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PAPER 4

MANAGING THE FPS: OUTSTANDING ISSUES

One of the main aims of the NHS Review is to devolve responsibility and accountability down the line so that resources will benefit patients in the most cost-effective way. The quality of service will improve as doctors compete. Money will then follow the movement of patients.

The papers sometimes lose touch with this theme. There is a tendency to haul in the reigns and centralize power and controls. Any improvement in performance at the operating level is then compensated by marginal cash payments (top-slicing) or no payment at all. Kenneth Clarke's paper on managing the FPS suffers from the same problem.

Budgeting and Organisation

Para 2-6 Three important points still need clarification.

First, the paper does not specify how resources will be allocated to FPCs for drug expenditure. Any new system of allocation should be as simple as possible and coherent. This paper is neither. We will need to be quite clear as to whether cash will be allocated on a weighted capitation basis, or on an unweighted capitation basis or on a baseline of this year's actual expenditure.

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Second, the levers for controlling over-prescribing are not clear. The paper proposes two main driving forces:

(1) FPCs would be able to retain a proportion of any savings to finance primary care initiatives in their area (Para 3iii);

(2) FPCs would impose financial penalties where GPs persisted in over prescribing (Para 3 iv).

There is a real risk that these initiatives could lead to a major confrontation with the profession without ever achieving any comensurate benefits. Presumably, point (2) would only come into play if GPs prescribe at a rate well above the average for the area (say 25% above). A DoH contact estimates that this strong arm tactic will apply to 1,000 GPs. But the impact on the remaining 26,000 or so GPs is unclear.

Kenneth Clarke will need to spell out precisely how point (1) will work in practice. Will GPs be paid a performance bonus depending upon cost savings and quality of service? Or will the money be spent on health promotion in the area?

Third, a key point is made in Paragraph 6 - "we shall need to invest in the management as well as information capacity to make it work". But we should be careful not to set in motion another centralised Resource Management Initiative (RMI). One of the main reasons why the RMI has been expensive and time-consuming is that it has been handled as an 'information technology' problem only.

> A well known case study at Harvard Business School compares two giants of industry - Mitsubishi of Japan and IBM. Mitsubishi central management requires a minimal periodic report on the operations of its subsidiaries. Yet subsidiaries are given freedom to

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innovate locally. Operations tend to adapt to local conditions and management excel in this free enterprise environment. On the other hand IBM tends to be rather complacent. New recruits are seeped in the IBM culture and taught standardized business practices. Administrators thrive in this environment while innovators are subdued. The IBM monolith is losing its momentum. Do we really want a top heavy system like IBM?

The main role of the centre should be to set overall targets, allocate resources and monitor performance - with as few performance indicators as possible. FPCs (or DHAs, if FPCs are merged with them) should be given the freedom to appoint good local managers. Systems should be developed locally - or bought from other districts or outside firms. The development of information systems should not be subject to heavy-handed circulars from the Department of Health.

Questions:
- How will the drugs budget be allocated to Regions and to FPCs and to GPs?
- How will the FPCs spend any savings generated by GPs?
- Will FPCs be given local freedom to develop their information systems with limited guidance from the centre?

Para 7-10

There is little justification for keeping DHAs and FPCs apart:

- The NHS Management Board will now become responsible both for primary and secondary care. Currently reporting lines meet at the Secretary of State level only.

- The introduction of GP budgets will also strengthen the links between the two sectors.

- In the new organisation, DHAs will become more like FPCs - buying services under contract.

Yet Ken Clarke insists on retaining - and strengthening - FPCs for the time being. I can see two possible reasons only for keeping the status quo, but one is illusory and the other depends on the outcome of the Griffiths report on community care.

1. In the past, districts and regions have not understood the ethos of the independant contractor. But for the reason stated above, this attitude will have to change.

2. Ken Clarke has yet to present a paper on community care. If the Griffiths report is accepted - with greater controls over local authorities - DHAs and FPCs should be merged. If the Department of Health takes over responsibility for community care, the merger should be reassessed.

Question Why not merge FPCs and DHAs?

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GP Numbers

Three points of clarification are required on this section.

First, Paragraph 13 states that GPs received an average income of £55,000 in 1987/88. But it should be made clear that the average target net income after expenses is approximately £28,000, a much lower figure.

Second, Paragraph 21 suggests that an increase in the qualification for the Basic Practice Allowance (BPA) would tend to depress the size of practices. This is not true. It may reduce the numbers of GPs in a practice which has below-average list sizes. Surely, this is an effective way of controlling GP numbers without the additional need for bureaucratic direct manpower controls.

Third, Ken Clarke has not suggested his preferred option in this paper.

Question: Why not move towards a pure capitation basis over a 2 to 3 year period?

GP Practice Budgets: Incentives

This section now includes a proposal for giving GPs a personal incentive for managing a budget for elective surgery. This is most welcome. But the proposals are still vague and confusing.

Doctors are also unimpressed. I have heard that the Powys experiment is failing at the starting gate. GPs in the area have voted not to manage their budget on an experimental basis. Apparently, the benefits are not sufficient to

outweigh the increased responsibility and risk.
Paragraph 24(ii) states that GPs will be able "to generate funds to improve their practice by viring within the scope of the budget, for example by employing more staff or improving practice premises." This is an indirect boost to income. But the edges seem very blurred.

I believe that we should treat the GP budget like a 'client account' in a firm of solicitors. The bank balance would be segregated from other GP practice money. Expenditure could be incurred by the GP practice as follows:

(1) Up to, say, £5,000 towards the cost of managing the budget.

(2) Payment for elective surgery from DHA-run hospitals, self-governing hospitals or the private sector.

(3) Payments for minor surgery carried out in the GP practice.

(4) A performance bonus would be paid to each GP in the practice as in Para 27. This could be retained personally or invested in the practice for the future.

(5) Savings would be retained as a reserve for future years.

Ken Clarke will need to state - step-by-step - how he proposes to let GPs use the budget for elective surgery, along the above lines.

Question Will the incentives be sufficient?

What was the main problem in Powys?

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Other matters

In an earlier paper on GP practice budgets (HC 40), Sir Roy Griffiths suggested that we should be ready to extend the scope of the scheme to cover areas of hospital expenditure like accident and emergency work if GPs so wish. Unfortunately, this suggestion proceeded no further. But we should take a final look at this issue for two main reasons:

(1) There is a danger that GP budgets for large practices will have a marginal impact. If budgets are available for large practices and applications of small practices, this reform is likely to involve up to a maximum of 10% of GPs in the early years. If elective surgery accounts for 25% of the hospital budget, this change will effect 25% x 10% = 2.5% of hospital expenditure.

(2) There are many foggy boundaries between elective surgery and accident and emergency services.

Question Why not include accident and emergency services in the budget? (Separating the two budgets will be extremely complex.)

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