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PRIME MINISTER

Budgets for general practice

[Paper HC47 by the Secretary of State for Health]

DECISIONS

1. There are three main issues on this paper. First, opting out by GPs. At the last meeting the group agreed that provision for opting out by GPs in large practices was an important part of the package of reforms. But it asked for more work to be done on how this would work in practice. The group will need to decide whether the practical arrangements for opting-out have now been developed in sufficient detail to be included as an important feature in the White Paper. Treasury Ministers may be doubtful.

2. At its previous meetings, the group has agreed on the need to get better control over GPs' expenditure. Treasury Ministers proposed to merge the DHAs and FPCs and cash limit the combined bodies. Mr Clarke resisted both such a merger and any cash limit, at least in the medium term, on GPs' expenditure. At the last meeting the group were attracted to a compromise proposal by which FPCs would be given responsibility for general budgets - which would in effect be cash limited, though this would not be said - covering the whole of their contractors' expenditure. Individual GPs would not be cash limited but would receive indicative budgets from their FPCs and would be subject to FPC audit if their expenditure threatened to become excessive. Mr Clarke's paper in effect argues against such a system. Treasury Ministers will express disappointment at this. You will wish to consider in the light of discussion whether to re-affirm that the group is attracted to the principle of a general budget for FPCs and would like it to be re-examined in detail by the Treasury and Department

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of Health jointly.

3. Finally, the group will need to return to the question whether FPCs and DHAs should be merged. The application of budgets to FPCs assumed that they would continue as separate bodies and you might wish to confirm this as a provisional conclusion while the Treasury and Department of Health consider in detail how to give effect to FPC budgets. Decisions are also needed about the composition of the FPCs.

ISSUES

4. You may wish to take the discussion in two separate stages:

a. budgets for opted out GPs;

b. budgets for FPCs.

There are links between these questions but they are essentially separate, although Mr Clarke's paper sometimes confuses them.

BUDGETS FOR OPTED-OUT GPs

Scope of the budget

5. Mr Clarke suggests that budgets for opted-out GPs should cover outpatient services, defined acute elective inpatient and day case treatment, diagnostic tests by hospitals at GPs' direct request, and GPs' practice expenses.

6. At the last meeting the group asked him to consider whether the opted-out budgets could also cover drugs. He advises that GPs opting out could have a 'further option' of having a drugs budget. This suggests that he has in mind that practices could opt out without the inclusion of drugs in their budgets. You will want to check whether this is so, and consider whether it should be a condition of opting-out that the opted-out budget should cover

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drugs. Inclusion of drugs in all opted-out budgets would provide control over one of the biggest costs for which the GPs are responsible. Appendix II to the paper shows that expenditure on drugs in 1986-87 ranged from £259,000 to £401,000 per 10,000 resident population. The total drug bill nationally was £1,357 million (paragraph 9 of the paper).

7. More generally, you may want to ask whether the opted-out budgets should cover a wider range of treatment, perhaps even all treatment for the patients of the practices opting out. This would have some advantages:

i. It would extend over a wider area the dispersal of decision-taking represented by GP opting-out.

ii. It would give the maximum scope for viring between different items of spending.

iii. It would be much simpler. Otherwise GPs would have to apply different procedures according to whether treatment required by a patient fell into the opted out category or not.

Determination of size of budgets

8. Mr Clarke proposes that budgets should be allocated by Districts to opted-out GPs on broadly a pro rata basis. He argues that only practices with below-average costs will then have an incentive to opt out. This may be satisfactory, but you may wish to question the role of the DHA. The group has not finally decided whether to keep FPCs separate, as Mr Clarke would prefer, but if FPCs are retained should not they rather than DHAs allocate budgets to the opted-out GPs?

Buying hospital services

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9. Mr Clarke suggests that opted out GPs' contracts with hospitals might provide for payment on different bases according to the type of treatment involved:

- directly requested diagnostic tests and continuing outpatient treatment on an 'item of service' basis;

- initial outpatient referrals on an 'annual fee' basis;

- inpatient and day case treatment as a 'cost and volume' basis.

Mr Clarke says that the arrangements will be for GPs and hospitals to negotiate freely. Nevertheless, you may wish to question whether the arrangements he has in mind are too complicated. GPs will need to have different procedures, not only as between opted out and other treatment, but also as between different types of opted-out treatment.

