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PRIME MINISTER 15 February 1989

NHS REVIEW: DETAILED WORKING PAPERS

Fudging the Budget

Kenneth Clarke has redrafted the paragraph on GP budget setting (attached - para 4.5). It is shorter but the approach is much the same. It fails to address the potential for a huge bureaucracy at regional level.

What is being proposed?

The Regions will determine two amounts for each practice:

- a target budget for the practice, based on age-weighted capitation;

- actual expenditure for the previous year.

The RHA will then have the discretion to set the actual budget 'at a point between the two, taking account of local and social factors'.

The target budget and local factors are essential ingredients.

But why the need for actual expenditure?

Kenneth Clarke wants to encourage the inefficient GPs to participate in the practice budget. Over time, the Regions would then 'ratchet-down' the expenditure of the inefficient GPs. Also, he wants to avoid giving highly efficient GPs a sudden windfall. Efficient GPs would receive a budget slightly above their existing level of expenditure but somewhat

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below the target level.

but para 6.9 added "There are social and other local features which affect the use of hospital services, and these too will be reflected in the budget".

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Why is this a problem?

We are moving away from one of the main principles of the Review, explicitly stated in the White Paper:

> **'The size of each practice's budget will depend primarily on the number of patients on the practice's list' (Para 6.4).**

While accepting that we must account for special local features - such as high morbidity rates - there is no justification for referring to actual levels of expenditure in the working papers.

Other incentives could be offered separately to inefficient GPs without breaking the main principles of the Review.

Proposed redraft of Para 4.5

'Each practice's share will be based on the number of patients on its list, weighted for the age and sex of its patients, adjusted by social and other local features which affect the use of hospital services in the area. The budget will be determined by using the District's capitation rates, adjusted for the specific needs of the local community. Budgets will not, however, underwrite high referral rates for which there is no demonstrable cause'.

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SECTION 4: SETTING OF BUDGETS

4.1 Regions will have responsibility for allocations: to DHAs in respect of hospital and community services, to FPCs for expenditure on drugs and other primary care services; and to GP practice budgets. This will ensure that the allocation of funds to DHAs, FPCs and GPs are based on consistent principles and that no problem arises when patients registered with a practice are drawn from more than one district.

4.2 GP practices within the scheme will receive their budgets direct from the relevant RHA. Where patients are drawn from more than one Region, the Region within which the practice is located will take lead responsibility, negotiating an appropriate financial contribution from the other(s). The FPC will continue to hold the GPs' contracts and be responsible for monitoring expenditure against the budget. The Government expects FPCs to work closely with RHAs in agreeing budgets with participating practices. The Government recognises that GPs may need to look to other disciplines for skills associated with managing and controlling budgets. Accordingly, each practice's budget would include a fee set at a level which recognises the management and other costs associated with participation. The Government will discuss with the profession the size of the fee.

4.3 It is the Government's intention to move towards a weighted capitation approach to setting budgets in line with that proposed for RHAs and DHAs. Initially, however, budget setting will need to have regard to the different expenditure components contributing to the total budget. In addition, the overriding principle that budgets must sensitively reflect at the practice level the requirements of patients, for hospital and primary care services, of necessity points towards more detailed assessments than might be justified at DHA or RHA level. Once the practice budget scheme is bedded down, however, a simpler approach is anticipated.

Hospital services

4.4 Budgets must reflect the relative needs of patients for specific hospital services. The NHS Management Executive will discuss with the profession the factors, other than size of list,

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that need to be taken into account when agreeing the budget component in respect of hospital and community health services and the relative weights to be attached to them.

4.5 The approach to determining the hospital services component of the practice budget will be a comparison of the costs of the relevent services provided as a result of the practice's referral pattern in the previous year with the average for the District(s) taking account of the number, age, sex and health of the practice's patients. The actual budget will be set at a point between the two taking account of local and social factors. Budgets will not, however, underwrite high referral rates for which there is no demonstrable cause. Both Regions and GP practices will have access to the available information on the costs and use of services by practices.

Directly reimbursed expenses

4.6 Budgets will be based initially on the existing amounts the practice receives as directly reimbursed expenses in respect of practice staff and premises (cost-rent and improvement grants - paragraph 3.9), together with a pro-rata addition out of the additional cash allocated to the FPC in future for these purposes.

4.7 GPs currently receive direct payments for the cost of rent and rates. Where the GP is an owner occupier he would receive 'notional' rent based on the District Valuers' assessment of current market rents. GPs may also receive payments under the cost-rent scheme and improvement grants where they improve premises, including building new ones. These payments would be in place of notional rents. Over time, payments under the cost-rent scheme decline in real terms and become lower than notional rent. At this point, GPs may opt to receive notional rent instead of cost-rent. When a participating practice whose budget was initially based on cost-rent

payment opts for notional rent, budgets will be reduced to reflect the cessation of cost-rent payments. Notional rent will become payable separately by the FPC, as now.

Drugs

4.8 Working Paper 4 outlines the Government's proposals on indicative prescribing drug budgets for the generality of practices. It is proposed that indicative budgets be based on the Net Ingredient Cost (NIC) of prescriptions (basic list price). For GPs participating in the Practice Budget Scheme, the prescribing costs element of their global budgets will be found from within the overall drug budgets for RHAs. ~~The setting of drug budgets requires particularly careful analysis.~~ The drug component of practice budgets allocated by Regions will be in accordance with the principles outlined for indicative budgets.

4.9 FPCs will continue to be responsible for reimbursing pharmacists in respect of drugs dispensed. FPCs will need to invoice participating practices in respect of drugs prescribed by the practice and dispensed by retail pharmacists. Where the practice dispenses drugs for some patients, the costs of drugs will fall as a direct charge against the practice budget. When agreeing budgets, RHAs will need to take account of the average discounts received by dispensing doctors on the price of drugs purchased. Dispensing practice also incur VAT in respect of the cost of drugs dispensed and which is included in the costs currently reimbursed by FPCs to dispensing doctors. The drug component of practice budgets will need, therefore, also to include an allowance for VAT where appropriate.