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DEPARTMENT OF HEALTH AND SOCIAL SECURITY
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From the Secretary of State for ~~Social Services~~ Health

Prime Minister
To note
AT 23/6

Andrew Turnbull Esq
Principal Private Secretary
10 Downing Street
LONDON SW1

22 June 1989

Dear Andrew

At today's Cabinet meeting, my Secretary of State undertook to circulate details of and a line to take on recently publicised research on variations in general practice services.

The researchers found that there were differences in the standard of GP service between deprived and affluent areas with the latter having more innovative practices offering a wider range of services. The researchers concluded that the new GP contract would make the position worse. The Secretary of State considers the conclusion drawn to be perverse. The research demonstrates the inadequacies of the existing contract which has few incentives for doctors to provide a better service. The new contract does provide incentives and should stimulate poor doctors to work harder and improve services.

A copy of the statement issued by the Secretary of State to the press and a summary of the research is attached.

I am copying this letter and enclosures to the private secretaries to Cabinet Ministers and to Trevor Woolley.

Yours

Andy

A J McKEON
Principal Private Secretary

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STATEMENT BY THE SECRETARY OF STATE FOR HEALTH

Two York University economists yesterday published a report on GP's services entitled "Family Doctors and Economic Incentives" which in my opinion made an excellent case in favour of the Government's NHS reforms and the new contract for paying GPs. Their survey showed that there were wide gaps between the best and the worst services offered by family doctors. GPs in affluent areas tended to be more innovative and to offer a wider range of services than those in inner cities and industrial areas. Under our existing arrangements until now, the quality of care received by patients tends to depend on where the patient happens to live.

The Government's NHS reforms aim to bring the standards of all the NHS up to the level of the best. The new GP contract offers new incentives to GPs to introduce services and to achieve performance targets.

Nicholas Bosanquet, a persistent critic of the Government, tried in my opinion to draw quite perverse conclusions from his own research. He assumed that good doctors will get better and be paid more and bad doctors will get worse and be paid less under a performance based contract. In my opinion good doctors will be more fairly rewarded and others will be encouraged to work harder and improve their services.

Professor Bosanquet and Dr Leese's work shows the failure of the old GP contract to stimulate good quality services for all patients. The new contract will tackle the problems that he describes.

The main task of family doctors is to give medical help to their patients. At the same time they have to be 'businessmen', as their ability to attract and use resources inevitably affects the help they can provide. How do they do this? What factors influence their financial decisions?

Research carried out by Nick Bosanquet and Brenda Leese of the Centre for Health Economics at York has looked at the economics of general practice. The research, which was funded by the Health Promotion Research Trust, has focused specifically on the 'business' decisions which doctors face in running their practices and on how they react to incentives. The principal incentives considered in this research are higher professional standing and financial payments both to improve the facilities they can offer their patients and to maintain and improve their own standards of living. The following conclusions have been drawn from the work which has been carried out against the background of contemporary moves towards restructuring the system of primary health care.

- At present, forward-looking, 'innovative'[1], practices are uncommon in less affluent areas; this situation is likely to persist. Allowances proposed under the current NHS review will probably be insufficient to stimulate changes as list sizes continue to fall for demographic reasons.

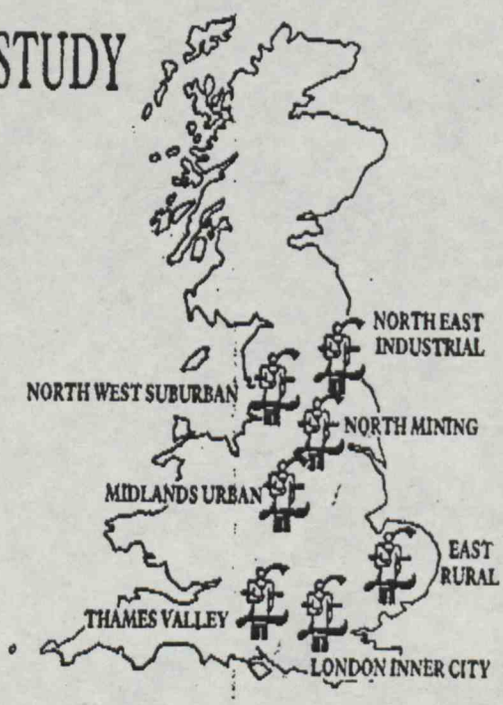
BACKGROUND TO THE STUDY

The National Health Service has its roots in the panel system, under which many workers were insured and did not pay for visits to family doctors at the time of consultation; however, the majority of the population, including the dependents of insured workers, did pay for attention as it was received. The National Health Service was introduced in 1948 and in its first years the payment system and practice arrangements were carried over from the days of the panels. But many more patients went to their doctors under the NHS – the whole population was now effectively insured. Real changes in the financing of family doctors did not come about until the Family Doctor Charter was negotiated in 1965. At this point, doctors' incomes were stabilised and new policies were introduced for investment in premises, and for encouraging the employment of ancillary staff and vocational training. As a result of the Family Doctor Charter there are three segments to the payment system for general practitioners:

- Flat rate practice and other allowances (45%)
- Capitation payments (45%)
- Fees for services, such as immunization, cervical cytology and family planning (10%)

The current proposals, the details of which are still under negotiation, are for a performance-related contract. There would be capitation fees of about 60% of total pay, and competition for patients would be encouraged. The special needs of deprived areas, where there are higher workloads, would be recognised by the payment of a special allowance.

THE STUDY



Professor Bosanquet and Dr Leese have considered three groups of factors which are likely to influence decisions about practice strategy, and in particular, whether the practices are innovative.

- The personal characteristics of the partners – are they young or old, are they members of professional organisations, are their ethnic origins of significance?
- The payments system – are there incentives to increase the sizes of partnerships, or to employ nurses, secretaries, practice managers, and to install computers and use other modern technology?
- The environment – pressures from the local community or 'market' affect other businesses; they are also relevant to practitioner practices.

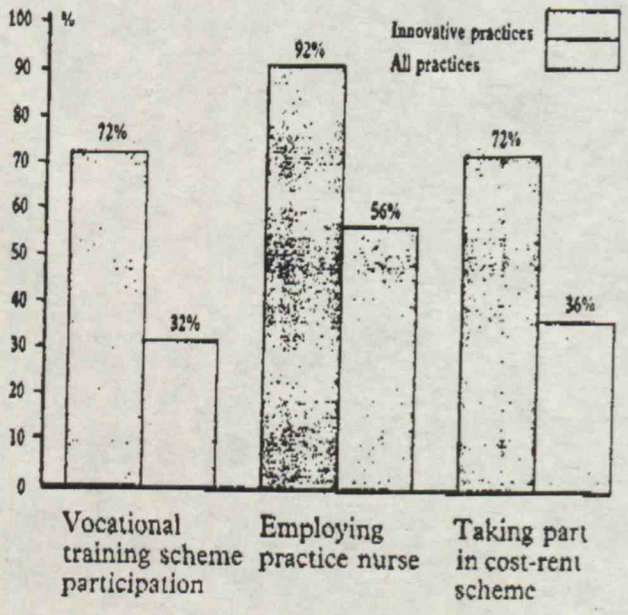
The survey was carried out by interviewing one partner in each of 260 practices in seven areas of England. The approximate locations are shown on the map, and were carefully chosen to include a wide cross representation of geographical and economic areas throughout the country.

- Competition will lead to greater variability in activity within any particular geographical area; those practices with many elderly and less mobile patients may not have the funds and confidence to develop new sevices, and are likely to be struggling practices.
- Policy decisions must be taken about the numbers of family doctors that will be needed in the future.
- There is a need to encourage mergers among practices, since larger practices tend to be more efficient and to provide a wider range of services.
- Practices in deprived areas of the community will find it difficult to improve their standard of care.

THE RESULTS

- Many practices include Asian doctors; they were partners in 60% of practices in the North Mining Area, but in only 3% of those in the East Rural Area. Asian partners were likely to have lower incomes and be in non-innovative practices. Currently, they are less willing or less able to invest, and have a higher chance of location in poorer inner city areas.
- A number of practice management decisions are linked. Innovative practices were more likely to employ practice managers and practice nurses, to use computers and to take part in vocational training schemes and in the cost rent scheme. Figure 1 summarises some of the main results of the survey in these matters. Innovative practices are likely to provide better services for their patients – appointment systems and mother and baby clinics, for example.

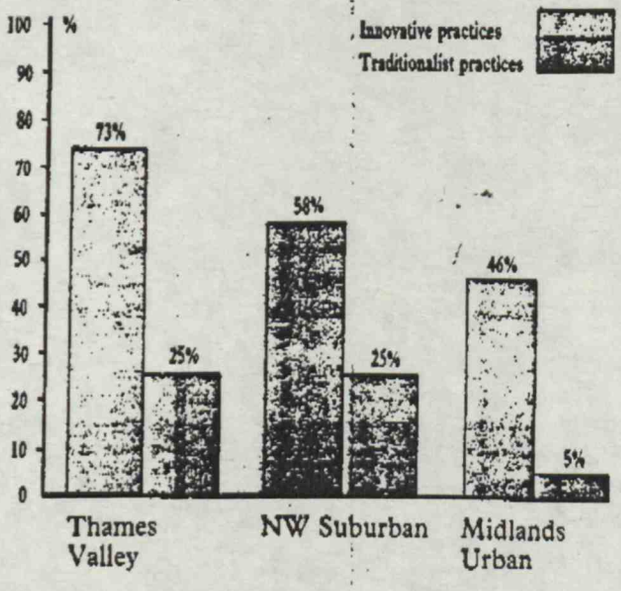
FIGURE 1: Characteristics of innovative practices in comparison to all practices



