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PART 1

CONFIDENTIAL FILING

Primary Health Care

NATIONAL HEALTH

PART 1:
March 1986

(In Attached Folder: Primary Health Care: Draft Consultative Paper) plus Draft White Paper.

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~17.3.86~~							
~~19.3.86~~							
~~22.3.86~~							
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~~17.9.87~~							
~~26.10.87~~							
30.10.87							
PART ENDS							

PREM 19/2346

Previous papers are on Nat. Health: Seminars Pt2

PART 1 ends:-

DRN TO DHSS 30.10.V7

PART 2 begins:-

DRN TO DHSS 2.11.V7

SUBJECT MASTER

SECRET

MT 21 MS 8

File

10 DOWNING STREET

LONDON SW1A 2AA

30 October 1987

From the Private Secretary

Dear Geoffrey

PRIMARY HEALTH CARE WHITE PAPER

The Prime Minister yesterday had a meeting with the Secretary of State for Social Services to discuss the draft White Paper on primary health care circulated with his undated letter to the Lord President. Mr John O'Sullivan, No.10 Policy Unit, was also present.

After congratulating Mr Moore most warmly on his handling of the social security uprating announcements, the Prime Minister expressed her concerns about the draft White Paper. This did not seem to her sufficiently to bring out the importance of capitation fees as a way of remunerating GPs. Capitation fees could in due course become a means of ensuring that money moved with patients, so creating a form of internal market within the NHS. The emphasis in the White Paper on payments for specific services would tend to remunerate doctors twice, once through the specific payment and once through payments they would anyway receive as GPs.

Your Secretary of State explained that he shared the Prime Minister's objectives. The handling of discussions with the profession was however extremely difficult. The Government needed to maintain a good working relationship with the medical profession to be able to deliver the new charges on dental and optical examinations, and the sale of the General Practitioner Finance Corporation could not be achieved without the agreement of individual doctors. The White Paper represented a step towards the Prime Minister's objectives and would provide a good basis for negotiation. The balance between capitation fees and payments for specific services was a difficult issue and capitation fees would not be appropriate in all circumstances. But the White Paper would offer opportunities for change and the objective implicit throughout was to create a better internal market.

In further discussion the Prime Minister questioned very strongly whether the White Paper did in fact move in the right direction. Weakness now could jeopardise achievement of the longer term objective and that would be

too high a price to pay even for the savings which would result from the changes mentioned by your Secretary of State. The Prime Minister however agreed to consider the commentary on my letter of 26 October which was handed to her by your Secretary of State.

Yours sincerely

Derek Allen

pp. David Norgrove

Geoffrey Podger, Esq.,
Department of Health and Social Security.

10 DOWNING STREET

Prime Minister

John Moore and DHSS have moved quite a way, though strong follow through from No 10 will be needed.

John O's is content subject to one small change.

Agree to write as proposed?

DN
30/10

Well done - we must think them - agree we write but we should only [illegible] word if it is really necessary should not

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PRIME MINISTER 30 October 1987

AMENDMENTS TO THE PRIMARY CARE WHITE PAPER

I enclose some suggested amendments to the Primary Care White Paper, agreed between myself and DHSS officials,* to meet your criticisms of the draft document in last night's meeting with the Secretary of State for Health and Social Security.

* and, now, John Moore.

They represent important concessions by the Department and meet our major points on:

a. increasing the capitation fee as a proportion of GPs total remuneration, both as an immediate step in the forthcoming negotiations with the profession and as a long-run objective to increase patient choice;

b. relaxing the restraints on advertising by GPs; and

c. opening up primary care, in particular NHS pharmacies, to greater competition.

My only suggestion for further re-drafting is that we should seek to replace the one word 'prerequisite' by 'element' in line 3 of the re-drafted paragraph 3.8. This would remove a possible excuse for delaying future increases in the capitation fee.

Otherwise I recommend that you accept the amendments.

We have a White Paper which points, somewhat uncertainly, in the right direction. Now we must win the war of interpretation.

John O'Sullivan

JOHN O'SULLIVAN

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AMENDMENT TO PARAGRAPH 1.7 OF THE WHITE PAPER.

