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

Copy No 1 of 1

COVERING SECRET

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

14 October 1988

Dear Paul,

NHS REVIEW: PAPERS FOR MINISTERIAL GROUP ON 17 OCTOBER

I enclose the following papers for discussion at the meeting of the Ministerial Group on the NHS review to be held on 17 October:

HC 46 Self-governing Hospitals
HC 47 Budgets for general practice.

My Secretary of State has suggested that colleagues attending the meeting may wish to have with them also paper HC 44, the outline White Paper, circulated with my letter of 30 September. This will again be on the table for discussion.

I am copying this letter and enclosures to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Wales, Northern Ireland and Scotland, to the Chief Secretary, to the Minister of State and to Sir Roy Griffiths in this Department, to Professor Griffiths and Mr Whitehead in the No.10 Policy Unit, and to Mr Wilson in the Cabinet Office.

Yours sincerely,
Geoffrey Podger

G J F PODGER
Private Secretary

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HC 46

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NHS Review

SELF-GOVERNING HOSPITALS

Note by the Secretary of State for Health

1. Following the Group's discussion of my last paper on self-governing hospitals (HC 39), I was asked to consider further a number of detailed issues. This paper puts forward comprehensive proposals on the nature of self-governing hospitals and how we should bring them into being. For the sake of completeness it repeats a number of points made in earlier papers.

2. In summary, the key proposals are:

* self governing hospitals, by definition, will have powers which cannot be conferred simply through delegation from districts.

* in addition to having powers which now rest with Regions, self governing hospitals will have powers which Districts do not have - for example settling the pay and conditions of their own staff, so freeing them from the constraints of the Whitley system.

* self governing hospitals will own their assets, but will be subject to the market discipline of paying charges for them. To safeguard the public interest major capital needs and disposals will have to be approved by Regions.

own but pay?

* there will be community involvement, including £ for £ capital raising schemes.

* self governing hospitals will be run by boards of management, known as hospital trusts, set up under legislation like housing action trusts.

* boards will be small (11 in all) and have an equal number of executive and non-executive members, with a non-executive chairman. The chairman and two non-executive members will be appointed by the Secretary of State. The other two non-executive members will be drawn from the community, often through hospital clubs, but formally approved by Regions.

* self governing status will be available to all 260 major acute hospitals.

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* there will be a centrally driven programme of action to ensure that as from April 1991 there is a steady stream of candidates for self-governing status.

* there will be a managed programme, overseen by Regions, to help hospitals with the transition to self government.

* final decisions on approving self governing status will be for the Secretary of State.

* the introduction of self governing hospitals will incur costs which will have to be considered in the appropriate PES rounds.

what costs only

* the basis of self government will need to be spelt out in primary and secondary legislation so that hospitals know the arrangements and are assured that the position cannot be changed overnight by administrative action.

3. Self governing hospitals with these features will be clearly seen as distinct from other NHS hospitals. By bridging the gap between directly managed DHA hospitals and independently managed private sector hospitals they will significantly increase choice and sharpen competition. At the same time, they will be seen as a logical development from our recent NHS management initiatives and so as a natural part of a wider NHS coverage.

I THE NATURE OF SELF-GOVERNING HOSPITALS

Objectives

4. Our overall objective for the organisation of service delivery is to establish more varied, flexible and competitive interrelationships between Districts, GPs, hospitals, community health services and the private sector. Within that, our basic objectives for the management of hospitals are twofold:

i. for all 260 major acute hospitals

- to devolve management responsibility to hospital level.
- to strengthen hospital management.
- to fund hospitals for performance to agreed standards, with money following the patient for elective surgery.

ii. for at least some major acute hospitals to be self-governing within the NHS. ? - but aren't they are surely all public sector hospitals?

5. I see the links between these objectives in the following terms:

* We should pursue objective (i) determinedly, until all hospitals are capable of working as independently as possible within overall District control. We shall make progress more quickly with some than with others. A few, such as Guy's, are well on the way now.

* Only those hospitals which are capable of exercising full, devolved responsibility will be ready for self-government (objective (ii)).

* Self-government will confer powers and freedoms from which all hospitals could in principle benefit but which cannot be conferred simply by means of delegation by Districts within the present structure.

6. The following paragraphs define in detail the nature of self-government (objective (ii)).

Powers

Powers which now rest with Districts

7. It is central to self-government that a hospital will be able to do for itself what would otherwise be done for it by its District. Specifically, a self-governing hospital will

* hire and fire its own staff. . . Hold Doctors contracts

* contract directly for the provision of its services with its "home" District, with other Districts, with "opted out" GP practices, with Regions (for regional specialties, research and professional training overheads) and with private individuals and insurance companies.

* buy in for itself the services and supplies it needs, and sub-contract as it wishes the services it provides.

* receive capital grants directly from its Region.

The hospital will be in business to use these powers to provide services. It will be accountable for the quantity and quality of its services through the terms of its contracts with its "buyers".

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8. The powers listed in paragraph 7 are essential. The real, practical difference will be made by giving self-governing hospitals powers and freedoms which Districts do not have.

Powers which Districts do not have

9. We shall have to face arguments against giving self-governing hospitals the freedom to do more than Districts can do: if freedom from constraints is right for a self-governing hospital, why is it not right for an equally competent District-managed hospital? And if self-governing hospitals are accorded freedoms which District-managed hospitals do not have, does that not amount to unfair competition?

10. But in my judgement it will be essential to go further if self governing hospitals are to achieve what we want - that is, extending the range of choice by bridging the gap between DHA and private sector hospitals and acting as a catalyst for change. Giving additional powers would also strengthen the incentives to seek self governing status. I am confident we can inject such freedoms without distorting competition unacceptably and without driving up costs.

11. Specifically, I suggest that self-governing hospitals should be free to

* settle the pay and conditions of their own staff, other than the pay of doctors, nurses and others covered by the Review Bodies, free from the constraints of national agreements - that is, no longer to be limited by the Whitley system. Local management would undoubtedly see this as a major prize. The net effect would almost certainly be to push up pay levels. But it would not necessarily push up pay costs, for two reasons:

  - first, the buyers of the hospitals' services will be working within cash-limited budgets, so that any pay increases would have to be funded through increased efficiency.

  - secondly, removing the constraints imposed by national agreements would enable staff to be deployed more flexibly. For example, "on-call" allowances are very expensive, yet more flexible staffing cover could be negotiated locally; and disputes procedures require the continuation of the status quo, even though the actual circumstances and conditions of work may have completely changed.

* employ consultants. Real self-government would be limited if a hospital did not hold its own consultants' contracts, and consultants might in practice be more likely to move from one hospital to another in these circumstances.

* employ whatever staff they judge necessary, irrespective of any manpower controls which may apply to Districts. The only exception should be junior doctors' posts, which will continue to need the approval of the relevant Royal College for training purposes.

* free to subcontract as much as they wish, for example by contracting work out to the private sector.

* raise capital privately, within defined limits. This is part of a wider subject on which I have prepared a separate paper (HC 45).

12. Self-governing hospitals would not be affected by the budgetary limits on carry-forward which would continue to apply to Regions and Districts.

