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CABINET

PRIMARY HEALTH CARE

Note by the Secretary of State for Social Services

The attached draft discussion document, under cover of H(86) 11*, was considered by the Home and Social Affairs Committee on 19 March 1986. The Committee endorsed its publication and agreed to my proposals for a consultative exercise on it.

2. The Prime Minister invited me to give a presentation on the document to the Cabinet. I would welcome my colleagues' agreement to its early publication.

Department of Health and Social Security

3 April 1986

* already circulated to Members of the Cabinet

Primary Health Care

An Agenda for Discussion

PRIMARY HEALTH CARE

Contents

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Chapter 1: Introduction

The Nature of Primary Health Care

1. The primary health care services are in the front line of the NHS. They are the services provided outside hospitals by family doctors, dentists, retail pharmacists and opticians (these four professions make up the family practitioner services) and by community nurses, midwives, health visitors and other professions allied to medicine (the community health services). Each year most people make use of one or other of the primary health care services. In round numbers 650,000 people are seen by their family doctor on any working day and about the same number get prescription medicines from their local retail pharmacist. Nearly 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 30,000 go for a sight test. Extensive use of the services is made by people in good health who require advice or screening as well as by those suffering from illness. They account for 90 per cent of all contacts with the NHS; and they account for over 30 per cent of the gross expenditure on the health service in the UK. The current annual gross expenditure on these services in the UK is over £5 billion.

2. These figures indicate the extent of the use of primary health care that is provided under the National Health Service. In addition there is the health care which people obtain outside the NHS, normally by treating themselves but sometimes by making use of private practice. There are some signs of development in private primary health care but for the foreseeable future most people are likely to continue to look to the NHS for the majority of such care.

3. Primary health care services are more fully developed in the United Kingdom than in most other countries, where patients have more direct access to specialist care and rely less on general practitioner and community health services.[1] Our services are generally provided to a high standard and are well appreciated by the public. The Government considers that British primary care arrangements have made an important contribution to both the quality and cost-effectiveness of our health care system, and this view is widely held both by commentators in this country and abroad.

The Need for Review

4. Over the last 6½ years the Government has given priority to the development of the National Health Service. Since 1979, the Government has directed significantly more resources to the Hospital and Community Health Services, while health authorities have made increasingly better use of scarce resources. The result is that in England alone the annual number of in-patient cases has risen by over ¾ million; at the same time 57 major hospital building projects have been started as part of a massive capital programme amounting to more than £1 billion. The number of mentally ill and mentally handicapped patients resident in hospital has continued to decline as the policy of providing support for people in more appropriate settings has been backed with a significant increase in the level of spending on all services for these patients and clients. Above all there has been a fundamental change in the management of the services so that now general managers have been appointed to ensure the best possible services to patients within available resources.

[1] Appendix 1 describes primary health care arrangements in other countries.

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5. At the same time, improvements have been made in the primary care field. In England and Wales these include:

stronger and more independent Family Practitioner Committees have been established charged with local responsibility for family practitioner services;

community health councils' responsibilities in relation to family practitioner services have been clarified and extended;

and new higher standards have been set for doctors' deputising services and the use of those services.

Other improvements extending throughout the United Kingdom include:

unncessary spending on expensive drugs has been reduced by the introduction of a selected list of medicines in certain categories;

reviews of the community nursing services have been launched;

consumer choice has been increased by ending the restrictive opticians' monopoly over the sale and dispensing of frames and glasses, with a marked fall in their price and the introduction of new ranges of budget-priced frames;

funds have been allocated to improve primary care in inner cities.

6. Our primary health care services are good but could be better still. The Government believes there is scope for improving the quality, effectiveness, and value for money which patients and the nation get from them. The primary health care services have never been comprehensively reviewed. This paper concentrates on the family practitioner services (FPS)–the services provided by family doctors, general dental practitioners, community pharmacists and opticians. Together with the separate reviews of the community nursing services[1] being carried out in different parts of the UK this paper provides the opportunity for a wide examination of the main elements of the primary health care services.

7. Much health care depends on co-operation and teamwork. Consideration of primary health care inevitably raises questions about the boundaries between the different professions involved. Are we making the best use of pharmacists? And are we realising the full potential of nurses? Can family doctors be helped to make more effective use of their particular skills and knowledge? These questions need to be widely discussed and the Government hopes that a constructive debate will take place about these and the other issues raised in this paper.

[1] See Chapter 10.

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The Family Practitioner Services

8. Family practitioner services are provided by independent professional people who contract individually with the Government to provide their services to patients. This is in contrast with the hospital service, where members of the same professions – doctors, pharmacists, dentists and opticians – are salaried employees of health authorities. In some ways, the individuals contracting to provide family practitioner services are like 66,000 small businesses, although in their job security and pension arrangements, they are more like salaried employees. This system has brought a number of benefits over the years and the Government does not intend to depart from it. It does mean, though, that the ways in which the Government discharges its responsibility to the public to provide a comprehensive and efficient service are quite different from those by which it ensures a proper and effective use of resources by health authorities, who operate within a framework of cash limits, priorities, Ministerial guidelines and accountability upwards with delegation downwards. The FPS are also different in not being provided largely in major institutions in which professional performance can more readily be judged by others. The result of the contractual nature of the relationship with family practitioners and of the organisation of primary health care services is that the individual members of the public as the recipients of the services are often better placed to judge the quality of delivery of services than the NHS bodies responsible for them. There is therefore considerable emphasis in this paper on ways of enabling the patient to exercise an informed choice in using the services.

9. The Government believes that consideration of the family practitioner services should have the following purposes in mind:

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

to encourage the providers of services to aim for the highest standards and to be responsive to the needs of the public;

to provide the taxpayer with the best value for money from NHS expenditure on the family practitioner services;

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

10. The Government is determined to ensure that the public receives the highest possible level of family practitioner services. The interests of the public are our paramount concern. The convenience and comfort of patients should be regarded as an important part of the standard of care which they receive. Within sensible limits of cost, they are entitled to choose who they are treated by and where they go to be treated. They are entitled to know what services are available for them. They are entitled to have complaints dealt with properly when they consider that the services let them down. The central aim of this document is to seek ways of improving the family practitioner services for the public. The Government believes that the professions providing the services will themselves wish to do so in ways that meet public and individual needs while meeting their own professional standards.

—end of chapter 1—

Chapter 2: Primary Health Care Today

Introduction

1. Many factors influence the health of the population. General economic and social conditions affect the opportunity to obtain adequate food and shelter. Public and environmental health measures help to reduce or eliminate common risks by, for instance, safeguarding the quality of public water supplies. Individuals and families have major responsibilities for their own health in, for example, diet, exercise and road safety. When, however, people need professional help to maintain or improve their health it is important that the services they receive are delivered as conveniently and acceptably as possible, as well as that these services are effective.

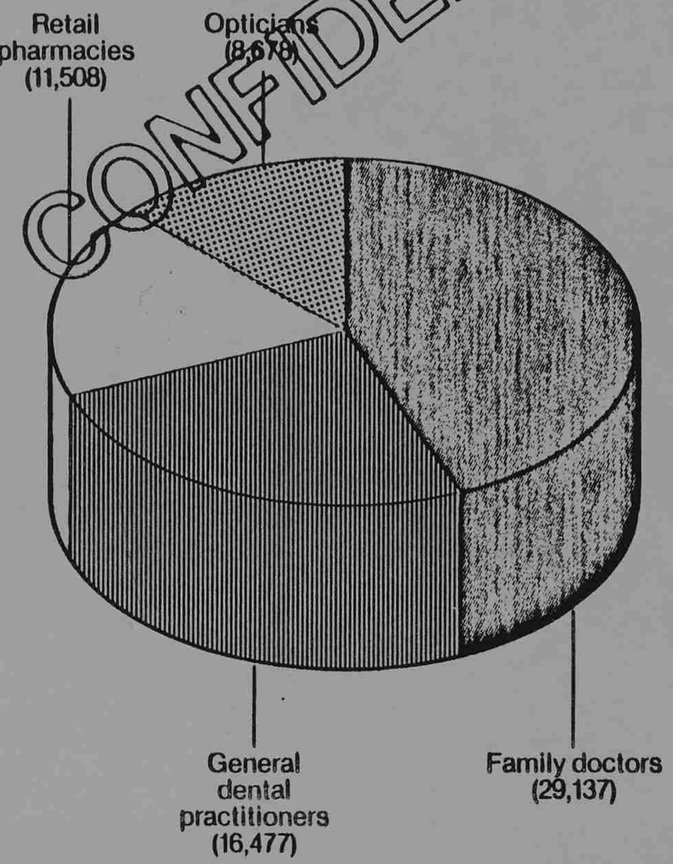
—take in fig 1—

Size of the Family Practitioner Services

2. The scale of family practitioner services is large and has been growing, in some cases considerably. The number of *doctors* in the UK who have contracted to provide general medical services has risen from 26,345 in 1979 to 29,137 in 1984, an increase of 11 per cent. There are over 225 million consultations with family doctors each a year. The cost of these services was about £1.2 billion in the UK in 1984-85; while the cost of supplying medicines on prescription under the family practitioner services in the UK in 1984-85 was over £1.9 billion. The cost of supplying medicines on prescription has risen by 28 per cent in real terms over five years.

3. The number of *dentists* in the family practitioner services in the UK in 1984-85 was 16,477, an increase of some 2,300 over five years. These dentists provided some 36½ million courses of treatment in that year at a gross cost of about £750 million. In addition, the equivalent of about 1,740 dentists are employed full-time in the community dental services under which the teeth of over six million school children were inspected and over 1.4 million school children had dental treatment.

Figure 1 Numbers Contracting to Provide Family Practitioner Services in the United Kingdom, 1984



4. The number of *opticians* in contract to provide general optical services rose by 11 per cent in the five years to 1984-85 to a total of 8,678. Over the same period there has been a slight rise in the number of retail *pharmacies* in the UK from 11,034 to 11,508, an increase of just over 4 per cent, though numbers are at present growing faster.

—take in fig 2—

—take in fig 3—

Figure 2 Family Practitioner Services: Gross Costs in the United Kingdom, 1979/80—1984/85

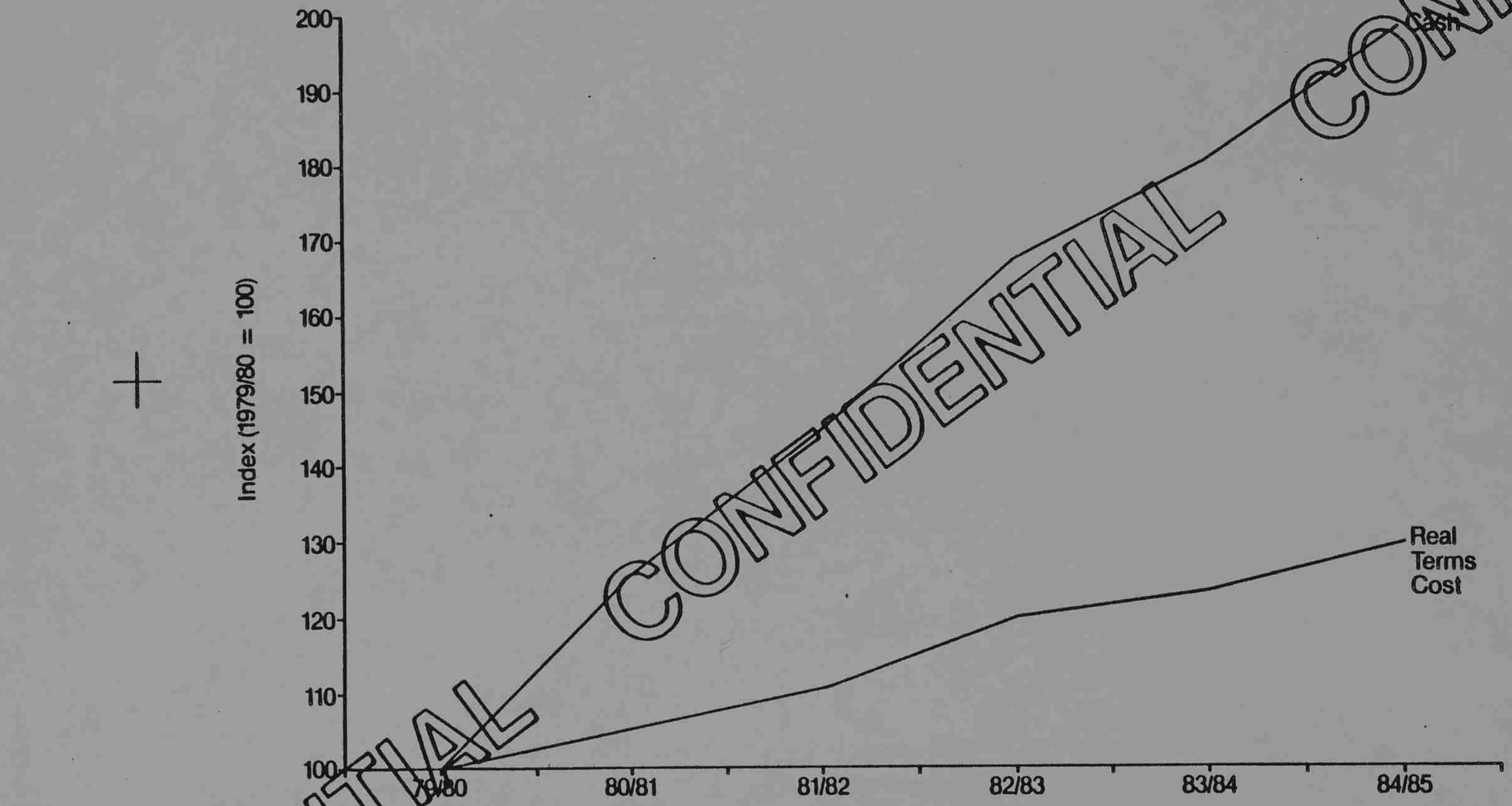
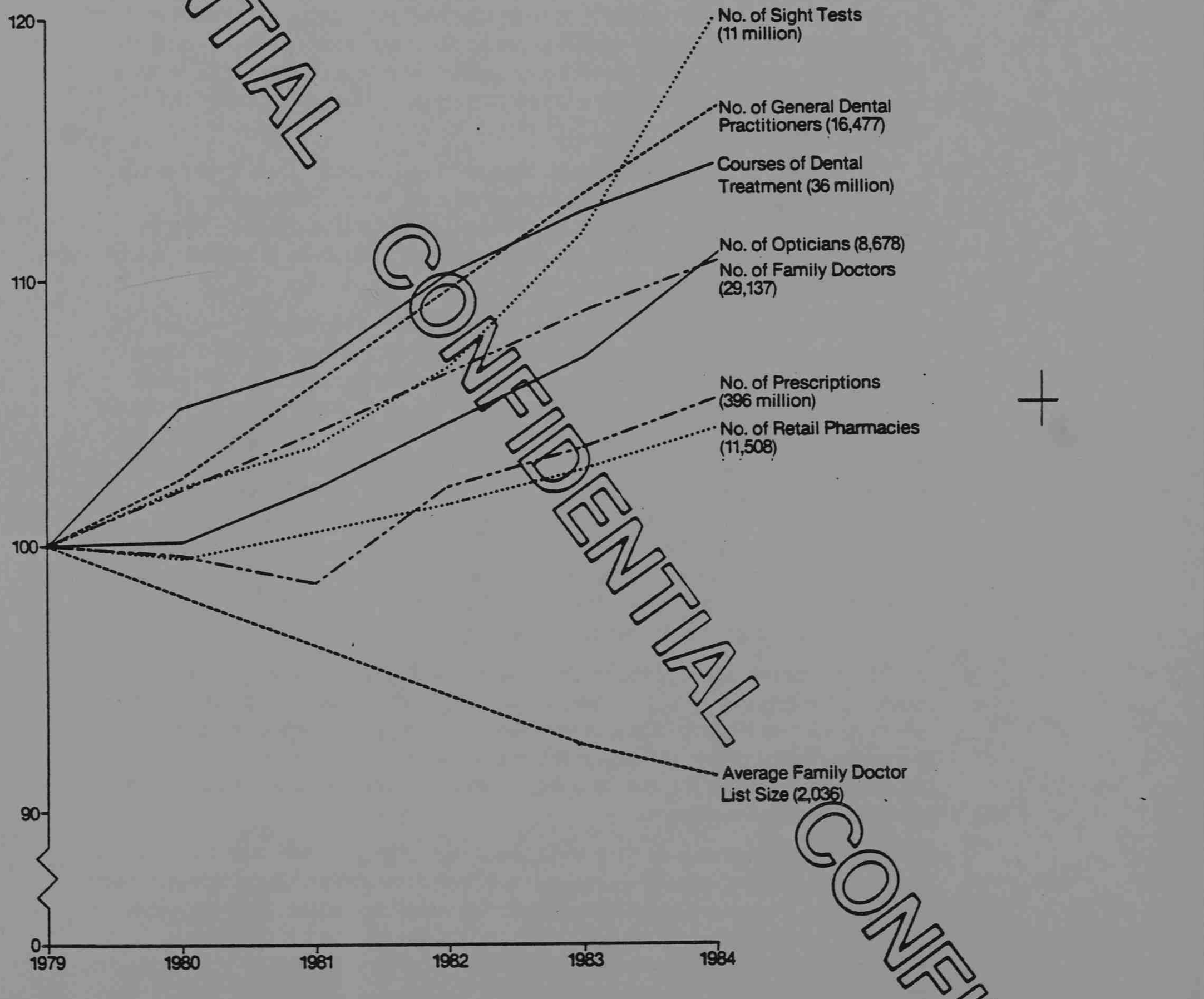


Figure 3 Family Practitioner Services in the United Kingdom, 1979—1984



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Access to Services

5. Except in the case of an emergency, where any NHS general practitioner is required to provide all immediately necessary treatment, a patient must be registered with a family doctor to get general medical treatment under the National Health Service. Anyone can apply to the doctor of his choice in the area in which he lives for acceptance as a National Health Service patient. If the doctor accepts him, a simple registration form is completed and sent to the local Family Practitioner Committee or Health Board, which adds his name to the doctor's list of registered patients. Registration is necessary because once a patient is on a doctor's list the doctor has a continuing contractual responsibility for his medical needs and in return receives an annual fee, irrespective of whether or not the patient needs to seek treatment.

6. Ninety-seven per cent of people are registered with a family doctor and rarely change to another unless they move to another area. No one needs to be left without a doctor because Family Practitioner Committees and Health Boards have powers to allocate patients who are experiencing difficulty in registering to a doctor's list.

7. Unlike family doctors, dentists do not have a continuing responsibility for their patients once a particular course of treatment is completed and are paid only according to the treatment they provide. There is, therefore, no need for formal registration with a dentist, and those in need of dental treatment are free to obtain it from any dentist willing to accept them as patients. A dentists who accepts a patient for National Health Service treatment is required to provide that patient with all the treatment that is necessary to secure dental fitness. Some dentists, however, are not willing to accept a patient for a course of treatment which involves the provision of certain items, for example dentures or crowns, which they will only provide privately. Family Practitioner Committees and Health Boards have a responsibility for helping people to find a dentist but cannot, as they can with family doctors, require dentists to treat a particular patient.

8. Patients obtain most of the medicines and appliances they need by taking a doctor's prescription to any chemist's shop where a pharmacist dispenses it. In some rural areas doctors dispense the medicines they prescribe for patients who live some distance from their nearest chemist. Some medicines, however, do not require a prescription and can be bought over the counter at chemists: others are available in shops and stores.

9. People who wish to have their sight tested can go to any ophthalmic optician or ophthalmic medical practitioner who is required to give them a prescription if they need glasses. Under the new arrangements for supplying glasses most people are then free to take their prescription to any shop where glasses are on sale and choose the best buy. Children and those entitled to National Health Service glasses must, however, go to the registered suppliers.

Paying for services

10. Family practitioner services are mainly paid for from taxes. Of the total expenditure on family practitioner services in the United Kingdom of over £4 billion in 1984-85 the users paid less than 10 per cent in patient charges. About £145 million was paid in prescription charges; £195 million in dental charges; and about £52 million in optical charges. Thus over 90 per cent of the expenditure was paid for from taxes and NHS contributions and the effective and efficient working of family practitioner services is therefore of interest to everyone however much or little they need to call upon these services.