10. If one form of contract were to be standard for all opted-out treatment, you might explore the case for an annual fee, so that the hospital had to provide all this treatment for a sum fixed in advance, thus putting on the hospital the rsponsibility for keeping within the defined limit. This should provide better control over costs, would extend the scope for viring over the whole of a hospital's costs, and would help to deal with any worries that GPs would not be competent to administer a budget. Perhaps the best answer is to leave it to the GPs to decide what contractual arrangement is in the best interests of their patients, within what they can afford.

Overspending and underspending

11. The group at its last meeting were concerned to know what would happen if opted out GPs overspent or underspent their budgets. As to overspending, Mr Clarke proposes that it should trigger a process of medical and management audit, with the loss

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of opted-out status as the final deterrent. This seems satisfactory, but you may want to confir that there would be arrangements to deal with an overspend clearly caused by events outside the GPs' control, such as an epidemic. The Departmen t of Health would need to be prepared to fund exceptional situations of this kind.

12. On underspending there was some concern at the last meeting, especially from Mr Walker, that GPs might be encouraged to underspend on patient care if they could keep any surplus for their own use. You will want to consider whether the arrangements proposed by Mr Clarke meet this worry. His main proposal is that use of a surplus inside the practice will require the agreement of the FPC. This assumes a decision to keep separate FPCs, and you may also want to check that such a role would be practical for FPCs, at least without building up massive bureaucracy.

FPC BUDGETS

13. At the last meeting the group were attracted by a proposal that FPCs should have responsibility for general budgts covering all their contractors' expenditure. The implication was that the FPCs would be cash limited. Individual GPs would not be cash limited but they would receive 'indicative budgets' and would become subject to audit by the FPC if their spending threatened to become excessive. Mr Clarke's paper examines this possibility.

14. The paper says that the main categories of cost to be considered for this purpose are:

a. remuneration and indirectly reimbursed expenses of GPs;

b. directly reimbursed expenses;

c. drugs.

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15. Mr Clarke's argument is that a and c cannot be covered by cash limited budgets and that the Government is already committed to them for b. In effect therefore he proposes no change. You will wish to question this. You might best do so by examining in turn the expenditures - a and c - for which he suggests budgets are not possible.

Remuneration and indirectly reimbursed expenses

16. Mr Clarke's paper says that the essential feature of present contracts is that they are on a cost-plus basis. Expenses, which account for the bulk of remuneration costs are reimbursed by FPCs. You may want to ask whether arrangements based on a cost plus principle are not very likely to lead to lack of financial discipline, and to explore further the case for bringing them within a budget.

Drugs

17. You may wish to examine one by one Mr Clarke's arguments against bringing drugs within an FPC budget:

a. It would involve enormous expenditure in supplying all GP practices the necessary information on prescribing costs. But even if this is so effective control over spending on drugs would be such a gain that expenditure of this sort might be worthwhile.

b. GPs would have a disincentive to take patients with high drug costs. But the proposal is that the budget would be held by FPCs, for whom risks of this sort would be evenly spread. The GPs' indicative budgets would take account of the characteristics of their patients.

c. 30,000 GPs would protest. But the effective cash limiting would be on the FPCs. If GPs overspend, their funds would not be cut off - so jeopardising their patients - they would

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only be subject to audit.

d. Renegotiation of the Pharmaceutical Price Regional Scheme (PPRS would be required). But this scheme, with its guaranteed returns for the drug companies, already represents a major departure from the free market and needs to be reconsidered.

18. Depending on the course of discussion, you may wish to indicate that the group are still attracted in principle to FPC budgets, and that the Treasury and Department of Health should jointly consider how best to make them work, in the light of points made at the meeting.

Future of the FPCs

19. At its last meeting the group postponed a decision about the proposal that the FPCs and DHAs should be merged. But the idea of FPC budgets, which attracted them, assumed that the FPCs would continue as separate bodies. If therefore the group reaffirms its support in principle for FPC budgets, it might also state the provisional conclusion that FPCs should continue.

20. There is also a point to settle on the composition of the FPCs. Mr Clarke wanted to remove the contractors from membership. The group as a whole thought there was a strong case against doing this, because one theme of the reforms is that professionals should be given more management responsibility. You will wish to consider whether to reaffirm this view; the arguments do not seem to have changed since last time.

RW.