Add as an additional indent between the existing second and third indents of paragraph 1.7 the following:

"- the need of consumers for better, more detailed, and more accessible factual information about practitioners and the range and pattern of services they provide;"

Then either as an addition to paragraph 1.7 or as a new paragraph between paragraphs 1.7 and 1.8, add the following:

"The Government accepts the need actively to address these important themes and believes that the best way of doing so is by requiring practitioners to increase the range and quality of services they provide. The Government believes that there are three inter-related ways of achieving this aim, namely:

- no opportunity should be lost to increase fair and open competition between those providing family practitioner services;

- to that end, consumers should have readier access to much more information about the services provided;

- and the remuneration of practitioners should be more directly linked than at present to the level of their performance."

3.8 The Government sees these steps as leading the way towards a family doctor service which responds effectively to the needs of the consumer. An important demand prerequisite is a much better understanding by the consumer of what is on offer and what is needed. The Government intends that consumers should become better informed about the services they can expect their doctors to provide and more effectively to exercise their right to choose the doctor who best suits them. To this end a greater degree of competition in providing services to patients is the necessary impetus and the combination of a better informed public and a remuneration system geared to consumer demand provides the mechanism.

3.9 It is the Government's intention therefore to make the NHS contract with family doctors more sensitive to the range of services provided. This will be achieved over time by adjusting the balance between the doctor's income from capitation fees and the income from allowances. A basic core of health provision is expected for the payment of capitation fees which in turn will be complemented by incentive payments designed to encourage the provision of services targeted at specific health care objectives (eg high levels of vaccination, immunisation and cervical cytology). At present capitation fees form an average 47% of the doctor's income. The Government intends to raise this to at least 50% in the first instance. As public awareness increases and services improve, the Government intends to move further in this direction in order to encourage doctors to practise in ways that meet patients' needs.

3.10 The Government will therefore open discussions.....

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DRAFT ADDITION TO PARAGRAPH 3.23 OF THE WHITE PAPER - THE PARAGRAPH ON ADVERTISING

Amend and add to the final sentence of Paragraph 3.23 so that it reads as follows:

> "The Government has noted with approval the General Medical Council's recent statement that "the ethical dissemination of relevant factual information about doctors and their services is strongly to be encouraged", but believes that there are still too many restraints on the extent to which general practitioners may publish factual information about their practices and the services they provide. Such restraints deprive the consumers of information to which they have a right and discourage proper competition between practitioners. The Government intends, therefore, to open discussions with the General Medical Council with a view to reducing these restraints, subject to proper safeguards for the professional status of the practitioners and for the protection of the public."

6.7 The new contract for NHS pharmacies is still relatively new and will need time to settle down. It will be reviewed in the light of experience to consider whether more competition is needed in the provision of services to consumers. In the meantime the Government will seek to build on the recommendations of the Nuffield report.

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NBPM - (covering Secret

Prime Minister 29 October 1987

DHSS Response

The first page of the DHSS response, delivered by the Secretary of State, makes it crystal clear that the White Paper opposes capitation fees in principle. To take its three points in reverse order:

Point (c) states plainly that higher capitation fees are not complementary to performance-related income but that, for financial reasons, the two are mutually exclusive alternatives.

Point (b) argues that higher capitation fees would lower medical standards by making "good practice" performance-related pay unnecessary.

Point (a) assumes that patients are bad judges of what they need and that capitation fees would therefore result in damaging and wasteful medical practices.

All this may previously have been implicit in the White Paper. It is now explicit and on the record - as total a rejection of the whole internal market and patient choice approach as could be imagined. If serious changes are not now made in the White Paper because of the time factor, this will be an incentive for the DHSS in future to propose far reaching changes unwelcome to you at notice too short for resistance or amendment.

Other points in the response I will return to later.

John O'Sullivan

JOHN O'SULLIVAN

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Note on No 10's letter of 26 October

Primary Care White Paper

The need to sharpen up the doctors' remuneration system to encourage the raising of standards and to achieve better value for money is recognised and fully reflected in the draft White Paper.

In the Primary Care Discussion Document Norman Fowler floated the idea of a good practice allowance together with greater reliance on capitation fees as a means of achieving those objectives. Little support was forthcoming from either professional or lay opinion.

A number of serious difficulties emerged which are summarised below:

(a) While more money via capitation will encourage doctors to look for patients it will also have the adverse effect of encouraging doctors to give their patients what they want. This will lead to wasteful over-prescribing and unnecessary referral to hospital.

(b) Capitation fees as such are no guarantee of the quality and extent of care. Some doctors might be content to earn the higher capitation fee and not bother with the good practice allowance.

