MT

PART 2

SECRET

CONFIDENTIAL FILING

PRIMARY HEALTH CARE

NATIONAL HEALTH

PART 1: MARCH 1986

PART 2: NOV 1987

Folder containing "Promoting Better Health" White Paper attached.

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~2.11.87~~							
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CLOSED

CCPU

NBLM

PRCO

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IAN GRIST MP

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From The Parliamentary Under-Secretary

CT/5396/88

20 July 1988

Dear John,

at flap

I have seen a copy of your letter of 7 July to John Wakeham covering the draft of the statement on public health in England you have it in mind to make before recess on taking forward the recommendations made in Sir Donald Acheson's report.

Whilst I acknowledge that, as you say, the text is unlikely to prove to be controversial I am slightly concerned that the statement is not as clear as it might be about the application of Sir Donald's recommendations. My officials have previously made the point that the statement ought to be clear that those with responsibilities for health matters in Scotland, Wales and Northern Ireland are separately considering the implications of this Report. I support this view and accordingly recommend the addition of a further sentence at the end of the first paragraph of the statement to the effect:-

> "The extent to which the Report has implications for Scotland, Wales and Northern Ireland is under separate consideration by the responsible territorial Departments".

/I very much

The Rt Hon John Moore MP
Secretary of State for Social Services
DHSS
Richmond House
79 Whitehall
LONDON

NAT HEALTH: Primary Health
Pt 2
1

I very much hope you will understand the reasons for this request and that you will agree to incorporate this additional important sentence in the statement.

Aside from this I am content with what is proposed. I am copying this letter to the the Prime Minister, members of H Committee, John Wakeham and to Robin Butler.

Yours ever,

Ian

001/3294

CPRJ

CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street, SW1P 3AG

The Rt Hon John Moore MP
Secretary of State for Social Services
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1A 2NS

NBPM

RRC 6

19/7

19 July 1988

Dear Secretary of State,

PUBLIC HEALTH IN ENGLAND

You wrote to John Wakeham on 7 July seeking H Committee's agreement to the statement that you propose to make about the implementation of this report.

You explained that any additional costs can be contained within existing DHSS departmental and running costs allocations, and that no major financial implications are envisaged for the other health departments or local authorities. In view of this assurance, I am content for the proposed statement (which I note has been cleared with my officials) to be made.

I am copying this letter to the Prime Minister, John Wakeham, other members of H Committee and Sir Robin Butler.

Yours sincerely,

John Major

pp **JOHN MAJOR**

(Approved by the Chief Secretary and signed in his absence).

RA

Prime Minister

Prime Minister 4
You will want to see David Hart's ideas - which relate fairly closely to a number of the emerging main conclusions.

See attached folder.

REFORMING HEALTH CARE

ARGUMENT

I commissioned MORI to conduct a poll on Health Care in June. Although many people (63 per cent) say that they want the NHS to go on as before and almost as many (58 per cent) think that the public sector can provide a better overall standard of care, polls will always get this kind of result until people are shown a credible alternative.

More important, many people sense that there has to be change. Half of those who think that the NHS provides a good overall standard of care today think that it will not in five years time.

Most important, 45 per cent of those not currently covered by private health insurance say that they would buy such cover if they could afford it. This is a very significant statistic.

Superficially, a centrally funded, State run, health service has attractions, particularly to the Treasury, since it appears to offer control over the amount of public money the nation spends on health care. But public pressure, not the Treasury, is often master of the public purse where health spending is concerned.

PROPOSALS

By now, you will have had an enormous amount of advice on this issue. Broadly there are two sensible ways that a modern State can make sure that the needy get proper health care. By a system of health vouchers supplied to the needy by the State. By a system of compulsory insurance where the State pays the premiums of the needy. In both cases the private sector provides the services and the un-needy pay for themselves.

But to leap from where we are today to either of these systems in one bound would entail enormous dislocation at unacceptable political cost. Instead, we need reforms that provide much more efficiency and choice and make either system possible in the future.

You should aim for a system where it is a matter of public indifference whether services are produced by the public or the private sector.

The following proposals make no attempt to abolish the NHS, nor to undermine the assumptions upon which it was founded. Rather they are intended to honour the founding intentions, to take account of present strengths, to deal with weaknesses and to encourage private medicine to flourish.

REFORMS

Administration

The present administrative structure is cumbersome and wasteful from top to bottom.

1. The DHSS should be split into a new Department of Health and a new Department of Social Security. I believe you have this in mind.

2. The Health Services Supervisory Board and the NHS Management Board should be streamlined where possible and run by the new Department.

3. The Central Health and Miscellaneous Services Board should concern itself primarily with preventive medicine, continue to deal with those matters that the proposed new structure cannot undertake and be run by the new Department.

4. New Local Health Authorities should be created that will combine in one unit the financing functions of District Health Authorities and Family Practitioner Committees. Regional Health Authorities should be abolished and necessary functions transferred to Local Health Authorities or, in some cases, to the new Department of Health.

5. Local Health Authorities should be as small as is practicable. Possibly one for each county.

6. The functions of Local Health Authorities should, broadly, be that of HMOs. But they should not be called HMOs. It is a new and frightening term and will give you an unnecessary amount of explaining to do. Calling them Local Health Authorities would be very acceptable because it would enable you to give the lie to the claims made by your opponents that you are against all things local in general and Local Authorities in particular.

7. Existing management, where suitable, and existing NHS facilities in each area covered by a Local Health Authority would be transferred to them and become their responsibility. There should be no political appointees.

8. Local Health Authorities would be funded by the State, on a variable capacitation basis using similar criteria as the RAWP uses relating to the age, sex, geographical and social conditions and morbidity patterns of the individuals in the Local Health Authority area.

9. Eventually, Local Health Authorities could be funded by the State under a voucher system or by private insurance companies under a Compulsory Health

Insurance Scheme without any great dislocation should the government wish.

10. Local Health Authorities must have peer review arrangements as HMOs do in America.

11. Consultants must be employed by Hospitals not Local Health Authorities.

Timely Treatment

12. Local Health Authorities should have a legal obligation to provide timely treatment. This is difficult but not impossible to define. Its definition should, if possible, be agreed with the professional bodies. Where a Local Health Authority cannot provide timely treatment from its own resources it will have to obtain it from the private sector.

This is the undertaking you will need to give to the public in order to obtain their approval for the other reforms. If you do this it will be very hard for your opponents to make any kind of case against you since this will, in effect, be the most far reaching and substantial reform introduced into the NHS since it began. Quite simply, in due course, it will put an end to waiting lists.

Private Insurance

Since the State cannot spend a much greater proportion of national taxes on the nation's health than it presently does and since, it is clear from polls, including mine, that nearly half of the population want to spend more on their health care, providing they can afford it, individuals must be encouraged to buy private health insurance.

13. Those who buy private health insurance should be given tax credits. As a quid pro quo, they should be obliged to opt out of the NHS. But only for those illnesses for which they can obtain insurance. Thought should be given to the effects of their being permitted to opt in again at say, 24 months, notice.

The Cost/Savings Argument

14. There are arguments that this system will require more public spending but there are many reasons for doubting it.

An increasing number of treatments are currently bought in by the NHS from the private sector and are found to be cheaper. There is therefore a presumption that tax credits equal to private insurance premiums will lead to a net saving.

State Provided Services

15. For the time being, the NHS will have to continue to provide for all accidents, most emergencies, chronic illnesses and much mental illness, i.e. un-insurable illness.

National Treatment Guarantee

16. It will also have to promise a long-stop service for those whose private treatments have not worked, exactly as it does at present. Local Health Authorities should have a legal obligation to offer this service. It should be given a name - National Treatment Guarantee - and be trumpeted.

Privatising Hospitals

17. Existing State owned hospitals should be encouraged to enter the private sector by offers of very generous government loans to staff who want to buy their hospitals. The staff would have to organise themselves into some form of acceptable body be it a Trust, a Charitable Trust or, possibly, certain forms of Corporation. Such Hospitals would have to continue to provide their services to the Local Health Authorities on terms acceptable to both parties and the government.

18. Local Health Authorities should have an obligation to entertain offers from the private sector for any hospital they own providing a substantial majority of the staff, say 60 per cent, were agreeable to being taken over by the offeror and the terms were commercially reasonable. Private Health Companies would ensure this in cases where they really wanted to buy hospitals by offering attractive contracts to the staff.

General Practitioners

19. The present GP service should be left largely as it is. As the private sector expands more GPs will have more private patients. There are many good arguments for introducing a nominal charge for visits to a GP. But if the other reforms here proposed are introduced it would offer an unnecessary opportunity to your opponents.

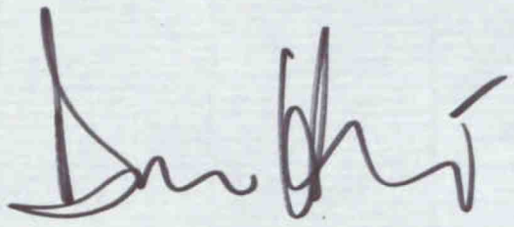
20. Groups of GPs, however, should be allowed to become budget holders for their patients and receive funding directly from the Local Health Authority on the same basis as the Authority receives it. Such groups of GPs would be permitted to purchase treatment for their patients from any source public or private. This would provide a further welcome element of competition and choice.

CONCLUSION

You are perceived as a radical reformer by most of the electorate. They cannot be blamed for this. You have undertaken a radical reform of the economy and everyone can see the results. Your success is servant to your readiness to rethink the comfortable old assumptions and to challenge vested interests, however powerful and deeply imbedded in our national consciousness.

I have spoken to at least two hundred doctors and consultants during the last two months and they all expect substantial reform. More important, they accept that it is needed.

If you cease to be radical now you will confuse your supporters and give comfort to your enemies with a consequent loss of much of your political authority.



David Hart, 12th July 1988

JD

acBG

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

11 July, 1988.

Dear Geoffrey,

PUBLIC HEALTH IN ENGLAND

The Prime Minister has seen your Secretary of State's letter of 7 July to the Lord President. She is content for a statement to be made during the course of the current NHS Review and, subject to the views of colleagues, is content with the terms proposed.

I am sending copies of this letter to the Private Secretaries to the Members of H Committee and to Trevor Woolley (Cabinet Office).

Yours,
Paul

Paul Gray

Geoffrey Podger, Esq.,
Department of Health and Social Security.

SR

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for Social Services

Prime Minister
Content for this announcement to go ahead while the NHS Review is still under way?

The Rt Hon John Wakeham MP
Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1A 2AT

7 July 1988

Dear John.

PUBLIC HEALTH IN ENGLAND

I wrote to Willie Whitelaw last December seeking H Committee colleagues' agreement to the publication of this Report which was duly answered by a written answer on 14 January which promised a further statement on implementation 'in the near future'.

Since publication the Report has been considered by a wide range of affected NHS and professional bodies and my officials have been in touch with colleagues. It is clear there is broad acceptance of the principles of the Report and the time in my view is now right to indicate publicly that the Government endorses and will be taking forward the main recommendations of Sir Donald Acheson's Report. The Report relates to England only. It is of course for territorial colleagues to take whatever parallel action they find appropriate. I know Malcolm Rifkind has already done so.

A draft of a written answer in this sense is attached. I hope to make the announcement before the summer recess. It should not be controversial. There is an advantage in making clear the importance we attach to the development of the public health function as an important instrument in the prevention and control of communicable disease. The problem of responding effectively to the challenge of AIDS almost makes this self evident. The recent outbreak of Legionnaires Disease at the BBC is only another reminder of the continuing importance of effective systems for dealing with outbreaks.

I have considered carefully the financial implications of the Report's recommendations for both programme and Departmental running cost expenditure and remain of the view I took in December that these can be contained within existing allocations. No major implications can be foreseen for local authorities or the other health departments likely to be affected by the implementation of the Report. Within this understanding, Treasury officials endorse the proposed line of action.

I have of course looked also at whether making an announcement of this kind might impinge on the work of the NHS Review. The principles of the Report are likely to continue to be relevant whatever the outcome of the review for the financing and organisation of the NHS. Effective arrangements to secure and improve the public health will continue to be needed and the thrust of the Report towards better and more widely available information about public health matters should encourage individuals to make more informed choices. I see no difficulty therefore in signalling our acceptance of the principles in 'Public Health in England' at this stage.

Copies of this letter go to the Prime Minister, members of H Committee and to Robin Butler.

JOHN MOORE

DRAFT STATEMENT

The Report 'Public Health in England' (Cm 289) was published on 14 January 1988. Its recommendations affect central Government, health and local authorities and other statutory and voluntary bodies.

The Government has accepted the principle the Report advances of a greater commitment to improving the public health. The following steps are being taken at this stage to carry forward the Report's recommendations.

New guidance is being given to health authorities based on the Report's conclusions about their responsibilities to improve the health of the population including the prevention, surveillance and control of communicable disease. This guidance will also ask authorities to arrange for the publication of an annual report on the health of the public to be prepared by their Director of Public Health.

The capacity of the Public Health Laboratory Service and the Communicable Disease Surveillance Centre to provide specialist help to health authorities is being strengthened. My Department is also taking forward the Report's recommendations to review the present system for the notification of communicable diseases and the scope for bringing public health legislation up to date.

Third, a small multidisciplinary unit within the Department of Health and Social Security is being set up to monitor and analyse information about the health of the population and to provide an improved epidemiological input at the centre.

In the longer term the implementation of this strategy will depend on an adequate supply of appropriate trained manpower. The main professional bodies concerned are being asked to consider and act on those of the Report's recommendations which relate to education and training in the public health field.

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CONFIDENTIAL

cc BG

NBM

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Treasury Chambers, Parliament Street, SW1P 3AG

The Rt Hon Tony Newton MP
Minister for Health
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1A 2NS

8th March 1988

Dear Minister,

THE WHITE PAPER "PROMOTING BETTER HEALTH"

Thank you for your letter of 25 February.

I understand your reasons for not wanting to delay discussions with the professions on the Primary Care White Paper proposals. However, I am concerned that embarking upon a consultation exercise at this stage could cause difficulties and involve a potential opportunity cost by ruling out other options which might arise as part of the Health Care Review. Although the Review is particularly focused on the Hospital Service, it could also result in changes to the Family Practitioner Service.

On balance therefore, whilst I would prefer that the consultations did not proceed, I can accept their going ahead provided that it is made quite clear to the professions that any measures consequently implemented follow from the published White Paper and do not preclude the possibility of further changes resulting from the Review.

I am copying this letter to the Prime Minister.

Yours sincerely,

pp JOHN MAJOR

(Approved by the Chief Secretary and signed in his absence)

NAT HEALTH: primary Health care pt 2

JA 1BSC
ccPG

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

8 March 1988

THE WHITE PAPER "PROMOTING BETTER HEALTH"

The Prime Minister has seen your Minister's letter of 25 February to the Chief Secretary.

She is concerned that pressing ahead with the planned discussions with the contractor professions should not preclude the consideration of further options for change which might emerge from the current NHS review. Although she agrees that this review will be placing a special emphasis on the hospital service, there could well be substantial implications for the primary care sector. However, the Prime Minister also recognises the difficulties which would arise if the discussions with the contractor professions were now to be halted until the NHS review is complete. She is therefore content for these discussions to continue, as long as it is made clear at the outset to the professions that this process does not preclude the possibility of further proposals being put forward later in the negotiations as a result of the NHS review.

I am sending a copy of this letter to Jill Rutter in the Chief Secretary's Office.

(PAUL GRAY)

Miss Jenny Harper,
Department of Health and Social Security

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PMMATH

PRIME MINISTER

HANDLING OF FOLLOW-UP DISCUSSIONS ON PRIMARY CARE WHITE PAPER

The attached letter from Tony Newton of 25 February (which has only just arrived in No.10) proposes that the DHSS should press ahead with negotiations with the General Medical Services Council on proposals to last year's Primary Care White Paper. I gather the Chief Secretary continues to have reservations about this and would prefer the discussions to be put on ice, for fear that further talks now could close off possible options arising from the wider NHS review.

To make a judgement on this, I have also obtained the attached detailed negotiating brief the DHSS have prepared for any further meetings.

The present position is that meetings with the GMSC have already been cancelled in January and February. The meeting is now scheduled for 16 March, and DHSS are extremely keen not to cancel it further.

I think the decision whether or not to let such meetings go ahead is finely balanced. The issue turns on what implications might arise from the NHS review for the future role played and remuneration received by GPs. If anything radical were to emerge on this I can see the Chief Secretary's point that the detailed negotiations the DHSS want to embark on could limit freedom of manoeuvre.

Are you content for the DHSS to press ahead as they propose, or would you prefer effectively to put on ice the whole of the follow-up to the Primary Care White Paper?

I should prefer to put it on ice pending the views of other services. The actions of the G.P.s in refusals to [illegible] are crucial to what we want to do on

RRCG.

PAUL GRAY

7 March 1988

ICBG

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Minister for Health

The Rt Hon John Major MP
Chief Secretary
HM Treasury

25 FEB 1988

Dear John.

THE WHITE PAPER "PROMOTING BETTER HEALTH"

In the course of commenting on a paper to be sent to the general practitioners' representative body setting out our detailed intentions for the General Medical Services, your officials questioned whether it was right to proceed with the discussions foreshadowed in the Primary Care White Paper in view of the recently announced NHS Review. I understand that they have accepted the force of the arguments for pressing on but asked that we informed you and the Prime Minister of our intentions.

An important reason for carrying on the discussions with the contractor professions is that to put them on ice would hand a powerful argument to the opponents of the Health and Medicines Bill, now well into Commons Committee, that we should not proceed with the legislation because of the review. Not only does the Bill contain the measures for raising substantial resources for primary care from dental charges and sight testing (and for meeting our PES commitments), but it also goes to the heart of the general practitioner's contract in introducing cash limiting for some payments. To proceed with haste, as we must, with the revenue aspects of the Bill while delaying implementation of the improvements to the family practitioner services announced in the White Paper, would leave us open to major criticism. We would be particularly vulnerable to this in the Lords.

There would also be the presentational difficulties of holding up action on policy proposals that we announced as recently as 25 November last.

We have made it clear that the NHS Review will place a special emphasis on the hospital service. The discussions with the professions on the Family Practitioner Service contracts will take some time; and well before we are in a position to bring them to a conclusion, we should know the outcome of the NHS Review.

E.R.

We are, therefore, confident that in proceeding in this way we are in no way pre-empting future decisions arising from the NHS Review.

I am copying this to the Prime Minister.

Yours ever,
Tony

TONY NEWTON

CONFIDENTIAL

PRIMARY CARE WHITE PAPER: THE GENERAL MEDICAL SERVICES

The Government's Intentions

1. Introduction

1.1 The purpose of this paper is to provide a basis for discussions between the Health Departments and the GMSC on the Government's White Paper "Promoting Better Health" (Cm 249). It sets out in more detail than was possible in the White Paper the Government's views on how its plans for change in the general medical services should be implemented.

1.2 The Government regards chapter 3 of the White Paper as an integrated package of measures aimed at the achievement of specific policy objectives. It follows that while we aim to reach provisional agreement on amendments to the terms of service and on implications for the GP's workload in respect of each of the measures, final decisions on changes to the remuneration system and on the allocation of new resources can only be taken at the end of the consultation process.

1.3 The Government sees the restructuring of the remuneration system and the investment of new resources as important means to achieving higher standards of service to the population served. The Government will be seeking an end result from the discussions which fulfils its aim, as regards the remuneration system, of "improving incentives and introducing greater equity, so that the many family doctors who already work hard to provide comprehensive, patient-oriented services - and who incur substantial expenses - will be appropriately rewarded, while those whose standards fall short will have to improve their performance if they are to maintain the level of remuneration they receive at present" (Cm 249, Ch 3, paragraph 10).

2. The GP's Contract

2.1 Central to any consideration of service provision is the contract with the FPC* to provide services in accordance with the appropriate regulations and terms of service (the NHS (General Medical and Pharmaceutical Services), Regulations 1974). The measures in the White Paper seek to clarify the scope of a doctor's responsibilities towards his patients and to recognise and encourage through the remuneration system specific areas of work which are now increasingly undertaken by the better practices. The Health Departments therefore see considerable advantage in taking the opportunity, in the course of the forthcoming wide-ranging discussions, of clarifying, formalising and strengthening the relationship between the GP and the FPC and of embodying the outcome of those discussions in amendments to the terms of service and the statement of fees and allowances. Annex A contains a list of changes to the terms of service.

2.2 In the light of these changes, the terms of service will set out the core services which, in the Government's view, a GP should perform, list additional optional services and require the GP to provide the FPC with certain details about the delivery of those services and to agree certain provisions with the FPC, for example cover during absences. At present there is no single

*References in the this paper to FPC functions also apply to Health Boards in Scotland.

document which represents the doctor's contract with the FPC. We wish to see amendments to the present application form (FP 16) which will fully reflect the terms of service (as amended) and introduce a new section which sets out the FPC's undertaking to the GP. This two part document would be signed by both parties to the agreement and copies would be retained by both signatories (the GP and the FPC). We envisage that copies would also be made available by the FPC to people joining a doctor's list as a source of information about services he or she provides and to any person on the doctor's list who requests a copy.

2.3 An important feature of the new contractual arrangements would be that FPCs would in certain circumstances (ie where there is potential danger to patients) have the right to suspend a doctor from practice. We would like to discuss with you the circumstances when these rights might apply. These changes will require primary legislation.

3. Abolition or Modification of Outdated Allowances

3.1 Subject to the successful conclusion of discussions, the White Paper envisages considerable new public expenditure on the general medical services. In addition and as part of the discussions on restructuring the remuneration system, we suggest that resources currently deployed on a number of allowances should be redistributed within the system more effectively in ways consistent with the White Paper's aims of supporting and rewarding practitioners who offer a wide range and high standard of services to patients. A number of allowances currently in payment have in our view outlived their usefulness and sizeable sums for redistribution could be released by their abolition or modification.

3.2 A list of the main allowances in question showing current expenditure is at Annex B. For ease of reference a comprehensive list of allowances and expenditure, as submitted by the Health Departments to the DDRB is at Annex C.

4. Basic Practice Allowance (BPA)

4.1 Qualifying criteria for full BPA

Payment of full BPA is meant to reflect a doctor's basic commitment to the general medical services, expressed in terms of patient numbers and hours per week spent in direct services to patients. The Government's intention to tighten the criteria for receipt of full BPA reflects its desire to encourage a greater basic commitment on the part of the GP to work in the general medical services. Details of the new qualifying conditions are for discussion. The Health Departments are currently examining the implications of raising the minimum list size for full BPA from 1,000 to 1,500 patients. We also envisage that a GP should be required to spend on average 20 hours a week in surgery consultations, excluding the time spent on home visits and health promotion sessions (see section 6.4). The 20 hours should normally be spread over 6 days a week and the surgery should be open at times convenient to the patients on the GP's list. FPCs would continue to agree surgery times with GPs but would in future be required to pay particular attention to the implications of any relevant local circumstances to ensure easy accessibility for patients. Where a GP is unable to provide consultations over 6 days the duty to spend 20 hours in surgery could, at the discretion of the FPC, be discharged over 5 days, provided that a satisfactory level of service to patients could be maintained. Any rota system for maintaining 24 hour cover would need to be defined in the GP's contract and approved by the FPC.

4.2 Additional Considerations

We recognise that changes to BPA have far reaching consequences for the remuneration system. We wish to discuss with you implications in the following areas:

i. Partial BPA

We recognise the need for the payment of partial BPA to doctors who do not satisfy the conditions for full BPA. However we envisage a greater differential than operates at present. But see (vi) below.

ii. Supplementary practice allowance

This might usefully be absorbed into a higher BPA (see Annex B).

iii. "Passport" allowances

The level of BPA in payment affects the level of the following allowances: supplementary allowance, seniority allowance, sickness and confinement payments, designated area allowance, group practice allowance and locum allowances. We envisage abolishing a number of these, but will need to examine with you the implications of BPA changes on the level of a GP's income from other allowances.

iv. Partnership agreements

The Health Departments recognise that problems may arise in cases where the status of a partner is in doubt and consequently there is confusion over whether or not BPA and other allowances have been incorrectly paid. We would be glad to discuss with you more satisfactory ways for FPCs of assessing eligibility for BPA, including the possible introduction of a model claim form.

v. Doctors in sparsely populated areas

It is possible that some doctors in rural and other sparsely populated areas might be unfairly disadvantaged as a result of the BPA changes and the Health Departments are prepared to consider the need for special arrangements. The Health Departments are considering the evidence, including the workload survey report (see also paragraph 7.2).

vi. Part-time work/Job-sharing

The Health Departments recognise that some GPs have commitments which mean that they are unable to undertake full-time work in the general medical services. We wish therefore, to discuss in particular with you the implications of the BPA changes for doctors (particularly women doctors) who may wish to combine work in general practice with family responsibilities for part of their careers. Chapter 3, paragraph 44 of the White Paper expresses the Government's concern that women should be encouraged to enter and remain in general practice particularly in areas where there is a high proportion of women from ethnic minorities who are reluctant to consult male doctors. We are working up alternative schemes but would be glad of your views on how this might be achieved.

Capitation Fees

5.1 White Paper Proposals

The White Paper places considerable emphasis on encouraging doctors to provide a high standard of care delivered in ways which are sensitive to the needs of their patients. The Government believes that an important way of achieving this is by stimulating competition between doctors through an increase in capitation fees. Chapter 3, paragraph 9 of the White Paper makes clear the Government's intention to increase on average the proportion of a GP's income which is derived from capitation fees from 47 per cent to at least 50 per cent in the first instance. Paragraph 9 also indicates that the Government views capitation fees as remuneration in respect of "a basic core of health provision" to individual patients. We wish to clarify with you the elements which make up this core service and to reflect our conclusions specifically in the new GP's contract (see Annex A). Our view is that it should reflect the requirement for a doctor to take 24-hour responsibility for the care of his or her patients (including making home visits) and the duty to carry out appropriate health promotion and prevention of ill-health activities including both opportunistic and routine assessments. Further specific requirements in respect of particular age groups, for example elderly people (see paragraph 5.2(i) below) are also for inclusion in the contract subject to discussion. It follows, in our view, that supplementary capitation fees should be abolished and the resources released from this incorporated into a higher standard capitation fee. GPs would in essence be required to undertake the "out of hours" cover currently rewarded by the supplementary capitation fee.

5.2 Restructuring Capitation Fees

In this context we would be interested to discuss with you a number of changes in the structure of capitation fees themselves which would link the level of fees paid more closely to the workload involved in caring for certain categories of patient, as set out below.

i. Elderly people

While we would retain a differential fee for patients over 65 we wish to raise the level of the capitation fee for patients aged over 75. This would reflect not only the high routine workload in respect of very elderly patients but would also recognise the commitment which the Government has indicated it expects from GPs to ensuring that such elderly people are given comprehensive regular care (including in nursing homes). We wish to discuss with you what constitutes an appropriate level of care for such elderly people over and above that provided in response to specific ailments. In the Health Departments'view this would include regular assessment of the general physical (including dental) health of any patient over 75 with particular attention to mobility, the condition of the patient's feet and the effectiveness of the senses (including eye sight). We would also expect the GP and the practice team to form a general impression of the mental health of patients and to note any obvious medical or social problem which might need referring to the appropriate agency (including local authority social services and voluntary agencies). Regular contact in the patient's home might also usefully be specified. Confirmation that all these services have been provided for the over 75s would be required in the annual report (see paragraph 10.4).

ii. Women patients

Also for consideration is the introduction of a differential capitation fee for women between the ages of 10-64. This should, in the Health Departments' view, take the form of a higher capitation fee which would be paid to doctors in acknowledgement of the greater demands placed on them by women in this age band, and of the extra workload involved in offering services such as maternity medical services, contraceptive advice and cervical cytology. The new capitation fee would replace existing payments for these services. Doctors not wishing to supply these services to women patients would receive the lower "men's" capitation fee. We shall need to discuss the position of doctors who on conscience grounds do not give contraceptive advice.

6. Incentive Payments

In addition to proposing a restructuring of the core remuneration represented by BPA and capitation payments the White Paper also sets out the Government's intention to introduce a number of new incentive payments. They are intended both to recognise specifically the work increasingly done by the many GPs who, for example, run health promotion clinics or perform minor surgical operations and to encourage a greater involvement of GPs in these activities.

New payments are intended in the following areas:

6.1 Registration Fee (Chapter 3, paragraph 15)

When a patient joins a doctor's list immediate responsibility for the 24 hour a day care of that patient falls on the doctor concerned. In the majority of cases the GP is able to refer to the patient's medical record once it is available for details of the medical history and state of general health. In cases where no record is available, either because the patient has never been registered with the NHS or because the record has been destroyed as a consequence of the patient's prolonged absence from UK (currently after 3 years), we believe that an initial clinical assessment of the patient's state of health should be made by the doctor. Payment for the assessment would be on an "item of service" basis for qualifying patients other than the new-born. It would not be paid in respect of temporary residents. The elements involved are for discussion but we believe that they should include taking a medical history and details of lifestyle (smoking, alcohol consumption and exercise), checking height, weight and blood pressure and testing a urine sample. These tasks could, at the GP's discretion, be delegated to trained members of the practice team. Before undertaking any initial assessment for which he or she intends to claim the registration fee, the GP will need to satisfy him or herself that the new patient is not already registered with an NHS doctor. The Health Departments are prepared to issue guidance on this area.

6.2 Targets for Vaccination, Immunisation and Cervical Cytology

i. Setting targets

In proposing a system of "bonus" payments for these activities the Government's primary concern is the achievement of maximum cover in vaccination and immunisation of the under 5 population and in cervical cytology of women, between the ages of 20-64, and to reward doctors who have already achieved a high level of cover. The Health

Departments acknowledge that a number of factors may influence a GP's ability to achieve a high level of cover, including the level of activity of the community services in the area and the degree of parental and patient motivation. Any system of targets devised should, we believe, recognise these factors as far as possible. Nonetheless, while equitable treatment of doctors in different areas is important we believe that if a targets system is to work in practical terms it is essential that it should be simple to understand and administer.

Details of how targets should be set are for consideration, but current work in the Health Departments is concentrating on devising a formula which recognises substantial effort on the part of the GP towards reaching and actually achieving a target set for joint achievement by the GP and the Community Health Service. In setting targets full acount would have to be taken of the fact that the Government has accepted as desirable the WHO target of 90 per cent cover by 1990 in respect of the main childhood immunisations. Payments not merely for the achievement or maintenance of an ultimate target but also for significant percentage increases in cover - "steps" towards the target - might be made. Some national guidance to DHAs, FPCs and GPs will be necessary on local interpretation.

ii. Claims mechanism

We would expect records of coverage to be incorporated by the GP in the Annual Report for submission to the FPC, which would treat this section of the Report as a claim for payment of the bonus where appropriate (see section 10.4 below).

iii. Item of service payments

It is for consideration whether all or part of the funds currently deployed in item of service fees for vaccination, immunisation and cervical cytology might be incorporated into target payments. In the case of cervical cytology at least, the Health Departments would view this as a logical consequence of differential capitation fees for men and women (see section 5 above). The item of service payment for cytology would be abolished and payment for the work made through the higher capitation fee for women and through target payments.

6.3 Child Health Surveillance (Chapter 3, paragraphs 19-21)

The White Paper proposes a new allowance payable to appropriately trained doctors who undertake child health surveillance in respect of the under 5s. The British Paediatric Association joint working party's report on child health surveillance on which the GMSC is represented and other studies being carried out in this field will we hope prove helpful in drawing up a protocol. We shall want to discuss with you ways of determining what training might be required by doctors willing to perform this work. We hope that sufficient evidence will be emerging later this year to enable us to put firm proposals to you in the autumn.

6.4 Disease Prevention/Health Promotion

The Health Departments wish to explore ways in which doctors who take active steps to prevent disease and promote good health can be appropriately

remunerated. A range of interventions is possible. Examples might include operating health promotion clinics (eg for diabetc patients and hypertension), allocating additional time during ordinary consultation for preventive work, running structured assessment programmes, collaborating with district authority health promotional programmes and monitoring the practice team's prevention work through computerised record systems. We would want also to be sure that these services were accessible and relevant across the various ethnic groups in any GP's practice area.