- Professional incentives are just as important as financial ones. The government is underestimating the possible advantages to be gained from some of these, such as the vocational training scheme; professional programme building, based on local networks, as well as financial incentives, would encourage change for the better in general practice. The government should therefore sponsor a substantial increase in in-service training for family doctors.
- Early retirement should be encouraged for some family doctors.

1. For the purposes of this study, an innovative practice is one in which the doctors have taken interrelated decisions to invest in premises, employ nursing staff and take part in the vocational training scheme. They are also more likely to employ practice managers and receptionists, to run an appointment system for their surgeries and to hold clinics for special groups of patients.

FIGURE 2: Proportion of practices experiencing a population rise in their local area, by practice type and survey region



- Innovative practices are likely to have experienced a rise in population in the area that they serve (see Figure 2). The most striking example of the effects of population change and local social environment was within the Thames Valley area, where there were no innovators out of nine practices in the urban section, but in the more affluent suburban section 48% of practices were innovative.
- Although there were differences in membership of the BMA between areas, variations in membership of the Royal College of General Practitioners were more clearly related to practice strategy; among the innovative practices, 47% of those in the London Inner City Area, 63% of those in the North East Industrial Area and 57% of those in the North Mining Area had at least one partner who was a member of the Royal College of General Practitioners.

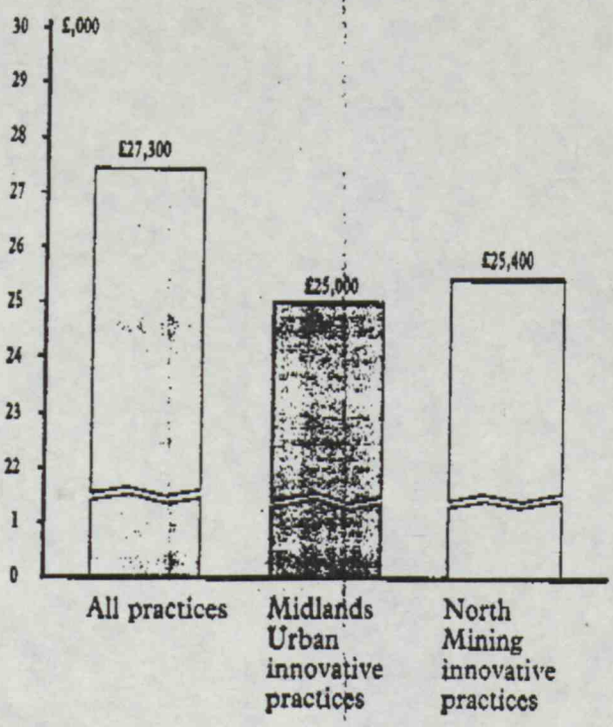
- The local environment has strong and complex effects on the practices, particularly on the sizes of practices and on the strategies followed. Large practices, which are more likely to be innovative, were more common in affluent areas; but in such areas small practices were also more likely to be innovative.

- Among small practices, those with young partners were more innovative; in larger practices, which are now becoming more common, the quality of care is independent of the age of the individual partners.

- The current payments system provides incentives towards increasing the size of the partnership. Typical costs of two-partner practices were 46% of gross income, and the net income of each partner was £21,000; costs of five-partner practices were 33% of gross income, with a net income per partner of £27,000.

- The returns from innovation are favourable in terms of net incomes for the participating doctors in affluent areas. In other areas, however, the doctors' incomes are considerably lower than those in the more affluent parts of the country (see Figure 3).

FIGURE 3: Average net incomes for innovative practices in the less affluent areas in comparison to the average net income fot all practices



The full report of this research, entitled 'Family Doctors and Economic Incentives' by N Bosanquet and B Leese, is published by the Dartmouth Publishing Company (£19.50, hardback, 158pp, ISBN 1 85521 009 6). To obtain a copy please complete the attached order form and return with your payment to Dartmouth Publishing Company Ltd, Gower House, Croft Road, Aldershot, Hants GU11 3HR.
Cheques should be made payable to Wildwood House Distribution Services.

Please send me _____ copies of 'Family Doctors and Economic Incentives'. I enclose a cheque/postal order for £ _____ (£19.50 per copy plus £2.50 post and packing).

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