Capital assets

13. I suggest that the assets of self-governing hospitals should be vested in whatever bodies are responsible for their management. To safeguard the public interest, it will, of course, be essential to ensure that important and expensive public assets are used efficiently and not exploited for private gain or otherwise misused in an unacceptable way. To this end I suggest that:

* proposals for major capital investment should be discussed with the relevant Region and pursued only with the Region's agreement. The hospitals will in any event be reliant primarily on grants from Regions to meet their major capital needs. Regions will in turn be accountable for taking an overall view of changes in medical technology, population distribution, and so on. Health "markets" are notoriously prone to over-investment in prestige assets which are wasteful in themselves and push up revenue costs.

* Similarly, a self-governing hospital should need its Region's consent to the disposal of major assets. This is important not only to prevent asset-stripping but also to ensure that essential hospital facilities are not lost simply as a result of poor management. It will be important to assure the public that hospitals which "go broke" will not just disappear, unless their failure to compete reflects the existence of better - and adequately accessible - alternatives.

* a self-governing hospital should be charged for the use of its capital assets, and should in turn reflect the cost of those assets in its prices. As I understand it this would be consistent with Treasury guidance, which recommends full cost charging for trading between government bodies and between government bodies and the private sector. From the

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Not if capital is raised locally

time it became self-governing the hospital would pay its Region a charge based initially on the current valuation of its assets and adjusted subsequently to reflect changes in value (including changes occasioned by investment or disposal). There are a number of technical issues here, but as I have argued in my wider paper on capital (HC45) I believe these problems to be entirely soluble. I also argue there that a system of charging for capital must be introduced for Districts also if we are to ensure a "level playing field".

14. The effect of these proposals is that self-governing hospitals would be free to use assets as they saw fit, subject to some minimum - but important - constraints laid down in each case by the Secretary of State, and subject also to the "market" disciplines implicit in a system of charging for capital.

Community support

15. We have seen hospitals as being more likely to attract the commitment of the local community and to be able and willing to raise money if they are self-governing. I see advantage in embedding this local commitment firmly into the arrangements for self-government.

16. This can be done partly through the composition of the board of management, to which I return below. I suggest also that, with the help of a modest supplement to the capital programme, we should establish a scheme for matching £ for £ any money raised locally for worthwhile capital investment in a self-governing hospital. There would need to be an upper limit, probably expressed as a proportion of revenue spending. The actual amounts would need to be settled in the context of the relevant future PES negotiations, but I hope colleagues will agree that the White Paper should announce an intention in principle to establish such a scheme.

Limits?

Boards of management

Alternative models

17. To exercise the powers outlined in paragraphs 7-14, self-governing hospitals will need to be constituted as legal entities with boards of management (or equivalent bodies). They could not otherwise employ staff, or enter into contracts, in their own right. I have considered four possible models for giving them the necessary legal powers:

i. as special health authorities (SHAs). Existing NHS legislation provides for SHAs to be created by Order of the Secretary of State. Several of the London postgraduate teaching hospitals are constituted in this way.

ii. as trusts, indemnified as necessary by the Secretary of State.

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iii. as companies limited by guarantee. Each member of the board of management would undertake to subscribe (say) £1 in the event of winding up. The Secretary of State could indemnify the company.

iv. as new statutory bodies, constituted specifically for the purpose.

18. We discussed at our last meeting the desirability, if possible, of establishing self-governing hospitals without the need for primary legislation. At first sight this points to one of options (i)-(iii).

19. SHA status would be the most straightforward solution of these three; and would enable the hospital's staff to remain in NHS employment, avoiding any problems of transferring their contracts. But I am advised that the use of existing SHA powers extensively for the purpose of creating self-governing hospitals might be challenged by the Joint Committee on Statutory Instruments as at least an "unexpected" use of the power or indeed "ultra vires". Primary legislation would be required in any event to enable an SHA to charge other health authorities directly, just as it will be needed to enable Districts to charge each other.

20. Adopting the trust or limited company models would have a number of presentational advantages. They also open up the possibility of charitable status, and its consequent tax advantages, although the Charity Commissioners would be unlikely to approve the appointment of employees (i.e. executive directors) to the board of management, nor might they approve the more entrepreneurial activities which we would wish self governing hospitals to undertake. More fundamentally, the trust and limited company models both run into difficulties of "vires" similar to those applying to the SHA model. Without special legislative cover either option would rely on existing powers for contracting out the Secretary of State's functions, and I am advised that the use of these powers on as extensive a scale as we envisage could be challenged in the courts.

21. We would therefore be wise to take explicit powers, in which case we are effectively driven to adopt the statutory body model. This at least has the advantage of enabling us to tailor the constitution, powers and functions of the boards of management precisely to their purpose. I propose using the word "Trust" in their title, as we have with Housing Action Trusts.

Composition

22. I suggest we leave some scope for flexibility in the composition of the boards of management, to take account of local wishes and circumstances. There must nonetheless be a clear, national framework set out in legislation. I propose the following:

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* no board should have more than 11 members, including the chairman.

* there should be an equal number of executive and non-executive directors with, additionally, a non-executive chairman.

* the chairman should be appointed by the Secretary of State.

* two of the other non-executive members should be drawn from the local community. Neither should be an employee of the NHS, of a major contractor or of a trade union with members who work in the NHS. I should like to see self-governing hospitals encouraged (but not statutorily required) to set up voluntary associations - similar to Canadian "hospital clubs" - whose non-staff subscribers would elect the two "community" members to the board. The appointments should be made formally by the Region.

Financial Director

* any other non-executive members should also be appointed by the Secretary of State, taking into account the advice of the chairman. These members, too, might be drawn from the local community, but should be appointed mainly for their experience or expertise. For teaching hospitals they will need to include a representative of the university.

* both the general manager, as chief executive, and the other executive directors should be appointed by the board as a whole.

* the executive directors should include the clinical director (or other senior consultant) and the senior nurse manager.

What is a "hospital"?

23. A "hospital" is not necessarily contained on a single site. Acute management units in the present structure often include two or more complementary hospitals, and may also include community-based services such as community midwifery.

24. I see no need to lay down a rigid definition of what a "hospital" should be for the purposes of self-government, although when considering an application for self-governing status (see below) the Secretary of State will need to satisfy himself that the unit concerned has a sufficiently clear identity, in both management and public terms. I can see positive advantages in hospital and related community health services combining if they so wish, or in self-governing hospitals offering to provide community-based services also where they can do so competitively. Current trends in medical technology and practice suggest that hospitals may become less important as a focus for health care provision, and we must be careful not to work against the grain of such changes.

25. Self-governing hospitals should be free to set up community-based facilities for which charging would be appropriate - nursing homes, for example.

How many hospitals?

26. The Group asked me to consider further how many hospitals we should wish to see moving towards self-government.

27. It seems right to focus our attention, as we have done so far, on the major acute hospitals in which we shall be working to implement the resource management initiative (RMI). In England these number some 260, all of which have more than 250 beds and a few of which have as many as 1200 beds. I do not see small hospitals as being candidates, nor those large psychiatric and mental handicap hospitals which we are trying to scale down or close. It is in the major acute hospitals that I see the greatest potential gains from the motivation and flexibility which self-government will bring.