(c) If the capitation fee were to form a much higher proportion of income (eg 70% instead of 47%), little financial room would be left for specific incentives (eg money targeted at increasing vaccination, immunisation and cervical cytology).

While it is not possible to say what proportion of total income capitation fees will form until our negotiations are complete, the White Paper proposals will enable us to achieve the same significant improvements which in theory it was thought could be got through a good practice allowance and capitation, namely performance related pay and a work sensitive contract with the doctors.

To take the key expressions from David Norgrove's letter - "internal market", "sanctions" and "incentives", the following proposals score pretty well:

- providing consumers with more information about local doctors, making it easier to change doctors and simplifying the complaints procedure; thus consumer choice is strengthened and a degree of competition introduced.

- paying the doctors through specific allowances for the services they provide (eg for extra attention to children and elderly patients); in this way we target the money at our health policy objectives;

- making it hurt financially if these services are not provided.

- abolishing out-of-date allowances that no longer provide an incentive (eg group practice allowance, vocational training allowance) and redistributing the money through more effective incentive schemes.

- tightening up qualification for existing allowances (eg requiring 1500 patients instead of 1000 to qualify for basic practice allowance - £7,850 pa); doctors currently paid full allowances for what is in effect a part time job will feel the pinch.

- extending practice teams to achieve a better service for patients and consequently some labour substitution (eg more patients to see the practice nurse, counsellor and others instead of the doctor).

- introducing new allowances related to current needs (eg to encourage doctors into inner cities and to keep up to date by attending courses).

- shifting the onus for payment towards bonuses for reaching targets rather than on item of service payments.

- strengthening the Family Practitioner Committees' management and enforcement role, in particular to monitor performance and to take remedial action (eg withholding rent and rates reimbursement where premises are sub-standard)

This is a comprehensive package. It needs to be to balance the impact of the new charging arrangements. There are in addition a number of health promotion developments in dentistry, pharmacy, ophthalmics and community nursing which are not covered here but which all add to the positive nature of the White Paper. The specific points raised in the annex to David Norgrove's letter are answered in the attached note.

DHSS's response to detailed comments from No 10

Paragraph 3.22
No 10

The proposal to publish more information on individual GP practices, together with simplification of the right to change doctor is welcome. It would also be useful to propose giving doctors the right to advertise (as is proposed for dentists), and the information published by the FPC might include the current size of each doctor's list of patients.

DHSS response

General Medical Council (GMC) has already eased restrictions on making practice information available to patients. More information for patients is encouraged but self promotion is not. The change agreed by the GMC opens the way for the Green Paper proposals that doctors should make greater use of leaflets to let patients know what services they provide. The GMC is currently under pressure from the Office of Fair Trading (OFT) to go further in the light of the Monopolies and Mergers Commission's pro-advertising reports. Advertising by doctors is a minefield because of the delicate relationship between patient and doctor and the profession is unhappy at going even as far as the GMC has allowed. Ministers have adopted a neutral position, being content to let the OFT fight the good fight.

We can explore the inclusion of list size on the FPC published medical lists, although such information may not be of much use to patients. A short list does not necessarily mean better service. Nor does a long list.

Paragraph 3.28

No 10

The proposal here is for a new allowance for doctors working in areas of deprivation. A high differential capitation fee might perform the same task more precisely since it would be targeted on deprived people rather than deprived areas.

DHSS response

An allowance is administratively much simpler than an enhanced capitation fee. There is a higher than average turnover of patients in inner cities. A capitation fee would have to be adjusted as patients moved in and out. This would create some instability of income for doctors which would work against our need to attract young doctors and their families into inner city areas. In addition an enhanced capitation fee would be expensive in FPC time without giving any benefits over a doctor-related allowance.

Paragraph 3.39

No 10

It appears from this paragraph that the General Practice Finance Corporation is to remain a statutory corporation, but be freed from restrictions on obtaining private finance. Why should it not be privatised outright?

DHSS response

Our objectives are:

- that Government should get out of the business of making loans to doctors.

- that we should deliver to Treasury, as agreed in the 1986 Survey, a once-off saving of £80m.

- that the sale of the GPFC should be in a form that is acceptable to the doctors who could otherwise scupper it (either by refusing to consent to have their loans transferred or through their opposition making it a commercially unattractive proposition).