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—take in fig 4—

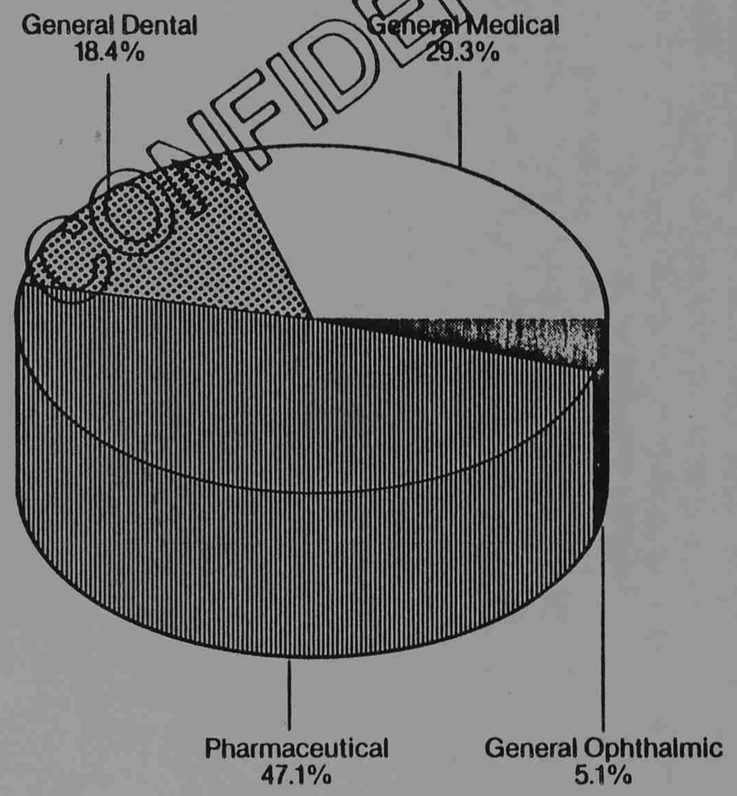
11. The members of the professions who contract to provide family practitioner services are paid under terms that are negotiated centrally between their professions and the Government. In all four services the professions' remuneration systems are based on the principle of 'cost plus', that is, payments cover both contractors' expenses in providing NHS service and their remuneration for doing so. Most fees and allowances are paid to practitioners at standard rates regardless of their individual expenses. This arrangement is important because it provide an inducement to the practitioner to run his practice with proper regard for cost-effectiveness and thus avoids the need for instrusive examination of the levels of expenses incurred. (There are three main exceptions to this: general medical practitioners are reimbused individually for the cost of their premises and for the major part of their expenditure on ancillary help, in both cases within laid-down rules. And pharmacists and dispensing doctors are repaid individually for the drugs they supply.) The remuneration element of practitioners' income is determined on the advice of the Doctors and Dentists Review Body[2] in the case of those two professions and by negotiation (and where necessary independent advice) in the case of pharmacists and opticians. A more detailed description of the remuneration systems for the four services is given in Appendix 2.

12. The remuneration system for family doctors is extremely complicated. The Government believes there may be scope to restructure these arrangements to take better account of the interests of patients by providing better incentives to doctors to improve services and to make it fairer to individual doctors by providing a level of remuneration which more accurately reflects differing workloads and commitments. this is discussed further in Chapter 3.

[2] The independent Review Body on Doctors' and Dentists' Remuneration was appointed in 1971 to advise the Prime Minister on the remuneration of doctors and dentists taking any part in the National Health Service.

Figure 4 Family Practitioner Services in the United Kingdom: Gross Expenditure, 1984/85

Total Expenditure £4 billion



13 Unlike doctors, the incomes of individual dentists (with the exception of a small number of salaried dentists and older dentists in receipt of seniority payments) entirely depend on the number of particular services they provide and their efficiency at doing so. A pilot study of a different system of paying dentists for treating children is described in Chapter 4.

14. In 1985 the Government reached agreement with the pharmaceutical profession on a new contract for paying for the NHS work of retail pharmacists. This would improve incentives to efficiency by replacing the flate rate element of payment in the old contract by remuneration related to the volume of work done. In addition, the arrangements for determining total costs will be improved to the benefit both of the taxpayer and the profession. Legislation is needed to introduce the new contract in full. A suitable Bill is now before Parliament. More details of these improvements are given in Chapter 5.

15. The most far-reaching changes to the relationship between the NHS and one of the family practitioner services are those relating to general optical services. As explained in Chapter 6, the Government is moving towards a system where those entitled to glasses under the NHS will receive a cash voucher instead so that they may take advantage of the wider choice now existing in the private sector. However the arrangements under which sight tests are provided free to patients within the NHS by the payment of a fee at a rate negotiated between the Government and the profession remain.

Administrative Arrangements

16. The scope and objectives of the primary health care services, the systems of remuneration and terms and conditions of service for doctors, dentists, opticians and community nurses are broadly similar throughout the UK. In the case of pharmacists there are separate Scottish and Northern Irish negotiating arrangements but these are in effect compatible with those in England and Wales. The most significant difference between countries concerns the responsibility for the administration of family practitioner services.

17. In England and Wales, NHS arrangements with professional practices are managed by Family Practitioner Committees (FPCs) which the Government has established from 1985 as authorities in their own right. FPCs are now autonomous authorities whose Chairman and members – usually 15 lay members together with 15 from the four family practitioner services – are appointed by the Secretary of State for Social Services or Secretary of State for Wales. This gives them a stronger and more independent base and enables them to have a higher profile than most have adopted in the past. There are 90 FPCs in England and eight in Wales.

18. FPCs have two essential roles: administering the contracts of the family practitioners and planning the development of the services in their area. FPCs need to keep the public informed of their activities and plans and the views of the public will be important in assessing the quality and standards of the services for which they are responsible. All FPCs have been sked to draw up a profile of the services in their area as a first step in a systematic approach to the identification of needs and priorities.

19. To assist and encourage FPCs to achieve high standards in the management of the resources for which they are responsible and in the development of positive planning, the DHSS and Welsh Office have introduced a system for reviewing the performance of each FPC, bringing to bear on FPCs the principles of sensible financial management. To help FPCs identify the scope for improvements the Departments have worked with them to produce performance indicators, enabling comparisons to be made between similar FPCs. The progressive computerisation of FPCs will also help to improve their efficiency and performance.

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20. In Scotland, responsibility for the administration of the services is undertaken by 15 Health Boards and the Common Services Agency. Health Boards were established in 1974 and their members are appointed by the Secretary of State for Scotland; each Board has responsibility for hospital, community and primary care services in its area. Boards have developed their own organisational sub-structure which includes a primary care administrative department to deal specifically with the family practitioner services. The integration within one administrative organisation in 1974 of all hospital, community and primary care services received wide public and professional support; it was regarded as the most appropriate administrative machinery for Scotland, given the scale of the NHS and the distribution of the population to be served by each Health Board.

21. Experience of the operation of these arrangements in Scotland in the last decade has not demonstrated any need to separate the administration of the primary care services from the rest of the NHS provision administered by Health Boards. The recently introduced arrangements for the general management of the NHS services which are designed to develop the efficiency, effectiveness and economy of these services will extend to the organisation of the primary care services in Scotland and the new General Managers of Health Boards will carry general responsibility for the administration of the primary care services.

22. In Northern Ireland there is a dual system whereby the practitioners' contracts are held by the Health and Social Services Boards and most administrative functions are performed by the Central Services Agency. Boards are responsible for the planning and organisation of all aspects of the health service – hospital services, family practitioner services, community health services and social services – and are particularly well placed to devise realistic plans for achieving a satisfactory balance between hospital and community provision. Greater integration of effort at the level of the primary care team will be important here and this will be pursued in the context of the accountability reviews which are held annually with each Board.

23. Monitoring of costs of certain aspects of the service is part of the monitoring function of the Central Services Agency (CSA) in Northern Ireland. The Agency is responsible for investigating unusual patterns of activity, a role which is of special importance in view of the Province's relatively high prescribing and dental costs. The Department of Health and Social Services is also involved in initiatives in this area and there are signs that these initiatives are beginning to bear fruit in terms of narrowing the gap between costs in Northern Ireland and those in Great Britain. The Department will wish to conduct regular joint reviews with the CSA to monitor progress in this area and to identify scope for further action to reduce costs while maintaining or improving quality in the family practitioner services.

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Private Health Care

24. Although the main expenditure on primary health care is met through the NHS, this is not the only route providing such care. Some, although a very small proportion, of patients obtain general medical services as private patients. There have been a number of interesting developments in the provision of primary care by the private sector – for example the provision of health maintenance and check-up programmes by private companies, and the introduction in at least one area of a full primary health care service by doctors operating in the private sector. There is a fair amount of private dental practice. The Government hopes that private primary care services will develop in ways that provide both an alternative source of care and also a means of comparing NHS services with those provided under quite different arrangements. There is merit in diversity and one advantage of the contractor system in the family practitioner services – under which doctors and other practitioners receive payment for their practice expenses as well as for their remuneration – is the relative ease with which it is possible to contemplate the Health Service entering into contractual arrangements with different types of health care providers. In the first place it might be sensible to proceed by experimenting in one or two limited areas. If suitable private health care organisations were interested they could be invited to tender to provide integrated primary care services under the Health Service for no more than the cost to the NHS under normal arrangements, in the same way that individual practitioners do.

25. The development of integrated schemes offering the full range of primary health care services is currently inhibited by regulations preventing anyone other than a dentist or doctor from running a dental business for profit. There are no similar rules in relation to other primary care professions, and provided there are safeguards for professional standards its removal may open the way to new schemes such as one stop health care shops which could be of considerable advantage to patients.

Changing Patterns of Primary Health Care

26. The boundary between primary health care and the hospital services is never static. Over the years the components of both have changed significantly in response to advances in medical science, social developments and changes in patients' expectations. In hospitals new methods of investigation and new therapeutic procedures such as heart surgery and hip replacement have increased demand for services. At the same time other medical advances have made it possible to care for patients in their homes who previously needed to be treated in hospital. Thus management of patients with duodenal ulcers has been revolutionised by the introduction of new medicines, significantly reducing the need for surgical treatment in hospital. In some conditions, as in diabetes, high blood pressure and in ante-natal and post-natal care both primary care and hospital services have an important role to play. Patients have also benefited from the trend in recent years to care for a greater proportion of the elderly, the mentally ill and mentally handicapped in the community.

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27. The content of primary health care and the balance between its component parts have inevitably been affected by these trends. The move towards the provision of care in the community has been assisted by the increasing involvement of a wider range of professional groups who with appropriate training are participating in the primary health care team and by increases in the numbers of support staff. For example, in the psychiatric field, the development of community psychiatric nurses and a new interest among consultants in community psychiatry has made it possible to care for many more patients without admission to hospital. In the five years to 1984 the number of ancillary staff employed by family doctors rose by 25 per cent. Changes in the patterns of illness and of service provision have also released resources to take on these new tasks. Conditions which once led to protracted illness or disability, such as pneumoconiosis and chronic bronchitis are fewer. Severe infections have largely yielded to antibiotics. Social changes including widespread car ownership have reduced the burden of home visiting. These changes and the steady rise in the number of general practitioners and consequent fall in list sizes have meant that the average number of home visits carried out by each doctor fell by seven per cent in the five years to 1984, while the average number of all consultations (at home and in the surgery) per doctor fell by two per cent.

28. These trends are likely to continue. At the same time, technological developments are likely to create new possibilities for change. The increasing availability of diagnostic kits will enable many tests to be done in the doctor's surgery rather than in the hospital laboratory. The growth in self-testing devices, for example for heart rate, blood pressure and intestinal bleeding, coupled with increasing health awareness, are likely to provoke a demand for confirmatory tests. The management of chronic diseases may be made more effective by the increasing availability of technical aids, such as personal continuous-infusion pumps for insulin and blood sugar monitors for diabetes. Discussion of primary health care services therefore needs constantly to question whether there are new opportunities for the management of health care.

—end of chapter 2—

Chapter 3: The General Medical Services

Introduction

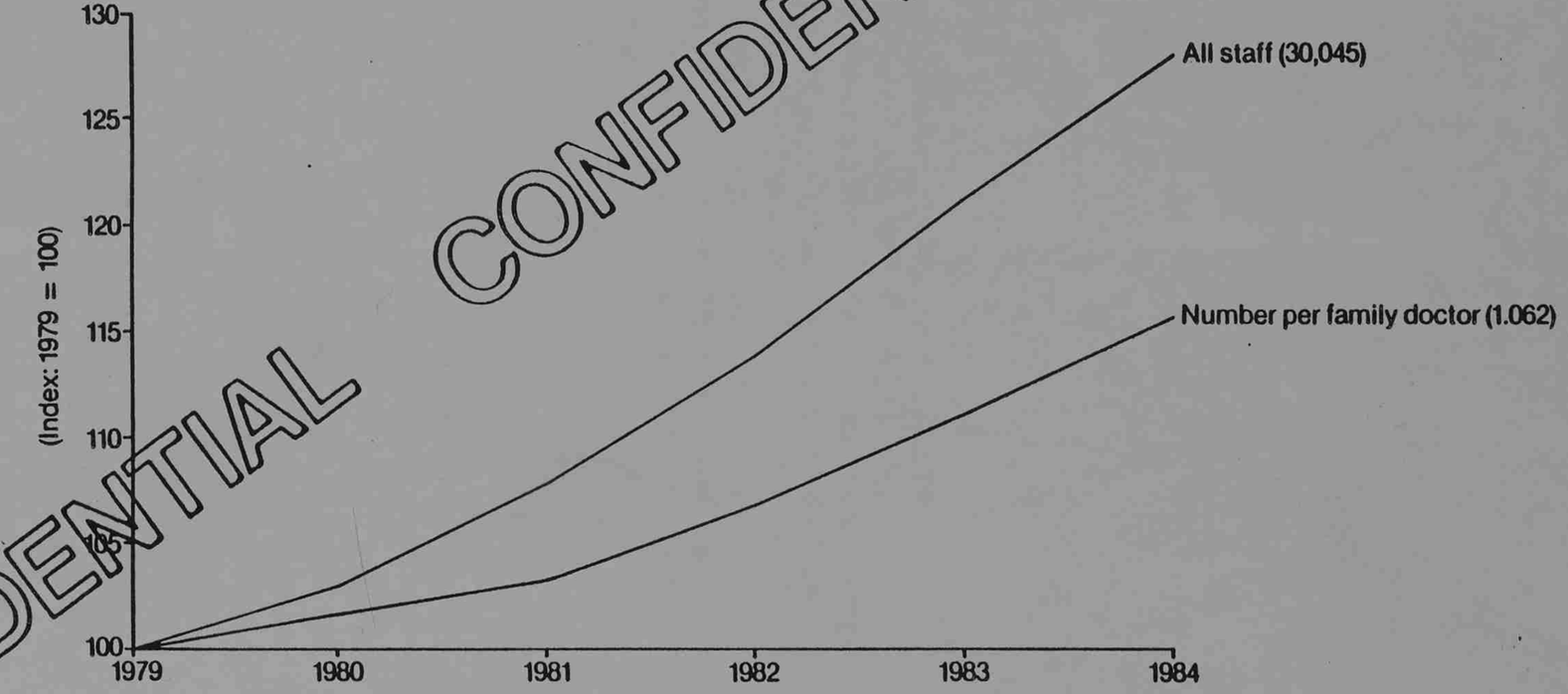
1. General practitioners – family doctors – have long been a key element in the delivery of health care in the UK. In this country almost everyone in need of medical treatment goes first to a family doctor rather than to a specialist in a particular field of medicine. The continuity of care which they provide for people on their lists, and their ability to arrange for patients to receive the most appropriate form of specialist treatment are hallmarks of our system. In no other developed country has the primary care physician achieved such a central role.

2. General practitioners have the advantage of seeing the patient's problems in the context of the patient's wider lifestyle and usually with considerable knowledge of the medical, family and social history of the patient. They should therefore be well placed to promote actively good health among patients and to mobilise where necessary the most appropriate forms of community care. Patients also see the family doctor as a source of advice on a wide range of other aspects of their lives that closely affect their health and well-being. Effective handling of the problems, whether medical or social, that patients bring to their family doctor have a significant impact on the use of resources.

3. In the 1960s the general practitioner's contract with the NHS was re-negotiated following the 'Family Doctor's Charter', a document that the profession had drawn up in response to widespread dissatisfaction among doctors. The result was a restructuring of the remuneration system with the intention, among other things, of providing various incentives to better standards. The main objectives were to achieve improvements in surgery premises, to enable doctors to employ more ancillary staff and to encourage group practice. The result is that today over 90% of family doctors in the UK work in practices employing some ancillary staff. Many doctors employ practice nurses, or have health authority nurses working in close association with them enabling the practice to provide a wider and more flexible range of therapeutic and preventive services, and helping doctors to concentrate on activities where medical skills are essential. Many doctors now practise from purpose built accommodation and the Government is now spending approaching £80 million a year on premises for general practice. Over three quarters of the general practitioners in the UK now practice in groups.

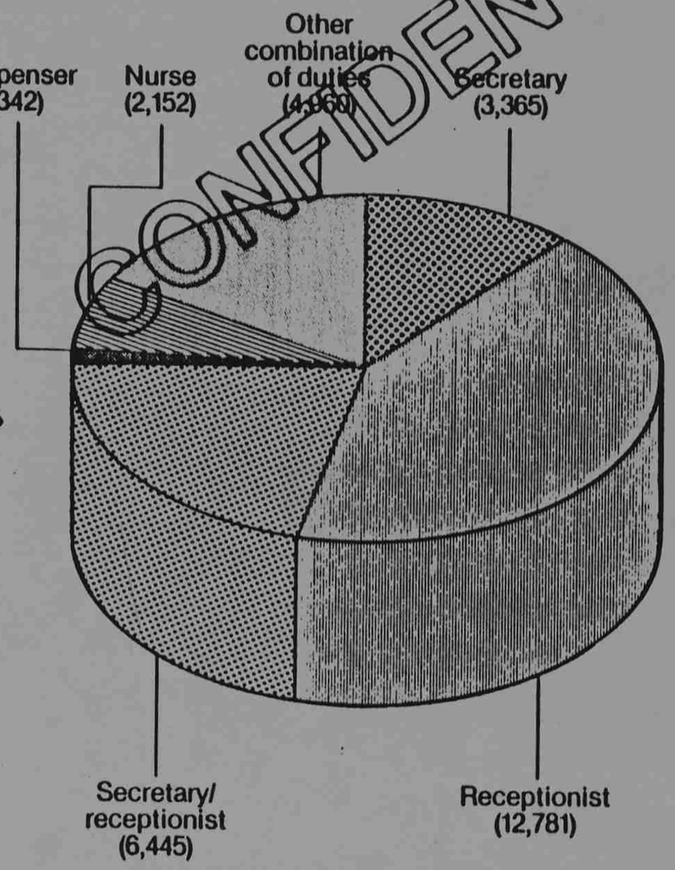
Insert Figure 5

Figure 5 Numbers of Ancillary Staff Employed by Family Doctors in Great Britain, 1979—1984



Note: The figures relate to the number of full-time or equivalent part-time staff engaged on the duties shown in figure 6 below.

Figure 6 Types of Ancillary Staff Employed by Family Doctors in Great Britain, 1 October 1984



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Insert Figure 6

4. Another landmark in the development of general practice was the introduction in 1981 of a compulsory three year vocational training for new entrants. This was a crucial step in maintaining and improving standards of care by specialised training. General practice is a specialty in its own right and is increasingly seen as an attractive career by many of our best medical students. The new generation of vocationally trained doctors are better equipped to tackle the present day needs in health care delivery.

5. These changes apart, the most significant long-term trend has been a fall in the number of patients each doctor looks after. In the decade to 1984 the average number of patients on a doctor's list fell by over 12 per cent to around 2000 and the Government expects to see a further fall. Despite increases in the number of elderly people the number of patients aged 65 and over on the average doctor's list has fallen slightly in the same period.

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Public satisfaction

6. Most people appear to be satisfied with the quality of care they receive. Nevertheless in spite of falls in doctors' list sizes and increases in ancillary help there are still criticisms from patients, particularly about the time it could take to get an appointment with a doctor, and long waiting times on arrival for appointments. This is happening at a time of rising expectations in all sections of the community, and at a time when people generally feel that they should have a greater right to participate in the decisions that intimately affect them. They want to be able to choose the services they use on their own judgements of the quality and nature of the services provided. Some doctors positively welcome this with its implication of increasing their accountability to their patients.