28. I deal later in this paper with my proposals for ensuring that we have a significant number of self-governing hospitals. But I remain of the view that no hospital should be forced into self-governing status. Self-government is much more likely to be a success if management, staff and the local community are committed to the idea.

29. How many of the 260 major acute hospitals are likely to become self-governing depends primarily on our strategy. I see two possible approaches:

i. limit the option to hospitals in the larger urban areas, where there is scope for some competition in the provision of core, local services.

ii. make self-government open, in principle, to all 260 major acute hospitals.

30. We recognised the advantages of the first strategy at our last meeting. It would, though, limit the scale and geographical coverage of the reform. As an indication of the scope for self-government under strategy (i), I append an analysis, by region, of those of the 260 major acute hospitals whose main centres are located within two miles of another of the 260; and those where the distance is between two and five miles. There are 75 hospitals within two miles of another of the 260, and 141 in total within five miles. The 141 include 58 of the country's 66 teaching hospitals.

31. The scope for competition in core services will depend in part on local geographical circumstances, including ease of transport, but will usually be limited. This is mainly because hospitals which are located close to each other tend

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to provide essentially complementary services, with the minimum of overlap and therefore little scope for competition. In recent years there has been extensive rationalisation of services to this end. Further, where potentially competing hospitals are particularly close together, and the population declining, there may be a prior need for rationalisation (as with the Westminster and St Stephen's Hospitals in London).

32. In principle I am in no doubt that strategy (ii) is preferable, for two main reasons:

* The purpose of the reform is not only to generate competition (which our funding reforms will also do, at least in respect of elective surgery) but also to stimulate motivation, innovation and community support. This applies just as much to a provincial town as to the middle of London.

* Since the successful devolution of responsibility is a necessary precondition for self-government, the prospect of self-government could prove a powerful incentive to the achievement of devolution.

Under strategy (ii) the number of hospitals which became self-governing would simply be the number which successfully applied. If, eventually, all 260 hospitals were to seek self-governing status, that would be a measure of the success of the reform. (It would also open the way to a substantial reduction in the number of Districts).

33. Whether strategy (ii) is the right approach in practice turns fundamentally, in my view, on whether the absence of competition for the provision of core services would threaten the control of spending and costs. I do not believe it would. Revenue spending would be controlled because all the NHS buyers of a hospital's services would be working from within cash-limited budgets, so that the hospital's income from the Exchequer would necessarily be limited. Any upward pressures on capital costs would be contained by keeping within sensible bounds the freedoms which self-governing hospitals enjoyed.

34. In short, I propose that we offer all 260 major acute hospitals the option of applying for self-governing status. In the remainder of this paper I suggest how we ensure that the reform does happen, and in a practical way.

II BRINGING SELF-GOVERNING HOSPITALS INTO BEING

Programme of action

35. Assuming that the necessary legislation is passed in the 1989-90 session, I propose that our first objective should be to ensure that at least, say, five or six hospitals become self-governing with effect from April 1991. Before we publish

our White Paper I would draw up a shortlist of possible candidates, so that we can begin discussions immediately with the Regions, Districts and hospitals concerned. The aim would be to identify which were most likely

* to be ready for self-government by 1991, and

* to offer the best prospects of local commitment to the process.

The Regions concerned would then be charged with ensuring that the selected hospitals received the advice, support and investment they needed.

36. Since implementation of the RMI is a necessary, though not sufficient, condition of readiness for self-government, I propose to begin the shortlisting process with the six RMI pilot sites and, when chosen, the 20 hospitals where implementation of the RMI is planned to begin next year. I aim to secure a reasonable geographical spread: it will be important to avoid any impression that this is a reform geared mainly to the south-east.

37. I envisage a similar process following on from each of the three subsequent years of the RMI implementation programme, perhaps with larger numbers involved, so that by April 1994 some 30 or 40 hospitals should have been guided to self-government. It would of course be open to other hospitals to work for self-governing status, and to seek the Region's help in doing so, either before or after 1994. It will be important for Government, Regions and hospitals themselves to build on experience, and we shall need to put the necessary monitoring and evaluation systems in place to this end.

Achieving self governing status

38. We shall need to establish formal procedures for enabling a hospital to achieve self governing status. It will in any event be important to spell out the details of self-government so that hospitals are assured that they can confidently plan ahead on a basis that cannot be changed overnight by administrative action. The basis of achieving self-governing status and the powers of self-governing hospitals should therefore be set out in primary or secondary legislation.

39. In deciding on the procedures we shall be able to learn from our experience with grant-maintained schools and housing action trusts. But in doing so we have to recognise that the circumstances are not identical. In particular, there is no constituency of interest equivalent to the parents of children attending a school. Nor do I believe it necessary to require specific Parliamentary approval before a hospital becomes self governing, as will be the case when an order is made to establish a housing action trust for a designated area.

40. There will be five steps on the way to self governing status:

first, initiating the procedure

second, preparing the ground

third, publicity for proposals

fourth, consultation on proposals

fifth, approval for proposals.

41. Initiating the procedure. Here we are closer to the housing action trust model, where there is no formal hurdle to clear before the process begins. I do not favour requiring an initial quorum of support like the 20% of parents for a grant-maintained school. We could not sensibly define an equivalent constituency since the patient catchment area for hospitals is not precise. I suggest our approach is to allow a variety of interests to initiate the process. Where we are ourselves seeking to stimulate action, as proposed in paragraphs 35-37, the initiative will, by definition, come from Government and Regions. We should also be open to proposals from the District Chairman, the hospital management team, staff (such as a group of senior consultants) or the community (for example supporters of the local hospital).

42. Preparing the ground. The initiative could not be taken far until the hospital has a clear identity. As we have already noted, a hospital has no clearly defined constituency equivalent to a school's children and their parents, and no non-executive management equivalent to a board of governers. Four necessary early steps would be:

* for the Secretary of State to satisfy himself that there is a good prospect of the hospital meeting the criteria for approval for self-government (paragraph 45 below).

* the identification by the Secretary of State of a "shadow" chairman, who could act for the hospital in preparing for self-government.

* where an adequate equivalent did not exist already, the establishment of a hospital association or similar focus for community support, and a commitment by that association to contribute actively to self-government.

* agreement locally, and with the Region, on the precise range of services and facilities to be encompassed by the self governing hospital.

43. Publicity for proposals. As with the procedures for grant-maintained schools and housing action trusts, we shall need to ensure that it is known, both to the public and to the hospital staff, that the process is under way. I propose that it should be the Secretary of State's duty, as it is with housing action trusts; to take steps to make certain the proposals are brought to the notice of all those likely to be affected. The responsibility will be exercised by Regions on his behalf.

44. Consultation on proposals. Consultation with local education authorities by the governing body and with local housing authorities by the Secretary of State is an important stage in the progress towards grant-maintained status and the establishment of housing action trusts. Because there is no constituency equivalent to parents, I do not think that any particular group should have the power of veto over self governing status. But there clearly need to be established arrangements for consultation. I propose that regions should have a duty to consult, on my behalf, those affected by the proposal including the district health authority, community health council and hospital staff. The outcome of the consultation would be formally reported to the Secretary of State and taken into account in his decision on the granting of self governing status.