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Cabinet Office
14 October 1988

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PRIME MINISTER

Self-governing hospitals

[Paper HC46 by the Secretary of State for Health]

DECISIONS

At the last meeting the group reaffirmed that the introduction of independent self-governing hospials would be an important change to come out of the review. But you asked the Department of Health to undertake further detailed work to show exactly how the change would operate and to put forward detailed proposals for achieving it. The group will now need to decide whether the practical arrangements for achieving self-government have now been developed in sufficient detail to form the basis of a White Paper.

ISSUES

Self-governing hospitals

2. You may wish to discuss the following points on Mr Clarke's proposals:

i. the procedure for moving hospitals to self-government;

ii. the number of hospitals to be self-governing;

iii. the need for legislation;

iv. fair competition between hospitals;

v. the regime for hospitals when self-governing.

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Procedure for moving to self-government

3. Mr Clarke proposes that the Government and regions should take the initiative in drawing up a list of hospitals likely to be suitable for self-government and should manage the transition for those chosen. This reflects a suggestion made by the Chancellor at the last meeting.

4. You may agree that some form of central initiative is necessary to give the process momentum, but you might wish to probe the respective responsibilities of the Secretary of State and the regions. Apparently both will be involved in both the initial selection and the management of the transition. This may make sense but you might check that it is necessary, that it will not lead to duplication, and that it will not increase RHA bureaucracy.

5. Mr Clarke proposes a formal procedure for approval of self-government which looks rather elaborate, for example with statutory criteria. You may wish to check that this procedure will not be unduly cumbersome and not lead to the risk of judicial review. You might also check that this judicial role for the Secretary of State is consistent with the suggestion that he should take the initiative in identifying the proposals to be prepared for self-government.

Number of hospitals to be self-governing

6. Mr Clarke recommends that self-government should be open in principle to all 260 major acute hospitals. The last meeting thought that self-governing status might be appropriate for only some, perhaps a minority, of major hospitals, principally those in urban areas where there is scope for competition. Nevertheless, you may see advantages in agreeing that the status should be open in principle to all major acute hospitals. It is a major part of the reform package and necessary to the working of other parts, such as opting out by GPs and DHA buying. The qualification 'in principle' would ensure that self-government does not proceed any faster than is practical.

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7. Mr Clarke also recommends aiming at making five or six hospitals self-governing by 1991 and 30 to 40 by 1994. You will wish to decide whether these are the right aims, and especially whether enough progress would be made in this Parliament.

Need for legislation

8. Mr Clarke argues that legislation is necessary. Although he already has power to make hospitals Special Health Authorities (SHAs), trust or companies, his legal advice is that it might be ultra vires to use them as extensively as would be necessary. The legal advice may have to be accepted, but you might ask whether a few of the early moves to self-government could be made under existing powers. For example if we are to aim at only 5-6 self-governing hospitals by 1991 could they be set up un der the SHA powers?

Fair competition

9. The paper does not address the question of how to ensure that there is fair competition between self-governing and DHA-run hospitals, given that most buying will be by DHAs. The problem is greater if, for many years, the great majority of hospitals continue to be run by DHAs. You may wish to ask Mr Clarke how he will ensure that DHAs will be even-handed in deciding whether to buy from their own hospitals or from self-governing hospitals.

Regime for hospitals when self-governing

10. At the last meeting you said that self-governing hospitals should be free of unnecessary central control and in particular should employ their consultants and own their assets. Mr Clarke has met these points. But, while vesting the assets in the hospitals he would make the region's consent necessary for major investment and for the disposal of assets. You may wish to explore why the region's consent is necessary in these cases. The whole aim of the exercise is to break away from monolithic central control and achieve greater efficiency and better service for patients by giving hospitals responsibility for

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running their own affairs. Would the need for the region's consent take away the freedom you wanted the hospital to have from owning its own assets?

11. The paper also suggests that the hospitals would depend primarily on grants from regions to meet their major capital needs. You might ask why this should be so. Why should they not meet these needs from revenue or by borrowing?

12. The last meeting asked Mr Clarke to give a fuller statement of the implications of the new arrangements for public expenditure. In this paper he says only that there will be 'significant costs' from an increase in the number of their staff and in pay levels, and that the subject should be pursued in next year's Survey. You may wish to ask why there need be any major increase in expenditure, given that control will be exercised through cash limits on the DHAs which will buy from the self-governing hospitals, and if necessary ask for the question to be further considered by the Treasury and Department of Health jointly.

RJW.

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14 October 1988