7. Despite the advances that have been and continue to be made in the provision of general medical services, some practices provide much higher standards of service in both medical and organisational terms than others. *The Government's objective is to raise the general quality of these services nearer to that of the best.* This involves consideration of the structure of the present contract with general practitioners; the availability to individuals of information about practices in a local area; the ways in which patients who are not fully satisfied with the care they have received can raise the problem; and the way in which patients can select and change their doctor.

Encouraging good practice

8. The present structure of the contract has undoubtedly encouraged improvements in general medical services since it was negotiated some 20 years ago. But it is only right that the financial incentives the system provides should be kept under review to see that they match up with current objectives. It is important to ensure that there are adequate rewards for doctors who provide improved services and proper incentives for others to raise standards of care. Many of those most closely concerned with general practice now accept that the incentives to reach high standards may be insufficient. Indeed, doctors who attain them may find that they suffer financially compared with other doctors because of the relatively higher cost of providing such services. *For these reasons the Government believes that the payments system should be developed in order to recognise high standards quite explicitly, probably through the introduction of a 'good practice allowance'.*

9. This would be in line with views expressed within the medical profession that better patient care can only be brought about by changes to the existing terms of service and remuneration system which would lead to a much wider spread income and more diverse patterns of service provision both within and without the NHS. The Royal College of General Practitioners has been active in this debate and has recognised that what constitutes quality in primary medical care in the 1980s and into the 1990s needs to be studied and discussed. Its recent publication 'Quality in General Practice'[1] sets out a number of suggestions about the components of good general practice and how these might be assessed and encouraged.

10. Building on the College's ideas it should be possible to identify reasonably objective criteria which could form the qualifying conditions for a significant part of the total payments to doctors. Entitlement to a good practice allowance might be linked to such factors as:

[1] Policy Statement 2, Quality in General Practice, published November 1985

personal availability to patients, both for surgery consultation and in terms of out-of-hours cover;

the provision of a wide range of services, including preventive activities based on systems for identifying certain patients for periodic review;

ensuring that certain services, eg immunisation, have been provided for an agreed proportion of patients in relevant categories;

attendance at recognised post-graduate education courses.

In addition to such objective measures, if a good practice allowance is to be based on a reasonably wide spread of those aspects of practice which are indicative of high quality work, provision would have to be made for some aspects of a doctor's services to be appropriately assessed, for example by other doctors. Similar arrangements already exist for approving training practices and are now an accepted part of general practice. The range of activities to be covered by such performance review would need careful consideration, but it may be possible to include examinations of such things as prescribing patterns and hospital referral rates.

11. A particular feature of general practice in some areas, especially in parts of Scotland, Northern Ireland and Wales, is the relatively large number of small practices which are necessary to provide appropriate services for people living in sparsely populated areas, for example in the more remote parts of the Highlands and Islands. Some elements in the remuneration system for doctors already recognise the different circumstances of general practice in remote sparsely populated areas. It would be important in the development of a good practice allowance that special provision was made to reflect these different circumstances.

Other aspects of the contract

12. A large part of the remuneration received by doctors is in the form of allowances which may have served the purpose for which they were originally designed – for example, the designated area allowance and vocational training allowance. An incentive for vocational training is no longer appropriate when such training is now mandatory. There are now very few districts designated by the Medical Practices Committee or the Scottish Medical Practices Committee as having particular difficulty in attracting doctors and in which doctors can qualify for a designated area (or district allowance). Other changes to the remuneration arrangements for doctors might also bring better value for money. Some payments have little connection with the work done by doctors and have too little regard for the doctor's personal commitment to the provision of general medical services. Some expenses are paid to doctors in a way which may include insufficient incentive to economy.

13. *Other aspects of the contract may also need to be re-negotiated including the proportion of a doctor's remuneration represented by capitation fees.* This is currently about 45% of fees and allowances; this may not adequately recognise the extent to which work and responsibility vary with the number of patients. Nor perhaps does it provide adequate incentive to doctors to practise in ways that will encourage patients to join their lists. An increase in the total proportion of income linked to the number of patients cared for (including a good practice allowance also paid on a capitation basis) could overcome these difficulties.

14. Changes to the contract are ultimately matters for negotiation between the profession and the Government. But they are also relevant to the wider debate about the future development of services because of their impact upon the quality of and range of care patients receive. The Government will decide what proposals to make to the profession in formal negotiations once full consultations have been completed. The profession's representatives have indicated their readiness to discuss a number of topics covered in this chapter including, for example, the supply of information to patients discussed below.

Information about services

15. In order to meet the Government's objective of helping the patient to choose his doctor it is necessary to supply the public with information about the different types of services available from medical practices. FPCs and Health Boards are currently required to prepare lists of doctors in their area but these only give the doctors' names and addresses, surgery times and particulars of any appointments system. These lists are only available from FPCs or Health Boards and in some cases from post offices. The need for more comprehensive and accessible information is increasingly being recognised by the profession itself. The Royal College of General Practitioners has recently been examining the extent and type of information that should be available to patients from the practice with which they are registered and has encouraged practices to produce brochures outlining the organisation of the practice, listing the doctors available, any special interests they hold, details of surgery times, and use of deputising services. The standards committee of the General Medical Council is reviewing its advice about dissemination of information and the British Medical Association has said that the information in official lists should be made more useful in assisting members of the public to choose a family doctor. *The Government welcomes these initiatives and would like to build on them so that information is provided on every practice and made widely available in the locality through surgeries and through Family Practitioner Committees and Health Boards.* Local consumer groups might also play a role in ensuring that patients had as much information as possible about the services provided by various practices in the area. The local media could also be used to disseminate factual information about practices, for example, surgery hours, times to telephone, and description of the clinics held. Information such as this would help patients to choose the sort of practices they want. It. would also help raise public awareness of doctors and encourage people newly moving into an area to sign on with a doctor rather than leave it to the time when treatment is needed, when they might have to have recourse to a hospital accident and emergency department.

Choice of doctor

16. *The Government believes that the freedom of patients to choose their doctor can be an effective influence on the quality of services.* A doctor's income is derived from the patients registered with him and the satisfaction of those patients ought to be, and generally is, a prime concern. Though this is not always fully understood, patients have the right, wherever practicable, to take their needs to the doctor of their choice. A number of suggestions in this chapter should strengthen the patients' position when choosing a doctor. There should be adequate incentives to doctors to practise in ways that encourage people to join their lists. Patients who are dissatisfied should have all the information they need to choose another doctor. Other measures may be needed. For example, the system for registering with a new doctor is already very simple, though this is not always appreciated, but could be made easier still by allowing a patient to register with a new doctor without, as at present, having to approach the FPC or Health Boards or the doctor whose practice they wish to leave. The Government would welcome views on these and other measures to promote patients' freedom of choice.

Dealing with problems

17. Information can play a useful role in improving the quality of practice by being fed back from consumers to providers of services. This can enable doctors and patients to work together to improve the quality of health care. Some doctors have taken the initiative to establish 'patient participation groups' where the patients have the opportunity to discuss with the doctor ways and means of improving the quality of health care. One useful outcome of such groups can be the formation of mutual aid groups of patients with similar problems, which can add to the total support available to such patients and at the same time reduce the demands upon the doctor for individual support. It is important that the difficulties some patients and their families have in getting access to their doctors by telephone are tackled. Answering machines and telephone systems which intercept and redirect calls can be substantial impediments to sick and anxious people seeking help, particularly when there are language and cultural difficulties.

18. To support a satisfactory relationship between doctor and patient it is important that there are effective arrangements for dealing with the inevitable occasions on which patients consider that they have been provided with less than satisfactory service. The first approach is for the patient to discuss his concern with his doctor. In some cases the involvement of a third party can prove helpful in providing the patient with an explanation of the background to the problem. Most FPCs operate some kind of informal conciliation procedures of this sort and they can often settle complaints to everyone's staisfaction quickly and efficiently. *The Government believes that all FPCs should offer such a service in suitable cases.* In Scotland, Health Boards have also been encouraged to make arrangements to try to clear up minor grievances that seem to arise from misunderstandings.

19. Most serious complaints are dealt with formally under a statutory procedure. This formal procedure, and therefore the suggestions relating to it which follow, apply to all four family practitioner services. Under it, complaints are investigated in the first instance by special committees (known as Service Committees) on behalf of the FPC or Health Board. These committees have an equal number of lay and professional members and a lay chairman. Their function is to establish whether the doctor, dentist, optician or pharmacist has complied with his terms of service and if not to recommend what disciplinary action should be taken.

20. Almost all serious complaints can be dealt with under the statutory procedures. This includes allegations that a practitioner has failed to exercise a proper degree of skill, knowledge and care in the exercise of his or her professional judgement in clinical matters. But some complaints, for example criticisms of a doctor's manner or the running of the appointments system, are not matters of contractual liability and cannot be investigated under this procedure. These complaints should not necessarily be the subject of statutory investigation but proper arrangements need to be made to pursue them where appropriate. One approach would be to bring such matters within the scope of the informal conciliation procedures referred to in paragraph 18.

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21. *The statutory procedure is complicated and often time consuming and the Government believes there is room for improvement in the arrangements.* For example, patients are currently obliged to put their complaint in writing: they may find it less daunting if complaints could be made orally in some circumstances. A complaint against a doctor in England and Wales must normally be lodged within eight weeks of the incident giving rise to it; in Scotland and Northern Ireland the period is normally six weeks but it can be extended to two months in certain circumstances. These periods may not be long enough, particularly where there has been a bereavement. Patients do not always find it easy to present their case. Some but not all FPCs allow the Secretary of the Community Health Council to represent the patient. The Government would welcome suggestions for ways in which the interests of patients might most appropriately be represented before Service Committees. The composition of Service Committees may need to be strengthened by increasing the quorum, regularly re-selecting members, and, in England and Wales, enabling the deputy chairman to take an active part. There may also be advantage in being able to draw members from outside the area of the FPC or Health Board. Finally, Service Committees may need to be given powers to summon witnesses and examine documents which are directly relevant to the patient's or practitioner's case. The Government would welcome comments on these suggestions.

Education

22. In recent years the Royal College of General Practitioners has been actively promoting better standards of practice, and the MRCGP examination has been introduced. Doctors wishing to enter general practice now have to complete at least 3 years vocational training. These developments have helped to establish general practice more clearly as a challenging and rewarding career choice. This change in attitude has been mirrored by increasing emphasis on primary care in the undergraduate syllabus. However, the undergraduate course content varies widely between medical schools, and in some general practice still only forms a relatively small part of the curriculum. There is scope for greater emphasis on the role of primary care and its interface with the hospital and specialist services. This would benefit not only those who then decide to seek entry to a general practice vocational training scheme, but also those students wishing to pursue a career in a hospital specialty since they would carry with them a greater understanding of the central role primary health care plays in the health of the nation. This is a matter principally for the educational and professional bodies.

23. The development of academic Departments of General Practice has helped, and will continue to help, in the development of general practice and the further education of doctors within a particular locality. Continuous post-graduate education is necessary if doctors are to keep abreast of modern medical developments, maintain and improve their standards of care and avoid the professional isolation that can result from their location in small groups in the community. There are also encouraging developments in the number of seminars and informal meetings in small groups where doctors can discuss each other's work. However, less than half of GPs attend any form of post-graduate education. Increased participation on post-graduate education should be encouraged by a good practice allowance. *The Government accepts in principle the case for raising the proportion of GPs involved in post-graduate education.*

Retirement

24. When the NHS started in 1948 the number of young doctors was insufficient to meet demand. In consequence, the arrangements made for elderly doctors were designed to encourage them to remain in practice. Now that there are adequate numbers of younger doctors who want to enter general practice these arrangements are out of date.

25. Unlike hospital doctors who must normally retire at the age of 65, general practitioners do not have a fixed retirement age. They can draw their pension at any time after the age of 60 and many do now retire in their early 60s. However, some stay on considerably longer and there are currently 515 practising in their 70s and a further 76 who are aged 80 and over. It is reasonable to believe that the replacement of very elderly doctors by younger vocationally trained doctors would generally lead to an improvement in the standards of care, particularly in inner city areas where, as discussed in Chapter 9, there is usually an above average number of elderly doctors and an above average incidence of health care problems. *The Government therefore intends to change the present arrangements.* Compulsory retirement at age 70, with doctors aged 65 and over needing the agreement of the FPC or Health Board to continue to practise might provide an appropriate degree of flexibility whilst ensuring that doctors do not 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.

26. *The Government also intends to end the present system known as '24 hour retirement',* under which doctors or dentists in the FPS can 'retire', take their lump sum and begin drawing their pension, and then re-contract with the NHS after a break of just one day. Those who take 24 hour retirement between the ages of 60 and 64 receive their lump sum and pension but the pension is abated so that pay and pension together do not exceed superannuable pay at retirement. The arrangements for those who take 24 hour retirement between the ages of 65 and 69 are even more favourable to them in that they can receive both pension and remuneration in full, without any abatement. This system, which is wholly exceptional in the public sector, is no longer justified.

Relations with the hospital service

27. An important feature of general practice in this country—one that has made a significant contribution to the effectiveness of the NHS—is the responsibility placed on family doctors to select and provide access to the right forms of hospital and other specialist care when patients need it. The development in some areas in recent years of new district general and other hospitals has given family doctors greater opportunity to select the most appropriate hospital and hospital consultants to which to refer patients, in the light of their particular needs and circumstances. But very little information is available about the extent to which individual doctors refer their patients to hospital, though there is reason to believe that there are very considerable variations. The Government believes that *doctors need to be given information on their referral rates and how these compare with other doctors.* The implementation of the Korner Steering Group recommendations in England and Wales should help this.[1]

28. Because of their unique position in mobilising hospital services for their patients family doctors are well placed to assess the adequacy of the services and to contribute to the planning and setting of priorities by health authorities. This is a development which will be fostered in England and Wales by the arrangements for collaboration between Family Practitioner Committees and District Health Authorities. The DHSS instituted a review of the arrangements for this and identified a variety of ways in which both types of authority can work together in developing co-ordinated services for the benefit of the patient.

Community child health services

29. For some 70 years doctors have been employed by health or local authorities to provide and manage a range of preventive and caring services mainly for young children. To provide these community medical services, District Health Authorities in England and Wales currently employ 6,000 doctors, many part-time, at a cost of about £60 million a year. About 70 per cent of the work of these doctors is spent on child health, and a large part of this time is given over to regular checking of children under school age to monitor progress and see what further help they may need. Yet these checks can most satisfactorily be carried out when the doctor has continuing responsibility for the child and is thus fully aware of his or her medical and family background. This means that very often family doctors may be best placed to provide this service. A number already do so, often working directly with health visitors. *The Goverment wishes to increase the numbers of family doctors involved in this work.*

[1] The NHS/DHSS Steering Group on Health Services Information was appointed in 1980. The relevant recommendations are in its first report, published in 1982.

30. Consideration is already being given to how this can be achieved and in particular to a number of key points which still need to be resolved, including:

the contents and timing of childhood screening and examinations;

the respective roles of health visitors and doctors;

the training of doctors for this work;

the need to continue to provide a service covering all the childhood population in the district with co-ordinated health authority and family doctor recall and recording systems to prevent children slipping through the net;

the special problems of inner cities where much greater involvement by family doctors may not be realistic.

Discussions on some of these issues are already underway with representatives of the professions concerned.

Prevention

31. Many services for prevention of ill health and promotion of good health are well established in general practice – family planning, cervical cytology, ante and postnatal care, vaccination and immunisation. There is scope for doing more, for example in the early detection of hypertension, in the prevention of coronary heart disease, by advice on smoking, diet and physical fitness. More can also be done in the prevention of mental illness and of incapacity in the elderly. The provision of call and recall systems as a component of a good practice allowance could encourage more family doctors to meet this basic requirement for good practice-based preventive work.

32. But the work of the practice needs to be related to the work in the Health District or Health Board as a whole. Because many preventive services can be provided both by family doctor services and by health authorities, these two areas of the NHS need to work closely together. Good services can be delivered in different ways, and there needs to be local assessments and experiments. Many are underway. But underpinning local variations in service delivery there needs to be a local health promotion strategy, drawn up jointly by those working in health authority and family practitioner services. This would for example include:

establishing a general preventive health strategy, with specific programmes for specific issues;

setting up systems for exchanging information;

reviewing services provided by both health authorities and family doctors, to see whether a more co-ordinated approach could provide a more cost-effective service.

33. Prevention is not solely for doctors. Nurses generally, as well as health visitors, and other members of the primary care team have important roles to play. Developments in dentistry and pharmaceutical services are mentioned later. People can also take positive steps to improve their health, e.g. through a balanced diet, reasonable exercise, and by giving up smoking. *The Government intends that discussions on this consultative document should consider what more might be done to promote this field of activity.*

Computers

34. The Royal College of General Practitioners in their policy statement, 'Quality in General Practice'[1], recognises the importance of computers in assessing and reviewing the quality of care provided to patients by family doctors and in general practice management. Computer systems can be used to detect when patients are slipping through the net and to increase the effectiveness of preventive health care through the introduction of call and recall systems based on age/sex registers and through the introduction of fail-safe methods for reporting and acting on the results of tests. Such systems are already in use in immunisation and screening for cervical cancer. Duplication of services could also be detected and services rationalised. The Government has already supported experiments into the use of micro computers in general practice. It now proposes to set up experimental schemes to explore the feasibility of introducing computer systems to aid quality assessment and performance review.

[1] Policy Statement 2, Quality in General Practice, published November 1985.

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Chapter 4: Dental Services

Improvement in dental health

1. Over the last decade there have been major improvements in dental health, particularly among children. For example, the proportion of five-year olds with dental decay fell from nearly three quarters to under half between 1973 and 1983. The improvements among adults have been smaller but are still significant. Between 1978 and 1983 the proportion of people with no remaining natural teeth fell from 37 per cent to 25 per cent.

2. Dental health is one of the areas where nearly everyone accepts the importance of the contribution that individuals can make to maintaining their own health through oral hygiene and by eating less sugar. However, the better availability of conservative and preventive treatment through the general dental service under the NHS has made an important contribution to improvement in dental health. There is also little doubt that factors such as the growing use of fluoride toothpaste and fluoridation of water supplies in some parts of the country have contributed to these improvements.