45. Approval for proposals. As with grant maintained schools and housing action trusts it should be for the Secretary of State to grant self governing status. He would do so in accordance with statutory criteria. I have in mind that he should be required to have regard to:

* the capacity of the hospital to become self governing
* the views of the hospital staff
* the public response to the proposals and the evidence of public support for it
* the views of the statutory and other bodies which have an interest.

46. In applying these criteria, the Secretary of State would need to take into account in particular:

* the capacity of management to run a self governing hospital, including the existence of sufficient expertise (in financial and contract management, for example, and in industrial relations) and adequate information systems (including RMI systems)
* the involvement of the professions, and especially of consultants, in the management of the hospital, and a good system of medical audit.
* the hospital's track record in, and plans for, improving services and responding to the needs and wishes of its customers.

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* a strong hospital association or other evidence of active community involvement in and support for the enterprise.

47. The Secretary of State will also need powers to revoke self governing status, after appropriate consultation, as with grant-maintained status for schools.

Transition to self governing status

48. The transition to self government should in each case be managed, and where necessary helped, in each case by the Region. Regions will be close enough to the ground to know the circumstances of the hospital well, but far enough away to be more detached than Districts. The Department will need to be sufficiently closely in touch to ensure that the Government's policy is being implemented as intended. I shall myself wish to keep a particularly close eye on the transition to self-government of the planned first tranche of hospitals. We shall of course need to take care that such management and involvement does not run counter to any statutory duties laid on the Secretary of State and the Regions.

Costs

49. Implementing the policy proposed in this paper will not be cost-free, although in the longer term I would expect the costs to be offset by the beneficial impact of self-government on efficiency. I see significant costs in two respects, both of which will apply to all hospitals as they take on more responsibility but the more so to self-governing hospitals:

* the number of staff employed at hospital level will need to be increased, for example in the fields of financial, personnel and information systems management. There will be some partially offsetting savings at District level, but inevitably some loss of economies of scale.

* pay levels will need to be improved where that is necessary to attract the skills and experience required.

I shall need to pursue this in more detail in next year's PES round.

October 1988

APPENDIX

LOCATION OF MAJOR ACUTE HOSPITALS IN ENGLAND

The table below shows the number and distribution of major acute hospitals in England which are located relatively close to at least one other major acute hospital. "Major" is defined as those hospitals exceeding 250 beds.

LOCATION	NUMBERS OF HOSPITALS			
	(a)	(b)	(c)	(d)
	‹2 miles	‹2-5 miles	‹5 miles (a + b)	Teaching hospitals included in (c)
Greater London	24	22	46	22
West Midlands	8	7	15	5
Trent	4	6	10	7
Yorkshire	11	0	11	4
East Anglia	2	0	2	0
Oxford	2	2	4	2
Wessex	2	4	6	2
N E Thames*	2	3	5	0
S E Thames*	2	0	2	0
S W Thames*	0	2	2	0
N W Thames*	0	0	0	0
North Western	5	7	12	5
Mersey	6	3	9	4
Northern	7	4	11	3
South Western	0	6	6	4
TOTALS	75	66	141	58

* = outside Greater London

CURRENT RMI SITES

Hospital	Region
Freeman (Newcastle)	Northern
Huddersfield Royal Infirmary	Yorkshire
Royal Hants County (Winchester)	Wessex
Pilgrim (S. Lincs.)	Trent
Guy's (London)	S E Thames
Arrowe Park (Wirral)	Mersey

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NHS Review

BUDGETS FOR GENERAL PRACTICE

Note by the Secretary of State for Health

1. This paper addresses three related topics: GP practice budgets, mainly for hospital services; budgets for FPS spending, including drugs; and, briefly, the composition of FPCs. It covers a number of issues discussed at the Group's last meeting. For the sake of completeness it repeats some points made in earlier papers.

I GP PRACTICE BUDGETS

2. We are agreed in principle that large GP practices should be able to opt to hold their own budgets for buying a defined range of hospital services. The purpose is to enable them to back their choices with money within an overall budgetary limit. Part I of this paper addresses the key practical issues. I suggest in part II a basis on which GP practice budgets might also cover drugs.

Scope and calculation of the budget

3. We are agreed that GP practice budgets should cover at least two categories of hospital services:

(i) outpatient services, including associated diagnostic and treatment costs.

(ii) a defined group of acute elective inpatient and day case treatments.

In addition, I believe we should include

(iii) diagnostic tests undertaken by hospitals at the direct request of GPs.

(iv) improvements to practice premises and the costs of employing practice team staff (as suggested in my previous paper).

I cannot yet see a practicable way of including accident and emergency department spending, even though that is often a substitute for inadequate general practice.

Premises improvements and practice team staff

4. Unlike categories (i)-(iii), category (iv) - premises improvements and practice team staff costs - is FPS expenditure.

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But it will be cash limited under the Health and Medicines Bill, and I foresee no significant difficulties of either principle or practice in enabling FPCs to give GP practices within our scheme budgets drawn from the FPCs' cash limits.

5. The amount of the budget would be a matter for negotiation in each case between the practice and the FPC. I would expect the budget for the first year to be based on the current costs of the practice team's staff, together with the practice's share of the money available for premises improvements. In each subsequent year the practice would receive its share of any growth money allocated to the FPC for these purposes.

6. There are two important advantages to including these costs within the budget:

* it substantially increases the potential size of the practice budget, and hence the scope for virement. This part of the budget for a large practice with, say, 12,000 patients could be £50,000 or more. The premises improvements element - on average about a third of this amount and some 3% of the total practice budget - would add useful budgetary flexibility. The prospect of freeing money for such improvements would be an incentive to make savings elsewhere.

* it usefully opens the way to the substitution of primary care for hospital services, in particular the possibility of employing additional nursing or other staff instead of using out-patient services. (Virement across the current divide between FPS and HCHS spending would, of course, require specific vote cover.)

Hospital services

7. The calculation of GP practice budgets for hospital services - categories (i)-(iii) in paragraph 3 - raises more complex problems. A workable system would be:

* stage 1: revenue allocations from the Department to Regions and from Regions to Districts will need to "ring-fence" that part of the total which is attributable to the services concerned. The information needed to do this with precision will not be available at the outset of the scheme, but adequate calculations will be possible as follows:

  - for inpatient and day case treatment, the DRG-based "tariffs" which I am aiming to develop by 1989 can be used to derive from national statistics reasonably accurate costs of the treatments to be covered. More precise costings will become available as resource management initiative (RMI) information systems are implemented nationally.

- the costs of outpatient services cannot currently be weighted by diagnosis, and there is no equivalent of the RMI for outpatient services. Nor can we currently link diagnostic or other support service costs to outpatient provision. We shall need to develop better information systems for outpatient services - a worthwhile investment even aside from GP practice budgets. In the meantime we must rely on fairly crude estimates of outpatient service costs, based on the best available information. The need for hospitals to price their services will be a stimulus to improvements in information systems locally.

- new information systems will also be needed (again for both budget calculation and pricing purposes) to distinguish the costs of GP-requested tests from the costs of hospital diagnostic tests generally. But this is not a major problem technically given some modest investment.