After lengthy consultations with the GPFC and the profession, and with advice from Hambros, we now have a package that will meet the three objectives and will deliver savings of well over £100m. The proposed Corporation will, in all but name, be a company under the Companies Act: it is envisaged that a financial institution would subscribe 51% - 75% of the equity capital with the balance owned by a Trust for the benefit of the medical profession. Tony Newton is meeting the profession next Thursday to conclude this - in time for inclusion in the Bill. In short, we are privatising the GPFC, in a way that, we think, will meet all our objectives.

Paragraph 3.54
No 10

The White paper rightly points to over-referral by GPs as a major cost and efficiency problem for the NHS. But it offers no solution beyond "inviting" the offending doctor to discuss his referral patterns "with a view to..... making effective use of hospital care". This is weak. It would be preferable to try to build in financial incentives through capitation fees so that, for example, a GP would be expected to perform a wide range of tests and minor surgery as part of his normal duties. A referral of a patient to hospital for treatment from this recognised range would be billed against the doctor by the hospital. The capitation fee paid to the GP would be high enough on average to compensate.

DHSS response

Referral rates of doctors can vary at least fourfold but the reasons are not fully understood. It is much too soon to look for radical solutions. We need first to understand why some doctors refer more

than others. Research projects are under way. Where we have the information and can understand its significance we can seriously consider the No 10 proposal, which would of course have substantial implications for the financing of health care.

Making doctors pay for their patient's hospital treatment would probably result in their resisting taking on elderly or chronically ill patients.

CHAPTER VI

No 10

Under the new contract for community pharmacists introduced this year, the local FPC pays a grant to meet the fixed overhead costs of NHS pharmacists as well as their variable costs. Ideally, pharmacists would be paid per prescription handled. This would hurt some pharmacists in rural areas. A second best alternative would be for the local FPC to estimate how many pharmacists are necessary in a given area, and put the contracts out to tender.

DHSS response

What is proposed here is in fact already in operation. The new contract for pharmacists introduced in April 1987 made two main changes. First it did away with the basic grant to pharmacists (the basic practice allowance) which used to cover fixed overheads and some variable costs. In its place larger fees are paid for each prescription dispensed. Small isolated pharmacies receive a special extra grant, so that they stay viable. Second, the new contract set up controls for entry so that the local FPC can now decide whether a new pharmacy should be opened. We propose to review the new arrangements when we have had sufficient experience of them.

Paragraph 6.21

No 10

This rules out the expansion of the selected drug list, noting the willingness of the medical profession to employ economic prescribing by voluntary means. To rule out an extension of the selected list scheme may, however, be to deny a useful incentive.

DHSS response

Three points:

- What is said in the White Paper is no more than was said only a few months ago in the General Election, something which the Chief Secretary accepted made a significant extension of the Selected List impossible.

- A statement that we have no plans now does not inhibit us from formulating them later, and it wouldn't rule out considering at some future time the "modest" extensions discussed in the PES bilateral.

- But the positive objective which we are seeking by referring to the Selected List in the White Paper is the linkage of the statement about non-extension with the comment on the medical profession's willingness to achieve savings by voluntary means. This would be a clear and important signal to the general practitioners that the Government would have to reconsider its position on the Selected List if they didn't make improvements voluntarily. This will be emphasised by additional words to be inserted in the White Paper.

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PRIME MINISTER 29 October 1987

Primary Care White Paper

Mr Rayner at the DHSS and Miss Boys at the Treasury discussed the White Paper with me this morning. They were helpful meetings but, with the partial exception of the GPFC (discussed below), I was not persuaded that our earlier approach need be changed. I would stress three points:

(1) The DHSS remains opposed to making a higher capitation element in GPs' remuneration an objective of policy. They say - to my mind, unconvincingly - that higher capitation fees might emerge from negotiations. But they do not believe that they should be increased substantially (i.e. to the point where they might be an incentive influencing patients and doctors) because that would limit DHSS ability to introduce or increase "performance-related" payments.

This is the crux of the argument. Do we believe that patients can be trusted to choose their doctors in a free, competitive market informed by advertising? Or do we want merely to improve, by means of better FPC monitoring and targetted financial incentives, a system in which officials move about large blocks of money to encourage practices currently favoured by the DHSS? If the latter, the White Paper is on course. If the former, then we should alter the remuneration proposals as follows:

(a) Prune existing item-of-service payments and be very sceptical of any proposals for future grants and payments. Once in place, they tend to remain. Remember the Prophet Enoch: "In the Welfare State, it is more blessed not to take away than to give".