—take in Fig 7—

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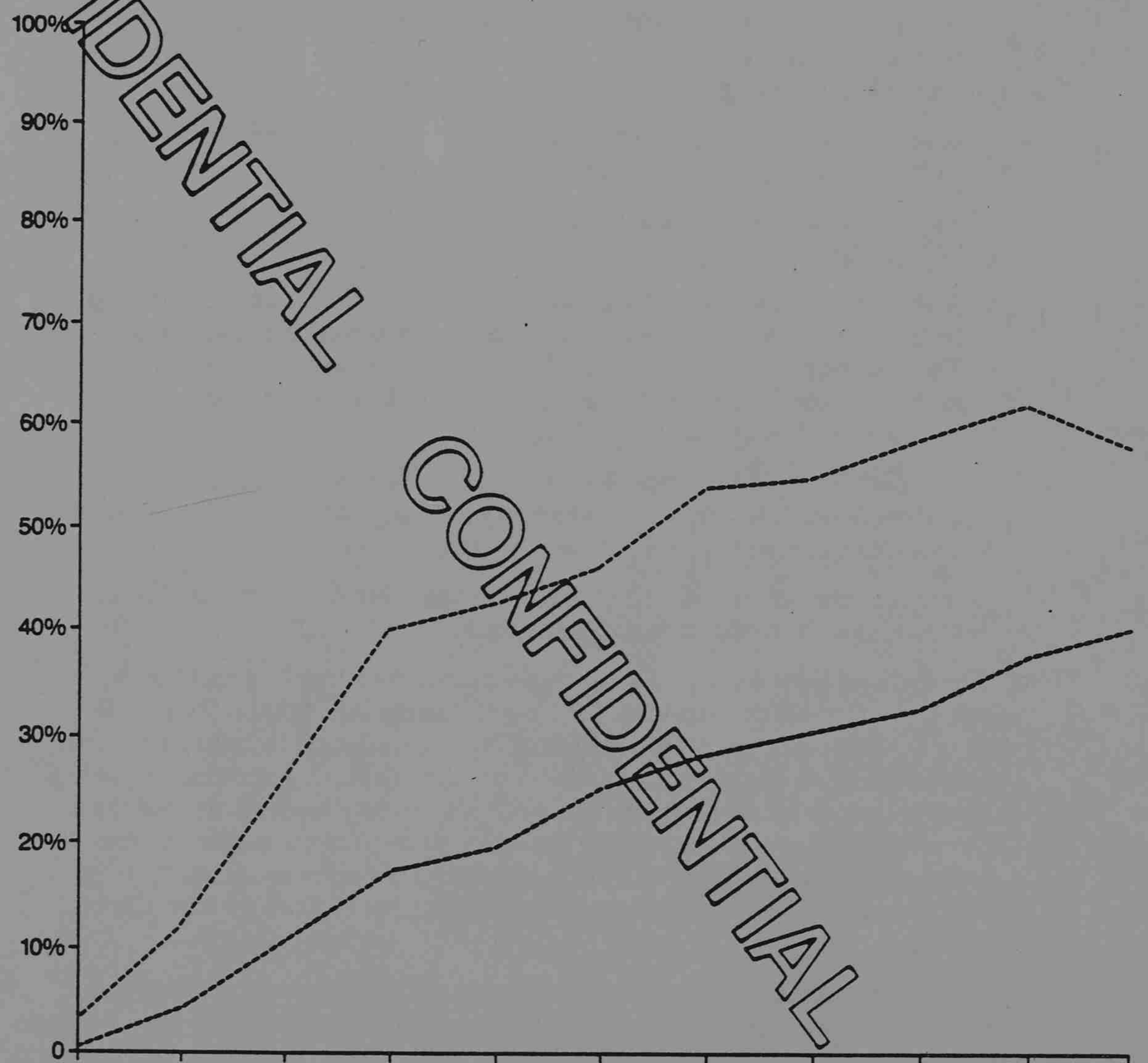
Figure 7
Proportion of Children with Some Decayed Permanent Teeth in England and Wales in 1973 and 1983



Source: Office of Population Censuses and Surveys

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Office of Fair Trading Recommendations

3. In August 1985 the Director General of Fair Trading published the conclusions of his study into the availability of NHS dental treatment and the cost of private dental treatment. He found:

little justification for the serious restrictions then in force on advertising by dentists though emphasising that advertising should be honest, legal and decent and have regard for professional propriety;

a lack of publicly available information about the cost of private treatment, with resulting high variations in the range of charges;

a lack of information about the availability in a local area of the full range of NHS treatments;

that current restrictions limiting the involvement of those who are not dentists or doctors in the business side of dentistry were no longer needed. The abolition of such restrictions should help encourage greater competition in the provision of private dental services, including the provision of more private emergency clinics;

that dentures could be obtained readily on the NHS (although in London and the South East it might be necessary to change dentists to do so) and this provided a competitive alternative to private treatment;

that the responsibility for fitting dentures should remain with dentists, and should not be passed to dental technicians.

4. The General Dental Council has already relaxed the current restrictions on advertising to enable dentists to give the public factual information about their practices. Advertisements on hours of opening and treatment including emergency treatment available on the NHS are now permitted. *The changes already made will increase the public's ability to make informed choices between dentists, and the Government welcomes them.* Further relaxation of restrictions on the nature of the advertising allowed and improved information on private fee scales might bring still more benefits. The Government is pursuing the possibilities with the General Dental Council.

5. For dental practices, alone amongst the primary health care professions, the law restricts ownership to the professionally qualified. This restriction was introduced in 1956 and makes it virtually impossible for any individual or company to offer a full range of primary health care services to the public. Removing the restriction would mean that dental care was not excluded from any moves towards the integrated provision of primary health care services by companies or others wishing to offer a full primary care service in one location. 'Health Care Shops' offering the full range of services might be appreciated by many people. On the other hand, fears have been expressed that allowing companies or people without professional qualifications to own dental practices might harm professional standards and in particular lead to unnecessary dental treatment – a risk possibly greater in dental practice than in other forms of health care because dentists are paid in the NHS by item of service. *The Government would welcome discussion of the balance of advantage between these two points of view.*

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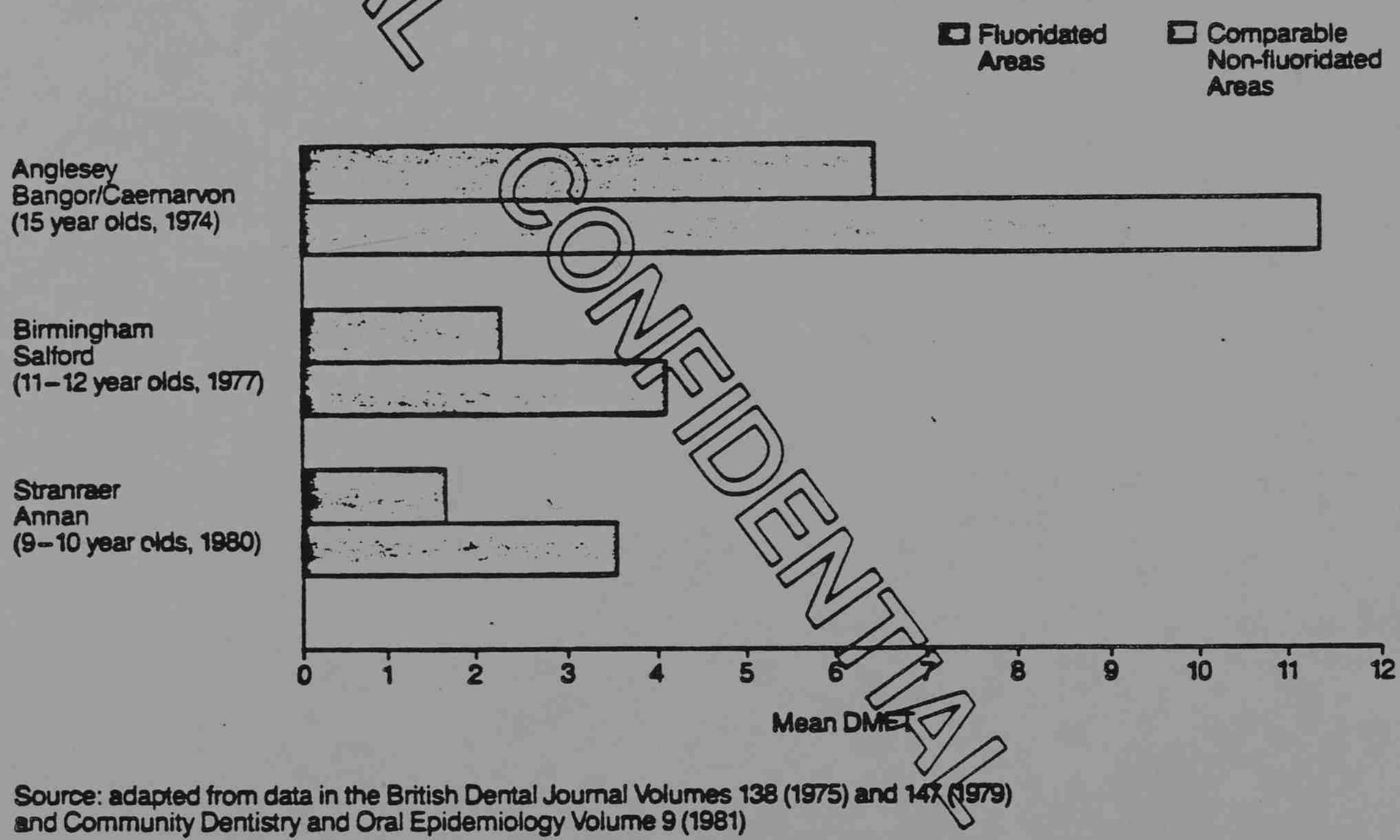
Prevention and Service Availability

6. The Government is committed to the prevention of dental ill-health. The Health Education Council is running a special campaign to encourage young people to look after their oral health. It has long been known that adding small amounts of fluoride to water supplies safely reduces dental decay and the need for fillings, particularly in children. The Water (Fluoridation) Act 1985 was an important step and confirmed health authorities' power to arrange fluoridation in their areas. At present, about five million people in England and Wales are supplied with fluoridated water, mostly in the West Midlands. Now the legal powers are clear, there is obviously potential to extend this benefit to more people. Fluoridation is a local choice, but *the Government expects health authorities in areas where dental health is poor or the level of attendance at the dentist is significantly below the national average to consider the benefits of fluoridation with particular care.*

—take in fig 8—

7. Prevention is most important for children, and there is a need to ensure that dentists have the maximum incentive to give very young patients a service properly emphasising preventive care and treatment – for example advice on oral hygiene and the use of new techniques such as fissure sealants which may reduce the number of fillings and extractions. In October 1984 the Government launched a pilot scheme within the NHS under which some dentists are paid a capitation fee – an annual lump sum – for their child patients instead of the item fees normally paid for individual fillings, extractions, or other forms of treatment. This has been successful, and showed that the small number of dentists so far covered tend to like the arrangement. Change to a full-scale scheme is a far-reaching process, and the Government is now extending the experiment to a larger number of dentists for a further three years. *If, as this second phase progresses, it becomes evident that the promising results so far achieved are confirmed, and that the scheme is cost-effective and popular with parents, the Government will make plans to give all children the opportunity of being treated on this basis.*

Figure 8
Caries Experience Among Children, Measured by the Number of Decayed, Missing or Filled Permanent Teeth (DMFT) in Fluoridated and Comparable Non-Fluoridated Areas Of the United Kingdom.



Source: adapted from data in the British Dental Journal Volumes 138 (1975) and 147 (1979) and Community Dentistry and Oral Epidemiology Volume 9 (1981)

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8. On occasions people may have difficulty in finding a dentist who will accept them for NHS treatment. There is also sometimes difficulty in getting the full range of necessary treatment from dentists in contract with the NHS, particularly items such as dentures. The first problem might be solved if the minimum times when individual dentists were available to provide NHS treatment were specified by agreement in their NHS contracts. They would then be obliged to offer NHS treatment to anyone seeking a vacant appointment during the hours specified by agreement for treating NHS patients. Patients might have more certainty of access to the full range of NHS treatment if the contract also required NHS dentists to provide a full range of normal treatment according to patient need. However, orthodontics require special skills and experience so would not be included in such a general requirement. To deal with the probably rare cases in which people might still find difficulty in getting NHS treatment, FPCs and Health Boards could be given powers to allocate patients to NHS dentists in the same way that they can already be allocated to doctors. *The Government would like views on whether difficulty of access to NHS dentists and the full range of NHS treatment is sufficient to justify the changes mentioned.*

9. The item of service system for paying dentists has the merit of encouraging high output and efficient service. However, the quality of service depends partly on the relative value of the different item of service payments. Probably the most important opportunity that the dentist has to promote long-term dental health is when he gives patients advice on how to avoid decay, for example by sensible eating and regular cleaning. It is sometimes asserted that the dentists' NHS contract and payment arrangements provide little or no cover for this function. In fact, it is covered by the fee for 'clinical examination, advice and report', which is included in the NHS payments to dentists for all courses of treatment except those given in emergency. The preventive element in NHS dental services might however be improved if the requirement to give proper advice on maintaining oral health were more fully and emphatically defined in dentists' contracts than at present; and perhaps also if this item were given greater value in the payment system, relative to treatments such as fillings and extractions. The Government will discuss these possibilities with the dental profession.

10. One of the results of item of service payments is that they appear to lead some dentists – albeit a small minority – to undertake unnecessary treatment. The Government set up a Committee of Enquiry in England and Wales and their report has recently been published. The Committee found that there is a 'small but significant and unacceptable amount of deliberate unnecessary treatment . . .' and a larger amount attributable to an out-of-date treatment philosophy. They were also particularly concerned about unnecessary orthodontic treatment. However, they did not consider that the problem is so widespread that patients should in general lose confidence in their dentists.

11. They recommended improving monitoring of dental practice; stronger powers for FPCs and the Dental Estimates Board to deal with suspected overtreatment cases; clearer and more public criteria for giving or refusing approval to treatment where this is required in advance; the development of more realistic criteria for approving orthodontic treatment; more explicit warnings to dentists against over-treatment by the General Dental Council; more guidance to the profession generally on treatment standards; and guidance to patients on their own role and rights of choice as consumers.

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12. The Government endorses the Committee's general approach and consultation with the interests affected is already under way. *The Government hopes to introduce the majority of the recommendations later this year.*

Community Dental Services

13. The Community Dental Service has, since 1948, performed the important function of inspecting children's teeth and providing them with some treatment. With the decline in dental caries amongst children, the fall in the school population, and the increase in the number of general dental practitioners, the need for routine inspections and treatment of children through the community dental service is now less clear. However, there is a need for increased effort in dental health education, group preventive programmes, screening in areas of special need, and the treatment of people who for other reasons require special care such as some mentally handicapped people. *The Government intends to discuss the development of the community dental service along these lines with the professional and other interests concerned.* A consequence would be that in most parts of the country the routine care and treatment of schoolchildren would in future be undertaken by general dental practitioners; and that in all areas the role of the community dental service should be reviewed to determine the best use for it and the most fruitful relationship with the general dental services.

Retirement

14. There is at present no fixed retirement age for general dental practitioners. They can draw their pension at any time after the age of 60 but some stay on much longer and there are over 400 dentists aged 65 or more still in contract with FPCs and Health Boards. *As with doctors, there are good reasons for reviewing the present arrangements so that dentists do not continue working in the NHS beyond the age when this is sensible.* The Government will discuss with the profession whether compulsory retirement at 65 or 70 would be reasonable. If 65 is chosen as the general rule, FPCs should be able to agree extensions up to age 70 where this was justified on service grounds. The Government will also discuss with the profession whether the present entitlement to retain seniority payments until retirement is providing an artificial incentive to remain in NHS practice beyond a reasonable age.

Training and Education

15. Discussions are already in progress on a scheme to encourage newly qualified dentists not to enter practice on their own account without a period of vocational training with a dentist suitably experienced in general practice. To help meet concern over anaesthetic skills available within the dental profession, the Government has agreed to fund some extra hospital posts for the post-graduate training of dentists in the techniques of general anaesthesia.

16. Dentistry is likely to see changes in clinical techniques and materials in the coming years. It is important that dentists already in practice should keep up-to-date and take refresher training when necessary. The Government will be discussing with professional and academic interests whether existing post-qualification training opportunities are sufficient and how any increase in refresher training could best be financed within necessarily limited resources.

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Chapter 5: Pharmaceutical Services

Importance of Pharmacy

1. There is rising public interest in medicines and health. Patients need their medicines promptly and accurately dispensed; but they also want to understand more about their treatment and possible side-effects, and to accept a greater personal responsibility for their own health. There is increased recognition that individuals can make a significant contribution to avoiding ill-health, and that a judicious measure of self-care can assist in the maintenance of good health. The pharmacist has a traditional role as an accessible and responsible source of advice about the treatment of minor ailments. The advice can include suggestions for medicines available without prescription 'over-the counter', or a recommendation to consult a doctor at once or if symptoms persist. This advisory role is in addition to the important task of dispensing accurately and promptly medicines prescribed by doctors, and counselling patients on their use.

2. There has however been a shift of emphasis in the pharmacist's role. Community pharmacists are now rarely called upon to make up a medicine from ingredients although at one time this was the very essence of their skill. Most medicines are now supplied in a form suitable for dispensing and increasingly in a form for direct supply to the patient. Medicines have become more numerous and are more powerful. They are able to provide relief or cure for a wide range of illnesses but they bring with them also the possibility of unexpected or adverse side-effects. While the pharmacist's knowledge about the composition and formulation of medicines is now a less important component of retail pharmacy, other components of the pharmacist's knowledge are increasingly important. The action of medicines in patients, the limitations of medicines, their contra-indications and side-effects, and the interactions between different medicines and foods are all important in modern treatment as are the varying ways different people respond to medicines.

Extended Role for Pharmacists

3. *The Government believes that these developments create a need and provide an opportunity for pharmacy skills to be put to more and better use.* It therefore welcomed the initiative taken in 1984 by the Nuffield Foundation in setting up an enquiry into the future development of pharmacy. With the benefit of their report and the debate that will follow its publication, the Government will examine carefully and positively what additional contribution pharmacies might make to NHS primary care, and how that contribution would best be monitored and paid for to ensure the right quality of service and value for money.

4. Various suggestions have been made in evidence to the Nuffield enquiry, such as:

a renewal of emphasis on the pharmacist's role in advising patients on minor symptoms, and on the most sensible and effective ways of using medicines;

increased domiciliary services, or home collection and delivery services including perhaps mobile or part-time pharmacies, to improve services to people who are housebound or in isolated communities;

the encouragement of pharmacists to participate more actively in the continuing education of other workers who contribute towards community health such as health visitors, district nurses, social workers, home help organisers, or those managing residential homes for those with special needs such as elderly people and mentally handicapped people. The aim would be to equip such workers better to detect problems with medicines or their administration and to provide them with a source of specialist help;

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the use of pharmacies to display health education and health promotion material;

the keeping by pharmacists of 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. It might be particularly useful for elderly patients who tend to take a fair number of different medicines and regularly use the same pharmacy;

the encouragement of some pharmacists to specialise in advising general practitioners on the administration and handling of particularly complex substances, eg cancer treatment and intravenous feeding;

through membership of Drug and Therapeutic Committees, or other agreed local arrangements, the offering of advice by pharmacists to doctors on economic and effective 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 drugs.

5. The use of computers in pharmacy practice has increased rapidly and many pharmacies now have computers which could be used to store information on prescriptions and/or patients and which can communicate with other machines. This opens up many interesting possibilities for the sharing of information, the updating of records and speedier communication generally and would greatly facilitate some of the developments described above. Trials will begin shortly to test whether information on medicines can be communicated automatically from pharmacies to the Prescription Pricing Authority.

6. As more conditions become treatable in the community it is important to ensure that the appropriate facilities for that treatment are available as cost effectively as possible. For example, oxygen concentrators, which are more cost-effective than cylinders in providing oxygen to people who need it in large quantities were introduced into the family practitioner services in England and Wales in January 1986.

7. The role and future development of pharmacy is therefore already the subject of lively debate within the profession. The issues under discussion have implications for other professions as well as for patients and the NHS. Effective primary health care needs co-operation and team work between the different professions, and current developments mean there is a need to consider afresh the competence of particular professions to undertake different tasks. Neither the professions nor the Government would wish to see an extension of the pharmacist's role result in confusion over responsibilities to the patient. The Government is, nevertheless, anxious to ensure that the skill and knowledge of *all* professions are used to their best advantage.

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The NHS Contract for Pharmacies

8. Pharmacy contractors are paid on a 'cost-plus' basis, that is, within broad bands they are reimbursed their costs and there is an addition which represents profit. In June 1985, after a long period of negotiation with the representatives of contractors, the Government concluded an agreement on a new NHS contract for retail pharmacy in England and Wales. Similar arrangements were agreed in Scotland. Two main considerations prompted the change. First, the present contract is complex and inefficient. In the past large under- or over-payments have built up leading to disputes between Government and the profession. Secondly, the payment arrangements are causing a mismatch between supply and demand which increases costs to the taxpayer but does not improve services to the patient. In essence, pharmacies with small volumes of NHS business incur higher unit costs than those with larger volumes and so under the reimbursement principle they are paid larger sums per prescription. It had been hoped that this would make it easier for small pharmacies to open in small or isolated communities. In practice, the reverse has happened. There has been a steady increase in the number of pharmacies but most of these have opened in places where there were a number of pharmacies already providing a reasonable service. So, since the NHS pays the NHS costs of *all* pharmacies, the cost to the taxpayer goes up but, since the demand was previously adequately fulfilled, the extra pharmacies provide no real improvement in service.

9. The new contract remains basically 'cost-plus', but there will be an improved system of annual negotiations and cost enquiries to a fixed timetable to enable settlements to be reached on 1 April each year. This will remove as far as practicable in a 'cost-plus' contract the need for large retrospective adjustments.

10. Balancing supply and demand calls for a more selective mechanism which would encourage the right number of pharmacies in the right places and which would produce a service which matches the needs of the people who use it. The new contract will, therefore, provide for an improved level of financial support to essential small pharmacies which provide services to mainly rural areas with small populations where they would not otherwise be economically viable. These will now enjoy a minimum income guarantee to ensure their continuing viability and therefore the continuance of services.