* stage 2: Districts will allocate budgets to each GP practice within the scheme. In each case, the District within which the practice falls will need to

- establish how many of the practice's patients are resident within the District and how many (if any) within other Districts. We shall need some investment in enabling all FPC computer systems to supply Districts with the necessary information, but this poses no technical problems.

- calculate for itself, and agree with any other Districts involved, a capitation-based budget for the whole range of hospital services to be covered. This budget would represent a share of each District's allocation proportionate to the number of the practice's patients, weighted within the District in the same way as we envisage for allocations to Regions and Districts. The experience of the first practices which opt into the scheme should help Districts and ourselves to assess whether it would be desirable in the longer run to apply a more sophisticated weighting system to the derivation of practice budgets from District allocations.

8. An important feature of this approach is that, by giving practices no more than their fair share of District allocations, it avoids underwriting excessive referrals. Only practices which already beat the average, or believe they can do so, will have an incentive to opt into the scheme. I believe this is as it should be. Cash limits on District spending will keep overall expenditure under control.

Participation

9. I think we are agreed that participation in the scheme must at first be optional. I suggested in my last paper on this subject (HC40) that the scheme should be restricted to practices with list sizes of at least 11,000, which is twice the national average. On this basis over 800 practices would be eligible in England - 9% of all practices, or just under 90% of practices with six or more doctors, covering between them around 20% of the population. The minimum size of practice within the scheme might expect to receive a budget in the region of £400,000 a year on average, covering all four categories of spending listed in paragraph 3.

10. I believe this remains a sensible starting point. But it is an arbitrary limit, and I suggest we should be prepared to relax it if

* other categories of spending, such as drugs, are included within the budget.

* experience shows that budgets for 11,000 patients are more than large enough to allow room for budgetary flexibility.

* smaller practices are prepared to group together in order to qualify, as Sir Roy Griffiths has suggested.

11. I suggest that a practice wishing to participate in the scheme should apply to its Region. This avoids the risk of progress being blocked locally by the FPC or DHA. In reaching its decision the Region should have regard to

* the capacity of the practice to manage its budget effectively - for example its practice management, its technology and its access to hospital information.

* the GPs' commitment to, and policies for, the management of a collective budget constraining their individual decisions.

Buying hospital services

12. Where costs are under the control of the practice itself, as with practice staff and premises improvements, there should be no major difficulties in keeping within budgets (although practices may need to allow for a pay squeeze on their staff costs). But the costs incurred by hospitals in treating patients referred by the GP are not within GPs' control. We must satisfy ourselves that practices will be able to control their expenditure, and so keep within budget, and that they will be able to do so without prejudicing the needs of their patients.

13. To achieve this, practices will need to adopt one - or a combination - of broadly three different arrangements in respect of the various services they will be buying:

* "annual fee": hospitals would provide an agreed range of services to all patients referred, for a fixed payment. The practice knows how much it will spend, and the risk of increases in cost or volume is borne by the hospital.

* "cost and volume": the number of cases to be treated would be specified within a range, with payment on the basis of work done above the minimum. Prices could take account of casemix. The risk to both parties would be minimised, at the price of some loss of flexibility on both sides.

* "item of service" (or what HC40 called "cost per case"): payment would be made on a case by case basis, at a price quoted by the hospital. This frees practices to spend when and where they wish, but gives hospitals no guarantee of income and leaves practices to bear the risk of unexpected costs.

14. GPs and hospitals - public or private - will be free to make their own choice of arrangements, and to negotiate the best deals they can. The following paragraphs outline what I believe to be a workable approach, but not a rigid prescription.

Directly requested diagnostic tests

15. X-ray examinations and pathology tests requested by a GP direct would lend themselves to an "item of service" approach. For example:

* demand will be broadly predictable from past experience, and prices straightforward for hospitals to standardise; so predicting expenditure within an acceptable range should not be difficult.

* unit costs are low, so any overrun on this budget should be containable without depriving patients of necessary tests (especially if there is some provision to carry an overspend or underspend, as I propose below).

* for many practices there will be a good deal of scope to shop around in-year, in both the public and private sectors, and perhaps to buy at marginal cost.

Initial outpatient referrals

16. It will be crucial to ensure that initial referrals to a consultant are not blocked by budgetary limits, as the GP will often not know whether his patient needs urgent treatment - is the lump harmless or malignant? This points to an "annual fee"

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contract, which would enable the GPs in the practice to refer freely at a fixed annual cost and therefore at no risk to their budget.

17. A contract of this kind would need to be carefully negotiated. The volume of business will be significant: an average of over 1,000 patients a year for a practice with a list size of 11,000. So, for example:

* the hospital might wish to establish
  - a clear understanding that a rate of referral significantly above that assumed in the fee would be reflected in renegotiated prices for the following year, thereby curbing any incentive to over-refer.
  - different prices for some major specialty groups, for example to reflect variations in average diagnostic costs. These would be refined as information systems are developed.
* the GP practice might wish to negotiate
  - a discount for the following year if their rate of referral was significantly below that assumed in the fee.
  - maximum waiting times for outpatient appointments.

18. I would expect most practices to hold back some money to pay on an "item of service" basis for referrals to hospitals with which it was not worthwhile to negotiate a contract, but the scope for negotiating in-year deals at marginal cost will probably be limited.

Inpatient and day case treatment

19. Inpatient and day case treatment will be the lowest volume, highest cost and least predictable of the categories of service for the GP practice to buy. A practice with a list size of 11,000 will average around 300-350 inpatients or day cases a year within the scope of the scheme, but with wide variations in cost: for example, a more than threefold difference between hernia (£650) and hip replacement (£2,200) operations.

20. This points to a series of "cost and volume" contracts, which would have two important advantages:

* the minimum payment would assure the hospital of receiving a contribution towards its substantial fixed costs, whilst leaving the GPs free to switch their business elsewhere if they were exceeding the minimum.

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Costs of the scheme

28. A GP practice budgets scheme along these lines would incur costs in two respects:

* there would be short to medium term costs, primarily in the information systems needed to support the calculation of budgets and the pricing and costing of hospital services to GPs.

* there could be some longer-term FPS costs to the extent that

  - GPs increased their workload in order to keep down their referral and outpatient service costs, or

  - surpluses were invested in indirectly reimbursed expenses (such as computers).

Both of these would feed indirectly through into GPs' remuneration. But the impact of a relatively few practices on national average workload and expenses would be relatively small, and the cost of workload increases could be offset by the more efficient use of hospital resources.

II BUDGETS FOR FPS SPENDING, INCLUDING DRUGS

General budgets for FPCs

29. It was agreed at our last meeting that the proposal to give FPCs responsibility for general budgets covering all their contractors' expenditure should be worked up in detail.

30. Annexed to this paper is a note prepared by DH officials setting out how a scheme of general budgets for FPCs might work. Briefly, it suggests that:

* in deciding what expenditure should be covered by such a budget, the basic principle should be that contractors themselves have control over the level of spending, and that the FPC could therefore influence spending by influencing practitioners' behaviour.

* aside from directly reimbursed expenses of GPs, most of which are to be cash limited anyway, the clearest candidate is expenditure on drugs.

* it is possible to devise a system of indicative drug budgets, backed by sanctions and incentives and supported by a flow of information to both FPCs and GPs.