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(b) Hold down, even reduce, the Basic Practice Allowance. At present, we pay out £7,500 - £11,000 wherever a doctor puts a plaque on his door. The White Paper proposes more severe conditions of service. BUT

(c) These could be better attached to a higher capitation element in GP's renumeration. So could many of the special payments which at present are "performance related" and FPC-monitored. Under a capitation system, of course, the patient would be the monitor.

It is very well worth noting that the reforms which doctors are expected to resent most fiercely are, in particular, the greater monitoring of performance-related pay which the DHSS is advocating. The capitation approach, of its nature, would mean less monitoring.

(2) The Treasury and DHSS have reached a general compromise on privatising the GPFC as a statutory corporation provided that its articles of association ensure it differs in no way from a normal company. They also agree that this would raise £123 million under present conditions.

Negotiations continue on two outstanding difference. First, the Treasury opposes - rightly - raising the GPFC borrowing limit while it remains in the public sector. Second, the DHSS would like the Government to retain £10 million worth of shares in the company to reassure GPs. Such reassurances are quite needless since GPs are good risks who borrow from a wide range of institutions.

In general, the DHSS is using the GPFC as a hostage. "Go along with our general approach in the White Paper", they say, "or the doctors will refuse to co-operate on selling the GPFC and you will lose a large contribution - £80-123 million - to public finance." I don't believe this. But suppose it to be true. The effect would merely be to reduce

the Government's borrowing next year by £80-123 million. That is a nice sum, of course, but not so nice that we should stick with an unsatisfactory policy on Primary Care for that reason alone.

(3) There should be a paragraph or, at the very least, a sentence in the White Paper holding out its prospect of more competition and private finance in primary care. Such points are absent only because the Green Paper was carried through in the pre-election period of "silence in the NHS is golden". Matters are different now.

We might, for instance, offer a commercial locum service, like Aircall, the right to tender for GP services in the under-doctored inner city. Or allow NHS patients to pay their doctor for certain services - such as an annual health check leading to a personal good health programme.

On the same point, we might reconsider the WP proposal to mandate GPs to carry out a personal health assessment as part of the Basic Practice Allowance. Such assessments are, in terms of medical value and political popularity, much less useful than meeting known shortages in the acute sector. If we want to follow fashion in this, why not encourage most patients to pay for such regular checks as a private service not now offered.

On tendering for NHS pharmacies, on making improvement grants into loans, and on removing the pledge not to extend the selected list scheme -- on all of which we have the Treasury support -- I would maintain our line.

John O'Sullivan

JOHN O'SULLIVAN

SECRET

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DEPARTMENT OF TRADE AND INDUSTRY
1-19 VICTORIA STREET
LONDON SW1H 0ET
Telephone (Direct dialling) 01-215 5147
GTN 215)
(Switchboard) 01-215 7877

From the Chancellor of the Duchy of Lancaster and Minister of Trade and Industry

THE RT HON KENNETH CLARKE QC MP

Rt Hon Tony Newton OBE MP
Minister for Health
Department of Health and
Social Security
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY

NBPM.

29 October 1987

Dear Minister,

PRIMARY HEALTH CARE WHITE PAPER

Thank you for copying to me your recent letter enclosing a copy of the draft White Paper "Promoting Better Health".

Overall, I agree with the main aim of the proposals, and in particular welcome the emphasis on greater responsiveness to the consumer, for example through improved information on doctors' services, simplified complaints procedures, and making it easier to change doctor. The paper that you are to present to E(CP) will provide an opportunity for further consideration of matters such as healthcare shops and ending the restrictions on ownership of dental practices. Although I note that these ideas received little support, I believe we should not rule them out, and I am glad the White Paper does not do so.

On the provision of private sight tests, I agree that there should be no prohibition on arrangements such as described in paragraph 5.5: "patients may be offered a free sight test if they purchase spectacles from the practice which tested their sight". However, there is the risk that such arrangements could lead to the two services becoming tied in a way which might undermine the competition we have so far established in spectacle provision, and which the steps described in 5.6 are designed to prevent. If so, this is something which might require action under competition law. Whilst not ruling out such developments in advance, therefore, I do not think we should suggest that this is what we expect to happen, as the sentence I have quoted might appear to do. Since it could seem to be inconsistent with our policy, and is at best unnecessary, it might therefore be better deleted.

