266

SECRET

P 03303

PRIME MINISTER

Managing the FPS: Outstanding Issues
Paper by the Secretary of State for Health,
HC 63

DECISIONS

This paper takes up some outstanding issues on management of the FPS, most of which have been before the group, and the subject of disagreement, for some time. You may want to ensure that as far as possible the group takes final decisions on them at this meeting, so that drafting of the White Paper can be completed.

2. You may wish to take the issues in the order in which they are set out in the paper:

i. budgets for prescriptions (paragraphs 2 to 6). The paper accepts that there should be a system of 'reasonable budgets' to cover the cost of prescribing drugs. This is an important step by Mr Clarke. The question is whether it takes the right form. He proposes that with effect from April 1991 there should be a single, national drug budget for each of England, Wales, Scotland and Northern Ireland. Individual budgets would be allocated by the Department of Health to Regions, and by Regions to FPCs which would in turn allocate indicative drug budgets to GP practices (other than those covered by the scheme for large practices). The group will wish to consider whether these proposals provide the control over FPS expenditure which it has always sought. You may wish in particular to concentrate on whether the budgets should cover non-drug expenditure as well as drugs, and whether the arrangements for dealing with overspends are satisfactory;

ii. merger of FPCs and DHAs (paragraphs 7 to 10). Mr Clarke is opposed to treating this as a 'green' issue. He does not rule out the possibility that merger may become desirable in due course but he wants the White Paper to say, at most, that it is

SECRET

far too soon to reopen the issue. The main case for merger has always been that it would facilitate control of FPS expenditure. In the light of the discussion on drug budgets you will wish to consider how far to press the case for merger;

iii. control over GP numbers (paragraphs 11 to 21). Mr Clarke makes suggestions for controlling the number of GPs by increasing the capitation element in their renumeration. He does not rule out combining this with a statutory limit on numbers. You will wish to decide what the White Paper should say on this.

iv. incentives for GPs (paragraphs 23 to 28). The paper refers to the possibility of performance-related additions to pay but effectively makes no new proposals. You will wish to decide whether Mr Clarke should develop this further for the White Paper.

ISSUES

Budgeting

3. The group has agreed with the importance of controlling FPS expenditure in principle, but has disagreed about how it might be achieved. Treasury Ministers have advocated merging FPCs and DHAs and cash-limiting the combined body. Mr Clarke has opposed both merger and cash limits. At the last meeting, he argued against budgets for the FPS, on the ground that there was not enough information at present to reach a proper view of the level of expenditure on drugs and hospital referrals. He implied that he might regard budgets as practical when such information was available. You concluded that most members of the group agreed that the right way to get proper control of FPS expenditure was to merge the FPCs and DHAs and set reasonable budgets for them. You also said that the White Paper would have to set out the case for making this the aim. You therefore asked Mr Clarke to prepare a note setting out his view of the timetable for getting the necessary information and basing budgets on it. The first part of HC 63 is the result.

4. Mr Clarke now proposes a system of budgets for prescribing costs, to come into effect by 1991. The group will want to decide

C

whether this system would meet its agreed objective of providing adequate control over FPS costs. You might wish to ask the following questions about it:

a. Is the scope for viring great enough? The main argument for merging FPCs and DHAs and cash limiting the combined body is that there would be scope for viring between FPS expenditure and hospital expenditure. Mr Clarke hopes to give scope for viring by fixing the drugs budgets at Regional level. But all the expenditure within the budgets is still on drugs and could be affected by, for example, an epidemic. You may wish to explore the case for bringing both drugs and non-drugs expenditure within the same budget and so allowing viring between the two.

b. Why could not the budget cover the whole of FPS expenditure? Drugs account for less than half of FPS expenditure, the remainder being mainly spent on practitioners' remuneration and expenses. You may wish to ask whether viring would be easier, and control more effective, if the whole of FPS expenditure were in the budget.

c. Would the system be effective at preventing overspends? Mr Clarke says that if outturn exceeded forecasts, in-year increases would be necessary. This defeats the object of the change. You may wish to ask about the alternatives: for instance, whether it would be possible to require Regions to establish reserves to be used in emergency. And Mr Clarke is not explicit about the exact status of the budgets for Regions and FPCs. You may wish to ask whether the budgets could be converted into cash limits, at least at Regional level.