6.5 Minor Surgery (Chapter 3, paragraph 63)

The Health Departments would like to discuss the payment of a sessional fee to suitably qualified/trained GPs who undertake minor surgical operations. We would be glad to draw up with you a list of appropriate operations, and to discuss arrangements for training for doctors wishing to undertake such work. The list of operations might include excision of sebaceous cysts, lipoma excision, removal of skin lesions for histology, some forms of aspiration, foreign body removal and cauterisation of warts and verrucae. We do not expect GPs to perform surgery which requires the use of a general anaesthetic. GPs who have become Fellows of the Royal College of Surgeons in the last five years would be exempted from the requirement to undertake training initially but all GPs would be expected to attend regular refresher courses in minor surgery if they wish to provide this service.

7. Improved Service Provision

A number of measures in the White Paper are seen by the Government as contributing significantly, if in a less direct way than the changes to the remuneration system set out in sections 4-6 above, to improved service provision to patients. They include measures broadly relating to the distribution of doctors (particularly with reference to deprived or sparsely populated areas), to practice team development and premises improvements and to education and training.

7.1 Deprived Areas Allowance

Chapter 3, paragraph 37 of the White Paper refers to the Government's intention to discuss with the MPC how more account can be taken of local information about medical and social needs in determining the distribution of doctors. The Health Departments are currently developing criteria for defining "deprivation" in order to arrive at a formula which pin-points areas of "deprivation". GPs covering such areas would qualify for the deprived areas allowance.

7.2 Rural Areas

The Health Departments are considering whether corresponding arrangements would be applicable in sparsely populated rural areas if it is evident that similar deprivation exists. Our doubts about the existing system of rural practice payments are recorded in Annex B.

7.3 Practice Team Development

The primary objective of the Government's plans for practice team development as set out in the White Paper is to raise the quality of care for patients where most needed. Subject to the passage of the Health and Medicines Bill, funds will be allocated before the beginning of each financial year to FPCs

which, in collaboration with DHAs, will be required to devise locally agreed strategies for developing practice teams. Such strategies would take account of the provision available under the community health services and in particular from community nurses. The funds allocated to FPCs will be adequate both to cover the current costs of direct reimbursement for ancillary staff which FPCs will continue to meet, and to allow for practice team development. Restrictions on the numbers and type of staff in respect of whom GPs qualify for direct reimbursement of employment expenses will be lifted. Staff employed in direct patient care will however be required to have appropriate qualifications. Under the new arrangements FPCs will have discretion to vary the percentage reimbursement which they provide in respect of team members according to their own priorities. Guidelines about the arrangements and procedures will be issued by the Health Departments. GPs might use their Annual Reports to notify FPCs of any changes planned in the practice team and to apply for direct reimbursement.

7.4 Education and Training

i Postgraduate Education Allowance

The White Paper acknowledges that the current postgraduate training allowance is of limited value in supporting GPs and encouraging them to undertake further training. A new allowance is proposed which would be paid each year to doctors who maintain a regular programme of education and training. Initial qualification for the allowance would be through completion of two courses per year over a five year period; thereafter a rolling five-year qualification period would operate to encourage GPs to keep up to date. In recognition of the special problems which single-handed doctors in rural areas face in undertaking regular postgraduate training we also propose to extend the existing locum arrangements (which apply in respect of prolonged study leave) to cover doctors in such areas. We would be glad to discuss with you details of the new arrangements and of the content of courses to be approved by the Government for the purpose of this allowance.

The White Paper makes clear the Government's intention to abolish both the current postgraduate training allowance and the vocational training allowance. The resources freed from this step will be available for redistribution. We propose that doctors currently in receipt of postgraduate training allowance would automatically qualify for the new education allowance in the first instance although they would have to satisfy the qualifying conditions for continued receipt of the new payment.

We believe that some means should be found of informing consumers that a doctor is in receipt of the new Postgraduate Education Allowance. The Practice Leaflet might be a suitable means.

ii. Training of Practice Team Staff

The White Paper makes clear the Government's intention to extend the existing arrangements for the direct reimbursement of training costs to cover all professional staff who are members of the practice team. Part of the funds allocated to FPCs for practice team development will be used for this purpose, and FPCs will again be given sufficient flexibility to target the available resources in areas

where training would be of most value. We would expect them to pay particular attention to the training needs of practice nurses. Guidelines on the management of the training budget will be issued to FPCs.

iii. Academic Departments of General Practice

A number of options for strengthening support for GPs who are involved in the clinical training of under-graduates are under consideration in the Health Departments.

7.5 Premises

i. Cash limits

The White Paper makes clear the Government's desire to continue to encourage improvements in the standard of practice premises. As for practice team development (section 7.3 above), cash-limited funds will be made available to FPCs which, in the light of guidance to be issued by the Health Departments, will be expected to target assistance where it is most needed within their areas. Details of the mechanism for allocating funds to FPCs and the operation of the cash-limiting system are being developed for discussion with the profession's representatives and FPC interests.

ii. Other considerations

The White Paper makes clear that the Government intends to examine the scope for introducing regional variations in cost limits for the cost rent scheme to take account of higher building costs in some parts of the country (Chapter 3 paragraph 51) and to review its minimum standards for premises (paragraph 52). We intend to cover both these areas in our discussions on premises.

7.6 Hospital Referrals

New arrangements to encourage good practice in referring patients to hospital are proposed in Chapter 3, paragraph 62 of the White Paper. The Health Departments hope that initial feed-back from the study currently being conducted in East Anglia on this aspect of general practice will inform discussions with you on the implementation of this measure.

7.7 Computers

The help that computers can provide in running an effective practice was acknowledged in the White Paper. The changes set out in this paper highlight the importance of maintaining full records for annual report purposes, for call and recall facilities and to enable family doctors to apply for prevention target payments. The Health Departments are making proposals to the profession on a core specification for computer systems in general practice. The onus is on individual doctors to decide for themselves whether or not to invest in computers for these and other purposes. The Health Departments will be glad to see an increased use of computers to further the aims of the White Paper.

8. Retirement

8.1 Compulsory Retirement

The Government's intention to introduce compulsory retirement for GPs at age 70 is made clear in the White Paper. Powers to do this are currently being sought through the Health and Medicines Bill. There is scope for discussion on the detail of administrative aspects of this development. FPCs will need to consider the effect which the introduction of compulsory retirement for elderly doctors will have on service provision in their areas and will need to develop succession planning.

8.2 Abolition of "no abatement" aspects of "24 hour retirement"

The Government intends to abolish the arrangement whereby a GP may currently retire at age 65 or over and, on resumption of employment, may receive full pay and unabated pension. There is no intention to alter the arrangements applying for doctors in the 60-64 age group who take "24 hour retirement" and are subject to abatement of pension; these arrangements will in future apply for the 65-69 age group. Subject to the passage of the Bill, information will be issued by circular to FPCs and GPs.

8.3 Transitional Arrangements

We would be glad to discuss with you an appropriate timescale for introducing the two changes in (8.1) and (8.2) above. The Government recognises that many elderly practioners will need time to adjust their retirement plans in the light of the new measures and is prepared to allow for a suitable transitional period before they come into operation.

9. Procedures for dealing with doctors whose competence is questioned

The Government's decision to review the operation and effectiveness of the procedures followed by FPCs in cases where a GP's competence is in question is at Chapter 3, paragraph 43 of the White Paper. The Government's primary concern is the need adequately to protect patients who may be at risk during the often lengthy procedures currently undertaken. Changes leading to suspension as described in paragraph 2.3 will help. The Health Departments will be considering whether any other steps are necessary.

10. Measures of direct benefit to the Consumer

The Government's desire to improve the standard of services to patients and to make GPs in general more sensitive to patients' needs and wishes is central to many of the changes already discussed in this paper. A major theme of the White Paper is the need to provide better information to consumers about services offered by GPs in their area, to increase choice and to ensure that consumers' views are taken into account in any changes. This information needs to be available also in the languages of any substantial minority groups in the area. The following steps are envisaged:

10.1 Improved Information to Patients

i. FPC lists

We intend to include details of qualifications (including date of qualifying) and sex. The inclusion of other information is for consideration.

ii. Practice leaflets

As a source of information practice leaflets are widely supported. We would like to discuss what constitutes "good practice" in this area, in terms of the content of leaflets, and how practices might be encouraged to produce this type of information for patients. A check list of those elements which the Health Departments feel are important is at Annex D. We would also like to discuss how the availability of leaflets to the public might be improved. It is essential that each patient should have access to detailed information about the services provided by the patient's doctor and by other members of a practice and there is a good case for making practice leaflets a requirement.

iii. Advertising

The Government wishes to see a relaxation of restraints on the extent to which GPs may make available factual information about their practices and the services they provide. The Office of Fair Trading is currently discussing this question with the General Medical Council.

iv. Meeting with patients

Some practices encourage contact with patients through patient participation groups. We would like to explore with you how such arrangements can be extended to practices not currently offering this facility.

10.2 Simplifying procedures for changing doctor

The White Paper makes clear the Government's intention to amend regulations to enable patients to register with a new doctor without first approaching their FPC or existing doctor. Details are being worked up. The main areas to be covered in discussion are:

i. rights of patient and GP;

ii. arrangements for transferring records;

iii. arrangements for payment of capitation fees;

10.3 Complaints

The measures set out in Chapter 8 of the White Paper are expressed in sufficient detail to form a basis for discussions.

10.4 Annual Reports

The provision of Annual Reports will in the Government's view encourage a sense of self assessment and of accountability among GPs and will allow FPCs more effectively to monitor and improve the standard of general medical services in their areas. The Health Departments attach considerable importance to the proposal that GPs should be required to submit Annual Reports, on an individual basis, to FPCs on matters covered by their terms of service. In the interests of simplicity a standard format requiring mainly statistical information would be adopted, although doctors who wished to provide additional information, for example on service provision aspects of their

practices, would be encouraged to do so. It is for consideration what information from the contract should be included. We are aware that many practices already draw up full reports on their activities over the year.

In due course we will need to discuss arrangements for handling reports, including the possibility of a computer input format, with FPCs. As already indicated above (section 6.2 (ii)) we envisage that the Annual Report should be treated as an application for payment in respect of certain aspects of a doctor's work (eg target bonuses). It might also prove useful to FPCs in respect of their forward planning on premises and practice teams (see sections 7.3 and 7.5 above). FPCs should make annual reports available on request to interested organisations (eg CHCs) and to members of the public.

Suggested headings for a standard Annual Report are attached (Annex E).

10.5 Consumer Surveys

To complement the Annual Report and to ensure that the consumers' views are fully understood by the FPC we intend to require FPCs to undertake regular surveys to establish the level of satisfaction among consumers with the organisation and delivery of services provided by individual doctors. Clinical matters would not be covered. A standard questionnaire will be developed which patients will be asked to complete on an anonymous basis. Doctors will be fully informed of the outcome of surveys by the FPC and may be invited to discuss possible improvements to their practices. The Department believes that this should provide a useful means for GPs,as well as for FPCs, to assess and act on the views of patients on the services they provide. We will be glad to discuss details with you.

ANNEX A

Proposed changes to the Regulations including Terms of Service

(Some of this is already covered by the existing terms of service but is included for the sake of completeness. There are other existing provision not listed here that we would want to remain in force.)

i. Applications for inclusion on FPC lists to include the following:

name, address, phone number, sex, date of birth, qualifications (including date obtained), Medical Register (date), other professional commitments, other FPC contracts, address and telephone number of practice premises, previous appointment, partnerships arrangements, details of cover when not available (to be agreed with FPC).

ii. Terms of service to lay down an undertaking on the part of the practitioner:

a. to provide 24 hour service, 20 hours in surgery over 6 days and convenient to patients, home visits, health promotion, prevention of ill-health (including injury), opportunistic screening, regular assessment of elderly patients, disabled patients and other vulnerable groups, check-ups for rarely seen patients, premises to acceptable standards, annual reports, training for staff, notice to patients of changes in practice arrangements, production of practice leaflet;

b. to employ properly qualified staff where those staff are directly involved in patient care;

c. to provide cover when not available;

d. to live within reasonable distance of surgery (to be agreed with FPC);

e. to give notice of termination of contract three months or other period to be agreed with FPC);

f. to advise patients on sources of assistance available from other agencies (including voluntary agencies).

iii. Optional provision (subject to qualification where appropriate):

to provide child health surveillance, full service for women patients (ie maternity, cytology and contraceptive advice), minor surgery.

iv. Regulations to give FPCs the power/duty:

a. to pay in accordance with SFA and to apply appropriate superannuation arrangements;

b. to suspend a GP's right to practice under the NHS in defined circumstances.

ANNEX B

ABOLITION OR MODIFICATION OF OUTDATED ALLOWANCES

A list of the allowances under consideration in the Health Departments with brief comments on our reasons for suggesting abolition or modification is below. The 1986/87 expenditure on each item is listed in Column 3.

ALLOWANCE	COMMENTS	1986/87 EXPENDITURE £ million (GB)
Group Practice Allowance	Group practice is now an established feature of modern practice and the many benefits it brings both to doctors and patients are widely recognised. A strong financial incentive for doctors to practise in groups is in our view no longer necessary.	28.780
Seniority Allowances	A system of allowances based on the completion of a number of years in practice, irrespective of the standard of care provided, is inconsistent both with the White Paper aims and with the independent contractor status of the GP.	59.882
Vocational Training Allowance and Postgraduate Training Allowance	The Government's intention to abolish both these allowances is set out in Chapter 3, paragraph 48 of the White Paper. The Vocational Training Allowance is now redundant as vocational training is mandatory for all principals in general practice. The short period during which GPs qualify for the Postgraduate Training Allowance makes it of limited value. The introduction of the new Postgraduate Education Allowance will replace both allowances.	12.189 1.049

Supplementary practice allowance and Supplementary capitation fees	In view of the GP's responsibility for providing treatment to patients 24 hours a day and of the Government's aim of increasing the basic commitment of GPs to work in the general medical services the continuation of special payments for "out of hours" services is not, in our view, appropriate. Subject to the outcome of negotiations, the resources released by abolition of these two allowances might be incorporated in the standard basic practice allowance and capitation fees.	41.628 42.101
Initial Practice Allowance	The current allowance is complex and claimed by very few GPs.	0.215
Rural Practice Payments	The current system of payments is based on complex and out of date criteria. We believe the case for continued payments under this scheme should be re-established; if it is not, the scheme should be abolished.	14.858
Item of Service Fees for Cervical Cytology	We propose to review these payments in the context of our discussions over higher capitation fees for women patients (section 5.2(ii))	6.241
Fee for Contraceptive Services		31.322
Maternity Medical Services Fees		50.617
Dispensing payments to non-dispensing GPs (Personal administration elements)	It is for consideration whether payments made under paragraph 44.5 of the SFA in respect of materials (such as anaesthetics, injections etc) supplied and personally administered by GPs should be continued.	9.459 (1)
		Total 298.341

(1) England and Wales

ANNEX C

TABLE GMP 7

General Medical Practitioners: Expenditure by Family Practitioner Committees Great Britain

TYPE OF PAYMENT (a)	(1) 1985/86 EXPENDITURE (b) £ millions	(1) 1986/87 EXPENDITURE (c) £ millions	(2) 1987/88 EXPENDITURE (d) £ millions
1. Basic Practice Allowance	199.568	210.724	231.267
2. Additions for:			
(a) Designated area Type 1	0.576	0.364	0.213
" " " Type 2	0.023		
(b) Group practice	27.190	28.780	31.725
(c) Seniority	58.312	59.882	64.027
(d) Vocational training	10.868	12.189	14.651
(e) Employment of assistant	0.327	0.361	0.536
3. Standard capitation fees:			
Under 65	334.036	345.510	379.127
65 - 74	43.896	46.038	49.624
75 and over	40.865	43.080	47.082
4. Payment for out of hours responsibilities:			
(a) Supp.practice allowance	39.591	41.628	46.757
(b) Supp.capitation fees	40.844	42.101	43.570
(c) Night visit fees	15.331	15.440	16.570
5. Item of service fees for reasons of public policy:			
(a) Vaccinations & immunisations	19.449	21.522	26.548
(b) Cervical cytology tests	6.238	6.241	7.909
6. Contraceptive services fees	30.319	31.322	33.992
7. Maternity medical services fees	48.386	50.617	55.098
8. Temporary resident fees:			
up to 15 days	6.056	6.247	6.395
over 15 days	5.612	6.099	6.112
9. Emergency treatment fees	1.098	1.220	1.394
10. Anaesthetics fees	0.050	0.035	0.031
11. Arrest of dental haemorrhage fees	0.008	0.009	0.034
12. Postgraduate training allowance	0.884	1.049	1.296
13. Trainee practitioner scheme payments	44.546	47.523	50.694
14. Initial practice allowance	0.325	0.215	0.247
15. Rural practice payments	14.247	14.958	15.841
16. Dispensing payments	129.024	146.326	162.152
17. Inducement payments	1.355	1.072	1.169
18. Doctors' retainer scheme payments	0.442	0.546	0.645
19. Payments during sickness/confinement	1.726	1.979	2.341
20. Prolonged study leave payment	0.300	0.260	0.269
21. (a) Practice accommodation	79.338	91.190	101.417
(b) Ancillary staff	155.236	167.728	191.173
TOTAL £M	1,356.066	1,442.155	1,590.906

PRACTICE LEAFLETS

Practice leaflets should set out for the public useful information about the doctors, the services they provide and the organisation of the practice.

AIMS

To provide a profile of the practice (including practice team).
To indicate the activities of the practice team.
To list the times of the activities.
To provide additional information of other local facilities and services which affect the practice.

CONTENTS

Full names, qualifications and dates of qualification of the doctors.
Full names and qualifications of all practice team members.
Duties of the team members.
Surgery and clinic times.
Information on how to make an appointment if applicable.
Arrangements for home visits.
Arrangements for emergency calls.
Arrangements for off duty cover.
Arrangements for cover at weekends and holiday times.
Arrangements for repeat prescriptions.
Dispensing arrangements if applicable.
Details of particular services eg health promotion and education.
Patient participation activities.
Local information eg public transport times.
Subject to appropriate safeguards other information which the practice would consider useful for patients.
Entitlement to postgraduate education allowance.

Annual Report

Possible Headings:

Profile of Practice

Location
Personnel
Accommodation
List size (analysed by age and sex)

Services to Patients (narrative and statistics, current year and previous year in terms of home visits, consultations, numbers of V & Is etc)

Surgery hours
Health promotion
Disease prevention
Child health
Maternity
Family Planning
Elderly
Minor Surgery
Other (eg diabetic care)

Significant Developments

New staff
New services
New accommodation
New equipment

State of Health analysed

	This year	Last year
Smokers		
Blood pressure		
Cholesterol		
Weight		
[Others ?]		

Practice Prescribing Policy

Repeat prescribing monitoring
Practice formulary
Policy for particular therapeutic groups
Generic prescribing

Prescribing Information

- Costs
- Number of items
- Others

Hospital Referrals

	This year	Last year
Specialities		

Education

Courses attended (all personnel)

State of Health improved [including data for target payments]

	This year	Last year
V & I (detailed)		
Cytology		
Smoking		
Blood pressure		
Others		

Comments on the past year

Objectives for following year
(including plans for practice team development)

DRN

CONFIDENTIAL until 4.00 pm on 25.11.87 cc PS

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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From the Secretary of State for Social Services

Mike Eland Esq
Private Secretary to
The Rt Hon Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1A 2AT

25 November 1987

Dear Mike,

You will remember that the final draft of the White Paper "Promoting Better Health" went to Cabinet earlier this month. Mr Tony Newton, the Minister for Health, will be announcing its publication, together with that of the Health and Medicines Bill, in the House this afternoon and thought you would wish to see a copy. I- folder

Copies of this letter and of the White Paper go to Private Secretaries to the Prime Minister, members of H Committee, to members of Cabinet who are not members of H Committee, and to Sir Robert Armstrong.

Yours sincerely,

Geoffrey Podger

G J F Podger
Private Secretary

CONFIDENTIAL

Primary Health Care

3.30 pm

The Minister for Health (Mr. Tony Newton): With permission, Mr. Speaker, I will make a statement about the Government's plans for improving the primary health care services. Those plans are set out in the White Paper entitled "Promoting Better Health" which has been published today. Copies are available from the Vote Office.

The primary care services — those provided outside hospitals by family doctors, dentists, pharmacists, opticians, community nurses and others — account for nine tenths of all patient contacts with the National Health Service. They cost over £5,000 million a year.

In 1986 the Government set out their proposals for improving primary care. They attracted over 2,000 written comments and were the subject of public consultation meetings chaired by Ministers in different parts of the country. We are grateful to all those who commented, and to the Social Services Committee of this House for its constructive report published earlier this year. The White Paper includes a detailed response to that report.

The consultations showed a wide measure of support for the Government proposals, in particular for placing the promotion of better health at the centre of the stage. The White Paper shows clearly the amount of preventable disease in this country, and it contains many proposals for tackling this problem. Those include the setting of targets for family doctors to achieve higher levels of vaccination, immunisation and cervical cytology screening; more health promotion sessions in general practice; a greater role in health education for pharmacists; regular health checks for particular groups, such as the under-fives and elderly people; a new contract for dentists which will encourage prevention; an extension of the primary care team to include chiropodists, physiotherapists and others and action to see that the skills of community nurses are better used, in connection with which we are issuing today a circular to English health authorities advising on the steps to be taken following the Cumberlege report on community nursing.

To achieve those aims we shall be making general practitioners' contracts more sensitive to actual performance and will look to family practitioner committees to monitor more vigorously the contracts they have with family doctors. The White Paper also emphasises the needs of the consumer of primary care services. In particular, it sets out ways of giving people much more information with which to choose their practitioner and of making it easier for people to change doctor. It also provides improvements in complaints procedures.

The various measures that the White Paper sets out — which include also compulsory retirement for the older doctors and dentists and more effective improvement of primary care premises — will affect all parts of the country. We expect them to bring particular benefits to inner cities and other deprived areas. In addition, the White Paper sets out the Government's intentions for improvements specific to such areas, for example by paying particular attention to their dental, pharmaceutical and community nursing services.

All primary care professionals have a part to play in the improvements we seek, and the White Paper describes our intentions for each part of the service. The Government have already made provision for a large increase in expenditure on the family practitioner services, and are prepared to invest substantially more on top of that. In many cases, the actual amount will depend on the outcome of the negotiations that will now take place with each of the practitioner professions. The White Paper makes clear our intention to proceed quickly with the introduction of blood glucose testing strips for diabetics, which I believe will be widely welcomed in the House.

Expenditure on family practitioner services has already risen by £1·5 billion, or 43 per cent. in real terms, since 1978-79. That is reflected, for example, in the increase of nearly 4,000 to over 30,000 in the number of general practitioners, and a consequent fall from over 2,200 to fewer than 2,000 in the average number of patients on each doctor's list. To achieve the strategic development set out in the White Paper will mean giving still greater priority to these services as a whole, and we have therefore thought it right also to look carefully at priorities within them. We have concluded that it is reasonable to secure some additional resources for development by asking those who can afford it to pay for sight tests and to meet somewhat more of the overall cost of dental care, through a system of proportional charges extending also to examination costs, for which at present no charge is made. The proportional charge system will be simpler, and will relate patient charges more directly to the costs of the particular treatment. It will benefit regular attenders who look after their teeth, some of whom will have no increase or may even pay a little less. Current exemptions from dental charges will, of course, continue for children, adults on low income, expectant and nursing mothers and certain other groups. NHS sight tests will remain free for children, those on low income, the blind and partially sighted and other specified categories.

Existing plans already provide for additional expenditure by 1990-91 of some £570 million in real terms. That will be further increased by the substantial extra resources that the Government will make available to finance the improvements that I have described today. Towards the additional expenditure as a whole, the extra payments which people will make towards dental care and sight testing will contribute some £170 million by 1990-91.

The necessary legislative provisions, together with other health measures, are contained in a Bill which will also be published today. The proposals in the White Paper and the Bill will generally apply throughout the United Kingdom, but my right hon. Friends the Secretaries of State for Wales and for Northern Ireland, and my right hon. and learned Friend the Secretary of State for Scotland, will be considering the ways in which certain of our proposals will require to be adapted to the particular circumstances of those countries.

Our proposals will enable people to make more informed choices of practitioner, will give them access to higher quality services and, above all, will place the greatest emphasis on preventing illness and promoting positive good health. I believe that it is a strategy that will be widely welcomed and supported.

Mr. Robin Cook (Livingston): The Minister praised the constructive report of the Select Committee. I would find his flattery more sincere if in the past half hour I had been able to find a single case in which he accepted a single recommendation from the Select Committee in which it differed from the consultative document.

Why, in particular, has the Minister rejected the unanimous recommendation that he re-examine the integration of the family practitioner committees that run the GPs with the district health authorities that supply the community nurses with whom they are supposed to work? What is the point of expressing pious hopes that health professionals will work together as a team, when he has decided to keep the administrators playing in two separate teams? If he seriously expects family practitioner committees to monitor "more vigorously" the quality of primary care, why is his Department choosing this year to cut their administrative budgets, and why have the committees been told to expect more staff cuts next year? Is the Minister aware that they are expected to shed 600 posts by next March, that Birmingham has suspended all planning functions, that East Sussex has stopped monitoring general practitioners' claims and that Kingston has halted all inspections of GPs' surgeries? How does he expect us to believe that this small, shrinking band of administrators can make a reality of more vigorous monitoring?

The Minister will be aware that his proposals will be judged on how they remedy the most serious failings of primary care in the inner cities, where large numbers of the elderly, the unemployed and the homeless place special demands upon it. Will he acknowledge that those pressures are being increased month by month by the persistent closure of accident and emergency units, 15 of which have closed in London alone? How will those pressures be helped by payment by performance, which may draw more GPs away from the cities to areas such as Braintree, where it may well be easier for them to hit his targets?

How does the Minister imagine that it will help the chronic problem of crowded, crumbling surgeries in the inner cities to privatise the General Practice Finance Corporation, a proposal to which he did not refer but which is to be found in his White Paper? Is he not aware that that is a rare source of funds for new premises in unfashionable areas where banks will not lend? Why, given the deep public concern about them, does neither his statement nor the White Paper even mention the appalling quality of the deputising services?

Is the Minister further aware that studies suggest that the average consulting time per patient of only six minutes is lower in Britain than almost anywhere else in Europe? Why, then, is he proposing to increase the capitation element to encourage GPs to compete for even longer patient lists? Does he not appreciate that, if he wants to improve the quality of care, he should be encouraging GPs to have shorter lists, not even longer ones?

Finally, the Minister will have anticipated that we unreservedly condemn his proposal to charge for dental examinations and for eyesight tests. Does he recall that in the consultative document there was no reference to charges for eyesight tests and that professional bodies have been unable to comment on the proposal? Even solicitors will still give clients free advice — and will now come cheaper than these NHS services.

How does the Minister imagine that he is encouraging preventive care by discouraging patients from visiting their dentists? Has he forgotten that, when dental charges went up by 25 per cent., the number of fillings fell by 5 million? Is he aware that one in 20 people calling for an eyesight test are referred on for medical examination for conditions such as glaucoma, which can be arrested if caught early enough? How many of them will be deterred by a tenner a test?

To the extent that today's proposals will oblige GPs to give priority not to their most needed services but to their most profitable ones, we wholly reject them. The Opposition will fight to preserve a Health Service that is publicly funded, publicly run and free to the public at the time they need it.

Mr. Newton: Perhaps I should take the last two points first and make it clear that in our view the proposed charges for dental examinations and the proportional system, which in some cases will have the effect of reducing treatment charges, are a sensible move towards generating the additional resources that we can then devote to exactly the purposes that the hon. Member for Livingston (Mr. Cook) outlined in his first questions. We wish to have more money to direct to the improvement of primary care in the inner cities. We wish also to develop the role of the family practitioner committees along exactly the same lines that the hon. Gentleman, too would wish. In the remote likelihood of the hon. Gentleman ever being a Minister, he would have to face up to the need to find the resources to achieve those desirable objectives. We have tried to face up to that need.

The hon. Gentleman referred to the proposal that family practitioner committees and district health authorities should once again be merged. Whatever may be the merits of the arguments that were fought over in 1982 when the present set-up was introduced, I cannot believe that it is in the interests of any part of the Health Service to have yet another administrative upheaval on top of those that it has already been through. However these authorities were organised, it would be essential to have proper co-ordination. In my view, it is right to concentrate on achieving proper co-ordination, and that is what we are seeking to do by many of these proposals.

The hon. Gentleman asked me about capitation fees. I make the simple point that, with a given number of doctors and a given number of patients, it is impossible for lists to become longer on average. Higher capitation fees will give doctors the incentive, among many others that we are proposing, to provide good treatment to their patients so that they will attract patients against a background of wider choice. The core of our proposals on general practitioners is to change the remuneration system to give greater incentives to those who provide the things that I outlined at the beginning of my statement — more screening programmes, more health promotion sessions and systematic surveillance of the health needs of under-fives and the very elderly. We all wish to see those things brought about.

Dame Jill Knight (Birmingham, Edgbaston): Is my hon. Friend aware that the eye test is a screening procedure and that many serious illnesses such as diabetes, glaucoma and cancer can be detected at an early stage? Therefore, does he really think that it would be cost effective to deter people from seeking eye tests because they would have to pay £10? Any person in some difficulty with their sight might well be told on going to see their doctor, to have their eyes tested and that it would cost £10 at an optician but nothing at a hospital. The hospital eye service is already under great strain. Therefore, does it make sense to direct more people to have their eyes tested at hospitals instead of at opticians?

Mr. Newton: I need hardly say that I respect my hon. Friend's views on those matters because of her direct knowledge of them and the views that she expressed when the voucher system was introduced some three or four years ago. The fears that were expressed about the introduction of the voucher system have proved unfounded. It has greatly extended competition, choice and consumer satisfaction. I believe that her fears about this further development will also prove unfounded.

Mr. Ronnie Fearn (Southport): We do not welcome the statement. It is probably one of the most deterrent things that we have heard. Prevention is what we need, but that is not what we are getting. Charging for eye testing and the inspection of teeth will not assist prevention, as it will not be possible to detect diseases such as cancer if eyes are not tested. It will bring about a medical upheaval. Will pressure from drug companies reflect the advice given by pharmacists to their patients?

Mr. Newton: I see no reason to suppose that that latter fear has anything to do with what we are proposing. We have been strongly pressed by pharmacists, who are an important part of the primary health care professions, to help them extend their role in advising people about health matters, and not least health education. They constitute a large range of outlets, with many people going to them frequently, where such information can be made available. We think that it is a sensible use of resources to encourage pharmacists to use that asset in the interests of health education generally.

Sir David Price (Eastleigh): My hon. Friend said that it was his intention that general practitioners' contracts should be more sensitive to performance. Will this enable such GPs to do more preventive medicine or more diagnostics? It is my view that a great deal more diagnosis should be done in general practice, thus relieving out-patient departments. Does he also recognise that this must mean smaller patient lists for such GPs?

Mr. Newton: It may well be that that will lead to reduced patient lists. I said in my statement that they have fallen substantially during the past seven or eight years. The details of the new arrangements will clearly have to be negotiated with the professions, but the basic answer to my hon. Friend's question is that we shall be aiming through the new remuneration system to encourage the sort of things to which he rightly attaches importance.

Mr. Barry Jones (Alyn and Deeside): Even at this stage, will the Minister think again about his decision to charge for eyesight tests and dental examinations? Does it not fly in the face of his policies on health education? Does he not see it as a colossal mistake?

Mr. Newton: No, I do not think that it does. The proposed charges contribute to our capacity to devote substantial additional resources to the promotion of good health and to the sort of measures outlined in the White Paper, which are directly related to improving the health of the nation. That is the basis on which the proposals have been put forward.

Mr. Roger Sims (Chislehurst): I congratulate my hon. Friend on the document he has produced, which from what he says includes a large number of items to improve the health of the community. I thank him and our right hon. Friend the Member for Sutton Coldfield (Mr. Fowler) for the enormous amount of time and trouble they put into consulting all sorts of people on the contents of the Green Paper before the present proposals were brought out.

My hon. Friend will be aware that nurses are particularly anxious to play a larger role in community health care and I wonder whether my hon. Friend will enlarge a little on the remarks in his statement referring to nurses. Has there been any development on the suggestions in the Green Paper that pharmacists may play a larger role, particularly in visiting patients for whom they have prescribed preparations?

Mr. Newton: In relation to pharmacists and still more in relation to the optical services, we are looking at ways to pay practitioners to make domiciliary visits to the housebound, which is undoubtedly a gap in present facilities. That is illustrative of the sort of things we can do with the extra resources.