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Turning to inner cities, I am generally content with what paragraph 9 of the draft White Paper has to say; indeed I am sure that the measures to improve health care in deprived areas will be welcomed. I should just like to add a short sentence (after the first sentence in 9.1) on your Department's involvement in the Inner Cities Initiative:

> The Department of Health and Social Security is represented on the Ministerial Group on the Inner Cities Initiative, and there are close links with the Government's City Action Teams.

I am copying this to members of H, the Leader of the House, the Chief Whip, No 10 and Sir Robert Armstrong.

Yours sincerely,

Kenneth Clarke

KENNETH CLARKE

(approved by Mr Clarke
and signed in his absence)

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Nat Health - Primary Health Care Mar 86

PRIME MINISTER 28 October 1987

PRIMARY CARE WHITE PAPER

The assumption underlying Mr Moore's note is that the draft White Paper contains a number of 'unpalatable' proposals which the medical profession can only be induced to accept by a combination of financial generosity and concession on key points in the Green Paper.

That is questionable on several grounds. Almost all of the White Paper proposals are worthwhile but distinctly cautious. (The DHSS says "coded".) It injects very little competition or private finance into primary care. And it is extremely generous, offering a real increase in spending of 10% over three years in addition to the 42% extra already spent since 1978-79. What, precisely, are the major concessions demanded of the medical profession in this White Paper in return for such largesse? I see some useful reforms, but in the absence of something more dramatic, we seem to be bribing them to accept our surrender.

(1) Higher Capitatation Fees

I find it difficult to believe that GPs would be antagonised by a proposal to give them more money - even if it came in a form which their "representative groups" don't particularly like and had opposed in the consultation period. [Note, incidentally, that Norman Fowler and Tony Newton were not able to urge sympathisers to push for a higher capitation element in GPs remuneration, or for other internal market ideas, because the consultation period coincided with the pre-election run-up when caution on the NHS was the rule. Consultations are always weighted in favour of existing interests - on this occasion, more so than usual.]

Increased capitation fees are the hinge of 'internal market reforms'. On them depend a number of other changes - for instance, directing special assistance to deprived people

rather than deprived areas; and charging GPs for certain hospital tests and minor surgery to discourage over-referrals. Their absence from the White Paper would be taken as a sign that the Government had abandoned its efforts to give financial clout to patient choice.

(2) 'Good Practice Allowances' are quite another matter. They are not a market mechanism, but a set of bureaucratic incentives to manipulate GP services. Two things have happened to them in the White Paper: (a) the GPA, though formally abandoned, remains in the form of disaggregated item-of-service payments and specific grants; and (b), the sanction for poor performance has been watered down to a 'voluntary peer review'.

If you wish to retain good practice allowances under either dispensation, then a more effective sanction would be to put doctors on a fixed term franchise which, in notorious cases, would not be renewed. That would, of course, stimulate real opposition from the profession. And since there is no particular reason for us to favour GPAs, we might abandon the proposal altogether, even in its present weak form.

(3) Bearing the above points in mind, you might restructure the remuneration proposals in the White Paper as follows:

a. Remove some of the proposals for specific grants and extra payments and take a careful look at existing item-of-service payments.

b. Hold down the Basic Practice Allowance.

c. Attach the better performance conditions (now attached to special payments, grants and the BPA) to the provision of a higher capitation element in GPs remuneration as suggested in your letter.

Other Points

(1) We should question exactly how the information on local doctors will be provided to the general public. Who will see it? Where will it be published? What efforts will be made to bring it to the attention of most people - advertising, newspapers, local television, etc? Unless we have convincing answers on this point, we should press strongly for the removal of the ban on advertising.

(2) There is a strong division of opinion between the Treasury and the DHSS over the General Practice Finance Corporation. The DHSS thinks it would be easier to persuade the profession to accept its privatisation as a statutory corporation. Otherwise, GPs fear that a privatised GPFC would gradually abandon them as a loan market.

The Treasury would prefer straightforward sale to the private sector on the grounds that it would absolve the Government of responsibility for a body which would subsequently be making straightforward commercial decisions.

Properly handled, also, a direct sale would raise more money, approximately £123m as against £100m. To that the DHSS replies that opposition by the doctors to a full sale - and the subsequent row - would depress the price below the figure that a statutory corporation could raise.

