Prime Minister

NHS REVIEW

As you know, I shall be unable to attend Friday's meeting of the Ministerial Group; but there are a few points which I should like to register on the papers that have been circulated.

Pay and Conditions of Staff

I agree that there are considerable risks in giving local employers freedom to set or negotiate their own conditions of service - indeed one of the main purposes of the present arrangements is to prevent leapfrogging settlements. The present arrangements are an impediment to change and they have delivered centrally negotiated agreements which are unsuited to local management arrangements. They also permit unions to appeal outwith their employing authorities against the local application of national agreements. I therefore look forward to seeing the results of the further work which Kenneth Clarke has in hand; and my officials are ready to contribute to any detailed discussions.

At this stage I would simply flag up for consideration the possibility of removing nursing auxiliaries from the remit of the Nurses Pay Review Body. Much of the industrial unrest over regrading has stemmed from auxiliaries (supported by COHSE and NUPE) yet their pay has increased substantially relative to other unskilled staff such as ancillaries. Their action is portrayed in the media as being undertaken by "nurses" when this is not strictly the case; nor are there problems in recruiting auxiliaries which require their pay levels to receive the same consideration as pay for qualified staff. I understand that the RCN may decide next year to offer auxiliaries membership. We should therefore review the current position quickly and assess whether the benefits of this change outweigh the likely difficulties in the way of delivering it.

I agree Kenneth Clarke's specific point on the freedom to negotiate pay and conditions which should be offered to self governing hospitals.

Access to Private Capital

I welcome the clear statement in this paper of the extent to which existing rules permit a range of joint ventures between the NHS and the private sector and the commitment to explore ways of extending them to permit other worthwhile ventures.

Managing the Family Practitioner Service

Kenneth Clarke's paper proposes non-cash limited drug budgets for each country disaggregated for regions and FPCs, and subsequently into indicative budgets for each practice. Presumably, the normal formula arrangements would apply and I would have discretion to set the drug budget for Scotland within my block subject to subsequent estimates scrutiny in the usual way. Subject to that, and to working out the details and to consultations with the profession (which I am sure will be necessary) I think this scheme could be applied in Scotland. It would be a year later, however, before the necessary information systems could be in place. It would be necessary for my Department to combine the roles envisaged for the Department of Health and regional health authorities and that will carry running cost implications. The Health Boards already fulfil the role which Kenneth envisages for FPCs in England in relation to excessive prescribing; in the Scottish chapter of the White Paper I intend to float the idea that in future Area Medical Committees will have a more consultative role in relation to these investigations instead of acting as the Health Boards' agents as at present.

Paragraph 16 of HC63 identifies two changes currently being discussed with the medical profession in the negotiations flowing from the Primary care White Paper. The second change proposes that the qualification for the full Basic Practice Allowance (BPA) should rise from 1000 to 1500 patients. My officials have already pointed out that, at 1 October 1986, 29% of the total number of unrestricted principals in Scotland had a list size of between 1000 and 1500. Scottish GPs would, therefore, be particularly affected by this proposed change. Furthermore, although many of these GPs are in urban areas, where there may be scope for the GP to increase the number of his patients, about 450 GPs are in rural or semi-rural areas where the scope for such an increase is limited - if it exists at all. This factor has to be borne in mind in considering the overall effect of the interrelating factors which bear upon the structure of the proposed new remuneration package.

The first change is that capitation fees should be increased, as a proportion of fees and allowances, to over 50% - and might rise to as much as 60%. This also presents particular problems for me. The Scottish Medical Practices Committee is statutorily responsible for ensuring that the number of medical practitioners undertaking to provide general medical services in the areas of different Health Boards is adequate. If it decides that a practice is essential, then a doctor must be located in that particular area. If the income which the doctor can obtain is too low because of the current level of percentage of income attributable to capitation fees and the small number of patients available, the practice is identified as an "Inducement Practice". There are about 80 Inducement Practices in Scotland but, I understand, only about 3 in England.

As paragraph 19 of HC63 indicates, the Review Body each year recommends an intended average net income and average expenses, both to be reimbursed through fees and allowances. All Inducement Practitioners have their incomes brought up to an average net income determined by the Review Body on the basis of the evidence which it collects. If we were to decide that capitation fees are to form a greater proportion of income and that the Review Body must set fees and allowances accordingly, Inducement Practitioners, because of the sparsity of the population in their areas, might only be able to earn an income which is significantly below that of their urban counterparts.

While there is at present no numerical shortage of general medical practitioners willing to work in rural, sparsely populated areas, this is probably because such practitioners currently have a guaranteed level of income. If the rules are altered, the position might change rapidly with only less well qualified doctors applying for rural practices. I have no doubt that I would be open to criticism if proper account is not taken of such peculiarly Scottish circumstances; and it will be necessary to consider some means of safeguarding the position of those GPs who provide general medical services in sparsely populated areas.

On GP practice budgets, I propose to indicate in the Scottish chapter of the White Paper that we plan to introduce about 10 demonstration projects in Scotland along the lines discussed in the main chapter on this subject.

This number reflects the fact that list sizes in Scotland are generally smaller. I would not favour going beyond the indirect incentives we have already identified by adopting the personal financial inducements suggested in Kenneth's paper: the accusations summarised in paragraph 26 of his paper might be difficult to rebut.

Draft White Paper

I have already expressed a preference for a separate Scottish chapter in the White Paper; but I think that we should collectively reserve judgement on this point until we have an opportunity to consider the material from all three territorial Departments together. I have no particular drafting points to offer on the first three chapters, though clearly there are a number of differences of emphasis which will have to be picked up in the Scottish contribution.

I am copying this minute to Nigel Lawson, Peter Walker, Tom King, Kenneth Clarke, John Major, David Mellor, Sir Roy Griffiths, Sir Robin Butler and Ian Whitehead (Policy Unit).

MR

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15 December 1988