11. The other side of this objective is to discourage the opening of further pharmacies in those places, mostly in prosperous city centres, where the demand is already adequately supplied. The free market does not, and cannot, operate here with the full effectiveness because there is no price competition. The consumer (the patient) either pays the prescription charge or nothing at all. But the objective of the new contract has been to introduce the disciplines of a market by other means. Accordingly, there will be changes in the way remuneration is paid which will encourage contractors to be more cost-effective and efficient and to realise the benefits of economies of scale. This will put pressure on some pharmacies with high unit costs which are contributing to the over-supply. Nobody will be obliged to give up the NHS contract but for those small contractors who, after exercising their own commercial judgements, choose to do so compensation payments will be available for a period of two years. There is no target for the number who will choose to give up their NHS contracts, but the Government expects it to be small – perhaps some three per cent of the total, and certainly very much less than the 600 or so additional pharmacies that have entered the NHS contract during the last six years.

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12. These measures alone will not entirely solve the problem. Any payments system which meant it would never be worthwhile to open an unnecessary small pharmacy would have a detrimental impact on a large number of pharmacies providing valuable services, and services to the public would be reduced. So the changes to the payments system will be reinforced by new arrangements for granting NHS pharmacy contracts. Instead of the present system of free entry which entitles any pharmacist or pharmacy company to an NHS contract on demand, Family Practitioner Committees or Health Boards will have a duty to consider whether an application for an additional NHS contract is necessary or desirable in order to provide a reasonable standard of NHS services and to refuse the application where this is not the case. This will help ensure that pharmacies open or change their location to reflect the changing pattern of local needs but will also ensure that the taxpayer does not have to pay for excessive supply. Owners of chemists' shops will, however, remain free to make their own commercial judgements about those retail activities which do not come within the NHS. There will be no regulation of any private or retail activities; the purpose is simply to enable the NHS as a publicly-financed service to match its costs to the needs of its patients. This aspect of the new contract requires new primary powers which are being sought through the NHS (Amendment) Bill at present before Parliament.

13. The new contract will offer benefits for all. Patients will have a service which reflects more accurately the needs of the people who use it. Some of the expected savings will help finance the profession's wider role and the new remuneration arrangements will be simpler and more efficient for contractors. The taxpayer will achieve some savings and better value for money.

Supervision of Dispensing

14. The Government will be interested in views about how the skilled resources of pharmacy can be best deployed. At present the dispensing of medicines must be performed either by a pharmacist or under his direct supervision. The pharmacist must be directly aware of what is being done by his staff. Most modern medicines no longer need specialised dispensing skills as they are supplied ready made by the pharmaceutical manufacturer. A relaxation in the stringent supervision requirements for dispensing would enable the pharmacist to spend more time dealing directly with the public, explaining and advising on their treatment both with prescribed medicines and with those purchased medicines which do not require a prescription. The pharmacist would still supervise sales of medicines and take the responsibility for the quality of dispensing, which could be carried out by trained technicians or dispensing assistants.

Standards

15. The Terms of Service for pharmacists reflect their professional role and refer only to the dispensing activity. The shift in emphasis which is already taking place and, in particular, the adoption of any of the proposals described in this chapter, need to be accompanied by a clear definition of the standards of service to be provided and the arrangements for their monitoring. The Government has already started discussions on standards with the Pharmaceutical Society of Great Britain.

Training

16. A wider role for pharmacists is likely to put more emphasis on providing personal services direct to patients. It will be important to ensure that post-registration training supplements pharmacists' scientific training with skills relevant to their wider roles. There may also be a need to enhance technician/dispensing assistant training to enable the skills of pharmacists to be re-deployed. The provision of suitable training will be an important issue to be settled before making any major changes in the role of pharmacists.

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Restrictions on the sale of medicines

17. Medicines vary widely in their nature. Some are very powerful and while they would be the treatment of choice for some conditions in some people, for others they could be highly dangerous; or they might cause dependence; or they might be designed for the treatment of conditions that are serious and require the supervision of a doctor. Only a doctor can decide when medicines such as these might be safely taken. Other medicines may not call for medical oversight, but could still cause unpleasant side-effects if misused and therefore call for the advice of a pharmacist. Accordingly medicines are classified under the Medicines Act into three categories:

those available only on prescription from a doctor;

those for sale without a prescription but only under the supervision of pharmacist;

those on general sale, ie. available not only from pharmacies but also from other retail traders.

18. These restrictions on the sale of medicines clearly act as a valuable safeguard for the public. But it is important that, in its operation, the system does not impose unnecessary restrictions and make it more difficult than need be for patients to get medicines they require.

19. In 1982/83 the DHSS reviewed the operation of the system and issued new guidelines designed to help pharmaceutical companies seek some relaxation of restrictions applying to their own products. One of the results of this which is both important in its own right and illustrative of what can be achieved was that Ibuprofen, a non-steroidal anti-inflammatory analgesic, came off prescription in 1983 (action which was followed by the United States a year later).

20. Despite the steps that have already been taken the *Government would be interested to have the views of the interested parties on the operation of the classification system to see whether it would be appropriate to make any further changes.*

——END OF CHAPTER 5——

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Chapter 6: General Ophthalmic Services

Encouraging Competition

1. There have been major changes recently in the arrangements for supplying spectacles. These followed a 1982 report on 'Opticians and Competition' by the Office of Fair Trading which concluded that spectacle prices were unnecessarily high because of lack of competition between opticians caused by severe restrictions on advertising. This meant that consumers were denied information to enable them to shop around to achieve value for money.

2. The Government concluded that competition should be encouraged by removing artificial barriers to trade, while retaining appropriate safeguards to protect consumers. The necessary legal changes were made in the Health and Social Security Act 1984.

3. The first step was to end the opticians' monopoly on the supply of spectacles. From December 1984 unregistered suppliers have been allowed to sell spectacles to adults against a recent prescription and subject to minimal conditions. This change was followed in March 1985 by the removal of the unduly restrictive advertising rules for opticians so that customers may now have the chance to compare the services and goods on offer by different businesses supplying glasses.

NHS Services

4. The recent changes do not affect the arrangements for NHS sight tests for everyone. Where an optician carries out an NHS sight test and believes he has found an abnormality of the eye or of some other condition that needs treatment he is required to inform the patient's doctor. However the Government concluded that with extended competition in the supply of glasses and changed social conditions the universal availability of spectacles under NHS arrangements was no longer justified.

5. In recent years the subsidy for NHS spectacles had averaged about £5. This subsidy was removed in April 1985 and from that date the general supply of NHS glasses to the public at large was withdrawn. Vulnerable economic groups continue to be protected by having access to NHS glasses. Children, those on supplementary benefit and certain other groups get them free. People on low incomes also get them free or pay smaller charges; and those needing the most complex lenses can choose between supply through the NHS at cost prices or purchase on the private market.

6. A further step is still to come. Now that the private market is settling down, the Government intends to move to a voucher system under which those still entitled to free glasses or remission of charges will no longer be supplied through the NHS but instead by given vouchers which they can exchange for budget-price spectacles on sale through the private market, or put towards the cost of higher-priced frames if that is their choice. They will therefore continue to receive NHS help with the cost of glasses, but no longer be limited to the somewhat staid range of NHS frames. Vouchers will be exchangeable only for spectacles which meet the detailed prescription for the individual customer: there will be no increased opportunity for abuse. Separate consultation on the details of this change is already in progress.

Benefits of the changes

7. *The benefits the Government expected from a more competitive market have occurred and will continue.* Prices have come down, pricing information is more widely available and better displayed, and a wide range of budget-price spectacles is now being sold at rates which can compete favourably with the charge for spectacles supplied through the NHS. In some cases single-vision glasses are advertised for private sale at about £12, when the NHS charge for a comparable pair would be over £14.

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8. There have been improvements too in standards of service. The volume of optical business has increased since the Government liberalised the market because public awareness of what is on offer has improved. The number of opticians and other retail outlets for the sale of glasses has also increased, and some major and well-established retail companies have entered the market. Optical goods are therefore more easily available to the public. Many opticians have modernised and brightened up their premises and now for the first time offer to meet prescriptions for all but the most complex lenses within twenty-four hours. Opticians have since April 1985 been required to offer patients a copy of their prescriptions, so that shopping around for the best buy and the widest choice is easier. *Overall, customers are now being actively courted rather than passively accommodated; a better service has resulted, and the cost to the taxpayer has come down.*

9. Taking these measures as a whole, the Government believes that when the NHS supply of glasses ceases and is replaced with the voucher system *the right balance will have been achieved between maintaining health needs through the NHS sight-test and prescription, and increasing consumers' freedom of choice in a properly competitive market.*

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Chapter 7: Family Practitioner Services Resources and Priorities

1. The total expenditure of the family practitioner services in the UK was over £4 billion in 1984-85. In that year it accounted for 24 per cent of total NHS spending compared with less than 22 per cent five years earlier. The primary care services provide vital, immediate, health care, and are a cost-effective way of providing for people who might otherwise need expensive hospital facilities, and the Government welcomes the increased proportion of NHS resources devoted to the family practitioner services. But the very size of the funds provided for the FPS makes it all the more important to ensure that they are being well used and give good value for money. The resources that can be made available to the NHS can never be limitless. The hospital service also must develop to meet new demands as must the community health services. It is therefore important to establish, and to be able to implement, the right relative priorities within the Health Service.

2. At a number of points in this document there is discussion of various steps that might be taken to improve the quality and extent of NHS primary care. Many cost money. The extent to which they, or any other developments, can be financed depends not just on the funds available but also on the scope for making better use of the resources that are made available. This chapter therefore gives more details of the way money is spent in the family practitioner services, and examines some of the implications.

Analysis of expenditure

3. In cash terms the gross cost of the FPS has increased from about £2 billion in 1979-80 to about £4 billion in 1984-85. After allowing for inflation, the increase over the five year period was 24 per cent. As against a cash increase of 100 per cent in the FPS as a whole, the cost of the individual services has gone up as follows;

General medical services	109 per cent
General dental services	88 per cent
Medicines	89 per cent
Dispensing	119 per cent

Figures for the general optical services are not given in this chapter in view of the substantial changes that took place in the GOS on 1 April 1985.

General Medical Services

4. The cost of the services is determined by the number of doctors, their pay and expenses.[1] The remuneration system is complex, but after allowing for the average net pay agreed by the Government for the year the total cost of £1,192 million for 1984-85 can be accounted for as follows:

£667 million on doctors pay including employers' superannuation contributions;

£313 million for expenses indirectly reimbursed (through fees and allowances paid to doctors);

£135 million for directly reimbursed expenses for staff;

£67 million for expenses on the cost of premises.

[1] Appendix 2 contains a description of the remuneration systems for each of the practitioner services.

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5. The number of doctors has gone up from 26,345 in 1979-80 to 29,137 in 1984-85 (about 11 per cent). The average net pay increased from £12,867 to £21,615 for each doctor, an increase of about 10 per cent after allowing for inflation.

6. There are no charges to patients for services provided by a doctor under the general medical services.

General dental services

7. As with the general medical services, the cost of the general dental services is determined by the numbers of practitioners and by their pay and expenses.[1] The number of dentists went up from 14,200 in 1979-80 to 16,477 in 1984-85, an increase of 16 per cent. Their target average net income went up to £18,707 and their estimated average expenses went up to £27,433, increases of about 10 per cent in each case after inflation.

8. As explained in Appendix 2 the fees paid to a dentist are made up of two elements. The first reimburses their practice expenses in full and the second provides them with an average net income which is agreed annually by the Government. In 1984/85 the fees paid amounted to nearly £750 million comprising:

£419 million on expenses;

£331 million on pay, including FPCs' contribution to the dentists' superannuation scheme.

To this cost patients contributed about £195 million by way of charges. In April 1985 changes were made in the structure of dental charges. Patients pay a fixed charge for some treatments such as dentures and crowns; for other treatment they meet the full cost up to £17; if the treatment costs more than that amount, the patient pays £17 plus two-fifths of the balance. No patient pays more than £115 for a single course of treatment, and some who are not exempt from charges may be able to obtain help in meeting them. Children, expectant and new mothers and those on low incomes do not pay anything for their treatment. The effect of the exemptions in 1984/85 was that about 63 per cent of all courses of treatment were provided free. Check-ups are free to everyone.

Pharmaceutical Services

9. Expenditure on the pharmaceutical services is determined by the cost of the medicines prescribed by doctors and dentists and by the cost of dispensing them. The size of the latter item is mainly accounted for by the number of pharmacies and by the pay of pharmacists and other dispensing expenses. Total expenditure increased from £981 million in 1979-80 to £1,913 million in 1984-85, a rise of 28 per cent after inflation. The 1984-85 costs were made up as follows:

£1,484 million on medicines;

£429 million on dispensing.

In 1984-85 patients contributed £145 million to the total cost of the pharmaceutical services, about 7 per cent. The charging arrangements are different from those in the general dental services. First the charge made to paying patients for each item on their prescription in a flat-rate charge regardless of the cost of the medicine. Second, there are more extensive exemptions from charges: in addition to those groups exempt from dental charges and those with certain specified conditions, all those over pensionable age are exempt regardless of income. For those who do pay it is possible to purchase a prepayment certificate which – like a season ticket – allows a patient an unlimited number of prescription items for a set period without any additional charge. As a result of these arrangements in 1984-85 73 per cent of prescribed items were dispensed free. A further 5 per cent were covered by prepayment certificates.

[1] Within any financial year the cost is directly related to the number and types of treatment given: over the longer term there are arrangements to ensure that sums paid match the intended average net income plus expenses incurred.

—insert figure 9—

Managing the costs of the family practitioner services

10. Because the cost of the family practitioner services is to a substantial extent driven by demands placed on the services, particularly for medicines, it is difficult to control many of the factors which determine the overall level of expenditure in the short term. The normal discipline of annual cash limits would not therefore be practicable either for the family practitioner services alone or jointly with the hospital and community health services. Although the remuneration systems described in this document contain important regulators and controls which help to ensure that family practitioner services are provided economically, the services are subject to few direct controls by Government. This places a special responsibility on everyone to ensure that the tax-payer's interest is safeguarded and that value for money is obtained.

11. In the longer term the expenditure on the FPS, except for the drugs bill, is largely determined by the number of practitioners, their pay and the expenses they incur. It is desirable now to examine ways of improving the planning and control of expenditure – while at the same time preserving the essential features of the services, including the independent status of the contractors and their clinical freedom – with the object of helping to achieve the appropriate rates of growth in expenditure on the FPS having regard to the needs of the rest of the NHS.

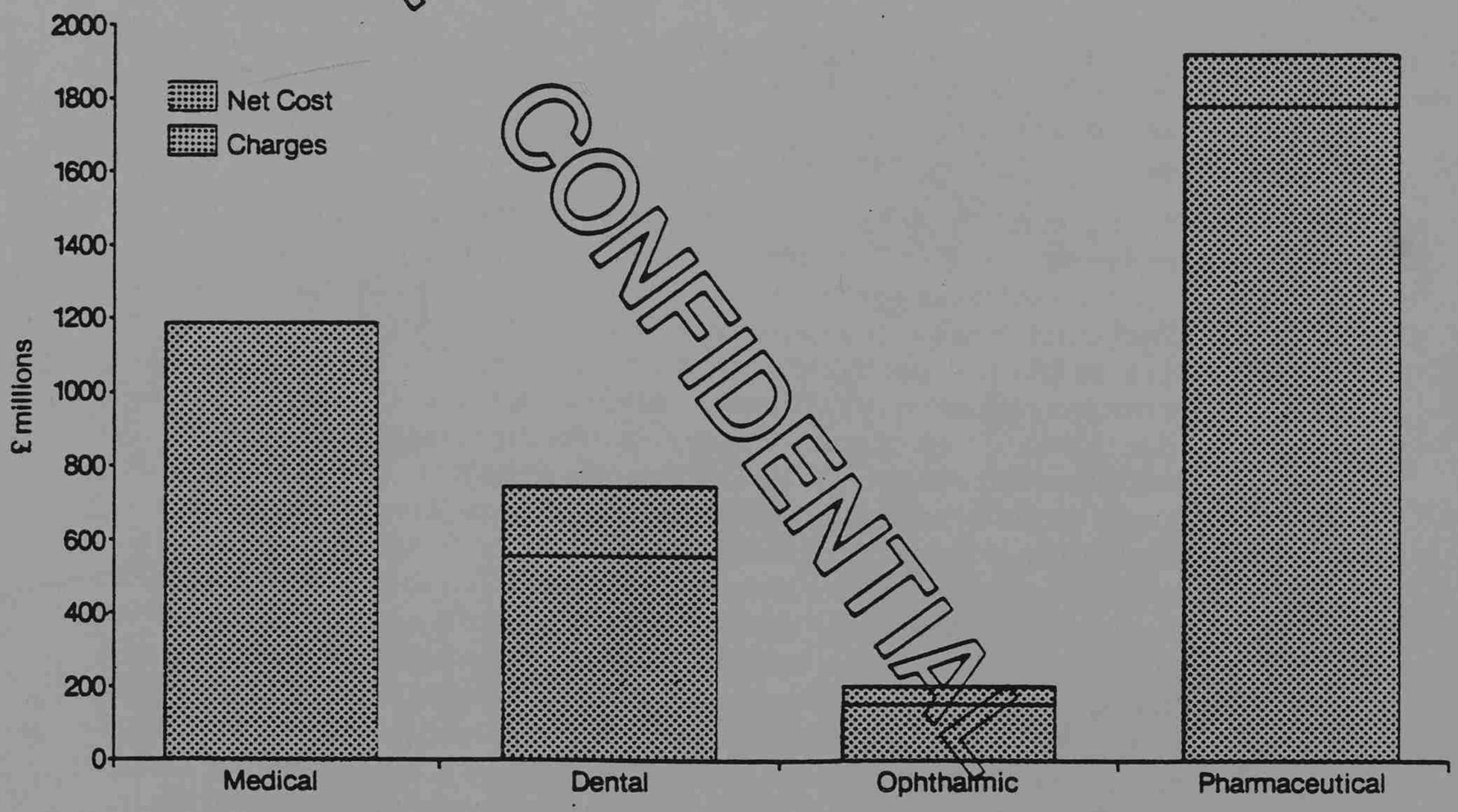
12. The Government is taking five major steps to improve the working of the existing systems that determine the various costs of the FPS:

First, it is obtaining better information on doctors' workload in co-operation with the profession so that the Doctors' and Dentists' Review Body can be better informed when framing recommendations on pay of doctors;

Second, as part of the new contract for pharmacists it has arranged with the profession to institute annual inquiries into the components of remuneration so as to avoid the large build ups of arrears or overpayments that have occurred in the past;

Third, in the negotiations on the Pharmaceutical Price Regulation Scheme it is exploring with the industry ways of increasing incentives to reducing the rate of rise in pharmaceutical costs;

Figure 9
Family Practitioner Services Net Costs and Charges Income in the United Kingdom, 1984/85



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Fourth, the selected list arrangements for medicines have introduced an additional element of economy into the prescribing of medicines and have released significant funds for the health service;

Fifth, the Government is improving its own procedure for forecasting the rate of growth in FPS expenditure.

13. The repayment of practice expenses accounts for a large proportion of the total cost of the family practitioner services. Where expenses are reimbursed to the professions as a whole through fees paid at standard rates, practitioners have a powerful incentive to avoid extravagance. Among the matters which the Government will want to discuss with the medical profession are whether two schemes of direct reimbursement of expenses – for premises and for ancillary staff – operate in ways that encourage doctors to incur expenditure at reasonable levels.