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Indicative drug budgets

31. The Annex suggests that indicative drug budgets would work as follows:

* Budgets would be notionally allocated to FPCs, on a weighted capitation basis. FPCs would then negotiate notional budgets with each GP practice, taking account of a range of relevant factors and in a way which is designed to drive down overspending.

* Where corrective action is needed for a practice to come within budget, doctors from the Department's Regional Medical Service (RMS) would investigate, offer advice to the FPs, and report to the FPCs. As a last resort FPCs would activate powers to withold a GP's remuneration.

* Practices would either keep, or be supplied with, detailed information on their prescribing practices month by month.

32. There are attractions in this approach, but I propose that we do not adopt it. The main reasons are as follows:

* There would be potential for 30,000 GPs protesting, and encouraging their patients to protest, at the perceived inadequacies of their budgets - especially if the sanctions bit effectively. GPs would complain and demonstrate that "cash limits" were preventing them from prescribing for individual patients.

* A scheme which could bite effectively would call into question the future of the Pharmaceutical Price Regulation Scheme (PPRS) and the policy of attracting inward investment to the pharmaceutical industry. There would be considerable opposition from the industry, backing up the protests of GPs.

* The scheme would involve administrative expenditure and effort in supplying all GP practices - or financing them to keep for themselves - the necessary detailed and up to date information on prescribing costs.

33. I would prefer instead to pursue the approach I proposed in HC 41, developing our use of existing levers - the Selected List, generic prescribing, feedback to doctors, peer review and RMS visits - and strengthening the ability of FPCs to influence GPs' behaviour locally. In addition, I suggest we pilot the proposal in the Annex (paragraph 20) for FPCs to be set targets for their practitioners' drug spending, with a proportion of any savings being used to finance primary care initiatives within the FPC's area. One FPC has proposed a scheme along these lines, which is understood to have the support of local doctors.

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Optional drug budgets for GP practices

34. The objections to a general scheme of indicative drug budgets do not apply with the same force to the possibility of giving real drug budgets to a limited number of large GP practices. The scale of the administrative costs would be much less, especially as large practices need computers anyway and could probably generate the necessary prescribing information at little extra expense. Any threat to the PPRS would be marginal.

35. I suggest, therefore, that large GP practices which opt to have their own budgets under the scheme described in part I of this paper should have the further option of having a drug budget. The purpose of this would be not so much to control their drug expenditure as to create scope for viring into and out of their prescribing costs and thereby strengthen the GP practice budget scheme as a whole. It would also demonstrate that at least some GPs were able and prepared to commit themselves to keeping down drug costs without harming their patients.

36. I would envisage the drugs element of the practice budget being negotiated for the first year along the lines set out in paragraphs 12-14 of the Annex. The FPC would not offer a budget in excess of the average level of spending which would be expected from the practice concerned, given the size and composition of its list. It follows that the proposition would be attractive only to those practices who believed they could beat this level or were already doing so. The key judgement for the FPC would be to strike a balance between these "expected" costs and the practice's actual level of spending: a budget too close to the actual would give the practice little incentive to opt for it; a budget too far away from the actual would represent a wasteful increase in total drug costs, since there would be no compensating savings elsewhere. I believe it is worth paying something to give GPs an incentive here, in the interests of securing the objectives outlined in paragraph 35.

37. I envisage the drugs element of the practice budget being renegotiated periodically. Between renegotiations the budget should be adjusted annually in line with forecast increases in prescribing costs. The incentive on the practice to keep down, or drive down, the rate of increase in its prescribing costs would be that of enabling them to invest in improving their practice and providing a better service.

38. A practice which has opted to have a drugs budget will need protection against the costs of epidemics. The present arrangements, described in paragraph 22 of the Annex, are for such costs to be voted through in Supplementary Estimates. I suggest that these arrangements should apply as necessary to GP practices with their own budgets.

III THE COMPOSITION OF FPCs

39. The introduction of GP practice budgets, and the need to make effective use of existing levers for bringing down the rate of increase in prescribing costs, further underlines the need for strong FPC management.

40. At our last meeting colleagues expressed some doubts about my proposal in HC 41 to remove the contractor professions from membership of FPCs. I remain of the view that we should at least make contractors a clear minority, if not remove them altogether.

41. There is no parallel with our aim of involving the professions more directly in the management of hospitals: there managers and clinicians are jointly and directly involved in organising the delivery of services, and clinicians are committing resources for which managers are responsible and accountable; in the FPS the task is to manage contracts with independent practitioners. I do not believe this can be done effectively and consistently where practitioners themselves dominate the management of their colleagues' contracts.

42. I invite the Group to agree that we should legislate to change the composition of FPCs accordingly. I also suggest that FPCs should be accountable to Regions, as HC41 implied.

October 1988

ANNEX

GENERAL BUDGETS FOR FPCs

Note by the Department of Health

Introduction

1. For the most part FPCs do not manage expenditure directly. They hold contracts with independent contractors, who in turn incur costs. It is already the Government's policy, set out in the Primary Care White Paper, that FPCs should exercise a stronger role in the management of these contracts.

2. The introduction of general budgets might best be viewed as a means of reinforcing this role by enabling FPCs to exert more influence over patterns and levels of spending on the Family Practitioner Services (FPS), short of applying cash limits. In this sense the budgets would be indicative rather than real, but could still be backed by a range of incentives and sanctions.

3. This note examines how, and how far, we could introduce indicative budgets for FPS expenditure.

Coverage

4. In determining the coverage of budgets for FPCs, expenditure on the general ophthalmic service and the remuneration of pharmacists might best be left to one side. The Government have already adopted a policy for introducing more competition between opticians. The remuneration system for pharmacists is currently under review and the Government now has powers to control the number of new pharmacies under contract with the NHS.

5. For the other family practitioner services the main categories of cost to be considered are:

* remuneration and indirectly reimbursed expenses for GPs and dentists.

* directly reimbursed expenses of GPs.

* drugs.

In deciding which of these categories should be included in any indicative budgets for FPCs, the basic principle might be that contractors themselves control the level of spending, and that the FPC could therefore influence spending by influencing the practitioner's behaviour.

6. On this principle there is little practical purpose in FPC budgets covering the first of the categories listed in paragraph

5, remuneration and indirectly reimbursed expenses. The current arrangements for paying doctors and dentists under the "cost-plus" contract are summarised in Appendix I. The essential feature is that total expenditure on these services is determined by two factors over which individual doctors and dentists have no direct control, namely:

* the average cost per practitioner (covering both remuneration and expenses), and

* the number of practitioners.

7. The fact that expenses are reimbursed on an average basis already acts as an incentive on individual doctors to keep their expenses down below the average. Further, fees for item of service payments are set in order to deliver to the professions the "amounts due" in respect of remuneration and indirectly reimbursed expenses. Any attempts by FPCs to influence practitioners' expenditure by reducing the number of item of service payments would be self-defeating. The fees would simply have to go up in future years to compensate, as Appendix I explains.

8. This leaves for consideration a range of FPS spending generated by GPs: directly reimbursed expenses; and drugs. The Government is already committed to real budgets for FPCs for most directly reimbursed expenses (ancillary staff and premises), as these are to be cash-limited under the Health and Medicines Bill. As a new reform for early implementation, therefore, the main scope is for indicative budgets for drugs.