On the matter of nurses, my hon. Friend will be aware that the Cumberlege report recommended the development of so-called neighbourhood nursing services. We believe that that needs to be actively examined around the country. We do not believe that we can lay down a blueprint for all areas regardless of their differing conditions, but there are already some good examples in practice that we believe other authorities could build on. We are anxious to improve the quality of the work done by nurses in general practitioners' practices. We are proposing to reimburse general practitioners directly for training of practice nurses, which I think will be widely welcomed.

Dr. Lewis Moonie (Kirkcaldy): How will the proposals in the paper ensure an improvement in the promotion of good mental health?

Mr. Newton: In the same way as they will seek to promote other forms of health — physical health. For example, one of the things for which we shall be able directly to reimburse general practitioners but for which we cannot at the moment, is the employment, alongside chiropodists, physiotherapists and other supporting staff, of staff who can provide counselling services at general practices. That has been pressed for many times and is directly related to the problem raised by the hon. Gentleman.

Mr. Jerry Hayes (Harlow): I welcome my hon. Friend's statement, particularly the points on more accountability for general practitioners. Does he think that it is about time that consultants were more accountable and that their contracts should be with district health authorities rather than regional health authorities?

Mr. Newton: I think that I have covered enough delicate issues in my statement without going into that one.

Mrs. Margaret Ewing (Moray): On behalf of my colleagues in Plaid Cymru and the Scottish National party, may I say that we do not like the underpinning philosophy of the White Paper, since it seems that the low income groups, which are often the most vulnerable in health conditions, are less likely to take up opportunities for testing if they have to pay?

May I pursue the Minister on the issue of cervical cytology? It is not clear within the White Paper whether the call and recall service will be part of the main contract.

Since that is one illness that could be prevented by effective screening, can he give us an assurance that that will be the case?

Mr. Newton: I should make it clear that all existing exemptions from charges continue to apply under the system that I have proposed, so I do not think that low-income people will be affected. As to cervical cytology screening, around the country we have set targets for the introduction of call and recall programmes. One matter about which I feel particularly strongly, as does my hon. Friend the Under-Secretary, is that we must ensure that the response of women to being called or recalled is raised, which is just as important as having the system in place. That is what we shall be encouraging general practitioners to help to bring about.

Mrs. Virginia Bottomley (Surrey, South-West): Does my hon. Friend agree with the increasing demand on the Health Service through demographic and technological factors, that it is high time that primary health care provision was properly scrutinised? The right way to provide primary health care is by being effective, efficient and responsive to the demand of consumers and, at last, by ensuring that general practitioners are more cost-conscious. There has been a phenomenal increase in spending in family practitioner services, and is my hon. Friend aware that there will be a wide welcome for the recognition that he is giving other members of the primary health team—chiropodists, physiotherapists and district nurses?

Mr. Newton: I am grateful to my hon. Friend for the support that she has expressed.

Mr. Speaker: I call Mr. Sam Galbraith.

An hon. Member: A consultant.

Mr. Sam Galbraith (Strathkelvin and Bearsden): May I echo the call of the hon. Member for Harlow (Mr. Hayes) for consultants to be made accountable? I welcome certain parts of the White Paper, particularly that with regard to a retirement age of 70, and I hope that it is a prelude to the introduction of retirement at 65. I welcome the part of the report concerning more information for patients. This is not advertising; more information will benefit patients. However, I am sorry that the Minister is going the wrong way on the capitation fee. What he is proposing will lead to larger practices, when even general practitioners are asking for smaller ones. The Minister should have taken the opportunity to reduce the capitation fee below £1,700. Will any items for service payments be cash-limited? Will they be cash-limited in general, or will each item of service within that be cash-limited? Will such things as cervical cytology smears or tests for blood examinations be cash-limited?

Mr. Newton: I express my gratitude for the first part of the hon. Gentleman's comments—[AN HON. MEMBER: "About consultants?"] I shall leave consultants out of the matter for the moment, but I understand the direct interest of the hon. Member for Strathkelvin and Bearsden (Mr. Galbraith) in these matters. The capitation fee issue should be considered alongside the introduction of specific incentives for the sort of particular purposes that I have outlined. There is no question of cash-limiting the tests that the hon. Gentleman mentioned. With regard to the sums that we shall make available for the further improvement of practice premises and for the additional employment of supporting staff of various kinds, we shall make specific sums available to family practitioner committees; they can decide what projects to support, and develop what is called their more "pro-active role" to encourage good services in their area.

Dr. Alan Glyn (Windsor and Maidenhead): If my hon. Friend is to put a greater strain on general practitioners and increase their primary services, is he satisfied that they will be given sufficient equipment to carry that out?

Mr. Newton: Part of the purpose of the exercise is to achieve precisely that. I should make it clear that we are not seeking to increase the strain on general practitioners generally; we are seeking to increase the rewards of those who are already taking the strain and making a lot of effort, and to encourage those who are not to do so.

Mr. Norman Hogg (Cumbernauld and Kilsyth): Will the Minister give an undertaking that he will convey to his right hon. and learned Friend the Secretary of State for Scotland the need for a detailed statement on the implications of the statement and the White Paper for the National Health Service in Scotland, with particular reference to general practitioner services in highland and remote areas, where doctors are having to work in difficult circumstances? Will he ask the Secretary of State for Scotland to comment on the ophthalmic and dental charges, which will have a detrimental effect on the socially disadvantaged in urban and rural Scotland?

Mr. Newton: The hon. Gentleman will have noticed that my hon. Friend the Under-Secretary of State for Scotland is present—*[Interruption.]* I am sure that in an appropriate way my right hon. and learned Friend will want to make available any further information about the application of these proposals to Scotland. We all seek to discuss with the professions how we may give better support to doctors who are virtually forced to practise on their own in isolated rural areas. Clearly, that will be of even greater importance in Scotland than in many parts of England.

Mr. Robin Maxwell-Hyslop (Tiverton): Does my hon. Friend believe that the measures that he has announced today will encourage more people to seek examination of their sight, which also covers incipient glaucoma and conditions like it, and have their teeth examined, or does he believe that the measures will discourage them? Will my hon. Friend say why he believes that the obvious discouragement to both will be beneficial to health? Does he not realise that there are many people on what are, by any standards, very low incomes who are above the threshold for free access to these facilities?

Mr. Newton: I have already said to my hon. Friend the Member for Birmingham, Edgbaston (Dame J. Knight) that similar fears expressed about earlier changes have proved unfounded. It will be open to opticians to offer free sight tests, as they may wish to do in connection with their general business of selling spectacles, even though they will not be able formally to tie patients to buy spectacles from the same place. The advantages and forces of competition will mean that these proposals will not have the effect that my hon. Friend fears.

Mr. Paul Flynn (Newport, West): In response to a moving letter from a constituent who lost her sight because of detectable glaucoma that was not detected in the early stages, I tabled a question to the Department asking for

[Mr. Paul Flynn]

an extension of eye tests to the plotting of visual fields, which would be a more sophisticated and more effective technique. Is the Minister aware that the International Glaucoma Association thinks that 150,000 people already suffer from glaucoma which has not been detected? Although the statement contains many items of value, the decision to withdraw free eye tests will be seen as an act of crass, wasteful, cruel stupidity.

Mr. Newton: I note the hon. Gentleman's views. I have already make it clear that I do not agree with him. I hope that I understood the first part of his question aright. I must point out that there is nothing in our proposals to restrict what is done in the course of an eye test.

Mr. John Redwood (Wokingham): Does my hon. Friend accept that, although many Conservative Members welcome any proposals to improve prevention, service and the range of choice, we must be sure that there will not be items of payment for services that encourage unnecessary activity, visits or referrals? The accent must be on a better deal and more choice for the patient.

Mr. Newton: Yes, and among other things we shall seek to ensure that general practitioners have better information about referral rates—for example, by other colleagues in the same area—and we hope that that will assist them in developing sensible practices.

Mr. Eddie Loyden (Liverpool, Garston): Does the Minister accept that the White Paper is clear evidence of the Government's intention to continue to undermine the National Health Service and to move away from the concepts upon which it was based? Is he aware that testing in that sense is part of preventive medicine? Luckily, I was diagnosed in an eye test as having glaucoma. I am one of probably many thousands of people who have been grateful for the fact that such a test disclosed that illness. Is it not an act of absolute stupidity to end free tests when, in view of public opinion, medicine is following the course of prevention rather than cure?

Mr. Newton: The essential emphasis of the White Paper, as I think I made clear throughout, is on extending the support that we give to preventive health promotion activity by general practitioners and by primary care services generally. The hon. Gentleman's initial remark is, frankly, absurd against the background of a 43 per cent. real increase already on primary care services, a further planned 11 per cent. real increase and the further increases entailed in my statement.

Mr. Andy Stewart (Sherwood): Is my hon. Friend aware that his statement may have opened up a rift between myself and my daughter, who is a dental surgeon, unless I can tell her this evening when she telephones me that the increased charges for inspection will be spent on dental care in general?

Mr. Newton: I hope that I have made it clear in my statement and answers that we have a number of proposals to improve the standards of dental care and to make some changes in the dentists' contract. We shall certainly seek to promote the standards of primary care generally. I am not in a position to give an undertaking that the money raised in one quarter will be spent only in that quarter and, indeed, unless it were thought that the existing balance of primary care was perfect in all respects, it would be absurd for me to do so.

Mrs. Rosie Barnes (Greenwich): Does the Minister agree that, in the light of his emphasis on preventive and community medicine, it would be well worth considering even further the role of health visitors and considering increasing the ratio of health visitors to population from one to every 5,000 people to one to every 3,000 people, so that health visitors can do their jobs much more effectively than they possibly can at present?

Mr. Newton: There has been a valuable increase in the number of health visitors. They are a singularly important part of the nursing profession and of the primary care services. Obviously, one of our objectives in encouraging health authorities to look at the proposals in the Cumberlege report and the circular which we have issued is to encourage the type of development which, in general terms, the hon. Lady wants.

Mrs. Elaine Kellett-Bowman (Lancaster): I welcome the proposals to support doctors in rural areas. Will my hon. Friend say a word or two about dispensing by doctors in rural areas?

Mr. Newton: This is another delicate issue which is not greatly covered in the White Paper. We have no plans at present to change the balance of the arrangements for the rural dispensing committee and the new arrangements under the pharmacists' contract instituted last April which seek to arbitrate between the interests of dispensing doctors and those of pharmacists, not least in rural areas.

Mr. James Lamond (Oldham, Central and Royton): Is the Minister really saying that, in the face of all the Chancellor's income tax cuts and all the boasting about how borrowing has been reduced almost to nothing, the only way that he can finance these welcome changes to primary care and preventive medicine is by attacking the services that are the backbone of preventive medicine? Is the hon. Gentleman aware that, despite all the high-faluting nonsense at the start of his statement, people in my constituency cannot get a simple flu vaccine, because supplies are not available, it seems, anywhere in the country, and they have to put down their names for the next year?

Mr. Newton: My hon. Friend the Under-Secretary of State for Health and Social Security—the hon. Member for Derbyshire, South (Mrs. Currie)—yesterday gave a first-class answer on flu vaccine, so I simply refer the hon. Gentleman to *Hansard.*

Mr. Nicholas Winterton (Macclesfield): As a Member who served on the Select Committee which produced this report, may I welcome my hon. Friend's statement. It takes much more account of the Select Committee's views than the hon. Member for Livingston (Mr. Cook) said it does. If our general practitioner service, which is the finest in the world, requires more resources to carry out the important task that is set for it, and if the new charges on certain services will reduce the number of people coming forward for those services, will my hon. Friend increase resources for general practitioners and review the charges imposed on certain services?

Mr. Newton: I can certainly give my hon. Friend the assurance that he sought in the first part of his question

about extra resources for general practitioners. Indeed, that is one of the main aims of the proposals. However, I would be hesitant about giving him any assurance on the second part of his question because I simply do not accept the fears that have been expressed.

Mr. Dave Nellist (Coventry, South-East): What is there in the White Paper to deal with that most primary of health care—the treatment of chronically sick babies? I have no doubt that the Minister and the House will join me in welcoming the news of about an hour ago that this afternoon Philip and Diane Barber will see the operation performed on David, their six-week-old son. The Barbers are constituents of my hon. Friend the Member for Newcastle-under-Lyme (Mrs. Golding). What is in the White Paper for the 34 other babies waiting for heart operations around the country? What is in the White Paper to answer the words of Dr. Eric Silove, the consultant paediatric cardiologist at Birmingham children's hospital who revealed this morning that in the past four days a baby has died because of a lack of operating theatre staff? If the Minister can increase charges for specs and teeth, why can he not do anything about intensive care staff and get these operations moving?

Mr. Newton: As with yesterday afternoon, I shall not seek to respond to the hon. Gentleman in the spirit of his question. I shall simply say that I, too, am delighted that Baby Barber is having his operation this afternoon. I understand that the operation started at 2.30 pm. I very much hope that it is successful and that the baby's parents will have their anxiety relieved.

Mr. Roger Gale (Thanet, North): I congratulate my hon. Friend on his statement and on the White Paper. Those of my constituents who are employed in the pharmaceutical industry will welcome the statement that the Government are to encourage

"the maintenance and development of a strong and efficient pharmaceutical industry in the UK"

and that

"the Government have no plans at present to extend the selected list scheme into other therapeutic areas or to introduce compulsory generic prescribing."

[HON. MEMBERS: "Reading."] Yes, from the White Paper.

Does the Minister intend to stimulate still further investment into research and development and manufacture—particularly research into cures for diseases such as AIDS.

Mr. Newton: The basis of the relatively new pharmaceutical price regulation scheme and of the other steps taken is precisely to encourage a strong research-based pharmaceutical industry in this country. I welcome my hon. Friend's comments and I hope that he in turn will encourage those with whom he is in touch to co-operate with us on other ways of ensuring economic and effective prescribing.

Several Hon. Members *rose*——

Mr. Speaker: Order. I shall endeavour to call those hon. Members who have been rising and who listened to the statement. However, I would ask for brief questions.

Mr. Tam Dalyell (Linlithgow): I have two questions of fact on sight testing. In answer to the informed and reasonable question of the hon. Member for Birmingham, Edgbaston (Dame J. Knight), the Minister said that there was satisfaction in relation to consumer vouchers. What evidence does he have for that? Secondly, on paragraph 28 of the White Paper dealing with domiciliary sight testing, what extra monetary resources are likely to be available? Having received a cryogenic reception in the House on the sight testing proposals, should not the Minister go back to Alexander Fleming house and to his Cabinet colleagues and say, "The House of Commons is deeply unhappy about this. Think again."?

Mr. Newton: On resources, I have made it clear that we have to negotiate with the professions on many of these matters. Therefore, I cannot name specific sums that will go to any particular purpose. However, we shall want sufficient resources to be made available to provide an effective domiciliary sight testing scheme. On vouchers, when I have visited some of the new spectacle establishments that have grown up around the country and talked to customers there, I have found them well satisfied with the arrangements.

Let me make it clear that we propose a number of improvements in the voucher scheme. Vouchers will be made available for contact lens purchase, which is not permitted at present. The position of the partially sighted will be given special consideration in relation to other voucher groups and the voucher scheme will also be extended to help adults whose spectacles are damaged owing to physical or mental disability. We are making a number of further improvements which I believe will be widely welcomed.

Mr. John Greenway (Ryedale): Is my hon. Friend aware that his announcement on proportional charges for dental treatment, for which the British Dental Association has been pressing, will be widely welcomed? Can he confirm to the House that the proportional charge that the Government have in mind will be lower because of the phasing-out of the free dental examination? That will encourage people to go to dental practitioners more regularly.

Mr. Newton: They will be lower than they would otherwise have been. I must make it clear that, because of the absurdities in the present system, the effect of proportional charges will vary greatly. Let me give an example. At the moment, for a precious metal bonded crown which costs £68, the patient pays £33, which represents just under half the cost. For a much less good job—a synthetic resin jacket—the patient also pays £33, which represents 94 per cent. of the cost. That is ridiculous and above all our proposal is more sensible.

Mr. Harry Ewing (Falkirk, East): Is the Minister aware that his statement will do enormous damage to dental health and eye care? The evidence for that comes from the White Paper. Paragraph 2.13 says that the Government are to introduce charges for dental examination because of massive improvements in dental health in this country. Is the Minister so stupid that he does not understand that the reason why dental health has improved so massively is that we had free inspections? If we go back to the system of paying for examinations, we shall go back to bad dental health.

On the general practitioner service, the Minister should be aware that the massive difference between his Government and the Labour Government is that under Labour the services were always demand-led and no other part of the Health Service had to pay for increased costs in the general practitioner service. The Minister's

[Mr. Harry Ewing]

statement, on the other hand, makes it clear that other parts of the Health Service will pay for the increase in costs in the general practitioner service.

Mr. Newton: On the point about dental charges, the hon. Gentleman has got it wrong. The principal reason for the great improvement in dental health is that the nation and parents have been taking much greater care of the dental health of children. Under the proposals, all dental treatment for children will be as free as it is now.

Mr. Peter Thurnham (Bolton, North-East): The provisions of the White Paper are welcome—especially the proposal to set targets so that general practitioner pay is more closely related to performance. Will my hon. Friend say more about the setting of targets, especially for doctors in the deprived inner-city areas?

Mr. Newton: Again, I face the difficulty that we shall need to negotiate with the profession. Therefore, I cannot give my hon. Friend the detailed information that he seeks. I assure him that among the matters to be negotiated will be arrangements to give greater encouragement to general practitioners to practise in inner-city areas and to give them better premises in which to practise. That is possibly the single most important need that we must consider when improving primary health care. The services are very poor in some of our inner cities.

Mr. Andrew Faulds (Warley, East): Is it the case, as is widely believed throughout the country, that junior Ministers in this benighted Government—particularly in the Department of Health and Social Security — are given special training in the presentation of policies and supportive arguments in which they themselves cannot possibly have any belief?

Mr. Newton: I hardly dare speculate about that. I have no doubt that the hon. Gentleman intended his remarks as a compliment. I believe that we should all be trained to face up to realities and to find resources to achieve good purposes.

Mr. Richard Holt (Langbaurgh): Will my hon. Friend accept from me, as a diabetic, that his announcement about diabetes will be widely welcomed? Will he also accept from me, as somebody who uses the National Health dental service, that I am not in the least enamoured of his proposals? What proportion of the charge will be retained by the dentist, what proportion will be passed on to the kitty, and will the dentists themselves be remunerated additionally for becoming tax collectors?

Mr. Newton: Dentists will be no more tax collectors than they are now, because there are already very substantial charges. I need hardly say that the remuneration of dentists will need to be negotiated, as ever, with the profession.

Mr. Ernie Ross (Dundee, West): The Minister is trying to put on a brave face. As my hon. Friend the Member for Oldham, Central and Royton (Mr. Lamond) said, the Minister is finding it difficult to justify a self-financing package when he should be arguing with the Chancellor of the Exchequer for more funds for the Health Service. Will he ensure that, unlike the occasion of the announcement on Scottish homes, his right hon. and learned Friend the Secretary of State for Scotland comes to the House and makes a statement on the implications for Scotland of the measures in the White Paper?

Mr. Newton: I note again what the hon. Gentleman said about Scotland, and no doubt my right hon. and learned Friend did so too. I see no need to apologise for a statement that provides an additional £600 million for primary care services by 1991, of which a relatively small part will be raised by the measures that I have proposed.

Mr. Chris Butler (Warrington, South): I do not suppose that the medical profession will be surprised at losing its perquisite of retiring and then immediately being re-contracted. Can the Minister tell me a little more about the compulsory retirement arrangements? Is he aware that some young GPs are very up to date, but some elderly GPs are very wise old birds indeed?

Mr. Newton: I entirely accept that it is not possible to state that at any particular age a particular group of people is totally past it. I emphasise that there is nothing to prevent any doctor from continuing in private practice if he so wishes. However, we think that, as an act of general policy, it is sensible no longer to enter into NHS contracts with people aged over 70. The precise nature of the change will again be the subject of discussions with the profession, and there will be a transitional period. I believe this to be one of the changes that will gain widespread support both in the profession—that has already become evident—and among many outside it.

Mr. Max Madden (Bradford, West): Why has the Minister set the compulsory retirement age at 70 rather than lower? What is his estimate of the proportion of pensioners who will have to pay for dental and eye checks? Does he accept that, as the proposals to introduce these charges were not contained in the consultation paper or the general election Tory manifesto, they represent a cowardly attack on health prevention?

Mr. Newton: The changes that I have outlined this afternoon for dental examinations and eye tests require legislation, and that is contained in the Health and Medicines Bill that will be published later today. There will be no shortage of opportunity for debate and discussion and for those outside to make their views known.

Mr. Nicholas Bennett (Pembroke): Does not my hon. Friend agree that the Opposition attacks on the principle of charging are rather hollow because it was their Government who, in 1951, first introduced the principle? Does he further agree that, for those who are not exempt and have good incomes, a £10 charge towards helping to keep their health is very good value? Is that not especially true when compared with, for example, the expenditure of £500 on a holiday? Is that not the sort of value standard that we should be considering?

Mr. Newton: I agree with my hon. Friend. Although £10 is the payment that we make now to ophthalmic opticians for sight tests, the payment to other sight testers, such as ophthalmic medical practitioners, is substantially less. As I have already said, I expect that under the new system there will be considerable pressure to keep charges down.

Mr. Bob Cryer (Bradford, South): May I draw the Minister's attention to the remarks of his hon. Friend the Member for Birmingham, Edgbaston (Dame J. Knight),

who pointed out that it is not just a sight test, but an eye test, as the eyes are also screened for diseases? Will not charging act as a deterrent to the very basic primary care the Minister claims he is trying to improve? Is not that same principle applicable to dental charges? Will they not also be a deterrent, and, therefore, will not the standard of dental care decline, with the consequent effect of greater costs in the community through loss of work and working hours and so on? Is it not true the people will face those charges at a time when the Government are pouring some £11 billion into nuclear deterrence? People should know that mass extermination has a higher priority than the dental and eye care of our people.

Mr. Newton: Given that, at current rates, the charge for a dental examination will be about £3 or less, and in the light of what I have said about sight testing charges, I refuse to believe that, in a country whose standard of living is growing as fast as ours, the effects of the proposals will be as the hon. Gentleman suggests.

Mr. Nicholas Fairbairn (Perth and Kinross): Will the Minister and the House pause and comprehend that if, in the Health Service, we start to identify particular patients to receive treatment in advance of others, it will do grave damage to the NHS and its patients? I am, of course, referring to Baby Barber. Does my hon. Friend understand that if we were to alter our system of funding drugs, and not have huge companies that, in America, do not accept such disciplines, Britain would have the enormous advantage of ordinary drugs, the Health Service would benefit greatly and we would not have to make these appalling decisions of choice?

Mr. Newton: It is certainly true that the various actions that the Government have taken to ensure that the drug bill is effective and economical contribute, as did the introduction of the selected list, to other things that we want to do in the Health Service. It is all about priorities, and much of my statement was about priorities. I think that they are the right priorities.

Mr. Tony Banks (Newham, North-West): Is the Minister aware that dentists in inner-city areas are already gravely concerned about the deterioration in the state of the teeth of those living in inner cities? Has that not come about because of charges, which are clearly a disincentive? Yet, under the White Paper, charges will rise, and charging for what is currently free dental inspection will add to the deterrent effect.

The Minister mentioned accident and emergency provision. Is he aware that in the London borough of Newham that provision is now approaching breakdown point? I now understand why the Prime Minister does not want to televise the proceedings of the House — it is because the people of this country would see what an evil, rapacious and uncaring bunch the Tory Members have become.

Mr. Newton: I wish to make two points. First, if there is any sort of decline in the standard of teeth in inner-city areas, it is a result of the generally poor quality of primary health services in those areas — something that a large part of the thrust of the document is designed to tackle to bring about improvement. Secondly, one of the pressures on inner-city accident and emergency departments is again the inadequacy of the primary care services, not least the extent to which general practice is conducted from lock-up shops. That leads people to go to the local hospitals. Again, we come back to the essential need for the improvement of primary care services, and we are seeking to direct resources to that through this White Paper.

Mr. Robin Cook: On a point of order, Mr. Speaker.

Mr. Speaker: Order. Is it concerned with the statement?

Mr. Cook: Yes, it is.

Mr. Speaker: Well, the hon. Gentleman has the right to ask another question. He does not need to raise a point of order.

Mr. Cook: I am very happy to make my point under whichever procedure you recommend, Mr. Speaker.

I understand that the Minister is addressing a press conference on the White Paper and the Bill at 4.30 pm. The House is in some difficulty because the Bill is not available to hon. Members until it is presented, which may be another 15 or 20 minutes. It would be a courtesy to the House if the Minister did not refer to the contents of the Bill until it is in the hands of hon. Members.

Mr. Newton: Further to that point of order, Mr. Speaker. I entirely accept what the hon. Gentleman said. It may be difficult for me to respond to some of the questions that I may be asked, but I shall try to stick to the spirit of what the hon. Gentleman reasonably asked.

Mr. Cryer: Further to that point of order, Mr. Speaker.

Mr. Speaker: No. The Front Bench has a right to a further Question. I will take points of order after the applications under Standing Order No. 20.

MCA

CONFIDENTIAL until 4.00 pm on 25.11.87

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

MGT

Mike Eland Esq
Private Secretary to
The Rt Hon Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1A 2AT

25 November 1987

Dear Mike,

You will remember that the final draft of the White Paper "Promoting Better Health" went to Cabinet earlier this month. Mr Tony Newton, the Minister for Health, will be announcing its publication, together with that of the Health and Medicines Bill, in the House this afternoon and thought you would wish to see a copy.

Copies of this letter and of the White Paper go to Private Secretaries to the Prime Minister, members of H Committee, to members of Cabinet who are not members of H Committee, and to Sir Robert Armstrong.

Yours sincerely,

Geoffrey Podger

G J F Podger
Private Secretary

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Nat Health

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SECRET

8

PRIVY COUNCIL OFFICE
WHITEHALL. LONDON SW1A 2AT

23 November 1987

NBPM

Dear John

PRIMARY HEALTH CARE WHITE PAPER

WILL REQUEST IF REQUIRED.

You wrote to me on 6 November enclosing the revised draft of the Primary Health Care White Paper which you propose to publish at the same time as the Health and Medicines Bill.

Geoffrey Howe and Norman Fowler both wrote indicating that they were broadly content with the revised draft but setting out some detailed comments. Geoffrey was concerned that the proposals on performance-related pay for GPs might not be fully effective; and he also suggested that, for the future, consideration might be given to linking the prescription charge to the cost of the medicine concerned. Norman sought clarification of the proposals on performance-related pay for GPs. He expressed concern that no specific mention was made of private health, and suggested that greater encouragement should be given to the idea of health care shops. He also suggested that local media could be used to disseminate information about local primary health care practices.

You wrote responding to the points raised in both letters, offering a drafting change to meet Norman's point about health care shops. Norman has written urging that the White Paper should be published as soon as possible, and asking that your officials keep in touch with his on developments in performance-related pay for GPs. I understand that Geoffrey Howe is also now content. No other colleague has commented on the draft White Paper and you may therefore take it that you have H Committees' agreement to publish it.

I am sending a copy of this letter to the Prime Minister, Cabinet colleagues and Sir Robert Armstrong.

Yours ever

John

The Rt Hon John Moore MP

SECRET

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SECRET

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Sir Geoffrey Howe QC MP
Secretary of State for Foreign and
Commonwealth Affairs
Foreign and Commonwealth Office
Downing Street
LONDON
SW1

16 November 1987

Dear Geoffrey

PRIMARY HEALTH CARE WHITE PAPER

Thank you for your recent letter about the draft White Paper circulated earlier this month.

I was glad to have your supportive remarks about the general thrust of our plans. As to the specific points you raise, I hope I can reassure you on both counts.

One of the main problems with the family doctors' remuneration system in its present form is that it fails to reward adequately the doctor who gives a first class service and pays more than is justified to the doctor who is not so good. The package of measures we intend to introduce will, we believe, target the funds much more effectively. Incentive payments related to performance will encourage doctors to provide more services. At the same time, tightening the qualifications for basic practice allowance (about £7,800 a year) and increasing capitation fees as a proportion of income will encourage doctors to recognise that they must keep their patients in order to maintain their income. It is important to see these developments within the context of the package as a whole. Sharpening up the remuneration system will not in itself deliver the improvements we want. What is equally important is better informed consumers who can decide between practices on the basis of their improved knowledge of what is on offer. Thus a greater degree of competition is introduced which will be underpinned by a vigorously monitored and more work-conscious contract with Family Practitioner Committees. I am determined to carry this forward in our negotiations with the medical profession.

As to the medicines bill, you suggest that we might consider for the future an arrangement under which the prescription charge would

E.R.

be linked to the cost of the medicine, in order to give GPs and patients a better idea of the costs of various medicines. This is something we have looked at on a number of occasions. There are very considerable administrative complexities - for example, it would mean ensuring that all pharmacists and dispensing doctors had the necessary information to calculate the cost of the medicines dispensed. In addition to these complexities, costly in themselves, we would have to increase pharmacists' remuneration to take account of the additional work involved. There is also the point that such a system would penalise in particular those people who need very expensive medicines.

We have to bear in mind, too, that less than 20 per cent of prescriptions attract a charge, and that in about 40 per cent of cases the current charge actually exceeds the cost of the medicine. The potential effect on the drugs bill is therefore limited.

It seems to me that the best approach lies in other ways of making general practitioners more conscious of their prescribing costs. I am glad to say this is an area where we continue to make both significant progress and look for further ways of promoting cost consciousness.

First, the Selected List initiative saved £75 million in 1985/86 and has been accepted by the medical profession. Second, we are devoting much effort to encouraging general practitioners to prescribe more effectively and economically.

August next year will see the birth of a new information system for general practitioners which will provide them with timely, well-presented data about their prescribing costs. They will be encouraged to review critically both their costs and their prescribing patterns. The Department's Regional Medical Service has launched a scheme whereby medical officers in two Regions will be dedicated to discussing direct with general practitioners prescribing patterns with a view to achieving savings. We will shortly be issuing Cost Comparison Charts to all general practitioners drawing their attention to the difference in cost between certain proprietary brands of medicine and their generic equivalents. Finally, we are conducting a review of the prescribing publications for which this Department is responsible to determine whether or not they are what general practitioners want and that they are being effectively targeted.

Copies of this letter go to the Prime Minister, Cabinet colleagues, and to Sir Robert Armstrong.

JOHN MOORE

Nat Health - Primary Health Care P+2.

6

SECRET

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12 November 1987

The Rt Hon John Moore MP
Secretary of State for Social Services
Alexander Fleming House,
Elephant & Castle
London SE1 6BY

DF

Dear John.

N Bpm

PRIMARY HEALTH CARE WHITE PAPER

Hoa.

Thank you for your letter of November 11. I am entirely content with the general reference you are making to private practice and with what you say about disseminating information.

I take your point on health care shops and I assume that, if any legislative changes are required, they will be made to enable experiments to take place.

On performance related pay, I share the reservations of Geoffrey Howe. As you say, the position has not been made easier by the Royal College of General Practitioners shifting their position. Nevertheless I do hope that we can explore with the profession rather more direct ways of rewarding good doctors and paying the profession on a performance related basis. Indeed I hope that you might keep in touch with my Department on this.

None of this detracts from the White Paper which I hope will be published as soon as possible.

I am copying this letter to the Prime Minister, members of H Committee and to Sir Robert Armstrong.

Yours ever Norman

NORMAN FOWLER

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SECRET

5

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Norman Fowler MP
Secretary of State for Employment
Department of Employment
Caxton House
Tothill Street
LONDON
SW1H 9NF

11 November 1987

NBPQ.

with DRN?

PRIMARY HEALTH CARE WHITE PAPER

Thank you for sending me a copy of your letter of 10 November to Willie Whitelaw in which you make some kind comments on the Primary Care White Paper and offer some suggestions on it. I am sorry that you didn't receive the draft when it was circulated to H Committee members.

Your first and second points both concern the place of the private sector in this area. You may recall that attempts were made during the consultations on the Primary Care Discussion Document to get private health care providers to respond positively to the idea of "health care shops" and to the idea that the NHS would enter into a contract not with individual family practitioners but with companies who would undertake to provide integrated primary care embodying more than one service in return for a single capitation payment for each patient. But I understand that in the event none of the private health care firms could be persuaded to show interest in this in the consultations, despite some discreet lobbying by DHSS. The reason appeared to be that they did not feel they would be able to provide satisfactory services for the total of the amounts which the Government pays for each of the individual services under the normal arrangements. It was in order to leave the door open for experiments of the sort the Discussion Document outlined that the White Paper makes it clear that Government will be willing to consider any proposals it receives in future. In the light of your letter I am adding the following at the end of the paragraph to which you referred:

E.R.

