Minister said that the group had agreed the policy in this chapter subject to revision of the approach on funding in paragraph 3.12. They were content that expenditure on accidents and emergencies should not be included within practice budgets. The proposal in paragraph 3.10 for practices to be able to choose whether or not to include prescribing costs within their budgets had been overtaken by the new proposals for indicative drug budgets and would be amended. On paragraph 3.21 it was important to ensure that the timetable for introducing a substantial number of budgets by April 1991 was consistent with the proposals for Scotland: at present the Scottish text referred to 1992 ~~but should be consistent~~. More generally, the language of the drafting in this chapter could be improved: for instance, paragraph 3.4 was clumsy, and the reference to extending competition in paragraph 3.6 was inappropriate.

Chapter 4

In discussion of chapter 4, the following were the main points made:

a. It was very important to spell out clearly, right at the beginning of the section on the hospital service, that self-governing hospitals would remain within the NHS.

b. On paragraph 4.3 it was wrong to refer to 'pushing down' decision-taking since this implied resistance and an inferior position. The Government ~~intended to~~ would 'delegate' and 'devolve' responsibility.

c. On paragraph 4.5 it should be made clear that people who were non-executive members would all be appointed in their own right and for the contribution which they could make in a personal capacity; and that there would be no representatives from any organisation or special interest group, whether from those listed in the text, ~~or~~ from local authorities or from any other body.

d. On paragraph 4.7, the reference to a hospital 'generating income by selling its services' was inappropriate: 'earning its income from the services it performs' was better. The use of 'buyers' in the second sentence should ~~also~~ be changed.

e. Paragraph 4.7 was ~~also~~ incomplete without some reference to, and explanation of, core funding.

f. The last sentence of paragraph 4.10 conveyed too negative an impression. There should be no possible implication that the Government had ever contemplated an arrangement in which people requiring urgent treatment might be turned away from a hospital.

g. The last sentence of paragraph 4.14, as drafted, might help perpetuate restrictive practices. It would be better if it read: "But subject to their contractual obligations Hospital Trusts will be free either to...."

h. Paragraph 4.17 should refer to the group's decision that self-governing hospitals would bid for an allocation of capital from within the annual financing limit.

i. The point in the last sentence of paragraph 4.20 was important and had to be made. But the drafting could be given a more positive flavour, for instance by explaining that the closure of old hospitals was often an unavoidable part of proposals designed to provide new hospitals and a better service for patients.

j. The first sentence of paragraph 4.22 ~~wrongly~~ gave the impression that Regional Health Authorities would have a directive role in relation to self-governing hospitals. It should be made clear that what was being described was an aspect of core-funding.

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The Prime Minister, summing up this part of the discussion, said that the group had agreed the points made in discussion and invited the Secretary of State to arrange for them to be incorporated in revision of this part of the White Paper.

Chapter 5

In discussion of chapter 5, the group first considered the respective roles and responsibilities of the Secretary of State, the Department of Health, and managers within the NHS, as reflected in paragraph 5.2. Their discussion also covered paragraphs 9.8 and 9.9, about the central management of the NHS. The Prime Minister, summing up this discussion, said that Ministers could not be expected to answer to Parliament for every detail of the running of the NHS. Nor could, or should, the Department of Health be expected to manage the NHS. The whole thrust of the Government's proposals was greater devolution of responsibility, and the implications had to be spelled out in the White Paper. The second sentence of paragraph 9.2 should be

amended by deletion of 'fully' and 'and for the services which they finance'. The third sentence appeared to run contrary to the conclusions of the review. Ministers would have benchmarks for judging performance and would be able to ask the National Audit Commission to investigate particular matters; but neither they nor the Department should be involved in operational management, nor would they direct it. Subject to the normal arrangements for collective responsibility, the Policy Board, chaired by the Secretary of State, would be responsible for strategy on the NHS, its objectives, its finance and the monitoring of the Management Committee. The Management Committee, chaired by the chief executive, would be responsible for all operational matters, within the policy framework laid down by the Secretary of State. The Secretary of State should arrange for this approach to be brought out clearly in the White Paper.

In discussion of the rest of chapter 5, the following were the main points made:

a. The heading to paragraph 5.7 - leaner and fitter regions - should only be used if it were true that there would be a net reduction in the size of RHAs. The group had earlier agreed that there should be.

b. The opening of paragraph 5.19 with its reference to regional information strategies was obscure. It should be shortened to read: "The Government remains committed to introducing modern information systems to support..."

c. Paragraph 5.24 should be included. But 'market' should be deleted from the first sentence. The second sentence should be amended to read: "...national pay spine, to reward individual perforamnce and to take account of market conditions".

The Prime Minister, summing up this part of the discussion, said that the group invited the Secretary of State to revise the chapter in the light of these points.

Chapter 6

In discussion of chapter 6, the following were the main points made:

a. Paragraph 6.7 should make it clear that the results of audits should be available to management, and that there could be joint inquiries, as agreed earlier.

b. It should be possible for consultants to contract to provide the NHS with a smaller proportion of their time than nine-elevenths, say five-elevenths. The point could be met by amending the first sentence of paragraph 6.13 to read "...their use of resources and the extent of their services".