d. What would the distributional effects of the new system be? Paragraph 3(ii) of the paper says that more work will be needed on distribution between regions before publication of the White Paper. There is not much time left for this. You may wish to ask Mr Clarke now if there could be major imbalances between areas. Would allocations be based on previous expenditure on drugs, or would there be some

evening up? (Barnet FPC is one of the lowest spenders on drugs - Appendix II of HC 47). You could also ask if any imbalances would result from setting a separate drugs budget, as Mr Clarke proposes, for each country. Would Scotland, for example, get more or less per head than England? Either would be difficult.

Since a final decision ought to be taken at this meeting, you might wish to take Mr Clarke's acceptance of indicative budgets as a starting point and concentrate on making it more effective, by for example covering more FPS expenditure and giving tighter control over overspends.

The future of FPCs

5. This is another long-standing issue for the group. In previous meetings most members have argued that DHAs and FPCs should be merged, but Mr Clarke has dissented. You have suggested that this part of the White Paper could be 'green' in character.

6. Perhaps the most important argument for the merger has been that it would allow cash limiting of the FPS and hospital services together, thus giving maximum scope for viring. Mr Clarke's arguments against have been that:

a. the real obstacle to cash limiting the FPS is our ignorance about, and lack of control over, prescribing and referral habits;

b. merger would lead to administrative reorganisation and upheaval;

c. the merged body would be dominated by the hospital side, whereas one of the main themes of the review has been to increase GPs' responsibilities and independence;

d. merger would mean reversing the separation which the Government made as recently as 1985.

e

7. You will wish to decide how far to press the case for merger. To some extent this may depend on how far you are satisfied that Mr Clarke's proposals would provide really effective control without a merger. Depending on how the discussion goes, one possibility might still be to include the merger of FPCs and DHAs as a long-term aim in the White Paper, but to make its introduction dependent on progress with the other reforms. The line might be that the more self-governing hospitals and large GP practices with their own budgets there are, the more the roles of DHAs and FPCs will anyway change; and the Government will therefore wish to keep under review the scope for merging and rationalising them in particular areas, so as to enable them to carry out effectively their responsibilities for the remaining hospitals and GPs within their control.

GP numbers

8. At the group's last meeting, Mr Clarke suggested, in HC 51, a system of statutory control, although he did not work it out in detail. The group asked him to consider the possibility of increasing the capitation element in pay so as to put downward pressure on numbers. This he has done.

9. The main decision for the group is whether the White Paper should refer to the need to control numbers and mention the possibility of increasing the capitation element in pay, or introducing statutory control over numbers, or both. The argument for direct control is that it is more certain in its operation. The arguments for controlling numbers by changing the pay basis are that:

i it is less bureaucratic;

ii it would not need primary legislation;

iii it would be less high profile, with both the public and the profession. Moves in this direction have already been proposed to the profession;

f

iv statutory control requires a choice between various options (set out in HC 51) which there may not in practice be time to consider before publication.

Mr Clarke now says that there is no substance in the earlier objection seen to raising the capitation element in pay, that the Review Body would take offsetting action.

10. If the group does decide that the White Paper should mention an increase in the capitation element, you will want to consider whether it should give a figure for the new proportion and, if so, what it should be. The Department of Health have already proposed an increase to 'over 50%', but the table in paragraph 17 shows a figure of 60%. You will wish to ask what Mr Clarke has in mind, and consider whether 60% is sufficiently ambitious.

GP practice budgets: incentives

11. At the group's last meeting, Mr Clarke was asked to examine the possibility of giving GPs more incentive to opt into the practice budget scheme. The last part of HC 63 is designed to fulfil this remit. It makes no new proposals, but refers to the possibility of performance-related additions to pay. It says the detail of these still has to be worked up. Performance-related pay for GPs has obvious attraction but, as the paper says, it would be important to ensure that the additions were not seen as increasing GPs' pay at the expense of services to patients. One possibility would be to ask Mr Clarke to include his proposals in the White Paper, when he has worked them up, so that the Group may see what the overall package looks like.

R T J WILSON
Cabinet Office
13 December 1988