"Furthermore, the Government sees no reason why private primary care services should not be developed in ways that provide both an alternative source of care and a means of comparison with NHS services. Such a development would improve services through competition and at the same time offer greater choice to consumers."

The answer to your third point is that the proposals for performance-related pay differ from the idea of a good practice allowance in being targeted at specific activities, mainly in the prevention field, and in not including the subjective assessment of a general practitioner's quality by other doctors. You may recall that after the Discussion Document was published the Royal College of General Practitioners, on whose statement about peer assessment you had felt able to rely, did an about turn on this issue. It then became impossible to proceed with something that would of course have required the cooperation of the medical profession. In fact, I think the intentions set out in the White Paper offer better ways of improving general practice because, as was pointed out in the consultations, the good practice allowance would have been paid on an all-or-nothing basis and would therefore not have provided an inducement to doctors at the lower end of the spectrum.

On your fourth point I certainly agree that it should be possible to use the local media to disseminate the sort of information about practices to which you refer.

I am copying this letter to the Prime Minister, members of H Committee and to Sir Robert Armstrong.

JOHN MOORE

4

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Minister for Health

SECRET

The Rt Hon John Major MP
Chief Secretary to the Treasury
Treasury Chambers
Parliament Street
SW1P 3AG

11 NOV 1987

Dear John,

Thank you for your letter of 26 October about the draft White Paper on Primary Health Care.

I was very glad to have your supportive remarks about our proposals. As to the three points you raised I hope you find the following comments reassuring.

1. Practice Premises

It is certainly our intention to end the open ended nature of the cost rent scheme. We have been careful in the draft White Paper not to labour the cash limiting aspects of our plans for fear of provoking the medical profession, with whom we have to negotiate, into adopting an unhelpful stance before we have even sat down at the negotiating table with them.

You expressed doubts about improvement grants. We have found these a useful mechanism for upgrading premises in the past. We believe FPCs have found the grants particularly effective in persuading GPs to act quickly to remedy specific aspects of their premises which fall below minimum standards. The weakness of the current scheme is the lack of control over where the money goes. The new scheme will enable us to control the total volume of expenditure and to target it where it is most needed. In these circumstances, there is no financial advantage to be gained by the taxpayer from a substitution of loans for grants because under the 'cost-plus' contract expenses which are not met directly are returned to the profession indirectly through their fees and allowances. We can be far more confident about the attainment of our objectives by continuing the present system of grants which provide direct incentives to individual doctors whose behaviour we are seeking to influence.

E.R.

2. General Practice Finance Corporation (GPFC)

Since you wrote there has been a lot of activity on this front and I was very glad to hear that you are broadly content with our plans for the GPFC. Although we are not proposing the outright sale of the GPFC, our proposals are designed to have the effect of privatising the Corporation - and delivering a sum in excess of my PES commitment - in a form acceptable both to the present Corporation and to the profession. Taking the profession with us is important, not only because of their potential for making difficulties over the sale of loans but also because we are anxious to get the negotiations with them on the wider White Paper proposals off on the right foot. The profession will not welcome many of our proposals. It is important that we negotiate from a strong position and not against the background of a row over the GPFC. We shall of course keep your officials informed of progress.

3. Prescribing

I agree that the White Paper should make more of our activities in encouraging economic prescribing. We are revising this section of the White Paper to bring this out more clearly. I would, however, be reluctant to announce our target of 50% generic prescribing. First, because I think the profession's representatives might over-react if they were to see this stated quite so starkly; and, second, because this is an internal management target whose achievement is dependant to a large extent on the success of the initiatives in hand to persuade general practitioners to prescribe more effectively and economically; and third, it is possible that we may, after all, be able to improve on this target.

Your point about the selected list is well taken. The relevant paragraph will be redrafted to read:

> "The Government has no plans, at present, to extend the selected list scheme ....."

The introduction of the expression "at present" keeps the door open. I should, however, emphasise that the positive objective which we are seeking by referring to the Selected List in the White Paper is the linkage of the statement about non-extension with the comment on the medical profession's willingness to achieve savings by voluntary means. This would be a clear and important signal to the general practitioners that the Government would have to reconsider its position on the Selected List if they did not make improvements voluntarily.

E.R.

Finally you asked about the timing of the announcement of the new charging arrangements. We expect to give details of these during the Second Reading of the Health and Medicines Bill.

Copies of this letter go to the Lord President and other members of H Committee, to the Leader of the House, the Chief Whip, No.10 and Sir Robert Armstrong.

Yours ever.
Tony

TONY NEWTON

KW/DNo.15

Nat Health: Primary Health Care PT2

SECRET

From: The Rt. Hon. Sir Geoffrey Howe, QC MP

(3)

HOUSE OF COMMONS
LONDON SW1A 0AA

RNBPM

Dear John

PRIMARY HEALTH CARE WHITE PAPER

I have read with interest the White Paper circulated under cover of your letter of 6 November. Since this is a subject which has long interested me I want to make one or two comments.

I welcome your stated objectives of more and better services through competition, information and incentives, as well as your strategic shift towards general practices. The difficulties both of establishing a more consumer responsive health service, and attracting more private sector resources into it, are well known, but I believe they are fundamental. Your advocacy of more preventive medicine, more information about suitability of GPs, more local consultation about services, more convenient hours for surgeries, and wider ranges of services at combined practices, seem likely to find a ready response with the general public.

The Rt Hon John Moore MP

SECRET

But I am puzzled about how your proposals for more incentives in GP remuneration will actually achieve the desired effect. This part of your White Paper seems to have fairly green edges to it. Will increasing the proportion of income from capitation fees necessarily improve the quality, as opposed to the quantity, of work undertaken in practices? Or will it simply increase the delays in waiting rooms and diminish the time doctors have for patients? Payments for initial assessments, achievement of targets in vaccination, immunisation and screening, and for carrying out preventive activities will help. But it is difficult to see how this adds up to a coherent scheme for ensuring GPs see a close relationship between the quality of their service and their own financial interests. I hope that the consultations to which you refer will be able to carry this a bit further forward.

One other point in your paper I find particularly striking: the still enormous size of the medicine bill as a proportion of costs. Although I recognise it is too late for consideration this time round, must we forever set aside the idea of charging a percentage of costs so that both GPs and patients have some sense of the costs of various treatments and drugs?

I am sending copies of this letter to the Prime Minister, and all Cabinet colleagues.

GEOFFREY HOWE

NAT HEALTH

PRIMARY HEALTH CARE

PT 2

SECRET

2

Caxton House Tothill Street London SW1H 9NF

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10 November 1987

The Rt Hon Viscount Whitelaw CH MC DL
Lord President of the Council
and Leader of the House of Lords
Privy Council Office
68 Whitehall
London SW1

NBPM

Dear Willie.

PRIMARY HEALTH CARE WHITE PAPER

Regrettably I was not copied the draft White Paper that was recently circulated on Primary Health Care. I have now seen the later version and, although I have a number of comments on it, I believe that overall it is an excellent and well written document and reflects very great credit on the team at the DHSS who have been working on this. Some of the points that I would have wanted to have made have now been covered in the additions at paragraphs 1.8, 3.8 and 3.9 and 6.7. There are, however, a number of others.

First, it does seem strange to me that no specific mention is made of private health care. In the discussion document on Primary Health Care which we published last year there was a short section on this and I would have thought that there was some merit in underlining our belief that private primary care services should develop in ways that provide both an alternative source of care and also mean that there is a means of comparison with NHS services.

SECRET

Second, I think we could go further on the idea of health care shops. At 1.14 the White Paper says that the "idea of health care shops received little support in the consultation period and there are no plans at present to introduce this form of health care provision". It adds that the Government will then look further at the feasibility of the arrangement for such services if firm and costed proposals are received for consideration. I think this is too cautious. It is not altogether surprising that the idea received little support in the consultation period because predominantly the people responding in the consultation period were the health professions themselves. Had we waited for the profession we would never have, for example, deregulated the opticians. It seems to me that from the consumer's point of view there might be advantages in the member of the public being able to get different primary care services in the same premises. I would have thought that all the Government has to do is to remove any obstacles which make that impossible. However, as I understand it the law would have to be changed. Is there anything to prevent such a change in the law?

Third, I welcome the fact that the Government will open discussions with the medical profession with the aim of improving incentives and introducing greater equity. We will obviously be questioned on how this proposal differs from the original proposal of a good practice allowance and I am unclear on what the answer to that is.

Fourth, I also welcome the discussions that the Government intends to open with the General Medical Council on the provision of information. I am sure that the present restraints discourage proper competition between practitioners. I wonder, however, whether the aim will be to ensure that the local media can be used to disseminate information about practices (for example surgery hours, times to telephone and descriptions of the clinics held) as this would certainly be most effective for the public.

I would welcome clarification on these points. I repeat my view, however, that this is a very good White Paper and I particularly welcome, for example, the proposals on retirement for doctors and dentists, the complaints procedure, and making it easier to change doctor.

I copying this letter to the Prime Minister, members of H Committee and Sir Robert Armstrong.

Yours ever

NORMAN FOWLER

NATIONAL HEALTH
PRIMARY HEALTH
CARE

PT 2

SECRET

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon the Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
68 Whitehall
LONDON
SW1A 2AT

6 November 1987

Dear Willie

PRIMARY HEALTH CARE WHITE PAPER

I am grateful for the helpful responses from colleagues to the draft White Paper that Tony Newton recently circulated. Exchanges with No 10 have led to some important changes to Chapters 1, 3 and 6. In particular, can I draw attention to paragraph 1.8 which has been introduced to bring out the importance of consumer choice and competition and paragraphs 3.8 and 3.9 which are new and address the same issues in the context of the family doctors' remuneration system. Paragraph 6.7 is redrafted to bring out the competition point as it applies to retail pharmacies.

One further point on the White Paper. We intend to incorporate the response to the Social Services Select Committee's report on Primary Care (published in February) as an annex. Since the great majority of the Select Committee's recommendations are covered in the White Paper itself, I am not circulating the annex, but if anyone is keen to see the draft annex I shall be happy to supply it. The annex is, of course, being cleared with officials of all interested Departments. It is our intention to publish both the White Paper and the Health and Medicines Bill on 19 November.

Copies of this letter and revised draft White Paper go to the Prime Minister, all members of H Committee, to Cabinet colleagues who are not members of H and to Sir Robert Armstrong.

JOHN MOORE

SECRET

SECRET

PROMOTING BETTER HEALTH

The Government's programme for Improving Primary Health Care

SECRET

[TITLE]

Foreward by the Secretaries of State for Social Services, Wales, Northern Ireland and Scotland

Primary health care services are those provided by family doctors, dentists, retail pharmacists, opticians and community nurses. Their importance cannot be over-stated. These services

- are our first point of contact when we need advice or treatment;

- in the case of doctors and dentists, are the gatekeeper to the more specialist hospital services;

- are locally based and available to everyone;

- account for £5,000 million public expenditure every year.

For these reasons and for the first time since the NHS was founded in 1948, the Government has carried out a comprehensive review of the primary care services. The review started with the publication of "Primary Health Care: An Agenda for Discussion" in April 1986. The Government's objectives were:

- to make services more responsive to the consumer;

- to raise standards of care;

- to promote health and prevent illness;

- to give patients the widest range of choice in obtaining high quality primary care services;

- to improve value for money;

- to enable clearer priorities to be set for family practitioner services in relation to the rest of the NHS.

We have been at pains to seek the views of consumers and health professionals and allowed eight months for the consultation period. We are grateful for the enthusiastic and thoughtful response and for the mass of helpful comments received. The publication in February 1987 of the report of the House of Commons Select Committee on Social Services about Primary Health Care was a valuable contribution to the debate.

This White Paper, ["short title"], is the outcome of our review. It is clear that the time has come to shift the emphasis in primary care from the treatment of illness to the promotion of health and the prevention of disease. That message came through loud and clear during consultation on the Discussion Document. The health professionals in the primary care services are uniquely placed to lead that change. ["short title"] sets out the Government's programme for enabling the professionals to deliver a service properly tuned to the present and future needs of all consumers. The Government will continue to give a high priority to these services. Our objective is positive and straight-forward: a healthier Britain.

JOHN MOORE

PETER WALKER

TOM KING

MALCOM RIFKIND

CONFIDENTIAL

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CONFIDENTIAL

CHAPTER 1: THE FUTURE OF THE PRIMARY HEALTH CARE SERVICES

1.1 This White Paper sets out the Government's plans for improving the primary health care services.*

Use of the Primary Health Care Services

1.2 Every family uses the primary health care services. On an average working day, about ¾ million people are seen by their family doctor and about the same number get medicines on prescription from their local pharmacist. About 300,000 go to the dentist. At least [100,000] are visited by nurses or other health professionals working in the community. [50,000] attend community health clinics and 40,000 have their sight tested. Over £5,000 million a year is spent on primary care.

The need for Review

1.3 In 1986, for the first time since 1948 when the National Health Service came into operation, the primary health care services were comprehensively reviewed. On 21 April 1986, the Government published "Primary Health Care - An Agenda for

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* The primary health care services comprise all those services provided outside hospital by family doctors, dentists, retail pharmacists and opticians - the family practitioner services - and by certain members of the community health services, including community nurses, midwives, health visitors and other professions allied to medicine.

Discussion" (Cmnd 9771) together with the report of the Review of Community Nursing in England "Neighbourhood Nursing - A Focus for Care".* The Goverment made it clear that it wished the two documents to form the basis of a widespread public debate on the future of primary care. Later that year (August) the Government issued a separate consultation document on the family practitioner services complaints procedures.

Consultation

1.4 Health Ministers took a number of steps to encourage full public debate of their proposals. They allowed 8 months for the consultation period, which ended on 31 December 1986. They distributed over 6,000 copies of the two documents to some 2,700 organisations and ensured that further copies were available from HMSO bookshops throughout the country. In addition over 180,000 copies of a summary leaflet - entitled Primary Health Care - were distributed and their availability, free of charge, was extensively advertised in the national press. Health Ministers held twelve public consultation meetings in different parts of the country on different aspects of the review. Ministers took evidence for a total of 110 hours from 370 individual witnesses representing

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* Reviews of the community nursing services have also been carried out in Scotland and Wales.

73 organisations. Over 2200 written comments were received; these included comments from nearly 250 bodies representing consumer or voluntary and professional organisations.

1.5 There is therefore no doubt that primary health care has been thoroughly reviewed and that those with views to express have had every opportunity to do so. This White Paper sets out the Government's conclusions and the action it will now take.

The Government's Objectives

1.6 In the discussion document the Government set out its key objectives:

- to make services more responsive to the consumer;

- to raise standards of care;

- to promote health and prevent illness;

- to give patients the widest range of choice in obtaining high quality primary care services;

- to improve value for money;

- to enable clearer priorities to be set for family practitioner services in relation to the rest of the health service.

The discussion document contained a range of proposals for meeting these objectives.

The Outcome of Consultation

1.7 It was clear from the consultation process that there is wide support for the Government's key objectives. A number of themes came through strongly:

- concern about the extent of preventable disease;

- the value which consumers - whether individuals or families - place on accessible, effective, and sympathetic family practitioner and community health services;

- the need of consumers for better, more detailed, and more accessible factual information about practitioners and the range and pattern of services they provide;

- the needs of the increasing numbers of elderly people;

- an overwhelming interest in the promotion of good health;

- the need to improve services in deprived areas particularly inner cities and isolated rural areas.

1.8 The Government accepts the need actively to address these important themes and believes that the best way of doing so is by requiring practitioners to increase the range and quality of services they provide. The Government believes that there are three inter-related ways of achieving this aim, namely:

- no opportunity should be lost to increase fair and open competition between those providing family practitioner services;

- to that end, consumers should have readier access to much more information about the services provided;

- and the remuneration of practitioners should be more directly linked than at present to the level of their performance.

Preventable Disease

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~~1.8~~ There has been a record of continuous progress in the prevention of disease and its early control. Improvements to the environment, for example through clean air legislation, has been accompanied by screening and immunisation programmes which have virtually eradicated many former killer diseases such as smallpox, diptheria and tetanus. The scourge of polio has almost gone and great progress has been made in the fight against TB. The health of mothers and children has improved. In the last 10 years the number of pregnant women attending clinics has risen by 70,000 a year. On dental health, there have also been improvements; nearly half of all children under five years old now have no decay at all. There is an increasing consciousness of the need to promote one's own health and interest in, for example, a well-balanced diet. Between 1978 and 1984 the number of adults who smoked cigarettes fell from 40% of the population of England and Wales to 34%. In these and many other ways, health standards are improving. But there remains a massive amount of preventable disease. The following statistics illustrate the scale.

- coronary heart disease : 180,000 deaths and some 25 million working days lost last year;

- obesity : a quarter of young people are overweight;

- measles : 90,000 cases in 1986 and over 1,000 admissions to hospital;

- alcohol misuse : at least 8,000 premature deaths each year from alcohol misuse;

- drug misuse : the number of addicts newly notified in 1986 exceeded 5,000;

- smoking : 100,000 deaths each year caused by smoking;
: 50 million lost working days;
: £400 million a year in NHS treatment costs;

- cancer : most of the women who die from cancer of the cervix have never been screened;

- dental disease : children under 16 have some 2 million teeth extracted and 6 million fillings each year.

1.10

~~1.9~~ Much of this distress and suffering could be avoided, if more individual members of the public took greater responsibility for looking after their own health. The Government fully acknowledges its responsibility to raise the individual's awareness of the consequences for continued good health of his or her own actions. This is done by various health education initiatives, of which the 'Look After Your Heart' campaign, launched in April this year, jointly by the Department of Health and Social Security and the Health Education Authority is the latest in England. "Heartbeat Wales" has made its own significant contribution within the Principality, as will the newly-established Welsh Health Promotion Authority. Last year more than £2.5 million was spent on anti-smoking activity. But the Government recognises that there is still much to do. Family doctors in the more forward-looking practices already contribute significantly to this health education process; and

so do dental practitioners. The major role of health visitors is the promotion of health and prevention of ill- health, and community psychiatric nurses are concerned with the promotion of mental health. The Government intends positively to encourage family doctors and primary health care teams to increase their contribution to the promotion of good health. These professional workers as well as dentists and pharmacists are in daily contact with large numbers of the public and represent the front line of health care; they could hardly be better placed to persuade us all of the importance of protecting our health, of the simple steps we need to take to do so, and of accepting that prevention is indeed better than cure.

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Community Nursing Services

~~1.10~~ Nurses working in the community play a major role in the provision of primary health care. They may work in health centres, surgeries, community health clinics or in people's homes and are ideally placed to respond quickly to the needs of individuals and families. The Review chaired by Mrs Julia Cumberlege highlighted this, and emphasised the importance of the nurse's role in the promotion of health and the prevention of illness as well as in the support of elderly or handicapped people in the community, together with those who care for them. Their recommendations included proposals for

improving the organisation of community nursing services, making better use of nursing skills and improving training. The Report emphasised that primary health care services were best provided by a range of professional staff working together as a team. The Government recognises this, and have made the strengthening of the primary health care team a major objective.

The Government's Plans

1.12 ~~1.11~~ The discussion document stated that "Our primary health care services are good but could be better still". To achieve that improvement, the Government intends to introduce a package of proposals designed to create a family health service, with an emphasis on promotion of good health rather than just on the treatment of illness; in other words, giving the consumer a better deal.

1.13 ~~1.12~~ The Government therefore intends to enter into discussions with the professions with a view to introducing the following main changes:

- agreed targets for achieving higher levels of vaccination, immunisation and cervical cytology testing;

- more health promotion sessions in general practice (eg heart disease prevention, advice on how to give up smoking and dietary advice);

- regular and frequent health checks for particular sections of the community (eg children and some elderly people);

- more information for consumers to enable them to choose the doctor who best meets their needs;

- a wider range of services for the consumer at the doctor's surgery (eg interpreter services, counselling, chiropody and minor surgical operations);

- a new contract for dentists which will encourage prevention and promote the quality of treatment provided;

- measures to improve the distribution of dentists;

- a dental health campaign to promote an awareness of the value of regular check-ups among the young;

- free spectacle repairs for the handicapped and a domiciliary sight testing service for the housebound on low income;

- an extended use of the pharmacist's skills.

- an enhanced role for Family Practitioner Committees in administering these changes.*

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~~1.13~~ The changes address all of the major issues debated in the Discussion Document and subsequently during the consultation period. ~~However two ideas for changing the family~~ doctors' remuneration system are not being pursued in the form proposed: the good practice allowance and the greater use of the capitation fee as the means of remuneration. Instead a more selective approach is proposed in Chapter 3 to take account of the growing interest in performance related pay and the potential effectiveness of capitation fees in raising the standard of care for particular groups such as children and ~~elderly people~~. The idea of Health Care Shops received little support in the consultation period and there are no plans at

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* The role and responsibilities of Family Practitioner Committees (FPCs) are discussed in Chapter 10.

present to introduce this form of health care provision. The Government will look further at the feasibility of the arrangement for integrated services if firm and costed proposals are received for consideration.

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~~1.14~~ As to the choice of family doctor, the Government intends to strengthen the consumers' position in two important ways. Firstly, the consumer will be much better informed about the services offered by local practices and will be able to choose the one that best suits his or her needs. Secondly the new financial incentives for doctors and the stronger management role for FPCs will encourage doctors to provide a better services thus creating a more competitive environment which will itself have the effect of raising standards further.

Deprived Areas

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~~1.15~~ Deprived areas such as some inner cities and peripheral housing estates and remote rural areas will benefit from these changes. General practice in deprived areas can be particularly demanding for reasons which are discussed in Chapter 9. The Government believes therefore that the quality of care in these areas needs to be raised significantly. Proposals for change are set out in later Chapters especially Chapter 9.

Legislation

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~~1.16~~ Legislation will be needed to introduce some of the changes proposed in this White Paper. The Government will therefore publish a Bill - the National Health Service and Medicines Bill - for consideration in the present session of Parliament.

Report of the Select Committee on Social Services

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~~1.17~~ In reaching its decisions on the future of primary health care, the Government has been greatly assisted by the report, entitled "Primary Health Care" and published in February 1987, of the House of Commons Select Committee on Social Services. The Government welcomes the Committee's report from which it is clear that the Committee and the Government are at one in being firmly committed to building on the strengths of the primary care services and to continuing to develop comprehensive care of a high standard, available and accessible to all. A more detailed response to the Select Committee's recommendations is set out in Appendix 1.

Wales

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~~1.18~~ For the most part the proposals set out in this document will apply throughout England and Wales. However, the detail of some of the proposals and their implementation in Wales will need to be the subject of discussion among interested parties in the Principality. Some variation between England and Wales will need to be negotiated, not least in the

context of the problems of areas of multiple deprivation such as some of the valley communities in South Wales. Rural areas too have their special problems which may call for locally agreed approaches.

1.20

Northern Ireland ~~1.19~~ While in England and Wales practitioners are in contract with autonomous Family Practitioner Committees, in Northern Ireland practitioners are in contract with the four Health and Social Services Boards, and their contracts are administered on behalf of Boards by the Central Services Agency. Practitioners are represented on the Boards, which provide health and personal social services for their areas within an integrated framework. Boards are thus well placed to secure a comprehensive and co-ordinated approach to primary care.

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~~1.20~~ To ensure that full advantage is taken of this structure in the future arrangements for the delivery of primary care, the Department of Health and Social Services in Northern Ireland has been conducting, within the context of national consutaltion, a supplementary local review which has concentrated on some key issues of particular local concern.

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~~1.21~~ Consultation on these issues will now be completed against the background of the proposals in this White Paper. Parity with Great Britain will be maintained on most of those proposals. Some of the proposals may however need modification or may not be appropriate for application in the circumstances of Northern Ireland, where for example most family doctors already practise from health centres and the standard of practice premises is generally good. Supplementary proposals for local application will therefore be developed following completion of the local review.

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~~1.22~~ The chapters that follow set out more fully the changes which the Government intends to make and how they intend to effect them. Together the primary health care services have a central role in achieving the Government's main objective: a healthier nation.

CHAPTER 2: RESOURCES

Cost of the Family Practitioner Services

2.1 The Family Practitioner Services in the UK will cost about £5,080 million in the present financial year (1987/88). Gross expenditure on individual services is estimated to be:

	£ Million (1987/88)
General Medical Services	1500
General Dental Services	960
General Ophthalmic Services	180
Pharmaceutical Services (other than medicines)	530
Medicines	1910
Total	5080

2.2 Expenditure on the Family Practitioner Services is met mainly from taxation with revenue from charges accounting for some 9 per cent of the total. This proportion has remained fairly constant over the last five years.

2.3 The Family Practitoner Services are the first and most frequent point of contact that most people have with the health service. The Government remains committed to this form of cost-effective care as demonstrated by the level of resources which have continued to be devoted to it. Expenditure on the Family Practitioner Services now accounts for 24 per cent of total spending on the NHS compared to 22 per cent in 1979-80.

2.4 In cash terms gross current expenditure on the family practitioner services has more than doubled - from about £2,050 million to £5,080 million. After allowing for general inflation, expenditure on the family practitioner services has increased by some 42 per cent in real terms, compared to a real terms increase of 11 per cent in overall public sector expenditure.

The Government's commitment to the Family Practitioner Services

2.5 The Government expects spending on the family practitioner services to continue to expand in future to pay for further increases in the numbers of family doctors, dentists and other professionals, and to meet the cost of more complex and expensive medicines. Over the next three years gross expenditure on these services is expected to rise in real terms by 12 per cent (or over £600 million in 1987-88 prices).

2.6 On top of this the Government is prepared to invest substantial extra resources into those parts of the primary care services where they are most needed, in order particularly to develop positive health promotion activities, raise standards and make the services more sensitive to the consumer. The exact amount to be spent on each family practitioner service will depend on the outcome of negotiations with the profession concerned and its willingness to accept changes to meet these and other objectives. The timing of the introduction of changes will depend on when resources become available and on the time it takes to complete the negotiations. In addition the Government will establish a Primary Care Development Fund to be disbursed by the Health Departments and by Family Practitioner Committees (and Health Boards) to finance individual projects.

2.7 All this means large sums of extra money for the Family Practitioner Services which will be directed at those areas of the services where the need for improvement is greatest.

2.8 The discussion document outlined various ways in which the primary care services could be improved but pointed out that developments which cost money would have to be funded through better use of existing resources. In the comments made during consultation, no one who supported such developments suggested where economies could be made in the Family Practitioner Services to finance them. As a result the Government has considered how the substantial extra sums it proposes to make available should be financed.

2.9 The Government has carefully reviewed the priorities within the Family Practitioner Services and has concluded that in order to finance important developments in the primary care field it should reduce its current level of expenditure on the general ophthalmic and dental services. In reaching these conclusions the Government noted the very substantial improvements in dental health that have occurred in recent years and also noted the benefits to the public that have flowed from the introduction of greater competition in the optical market following the changes made in 1984 and 1985.

Sight Testing

2.10 Following changes to the General Ophthalmic Services introduced by the Government in the last Parliament, the provision of spectacles under the NHS was phased out and all patients now obtain their spectacles privately. Children and those on low income however receive a voucher which meets the needs of those who could not be expected to afford the cost of

spectacles purchased privately. These new arrangements have worked well and benefited both the patients and those involved in dispensing spectacles by lowering prices, and increasing choice and extending professional freedom. They have also reduced the cost of the General Ophthalmic Services to the taxpayer, enabling scarce resources to be moved to other priority areas. The Government now believes that similar benefits can be obtained by adopting the same approach to sight testing. The Government intends therefore to take powers in the NHS and Medicines Bill to remove sight testing from the NHS for those who can afford to pay. Children, adults on low incomes and the registered blind and partially sighted will however continue to be eligible for sight tests under the NHS. The additional cost to most patients, who it is estimated have their sight tested every three years on average will be small. Competition between opticians may well result in the cost of the sight test being wholly or mainly absorbed by opticians. This measure will however release a substantial sum towards the cost of the major improvements in primary care set out in this White Paper.

Dental Charges

2.11 The Government also intends to generate increased resources for primary care service developments by adjusting patient charges for dental treatment. Since 1951 patients have been required to make a contribution towards the cost of the provision of dental services with the exception of children and young people, pregnant women and mothers who have had a baby in the previous 12 months and those who cannot afford to pay NHS charges. The government intends to continue to exempt from charges those priority groups, who account for just under half of all courses of treatment under

the general dental service, but to expect those who can afford it to pay more towards the cost of their treatment.

2.12 The Government proposes to replace the present complex system of dental charges with a fully proportional system under which all charges would be related to the cost of treatment. The new arrangements should be such as to allow that relationship to continue under any future dentists' remuneration system that might be introduced. The Government therefore intends to take powers through the NHS and Medicines Bill to introduce different systems of charges (including a fully proportional system), and to give scope for raising charges on any new fees and allowances which might be introduced into the dental remuneration system.

2.13 The nation's improving dental health means that greater emphasis will increasingly be given to regular dental examinations, preventive treatment and advice, and proportionately less to interventive dentistry. Dental examinations already form an increasing proportion of dentists' work. The Government has concluded therefore that it should take powers to require patients other than those who are exempt from charges to contribute towards the cost of their dental examination.

2.14 The overall effect of these changes will be to increase the proportion contributed in charges towards the cost of the general dental services. Nevertheless for a substantial number of patients, mainly those who attend the dentist regularly and require little treatment, the amounts they pay will actually fall or not increase at all. The new charge for a dental examination, which many patients will have ~~about once a~~ no more than once a year, will be set by the Government in the same way as other dental charges, and at today's prices would be under £3·00.

year, will be very modest. Those paying more for treatment under the new system will do so because that treatment is more expensive than that provided for other patients. The new system is therefore fairer and will benefit those who look after their teeth.

CHAPTER 3 - GENERAL MEDICAL SERVICES

Preface

3.1. This chapter describes a range of measures which the Government believes will secure significant improvements in the General Medical Services (ie the services provided to the public by family doctors). The Government will shortly open negotiations with the profession with the intention of securing their agreement to the changes proposed. Extra funding for the changes will be available, although the extent of new investment in the services will need to reflect the outcome of negotiations.

Introduction

3.2 Nearly everyone - 99 per cent of the population - is registered with a general medical practitioner (GP - the family doctor), who is for most people the first point of contact with the NHS. Family doctors and their practice teams provide continuing care for people on their lists, and treat the vast majority of illness without referral to hospital. On average people see their family doctor four times a year. 90 per cent of medical episodes are dealt with outside hospitals, the majority by family doctors.

3.3 There are currently over 30,000 family doctors providing General Medical Services in the UK. The number is rising by about 1.7 per cent a year, and general practice continues to be a popular career choice for young doctors. Correspondingly the rise in numbers of doctors has been balanced by a steady fall in the average number of patients on a GP's list (see Table 1).

3.4 Rising doctor numbers have been accompanied by developments in and changing demands on the General Medical Services. In the mid 1960s the medical profession published the "Family Doctor's Charter", a document which expressed the widespread dissatisfaction among family doctors at the time, particularly about poor standards of surgeries and the difficulties facing those wishing to form group practices and to employ more ancillary staff. The ensuing negotiations between the health departments and the medical profession led to a restructuring of the family doctors' remuneration system, one objective of which was the introduction of incentives to raise standards.

3.5 As a result family doctors have been able to reorganise the services they provide in a way which has eased the burden on individual doctors while at the same time improving the range and standards of service to the public.

The Need for change

3.6 The Government recognises the important contribution of the General Medical Services to the provision of health services in this country, and acknowledges the key position which they hold in the NHS. Standards of service delivery have undoubtedly improved. Nevertheless there are wide variations in standards across the country, particularly in inner cities, where too many, often elderly, doctors are operating single-handed practices where group practices would be more effective. Generally there is still too little team working in general practice, and there are too many surgery premises whose standard is unacceptably low. Moreover, while the better practices are meeting the increasing demand from patients for preventive services and for advice on health promotion, some practices do not. The Government intends to raise standards of all practices nearer to those of the best.

3.7 A range of new measures is now needed to:

- ensure the patient's requirements are met

- raise standards of care

- encourage health promotion and prevention of ill-health

- give the public a greater choice

- improve value for money.

- improve service provision in inner cities and other deprived areas.