Number of practitioners

14. The growth in FPS expenditure is linked to the growth in the numbers of practitioners in contract with the NHS. FPCs and Health Boards are required by law to enter into contract with qualified doctors, dentists, pharmacists and opticians regardless of the existing level of provision.[1]

15. The numbers of doctors and dentists working in the family practitioner services have increased over the years faster than the population. And the Government intends that there should be further increases, though – given the direct effect these have on FPS costs – these cannot be uncontrolled if decisions are to be taken on the relative future priorities of the FPS and the hospital and community health services. There are different ways of influencing the growth rates in the numbers of practitioners. As outlined in Chapter 5, the new NHS contract with the pharmaceutical profession is designed to limit the number of contractors to what is required to provide an adequate service to the public. In April 1985 new immigration rules came into effect to control the numbers of doctors and dentists coming here for employment. The retirement rate is another factor and Chapters 3 and 4 discuss the desirability of arranging for the retirement of the more elderly doctors and dentists. It may be necessary also to introduce legislation to provide a reserve power to limit open access to contract with FPCs and Health Boards. For the longer term it is necessary to review the numbers of student training places. Such a review of the numbers of medical student places is already planned to start later in 1986, and the Government proposes to consider with the dental and academic concerned whether there should be reductions in the intake to dental schools in addition to those that have already been made.

16. Policies to influence the numbers of practitioners in contract with the NHS need to be framed in such a way as to support policies for a more even distribution of services. In the case of doctors there are already arrangements for this. In the case of dentists there have long been significant differences in the average number of people per dentist in different parts of the country. Although these have declined over the last five years there are still substantial geographical disparities. For instance in the Trent Region there are nearly twice as many persons per dentist as in the North West Thames Region, and about one-third more than the average for the UK as a whole. In 1983 the British Dental Association provided dentists with information about the higher levels of earnings that should be available in the least well provided parts of the country. It remains to be seen whether this will lead to a more even distribution or whether other measures are needed, such as a redistribution of income to provide financial incentives or using the reserve powers to control entry to contract referred to in the previous paragraph.

[1] In the case of doctors this is subject to the decisions of the Medical Practices Committee and the comparable Scottish Committee and to the compulsory vocational training requirement.

—insert figure 10—

Medicines

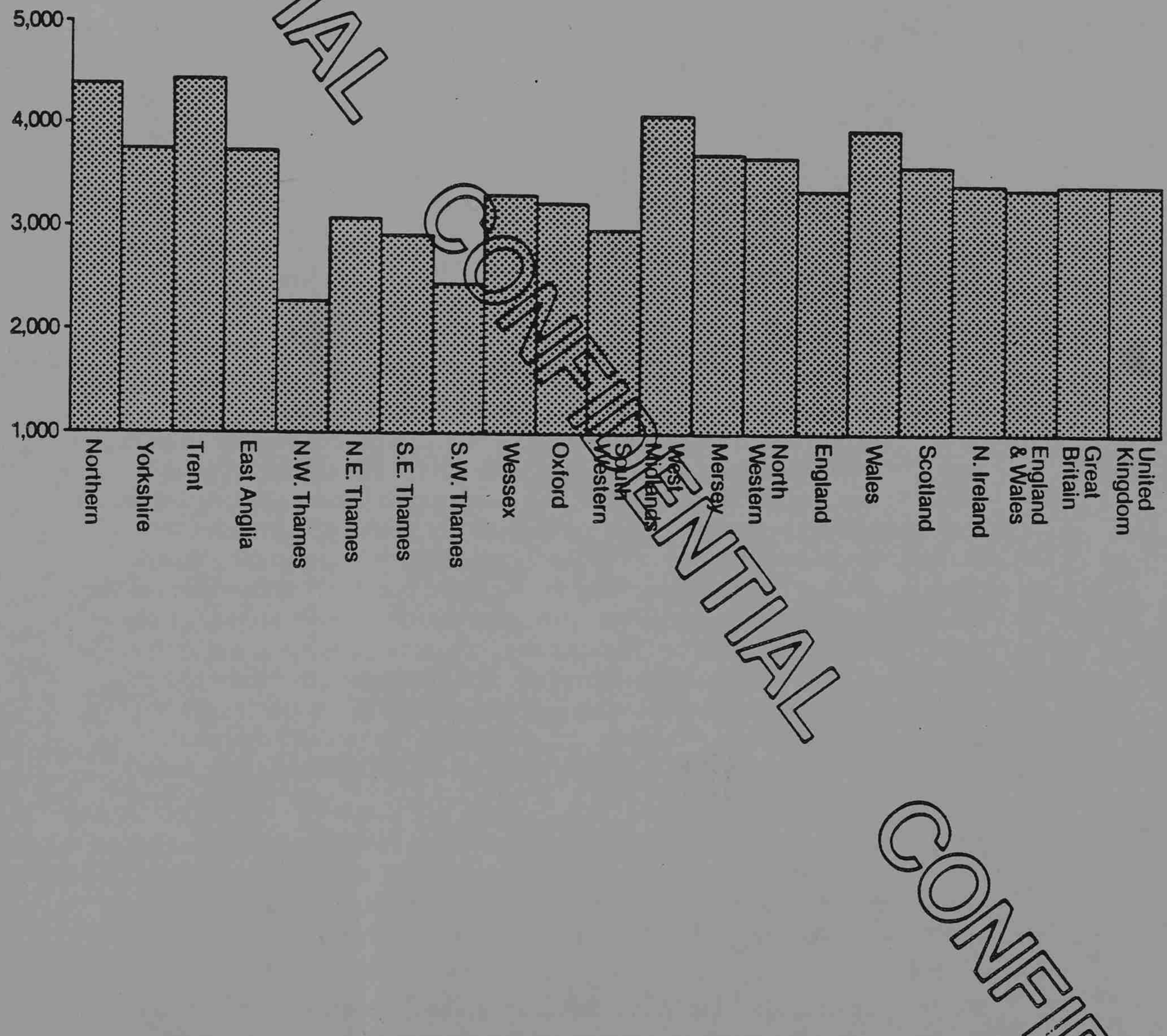
17. The medicines supplied under the family practitioner services in the UK cost about £1,480 million in 1984-85. The bill for these medicines has increased in cash terms by over 13 per cent a year over the last five years and in 1984-85 accounted for 36 per cent of gross family practitioner services expenditure.

18. The introduction of new medicines has been responsible for significant advances in the treamtnet of illness. Much of the increased expenditure on NHS prescriptions in the family practitioner services has therefore provided value for money in terms of benefits to patients. However, there is general agreement that economies could be made on the drugs bill without affecting patient care, for example, by not prescribing when drugs are unnecessary, by prescribing generic drugs rather than expensive proprietary drugs when possible. The Government has already taken some action to secure better value for money by introducing from April 1985 a selected list of drugs, which restricts the range of medicines available under the NHS in certain categories, mainly simple remedies, to those which meet all clinical needs at the lowest possible cost to the NHS. This policy is already achieving significant benefits by making available to the Health Service an estimated £75 million in annual savings which would not otherwise have been available.

19. The Department of Health and Social Services in Northern Ireland has since the middle of 1984 been pursuing a comprehensive programme of action aimed at promoting safe, effective and economical prescribing which should in turn reduce unnecessary public expenditure. The early signs are that this action is achieving the desired results.

20. In September 1985, the Health Departments held a conference of all interested parties to consider the future action to achieve more effective and economic prescribing throughout the UK. They have since been engaged in discussions with the medical and pharmaceutical professions about how to take this forward. The first result has been agreement on the need to provide individual doctors with better information on their own prescribing patterns and how they compare with other doctors. The Government has allocated funds to the Prescription Pricing Authority and Welsh Pricing Committee for new computers for this purpose, and discussions are continuing with the medical profession and other professions on the type of information that should be provided. Methods are also being developed for providing such information in Scotland. Other matters under consideration include:

Figure 10
Number of Persons per General Dental Practitioner by Region and Country, 1984



how to make more helpful to doctors the sorts of information they receive about the therapeutic benefits and side-effects and comparative prices of different medicines;

encouraging the use of local practice formularies to achieve more rational prescribing;

encouraging doctors not to prescribe when no medicine is necessary; and

educating the public about the properties of medicines and the importance of compliance with the doctor's instructions.

21. Parallel with this, the Government has entered into discussions with the Association of British Pharmaceutical Industry on ways in which the prices of medicines supplied to the NHS may be determined in future so as to achieve both a measure of stability that would enable a successful industry to plan further investment and research and development with greater confidence and the means of ensuring that expenditure on drugs does not imbalance the NHS. A description of the current arrangements for controlling the cost to the NHS of drugs supplied by the pharmaceutical industry is given in Appendix 3.

The Structure of patient charges

22. NHS dental costs have risen very considerably in recent years. As indicated in paragraph 8, the structure of these charges is complicated. It could be changed so as to relate the payments made by patients more closely to the cost of the treatment they receive. A step was taken in this direction in the pattern of charges introduced in April 1985. The result is that though people who have relatively little work done at any one time still pay a greater proportion of its cost, those who have extensive intervention now make a fairer contribution than they did before. It would be possible to take this further towards wholly proportionate charges, and in fact the British Dental Association has recently indicated that it would favour such a move. A fully proportional system under which patients not exempt would pay a uniform proportion of cost would be simpler than the present arrangements.

—insert figure 11—

Figure 1
Pharmaceutical Services: Charges and Exemptions in England, 1984/85

Number of items 343 million

* Specified Conditions Exemptions

\+ Low Income Exemptions

23. For prescription charges a closer link between drug costs and the charges paid might be fairer. In France and Portugal, for example, the basic charge levied for drugs dispensed is augmented by a percentage charge based on the cost of the medicine. In some other countries, the level of charges is related to the importance of the medicine: life saving medicines may be free (as in Belgium, France, and Italy) or attract only a small percentage charge based upon the medicine cost (Denmark, Sweden), and medicines at the other end of the scale of importance may be charged for in full. Whatever charging arrangement is adopted, arrangements on existing lines for pre-payment certificates could be retained as a safeguard for those likely to require an above average number of prescriptions.

24. The Government would welcome views of the case for changes.

Chapter 8: Quality in Primary Health Care

1. The quality of health care is determined largely by the standards of the professional people giving it and by those of the authorities responsible for managing the services. There is much in the primary care system that those responsible for it can be proud of, but with so many thousand health care workers and over 300 authorities involved it is hardly surprising that standards should vary.

2. Many of the issues discussed in this Paper are relevant to the quality of the services – the provision of information to patients about practices, the greater use of computers, extension of postgraduate education and so on – and there are already a number of forms of 'quality control' in operation throughout the United Kingdom:

professional bodies assess the standards of those who wish to provide training, eg in general medical practice and in nursing;

FPCs, Health Boards, and the CSA administer a scheme for testing samples of medicines dispensed by pharmacists: the Pharmaceutical Society of Great Britain act as agents for the Health Departments;

FPCs, Health Boards, and the CSA inspect practice premises;

the DHSS and Welsh Office Dental Reference Service, the SHHD Regional Dental Service and the DHSS Northern Ireland Referral Dental Service examine a proportion of patients;

the Dental Estimates Board, Scottish Dental Estimates Board and the CSA refuse approval for dental treatment it judges unnecessary.

In addition:

the DHSS Regional Medical Service, the Division Medical Office in Wales, and the DHSS Northern Ireland prescribing unit visit doctors with particular reference to prescribing patterns;

the DHSS and Welsh Office carry out performance reviews of FPCs; and the DHSS Northern Ireland carries out accountability reviews of the four Health Boards and the CSA;

RHAs and in Wales, the Welsh Office, carry out performance reviews of DHAs dealing with community services among other things.

To this list may possibly be added in the future the assessment of the standards of those doctors who apply for the good practice allowance discussed in Chapter 3.

3. The setting of professional standards is very much a matter for the professional bodies. The main responsibility of Government is for the standards of service delivery. In April 1985 FPCs were reconstituted as free-standing health authorities, a major objective being to improve collaboration between the primary care services by establishing separate Committees able to claim a place as of right at the planning table. The evidence so far is that the change of status is having the effect intended. But effective planning can only take place against a background of regular appraisal of the quality and quantity of services being provided. It is already clear that there is a need for FPCs to develop more systematic means of measuring quality and detecting shortfalls in the provision of services. A number of promising ideas have emerged and some initiatives have been taken, for example in compiling reports about services. The Citizens' Advice Bureau, voluntary bodies, and Community Health Councils can be a valuable source of information on consumer attitudes. Committees could also undertake their own consumer surveys or retain an agency to conduct one on their behalf. An analysis of complaints, both written and oral, can shed light on standards of care. Closer working relationships could be established with many national and local bodies representing client groups such as the mentally and physically handicapped and the elderly, the great majority of whom receive their health care in the community. FPCs also need to examine the adequacy and use made of the information they and District Health Authorities already hold and how this can contribute to the development of a comprehensive strategy for assessing standards of care in their area.

4. Whilst there is a need for FPCs to respond to their new responsibilities for standards of service delivery in these ways, the results of major policy changes like this need to be evaluated more independently. *The Government proposes to appoint a team, composed mainly of health service personnel, to make a study in depth in one or two areas in England of the ways in which primary care services are being co-ordinated, planned and delivered.* A starting point would be whether the services meet the public's needs and how they could be improved within available resources. Amongst other things they would examine the ease of access to the services and the extent of the public's knowledge of them.

5. In the first place this would be an experiment in quality control in primary care and its results would be of interest to health authorities elsewhere in the UK. It may well be that the benefits from giving the chairmen and members of FPCs and DHAs an independent assessment of the quality of the services they are responsible for, and of giving Ministers feedback on the quality of primary care at the local level, would justify the costs of a permanent monitoring system. In this case it would be necessary to consider how such a system should be organised, having regard to the management arrangements for health authorities throughout the UK.

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Chapter 9: Inner Cities

1. An underlying principle of a national health service is the promotion of equality of access to, and quality of, health services in different parts of the country. The continuing policy of redistributing Hospital and Community Health resources is based on that principle, while taking into account that different areas may have different needs. Yet, for a variety of reasons, the quality of primary health care services available in many inner city areas is almost certainly poorer than elsewhere.

2. The nature of these problems has been studied closely. As far as London is concerned, a major inquiry was commissioned in 1979 by the London Health Planning Consortium.[1] It made a number of recommendations aimed at:

improving the availability of young, vocationally trained general practitioners in inner cities;

the improvement of general practice premises, and the formation of group practices;

the development of primary health care teams;

the better co-ordination of the different agencies involved in primary health care, and the identification of specific management responsibilities within the health authorities for community services;

more education for general practitioners and community nurses;

the involvement of Academic Departments of General Practice with their local primary health care services;

better information for the public about the range of services available within general practice;

better communication arrangements for patients with their general practice;

alternative ways of providing primary health care where existing services are not meeting the needs of certain groups.

3. The Government recognised the importance of the Report, taken as a whole, and its significance for primary health care in both London and other inner city areas. It has taken steps to promote action by the wide range of bodies at whom the Report's recommendations were aimed, and some progress has been made on all major fronts identified above. The Government has made additional resources available to implement improvement in inner cities in England. The money is being used:

to provide financial incentives to general practitioners in Inner City Partnership areas to form group practices and to improve the quality of practice premises;

to increase the number of training places for community nurses;

to allow Health Authorities with Inner City Partnership areas in their boundaries to fund improvements directly concerned with the provision of primary health care in those areas;

to fund specific projects or innovations for which either central funding is the most appropriate channel, or which may be 'pilots' to be adopted by Health Authorities or Family Practitioner Committees after evaluation.

[1] A study group under the chairmanship of Professor Donald Acheson (before his appointment as Chief Medical Officer) was commissioned by the London Health Planning Consortium to define the problems of organising and delivering primary health care in inner London and to make recommendations on how these policies might be overcome. Its report was published in May 1981.

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4. Many of the proposals in this consultative paper have particular relevance to inner city problems. The number of elderly doctors tends to be higher in inner cities than elsewhere and many practise single-handed without proper support staff. The changes to retirement policy proposed in Chapter 3 would accelerate their replacement by younger vocationally trained doctors who are more likely to wish to practise in groups and as part of a primary health care team. The provision of better information about services should encourage patients to make better use of family doctors, rather than relying on hospital accident and emergency departments, as often happens at present, where staff are not trained in general practice and are unable to provide continuity of care. As the health problems associated with social deprivation call for higher standards of care, inner cities should gain particular benefit from the introduction of a good practice allowance. The development of neighbourhood nursing teams should also help because these are the areas where there is most scope for rationalisation of the ways in which members of the primary health care team operate.

5. But much more needs to be done and new approaches need to be developed directed at problems peculiar to inner cities. The main problem is often the absence of suitable premises from which a full primary health care team can operate. Despite the introduction in 1983 of special 60 per cent grants for improvements to certain inner city premises too many GPs in these areas still practice in accommodation which is too cramped for adequate support staff. Financial incentives which in other parts of the country have led to major improvements have not always proved effective in encouraging sufficient GPs to inner cities to invest in new premises. Those who do so can receive a 'cost rent' which in effect covers the interest payable on the capital employed subject to certain limits on building costs. The scheme is operated on a national basis and limits which are generous in some parts of the country may not be adequate to cover the higher costs in some inner city areas. *The Government believes that the scheme needs to be made more sensitive to local needs.* However, many inner city areas exhibit problems other than those of resources that make it difficult to meet the need for high standard premises and call for the involvement of FPCs, health authorities and local authorities as well as doctors. Either the available property is unsuitable and cannot be improved and there are no new sites for development or the area is such that doctors will not invest money there because they will be unable to dispose of the premises without financial loss. Only an imaginative and flexible approach by all the agencies concerned can resolve these problems.

6. Although some young and enthusiastic doctors elect to enter inner city practice, the fact remains that it is a less popular career choice. The high cost of living, the shortage of suitable, or suitably priced, private and practice accommodation, and the difficult working conditions mean that working in these areas is often less rewarding both financially and in other respects. *There is a case for providing financial incentives to ensure that practising in these areas offers equivalent attractions to working elsewhere.*

7. More could be done to make services accessible to ethnic groups and enable them to make better use of the system. For example, in areas serving some Asian communities where women are reluctant to seek treatment from men there may need to be special arrangements to attract women doctors and to encourage their appointment to the vacancies that occur. Special staff could be more widely employed by local health authorities to assist their ethnic populations and to facilitate access to services.

8. Finally, there may be advantages in developing different contractual arrangements for some doctors. Because the demands of working in inner cities call for special commitment it might be appropriate for FPCs to contract with some doctors on the basis of fixed-term contracts for limited periods of say 3-5 years. The nature of such contracts might need to be decided with regard to the peculiar difficulties faced and need not necessarily be determined by generally prevailing scales of fees and allowances. *The Government will explore the possibility of experiments along these lines in a small number of pilot areas.*

9. The Government is determined to tackle the problems of providing high standards of primary health care in inner cities. Special effort will be made during the consultation on this paper to explore their needs and establish what more needs to be done.

Scotland

10. Many of the problems of multiple deprivation found in inner cities are not confined to such areas. In Scotland, a report in 1980 'Scottish Health Authorities Priorities for the 80s' (SHAPE) identified as a top priority the provision of Health Board services for the multiply deprived (including improved maternal services, better access to health facilities and greater provision of domiciliary services) as well as community nursing services, with particular emphasis on the over 75s and on preventive measures. Because the child population was already falling, the report doubted whether top priority should be given to the provision of additional resources for acute child health. It stressed that child health should be promoted by expanding preventive, screening and assessment services. Health Boards' programmes following the SHAPE report are being monitored with them by the Scottish Home and Health Department.

Wales

11. Similar conditions are to be found in many of the valley communities in South Wales. The Welsh Office is committed to tackling these problems, which are associated with an ageing housing stock, environmental dereliction and the decline of traditional sources of employment. The Department recognises that there are difficulties in attracting and retaining professional staff to serve those communities and will be considering how the practitioner services to those areas can be improved.

Northern Ireland

12. Official research in Northern Ireland has shown that there are areas of significant multiple deprivation in West Belfast, West Londonderry and in electoral wards in other towns to the west and south. The Department of Health and Social Services, in conjunction with Health and Social Services Boards and in liaison with other government Departments, has mounted a number of co-ordinated programmes aimed at improving not merely poor quality primary health care, which is only one feature of deprivation, but other aspects such as sub-standard and over-crowded housing, unemployment, low income and poor environment.

——END OF CHAPTER 9——

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Chapter 10: Community Nursing Services

1. There is one important area that has not yet been covered in this discussion document, namely the role of nurses in primary health care. The greatest contribution comes from the community nursing services managed and funded in England and Wales by District Health Authorities. In England these services are provided by some 50,000 full and part-time staff employed by health authorities primarily:

health visitors and school nurses, who have a health promotion/illness prevention role largely in relation to children and young people;

district nurses who provide clinical care at home to patients either discharged from hospital or not requiring hospital admission;

and their support staff of registered and enrolled nurses and nursing auxiliaries. Services are also provided by community midwives, community psychiatric and community mental handicap nurses, and other specialist nurses working in the community.