Indicative drug budgets

9. Indicative budgets for drugs would offer potentially major gains. The drugs bill is the largest single element (36%) of FPS expenditure. In 1986-87 expenditure was £1,375m, equivalent to £152,000 per practice or £28 per patient. Cash expenditure is expected to rise by 10% p.a. over the next few years. The aim would be to contain this growth. There are wide variations: even at FPC level spending per 10,000 population ranges from £259,000 to £401,000 (Appendix II). These variations will reflect, to an unknown extent, differences in population structure and morbidity.

10. Paper HC41 summarised the levers currently available and some of the Government's current initiatives. The introduction of indicative drug budgets for FPCs would significantly strengthen this armoury. It would need careful presentation in the light of the Government's stated commitment to achieving more economic and effective prescribing by voluntary means, at least in the first instance. To the extent that significant savings were achieved the present medicines pricing policy, the Pharmaceutical Price Regulation Scheme, would need to be renegotiated. Opposition from the industry could be expected.

Calculation

11. Indicative budgets could be allocated initially to FPCs, which would in turn assign indicative budgets to GP practices. At the level of the FPC there would be sufficient flexibility to make it unnecessary to take into account many of the factors beyond age which could influence expenditure patterns. But, if they were to win general acceptance and influence behaviour, budget allocations down to practice level would need to reflect the additional factors beyond the age composition of practice lists which influence expenditure. This is all the more important if indicative budgets were to be supported by sanctions and incentives which penalised or rewarded performance against budget.

12. Drug budgets at practice level might be be set by negotiations, having regard to:

* the practice's actual level of expenditure.

* the level of expenditure which might be expected, given the size and composition of the practice list.

* the forecast growth in drugs expenditure and the extent to which the Government wished to constrain it.

13. In interpreting comparisons of actual against average or "expected" expenditure, there may be good reasons why a practice spends more, for example low referral rates to hospitals. Similarly, low spending may result in poor quality care. Performance against budgets would be indicative only of efficiency.

14. Where a practice's drugs expenditure was below the "expected" level, indicative budgets might reflect actual levels of spending. For practices with spending above the "expected" level the relative emphasis placed on actual and expected expenditure in setting budgets would depend on how large a change in prescribing habits was required to bring their actual expenditure down nearer to expected levels, and how quickly the Government or the FPC wished to see this happen. Medical audit might need to be applied to practices whose spending was significantly below expectation, in case the quality of service was suspect. Similarly, above average expenditure might be justified in some cases, for example where a practice had a large number of AIDS patients.

Sanctions and incentives

15. To be successful in influencing prescribing behaviour, indicative budgets would need to be supported by a range of sanctions and incentives.

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16. As to sanctions, we would need if possible to find a way forward which did not involve renegotiating the contract. There are two possibilities:

* Regulation 16 of the NHS (Service Committees and Tribunal) Regulations 1974, which has not been used for many years in preference to a more educative approach. Regulation 16 currently provides for the Secretary of State to refer cases of excessive prescribing to the Local Medical Committee (the local body representative of GPs) for investigation. If the LMC finds that the doctor has prescribed excessively (i.e. in excess of patients' needs) it can recommend withholding the doctor's remuneration.

* building on the existing role of the Department's Regional Medical Service (RMS).

17. The Department already plans to propose giving FPCs the statutory responsibility for deciding action under Regulation 16, and the investigation of such cases would move from the LMC to the FPC's Medical Services Committee. Secondary legislation will be required to effect this shift in responsibility. This should make the Regulation a more usable and effective instrument in the face of recalcitrant GPs to be used as a measure of last resort. The willingness of FPCs to deploy these powers would need to be monitored.

18. The RMS already has an important role in this field. For example:

* Practices designated as "high-cost", where their overall prescribing costs (net ingredient cost, excluding dispensing costs) exceed the average for their FPC by 25% or more, are visited by RMS doctors. The visits, which are educational, save on average around £10,000 per practice in the first year.

* Where the quantity prescribed is usually large or net ingredient cost is very high (£200 or more), prescriptions forms for drugs or appliances are referred to the RMS. An RMS doctor discusses the reason for the prescription with the doctor concerned. Again this is educational.

19. If the RMS were to be ready to intervene where corrective action was needed for a practice to come within a budget, and not only when costs are 25% or more above the local average, it would need to be substantially strengthened. An initial estimate is that this would cost £3 million, which would need to be charged to FPCs.

20. Incentives could include

* bonuses paid to practices who change their prescribing behaviour. Presentationally, this would risk the charge that GPs were being given a personal financial inducement to undertreat patients.

* a savings scheme for FPCs. Each FPC could be set a target level of spending on drugs, with a proportion of any savings being returned to them to use for improvements in patient care, in consultation with the LMC. This would appear to be the more practical approach.

Expenditure control

21. The introduction of indicative drug budgets could be expected to exert downward pressure on expenditure - probably, in practice, a slowing down in the rate of growth rather than an actual reduction. In doing so it would need to allow for unavoidable and unexpected increases in expenditure.

22. The size of the drug bill is affected by a variety of factors, including the volume and price of items prescribed but also "product substitution" (often new, better and more costly drugs coming on to the market). Not all these factors are amenable to accurate forecasting, and some are subject to uncontrollable influences such as epidemics. To the extent that the forecasts underlying budget provision fell short of out-turn, in-year increases would be necessary. Under the present arrangements these are voted through in Supplementary Estimates. It would be necessary to continue this arrangement to ensure that practitioners, and patients, did not pay the penalty for forecasting errors or increased incidence of a disease because of an epidemic.

23. Information is now becoming available to support the more intensive monitoring and follow-up which indicative budgets would imply. In August 1988 an improved prescribing information system was introduced which provides good quality feedback to doctors about their prescribing three months after the quarter to which it relates; and from 1990/91 FPCs will have access to this information to pursue their new role, outlined in the Primary Care White Paper, of promoting more effective and economic prescribing.

24. Appendix III summarises the "levels" of feedback available. This information already recognises the impact of the elderly on prescribing costs. To the extent that we wished to take account of additional factors, the detailed ("level 3") feedbacks should provide useful pointers. Indicative budgets would have to be supported by more frequent, monthly, feedbacks if practices were to be in a position to take any corrective action necessary within year.

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Turning indicative into real budgets

25. Ministers may wish to consider translating indicative budgets into real ones for at least some GP practices.

26. Some 350 million prescriptions are dispensed each year in England alone, the bulk of these (94%) by community pharmacists and the remainder by dispensing doctors. The introduction of real drug budgets for non-dispensing doctors would require a mechanism for transferring cash from practice budgets to the pharmacist in respect of the drugs dispensed. Appendix IV describes the present system for reimbursing community pharmacists and the changes that would be implied by the introduction of real as opposed to indicative budgets. Essentially the changes are two-fold:

* for practices with their own budgets, the FPC would need to invoice each practice in respect of all prescriptions prescribed and dispensed. These would be based on the current "level 3" feedbacks but would need to be more frequent than quarterly - probably monthly. Monthly feedbacks at this level of detail would have cost consequences for the Prescription Pricing Authority which we are unable to establish without discussions with the PPA themselves.