3.8 The Government sees these steps as leading the way towards a family doctor service which responds effectively to the needs of the consumer. An important element is a much better understanding by the consumer of what is on offer and what is needed. The Government intends that consumers should become better informed about the services they can expect their doctors to provide and more effectively to exercise their right to choose the doctor who best suits them. To this end a greater degree of competition in providing services to patients is the necessary impetus and the combination of a better informed public and a remuneration system geared to consumer demand provides the mechanism.

3.9 It is the Government's intention therefore to make the NHS contract with family doctors more sensitive to the range of services provided. This will be achieved over time by adjusting the balance between the doctor's income from capitation fees and the income from allowances. A basic core of health provision is expected for the payment of capitation fees which in turn will be complemented by incentive payments designed to encourage the provision of services targeted at specific health care objectives (eg high levels of vaccination, immunisation and cervical cytology). At present capitation fees form an average 47% of the doctor's income. The Government intends to raise this to at least 50% in the first instance. As public awareness increases and services improve, the Government intends to move further in this direction in order to encourage doctors to practise in ways that meet patients' needs.

3.10 The Government will therefore open discussions with the profession with the aim of improving incentives and introducing greater equity, so that the many family doctors who already work hard to provide comprehensive, patient-oriented services - and who incur substantial expenses - will be appropriately rewarded, while those whose standards fall short will have to improve their performance if they are to maintain the level of remuneration they receive at present.

Health Promotion and Prevention of Ill-Health

3.11 As Chapter 1 makes clear, the Government attaches great importance to the promotion of good health and the prevention of ill-health. In the responses to the Discussion Document there was overwhelming support for doing more in the primary care field to promote good health and the prevention of ill-health. In its report the Social Services Committee said that "Few, if any, commentators would disagree with the premise that the next big challenge for the NHS, and one especially for primary health care, is to shift the emphasis from an illness service to a health service offering help to prevent disease and disability."

3.12. The link between life-style and ill-health is now better understood. In the health care system family doctors have a key role in advising patients about life-style. Many doctors already offer advice on giving up smoking, reducing alcohol consumption, and on diet and exercise, but there is scope for considerable extension of this role, including through provision of health promotion clinics. Routine screening for high blood pressure could identify people at particular risk from heart disease.

3.13. More women aged 25-65 die from cancer than from any other cause. Screening and early detection can reduce mortality from cervical and breast cancer and the Government has taken a number of steps to improve the effectiveness of cervical cancer screening programmes and to ensure that the highest possible standards are maintained. Sir Roy Griffiths, Deputy Chairman of the NHS Management Board, is overseeing the implementation of the Government's policies on both breast and cervical cancer screening.

3.14 GPs play a key role in cervical cancer screening, which has been available to women aged 35 and over since 1966 and to younger women since 1984. FPC-based computerised call and recall systems will have been introduced throughout the country by spring 1988, and are being extended to cover all women aged 20-64. Deaths have fallen by 10 per cent in the last 10 years, although the....

.... incidence in younger women is increasing. The Government has also announced the introduction of breast cancer screening. Women aged 50-64 (the age group for which mammographic screening has been shown to be effective) will receive regular invitations, preferably from their own GPs, to be screened at the new units which health authorities are setting up throughout the country between now and March 1990.

3.15 Through their regular contacts with families and patients, GPs and other members of the primary health care team such as health visitors, community nurses and practice nurses are well placed to promote good health and to prevent ill-health by giving advice on lifestyle, by providing screening for certain conditions eg high blood pressure and by improving take-up of vaccination and immunisation. In the best practices family doctors and their teams already do so, but there are some who do not although public demand for advice and information is increasing. In recognition that a doctor's responsibility for the continuous care of a patient begins once he or she registers with the doctor and that the doctor, with the primary care team, has an immediate health promotion role, the Government intends to pay a special fee to encourage doctors to provide an initial clinical assessment (ie. a health check and any necessary follow up) for patients registeringfor the first time with an NHS doctor.

3.16 In its comments on the Discussion Document the medical profession's representatives said that there was scope for developing preventive services by building on existing financial incentives for GPs. The Government will consider what incentives may best be incorporated in the remuneration system so as to achieve specified target levels of provision

for vaccination and immunisation and for screening and to meet the cost of call and recall systems. The Government will also consider amending the doctor's terms of service to clarify his role in the provision of health promotion services, and prevention of ill-health. Doctors will be encouraged to recognise the role played by the primary health care team in meeting locally agreed targets.

Standards of care

3.17 The Discussion Document proposed that the GPs' remuneration system "should be developed in order to recognise high standards quite explicitly, probably through the introduction of a 'good practice allowance'". It suggested that entitlement to the allowance might be linked to such factors as:

- personal availability to patients
- provision of a wide range of services, including prevention
- ensuring certain services had been provided for an agreed proportion of patients in certain categories
- attendance at recognised post-graduate education courses.

It also suggested that payment of the allowance would require introduction of "peer review" arrangements whereby some aspects of a doctor's services would be assessed by other doctors.

3.18 Although the concept of an all embracing Good Practice Allowance did not gain wide support during the period of consultation, it was clear that the factors listed in the previous paragraph did. The Government believes that family doctors who offer a full and accessible service at times convenient to consumers should be properly rewarded for doing so. Indeed the profession's representatives are on record as supporting the concept of performance related pay. Much of what is recommended in this chapter seeks to relate pay to the type and extent of services provided. Looking beyond provision to the actual quality of care, the Government welcomes and will support financially experiments in voluntary peer review.

3.19 Although many doctors provide an impressive service for their patients, some appear to provide no more than the minimum. In 1985/86 the Health Departments and the General Medical Services Committee of the British Medical Association undertook a survey of the workload of family doctors. The survey showed that the average family doctor spent 38 hours each week on General Medical Service duties. There were, however, wide variations between individual doctors. For example, about 15 per cent worked 50 hours or more while 24 per cent worked fewer than 30 hours.

3.20 The Government intends to change the remuneration system to encourage greater basic commitment than at present to the General Medical Services. <u>The Government intends therefore to tighten the qualifications for full basic practice allowance</u> Current entitlement to full basic practice allowance (BPA) - £7,850 - depends on a minimum list of 1000 patients, and an average 20 hours per week of provision of services to patients. The Government

intends to increase the minimum list size and to increase the average number of hours spent per week in surgery sessions. In addition, payment of the allowance should depend on a doctor carrying out health promotion and prevention of ill-health activities. It is important that services should be provided at hours more convenient to patients and the Government will discuss with the profession the conditions for achieving this objective. Family doctors will continue to be responsible for the care of their patients for 24 hours a day.

Minor Surgery

3.21 Patients requiring minor surgical operations are sometimes faced with long waiting times before they can be treated in hospital. One way to reduce waiting times would be for more family doctors to undertake minor surgery in suitable cases. Patients would benefit from a rapid and more convenient service and minor surgery cases would not take up time in out-patient departments, which could more appropriately be used for serious problems. <u>The Government is considering an incentive in the remuneration system to encourage doctors to carry out this work.</u>

Putting the patient first

3.22 The Discussion Document proposed a number of other measures intended to improve services to patients, including the provision of more information, greater freedom in the choice of doctor and a simplified complaints procedure. During consultation there was strong support for all these proposals.

More information for patients

3.23 The Social Services Committee endorsed the Government's view that the freedom of patients to choose their doctor could be an effective influence on the quality of services, and supported its intention to make the complaints procedure simpler,

more accessible and more effective. The Committee also recommended that Community Health Councils (CHCs) should seek to make available to patients much more information about the services offered by local practitioners and urged GPs to participate fully in putting together useful information for the public; and that all CHCs should publish information about the health services in their area in the language of the minorities in the community, as well as in English.

3.24 To enable people to make an informed choice of doctor, the Government will require FPCs (in Scotland, Health Boards (HBs)) to provide more comprehensive information about practices in their areas. In addition to names and addresses, (which are currently recorded on Medical Lists), doctors' year of qualification, sex and qualifications should be included, along with essential practice information such as opening hours and services provided and arrangements for emergencies and night calls. The Government intends that these lists should be made more widely available locally.

3.25 Good communication between doctors and patients, and between doctors, including between those working in primary care and in hospitals, is fundamental to the provision of good patient care. The British Medical Association has issued guidelines to family doctors advising them on the production of practice booklets for patients, and recommended that they should be provided to prospective patients. The Royal College of General Practitioners has also encouraged practices to produce factual leaflets or brochures which set out for the public useful information about the doctors, the services they provide and the organisation of

the practice. The Government believes that wider practice leaflets of this kind will be a valuable supplement to FPCs' and HBs' official lists, and will encourage their wider provision.

3.26 The Government has noted with approval the General Medical Council's recent statement that "the ethical dissemination of relevant factual information about doctors and their services is strongly to be encouraged", but believes that there are still too many restraints on the extent to which general practitioners may publish factual information about their practices and the services they provide. Such restraints deprive the consumers of information to which they have a right and discourage proper competition between practitioners. The Government intends, therefore, to open discussions with the General Medical Council with a view to reducing these restraints, subject to proper safeguards for the professional status of the practitioners and for the protection of the public.

Changing Doctor

3.27 The provision of more comprehensive and accessible information will enable people to be more discriminating in their choice of practice and of doctor and thus a degree of competition will be introduced which should further encourage doctors to improve the quality of services. To enable patients to make use of this information the Government will make it simpler to change doctor by amending the NHS (General Medical and Pharmaceutical Services) Regulations 1974 and the corresponding Scottish Regulations so that patients will no longer have to approach their FPC (or HB) or existing doctor before registering with a new doctor.

Simplified Complaints Procedure

3.28 The Government's plans for improving the procedures for dealing with complaints, set out in Chapter 8 of this document represent a further significant step towards a more consumer-orientated service. In particular the extension of informal conciliation procedures to those FPCs which do not at present offer such a service, and of the informal procedures to contractor services other than just doctors as at present, will be of benefit to the patient in providing for problems to be resolved quickly and effectively.

Taking the Patient's View into Account

3.29 In many fields the importance of the views of consumers is well recognised, and their comments are taken into account. While Community and Local Health Councils have a role in representing the consumers' interests in the NHS, until very recently there has been little indication that the views of consumers have influenced the organisation or provision of the family practitioner services. The Government now intends to take steps to ensure that the public's comments are sought on the services provided locally and that the views expressed are taken fully into account in any changes introduced. In this respect FPCs and HBs will be expected to consult more closely with Community and Local Health Councils as well as with consumers directly through local public opinion surveys.

Quality of Services

3.30 A number of factors affect the quality of General Medical Services, which varies considerably from place to place with inner cities as well as the remote rural areas and peripheral housing estates having their own special problems. First, because of the differences in age structure and medical and social needs, the demands placed upon doctors in some areas are greater and more varied and the turnover of patients is much higher than in others. Second, the standard of practice premises is often poor: in some areas a substantial proportion of premises are considered below minimum standards. Yet the shortage of suitable premises and in inner cities the relatively high value of some property make improvement difficult. Third, there is widespread variation in the development and use of practice teams. Fourth, the needs of certain people, including ethnic groups who tend to live in the inner cities, place special demands on

those providing medical services. The proposals which follow will ensure that the quality of services will be improved, and that variations in standards of care will be reduced.

Distribution of Family Doctors

3.31 The Medical Practices Committee (MPC) and its Scottish counterpart control the distribution of doctors to ensurethat there are adequate numbers of doctors throughout the country. This is a complex task, and one which at present includes consideration of local features such as geography, communications and morbidity data. Such local factors may significantly affect doctors' workloads, especially in inner cities and other deprived areas where the demands on the services available are greater than elsewhere. Nevertheless in determining the distribution of doctors there is scope for giving greater emphasis to local information about medical and social needs. Therefore the Government will discuss with the MPC and its Scottish counterpart how more account can be taken of such local information in determining the distribution of doctors.

3.32 A system more closely related to medical and social needs will create new vacancies in areas where doctors' workloads are high in relation to their list size. To support doctors practising in these areas the Government will introduce a new allowance especially related to working in areas of deprivation. The effect of these arrangements will be examined and if necessary other changes in the remuneration system will be introduced, for instance to help doctors in sparsely populated areas.

Rural Areas

3.33 The Government recognises that the practices of doctors in isolated rural areas, and especially of those who are single-handed, are affected by a number of factors which can contribute to professional and social isolation. Particular difficulties can be experienced by those doctors and their families for example in arranging regular time off for leisure and study and coping with family emergencies and the stress of being constantly on-call. To take account of the particular pressures on these doctors, the Government will examine, in consultation with the profession, the scope for introducing measures aimed at alleviating their isolation, in particular by means whereby they might have more opportunities to attend post-graduate courses.

Retirement

3.34 There are at present about 550 family doctors aged 70 or over in general practice and 20 of those doctors are more than 85 years old. It is not reasonable to expect doctors to continue to work past the age at which they can be expected to carry out properly the exacting responsibilities of a principal in general practice. Therefore the Government will introduce a compulsory retirement age of 70 for GPs and will end the practice known as 24 hour retirement (whereby doctors aged 65 or over can retire, draw their pension and return to practice a day later without abatement of pay or pension). These measures were widely supported in consultation on the Discussion Document and by the Social Services Committee. The places of retiring doctors should be taken by younger, vocationally trained doctors, who are generally keen to work in group practices and as members of primary health care teams.

3.35 Detailed arrangements including the possible need for limited transitional provision will be the subject of further discussion with the profession. The Government does however intend to provide that, exceptionally, an FPC or HB may continue to contract with a doctor aged 70 or over where the doctor's retirement would adversely affect the continued provision of an adequate service to the public. FPCs and HBs - in association with the MPC and its Scottish counterpart - will be asked to plan for the replacement of the retiring doctors. Opportunities should be sought for replacing single-handed practices with group practices where appropriate and in co-operation with other local agencies FPCs and HBs should assist in identifying suitable premises for the new practice.

Women Doctors

3.36 Many women, particularly from ethnic minorities, are reluctant to seek medical advice from male doctors. In the comments on the Discussion Document the need for more women doctors was emphasised. The Government has already acknowledged that there may need to be special arrangements to attract women doctors to general practice and to encourage their appointment to the vacancies that occur, and the Social Services Committee has expressed agreement with this view. Over the last decade, the percentage of women family doctors has increased from 13% to 19%. Today about 40 per cent of GP trainees and 46 per cent of medical undergraduates are women a considerable increase over the level of the mid 1970s. The Government will discuss with the professions what arrangements (such as the development of opportunities for job sharing and part-time working) might be made to ensure that more women are encouraged to enter and remain in general practice.

Primary Health Care Teams

3.37 <u>The Government remains firmly committed to the continued development of primary health care teams.</u> A large majority of those who commented on the Discussion Document attested to the value of a team of professionals working closely together under one roof to provide primary care services. Patients can benefit from the sharing of tasks between GPs and other members of the team. This method of working is more efficient and effective and provides higher quality of care and wider choice for patients. For example, trained nurses can provide vaccination and immunisation and screening services; chiropodists can help elderly people to remain mobile; physiotherapists can help patients with their disabilities; and practice managers can improve the organisation and efficiency of practices. The Social Services Committee suggested that some social workers might work from the same premises as the GP, and the Government endorses this. Practice teams offering a wider range of expertise should improve services to patients and help to reduce the period between requesting and obtaining an appointment, as well as the time spent in the waiting room before seeing the doctor - both frequent causes of dissatisfaction among patients.

3.38 At present a family doctor may employ any number of staff in the practice. Through the remuneration system (see Appendix 2) the costs of employing such staff are indirectly reimbursed to the profession on an average basis, apart from 70 per cent of the salaries of certain staff (nurses, dispensers, secretaries and receptionists) which are directly reimbursed subject to a maximum of 2 full-time staff per GP. Although the number of employed staff has risen over recent years the average attracting direct reimbursement is however only [1.1 whole time equivalent per doctor] and there are wide variations between practices.

3.39 The Government believes that the time has come to remove the restrictions on the types and number of staff whom the general practitioner is encouraged to employ through the direct reimbursement scheme. And it will provide additional resources to finance an extension of the scheme. Funds will be allocated to FPCs and HBs to cover all the payments for the direct reimbursement of expenditure on staff. FPCs and HBs, in consultation with local medical committees, will be responsible for ensuring that the best use is made of the funds allocated to them for this purpose. This system should ensure that the fullest possible account is taken of local need; and should encourage FPCs in collaboration with District Health Authorities and HBs to devise locally agreed strategies for developing the use made of practice teams. Doctors providing services to ethnic minorities will particularly benefit from this proposal, since they will be able to apply for direct reimbursement for interpreters and link workers.

Premises

3.40 A major objective of Government policy is to continue to improve practice premises, particularly in deprived areas. To achieve this the Government will increase the assistance available to doctors in improvement grants and under the cost rent scheme, (which provides doctors with financial support for their investment in premises development). For these purposes funds will be allocated to FPCs and HBs in accordance with need, and will be targeted on premises where the greatest improvement is required. FPCs and HBs will provide advice and encouragement to those responsible for premises in need of upgrading to ensure they obtain and use the funds available to improve standards to an acceptable level. The Government will also examine the scope for introducing regional variations in cost limits for the cost rent scheme to take account of higher building costs in some parts of the country.

3.41 The Government will also review its minimum standards for premises. FPCs and HBs will continue to be responsible for the inspection of premises, and will be required to apply sanctions more stringently than before in respect of inadequate premises. These include the witholding or abatement of payments for rent and rates (and, if necessary, use of service committee procedures) if the doctor fails to take action to improve the surgery premises.

General Practice Finance Corporation

[DN. The following paras about the GPFC are drafted on the assumption that a privatised but statutory GPFC will emerge from current considerations and that an announcement will be made before the White Paper is published.]

3.42 The General Practice Finance Corporation (GPFC) was set up in 1966 as a Government guaranteed source of loans to enable family doctors to acquire surgery premises. In the intervening years the GPFC has contributed significantly through its loan schemes to improvements in the environment in which patients are treated.

3.43 The Government proposes to change the constitution of the GPFC to enable the Corporation to make maximum use of private sector funds for loans to doctors. In recent years the availability of finance from the private sector for loans has improved dramatically compared with the situation in the mid 1960s. There is now a much greater willingness on the part of private financial institutions to lend to doctors and the Government believes that full advantage should be taken of the new situation.

~~3.44~~

~~3.41~~ Family Practitioner Committees and Health Boards with deprived areas within their boundaries will be particularly keen to see improvements in

the quality of local practice premises. The Government has no reason to believe that the private sector will be reluctant to lend to doctors practising in these areas. Indeed the central thrust of the Government's deprived areas policy is that the regeneration of inner cities should be led by private sector investment. Nevertheless if evidence should emerge that private sector funds are not available to doctors practising in these areas, the Government will be prepared to consider making arrangements to ensure that funds are made available.

Elderly People

3.45

~~3.44~~ Consultations with elderly people represent a substantial part of a doctor's workload. Table x shows how the elderly population in England is expected to grow in the next 25 years: those aged 85 will almost double in number, and the rate of growth among these aged 65 and over is more than twice that of the general population. A doctor has 5 consultations on average per annum with each patient aged 65-74, compared with 4.3 for patients of all ages. For patients aged 75 or over the number rises to 6.3. 50 per cent of these consultations take place in the patient's home.

3.46

~~3.45~~ Certain doctors have a much higher proportion of elderly patients than others, for example those who practice in areas where there is a growing number of residential and nursing homes for elderly people. Some elderly people living in the community, for example those living alone, may have special needs. Assistance in maintaining a healthy lifestyle and regular and frequent assessment as part of a continuing programme of care are therefore particularly important for them. Therefore the Government will, through changes in the remuneration system, encourage doctors to provide comprehensive regular care for elderly people.

Children

3.47 ~~3.46~~ In the early years of life, children are particularly prone to illness and accidents, and many parents need frequent advice on treatment and care. On occasions, appropriate preventive measures and prompt action can avoid the possibility of life long handicap. It is important for doctors to be alert to, and to recognise, situations in which children might be at risk. In particular, the risk of child abuse is something which family doctors, because of their frequent contacts, are well placed to identify. The Government expects a greater commitment from family doctors in overseeing and promoting the well-being of children, and proposes to make a change in the remuneration system in recognition of this workload.

3.48 ~~3.47~~ The discussion document put forward the proposition that more family doctors should be involved in child health surveillance. This function requires all aspects of the health of the child including his or her family setting and environment to be taken into account. It is the responsibility of the district health authority to provide this service. Some authorities have appointed consultant community paediatricians to oversee this task. Child health surveillance is a broader and more systematic process than the opportunistic assessments envisaged in the previous paragraph. It is a process to which many health care and other professionals contribute. During consultation on the Discussion Document there was strong support for the greater involvement of family doctors in this work.

3.49 ~~3.48~~ The Government intends that progress should be made towards achieving this objective. Therefore FPCs acting with the agreement of DHAs, will be asked to experiment locally with the assignment of the medical aspect of child health surveillance of the under 5s to suitably trained GPs. The Government will be willing to introduce an

allowance payable to GPs who receive appropriate training (the profession's views will be sought on what training should be required) and who provide child health surveillance services for the under 5s for the District Health Authority. If the experiments prove successful, and in the light of the outcome of the current studies already referred to, the Government will seek ways of extending them to other areas. It is clear, however, that any change will take place gradually and that there will continue to be an important role for community health services in child surveillance.

Education and Training

3.50

~~3.49~~ In the comments on the Discussion Document there was wide agreement on the importance of continuing relevant medical education. The present post-graduate training allowance has served a useful purpose in helping doctors to keep abreast of developments in knowledge and professional expertise, but it is only available to doctors in their first years of practice and therefore its value is restricted. Now that vocational training for principals in general practice is mandatory, the vocational training allowance is redundant and the Government proposes to abolish it. The Government will introduce a new post-graduate educational allowance in place of both these allowances. Doctors will qualify for the allowance if they maintain a regular programme of education and training throughout their careers. The Government will discuss with the profession the range and provision of approved training courses and distance learning. The Government will also strengthen support for family doctors who, in association with academic departments of general practice, are involved in the clinical training of undergraduates. The Government values the

contribution which these doctors make in promoting higher professional standards and in developing research and good practice within the General Medical Services.

3.51
~~3.50~~ Both at the public Consultation meeting in Manchester in November 1986 and in written comments made on the Discussion Document, notably by the Social Services Committee, great stress was placed on the importance of training for practice nurses.The Government accepts the importance of providing for the training of all professional staff, including nurses employed in practices. At present the costs of only some training are directly reimbursed, the remainder - including most practice nurse training - is indirectly reimbursed on an average basis to the profession as a whole. The Government will now arrange for the training costs of all professional staff to be reimbursed directly on a similar basis to existing arrangements Part of the funds to be made available to FPCs and HBs for the direct reimbursement of employed practice staff will be allocated for this purpose.

3.52
AIDS

~~3.51~~ The demands upon the health service change over time, an obvious example being the emergence of AIDS. People suffering from AIDS require specialist hospital services, but they spend far more time out of hospital than within. General practitioners and Primary Health Care Teams therefore have an important role in counselling, care and treatment. The Government has already supported courses and training posts for general practitioners and community nurses and will ensure that people can be cared for in their homes when this is possible and is what they wish.

Computers

3.53

~~3.52~~ At the public consultation meeting in Exeter in October 1986, as well as in written comments, there were calls for greater use of computers in primary health care to enable call and recall systems to be extended for preventive purposes, screening and surveillance. A variety of computer based systems alrady exists, some based on DHAs, some on FPCs and some on individual practices. The Government has acted to speed up the computerisation of FPCs which should be complete by March 1988 and to extend the use of computers in screening for cervical cancer and breast cancer. But there is scope for further development (for example to make available to family doctors information about hospital waiting lists and times, information on prescribing, and about practice activity generally). In particular,although it is important to provide adequate links between computers in doctors' practices and in FPCs, links with hospital services which would enable family doctors to receive immediate information on the discharge of their patients would also be valuable. The Government will encourage the continued development of information and communication technology and computerisation in primary care, especially with regard to health promotion and prevention of ill-health.

3.54

~~3.53~~ In Scotland considerable progress has already been made in this area and the General Practice Administration System for Scotland (GPASS) is currently used by nearly 25% of general practices. Although GPASS allows for the insertion of recall markers against individual patients, a more comprehensive call/recall system is being developed based upon the existing Community Health Index (CHI) System. This involves the

redevelopment of a module for immunisation recall and the development of a full call/recall system for cervical and breast cancer screening. Both should be available shortly and plans are in hand to provide link ages to GPASS in due course. Longer term plans to link with an appropriate hospital clinical system will further increase the scope for the integration of primary and hospital care.

Value for money

3.55

~~3.54~~ The costs of the General Medical Services have been rising in real terms in recent years. Yet it is not clear that the public has benefited from a corresponding improvement in quality of service.

3.56

~~3.55~~ Many of the improvements set out earlier in this chapter will improve value for money. Tighter qualifications for basic practice allowance will encourage doctors who do not provide a full time service to increase the basic level of services provided under the General Medical Services. The introduction of compulsory retirement will raise standards of care without additional cost. New fees and allowances, linked directly to the provision of specific services, such as health promotion and vaccination and immunisation, and the Government's policy for practice premises will target resources at areas where greatest improvement is needed. A wider range of employed practice staff will not only improve the quality of service to the public but also raise cost effectiveness.

Hospital Referrals

3.57

~~3.56~~ The cost of medicines prescribed by doctors is the largest single element in family practitioner services expenditure, and the

Government's intentions in relation to prescribing are set out in Chapter 6. Health authorities incur a very substantial cost through family doctors' decisions to refer patients to hospital and through their use of hospital diagnostic and treatment facilities. It is important that expensive hospital facilities are used in the most cost-effective way, and the wide variation in referral rates suggests that this may not always be the case. Family doctors (who have no information about the costs) have little reason to examine their criteria for referral. A minority may refer substantially more patients to hospital than the requirements of the individuals concerned merit. Equally, there are doctors who refer substantially fewer patients than average and whose patients maynot therefore reap the advantages of the full range of modern health care. The Government welcomes work being done in some areas by family doctors and specialists to examine the criteria used in making referral decisions.

3.58

~~3.57~~ Once a system for supplying referral information in respect of individual doctors has been developed, it is proposed that FPCs and HBs should use independent medical advisers to encourage good referral practice. Doctors with abnormally high or low rates of patient referral to hospital will be invited by the medical adviser to discuss their referral patterns with a view to assisting them in making effective use of hospital resources.

Annual Reports

3.59

~~3.58~~ In its report the Social Services Committee said that "Group practices .... could be required to demonstrate, possibly in the form of an annual report to the local FPC, how they have fulfilled their undertakings in any one year in relation to locally agreed objectives", and recommended accordingly.

3.60

~~3.59~~ The Government sees advantage in practices submitting annual reports to FPCs and HBs about the range of services offered and the workload undertaken in the period in question. This should encourage doctors to focus more clearly on the provision of high-quality, patient-oriented services with clear objectives and the need to plan for their development and improvement as well as improving the managerial function of FPCs and HBs. Therefore the Government intends to discuss with the profession's representatives the feasibility of requiring practices to submit annual reports to FPCs and HBs.

FPCs, HBs

3.61

~~3.60~~ The Government recognises that the proposals in this chapter will increase the functions carried out by FPCs and HBs. Chapter 10 discusses in detail the Government's intentions in respect of these bodies.

Conclusion

3.62

~~3.61~~ The Government will shortly open negotiations with the profession on the policies outlined in this chapter of the White Paper. On completion of the negotiations evidence will be put to the Review Body on Doctors' and Dentists' Remuneration.

Fig 1. Number of doctors and average list size

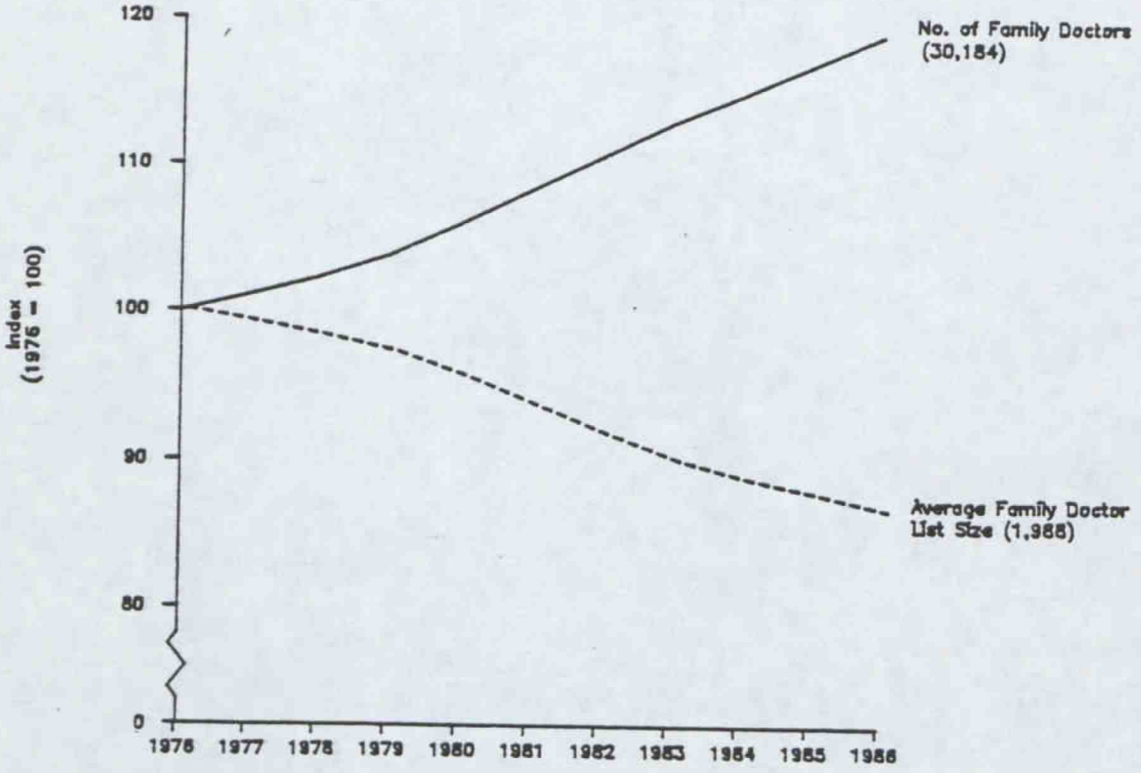
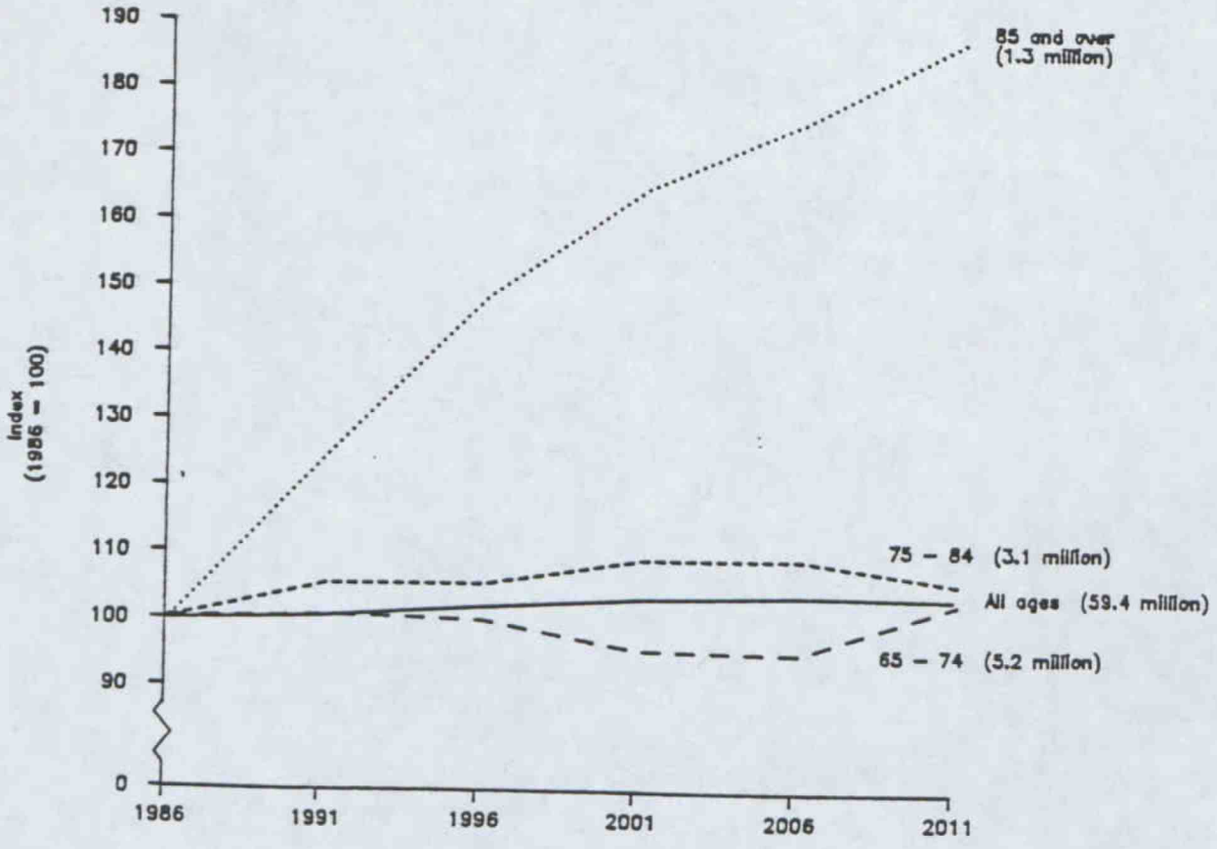


Fig x. Changes in elderly population, U.K.