2. These community nurses may work in health authority health centres and clinics, in people's homes, or in premises owned by family doctors. And family doctors may themselves employ practice nurses – there are some 2150 in terms of whole time equivalents – who work within the practice, usually in treatment rooms, providing for example immunisation, cytology. Primary health care is best provided when family doctors, community nurses and practice nurses work together as members of a primary health care team.

Review of Community Nursing Services

3. The Government has launched separate reviews of community nursing services. In England the review was undertaken by a small team under the chairmanship of Mrs Julia Cumberlege.

The English review team's report, 'Neighbourhood Nursing – A Focus for Care', is being published simultaneously with this discussion document, and *the Government intends that there be discussion and comment on that report as part of the primary care debate in England.*

4. Community nursing reviews are also being undertaken in Wales and Northern Ireland. In Wales, a two year review was initiated in April 1985 to consider the future pattern of community nursing provision in the light of the particular needs of the Principality, and in relation to primary health care as a whole. A broadly comparable review is underway in Northern Ireland. These are expected to report in July 1987 and January 1987 respectively. Aspects of community nursing are also being studied in Scotland in a number of ways. For example, a fact finding study of primary health care team work, 'Health Care in the Community: A Review of Activities in Primary Health Care', commissioned by the Scottish Home and Health Department, was undertaken during 1985 and its findings made available to Health Boards and professional bodies. Follow up work to that study is now being considered, and the recommendations of the Cumberlege report will, as appropriate, be taken into account.

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Recommendations of the review team in England

5. The review was set up because of concern that community nursing services were no longer meeting people's needs as efficiently and effectively as they might. The report shares that concern and makes 14 recommendations plus many detailed comments and suggestions covering five main themes:

neighbourhood nursing services

making better use of nursing skills

improving the effectiveness of the primary health care team

changes in nurse training

increasing public involvement in the way services are run

6. The report recommends that community nursing services should be planned, organised and provided on a neighbourhood basis. In each neighbourhood, which would cover a population of between 10,000 and 25,000, the work of health visitors, district nurses, and school nurses would be integrated under the control of a neighbourhood nursing manager, in association with community psychiatric nurses, community mental health nurses and community midwives. This concept is intended to provide more flexible use of nursing services under local management, so improving the delivery of services to the community, collaboration in primary health care, and ensuring the best use of training skills.

7. The review team's report commends the principle of introducing the 'nurse practitioner' into primary health care. The term 'nurse practitioner' which originated in North America, has over time had a variety of meanings and could be misleading. But the Government wishes to see discussion on the important issues of how to make better use of nursing skills and clinical expertise, the grade mix in support teams (eg the use of nursing auxiliaries) and whether with additional training some nurses could do still more to help and assist patients. The Government would also welcome views on the report's other recommendation in this area which proposes that, as part of the nursing care programme, nurses should be able to prescribe a limited list of items and control drug dosage in well-defined circumstances.

8. *The Government shares the review team's belief that the strengthening of the primary health care team is a key objective.* The lack of adequate understandings between team members at present can lead to uncertainty and inefficiency in the provision of services. There seems advantage therefore in a team coming together, as the report recommends, to produce a written statement setting out the agreed activities of the team members. However discussion on this and on ideas for strengthening the team is needed before considering the detail of such a statement, or the role the review team saw for it as a qualifying condition for any incentive payments to doctors to improve the quality of general practice.

9. The report also suggests new measures for identifying and promoting good practice. The Government intends to consider this in the wider context of quality assurance in primary care generally, a subject discussed in Chapter 8.

10. The statutory educational bodies are at present considering changes in nurse education. They will no doubt wish to examine carefully the report's recommendation that there should be a common training course for all first-level nurses wishing to work outside hospital in what are now the fields of health visiting, district nursing and school nursing.

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11. The Government recognises the value of the many local groups that exist to represent patients' interests and it may be that more will develop as the report recommends. Mention has already been made in this consultative document of the development of patient participation groups. Informal health care associations arising in response to perceived local needs may also have a part to play.

12. The Government is not seeking comment on the review team's recommendation on the way in which doctors are reimbursed for the cost of employing practice nurses. The total cost of nurses employed by general practitioners is reimbursed, part to the individual doctor and the remainder in the pool of remuneration from which fees and allowances are paid to general practitioners as a whole. If neighbourhood nursing services develop in the ways recommended, it seems quite likely that more family doctors will wish to obtain their nursing advice and support from the health authority team. However, it is also likely that some practices will see advantages in employing their own nurses. The *Government does not propose to end the present arrangement of part direct and part indirect reimbursement of the cost.*

13. The Government notes the recommendation that it should give consideration to amalgamating FPCs and district health authorities. But independent Family Practitioner Committees have been in existence for only one year, and it *is too soon to contemplate changes, which would in any case need to be based on a close analysis of the likely benefits.*

14. The report also comments on the possibility of a salaried family doctor service. *The Government believes that the independent contractor status of family doctors has brought benefits and should continue.*

15. The Government intends that debate upon the review team's report, focused on the five main issues identified above, together with the proposals in this consultative document, will provide a framework in England for a comprehensive examination of all the major elements of primary care.

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Chapter 11: Conclusion

1. Primary health care has played a key role in improving the nation's health, not only in the treatment of disease but also in the maintenance and promotion of health and in acting as the means by which patients can receive the right kinds of increasingly specialised hospital services. The Government is 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.

2. The role of primary health care has changed significantly over the years, and the services have shown a capacity to respond to new needs. This quality will be no less important in the future as new challenges arise from technical advances in health care and changes in social factors such as the increase in the number of the very old. This paper is designed to open up discussion of ways in which the primary health care services can be helped to meet future needs.

3. The Government's main objectives are:

to give the public a choice of high quality primary care services;

to encourage high standards and responsiveness to the needs of the public;

to obtain better value for money and to set clearer priorities for the family practitioner services in relation to the rest of the NHS.

To this end this consultative document sets out a number of proposals on which views are now sought. Among these are:

the introduction of arrangments for selecting and rewarding the doctors with the highest standards of care;

increasing the proportion of doctors' remuneration made by way of capitation fees in order to provide an incentive to doctors to practice in ways that will encourage patients to join their lists;

giving information to patients that will enable them to choose the medical and dental practices that most meet their needs;

improvements in the arrangements for handling complaints;

arranging for the retirement of elderly doctors and dentists;

getting proper local strategies drawn up for the positive promotion of good health;

improving access to NHS dental services;

placing more emphasis in the dental services an oral hygiene and prevention of decay;

extending the role of pharmacists to provide better advisory and other services;

making local studies of the quality of primary health care actually delivered;

improving services in inner cities.

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5. This paper is a discussion document about the future of a vital part of the health service. The Government hopes that the issues it raises, together with the report of the review of community nursing services in England, will form the agenda for a widespread debate among the public and professions alike. To carry this debate forward the Government will be arranging a series of meetings over the next six months at which the professions and others will be invited to give evidence. A number of these will be held in areas of England outside London, particularly those with inner city areas, and elsewhere in the UK. Written comments will also be welcome and should be sent by 31 December 1986 to the addresses shown below.

In England to:

Primary Health Care,
DHSS,
Eileen House,
80-94 Newington Causeway,
London SE1 6EF.

In Scotland to:

Primary Health Care,
Scottish Home and Health Department,
St Andrews House,
Regent Road,
Edinburgh EH1 3DE.

In Wales to:

Primary Health Care,
Welsh Office,
Health and Social Work Department,
Cathays Park,
Cardiff CF1 3NQ

In Northern Ireland to:

Primary Health Care,
DHSS Northern Ireland,
Dundonald House,
Upper Newtownards Road,
Belfast BT4 3SF.

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Appendix 1

Primary Health Care Arrangements In Other Countries

This Appendix discusses the differences and similarities between primary health care in the UK and that in other countries. There are wide variations to be observed arising from differences in needs, geography, historical and cultural perspectives, and resources available. Some of the differences are very great indeed. To make the comparisons manageable and relevant the Appendix concentrates on the arrangements in Europe, North America and Australia.

Financing

2. In considering how primary care is funded it is necessary to begin by commenting on the financing of health care systems as a whole, including secondary care.

3. Among the countries studied the UK is unusual in the high proportion (85 per cent) of costs met out of direct taxation. By contrast responsibility in the USA rests to a much greater extent on the individual and often on his employer to arrange for the financing of health care through private insurance. However, difference between the two systems is narrowing as the private health sector in Britain grows and as the Federal and State governments in the USA assume greater responsibility for those ineligible or unable to pay for private insurance.

4. In Western Europe it is common for health care to be funded largely through Social Insurance, under which employers and employees contribute at rates determined by statute. But part of the expenditure may still be met from general taxation. For example about half the total costs of health care in Norway are met by Central and Local Government.

5. Payments by users of the services also vary widely. In some countries – for example Italy and the Federal Republic of Germany – general practitioner consultations are free, as they are in the UK. In others a charge is made. In Belgium there is a set fee which is reduced for those on low incomes; in France patients pay 20-30 per cent of the cost of treatment; in Finland primary health care is provided free in health centres but patients are charged 40 per cent of the costs if they go to independent contractor GPs. Prescription charges are common, though their structure varies. In virtually all countries patients are expected to make some contribution towards the cost of their dental care though the methods of cost-sharing differ. In France for example the state meets 75% of the set scale charges but actual fees may be higher than the scale so that the patient contribution may be greater than 25%. In Sweden 40% of the total cost of dental care is reimbursed. The coverage of the state system, too, varies and not all countries provide the full range of dental care to all who are insured under their arrangements. In the Netherlands only 70% of the population are covered by National Health Insurance and in many countries specific treatment, such as orthodontics or supply or dentures, are not covered. In Australia the NHS does not cover routine dental treatment at all. In Canada provision varies from Province to Province: for example, in Saskatchewan dental services are provided up to the age of 16, over that age all adults attend private dentists but treatment of those on social assistance is paid for by the Province.

Access to medical care

6. In some countries – notably Belgium, France and the Federal Republic of Germany – patients are able to refer themselves direct to specialists. In the UK, access to specialist services under the NHS is normally obtained only on referral by the general practitioner. In this country great importance is attached to the role of the family doctor as the co-ordinator and mobiliser of secondary care. This role is enhanced by the requirement on patients to register with a single doctor (a requirement unusual outside the UK and Scandinavia) and by the way in which doctors, nurses and other professionals work together in primary health care teams. This country is one of the few which require doctors to undergo three years' vocational training before becoming principals in general practice although the European Commission have now prepared a draft Directive that would extend compulsory vocational training to other member States.

Payment of Primary Health Care Workers

7. In most countries nurses and ancillary staff are salaried, but doctors and dentists are self-employed. Dentists usually are paid on a fee for item of service basis as in the UK. This is also the method of payment for general practitioners in many countries, though in the Netherlands, Italy and parts of Denmark and Spain there is a capitation system as in this country. In Portugal and Sweden general practitioners are salaried, as are some in Denmark, Greece and Spain.

Medicines

8. The UK occupies a fairly central position in its prescribing rates, substantially lower than Italy, Germany and France, and similar to Australia the USA and Canada.

9. Comparing the British system with other countries shows that the principle of charging for medicines is well established though the financial structure differs quite widely. Australia, Belgium, the Netherlands, Sweden, Norway and the Federal Republic of Germany have fixed prescription charges like the UK. Some other countries levy charges proportionate to the cost of the medicine (e.g. Denmark, Finland, France, Luxembourg, Portugal, Spain and Switzerland) while some (such as Greece), combine a flat rate charge with a percentage of the cost of the medicine. In some countries charges vary with the importance of the drug: at one end of the scale lifesaving medicines may be free, whilst at the other the full cost is charged.

USA

10. A separate section on developments in the USA is worthwhile because of the recent emergence of Health Maintenance Organisations (HMOs) as the provider of health care for an increasing proportion of the population. The traditional system has provided fee-for-service care. In other words both primary and secondary care are funded from insurance for those able to meet the fees. The HMOs – which provide a complete health care service for those enrolled with them on an annual pre-payment basis – are a response to excessive health care expenditure in a system that encouraged direct access to specialist treatment. The HMOs have been successful in reducing expenditure, typically cutting in-patient days by about 40 per cent. This was possible in the particular situation in the USA. What it demonstrates, however, is the effectiveness of primary care physicians in controlling the use of specialist services.

11. HMOs are competing with each other for custom. They are out to provide a quality product at a reasonable price. This shows in the emphasis which they place in achieving consumer satisfaction, in the high quality of the information made available to prospective patients, in the accent on good management, in the resources given to the setting of standards and to quality control, coupled with remuneration systems that relate doctors' payments to their performance.

12. A more extended discussion of HMOs is contained in the annex to this appendix.

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Annex to Appendix 1

Health Maintenance Organisations

Introduction

This is the Report of a visit to the USA which two DHSS officers made during the course of the Government's review of primary care in order to study Health Maintenance Organisations (HMOs). It sets out the background; it explains why HMOs are a response to the particular situation in the USA; it identifies features that are relevant to any health care system which seeks to be acceptable, effective and efficient.

Background

2. Health care in the USA is delivered by a variety of competitive 'providers' and was never designed as a system to function in a cost effective and integrated fashion. There has been expensive duplication, uneven allocation of resources, and until recently a disregard for costs. Economic incentives have worked the wrong way and many features of the system, notably the inaccessibility of health services to the poor, compare unfavourably with the UK. However the American environment allows for a wide variety of new approaches to a problem to be tested. Experimentation is encouraged by the competitive environment.

3. In recent years a new method of providing primary and secondary care, the Health Maintenance Organisation, has been expanding rapidly in the USA. This is related to current concern in the United States about cost-escalation. Fee-for-service practice and the insurance system have led to increases which have alarmed both government and industry, which bears the cost of much health insurance. (For example, Chrysler's health care costs add $600 to the price of a car.) Initially the development of HMOs was stimulated by Federally funded experiments, but now that the movement has taken off, government had adopted a regulatory and supervisory role. HMOs offer a prospect of cost containment because they are 'managed health care systems', surviving as a result of efficient and entrepreneurial management.

The Nature of Health Maintenance Organisations

4. HMOs are complete health care systems delivering comprehensive care on a prepayment basis. They compete both with each other, and with traditional 'fee-for-service' practice. They vary in the proportion of care they themselves provide, sometimes employing salaried doctors, sometimes having arrangements with existing group practices and hospitals, and often buying in the more specialised services that they need. In contrast, health care insurers like Blue Cross reimburse retrospectively for care which has already been given. HMO premiums are around $110 per month for an individual, or $250 for a family. Employers often pay 80%, but there may be patient charges at the time of treatment, for example for prescriptions. Subscriptions cover preventive services, primary and hospital care, emergency services and complex procedures like organ transplantation. Initially HMOs recruited mainly through employers, which selected a young and healthy population. This effect now is less dominant, and care is being offered to wider groups. During the last few years HMOs have accepted over 65s, who can apply their Medicare benefits to an HMO subscription. Five years ago the Federal Government launched a programme of experimental schemes for the elderly in which the premium was paid directly to the HMO at 95% of the average fee-for-service costs in that area in the previous year. The ability of HMOs to contain costs allowed them to make a considerable profit even though they offered extensive services. However, unless there is some system of meeting the costs of care, HMOs cannot provide it. For this reason nowhere in the USA do HMOs currently provide comprehensive care to all people in the area.

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Efficiency Measures and Incentives

5. HMOs have forced competition onto a very fat system, and this is conceded by the hospitals who are the sternest critics of HMOs. By bringing the budget of most forms of care under the same management and into close relationship with the doctors and the hospitals so that their performance can be monitored, HMOs have been able to influence medical decision makers. Financial incentives have been introduced, the use of hospital facilities has been cut, and drug usage has been examined.

6. HMOs normally control access to costly specialist care by insisting that patients first consult a primary care physician, who in the American context may be a family doctor, a general physician, a paediatrician or an obstetrician/gynaecologist. The result has typically been a 40 per cent reduction in hospital bed days compared with fee-for-service practice. This reduction in bed usage has affected the profit of hospital companies, and it has been predicted that some 1,000 hospitals in the USA will have closed by the year 2000. In Minneapolis-St Paul (where HMOs are particularly active) 60 per cent of hospitals were operating at or below 55 per cent occupancy in 1983.

7. Financial incentives are almost universal. Doctors are provided with target hospitalisation rates based on past performance and their incomes depend on undershooting this. Between 10 and 20 per cent of income may be withheld until the figures are known and doctors are told monthly of their performance. Doctors are provided with information about the expenses they incur by their referral of a patient or by the use of laboratory or radiological investigations. Costly behaviour on the part of one member of a group practice can jeopardize everyone's bonus. Centres can compare costs with each other, and they can see which hospitals are the best buy and which specialists have the lowest guaranteed fee for a particular procedure. American hospitals have always competed with each other and HMOs are taking advantage of this. The spare capacity which generally existed to avoid turning away trade is a handicap now there are fewer admissions and length of stay is shorter. As a result hospitals are linking to HMOs to protect their market share, closing wards, reducing manpower and setting efficiency targets. Doctors are changing their behaviour.

Consumer Satisfaction and Quality Assurance

8. To recruit each new patient as a subscriber may cost the HMO $60-100, and there is annual renewal. HMOs must ensure that people are happy so efforts are made to inform them about services and to establish personal relationships with their doctors. HMOs produce illustrated brochures setting out the doctors' qualifications, experience and special interests. Staff quality is important and HMOs can end contracts where necessary. Formal consumer surveys assess satisfaction, the time taken to answer the phone or book an appointment, in waiting for the doctor, or for laboratory tests to be performed. Individual complaints are dealt with rapidly by staff employed to investigate grievances. Accessibility and availability matter to patients, so locations are planned with care. Two HMOs seen had developed city centre offices which open early and closed late to help those working nearby. Regular newsletters provide information about services and health education topics. It is the non-users who change schemes and a 25 per cent turn-over at renewal time is not uncommon. TV commercials leave people in no doubt that their custom is sought after.

9. HMOs have an interest in demonstrating the quality of their care – which appears to be at least as good as under fee-for-service schemes – and under Federal regulations they have to establish a formal quality assurance programme. National guidelines, developed with professional help, do not define quality of care nor dictate methods for its assessment. However, an organisational structure is required which makes professional review possible. There must be a committee responsible for quality assurance activities, accountable to the governing body. The doctors must be involved in this and its work must be supervised by one of the HMO's physicians. Regular meetings must take place, and records of the action taken must be kept. The personal commitment of two 'medical directors of quality assurance' seen was impressive; one had an annual budget of $500,000 and a team of 10 staff. Methods used include peer group review, and random examination of records for completeness, legibility and the appropriateness of tests, diagnosis and treatment. Attempts were being made to review organisation structure, the process of care, and patient outcome, and to identify problem areas like the care of the young unmarried pregnant patient. Consumer surveys pin-point potential trouble-areas. Quality is valued both for its own sake and because it is an element in the marketing and survival of the organisation. There is cut-throat competition, and an HMO which has a good local reputation is at an advantage.

Medicines

10. Drug costs in the USA have been increasing at 20 per cent per year. HMOs generally pay for medicines although a contribution of $2-3 is required from the patient. Most HMOs seek savings, sometimes through using their own pocket formulary, which is in effect a Selected List. Generic substitution may be mandatory. Incentives are used, and doctor's prescribing costs may be one of the factors incorporated into a wider system which determines whether or not he will get a bonus. HMOs are often large enough to negotiate discounts either with pharmacy chains who dispense the prescriptions, or with the manufacturers themselves. One brand of antibiotic may be offered in preference, if its manufacturer makes a good offer. As a result of such efforts one HMO reduced drug costs from 7.5 per cent to 4.5 per cent of its total budget.

Preventive Medicine

11. Promotional literature and TV commercials demonstrate the importance of preventive medicine in marketing terms. An HMO which did not provide such service would not survive. HMOs, given half an indication that advice on conduct, diet, relaxation or exercise is worthwhile, will institute programmes in 'creative parenting strategies' or 'intensive couples workshops'. Nevertheless there is a reality and commitment behind these initiatives, and HMOs provide a good case for proven activities like cervical and breast cancer screening, both of which are widely offered.

