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DEPARTMENT OF HEALTH

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Harriet Harman MP
House of Commons
London
SW1

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 01 210 5155
From the Secretary of
State for Health

19 March 1990

Dear Harriet,

will request if required

NHS and Community Care Bill

I have seen a copy of your letter of 27 February to Local Medical Committees. I have to say that the letter contains several inaccuracies and misleading statements, bordering on the mischievous. I would like to put the record straight.

Indicative Prescribing Budgets and GP Practice Funds

We have repeatedly made clear that budgets for drugs will not operate as cash limits at any level and that the management arrangements proposed for operating the indicative prescribing budget scheme will not infringe in any way the right of a general practitioner to prescribe all those medicines which individual patients might need. This has always been Government policy and the proposals in the NHS and Community Care Bill are fully consistent with these assurances.

Similarly, we have no intention of cash-limiting at practice level the funds available to practice fund-holders. The level of individual practice funds will be set to take account of factors such as the age and sex composition of the practice list, previous hospital treatment and prescribing patterns, the number of chronically sick and disabled people and other potentially "high cost" patients. This will give the maximum guarantee that the fund is set at a level to meet the needs of all the patients on the practice list.

If, during the year, practices consider that their budget is likely to be insufficient because of, for example, an influx of patients to the practice or an increase in patients requiring expensive drugs they will discuss this with their Family Health Service Authority and, if necessary, their budget can be increased. Contingency reserves will be held by Regional Health Authorities for this purpose. No patients will be refused the treatment which they need because a fund-holding practice has run out of money.

NHS Trusts

Your comments about NHS Trusts are misleading on two counts. First, NHS Trusts will not "opt out of the local health service" as you suggest. They will remain firmly a part of the NHS but will take over responsibility for their own management from DHAs. Secondly, you suggest local people will have no say in the establishment of NHS Trusts. This is simply not so. We made clear in "Self-Governing Hospitals: An Initial Guide" that we expect all applications for Trust status to be subject to proper consultation, and that we expect the RHA to undertake such consultation. We have also indicated that such consultation will cover a wide range of interests: the local community, the Health Authority, the CHC, local GPs and, of course, the staff of the potential Trust. I do not believe ballots are the right way to proceed in this area. Applications for Trust status will include complex and detailed proposals on service, management and personnel matters. These cannot be reduced sensibly to a few simple words to form the basis of a ballot.

GPs' Choice Over Referrals

You cast doubt on the choice of hospitals that will be available to GPs. In fact I should emphasise they will as now have considerable say as to where patients are referred for treatment under the new contracts system. Indeed for the first time, District Health Authorities will need to work closely alongside local GPs in considering where to place contracts for health services and on the type of services to be provided. The object is to secure the referral patterns which local GPs wish to see put in place unless there are compelling reasons for not doing so.

There will always be occasions when GPs for good professional reasons will want to refer patients to hospitals with which no contract has been placed. We want to make sure that they can readily do so. The DHA will maintain a contingency reserve for this. GPs will therefore be able to make the referrals

they judge best for their patients in the confidence that the cost will be met. A DHA will not be expected to challenge a GP's choice of provider unless it can be shown that the referral is wholly unjustified on clinical grounds, or where an alternative referral would be equally effective for the patient, taking into account the patient's wishes.

Access to Local Health Care

Your comments about access to local health care ignore two important aspects of our proposals and are a good example of the tactics you have employed on this Bill. You have raised straw men and then knocked them down claiming triumphantly that your worst fears have been confirmed. Your prime error is to confuse the new role of the District with that of the unit. It will be the responsibility of District Health Authorities to assess the health needs of their resident populations and to commission a comprehensive range of high quality, value for money services to meet these needs. Access is one of the main factors Districts will need to take into account when they commission services. Many services will need to be provided locally for clinical reasons or for the convenience of patients and their families. The term "core" or "designated" service is not intended to reflect its quality or importance within the full range of NHS services. It simply relates to the service obligation which a District will place on an NHS Trust because the service needs to be provided locally and the NHS Trust is the only unit that can sensibly provide it.

Secondly, you refer to patients being forced to travel for treatment. This is a nonsense. No one is going to force patients to do anything against their wishes. What we do want - and our proposals will secure - is for patients to have the option of obtaining the best care available regardless of administrative boundaries. There is ample evidence that patients want to travel if it secures for them earlier or better treatment. We want to make sure the money is available to the host hospital to make sure that can happen.

I have copied this letter to all MPs and to FPC Chairmen and Local Medical Committees.

KENNETH CLARKE