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PRIME MINISTER 18 NOVEMBER 1988

LETTER FROM DR MICHAEL GOLDSMITH

Dr Michael Goldsmith has written a helpful letter (attached) describing an updated version of his earlier model for GP budgets. Many facets of his proposal overlap with the NHS Review, such as the need to focus on large practices. Yet he highlights one essential ingredient which is largely ignored in the Review papers: namely incentives.

On page 4, he stresses the need for GP incentives for two main reasons. First, incentives would encourage GPs to keep within the budget. Second, without such an incentive, many GPs may prefer to continue with the status quo.

If the Leningrad experiment can divide primary care savings between staff bonuses and improved facilities, we should not be constrained from giving personal incentives in this country.

Kenneth Clarke should be asked to clarify the detailed aspect of practice budgets - including incentives - as he indicated earlier in Paragraph 15 of his paper "Managing the Family Practitioner Services".

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MJG/JRD

16 November 1988

Dear Prime Minister,

As you might remember from our previous conversations I have for some time been intimately interested in new methods of budgetary management and provision for the National Health Service.

With your personal review of the Health Service well under way I thought it might be timely to send you the enclosed Paper which I have written on the subject of the GP as Budget Holder.

I have described a slightly different model to that which David Willetts and I discussed in our CPS Paper of February/March this year (Managed Health Care).

I do hope this is of some interest to you and would be happy to develop it further if you wish.

Kind regards.

Yours sincerely,

Michael Goldsmith

DR MICHAEL J GOLDSMITH

THE PRACTICALITIES OF THE GP AS BUDGET HOLDER

This short paper is an attempt to look at the problems and practicalities associated with a model of National Health Service provision which uses the GP and his team as budget holders for primary care and elective (cold) surgery.

Background

During the course of the last year many of us who are concerned with health care planning and change have been looking at different models of distributing the budget for NHS care. In particular David Willetts and I developed several items on the subject of managed health care. I feel it is critical that the consumer (the NHS patient) should have a greater say in the provision of his or her health care needs and in particular a greater choice. Since GPs are pivotal in their contact with their patients and as gate-keepers, it is only sensible to look carefully at a model where the GP holds the budget for their care. With over 220 million patient/GP contacts per year this must be a more sensitive way of influencing choice and quality.

In the model which I am examining in this paper, I suggest that a GP group of more than about 10,000 patients would probably employ a manager (with existing health service - or private sector - management experience) to control a budget which would have been awarded to it by the NHS for the provision of primary care and limited secondary care services.

The two main reasons for allocating budgets to a GP are firstly to encourage careful planning and utilisation of individual services, and secondly to make it possible for doctors to shift money between services and also between providers to obtain the best possible package for their patients. A secondary advantage to the Treasury would be the possibility of cash limiting of GP's services through this type of budgeting. Considerable expertise has been gained in the USA through family physicians receiving capitated payments from paying authorities (like Medicare and Medicaid) and entering into contracts with specialist, skilled nursing facilities, radiology departments and laboratories. For instance, in California over half the family physicians have entered into one or more such contracts.

Requirements for an English Style GP Budget System

1. A rapid enhancement of data systems which would need to give as a minimum the following information:-

   a) Waiting times for in and out patients

   b) Costs of the various primary care services being used, especially those provided by outside providers, eg for X-rays, blood tests, physio, etc

   c) Costs for secondary care for the in-budget elective surgery and medicine at Regional and Local NHS and private hospitals, both as in-patient and out-patient

   d) Outcome statistics

   e) Morbidity and mortality rates, both Regional and Local to that Practice

   f) A full accounting and spread-sheet package to enable the budget to take place

2. Budgets would cover an expanding range of services but would start with primary care services including drugs and progress to out-patient appointments, diagnostic tests and X-rays, elective surgery and ancillary and community staff and nurses.

3. An internal peer audit system must be developed both for the doctors and the ancillary workers. It has been shown that peer audit and quality control systems are essential to make gate-keeper budgeting work.

4. A utilisation control system which involves the doctors and their managers retaining control over the secondary services which were provided to their patients. This would be provided by pre-authorisation (where permission from a medical director is required before surgery or extended out-patient care can be given and which is based on purely clinical criteria but with a cost saving background).

How Would One Set Up and Operate Such a Budget?

The first requirement would be for an estimate of the practice expenditure on primary care. The picture for this would be built on research material and available returns from the DoH based on prescription pricing authority and various other GMS data available.

Difficulties here would be budgeting for the costs of work presently done by Health Authorities on primary care patients for the practice (eg X-rays, blood tests, etc). None of this is presently priced separately.

Other than for drugs we have little or no knowledge of actual expenditure by a practice. This presents a difficulty because it would be crucial to the decision by a GP to opt for budgeting for him to know whether or not his budget is workable. How will the practice know whether the budget on offer from the DoH or Local Health Authority represents a "good deal" unless he currently has knowledge of what is spent on his behalf within the NHS. Similarly a budget has to be set at a level which provides incentive to the GP to be efficient and to provide better service. I will deal with incentives later in this paper.

The recent Jarman index might be used to help set budgets. This index is meant to reflect the relative need for GP services (including diagnostic tests) and might also reflect the need for elective surgery.

What Methods are there for Buying Services on a Fixed Price?

There already exist well-established methods of pricing elective surgery on a case by case basis such as DRGs (Diagnostic Related Groups). The ability, therefore, for a trained manager to buy the requisite number of surgery operations for the practice is reasonably easy. An alternative method to buying DRGs would be to buy care on a capitated basis so that a Hospital Health Authority will charge a practice a capitated sum per annum to provide all necessary surgery in a particular speciality dependent on the list size of the practice. However, hospitals and GPs will have an interest in the most accurate cost information about services to ensure that charges and costs are not significantly out of step.