Recommendation: Support the Treasury position. There is no good reason for GPs' fears. They are excellent risks. And there are ample sources of finance compared to when the GPFC was originally established. If a further safeguard is thought necessary, the Government could retain a 'Golden Share' of limited life to restrict the avenues of investment. Firmly and persuasively argued, such a position should not attract too much medical opposition, particularly when so much else in the White Paper is welcome to them.

(3) Should the White Paper not include some reference to relaxing restrictions on private contributions to primary care? For instance, patients might be allowed to pay for an annual health check and a personalised good health programme. (At present the White Paper proposes an initial health check when a new patient joins a doctor's register). Or a company like Aircall, which provides locums on a commercial basis, might be invited to contract to provide GP services to an under-doctored part of the inner cities.

(4) We should support the Treasury proposal to transform improvement grants to practice premises into improvement loans, at subsidised interest rates if necessary.

(5) We should remove the sentence stating that the Government has no plans to extend the selected list scheme. This removes a good incentive for sensible prescribing.

(6) The earlier note elided a new distinction between some NHS pharmacies in rural areas which receive a fixed cost grant and most pharmacies which, under the contract introduced last April, have their fixed costs reimbursed under the general cover of prescription payments. This is a trivial point and in no way affects the proposal that there should be a tendering system for NHS pharmacies. That we should continue to press.

(7) To solve the problem of too many dentists, the White Paper proposes compulsory retirement. No age is cited but I gather that it would be at 70 years. That may not be enough to reduce the over-supply. If so, we might also consider a tendering system for dentists in the NHS.

I have a meeting tomorrow at the DHSS with Mr Rayner, when I shall discuss some of these points.

John O'Sullivan

JOHN O'SULLIVAN

SECRET

PRIME MINISTER

PRIMARY CARE WHITE PAPER

You and I are to meet on Thursday to discuss the draft White Paper on Primary Care that Tony Newton circulated on 20 October. You might find it helpful to have in advance a note on our general approach.

The White Paper serves a number of purposes:

- it provides a positive framework in which to set the large increase in dental charges and the removal of sight testing from the NHS, between them raising £140 million;

- in addition, it announces that the accompanying Bill will limit to a minimum the Government's future involvement in loans to general practitioners for practice premises, thus enabling me to realise £80 million from selling the General Practice Finance Corporation's loans;

- it stakes out the ground for some far-reaching changes in the family practitioner services, particularly in general practice;

- it represents our political commitment to improving the primary care services.

The White Paper is the next stage in the process started publicly by the Primary Care Discussion Document. Norman Fowler, Tony Newton and other Health Ministers carried out an unprecedented series of

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public consultation meetings, partly with the object of mobilising the support of the consumer bodies and thereby placing greater pressure on the professions. The consultations helped put us in a position to publish a White Paper setting out changes that the medical profession will find unpalatable in part.

But some proposals got a distinct thumbs down from practically everyone, among them the "good practice allowance" and the possibility of raising significantly the proportion of a GP's income paid in capitation fees. The first proposal cannot, in the form outlined, be introduced without the cooperation of the medical profession, but we propose to meet the main objectives in other ways. I frankly doubt whether the second proposal could, as a means of influencing GPs' attitudes to their patients, ever have been achieved alongside our other proposals for remuneration. More important will be the steps we will be taking to give patients much more information about the services that individual practices provide.

As it is, I expect a pretty hostile response from the medical profession to our intentions for the GPs' contract. To go further would, I believe, antagonise the sympathetic elements in the profession and damage our prospects of reaching a satisfactory agreement. Moreover, it would jeopardise completely the sale of the GPFC's loans which I am required to undertake to fulfil the PES commitment for £80 million entered into by my predecessor, Norman Fowler, and which can only be carried out with the agreement of the profession.

Finally, on timing, I intend publishing the White Paper simultaneously with the Bill in order to help with the presentation of the latter. To assist the business managers, who are anxious for early introduction of the Bill, I propose launching the White Paper on 19 November which in turn would require that it be sent to the printers by 10 November.

27 October 1987

J M

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Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Switsfwrdd)
01-270 0569 (Llinell Union)
Oddi wrth yr Is-Ysgrifennydd Seneddol

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Switchboard)
01-270 0569 (Direct Line)
From The Parliamentary Under-Secretary

IAN GRIST MP

SECRET

27 October 1987

Dear Tony,

VBPM.

PRIMARY CARE WHITE PAPER

FILE ON B/UP.

