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Prime Minister

Agree conclusions (page 10)?

DWB 8/6

PRIME MINISTER

Yes mt

8 June 1984

THE NATIONAL HEALTH SERVICE: FAMILY PRACTITIONERS

The NHS is popular. There is no question of mounting a head-on assault against it. Yet the Health Service is still widely believed to be suffering the death of a thousand cuts. This is untrue, and Ministers rebut the charge by showing the increase in the real volume of spending on the Health Service since 1979. But this is a funny sort of defence in a world of cash planning and cost-effectiveness. It concedes too much ground to the Government's critics - that the sole test of care and concern is the real volume of resources made available to a Department.

A more imaginative approach is needed. This would focus not on real volumes of expenditure, but on improving the efficiency and quality of patient care. The right pattern of economic incentives to strengthen the hand of the consumer of health services could also reduce costs.

The implementation of Griffiths is the best way forward for the hospital service. But there has been much less progress on the Family Practitioner Service. The forthcoming Green Paper provids an opportunity to float some radical options. It should not just be another boring account of how more

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real resources are required to meet greater demands on them, and how the Treasury should stump up the money.

Family Practitioner Service

There is a growing body of evidence that the Family Practitioner Service is expensive and inefficient:

- Last year's Binder Hamlyn Report showed that the size of the Family Practitioner Service was not determined by consumer demand or need, but by the supply of doctors coming off the medical school production line.

- Recent research in Manchester suggests that 47 per cent of all GPs in the area spend less than 20 hours a week actually in patient care. It also suggests that different patient list sizes in the 1,500-2,500 range do not appear to correlate with the quality of patient care.

- Family practitioners prescribe too many drugs, and prescribe expensive ones when cheaper, generic substitutes will do. Of the total drug bill of almost £1.5 billion, about £1.2 billion is attributable to the FPS.

- There is widespread public concern about the excessive

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use of deputising services.

The Private Sector Example: the Harrow Health Centre

The private sector provides a model of how to improve services and control costs. The Harrow Health Care Centre was set up 18 months ago as Britain's first - and so far only - independent GP service financed directly by private subscription. It is not a Harley Street practice for the elite. For an annual subscription fee of £70, the patient may have as many appointments with a GP in the Centre as he wishes, though home visits are charged at £10 each. An extra £25 annual fee will cover the cost of all drugs prescribed during the year.

The patient list now stands at about 4,000, and the target is to get to 9,000. The Centre does not turn anybody away. A wheezing 75-year-old will be accepted for the normal fee. So unlike some private insurance schemes, this clinic is genuinely universal. Patients are attracted by the better degree of care and attention at the Health Centre. Appointments are punctual, and each patient is always allocated 15 minutes. Elementary tests - such as X-rays - are available on site, so there are no frustrating delays as appointments which are booked at hospital out-patient units. So for anything but hospitalisation cases, it comes close to "one-stop shopping".

The fee structure creates a very effective set of economic

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incentives for the Health Centre. They obviously must keep their costs down, unlike the arrangements whereby insurance companies refund costs to private hospitals. And the Centre has to provide a good service to keep its subscribers. It also has an incentive to spot trouble at the earliest stage, and devotes more effort to preventive medicine than does the NHS. Patients are encouraged to stay in touch with the Centre. Fitness and health education classes are provided. The patient knows that he can call on the Centre as often as he wishes, with no extra cost. This model is catching on in the United States in the form of "health maintenance organisations".

The project has had a total start-up cost of about £750,000. It had planned to break even after approximately 2 years of operation, but it now seems likely that this will only happen after 2½ years. A major mistake was to set their fees too low, as potential customers are suspicious that there are hidden costs; and their existing patients would be prepared to pay significantly more. The Centre must become financially viable, and then the plan is to expand to open a variety of such Centres elsewhere. They plan not only to cover prosperous suburbs, but also places like Hackney, tailoring the exact balance of services to meet local needs.

We should be encouraging the development of Centres like this. They are difficult for even the most blinkered critic

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to attack. They follow the fundamental NHS principle of universality and, indeed, in one respect - the GPs are salaried - are closer to Bevan's original scheme than the NHS itself. They take the burden off existing NHS practices in the area. And because patients at the Health Centre are healthier than the average, they impose less of a burden on the hospital service.

But the Health Centre has a variety of complaints about niggling DHSS and establishment unhelpfulness:

i. They are not allowed access to NHS files, even with their patients' consent.

ii. The Centre carries out free child vaccinations normally carried out by the NHS. But the NHS will not provide them with free vaccine and, indeed, is trying to block supplies altogether.

iii. NHS obstetricians are making it difficult to integrate their ante-natal care service with maternity arrangements in NHS hospitals.

iv. The BMA has very strict rules about GPs advertising, which means that the dynamic Chief Executive - a qualified doctor, who runs the Centre and publicises it - cannot actually practise there.