CHAPTER 4 - DENTAL SERVICES

Introduction

4.1. The Dental Services have made an important contribution within the NHS to the improvements in the dental health of adults and children since 1948. It is the Government's intention that they should continue to play a major role in primary care over the years ahead.

4.2. The improvements in dental health (see Figures 1 and 2) in the years since the NHS was established have been considerable both for children and adults. The reasons for these improvements include:

- greater awareness of the need for caring for the teeth
- growing use of fluoride tooth paste
- fluoridation of water supplies in some areas
- improved eating habits and better standards of nutrition
- greater access to dental care

The expectation is that dental health will continue to improve.

4.3 Government policies aim to secure this continued improvement in dental

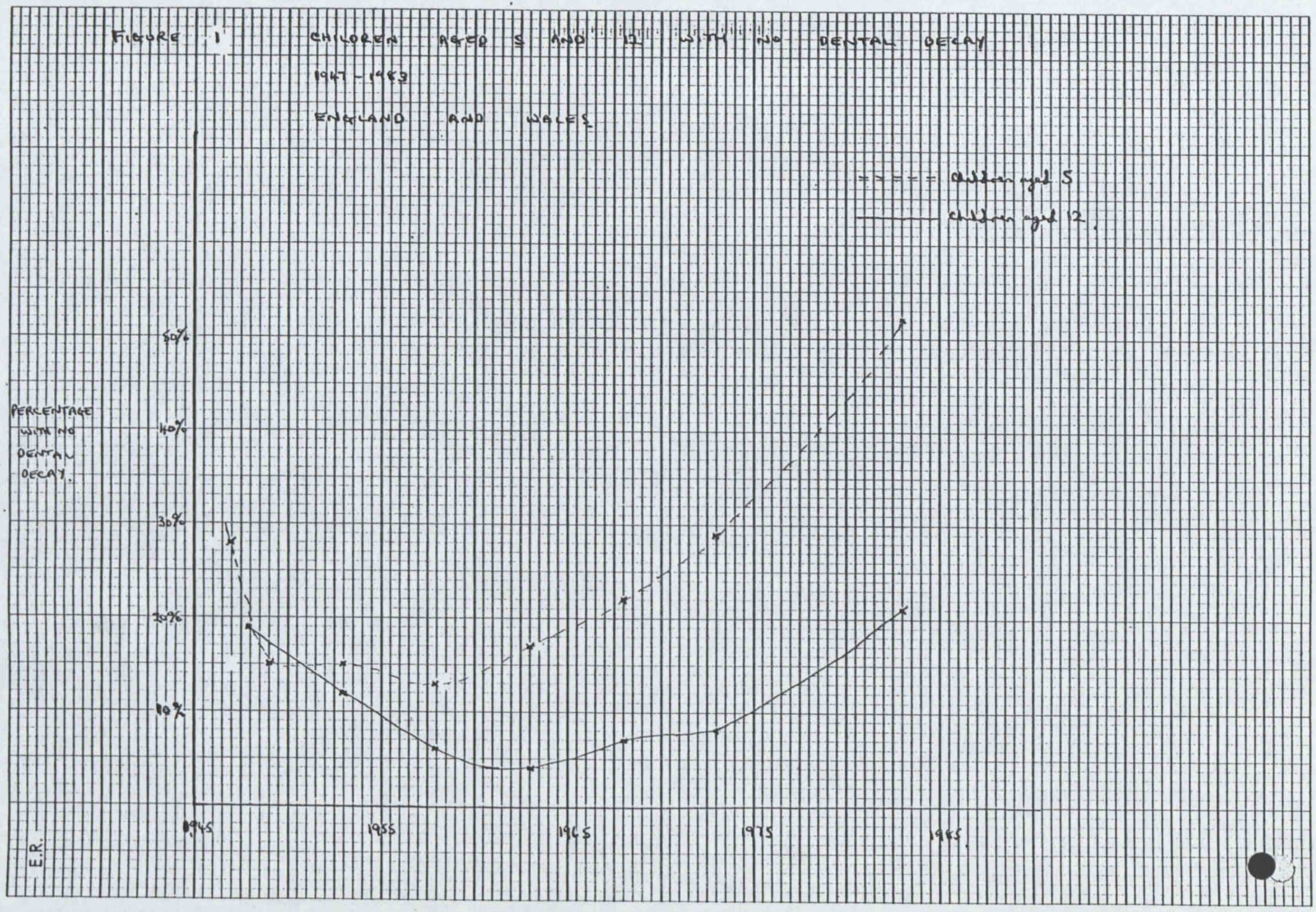
FIGURE 1 CHILDREN AGED 5 AND 12 WITH NO DENTAL DECAY

1947 - 1983

ENGLAND AND WALES

= = = = = children aged 5

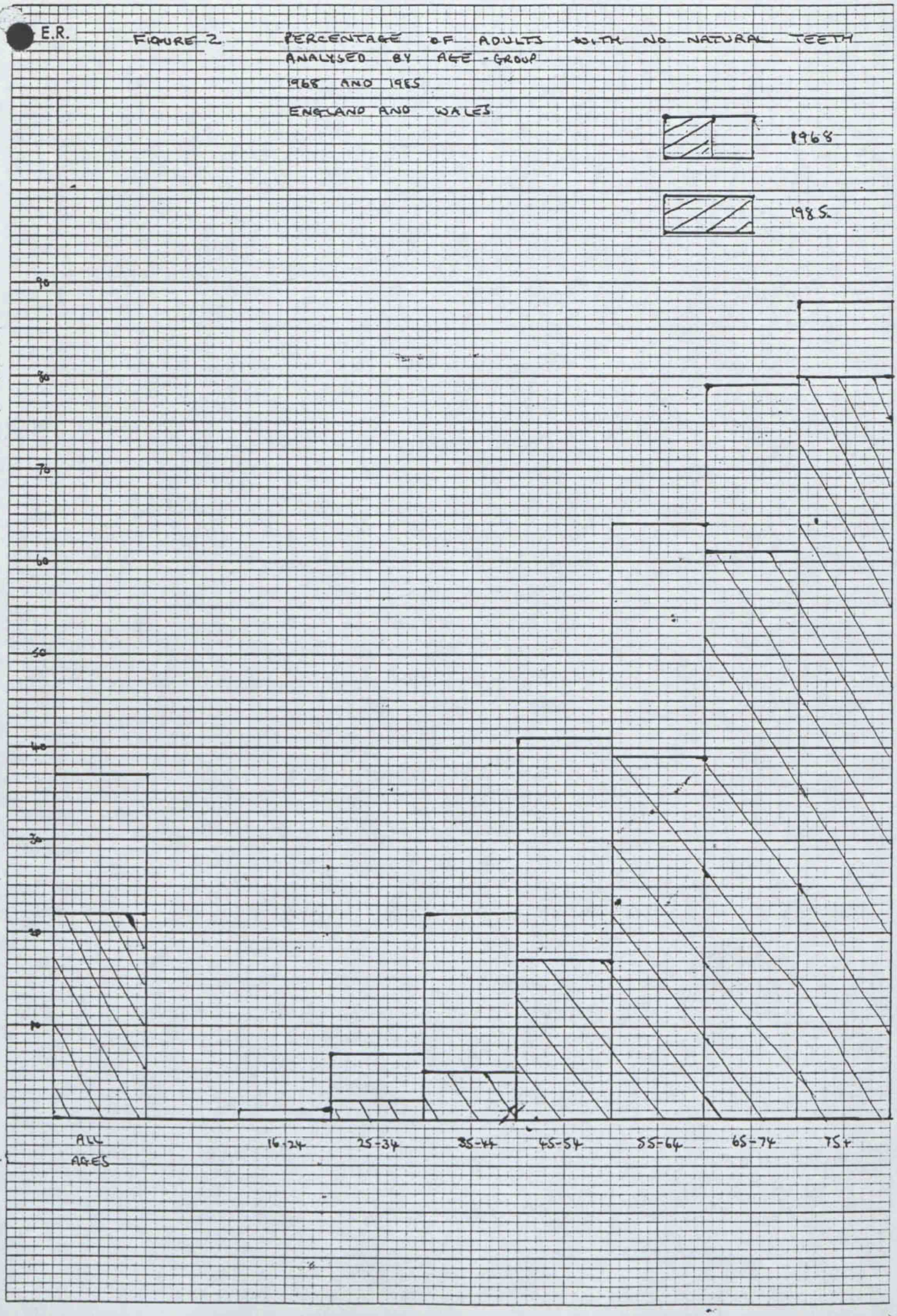
——— children aged 12.



E.R.

E.R.

FIGURE 2. PERCENTAGE OF ADULTS WITH NO NATURAL TEETH ANALYSED BY AGE-GROUP 1968 AND 1985 ENGLAND AND WALES



health by a variety of means, in particular by promoting;

- measures to prevent dental disease

- wider availability of dental treatment and better information for patients to help them choose a dentist.

- improvements in the quality of dental services

Fluoridation

4.4 Adding fluoride to water supplies is a safe and effective way of reducing dental decay and the need for fillings. Fluoridation is of most benefit to children, particularly in deprived areas where dental health does not always receive a high priority from parents and co-operation in other preventive measures may be poor. The benefit of fluoridation extends into adult life. Opinion polls have confirmed that fluoridation is welcomed by the majority of the public; it was supported by virtually all organisations that gave evidence during the primary care consultations. Fluoridation is a matter for local decision but the Government welcomes the current initiatives by Health Authorities in England to fluoridate water supplies. A number of additional schemes are under consideration, especially in the conurbations in the Midlands and the North of England where dental health is relatively poorer than the rest of the

country. For a number of years Health Authorities have been assisted with payments towards the cost of such schemes. It is the Government's intention to increase substantially the amount of money it makes directly available to Health Authorities to fund the many new schemes currently at the planning stage. It is also intended to meet a higher percentage of the total costs and to extend these payments to cover the major replacement costs of out-dated plant and equipment. In Scotland fluoridation schemes were terminated and the Secretaries of State's indemnity to water authorities in respect of fluoridation was withdrawn from 1 July 1983 on receipt of Lord Jauncey's judgement in the case of Mrs Catherine McColl v Strathclyde Regional Council. Following the passing of the Water (Fluoridation) Act 1985 the indemnity is being revised and once this is completed the Secretary of State will again be prepared to indemnify water authorities.

Health Education

4.5 The improvement in dental health has been helped by the growing awareness, especially amongst young people, of the importance of looking after one's own teeth better - through proper oral hygiene and improved eating habits.. Public health education campaigns have played a useful part in this development, particularly in promoting good dental health as an integral part of good general health and not as a topic to be considered in isolation. The Government proposes

therefore, in conjunction with the Health Education Authority in England and the Welsh Health Promotion Authority and after consultation with the profession, to build on earlier campaigns targetted at young people by launching a further initiative particularly in inner cities and other deprived areas to promote dental awareness and regular attendance at the dentist.

Role of the Community Service

4.6 It is important that dental services in the primary care field adjust their responsibilities in the light of the greater emphasis being placed on prevention and health education. In the Discussion Document the Government suggested that the need nationally for routine examinations and treatment of children through the Community Dental Service was now less clear. Thier was a requirement for increased effort in screening and for providing treatment in areas of poor dental health. These areas would also benefit from carefully designed group preventive programmes. The Discussion Document proposed therefore that the examination and treatment of children might in future be undertaken in most parts of the country by general dental practitioners; the community dental service would in future provide treatment in the main for children and adults who experienced difficulty in obtaining treatment from a general dental practitioner.

4.7 This proposal has been generally

welcomed. The Government therefore proposes legislation to permit changes in the responsibilities of the community dental services in England, Wales and Scotland and will thereafter issue guidance to health authorities on the future development of these services.

Prevention in the General Dental Services

4.8 If in future the treatment of children is to be concentrated in the general dental services it will be essential that practitioners provide on an increasing basis services such as advice on oral hygiene and the use of preventive or minimal intervention techniques exploiting modern materials. Some of those techniques have in the past two years been made available under the general dental services, The fee payable to dentists for examining patients, both adults and children, which includes the provision of advice, has increased by 50% since 1984 in recognition of the increasing amount of time devoted by dentists to advising patients. The Government welcomes these trends and the Health Departments will be discussing with the profession's representatives proposals to expand the description in the fee scale of what is required by way of prevention and to amend the dentist's NHS contract to define more clearly the requirement to give advice.

Capitation Fees

4.9. The Discussion Document described an experiment to pay dentists a capitation fee, or annual lump sum, for

maintaining the oral health of children rather than a fee for each item of service. The objective is to assess whether such a payment system will benefit children's dental health by giving dentists a positive incentive towards prevention and preventive techniques. The experiment still has some time to run but if successful the Government reaffirms that it will plan to give all children the opportunity of being treated on this basis. The Health Departments will shortly begin preliminary discussions with the profession on a national scheme, including the calculation of the fees payable.

Availability and choice of Dentist

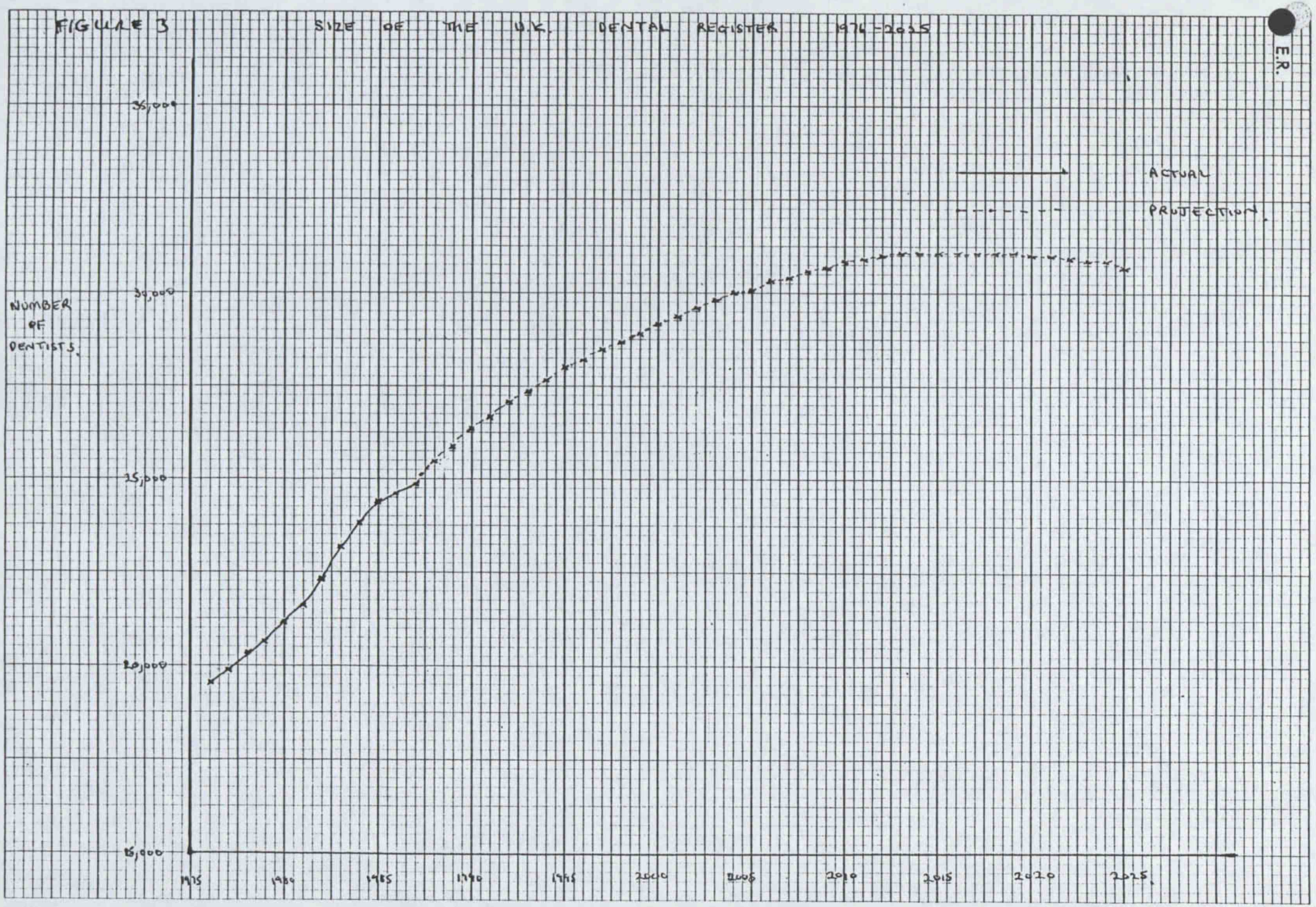
4.10. Two major factors govern the ability of patients to obtain dental treatment when they require it. First the availability of practices within reasonable travelling distance of their homes. Second, the hours a dentist is prepared to devote to NHS work and the range of services he is willing to provide under the NHS.

4.11. The number of practising dentists has increased dramatically since 1948.

(Figure 3)

4.12. Coupled with the improvements in dental health there is evidence that in the immediate future there may be more dentists than are needed to meet the demand for treatment in some areas. The

FIGURE 3 SIZE OF THE U.K. DENTAL REGISTER 1974 - 2025



Government has taken a series of measures to tackle this. It has introduced controls on dentists from abroad wishing to practice in this country and reduced the entry to university dental schools by 10% in 1984/85. A joint working group of the Health Departments and the profession again reviewed dental manpower and earlier this year and suggested amongst other measures that a further reduction of 10% was needed in the dental school intake. This recommendation has been accepted by the Government and is expected to be implemented at the beginning of the 1989/90 academic year. In the long term however, the combined effect of these measures will still permit a significant increase in the number of dentists over the next forty years. In the short term there is a lapse of over 5 years before reductions in the dental school intake start to have any measurable impact on the numbers of dentists in practice.

Age of Retirement

4.13 Further action is therefore required. In the Discussion Document the Government questioned the desirability of permitting general dental practitioners to continue to practice in the NHS beyond the age when this is sensible. At present there is no fixed retirement age for practitioners General support for change to the present position was forthcoming during consultation on the Discussion Document and the profession has indicated in its response to the Document that it would not be unwilling to consider specific

proposals. To ensure the maximum number of openings for young dentists entering general practice and in the light of a projected national over-supply of dentists the Government has decided that as with doctors it is right to take powers in the NHS and Medicines Bill to establish a compulsory age of retirement.

Regional Distribution

4.14 The projected national over-supply of dentists however conceals considerable local variations, as figure 4 below illustrates. For example, in the Trent Region there are still nearly twice as many people per dentist as in the North West Thames Region, and about one quarter more than the average for the UK as a whole. Urban areas of long-term industrial decline are particularly affected by shortages. Even in the well-dentisted South-East, the numbers of courses of treatment per head of population in some inner city areas are among the lowest in the country. It is clear that in such areas the dental services which exist are failing to reach many sections of the community.

4.15. Whilst, as the Discussion Document mentioned, the position has improved recently the improvement has not been fast enough. The measures taken by the Government to reduce the overall numbers of dentists, though essential, may reduce the pressure on dentists to move into areas that are under-provided despite the higher earnings potential of these areas.

Figure 4

1985 : Population per General Dental Practitioner

Further initiatives are therefore required to ensure a more even distribution.

4.16. In their response to the Discussion Document the British Dental Association suggested a number of contractual and financial incentives that might be introduced to have this effect. The Health Department will therefore be discussing with the profession possible measures to reinforce the effect of market forces on distribution. These will include new contractual arrangements for dentists setting up practices and financial assistance towards the cost of establishing and equipping such practices in designated areas. It would be a condition of assistance under such schemes that a full range of treatments (other than orthodontics) should be provided for a reasonable number of hours each week.

Availability of NHS Services

4.17 There is evidence that in some areas such as the South of England, which is relatively well supplied with dentists patients do not always find it easy to obtain the dental treatment they require under the NHS. The Government suggested therefore in the Discussion Document that the dentist's NHS contract should be amended to require dentists to offer a full range of routine treatment and provide NHS services for a minimum number of hours. The profession in its response indicated that it too felt that the current contract, which had remained virtually unchanged since 1948, may no

longer be appropriate to the changed circumstances of today. The Health Departments have recently put proposals for a revised contract to the profession. These are intended to improve the availability and quality of NHS services. The major changes include:

- a requirement to explain the treatment plan to patients and the probable cost

- a requirement to provide arrangements for out-of-hours treatment in an emergency

- powers to enable the FPC and HB to inspect dental surgeries and waiting rooms.

The Health Departments will be discussing these and other proposals including a greater contractual commitment to the NHS with the profession shortly.

4.18 The presence of dental practices in an area may in itself be insufficient to persuade patients to attend regularly. The location of surgeries and the services they offer need to be publicised locally. The Government is concerned to ensure that dentists should be free to provide patients with information about their services and so enable patients to make an informed choice of dentist.

4.19 The Discussion Document referred to

the action taken by the General Dental Council to relax its restrictions on advertising. These measures however still do not go as far as the recommendations of the Director General of Fair Trading in his 1985 study into NHS dental treatment and the cost of private treatment summarised in Chapter 4 of the Discussion Document. The Government therefore welcomes the recent decision of the Director General to refer the Council's restrictions on advertising to the Monopolies and Mergers Commission. (To be announced later this month). In the meantime the Government intends to improve information on FPC and HB dental lists and encourage dental practice leaflets.

Quality of Service

4.20 In the early years of the NHS a shortage of dentists and widespread untreated dental disease meant that the quantity of treatment provided sometimes became more important than high standards of quality of care. The dentists' NHS contract, based on fees for each item of treatment has ensured good value for money for the taxpayer in terms of lower unit costs. But it provides little incentive to dentists to achieve high quality through investment in their practices or through continuous training in updating their knowledge and skills. Morever, in recent years, there has been growing concern that the remuneration system might encourage dentists to maintain their incomes at a time of improving dental health by engaging in unnecessary dental

treatment.

4.21 For many years central Government has provided resources directly to maintain an overview of the quality and appropriateness of treatment provided and to encourage continuing education through:

- funds for dentists' postgraduate training

- the Health Departments' Dental Reference Services which routinely examine a sample of patients to ensure that all necessary treatment has been provided and to the proper standard

- the Dental Estimates Boards which monitor the treatment dentists provide

Changes to the NHS Remuneration System

4.22 Evidence given to the Committee of Enquiry into Unnecessary Dental Treatment, which reported in 1986, and the response to the Discussion Document indicated that, whilst these activities were desirable and should continue, further measures were required to ensure that patients were provided with the quality of care they expected. The profession in its response to the Discussion Document laid considerable emphasis on revision of the remuneration system as a way of introducing change in dental practice, including the possibility of a "good practice" allowance. The

Government will discuss new contractual arrangements including a new remuneration system with the profession. It believes however that any new system should combine incentives both for high efficiency and high standards.

Education and Traning

4.23 Dentistry has seen considerable changes in materials, techniques and approaches to clinical problems. It is important therefore that dentists in practice should undertake regular refresher training. The Social Services Committee too in its report noted that it seems pointless to spend substantial sums in training a dentist if the standard he achieves on graduation is not to be maintained. It is also important that new graduate entrants to the profession are given proper training in their first year in practice in such matters as practice management and can develop their professional skills in a climate free from undue financial pressures.

4.24 The Government therefore welcomes the introduction of new vocational training arrangements for newly qualified dentists which it has agreed with the profession will come into effect in 1988. It has also provided in England additional funds for the post-graduate training of experienced dentists, particularly those who do not normally attend post-graduate courses. The Government believes that many practitioners are still failing to update their knowledge and skills to the

extent needed and that more needs to be done. The Government will therefore be providing substantial additional resources to expand the number of places in the vocational training scheme more quickly than is currently planned, to increase the funds available for post-graduate vocational training courses and, as an incentive to undertake training, will for the first time, pay allowances to dentists to help offset income lost when they are absent from their practice attending approved training courses. The Government will also discuss with the profession changes to the remuneration system which will reward those who do undertake post-graduate training.

Monitoring the General Dental Service

4.25 A major part of the quality control procedures for the general dental services has been provided by the Health Departments' Dental Reference Services, which examine patients, both on a random basis and in cases where there is concern that a dentist may be providing unnecessary or inappropriate treatment. Following the report of the Committee of Enquiry into Unnecessary Dental Treatment the number of dental reference officers has been increased.

4.26. To meet the new demands for improved quality control the Health Departments have been discussing with the profession the establishment of a number of part-time general dental practice

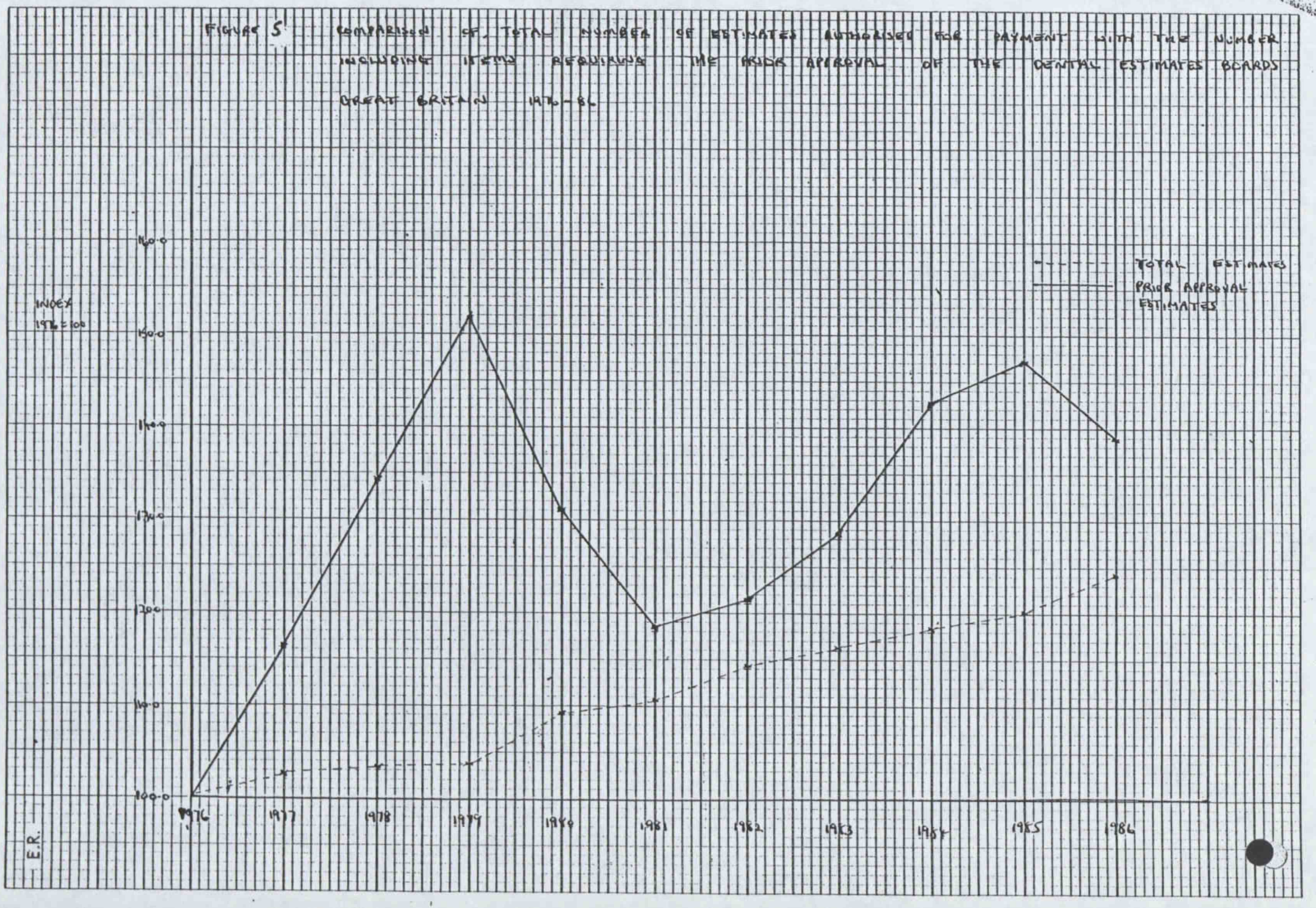
advisers under contract to FPCs to provide a support role for practitioners and relieve the Dental Reference Services of some of their non-disciplinary tasks. The report of a joint working group into the role and funding of these advisers has recently been completed. After consultation with the profession it is the Government's intention as a preliminary step to fund the introduction of advisers in a number of FPC areas. Corresponding measures to strengthen quality control procedures in Scotland will also be the subject of consultation.

4.27. Since 1948 the Dental Estimates Boards have had a statutory duty to consider and approve estimates for payment to general dental practitioners. These estimates include cases where treatment has already been carried out and a smaller number where the dentist is required to seek the approval of the Boards in advance of treatment. With the expansion of the general dental services the role of the Boards has also expanded and changed.

4.28 Figure 5 (below) indicates that over the years prior approval estimates have tended to rise as a proportion of total estimates. Yet no prior approval requirements exist to deter excessively large courses of routine treatment. After careful consideration and in the light of the recommendations of the Committee of Enquairy into Unnecessary Dental Treatment the Government has concluded that it is no

FIGURE 5 COMPARISON OF TOTAL NUMBER OF ESTIMATES AUTHORISED FOR PAYMENT WITH THE NUMBER INCLUDING ITEMS REQUIRING THE PRIOR APPROVAL OF THE DENTAL ESTIMATES BOARDS

GREAT BRITAIN 1976-86



longer appropriate for a large proportion of the treatments available under the general dental service to be subject to prior approval, and that many of the existing requirements should be removed or relaxed. A significant start has already been made this year, with relaxations of prior approval requirements for radiographs, and for the more common courses of orthodontic treatment. The Health Departments will be discussing detailed proposals with the profession and the Dental Estimates Boards for further, substantial relaxations to be introduced next year. At the same time it is proposed that prior approval be introduced for some very large courses of routine treatment.

Powers of the Dental Estimate Boards

4.29 These changes will release resources for the Boards to monitor individual practitioners and so contribute to improved standards of dentistry. The Government intends to legislate in the NHS and Medicines Bill to clarify the Boards statutory powers and responsibilities to act in this area.

4.30 In its report the Committee of Enquiry into Unnecessary Treatment concluded that the Boards should be able to satisfy themselves that they are making payment for treatment properly given. It recommends, therefore, that Boards should be able to impose a limited period of prior approval for certain items of

treatment on any dentist whose pattern of treatment appeared to them to be unusual. This would allow for effective monitoring of that dentist's practice. The prior approval requirement in such circumstances would not be disciplinary but there should nevertheless be some right of appeal against its imposition. The Government agrees that the interests of patients justify this provision and will through the NHS and Medicines Bill give the Boards this power in certain circumstances and establish appropriate appeal arrangements. The detailed application of the new procedures will be the subject of full consultation with the profession.

4.31 In the light of the changing and increasing role of the Boards and the consequences for dentists and patients the Government believes that it is right that those affected by the Boards' decisions should be able to seek to have complaints independently investigated. The Government therefore proposes in the NHS and Medicines Bill to include the Boards among those bodies which may be the subject of an investigation by the Health Service Commissioner.