* payments would be remitted via the FPC to the pharmacists. It would be necessary for the FPCs to have this intermediary role if the system is to be compatible with current methods of clawing back discounts received by pharmacists from their suppliers, and also to avoid the considerable extra burdens on pharmacists associated which would be with direct billing.

27. An alternative approach would be to retain the current three-month lag in feedbacks to practices but for large practices to record for themselves their own prescribing information for purposes of budgetary management. The definitive invoice, to be used for remittance and audit purposes, would still be the quarterly return. Large practices need computers for other purposes and this facility could probably be secured at little additional cost.

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APPENDIX I

THE "COST-PLUS" CONTRACT

1. The fees and allowances agreed each year for General Medical and Dental Practitioners are calculated to pay out within the year, on an average basis, the sum deemed to be due to the profession as a whole for

* reimbursement of their NHS expenses,

* an intended net income per practitioner, and

* any balancing adjustment needed to correct past under or overpayments to the professions.

The balancing correction may relate to work done up to three years previously.

2. Item of service fees cover some 37% of total FPS costs and 60% of remuneration costs. Individual practitioners are legally bound to provide these services on demand; were demand to exceed the level forecast, the budget would be breached through no fault of the practitioner. Annual constraints on expenditure in this area would ultimately serve no useful purpose: under the present arrangements a shortfall in amounts due in any one year will need to be made good subsequently.

3. The most important regulator of FPS expenditure is the "averaging" system. Practitioners are remunerated on an average basis, so that those with lower than average costs are rewarded at the expense of their colleagues who choose to spend more than the average. The system thereby builds in incentives to limit costs.

1. Too many G.Ps. – !!   %   F.P.C.'s

2. Overprescribing. =

3. Unnecessary referrals

{ Cost of referrals.
Overspending }

Better contract monitoring
Generic Prescribing

Rx 20% non G.P.   1900

Support staff 53%

APPENDIX II

DRUG EXPENDITURE: VARIATION BY FPC 1986/87

National Average (£k per 10,000 resident population): £ 307

Top 10 spenders:

	£k per 10,000 resident population
North Tyneside	401
Salford	391
Isle of Wight	371
Bury	371
Sunderland	369
Barnsley	363
Trafford	362
Lancashire	357
Dorset	355
Wigan	352

Bottom 10 spenders:

	£k per 10,000 resident population
Hertfordshire	275
Barnet	275
Northampshire	275
Wiltshire	275
Croydon	272
Buckinghamshire	269
Enfield and Haringey	267
Gloucestershire	264
Greenwich and Bexley	264
Oxfordshire	259

Notes:

i. All data relate to England (90 FPCs) 1986/87

ii. Includes drugs dispensed by dispensing doctors as well as pharmacists.

iii. Expenditure defined as cost at Drug Tariff or Proprietory List prices before discounts received by pharmacists and dispensing doctors from suppliers.

iv. Expenditure will include that on "temporary residents."

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APPENDIX III

GP PRESCRIBING - INFORMATION PROVIDED TO PRACTICES

The Prescription Pricing Authority has developed a 3-level reporting system based on data taken from prescriptions dispensed by community pharmacists (shortly to be extended to dispensing doctors):

* Level 1 reports are sent quarterly to each GP practice and within 3 months of the period measured. Each report compares the practice prescribing costs (calculated at list price) with the FPC average and the national average. It also compares the prescribing pattern with the FPC average in each of the 6 highest-cost drug categories (e.g. cardiovascular). The report gives information on the prescribing of individual GPs within the practice and about generic prescribing habits.

* Level 2 reports are sent automatically within a week of the level 1 report to practices whose costs exceed their FPC average by 25% or more and to those whose costs in any of the 6 major cost categories exceed the FPC average by 75%. Level 2 reports are sufficiently detailed to identify areas of high cost down to individual drugs. Tables show how individual GPs stand in relation to the practice as a whole, and how practices stand in relation to the FPC overall, in terms of

  - numbers of items prescribed
  - total cost (at list prices)
  - average cost per item

* Level 3 reports are available on request for those wishing to carry out a detailed audit. It provides a full catalogue of items prescribed. Analyses of prescribing can be provided in terms of

  - overall pattern
  - 6 major cost groups
  - all other drug groups
  - appliance and dressings
  - other preparations

2. The system is under continuing review. A leaflet explaining its methods and purposes has been sent by the Department to all GPs and group practices.

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APPENDIX IV

DISPENSING OF DRUGS: COST REIMBURSEMENT

Prescription Pricing Authority (PPA)

1. Prescription forms are sent by community pharmacies to the PPA for "pricing". The PPA, which has been recently computerised, calculates the cost of drugs dispensed and informs the FPC of the amount due in respect of drug costs and dispensing fees.

2. Each prescription form, which might include more than one item, will have on it unique pharmacy and GP identification codes. The pharmacy code is used for payment purposes. The GP code is used to link prescriptions with practices for feedback purposes (Appendix III).

Discount Scales

3. In recognition that pharmacies negotiate discounts from their suppliers, the amount reimbursed to pharmacies is based on list price less an average discount derived from periodic "discount inquiries". The size of discount varies according to the size of pharmacy on a sliding scale, the larger the pharmacy (by dispensing value) the larger the discount clawed back.

Real Budgets

4. It seems sensible that the introduction of drug budgets for GPs should aim to disrupt the present system as little as possible. Practice budgets could be calculated on, and charged according to the list price of, drugs dispensed. "Level 3" feedback returns which record this information in detail could form the basis of invoices (Appendix III). Feedbacks would have to be at monthly, rather than quarterly, intervals to facilitate budgetary management.

5. FPCs would continue to receive and be responsible for reimbursing the cost, less discount, of all drugs dispensed by pharmacies with whom they have contracts. For practices with their own drug budgets, FPCs could be informed of the cost (at list prices) of the drugs prescribed by those practices. The amount the practice would be charged would be the cost less the (FPC) average discount.

6. Drugs prescribed by a practice will not necessarily be dispensed in the same FPC. FPCs at present reimburse costs to pharmacies with whom they have contracts. Under the arrangements described above, FPCs will be invoicing practices for drugs which are not necessarily dispensed in that FPC and for which they have to make payment. This presents a problem only if FPCs were to be given cash budgets in respect of drug expenditure.

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7. The alternative to this approach would be to have practices billed directly by the PPA in respect of drugs dispensed. This suffers from the following disadvantages:

* For practices with their own budgets, the PPA would need to link prescriptions back from the pharmacy where they were dispensed to the prescribing practice. The information is there to do so but would require additional hardware and software.

* the actual cost to the NHS of a drug will vary according to where it is dispensed due to the operation of a sliding scale of discounts. GPs have no control over where prescriptions are dispensed and it seems unreasonable to expect GPs to bear this variability in cost. Whilst there will be an element of "swings and roundabouts" in most practices, there will always be vociferous exceptions, particularly in rural areas.

8. Separate "pricing" and reimbursement arrangements exist in Scotland and Wales. Where practices are located on the borders, prescriptions may be dispensed and reimbursed by a different authority, and special arrangements will have to be made.