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Patient Power in the National Health Service

Our approach to the Family Practitioner Service shouldn't just involve encouraging private sector Centres on the Harrow lines. Wherever possible, lessons from the private sector should be applied in the public sector. The ultimate objective would be for NHS clinics to become cost-centres dependent on satisfying their consumers, just as in the private sector. The Green Paper on the FPS should look at the following possible changes:

(a) Encourage the establishment of patient-user associations for individual clinics, just like parent associations in schools. They will bring the community into closer touch with their local GPs, with no extra bureaucracy or expenditure. They can provide a vehicle for preventive medicine. They could ultimately become a source of funding, just as schools associations now buy educational equipment. And they by-pass the Community Health Councils, which are so often taken over by Left-wing activists.

(b) Family Practitioner Committees should give much more information about the General Practitioner services available in their areas - a first step towards advertising. They should not just provide names and addresses, but details of opening times, and refer to

any specialities of the individual GPs. A spirit of competition should develop, and patients be encouraged to change GPs if they are dissatisfied.

(c) The quality of service provided by the NHS should be properly measured. Average waiting times for seeing a GP, and the average time given by the GP given to individual patients, should be recorded. This information should then be put onto the FPC circular so that potential patients can see which Family Practitioners are providing a more efficient service. The Government could even set targets for such measures, though obviously we need to be sure that they could be met without excessive public expenditure.

(d) Simple design features can be copied from the Harrow example. The receptionist areas are open and friendly. There is a play area for children near to the main waiting room, but separate from it. Doctors come out of their rooms to collect their patients. All these little things can increase patient satisfaction at little or no cost.

All these steps can be taken by a Government which cares about the quality of health care, without encouraging the delusion that the only measure of care and effectiveness is

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spending more money.

Drugs

The mushrooming drugs bill is the clearest example of the failure to establish a sensible set of economic incentives within the FPS.

1. The patient expects a prescription every time he visits the doctor.

2. The doctor, under a barrage of advertising and pressure from drug companies, prescribes brand-name drugs when cheaper generics with the same active ingredients will do.

3. The drug companies get cosy contracts fixing high prices for their drugs under the Pharmaceutical Price Regulation Scheme.

We need to act on each of these three stages in the cycle.

First, patient attitudes. It is increasingly recognised that putting chemicals into your body is not something to be done lightly. New trends in medicine support this. Health education campaigns should focus much more on the dangers of taking a drug for every minor ailment, and aim at dampening down expectations of a prescription every time you visit the doctor's. Prescription charges, of course, also help here.

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And straight placebos could be prescribed rather than expensive but ineffective drugs.

Second, change doctors' prescribing habits. They should be educated and encouraged to prescribe generic drugs - an improved Which guide to drugs might help here. Refuse to prescribe on the NHS some basic types of medicine such as Dispirin, which can be bought privately for self-medication. Carry on removing from the NHS list of drugs those which have been proved to be largely ineffective.

The Pharmaceutical Price Regulation Scheme is being reviewed. There is scope for large savings here. Currently, all sorts of costs are allowed for in calculating companies' rate of return on drugs, such as the promotional expenditure to encourage doctors to prescribe the drug unnecessarily in the first place! These costs should be cut out of the calculations. More radically, instead of buying drugs at prices fixed under the Price Regulation Scheme, the NHS could tender for drugs in the same way Marks and Spencer or Sainsbury deal with their suppliers. The NHS would specify the active ingredients that were needed for a drug, and then accept the cheapest bulk tender. The patient would then be prescribed an NHS "own brand" antiobiotic.

Parallel imports can help push down drug companies' prices. Parallel imports obviously need to be safe, and regulations issued last month will ensure this. But there should be no

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question of keeping out imports just because their cheapness makes life awkward for British drug companies. The important think is that the DHSS gets the benefit of these cheap drugs rather than it being pocketed by pharmacists, who are reimbursed by the DHSS on the basis that they had paid the full UK price.

Conclusions

1. Write to Kenneth Clarke pressing him to produce a radical Green Paper on the FPS. Positive themes would include:

   - shifting the debate from real resources to output;
   - encouraging the measurement of output and service quality;
   - strengthening patient power through patient association and information encouraging competition between clinics.

2. Encourage Harrow-type Health Centres and remove obstacles to them.

3. Ensure DHSS tackle the high FPS drug bill at all three points - patient, doctor and drug companies.

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