The Prime Minister, summing up this part of the discussion, said that the group accepted the minor modifications of its earlier proposals indicated in the last indent of paragraph 6.20, namely that distinction awards should still be payable, but not pensionable, within three years of a consultant's retirement. The Secretary of State was invited to revise the text to reflect the points made in discussion.

Chapter 7

In discussion on chapter 7, the following were the main points made:

a. The graph should be dropped.

b. The reference to "some two per cent" in paragraph 7.8 should be "three per cent" as agreed earlier.

c. In the penultimate sentence of paragraph 7.13 the reference should be to changes managed "over a transitional period".

d. The first sentence of paragraph 7.16 should be deleted, as should 'where necessary' in the second sentence. Both could be taken to suggest that there had been some doubt about immediate access for those needing urgent treatment.

e. ~~It was argued that~~ The proposals in paragraph 7.18 for core services to be funded on an annually negotiated contract could lead to the perpetuation of existing inefficiencies. There had to be some basis or formula for determining core funding, other than by reference to existing expenditure: the proposals would otherwise work to the disadvantage of good, efficient hospitals. On the other hand, the whole concept of DHAs buying health care involved the concept of shopping around and of negotiating the price at which core services were provided.

d. Paragraph 7.31 on waiting-times should be expanded and strengthened, if possible. Paragraph 7.32 on the appointment of more consultants should include a reference to the position of junior hospital doctors.

The Prime Minister, summing up this part of the discussion, invited the Secretary of State to consider further the passage in paragraph 7.18 on the funding of core services, with a view to including some indication of the criteria by which funding would be determined. More generally, the Secretary of State was invited to revise the chapter in the light of discussion.

Chapter 8

In discussion on chpater 8, the following were the main points made:

a. Paragraph 8.4 should make it clear that Family Practitioner Committees will have access to the results of medical audits of GPs. This would have to be built into their contracts.

b. Paragraph 8.5 should if possible give credit to GPs as a profession for the contribution they had made to the ~~development~~ introduction of medical audit.

c. The heading 'Competition' before paragraph 8.6 should read 'Patient Choice'. The reference to competition in paragraph 8.6 should be rephrased in terms of better value for money.

d. Paragraph 8.8 was needlessly dismissive of the contribution which some older doctors made to the NHS, and needed substantial modification and revision. The first and second sentences could be omitted, as could the second of the two steps which it was proposed the Government should take.

e. The heading 'Patients as consumers' before paragraph 8.9 should be deleted.

f. The last four lines of paragraph 8.11 should be deleted.

g. On paragraph 8.18 it would be better not to change the name of FPCs to Family Practitioner Authorities.

The Prime Minister, summing up this part of the discussion, invited the Secretary of State to revise the text in the light of the points made. The group also agreed that the White Paper should include an incentive for FPCs to reduce drug bills, by allowing them to plough back 50 per cent of savings into local services.

Chapter 9

The group had already discussed paragraphs 9.8 and 9.9. Summing up discussion of the rest of the chapter, the Prime Minister said that the proposal in paragraph 9.6 to allow local authorities to be consulted by RHAs as part of the normal appointments procedure

for DHAs should not be made in the White Paper. The group considered that it should be kept in reserve as a concession to be offered during the passage of legislation.

Chapter 10

Summing up the discussion of this chapter, the Prime Minister said that the group were agreed that the White Paper should include the proposals agreed earlier for giving tax relief in respect of private health insurance taken out by, or on behalf of, people over the age of 60. The earlier proposals in relation to company health insurance schemes would not however be pursued. The Treasury would monitor the growth of company schemes, in case action was needed at a later date.

SCOTLAND, WALES AND NORTHERN IRELAND

Summing up discussion, the Prime Minister said that there should be separate chapters on each of the territories. The first seven paragraphs of the Scottish chapter were excellent but the Secretary of State would wish to reconsider later passages, in particular in paragraphs 8 to 10 and paragraph 15, in the light of the discussion ~~about delegation of responsibilties earlier~~ at the meeting. She was very concerned that the chapter on Wales should give a more positive slant to the introduction of self-governing hospitals and GP practice budgets, for example by introducing a planned timetable; and the rationale for these important developments should be brought in line with the rest of the White Paper. The three Secretaries of State ~~should provide the Secretary of State for Health with~~ revised texts of their ~~contribution, for incorporation in the new version of the White Paper which the latter would now prepare~~ chapters to the Secretary of State for Health who would have overall responsibility for preparing and circulating a complete new text of the White Paper, reflecting the discussion.

(I have elaborated her concerns more fully in my letter of 13 January.)

The Prime Minister invited

NEXT STEPS

Concluding the meeting, the Prime Minister invited the Secretary of State for Health to circulate the revised text of the White Paper to the group on Thursday 12 January, for discussion at ~~the group's~~ its meeting on Tuesday, 17 January. Thereafter, the proposals would be

considered by E(A) at the meeting arranged for Tuesday 24 January, and by Cabinet on Thursday 26 January. The aim would be publication on Tuesday 31 January.

I am copying this letter to the private secretaries to Ministers on the group, to Sir Robin Butler and to the others present.