CHAPTER 5. GENERAL OPHTHALMIC SERVICES

Introduction

5.1 The Government's policy towards the general ophthalmic service since 1982 has been based on increasing competition whilst retaining adequate safeguards to protect consumers. This followed publication in that year of the report "Opticians and Competition" by the Office of Fair Trading.

5.2 This policy has been pursued in stages. The first step in December 1984 was to end the opticians' monopoly on the supply of spectacles. In March 1985 the undue restrictions on advertising were removed. In April 1985 the provision of spectacles under the NHS ceased other than for children and those on low income. In July 1986 the provision of NHS spectacles ended for those remaining groups and was replaced with a voucher system which is meeting the needs of those who could afford the cost of spectacles purchased privately.

5.3 The response to these changes has been very favourable. In their published response to the Discussion Document the Association of Optometrists while regretting the removal of arrangements for dispensing of optical appliances through the GOS nevertheless accepted that the voucher system "has undoubtedly increased the choice that patients have in purchasing appliances and, equally, importantly, the ability of optometrists to prescribe particular lenses, free of the constraints of the old GOS statement".

5.4 The benefits both to patients and the profession arising from competition in the supply of spectacles have been greater and realised more quickly than might have been expected. Budget price spectacles are readily available and information for patients on the costs of spectacles is better displayed. The number of opticians and other retail outlets has increased and some major, well-established retail companies have entered the market. Many opticians have improved their premises. Since 1985 opticians have also been required to offer patients a copy of their prescriptions so that they can shop around for the best buy. Opticians are now actively seeking customers, responding to their needs and wishes and providing a higher standard of service. Both the profession and consumer have benefited from the greater freedom of an open market.

5.5 The Government has decided to extend the principle of increased competition to sight testing. It proposes through the NHS and Medicines Bill to remove sight testing from the NHS except for children and young people in full time education, those on low income and the registered blind and partially sighted (about 30% of all sight tests are provided for these groups). Other patients will in future obtain their sight tests privately just as they obtain their spectacles. Without the constraints imposed by the NHS contract opticians will be free to offer either a standard sight test or a fuller eye

examination to meet their patients' needs and preferences. Patients may be offered a free sight test if they purchase spectacles from the practice that tested their sight. The competition which has proved so effective in the supply of spectacles will thus also operate in the provision of sight tests, and any additional costs to patients are expected to be small.

5.6 The Government does not consider that the consumer should be limited to the testing optician for any subsequent purchase of spectacles. At present opticians are required after conducting an NHS sight test to issue the consumer immediately with a prescription if spectacles are needed. The prescription can be used to purchase spectacles on the premises in which the sight test was conducted or the consumer can choose to shop around amongst other practices. The Government considers that this provision should remain in the future not only for those who remain entitled to NHS sight tests but also for those who have their sight tested privately. The Government intends therefore in the NHS and Medicines Bill to give consumers whose sight is tested for spectacles under the NHS or privately, the right to receive a prescription, or a statement that no prescription is necessary. The optician will not be able to charge for the sight test or for any glasses required until this has been done. The Bill will also prohibit an optician from only offering sight tests only on condition that any spectacles required are purchased from his business.

NHS Services for the Housebound

5.7 Comments on the Discussion Document indicated a concern about the lack of a domiciliary sight test service under the General Ophthalmic Service. The Government accepts that an extension of the service to the housebound is desirable. It therefore proposes to enter into discussions with the professions involved about an additional fee for the provision of such a service to those who remain entitled to an NHS sight test.

Vouchers for the Purchase of Spectacles

5.8 The Government sees no need to introduce any fundamental change to the voucher arrangements. These are working well. At present, however, vouchers are not exchangeable against contact lenses which have become increasingly popular in recent years. Consultation with professional and consumer bodies has shown there is considerable support for removing this restriction in the interest of giving voucher users increased freedom of choice. The Government, therefore, intends to amend regulations to permit consumers to use vouchers to purchase contact lenses.

5.9 The Association of Optometrists in their comments on the Discussion Document suggested that particular attention should be paid to the needs of consumers who require more expensive lenses and that the current voucher may not be adequate. The Government will give special consideration to the position of the partially sighted to ensure that such patients are not disadvantaged in comparison with other voucher groups.

5.10 Representations have also been received that help should be given to those who through mental or physical disability experience frequent damage to their spectacles. Children are already given vouchers for the repair or replacement of their damaged spectacles. The Government proposes to extend the voucher scheme so that this benefit is also available to adults whose spectacles are damaged as a consequence of their physical or mental disability.

CHAPTER 6: PHARMACEUTICAL SERVICES

Introduction

6.1 Over the years, there have been substantial changes in the pharmaceutical services. The Government's role is to promote those changes which will help to provide patients with a better service and taxpayers with greater value for money.

6.2 The core of the pharmaceutical service is, and will remain, the dispensing of medicines. As can be seen from the graph, the general trend in recent years - and in fact since the 1960s - has been for the number of prescriptions dispensed to rise each year. Up to 1980, the number of pharmacies continued its long-term decline but since then the number has increased again. The combination of a rise in the number of prescriptions and a fall in the number of pharmacies led to a steep rise in the average number of prescriptions dispensed by each pharmacy up to 1978. After a period of relative stability, there has been a fall since 1984, with the latest figure being just under 33,000.

6.3 Dispensing itself has also changed. Rarely now are pharmacists called upon to make up a medicine from ingredients. The need for them to measure or count medicines before dispensing them is increasingly rare since they are packed in containers intended for supply to the patient. New technology has found its way into most pharmacies: labelling machines are common place and computerised stock control and ordering even more common.

Recent Developments

6.4 Over the last few years, two issues have dominated the debate over the future development of the pharmaceutical service. These are the introduction of a new contract for community pharmacists from 1 April 1987 (from 1 July 1987 a Northern Ireland) and the proposals in the Nuffield Report (1) for a wider role for pharmacists under the NHS.

The new contract.

6.5 Two main factors led to the negotiation of a new contract. Firstly there was a need to avoid the build up of large underpayments or overpayments to pharmacies. These arose in the past because of difficulty in monitoring costs. Secondly, the Government wished to have more influence on the distribution of pharmacies in order to avoid excessive expenditure on dispensing. The additional pharmacies which have opened in recent years have tended to be in places where there is already a reasonable pharmaceutical service. Since the NHS pays the NHS costs of all pharmacies, the cost to the taxpayer has gone up without any real improvement in services occurring as a result.

6.6 The main features of the new contract are:

- more frequent and effective cost enquiries linked with annual negotiations. By this means large retrospective adjustments will, as far as possible, be avoided.

i. Pharmacy: The report of a Committee of Inquiry appointed by the Nuffield Foundation 1986

- changes in the remuneration system to encourage pharmacies to be more cost-effective and efficient and to realise the benefits of economies of scale. In this way some of the disciplines of the market are introduced to an area where a free market cannot operate with full effectiveness.

- a two year scheme to help pharmacists with a low turnover and high unit costs to give up the NHS contract on reasonable terms.

- more financial support for pharmacies which provide an essential service to small populations where they would not otherwise be economically viable.

- control of entry to contrait with the NHS. New pharmacies will only get an NHS contract if the Pharmacy Practices Sub Committee of the FPC or HB considers that the new pharmacy is necessary or desirable in order to secure the adequate provision of NHS pharmaceutical services in the neighbourhood. In this way, the provision of NHS pharmaceutical services will be more closely matched to the needs of consumers.

6.7 The new contract for NHS pharmacies is still relatively new and will need time to settle down. It will be reviewed in the light of experience to consider whether more competition is needed in the provision of services to consumers. In the meantime the Government will seek to build on the recommendations of the Nuffield report.

The Nuffield Report

6.8 The Nuffield report proposed that pharmacists should be encouraged to participate more actively in the continuing education of other workers who contribute towards community health. Of particular importance, in the Government's view is pharmaceutical supervision of the supply and safekeeping of medicines in residential homes for children, the handicapped and the elderly. The Government intends to introduce an allowance, payable by FPCs for pharmacy contractors who provide this service.

6.9 Another Nuffield recommendation was the use of pharmacies to display health education and health promotion material. Pharmacies are well placed for this task since large numbers of healthy people visit them each day. The Government regards the contribution which pharmacists can make to prevention as very important and will make funds available to assist in the provision of such material for display in pharmacies.

6.10 The Nuffield Report also proposed that pharmacists should keep records of medicines prescribed for or purchased by individual patients. This would help to detect adverse reactions and interactions for individual patients and could help patients and their doctors. Such an arrangement might be

particularly useful for elderly patients who tend to take a fair number of different medicines and regularly use the same pharmacy. The Government proposes to introduce an allowance payable to those pharmacies who maintain a substantial number of such records relating to patients who are either elderly or who may be confused and who are on long-term medication.

6.11 The Nuffield Report saw a role for pharmacists through membership of Drug and Therapeutic Committees, or other agreed local arrangements, in helping to develop policies on effective and economic prescribing generally and more specifically on the effects of medicines, their interactions with each other, and ways of encouraging patients to gain the maximum benefit from medicines. Experience in the hospital service has shown the value of discussion between doctors and pharmacists in improving patient care and in ensuring the effective and economic use of medicines. In some areas arrangements for making available the expertise of pharmacists in discussions with doctors about cost-effective prescribing are in place or under consideration. These arrangements include the provision of advice about formularies and independent drug evaluation. The Government will make funds available for a co-ordination centre to foster such local developments.

Further Development on the Pharmacist's Role

6.12 Further development of the pharmacist's role and, in particular, renewed emphasis on advising patients on minor symptoms and on the most sensible and effective ways of using medicines, as proposed in the Nuffield

Report, is closely linked with a more flexible approach to the supervision of dispensing. The Nuffield report suggested that pharmacists should be able to delegate to appropriately trained assistants some of their present responsibilities for the dispensing of prescriptions while retaining personal responsibilities for dispensing standards generally. Whilst the proposal for a wider role for pharmacists has met with widespread support, the suggestion that dispensing should be delegated has had a mixed reception within the profession. Yet it is crucial if the pharmacist is to have time to undertake the envisaged wider role. The profession is still considering its response to the Nuffield Report, and the Government is confident that it will respond to the challenge.

6.13 There is also, a need for more research into pharmacy practice. The Government will make funds available for pharmacy practice research. One priority will be a study of how the delivery of pharmaceutical services can be influenced by the nature of the remuneration system. Other areas for study include how advisory and information services can best be provided in pharmacies, and how the changing role of the pharmacist affects the need for training in such matters as optimal use of time and resources.

6.14 The changing role of the pharmacist also requires the acquision of new skills in addition to keeping abreast of a rapidly expanding field of pharmaceutical knowledge. The Government will therefore make available additional funds

for continuing education and in-service training for pharmacists. This will include provision for remunerated advisers and course organisers as well as increased reimbursement of expenses incurred by pharmacists attending courses, so that they are encouraged to participate.

Inner Cities

6.15 In common with other family practitioner services, pharmaceutical services are often poorest in inner cities and other deprived areas. Since hardly any pharmacies are solely engaged in the provision of NHS pharmaceutical services, virtually all are also engaged in retail trade both in medicines and in other goods, it is right that pharmacies should look first to the private sector for finance for setting up and improving premises. However, there will be occasions where the provision of an adequate NHS service cannot be achieved by these means. The Government intends to set up a fund for use by FPCs to help attract pharmacies to, or improve the standards of pharmacy services in, inner cities and other deprived areas. Flexibility will be the key, but possible uses include help in improving security, services for ethnic minorities, the establishment of health centre pharmacies and improvements to premises.

Classification Medicines.

6.16 The Discussion Document invited views of on the operation of the arrangements, governed under the Medicines Act 1968, by which medicines are classified into those available only on medical or dental prescription, those available

without prescription but only in pharmacies, and those available from any retail outlet. Patient safety is the main criterion for classifying medicines.

6.17 The consultation revealed no demand for the categories themselves to be changed and the Government has no plans to change the categories. Beyond that, there were divided views about how well the present arrangements worked but no specific proposals for improving them. The Government does not consider that a general review of the categorisation of medicines should be undertaken at present. It is open to interested parties (companies, trade and professional organisations, and consumer groups) to make a reasoned case for changes in the status of particular medicines or classes of medicines. Any such proposals will be carefully considered.

6.18 There was criticism that the statutory procedures for making changes were slow and cumbersome and should be simplified. The Government will discuss with those concerned what scope there may be for procedural changes.

Pharmaceutical Industry

6.19 The Department of Health and Social Security has a dual role in relation to the UK pharmaceutical industry. It is the principal purchaser of the industry's products and has responsibility as sponsor within Government for the success and future development of the industry. The Government thus has twin objectives of ensuring that the prices which the NHS pays for its medicines are reasonable while at the same time encouraging the maintenance and

development of a strong and efficient pharmaceutical industry in the UK. The Government's policies seek to maintain a proper balance between these two aims.

6.20 The Pharmaceutical Price Regulation Scheme (PPRS) is the main mechanism through which these aims are pursued. Negotiations with the industry led to the introduction of a revised PPRS in October 1986. That provided for for some improved profitability for the industry in 1986 and 1987, while reinforcing and making more explicit the arrangements for controlling costs. Success in the pharmaceutical industry requires a high level of commitment to long-term research and development, with high commercial risk for companies involved. Financial support for these high levels of research & development expenditure is a key feature of the revised PPRS.

Prescribing by doctors

6.21 The cost of medicines dispensed is a major element in the expenditure on the Family Practitioner Services. The Government believes there is scope for improvement in prescribing practices which would result in better value for money in this area. Through the introduction of the selected list scheme in 1985 the Government has already acted to reduce the growth in the cost of medicines prescribed by family doctors, without detriment to patient care. £75 million was saved in the scheme's first year of operation. The Government has no plans to extend the selected list scheme into other therapeutic areas or to introduce compulsory generic prescribing or substitution. This is because the Government has noted the willingness

of the medical profession to achieve more economic and effective prescribing by voluntary means and will be seeking clear evidence that such measures will yield positive results.

6.22 The Government has invested over £3.5 million in a new computer system at the Prescription Pricing Authorities in England and Wales and in full co-operation with the medical profession has developed a new prescribing information system. From next autumn this will provide all doctors with timely, well presented information about their prescribing. Family doctors are becoming increasingly interested in self audit and we expect them to pay greater attention to their prescribing habits once the improved information is available. Voluntary prescribing by generic name, is increasing. This is good professional practice and expected to continue. The Government will continue to pay for the production and distribution to doctors of the British National Formulary. This independent reference book provides information on the cost effective use of medicines. Improvements to the prescribing information system in Scotland are also being introduced as an adjunct to computerisation of the Prescription Pricing Division of the Common Services Agency.

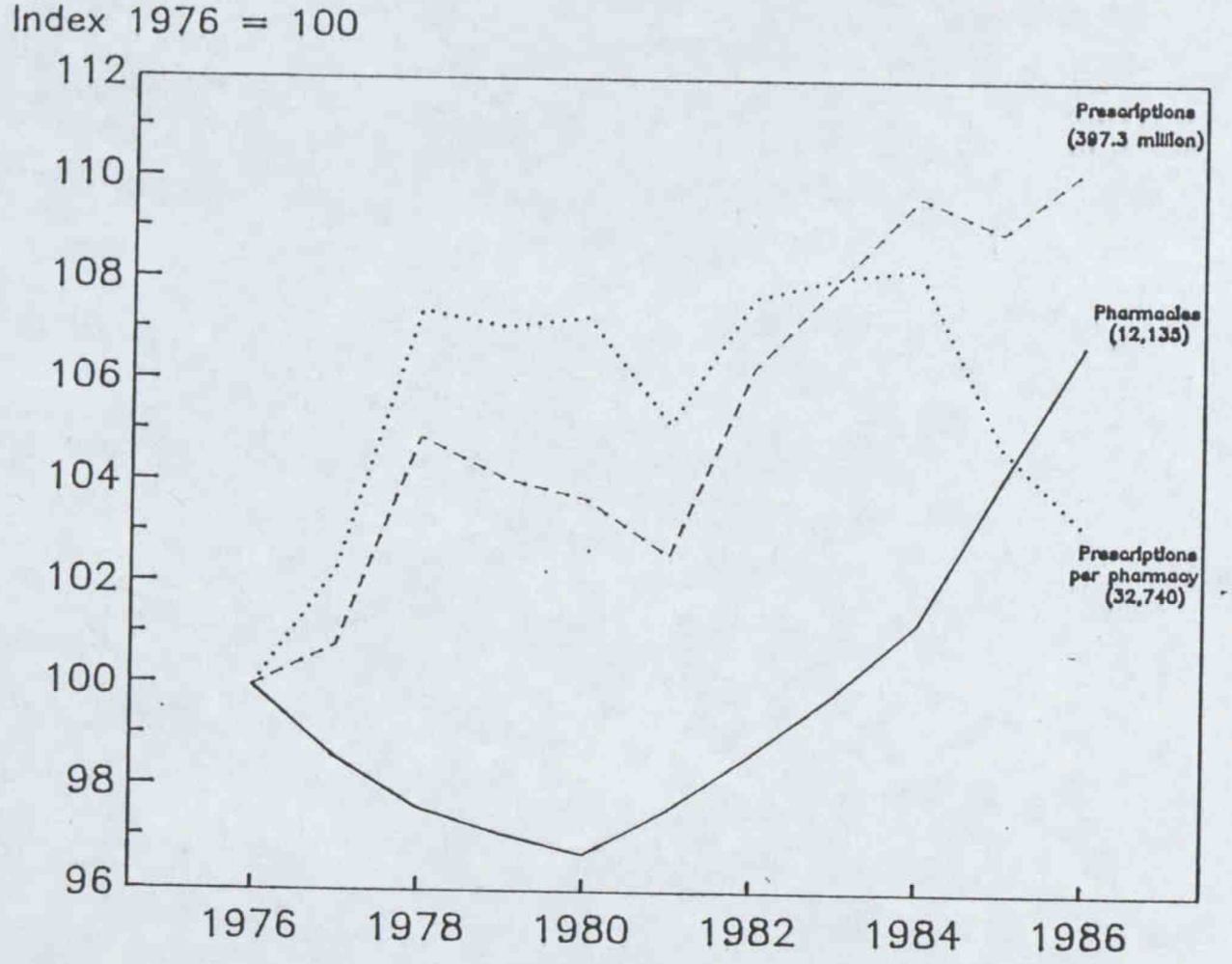
6.23 The Regional Medical Service will increase the number of visits made to doctors whose prescribing costs are considered excessive. An initiative has been launched in which two specialist medical officers will visit and meet family doctors in two health regions in England to assist them in developing better prescribing practices. FPCs will be given a role in

encouraging effective and economic prescribing. They will be expected to do this in consultation with an independent medical adviser.

Blood glucose testing strips and new wound care products

6.24 General practitioners may only prescribe appliances, dressings and chemical reagents which are on an authorised list set out in the Drug Tariff. To keep the list in line with the changing needs of general practice, the Government intends to make available on prescription, as soon as resources permit, blood glucose testing strips for diabetics and a new range of wound care products. Blood glucose testing strips help diabetics to monitor their condition more closely than is possible through urine testing, and thus help prevent complications Their wider availability will make a valuable contribution to enabling diabetics to treat and monitor their condition independently in their own homes. The new types of wound care products are more comfortable for patients than traditional dressings and make for quicker healing. Both types of product are currently available through the hospital and community health services but by making them available also on general practitioner prescription a better and more convenient service to patients will be provided.

Number of pharmacies and prescriptions dispensed United Kingdom 1976 – 1986



CHAPTER 7 - COMMUNITY NURSING SERVICES

Introduction

7.1 Most nursing staff working the community are employed by health authorities. Practice nurses, employed by some general medical practitioners to assist them in their practices, work closely with community nursing staff. Community nursing services provided by health authorities encompass a broad spectrum of services requiring a wide variety of staff, including district nurses, health visitors, school nurses, midwives, community psychiatric and mental handicap nurses, many of whom are supported by registered or enrolled nurses or nursing auxiliaries. In addition, they may call upon the expertise of other specialist nurses who are hospital based but whose work extends into the community. In England there has been steady growth in the number of community nursing staff over the last 10 years; in total, there are now about one-third more than in 1974. In recent years, the growth rate has averaged 2 per cent a year, but with this expansion there has been a shift in the mix of skills and grades. The number of staff with a district nursing qualification has decreased recently and is back to the level of ten years ago. In the same decade, the number of nursing auxilliaries more than doubled and the number of health visitors increased at an average of about one per cent a year until 1984 when the figures showed a decrease. Over the same period there have been changes in the training, knowledge and skills of community nursing staff.

Team Work

7.2 The services provided by these nurses, midwives and health visitors are an important part of the totality of primary health care. Primary care is at its best when provided by a range of professional staff, working together as members of a primary health care team. Development of this team approach has been established Government policy for many years, and its importance was reaffirmed in the 1981 report for the London Health Planning Consortium on Primary Health Care in London (the "Acheson Report") as well as in the joint report of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee (the "Harding Report"), also published in 1981.

7.3 Effective team working requires a willingness amongst all the team members to co-operate and communicate well, and to adopt a flexible approach which puts the quality of health provision to the population served above professional status and function. In many areas these arrangements work well, but in many others they do not. This was recognised in the primary care discussion document (paragraph 10.8) which stated that "The lack of adequate understanding between team members at present can lead to uncertainty and inefficiency in the provision of services". That is why strengthening the primary health care team is seen by the Government as being of paramount importance.

Community Nursing Review

7.4 The changed demographic structure of the population, in particular the increase in the number of elderly people, and the changes which have taken place in the organisation and provision of community nursing services, made it evident that a review of those services was needed if they were to be both efficient and effective. The Government agreed that such a review should be undertaken and in 1986, in England, a small team was established under the chairmanship of Mrs Julia Cumberlege, Chairman of Brighton District Health Authority. Community nursing reviews were also launched in Wales (reference) and Northern Ireland (reference) and aspects of community nursing are also being studied in Scotland.

7.5 Mrs Cumberlege's report. "Neighbourhood Nursing - A Focus for Care", was published at the same time as the primary care discussion document, and the Government invited comments on both. The main proposals in the Cumberlege Report are:

- community nursing services should be planned, organised and delivered on a neighbourhood basis;

- there is scope for making better use of nursing skills;

- the effectiveness of the primary health care team needs to be improved;

- there should be a more integrated approach to the training of all nurses working outside hospitals; and

- consumer groups should have a stronger voice.

Responses to Consultation

7.6 The Government commented on the report's recommendations in the discussion document. During the consultation which followed there was much debate about the recommendations and widespread endorsement for the support that the report gave to primary health are team working. The Social Services Committee report on Primary Health Care gave a cautious welcome to the proposals for neighbourhood nursing services, and expressed the hope that they would not be implemented rigidly. It endorsed the recommendations for better nurse training, and concluded that "Good primary health care teams will be a reality only if doctors and nurses learn to work together. We look to the Government to encourage them to do so."

Circular on Community Nursing

7.7 A circular (HN(87(x)) setting out the Government's response to to the Cumberlege Report will be issued to health authorities on [ ]. It invites health authorities to review the organisation of their community nursing services.

Neighbourhood Nursing

7.8 The Government accepts that the management and delivery of community nursing services at a level that is closer to consumers and more responsive to their needs is a welcome trend. Community nursing staff, together with other members, of the primary health

care team, are ideally placed to look after local needs because of their close contact with the community, their local knowledge and range of necessary skills. In addition, there are clear advantages in management terms in the opportunities for co-ordinating the deployment of different types of community nursing skills. The Government further accepts that a significant number of health authorities are already moving in the direction of a neighbourhood approach to the organisation of their community nursing services; and many more will want to consider whether it is appropriate in the light of their own particular circumstances. It does however recognise that there is no single right way of organising services and the decision about what is appropriate in different localities remains one for the health authority concerned.

Inner Cities

7.9 The Circular draws special attention to the fact that a neighbourhood approach may be particularly appropriate in inner cities which have special considerations of their own. In particular the disposition of practices, the larger numbers of people not registered with a practitioner, the tendency towards inadequate premises, and the concentration of people with particular problems may suggest the need for a flexible approach to the question of how far the nursing services should be organised geographically or on a practice list basis.

Written Agreements

7.10 The Cumberlege report recommended that each primary health care team should have a written agreement which set out individual roles and team objectives, and which each general medical practitioner and community nurse in the team should sign. The Social Services Committee has supported the idea if such agreements "will help doctors and nurses to work together as efficient primary health care teams". The Government agrees that the emphasis should be on "agreement" rather than "written" but also that a team is likely to operate more effectively if its members are clear about its objectives and their own roles within it.

Changing Role of Nurses

7.11 There was evidence from various quarters during consultation on the review of primary care that the role of nurses in the community was fast developing, that better use could be made of nurses' skills and experience, and that some procedures were wasteful of nursing resources. The main points centred on nurse practitioners, nurse prescribing, training for practice nurses and training in general.

7.12 The introduction of nurse practitioners into primary care was well supported although there were different views about how they might operate in practice and whether they might not overlap to a certain extent with the roles of some existing community nurses and practice nurses. The Government welcomes the interest shown in the concept and intends to look further at such issues as legal status, functions and qualifications. The Government has a complementary wish to see that the talents and skills of all nurses working in the community are properly used.

7.13 The Government also sees merit in giving nurses more freedom to prescribe or supply a limited range of items (eg dressings, ointments and medical sprays) and to use their professional judgement in relation to the timing and dosage of drugs prescribed by doctors for pain relief. To some extent this simply reflects developments that are already taking place. The Professional Standing Advisory Committees will be consulted about the professional and ethical issues with a view to their producing appropriate guidance. The legal implications are also being considered and if necessary an appropriate opportunity will be sought to introduce the necessary legislation.

7.14 The Government supports the development of training courses for practice nurses and welcomes the publication of an outline curriculum by the National Boards for Nursing, Midwifery and Health Visiting in all the countries of the UK. The Department will discuss with the professional and academic interests concerned how to increase the training opportunities for practice nurses in a way that reflects the need for greater accessibility for more nurses, and for flexibility of design.

7.15 The Cumberlege report also recommended common training for all first level nurses working outside the hospital. It is for the United Kingdom Central Council for Nursing, Midwifery and Health Visiting to take this forward in the light of the Project 2000 proposals.

Wales

7.16 In Wales the organisation of community nursing services will be considered in the light of a separate consultation exercise covering the recommendations of the Community Nursing Review chaired by Mrs Noreen Edwards.

Scotland

7.17 In Scotland aspects of community nursing were considered in a fact finding study of primary health care team work "Health Care in the Community: A Review of Activities in Primary Health Care" which was undertaken in 1985. This pointed to a number of areas in which further research work was required and in January 1987 the Chief Scientist's Office of the Scottish Home and Health Department invited applications from research workers to study these. The outcome of this research together with the reports of the community nursing reviews in the other parts of the UK will be taken into account in bringing forward proposals for the development of community nursing in Scotland.

Northern Ireland

7.18 A study of community nursing services in Northern Ireland was completed towards the end of 1986. The report of the study, which includes material relating to the organisation, efficient use and deployment of community nursing staff and the ways in which their work relates to that of other professions involved in primary care, is available as a contribution to consideration of the issues coming within the scope of the local review referred to in Chapter 1.

CHAPTER 8: COMPLAINTS ABOUT THE FAMILY PRACTITIONER SERVICES

Introduction

8.1 The statutory procedure for investigating complaints about doctors, dentists, pharmacists and opticians providing family practitioner services in England and Wales is set out in the National Health Service (Service Committees and Tribunal) Regulations 1974 ("the regulations"). Under this procedure, complaints are investigated in the first instance by special committees (known as service committees) on behalf of the FPC. Service committees have an equal number of lay and professional members and a lay chairman. Their function is to establish whether a doctor, dentist, optician or pharmacist who is the subject of a complaint has complied with his terms of service and, if not, to recommend what disciplinary action should be taken.

8.2 Almost all serious complaints can be dealt with under the statutory procedure, including allegations that a practitioner has failed to exercise a proper degree of skill, knowledge and care in the exercise of his professional judgement. But some complaints, for example criticisms of a doctor's manner or the running of an appointments system, are not matters of contractual liability and cannot be investigated in this way. Complaints of this kind may be followed up by the administrator of the FPC.

8.3 Compared with the total number of consultations and treatments conducted, as part of the family practitioner services the number of complaints made is very small. But it is important that the

complaints which are made should be investigated and resolved as impartially and as speedily as possible. In 1986, the Government issued a consultative document "F.P.S. Complaints Investigation Procedures", proposing a number of improvements in the way complaints may be pursued. Over 300 comments were received from various bodies and these have been taken into account in the proposals set out below. The proposals aim to simplify and streamline procedures and to recast the regulations as a whole in simpler and plainer language.

Making a complaint

8.4 Under the regulations, certain conditions are laid down for the lodging and accepting of a complaint. The Government believes that in some cases people may have undue difficulty in satisfying the conditions, with the result that comlaints which otherwise would merit investigation are not accepted, or are not lodged in the first place. Therefore in the discussion document a number of proposals were made aimed at making it easier to lodge a complaint.

8.5 For example, at present a complaint must be made in writing to the FPC. However some patients may be discouraged from complaining because of this requirement. For this reason the Government has decided that oral complaints should be accepted, subject to certain conditions designed to safeguard impartiality. The FPC officer inverviewing the complainant and recording the statement of complaints would be excluded from further participation in the service committee proceedings. In order to ensure that sufficient evidence is available for the complaint to be properly investigated the Government will also

revise regulations to empower the FPC Administrator to seek further particulars of the grounds for a complaint where he or she thinks this is necessary.

8.6 Confusion can also arise over the correct channels for making a complaint, and in some cases complaints may not be investigated if they have been addressed incorrectly. The Government will therefore require complaints to be accepted as properly lodged if they are received by a Regional or District Health Authority within the proper time limits. In this case, the authority would immediately pass the complaint to the appropriate FPC for action.

Time Limits

8.7 At present a complaint against the doctor, pharmacist or optician should be made within 8 weeks of the event which gave rise to it. Longer time limits apply where the complaint is against a dentist (6 months after the completion of the treatment or 8 weeks after the matter came to the complainant's notice, whichever is sooner) because deficiencies in treatment may take longer to come to light. The Government recognises that in some cases, 8 weeks can be an unreasonably restrictive time limit, but the time-scale has to be viewed, too, against the strain imposed on the practitioner where a complaint is outstanding. Taking these factors into account but bearing in mind the importance of dealing with complaints while events are still fresh in the mind, the Government has decided to extend the period for registering a complaint from 8 to 13 weeks.

8.8 Present regulations provide for the time limit for appeals to run from the date the party to the complaint receives notification of the

FPC decision. The Government now proposes that the time limit should run from the time that the party is given, or served, with the notification of the FPC decision. Proof of posting to the party's usual or last known address would be accepted as proof of service.

Membership of Service Committees

8.9 Impartial treatment of complaints is essential if they are to be fairly and properly resolved. In some cases this can present difficulties, for example in small FPCs where members of service committees may be acquainted with one or other of the parties to a complaint. Occasionally, too, the respondent practitioner might be a member of the FPC. To avoid possible accusations of bias, the Government will amend regulations to ensure that such complaints are transferred to another FPC for investigation.

8.10 In its Discussion Document the Government also put forward a number of proposals designed to strengthen the membership of service committees. Present regulations do not for example allow deputy chairmen to sit as members of service committees, except when acting as chairmen. The Government will lift this restriction by empowering the deputy chairman to participate in a service committee's proceedings as one of the lay members. Regulations will be amended to require deputy chairmen to be appointed from the lay members of service committees.

8.11 Although service committees have an equal number of lay and professional members, there is currently no requirement for equal numbers of laymen and professionals to be present at a hearing, and,

provided at least one lay and one professional member is present, the hearing can take place. The Government believes that these arrangements need to be tightened. Regulations will be amended to ensure that at the beginning of any hearing there should be, apart from the Chairman, an equal number of lay and professional members although, if a member has to leave once a hearing has begun, the proceedings would not be invalid. The quorum will be increased from one lay and one professional member to two lay and two professional members.

8.12 Currently only the Chairmen of service committees are subject to annual reappointment. The Government recognises that the quality of the service committee's decisions also reflects the effectiveness of its members. It therefore intends to extend arrangements for annual reappointments to service committee members.

