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PRIME MINISTER 8 February 1989

NHS REVIEW: DETAILED WORKING PAPERS

Ken Clarke plans to publish the eight detailed working papers shortly. But no date has been fixed.

The papers are good workmanlike documents, albeit turgid. They accurately reflect the proposals in the White Paper and they follow the more detailed conclusions of the ministerial group, with one notable exception.

My main concern lies with the determination of GP practice budgets. The working papers set out a far more complex and bureaucratic system than was proposed in the White Paper. The spirit of the policy is in danger of being thwarted by the letter of implementation.

What problems would emerge?

First, the proposed system is far too discretionary. In practice, budgets will probably be based on the previous years' actual expenditure. Inefficient GPs will benefit from this allocation. And efficient GPs will see no advantage in applying for a budget.

Second, the system will be far too complex for many GPs to understand. And the lack of clarity will deter candidates.

Third, a large bureacracy will build up in the RHAs. Endless discussions will emerge between the RHA, FPCs and the GPs.

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What did we agree in the White Paper?

Para 6.7 of the White Paper states the following:

> "Each practice's share will be based on the number of patients on its list, weighted for the same population characteristics as are proposed in chapter 4 for allocations to Districts. There are social and other local features which affect the use of hospital services, and these too will be reflected in the budget."

Proposed mechanism for allocation (See Appendix)

The working papers propose the following mechanism for determining GP budgets:

First, the RHA will determine the 'Target Share' of a GP practice. This calculation will depend on the expected cost of hospital services by age, age profile of the practice, morbidity rates and mortality rates.

Second, the Target Share will then be compared with the practice's actual usage and cost of relevant hospital services in the most recent year ('Actual Usage').

Third, the RHA will determine the extent to which the patients in a GP practice use the private health sector.

Fourth, the RHA will then set the actual budget by balancing the above factors.

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CONCLUSION

Ken Clarke should be asked to simplify the budgetary process. As an absolute minimum, the budget should not depend on the previous year's actual expenditure. At best, it should equate to a simplified version of the so-called 'Target Share'.

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4.5 The starting point for setting the ~~particular~~ practice budget will be the basic allocations to those DHAs from whom the practice list is drawn:

(a) Regions will estimate the target share of the practice of the relevant Regional cash limit. This will be built up as follows:

- estimate the expected cost of the relevant hospital service by age band using activity data drawn from patient activity statistics and surveys such as the National Morbidity Survey in General Practice and information on the unit cost of services.

- these estimates would be weighted to reflect variations between Districts in the health of the local population (probably using Standardised Mortality Ratios as proxies).

- the resulting age specific (morbidity weighted) per capita cost estimates would be applied to age profile and size of the practice list to derive an estimate of the target share of the practice of the relevant Regional cash limit (excluding contingency reserves - see paragraph [ ]).

(b) Target shares will be compared with the practices' usage and cost of relevant hospital services in the most recent year available. In early years, while information systems are under development, RHAs will draw on information from Korner systems, from individual hospital departments like Pathology and Radiology, and from the practices themselves. The actual budget for the practice in respect of hospital services will take both into account. The extent to which the actual budget is above or below the target share will be determined by reference to any additional social and local factors - for example, the propensity of patients to use the private hospital sector rather than the NHS, the prevalence of elderly single adult households

lacking the support of informal carers - compared with the norms for the District. Budgets will not underwrite high rates of hospital use for which there is no demonstrable cause. Both Regions and GP practices will have the available information in a common form.