One of the main problems is going to be budgeting for severe cases or the victims of medical accidents. Stop-loss reinsurance is required in the USA to deal with these problems and I see no reason why contingency stop-loss (against particular expensive cases) and aggregate stop-loss (against a large number of smaller cases becoming expensive in one year) should not be purchased by the GP budget holder on an annual basis. Some people have suggested that this stop-loss be provided by the Treasury direct in the same way as all other major public sector risks are taken without insurance. For this the Treasury could take say 5% of the budget and pay out directly when stop-loss parameters were met. I personally favour getting the stop-loss cover in the market on a commercial basis which would allow competition by the insurers to provide it. Such contracts already exist in the private medical insurance sector and work well.

Other Methods of Management

There is no reason for the GP to have to manage his budget directly himself. If he does not wish to employ experts to help him he could contract out the management of his budget to a third party administrator who should do the buying and the budgeting for him. For instance, the British private sector in medicine already has increasing numbers of expert firms like Medisure and Remedi who act on behalf of the buying client, ie companies, groups, police forces etc, to manage the costs of their private medical insurance plan. Companies like Medisure already have expertise in the bulk buying of hospital care and are well versed in controlling costs of both hospital and specialist care.

Incentives for Efficient Budgeting

Incentives would be required to encourage the GP to keep within his budget and safeguards would be required to prevent the GP from mis-managing his budget and leaving patients without both primary and secondary care in the latter part of the budgetary year. Without such incentives there is a possibility that many GPs may prefer to continue with the status quo rather than the entrepreneurial and adventurous as I would hope.

Whilst there would be general resistance to the GP being able to operate the savings which he made by stringent budgeting, there might be ways of allowing the GP to gain by being efficient. It is natural anathema to see a GP running around in a Porshe paid for out of money which ought to have been going into health care. However, in the USA and in Europe GPs who have acted as gate-keeper/budget holder have been allowed to keep a tiny percentage of those savings for themselves and this might be all the stimulus that is required for efficiency. At any rate the GP should be allowed to spend savings accrued on other forms of care for his patients, for instance a GP might save a considerable amount on his minor surgery budget by performing the surgery "in-house" and that money saved might be used to bring down cold surgery waiting lists. I believe much thought should be given to incentives and encouragements because unfortunately GPs seem to be mainly influenced by the effect of work on their income.

Obviously if patients are receiving poor service they should be permitted and indeed encouraged to move to another more satisfactory practice. This in itself acts as an incentive to give good service. However, medical audit will be a necessity for keeping quality standards up and although this would mainly be done on a peer audit basis I think that there is a case for outside professional audit of cost effectiveness. The profession is moving quite rapidly towards acceptance and implementation of peer audit systems and there is much good research information available from the USA on this subject where peer audit has been in practice for over 15 years. This type of information is acceptable to the profession in Britain compared with some other USA information which is less well regarded.

Advantages of GP Budgeting

- The GP has more clinical control over the total clinical pathway of his patients and can influence their care more
- The GP has the ability to share in efficient savings made on behalf of his patients and to redirect these savings into more care
- The patient has the GP looking after his interests and theoretically therefore has more choice of care
- The patient has the ability to influence his secondary care by changing GP if he is unhappy with the success of the GP's secondary care arrangements
- The free market will become increasingly important as GPs compete for patients
- Private sector firms with experience of health care cost management will emerge to help the GP manage the change
- Efficiency and quality will determine the size and make-up of an individual GP's list
- For the first time there would be an ability to put cash limits on the totality of primary care under the General Practitioner service
- This model would enable a system to be developed where the NHS hospitals could float free from District Health Authority management and be self-governing
- The need for a Medical Practice Committee (MPC) which presently allocates slots around the country for GPs would become much less pressing and an even spread of family doctors through the effects of increased competition would become the norm

Disadvantages of the System

- Even a 10,000 patient group practice may not produce the economies of scale which are found when the budget is controlled at the Health Authority level. These economies of scale do, however, apply to the managed health care type of model where the District Health Authority manager actually controls the budget for primary and secondary care.

- Many GPs might not wish to be involved in primary or secondary care budgetary management and may see their clinical time being diverted into management decision-making time. Therefore perhaps this type of provision should be made optional

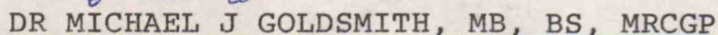
- In the first instance there will be insufficient trained mnanagers to assist the 26,000 GPs who would make budgetary decisions. A graduated system of entry into the budget making contract for GPs would therefore be required

- Primary care budget holder will be in competition and potential conflict with the local hospital management on a supply and demand basis. This may produce conflicts which affect quality of care

- Would the GP need to indemnify himself against the inadequacies of secondary care since he was the purchaser of that care on behalf of the patient? In other words, could the patient sue his GP for inadequate secondary care?

- Mechanism would have to be found to prevent GPs selecting an "easy" case mix of patients to his financial advantage, but this could be offset by an age and geographically related capitation fee and by the continuation of the arrangement whereby "difficult" cases can be forcibly allocated to individual practices (presently by FPCs).

On balance the advantages far exceed the disadvantages. These disadvantages can be minimised and problems can be fleshed out and solutions found. I believe it is important not to be too prescriptive when designing the system. We must give GPs flexibility and try a plethora of different ways of budgetary management just as they presently offer a plethora of different types of care. Given good will on all sides this type of system could genuinely produce a significant improvement in consumer choice and in quality of care as well as a step forward in the management of cost effective care.



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