Representation of Parties at Hearings

8.13 With a view to keeping hearings as informal as possible, regulations do not at present allow a paid advocate, barrister or solicitor to represent either party to a complaint at a service committee hearing. Some, but not all, FPCs interpret this as preventing secretaries of Community Health Councils, as paid officials, from representing the complainant. The Government intends to clarify the regulations to remove any doubt that a party to a service committee hearing can be represented by the Secretary of the local representative committee or by the secretary of the CHC. To preserve the present character of the proceedings it is also proposed that parties should not be represented at Service Committee hearings by barristers or solicitors whatever other role they may hold.

FPC Decisions on Complaints

8.14 At present, FPCs decide, on the basis of a recommendation from the service committee whether a contractor is in breach of his terms of service and recommend to the Secretary of State what action, if any, should be taken. This procedure is unnecessarily complicated and the Government believes that FPCs can and should act independently. It will therefore streamline the system to make FPCs responsible for determining the outcome of complaints, and the action to be taken, such decisions being final, except in the event of an appeal to the Secretary of State or in cases where the FPC believes a withholding of fees [above a certain level] to be desirable. [The level to be reviewed periodically]

The Informal procedure

8.15 Not all FPCs operate an informal complaints procedure and that procedure itself is limited to the general medical services at present. The system is normally operated by one lay member of the service committee, assisted by a professional member, where necessary. The emphasis is on improving understanding, seeking conciliation and resolving matters quickly on a personal basis. The Government recognises the value of this system and its proposal that all FPCs should operate an informal procedure received strong support during the consultation period. The Government will therefore amend the regulations to require all FPCs to make this procedure available, where it is appropriate, without prejudice to the rights of the parties concerned to have matters dealt with under the formal procedures at any stage, if they wish. Informal procedures will be extended to include general dental, pharmaceutical and optical services provided under FPS arrangements.

8.16 Complaints not concerned with breaches of the practitioners' terms of service, for example, the doctor's attitude cannot be investigated under statutory procedures, but the Government believes that informal conciliation may well be appropriate in these circumstances although on an extra-statutory basis.

Members of Parliament

8.17 At present, MPs have a right to receive reports of investigations only when they are one of the parties to a complaint. In other circumstances an MP may receive reports if one of the parties to the complaint exercises his or her discretion to send the Member a copy. Some MPs have expressed concern that there is no provision for them to be sent reports automatically in every case once they have become involved in a complaint. The Government believes that this concern is justified and will require an FPC to send a copy of the service committee's report, and of the FPC's decision upon it, to any member of either House of Parliament to whom a party to the investigation has at any time requested that they should be sent.

Other Minor Changes

8.18 The Government will also make a number of minor and technical amendments to the regulations as proposed in the discussion document on complaints, and which received support during consultation.

Scotland

8.19 In Scotland complaints that family practitioners may be in breach of their terms of service are investigated under procedures set out in the National Health Service (Service Committees and

Tribunal) Regulations 1974. The principles underlying these Regulations are the same as those of the corresponding Regulations for England and Wales which are discussed in the preceding paragraphs, but the Scottish Regulations differ in a number of details: for example, some decisions of Health Boards are already final in the absence of an appeal to the Secretary of State. In August 1986 the Scottish Home and Health Department issued a consultation document on the procedures in Scotland for investigating complaints against family practitioners; 46 bodies submitted comments on this document. Having considered these, the Government intends to revise the Regulations to implement certain of the proposals in the consultation document including those specified earlier in this Chapter. In addition a number of minor amendments set out in the consultation document which met with general approval of those consulted will be introduced with the aim of clarifying the Regulations. Differing views were expressed on the merits of introducing into the Regulations a requirement for Health Boards to operate an informal conciliation procedure of the type discussed in paragraph 8.15 above. The Government proposes to consult further on this matter.

CHAPTER 9: INNER CITIES

Introduction

9.1 The Government is committed to improving the primary care services in deprived inner cities and other areas of deprivation. Evidence gathered during the consultation on the discussion document showed that there is general agreement that the quality of primary health care services in many inner city areas is poorer than elsewhere. Some of the problems faced by the inner cities apply equally to certain other areas, such as large housing estates on the outskirts of some towns or cities, or some isolated rural areas. Many of the proposals described in the chapters dealing with the contractor professions and community nursing will have an important impact on those areas, particularly those measures aimed at promoting good health and preventing ill-health.

The "Acheson Report"

9.2 The report of the working party commissioned by the London Health Planning Consortium (Primary Health Care in Inner London, May 1981: the "Acheson Report") made a range of recommendations for improvements in service provision. Although the Report was concerned only with health provision in London, the recommendations in it were of wider relevance. A number were aimed at attracting better trained professional staff into the inner cities and encouraging group practices,

team working, and closer co-ordination between different agencies. Other recommendations pointed to the need to upgrade practice premises, to improve communication with patients and make more information available to the public; and to experiment with alternative ways of providing primary health care.

9.3 The Government recognised the importance of the Acheson Report in its Dicussion Document. Many of the Acheson Report's recommendations were directed at a wide range of bodies with responsibilities in the primary care field. The Government asked these bodies to give the Report consideration as a basis for action. In addition, to promote action nationally, the Government announced it would make £9 million available from 1983 for measures intended to improve service provision in inner cities in England. This money (much of which was passed to Regional Health Authorities to fund local projects) has been used:

- to provide incentives for family doctors in Inner City Partnership areas to form group practices and to improve the quality of practice premises;

- to provide more training opportunities for health visitors and district nurses;

- to fund improvements in primary health care provision in Inner City Partnership areas;

- to fund specific or pilot projects or innovations (for example, to explore different ways of organising primary health care provision based on small areas; improving the dissemination of information about primary health care in inner cities; and enhancing collaboration between FPCs and DHAs).

Improvements in the General Medical Services

9.4 A number of the measures outlined in chapter 3 (the General Medical Services - GMS) will lead to improvements in the standards of the GMS in inner cities and other deprived areas. For example, the introduction of compulsory retirement at 70 for family doctors will create opportunities in such areas for young vocationally-trained family doctors, who are often keen to form group practices and to work as members of primary health care teams.

9.5 The introduction of a post-graduate education allowance will encourage doctors to keep up-to-date with developments in medical knowledge and the provision of primary health care. The increased support to be made available for GPs involved in the clinical training of undergraduates in general practice

will improve standards of care in the profession, and the strengthening of academic departments of general practice (some of which have close associations with inner city practices) will encourage innovation and development in service provision. The removal of current restrictions on the direct reimbursement of the training costs of practice staff and the strengthening of practice teams will also contribute to raising the quality of care provided to the public in deprived areas, as well as elsewhere, by other members of the primary health care team.

Ethnic Groups

9.7 The Social Services Committee recommended an extension of the employment of link workers of relevant cultural origin by health authorities and more use of such workers by family doctors as well as by other primary care workers. The Government has already given a considerable impetus to the employment of link workers through the Asian Mother and Baby project and believes that the practice team development fund should provide incentives for the employment of link workers as members of primary health care teams.

9.8 Arrangements to encourage more women to enter and remain in general practice (Chapter 3, paragraph) will increase patient choice and help to ensure that women, particularly from ethnic minorities, who are reluctant to consult a male doctor, receive proper medical advice.

Distribution of doctors

9.9 The Government's intention of examining the scope for relating more closely the distribution of family doctors to local information about medical and social needs was set out in Chapter 3, paragraph . The extra workload falling on primary health care teams in inner cities and other deprived areas was emphasised in the responses to the Discussion Document. Gearing the distribution of doctors to take more account of local needs will enable those working in inner cities and other deprived areas to provide an improved service for their patients. The Government's related proposal to introduce a "deprived areas allowance" will support doctors who work in such areas.

Practice Premises

9.10 Many of those who commented on the Discussion Document agreed on the need to improve standards in practice premises. The Government has stated earlier in this White Paper (Chapter 3, paragraph) that it will increase the funds available for improvement grants and under the cost-rent scheme (which supports doctors with loans for this premises); this initiative together with the new responsibilities which the Government will be laying on FPCs to draw up a priority programme for premises improvements will be of particular relevance to inner city and other deprived areas.

Different Contracts for Doctors

9.11 The Discussion Document stated that there might be advantages in developing different contractual arrangements for some doctors in inner city areas and said that the Government would explore the possibility of experiments with fixed-term contracts for doctors for limited periods. Several experiments with salaried family doctors are already taking place. For example the DHSS is sponsoring two experimental schemes, each involving a salaried family doctor, for providing primary health care for the homeless and rootless who might otherwise have difficulty in obtaining medical assistance. It will continue to monitor them closely to see whether any further experiments are needed.

Dental Services

9.12 Chapter 4 on dental services pointed to the low number of courses of treatment provided under the NHS in some inner city and other deprived areas. The Government's objectives in promoting the prevention of dental diseases, improving access to treatment, and improving the quality of service, are to be translated into measures which will be of particular benefit to these areas. The fluoridation of water supplies (paragraph 5) will benefit all children, but particularly those vulnerable to dental decay. Dental health education (paragraph 6) is to be targeted particularly at areas where uptake is low to encourage dental awareness. The work of the community dental service in

identifying areas of special need and carrying out group preventive programmes will also bring inner city needs into focus.

9.13 The strategy of promoting a better distribution of dentists (paragraph 18), improving the quality and marketing of services (paragraph 20 ff) and further postgraduate training (paragraph 26) will all have a particularly strong impact on areas such as inner cities where there may be a shortage of dentists, and where their services are not sufficiently widely known.

Pharmaceuticals Services

9.14 The new contract for pharmacists introduced on I April 1987 gives FPCs and HBs the opportunity to influence the location of new pharmacies and this should lead to a better distribution of pharmacies. Where there are a number of small, uneconomic pharmacies competing with each other and each unable to afford to improve their premises and services, the payments available to pharmacists wishing to relinquish their NHS contract will ensure that more income will be available to those that remain. In addition the Government intends to create a special fund to help attract pharmacies to, or improve services in, inner city and other deprived areas (see Chapter 6).

Neighbourhood Nursing

9.15 The neighbourhood approach to the organisation of community nursing services recommended in the Community Nursing Review (the Cumberlege Report) and outlined in the DHSS Circular HN (87) X should be particularly appropriate in inner city areas where there is a pattern of small overlapping practice areas (see Chapter 7). In such areas, nurses covering specific areas of the community can identify gaps or overlaps in service provision and help to mobilise any existing community support networks. The most appropriate approach for Wales will be the subject of separate consultation.

Collaboration

9.16 Similarly, because of the special problems of deprived areas, it is important that good collaborative arrangements are established between FPCs, health and local authorities and the voluntary sector. The Government's objectives, set out in detail in Chapter 11, should ensure that high standards of care are provided in the most cost-effective way and wasteful duplication of services and gaps in provision are avoided.

Scotland

9.17 In Scotland problems of multiple deprivation tend to be concentrated in certain large housing estates on the periphery of some towns and cities. Health Boards have in recent years undertaken a programme of building health centres in such areas which has been beneficial in improving the co-ordination of and accessibility to the primary care services. The 1980 report "Scottish Health Authorities Priorities for the 80s" (SHAPE) identified as a top priority for the health service in Scotland the provision of services for the multiply deprived, and Health Boards' programmes to achieve this objective are being monitored by the Scottish Home and Health Department. A review of the SHAPE priorities is currently being carried out by the Scottish Health Service Planning Council.

CHAPTER 10: FAMILY PRACTITIONER COMMITTEES

Introduction

10.1 In April 1985 the Government established in England and Wales Family Practitioner Committees (FPCs)* as authorities in their own right, independent of District Health Authorities. The Government did so partly to allow FPCs to play a more active role in planning the organisation and development of primary health care services, and to enable them to collaborate as equal partners with other agencies concerned with the overall provision of health and social services to the public. FPCs have taken on a range of additional responsibilities and many FPCs are now taking the lead in initiating developments in services in their areas and computerisation, which will be fully implemented by March 1988, will make a valuable contribution to improving the efficiency and effectiveness of FPCs.

Collaboration

10.2 Responsibility for the provision of primary health care services is shared between various statutory agencies. FPCs are responsible for administering arrangements for the provision of services by family doctors, dentists, pharmacists and opticians; health authorities for the community health services (provided by community doctors, dentists and nurses, midwives, health visitors and other professions allied to medicine); and local authorities for personal social services. Community Health Councils and a range of voluntary bodies also have important contribution to make in this field. It is important that all these

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*Family Practitioner Committees are composed of a Chairman and 15 professional and 15 lay members, all appointed by the Secretary of State. They are responsible for the provision of Family Practitoner Services within their areas and hold contracts with family doctors, dentists, pharmacists and opticians.

agencies, statutory and voluntary, work together effectively to maximise their resources in the interests of patient care - for example, in the provision of health care for single homeless people or the running of cancer screening programmes. Similarly, where the policies of one agency have an impact on the services provided by another agency effective collaboration between them should avoid wasteful overlaps in provision.

10.3 Since 1985 substantial progress has been made in developing effective collaborative arrangements. Most FPCs have good relationships with the local representative committees of the contractor professions and with community health councils; they are expected to continue to consult these committees over any proposed changes. Increasingly FPCs, DHAs and local authorities are discussing and acting on areas of mutual concern. FPCs and voluntary bodies are now represented on Joint Consultative Committees. That is not to say that there is not room for further improvement. The Government will, therefore, positively encourage effective collaboration in FPC areas where it remains weak.

Examples of Collaboration

10.4 Effective collaboration has led to many valuable initiatives at both national and local levels. For example:-

Screening for cervical cancer. Since 1966, in recognition of the part that a comprehensive cervical cancer screening programme can play in saving lives, the Government has required health authorities to make smear tests available to all eligible women every 5 years. Initially the screening programme concentrated on the most

vulnerable age group, but more recently this has been extended to include all women aged between 20 and 64.

Computerised Family Practitioner Committee registers form the basis of the call/recall system, and a 3 year programme of computerisation in every FPC is now nearing completion. The Government intends that every health authority in the country will have implemented call/recall systems by Spring 1988. In the majority of cases the FPC will operate the call and recall programme on the Health Authority's behalf, although the HA will meet the costs involved.

In Scotland locally developed call/recall systems are available to 4 health boards. The Directorate of Health Service Information Systems aims to develop the software required for a full call/recall system early in 1988 and to make it available to all Health Boards during that year.

The establishment of a national breast cancer screening service, arising out of the Forrest report, was announced in early 1987. The intention is that all women aged 50 and 64 will be called for screening at 3 yearly intervals with optional screening for those aged 65 and over. FPC registers will again provide the basis for a call and recall programme for which health authorities will meet the running costs. Screening is to be carried out by mammography (x-ray) at about 100 centres througout the country. One centre in each Region will be established by 31 March 1988 with the remainder being set up by 31 March 1990. In Scotland

10 centres will be required; two of these will be established by 31 March 1988 with the remainder being set up by 31 March 1990.

A consultation document concerned with DHA access to FPC patient registers was issued on .

FPCs maintain registers with the name, address, date-of-birth and sex of all people registered with a family doctor in the area they serve. They are regularly updated and would provide health authorities with a valuable information-base for identifying and contacting target populations for screening and surveillance programmes, and for use in health services planning. At present, registration data is available to DHAs only under certain restricted conditions. DHAs, amongst others, have argued that readier access would greatly increase the scope for its use and, therefore, its benefit to patients. Concern has however been raised that the flow of information resulting from more open access should be subject to appropriate safeguards so that confidentiality was adequately respected. Subject to the outcome of the consultation, an early opportunity will be sought to obtain Parliamentary endorsement for a change in the present arrangements.

Alignment of the FPC planning system with that of the hospital and community health service (HCHS).

At present there are differences in the way FPCs and the HAs operate planning procedures and their respective timescales. The Government believes that this is not in the best interests of effective collaboration and will take steps to harmonise the two systems.

FPC performance reviews. FPCs are subject to a regular programme of performance review and scrutinies, reflecting their accountability to the Secretaries of State. The strength of local collaboration is a key issue at such reviews. One RHA has recently conducted a review of collaborative arrangements between one FPC in its region and its related DHAs. This was an entirely voluntary exercise (FPCs are not accountable to RHAs) and should provide useful insights into the further development and assessment of collaboration arrangements. The Government will take steps to encourage similar voluntary initiatives undertaken in other Regions and will carefully evaluate the results of such experiments.

Studies in service provision

10.5 The Government is concerned to improve the quality of care, and believes that this will be achieved through the measures set out in the previous chapters. In addition, the Government noted that the proposal in the discussion document to appoint a professional team to study the way primary care services are being co-ordinated, planned and delivered in one or two parts of the country was supported by nearly all who commented on it.

10.6 The Government has accordingly set up two such studies. One will be conducted in Halton by Cheshire FPC in conjunction with Halton District Health Authority, the other in Loughborough by Leicestershire FPC and Leicestershire District Health Authority. The studies will be completed in 1988 and reports will be submitted to the Secretary of State for Social Services.

10.7 The studies will be conducted by teams consisting of representatives of the contractor professions as well as nursing and lay representatives. They will examine the standards of service organisation and delivery with a view to identifying principles of good practice which other authorities will be invited to adopt.

An enhanced role for FPCs

10.8 Prior to 1985 FPCs played little part in the planning, development and monitoring of the provision of family practitioner services. In April 1985, however, FPCs became fully responsible for the planning and management of these services, including the level and quality of provision and the monitoring and enforcement of standards.

10.9 The development of such a management role takes time, but FPCs have generally made substantial progress towards establishing managerial control over the services for which they are responsible. The Government believes, therefore, that their responsibilities should now be extended and their management role strengthened.

10.10 In Chapter 3 (the General Medical Services) a number of proposals are made for changes in the General Medical Services which, taken together, will add significantly to FPCs' responsibilities. The main changes are:-

Premises: In consultation with the profession and with other local agencies, FPCs will be required to develop a policy for improving the standards of practice premises so that funds made available through improvement grants and the cost-rent scheme will be targeted at those premises most in need of upgrading. Family doctors will need to be given advice and encouragement on improving below-standard

premises. The sanction of withholding rent or rates (which are usually reimbursed in full) in cases where there is reluctance to raise premises standards will be applied more vigorously by FPCs.

Practice team development: The Government's intention to remove the present restrictions on the direct reimbursement of the costs of employing certain practice staff (Chapter 3), coupled with the allocation of funds for practice team development to FPCs will significantly add to those bodies' responsibilities.

Disease prevention targets: In collaboration with DHAs it will be necessary for FPCs to agree appropriate targets for disease prevention.

Succession planning: FPCs will need to consider the effect which the introduction of compulsory retirement for elderly doctors and dentists will have on the level of service provision in their locality. In areas which contain a high proportion of elderly practitioners it will be necessary to plan carefully in advance for their replacement. In such plans FPCs should also seek to encourage the establishment of group practices in deprived areas and to make improvements in the standards of premises.

Hospital referrals: FPCs will be required to obtain medical advice in relation to the rates and patterns of hospital referrals by individual doctors. If it seems appropriate the FPC should take steps to ensure that doctors receive advice and assistance. FPCs acting in collaboration

with DHAs should work to maximise family doctors' cost-effective use of hospital diagnostic facilities.

Monitoring performance: output measures and performance indicators for the family practitioner services will be developed to assist FPCs in their management of these services. The requirement that practices should submit annual reports to FPCs will enable them to monitor more closely the level and quality of service provision.

Consumer surveys: to ensure that the views of the public are obtained and taken into account, FPCs will be asked to arrange from time to time for consumer surveys to be undertaken in relation to representative samples of the population served.

FPCs and dental services

10.11 A number of the changes proposed in Chapter 4 (General Dental Services) will place more responsibilities on FPCs, chiefly:-

Measures to improve the provision of dental services in some areas: Although nationally there is an over-supply of dentists, locally there are considerable variations and in some areas the services which exist are failing to reach many sections of the community. The Government will be discussing with the profession new measures which should reinforce the effect of market forces on distribution. These will include the possibility of new contractual arrangements for dentists establishing practices and additional assistance towards the cost of establishing and equipping practices in

designated areas. The Government will expect designated FPCs to identify those within their boundaries which suffer from underprovision of service.

Powers to inspect dental surgeries: the standards of dental premises and the equipment they contain vary considerably, but at present FPCs have no powers to inspect dental surgeries and waiting rooms. In proposals for a new dentists' contract recently put to the dental profession, the Government has indicated its intention of giving such powers to FPCs.

The introduction of part-time dental advisers in FPC areas to monitor and counsel practices: following the report of the Committee of Enquiry into Unnecessary Dental Treatment, the Government has increased the number of dental reference officers, who have responsbility for monitoring and controlling the quality of dental services. To improve the monitoring of dental services the Government intends, subject to consultation with the profession, as a preliminary step to establish part-time general dental practice advisers initially in a number of FPCs in large urban areas to provide support practitioners and relieve the Dental Reference Services of some of their non-disciplinary tasks. It is envisaged that these dental advisers would be under contract to FPCs.

FPCs and pharmaceutical services

10.12 Similarly chapter 6 (Pharmaceutical Services) proposes new tasks for FPCs, namely:-

Prescribing: In Scotland HBs, acting on advice from the Area Medical Committee, have powers to monitor doctors' prescribing. In practice these powers are used in relation to prescribing regarded as excessive. In England and Wales these functions are carried out by the Department's Regional Medical Service on behalf of the Secretary of State. The emphasis has been on securing more effective and economic prescribing by voluntary means and the Government intends this emphasis to continue. The Government believes that FPCs too have an important role to play in encouraging better prescribing practice. They will therefore be required to exercise a leadership role in developing more effective and economic prescribing in England and Wales, for example by providing a local focus for discussion, encouraging the development of repeat prescribing control systems, practice formularies and other measures to improve cost-effectivess and, unltimately, to monitor individual doctors' prescribing. FPC access to independent medical advice will be essential for carrying out this function. Such measures have already been found effective in Northern Ireland where the Prescribing Unit of the Northern Ireland Department of Health and Social Services has since the middle of of 1984 been pursuing a comprehensive programme of action aimed at promoting safe, effective and economic prescribing.

Residential Homes: establishing the demand for pharmaceutical supervision of the supply and safekeeping of medicines in residential homes and

ensuring the service is supplied by paying an allowance to a suitable number of local pharmacy contractors.

Inner Cities and other deprived areas: FPCs will manage of a fund to help attract pharmacies to, or improve the standards of pharmacy services in, inner cities and other deprived areas.

FPCs in the future

10.13 The Government believes that FPCs will welcome these changes, which will increase the range of their responsibilities. By ensuring that they receive more information about the services for which they are responsible and improving their means of control, the Government will require FPCs to exercise a stronger role in the management of those services. In this way the Government expects to secure continuing improvements in the level, quality and cost effectiveness of service provision and greater accountability from those providing and managing the FPS. /In this connection the Government will be considering the effectiveness of existing arrangements for dealing with doctors whose competence is in question./ /DN. Inclusion of this last sentence is subject to further consideration in DHSS./

10.14 In view of the extended role proposed for FPCs they will need to seek medical advice on a wide range of issues. The Government believes that in many areas, such as the development and evaluation of policy on health promotion, they will benefit from the advice of community physicians who have specialist skills in the assessment of need and the planning and evaluation of services. FPCs will be encouraged to seek advice and will be free to obtain it in a number of ways, including from the relevant Health Authority or an academic department of community medicine.

10.15 The extra tasks set out in this chapter represent an increase in workload for FPCs. The Government recognises this, and will increase the funds made available to them to enable them to carry out these functions efficiently and effectively.

10.16 In addition the Government will set aside further sums to finance a range of developments at both local and national level. At local level these funds will enable FPCs to take initiatives or conduct experiments in different ways of providing services, or in responding to particular local service needs. At national level the funds will enable the Government to develop and test out new approaches to primary care by means of pilot schemes.

10.17 As a further aid to the efficiency of FPCs and to their taking on additional tasks, the Goverment will seek to devolve to FPCs as many powers of decision as are consistent with the Government's overall responsibility for managing the National Health Service and with its responsibility to Parliament. A joint working party has already begun to identify the scope for such devolution.

Scotland

10.18 In Scotland responsibility for the administration of the family practitioner services is undertaken by 15 Health Boards and the Common Services Agency. The primary care discussion document stated that the integration within one administrative organisation of all hospital, community and primary care services was regarded as the most appropriate administrative machinery for Scotland, given the scale of the NHS and the distribution of population served by each Health Board. This statement was widely supported during the

consultation period. The Government have, therefore, no proposals to alter the arrangements for administering the family practitioner services in Scotland.

10.19 Many of the proposals for an enhanced role for FPCs set out in paragraphs 5 to 12 of this Chapter will also be relevant to Health Boards. The Government propose to discuss with Boards and the profession the implementation of these proposals to the particular circumstances of the NHS in Scotland.

CHAPTER 11 : CONCLUSION

Introduction

11.1 In this White Paper the Government has reaffirmed its commitment to the continued development of the primary health care services throughout the UK. These services are the front line of the NHS. The practitioners and other health professionals who provide them normally build up longstanding links with individuals and their families and it is wholly appropriate that the public turn to them for help and advice about their health in the first instance. In the preceding chapters the Government has set out its intentions for introducing change in the contractor professions as well as in the community nursing services. They represent the Government's response to the mass of comments received during the consultations on the Discussion Document, itself the outcome of the first ever comprehensive review of the primary health care services. It was clear from the consultation process that there is widespread support for the Government's key objectives (set out in paragraph 1.6 above).

Health Promotion

11.2 One of the main themes of the Government's proposals is the development of health promotion and the prevention of ill-health. By helping people to adopt healthier lifestyles those working in the primary health care services can build on the considerable progress that has already been made in

enhancing the quality of life. By further improving services to prevent ill-health, more unnecessary suffering can be avoided and more lives can be saved. A greater emphasis on the avoidance of ill-health should in the longer term also lead to more cost-effective use of expensive hospital facilities, and enable resources to be targeted at areas in greatest need.

Responsiveness to the Consumer

II.3 Another important theme is the need to make the services more responsive to the consumer. Greater freedom of choice depends on members of the public having ready access to more information about the services available. It is also important to make the exercise of choice easier. Improvements in these areas will encourage the consumer to become more discriminating and the service provider to become more alive to the need to provide services which the public wants, at times which are convenient to patients and in premises which are attractive and up-to-date. The Government also intends that service providers should be more accountable for the level and quality of service provided.

Community Nursing Services

11.4 The Government's response to the Cumberlege Report, Circular HN(87)X invites health authorities to review the organisation of their community nursing services in the light of the proposals in the Report, and makes suggestions about possible developments in the range of activities

carried out by nurses working in the community. The strengthening of primary health care teamwork is essential if nurses are to be able to maximise their contribution to the provision of better primary health care services, [and in the encouragement of healthier lifestyles and greater self-reliance].

Services in Deprived Areas

II.5 The Government recognises that demands on the family practitioner and community health services are particularly heavy in deprived areas such as the inner cities as well as in some remote rural areas and on peripheral housing estates in the suburbs. Many of the measures described in preceding chapters (particularly in chapter 9) should improve services in these areas, for example through the strengthening of primary health care teams.

Standards of Care

II.6 The Government is also concerned to raise standards within the professions nearer to those of the best practitioners. It believes that this should be done by relating pay more closely to performance, so that the greatest rewards go to those who work hardest. It also intends to extend and develop training within the contractor professions. Medical services for the elderly and the very young will be improved.

FPCs and HBs

11.6 Family Practitioner Committees and in Scotland Health Boards will be given additional responsibility in relation to the monitoring and supervision of the family practitioner services, and their role in managing the provision of these services will be enhanced. To do so they will be given extra powers, and extra funds to carry them out. The Government will continue actively to encourage improved collaboration between these bodies and other satutory and voluntary bodies concerned with the provision of primary care.

Expenditure on and Investment in Primary Care

11.8 The changes the Government intends to make will improve value for money in a variety of ways. Although expenditure on these is expected to continue to rise in real terms in future years, the Government wishes to introduce the strategic shift in emphasis in these services outlined in previous chapters. To achieve that strategic shift and to underline the importance it places on achieving it, the Government is prepared to re-order its priorities in this part of the NHS; to raise additional revenue and to invest it in the important changes it intends to put into effect. The Government will shortly open negotiations with the professions on the measures outlined in the White Paper, and the amount of extra investment in the services concerned will depend on the successful outcome of the negotiations with each of the professions.

Conclusion

11.9 The Government believes that the policies it has set out in this White Paper and for which it is taking powers through the NHS and Medicines Bill will achieve important improvements in the provision of primary health care services in the UK. These will benefit the consumer through the provision of better services, the professions by relating financial rewards more closely to performance, and the taxpayer by more cost-effective targeting of the resources available. In short, the Government's plans point to making the nation healthier and to preparing the primary care services for meeting the challenge of the 1990s.

file

VC

cc: LPO D/Emp CO
LCO LPSO BG
HO DHSS
DES CDL
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WO Durham

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

2 November, 1987.

Dear Geoffrey,

PROMOTING BETTER HEALTH:
PRIMARY HEALTH CARE WHITE PAPER

The Prime Minister discussed with your Secretary of State the draft White Paper on Primary Health Care attached to the Minister for Health's undated letter to the Lord President, and agreed certain amendments. You undertook to circulate the changes to members of H to be sure that they are content.

I am copying this letter to the Private Secretaries to members of H Committee, the Leader of the House, the Chief Whip and Sir Robert Armstrong.

Yours, David

(David Norgrove)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

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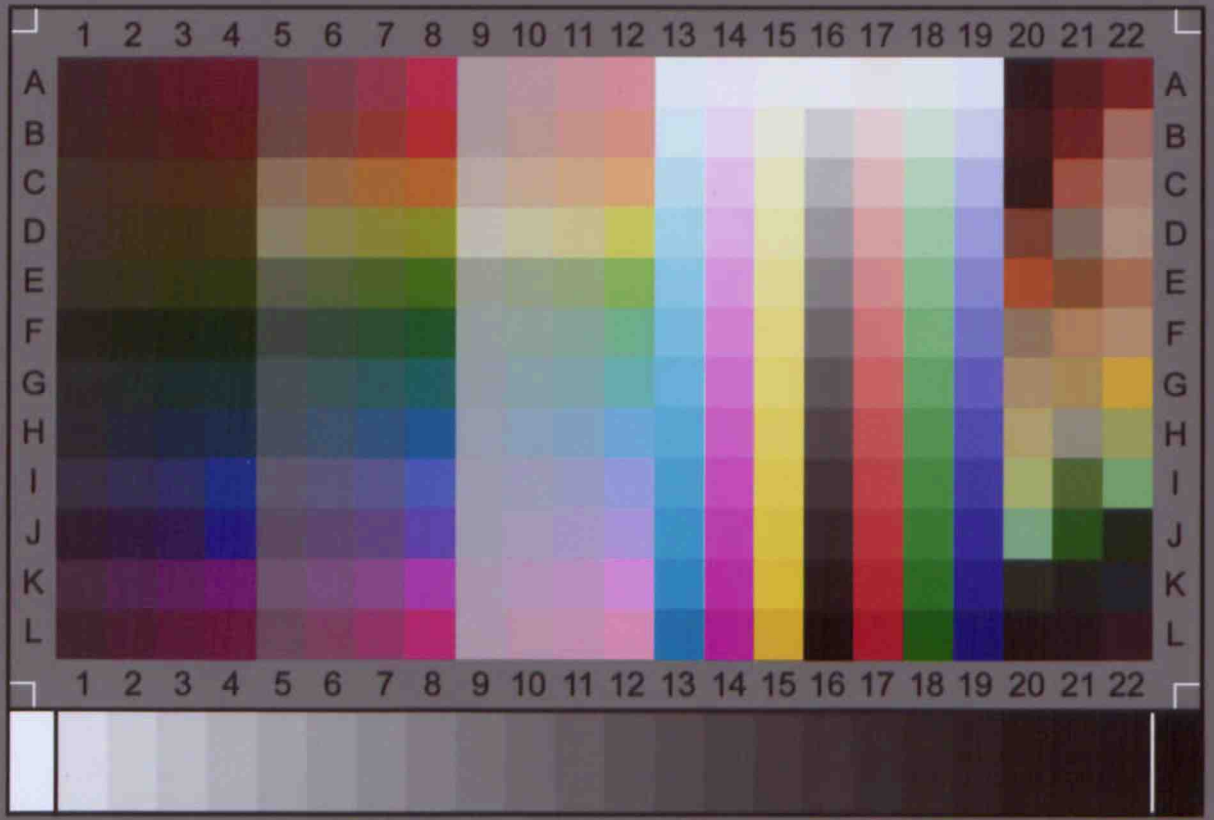
PART 1 ends:-

DLW TO DHSS 30.10.87

PART 2 begins:-

DLW TO DHSS 2.11.87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