Nurses

12. Nurses are employed as managers at the corporate headquarters and at operational level. They may be given a patient's admission details and projected length of stay so that progress can be monitored. They may also act as hospital discharge planners, making the necessary arrangements for which the doctors might not find time. Community nursing being cheaper than hospital care, HMOs are developing their own scheme to reduce the time spent in hospital. Nurses also assist in quality assurance, in handling complaints, and in the provision of 'nurse helplines' to assist patients in an emergency when practice premises may be closed. In addition 'nurse practitioners' may work side by side with medical staff as first points of contact for health care. This seemed particularly welcomed by female patients.

Summary

13. For those served, Health Maintenance Organisations provide a high standard of service. The management of all health care from a locally controlled budget avoids attempts to transfer costs at the margin, and has led to significant savings. Good information and competition has led HMO staff to seek to attract rather than repel patients. Patients can make a better choice of doctor and change with ease. The importance accorded to quality assurance and performance assessment is impressive. There are lessons to be learned from American experience.

---end appendix 1---

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Appendix 2

Paying the Professions

This Appendix describes how doctors, dentists, pharmacists and opticians in the family practitioner services are paid.

Doctors

1. The system for paying GPs is, like that of the other professions in the FPS, based on the principle of cost plus, that is the payments they receive are intended to be sufficient both to cover expenses and provide a given net income to the average GP.

2. Responsibility for advising the Government on the appropriate level of net income rests with the Doctors and Dentists Review Body (DDRB). The Government decides in the light of the DDRB report upon the average level of income for all GPs. The actual amounts individual GPs receive vary, depending on the service they provide and the expenses they incur, and some obviously earn more than the average and some less. For example, a relatively junior single-handed GP with around 500 patients might earn under £10,000 net, while a GP with a large list of 3,000 patients practising in a group and acting as a GP trainer could have a net income in excess of £30,000. The average net income which the system is intended to provide from June 1985 is £23,440.

3. Any expense incurred in providing general medical services is paid back to the profession in full. Some of these expenses are paid back to the individual GP incurring them (this is known as 'direct reimbursement'). The remainder are reimbursed on an average basis through standard rate fees and allowances (and usually referred to as 'indirect reimbursement'). It follows that the exact amout a GP receives by way of indirectly reimbursed expenses will not, except by chance, equal his or her expenditure and that the GP will have a strong incentive to economy so far as these expenses are concerned. A sample survey is conducted each year to establish GPs' average expenses and to help forecast what provision should be made for them in pay in the coming year. The provision in fees and allowances for 1985/86 is £11,320 per GP. On top of this, directly reimbursed expenses are expected to average about £12,400 per GP (excluding drug costs). The average GP's gross income in 1985/86 is therefore expected to consist of £23,400 net income, plus £11,320 in indirectly reimbursed expenses, plus £12,400 in directly reimbursed expenses.

4. With the exception of those expenses which are paid on an individual basis to the GPs who incur them (see below), both net income and expenses are paid to GPs through a range of fees and allowances. An individual GP's income depends upon which fees and allowances he or she qualifies for. Fees and allowances are of three principal types.

i. **Capitation Fees**

An annual fee is payable for each patient registered with a GP. Standard capitation fees are paid at three rates, depending upon the patient's age: that for patients under 65 is currently £6.85 a year; that for patients aged 65-74 is £8.85; and that for patients aged 75 and over is £10.90. Supplementary capitation fees are payable in certain circumstances to doctors undertaking to provide out-of-hours services. Capitation fees account for some 47% of the total paid in fees and allowances.

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ii. **Allowances**

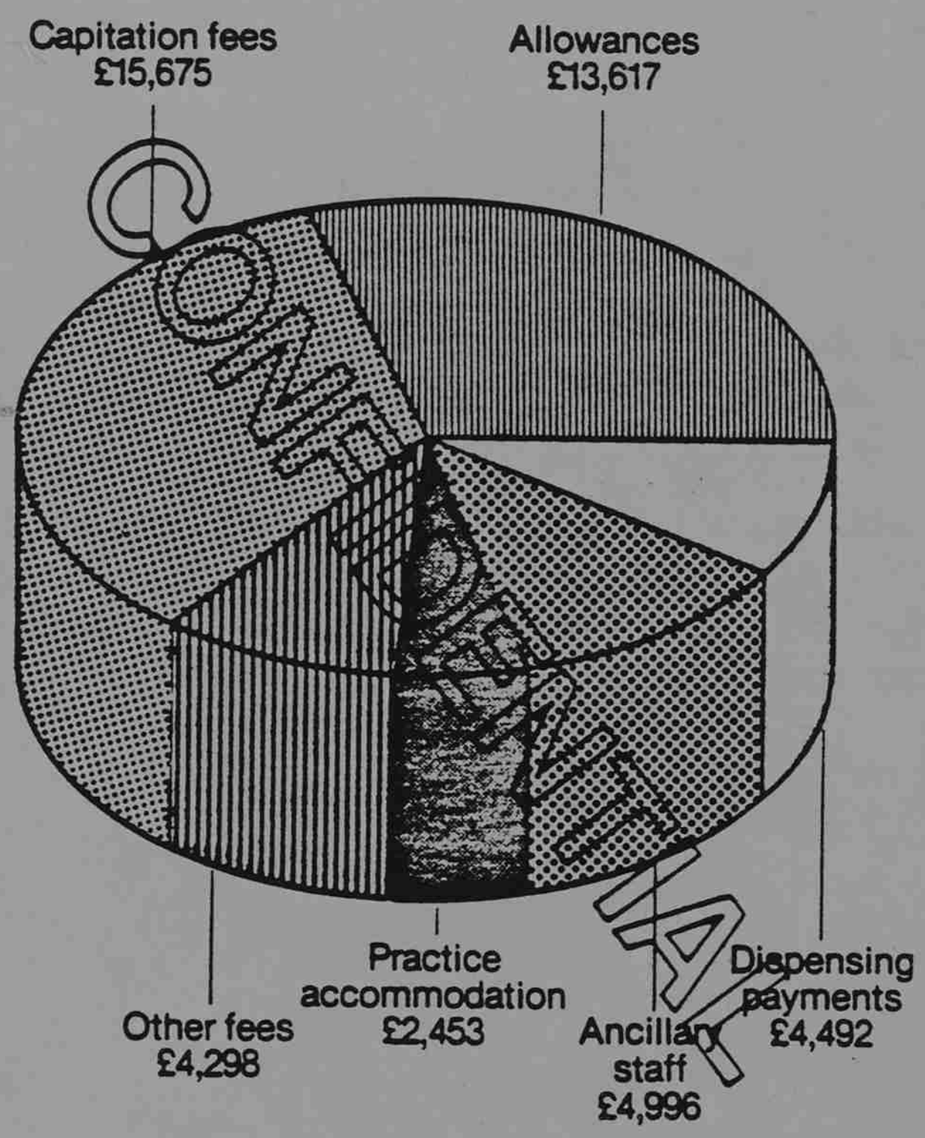
Apart from capitation fees, the biggest single element in a GP's pay is normally Basic Practice Allowance. The full rate allowance of just over £7,000 is payable to all GPs with 1,000 or more patients and who are regarded as devoting a substantial amount of time to general practice. A proportion of the allowance is payable to GPs with smaller lists. Doctors can also receive a Seniority Allowance at one of 3 rates (top rate £4,560 a year), depending on how long they have been in general practice. Doctors who have yet to become entitled to Seniority Allowances can, if vocationally trained, obtain an allowance of £1,450 a year. There are also allowances for practising in a group of 3 or more doctors for providing out-of-hours cover and for having completed postgraduate training Inducement payments are available to doctors setting up in certain sparsely populated areas. On average, allowances account for some 40% of GPs' income from fees and allowances.

iii. **Item of service fees and certain other minor payments**

A GP is entitled to a fee each time he provides certain services. For example, a doctor receives a fee for carrying out some vaccinations or immunisations (of £2.30 or £3.30); for carrying out cervical cytology tests on some women (£6.60); and for making a night visit (£15.55). Doctors also receive fees for providing contraceptive services (of up to £29.90 a year), and maternity medical services (the fee for providing a patient with complete medical services is £105.00). Fees of this kind account for about 18% of income from fees and allowances.

—Insert figure 12—

Figure 12
Estimated Average Payments to Family Doctors in Great Britain, 1984/85



Note: gross payments to unrestricted principals in general medical practice, excluding drug costs.

5. The other element in GPs' income is payments to cover expenses actually incurred. These include payment normally in full for rent and rates. Doctors who own their own surgeries receive a notional rent equivalent to the current market rental value of the premises as assessed by the District Valuer. (Doctors may also be entitled to receive extra financial help with the cost of building new purpose-built practice premises or improving existing ones). GPs can also claim back 70% of the salary of certain ancillary staff, up to a maximum of 2 staff per GP. Other expenses which are directly paid for include the cost of drugs dispensed; the salary and expenses of trainee doctors employed by GPs; and the cost of employing a locum whilst sick or on study leave. About half of the total cost of GPs' expenses is now met through payments of this kind, and half through fees and allowances.

Dentists

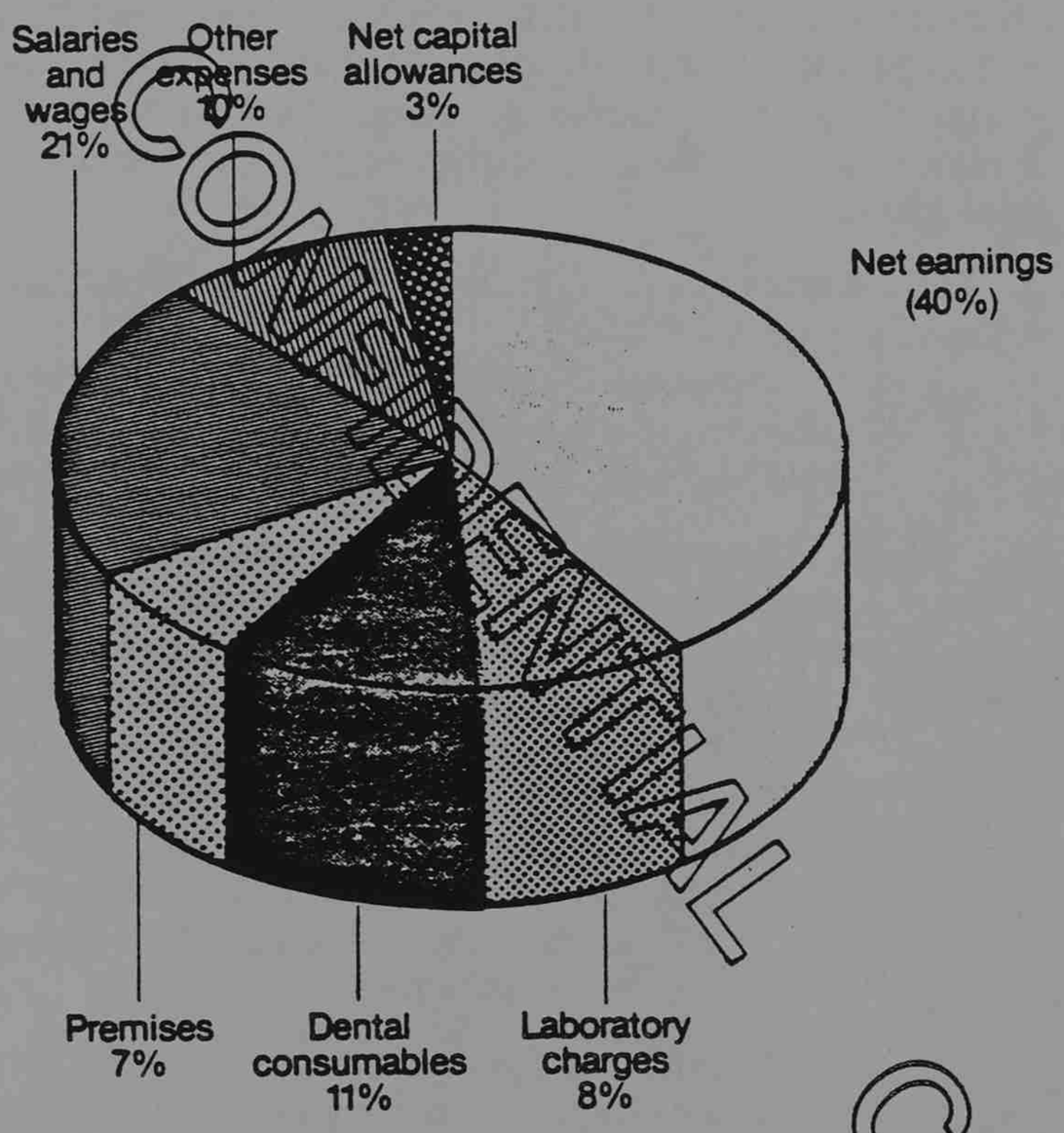
1. Dentists are paid a fee for every item of treatment they give to patients. There are 150 separate fees, and it would obviously be very difficult, if not impossible, to set the 'right' fee for each and every item of treatment in isolation. So dentists' pay, like that of GPs, is based on the principle that the average dentist should earn a certain income before tax from the NHS and have the expenses of running his or her NHS practice met in full. The amount individual dentists earn will depend on the amount of work they do and the amount of expenses they incur.

2. The net income which the average dentist should earn is decided by the Government in the light of recommendations by the independent Doctors and Dentists Review Body (DDRB). When making its recommendation, the DDRB makes use of information about the average dentist's hours of work and the amount and type of treatment which the average dentist does. The average dentist currently works about 30 hours a week in the NHS and the average net income the system is required to provide from 1 June 1985 is £20,280.

3. The amount due to dentists for expenses is determined by uprating information about the average dentist's actual expenses obtained every year from a sample. These expenses are substantial. For example, this year the estimate of average expenses is about £29,000 – getting on for 1½ times that for net income.

—Insert figure 13—

Figure 13
Average Payments to General Dental Practitioners in Great Britain, Broken Down into Net Income and Expenses, 1982/83



4. After forecasting the number of times the average dentists will do each of the different forms of treatment, the level of fees is set in such a way that the average dentist can earn an agreed net income. The relationships between the different fees are based largely on the time taken to carry out the different forms of treatment though, for some forms of treatment, the fee includes an allowance for expenses which can be specifically linked to that treatment.

Pharmacists

1. The amount due to pharmacists for dispensing NHS prescriptions is based on the labour and overheads costs incurred in dispensing NHS prescriptions plus an agreed rate of profit. The rate of profit is arrived at through direct negotiation between the Government and the pharmacists' representative organisation. Labour and overheads costs are assessed by sample statistical enquiries which are held periodically, normally every four years. For non-enquiry years the amounts due are increased by the latest statistical indices. The amounts due for labour and overheads plus the agreed rate of profit are paid out to contractors as remuneration in the manner described below. As with doctors and dentists, the payments made to repay them the cost they incurred in NHS dispensing on an average basis.

2. The amounts due for dispensing are paid to pharmacists through three main types of payment:

i. a professional fee per prescription of an average about 55p but varying according to the type of prescription dispensed, in accordance with the scale laid down in the Drug Tariff.

ii. a differential on-cost allowance calculated at varying percentages of the wholesale cost of drugs and appliances dispensed (before the application of discount). The on-cost percentages are on a sliding scale and vary with the number of prescriptions dispensed by contractors during the month. The highest rate of on-cost (23 per cent) is paid where the least number of prescriptions were dispensed during the month (1 to 249 prescriptions), the lowest rate of on-cost (8.4 per cent) is paid where the greatest number of prescriptions were dispensed during the month (over 5,000) and there is a full range of on-cost scale points (over 80) between these two extremes.

iii. a basic practice allowance at a rate of £3,000 per annum is paid for each pharmacy except one entering into contract with the NHS for the first time after 1 July 1980 where the new pharmacy is within 1 kilometre of another pharmacy.[1]

There are also additional payments, not common to every pharmacy inasmuch as they are only paid for a particular service performed:

iv. payments for remaining open outside normal hours on a rota service.

v. urgent out of hours dispensing.

vi. oxygen therapy cylinder service.

vii. essential small pharmacy payments (annual grants).

viii. grants for training pharmacy graduates in their pre-registration year.

3. Pharmacists are also paid the wholesale cost of drugs and appliances dispensed in meeting NHS prescriptions, less the discount which they can on average be expected to obtain from suppliers.

[1] There is no basic practice allowance as part of the Scottish remuneration arrangements and as a result the basis and levels of professionals fees and payments are different.

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Opticians

1. Opticians receive a fee for each NHS sight test or NHS dispensing they conduct. The average costs of NHS sight testing and dispensing are settled through negotiations taking into account information obtained from periodic cost enquiries, and an agreed profit element is added to arrive at the fees.

2. Between main enquiries, which are conducted at 4 or 5 yearly intervals, information on costs is updated using appropriate price and earnings indices. A past difficulty has been that updating of fees by this means has not prevented the build-up of sums due to the profession or the Department. This has been unsatisfactory to both parties and arrangements are in hand to convert to a system of annual enquiries into opticians' costs. This will bring about annual fee settlements and will remove the need for time-consuming arrears exercises which have been necessary from time to time under the old arrangements.

3. There is a standard sight-test fee payable to ophthalmic opticians. Because of the varying nature of dispensing, however, it is necessary to have seven rates of dispensing fee, taking account of factors such as type of frame chosen, whether single vision or bifocal lenses are dispensed etc. However, it is intended to replace the direct supply of NHS glasses with a voucher system to enable those still eligible for free supply or help with charges to obtain their glasses from the private market. Dispensing fees will then be unnecessary as suppliers will need only to claim the value of the voucher handed to them by the patient.

4. Opticians are responsible for approaching suppliers of optical appliances (i.e. frames and/or lenses) for NHS supply and in addition to receiving a dispensing fee are reimbursed for each NHS appliance dispensed. The rates of reimbursement are fixed after conducting monitoring of the prices paid by opticians for their supplies. Reimbursement is not intended to provide a profit since this is catered for in dispensing fees. These reimbursement arrangements will be discontinued once the voucher scheme is introduced.

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Appendix 3

Pharmaceutical Price Regulations Scheme (PPRS)

1. The prices of NHS drugs are subject to review and a measure of control through the Pharmaceutical Price Regulation Scheme (PPRS), a non-statutory arrangement that is administered by the DHSS with the agreement of the drug manufacturers.

2. The first objective of the PPRS is to secure the availability of safe and effective medicines on fair and reasonable terms to the NHS. As an important secondary objective the PPRS is intended to promote a strong, efficient and profitable pharmaceutical industry in the UK, capable of such sustained research as should lead to the availability of new and improved medicines both for the NHS and for export. The levels of profit for the industry as a whole which are allowed under the PPRS are based upon a return on capital employed which is broadly related at present to the rate of return allowable to defence contractors.

3. For the majority of companies the present method means that reasonable costs incurred in supplying medicines to the NHS are recovered through the prices charged and the company is allowed to earn a reasonable profit, expressed as a return on the capital employed. The reasonableness of profits is assessed across a company's range of products as a whole, since it does not matter to the NHS if a higher profit on one is counterbalanced by a lower profit on another. The DHSS can, and regularly does, challenge declared costs which it regards as unusual or excessive and if appropriate disallow them before approving proposed price increases or profits returned. Subject to that the scheme is inherently cost plus like the arrangement for reimbursing the professions in the Family Practitioner Services.

4. Capital employed is divided into two roughly equal parts: Fixed assets, such as land, buildings, plant; and the working capital involved in running the business including cash and stocks. While, as the name implies, the value of fixed assets changes relatively slowly, working capital is much more volatile and changes directly in relation to volume of sales.

5. If a company's sales fall as a result of more economical prescribing there are a number of inter-related effects. Reduced income from sales is offset to the extent that raw material and energy costs are less and sales-related costs such as sales promotion allowances under the PPRS are automatically reduced. The approved profit target will also fall because the capital employed, especially the working capital, will also decline with sales. At the end of the day some loss of profit may in some circumstances be recouped through compensating price increases within the product range. But generally the cost of such increases will be only a small fraction of the value of sales lost. And this effect will in any event tend to disappear within a year or two as the company adjusts to its new trading level. Furthermore, any increases arising from the higher unit costs of the losing company will tend to be offset by the lower unit costs of companies gaining sales. Clearly, therefore, it is very much in the financial interest of the NHS for doctors to prescribe the cheapest acceptable medicine available.

—end appendix 3—