I have been studying the White Paper draft which accompanied your letter to the Lord President and other colleagues in H Committee.

I know that discussions are continuing at official level on further minor drafting amendments but I am glad to see that those amendments which we considered essential, if the Welsh angle was to be covered adequately, have already been taken on board. I am therefore content with the proposals.

/ Copies of this letter go to all members of H Committee, the Lord President, the Leader of House, the Chief Whip, No 10 and Sir Robert Armstrong.

Yours ever,

Ian

Tony Newton Esq OBE MP
Minister of Health
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY

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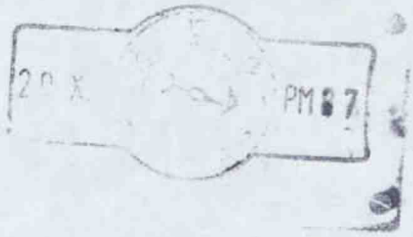

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Note on No 10's letter of 26 October

Primary Care White Paper

The need to sharpen up the doctors' remuneration system to encourage the raising of standards and to achieve better value for money is recognised and fully reflected in the draft White Paper.

In the Primary Care Discussion Document Norman Fowler floated the idea of a good practice allowance together with greater reliance on capitation fees as a means of achieving those objectives. Little support was forthcoming from either professional or lay opinion.

A number of serious difficulties emerged which are summarised below:

(a) While more money via capitation will encourage doctors to look for patients it will also have the adverse effect of encouraging doctors to give their patients what they want. This will lead to wasteful over-prescribing and unnecessary referral to hospital.

(b) Capitation fees as such are no guarantee of the quality and extent of care. Some doctors might be content to earn the higher capitation fee and not bother with the good practice allowance.

(c) If the capitation fee were to form a much higher proportion of income (eg 70% instead of 47%), little financial room would be left for specific incentives (eg money targeted at increasing vaccination, immunisation and cervical cytology).

While it is not possible to say what proportion of total income capitation fees will form until our negotiations are complete, the White Paper proposals will enable us to achieve the same significant improvements which in theory it was thought could be got through a good practice allowance and capitation, namely performance related pay and a work sensitive contract with the doctors.

To take the key expressions from David Norgrove's letter - "internal market", "sanctions" and "incentives", the following proposals score pretty well:

- providing consumers with more information about local doctors, making it easier to change doctors and simplifying the complaints procedure; thus consumer choice is strengthened and a degree of competition introduced.

- paying the doctors through specific allowances for the services they provide (eg for extra attention to children and elderly patients); in this way we target the money at our health policy objectives;

- making it hurt financially if these services are not provided.

- abolishing out-of-date allowances that no longer provide an incentive (eg group practice allowance, vocational training allowance) and redistributing the money through more effective incentive schemes.

- tightening up qualification for existing allowances (eg requiring 1500 patients instead of 1000 to qualify for basic practice allowance - £7,850 pa); doctors currently paid full allowances for what is in effect a part time job will feel the pinch.

- extending practice teams to achieve a better service for patients and consequently some labour substitution (eg more patients to see the practice nurse, counsellor and others instead of the doctor).

- introducing new allowances related to current needs (eg to encourage doctors into inner cities and to keep up to date by attending courses).

- shifting the onus for payment towards bonuses for reaching targets rather than on item of service payments.

- strengthening the Family Practitioner Committees' management and enforcement role, in particular to monitor performance and to take remedial action (eg withholding rent and rates reimbursement where premises are sub-standard)

This is a comprehensive package. It needs to be to balance the impact of the new charging arrangements. There are in addition a number of health promotion developments in dentistry, pharmacy, ophthalmics and community nursing which are not covered here but which all add to the positive nature of the White Paper. The specific points raised in the annex to David Norgrove's letter are answered in the attached note.

DHSS's response to detailed comments from No 10

Paragraph 3.22

No 10

The proposal to publish more information on individual GP practices, together with simplification of the right to change doctor is welcome. It would also be useful to propose giving doctors the right to advertise (as is proposed for dentists), and the information published by the FPC might include the current size of each doctor's list of patients.

DHSS response

General Medical Council (GMC) has already eased restrictions on making practice information available to patients. More information for patients is encouraged but self promotion is not. The change agreed by the GMC opens the way for the Green Paper proposals that doctors should make greater use of leaflets to let patients know what services they provide. The GMC is currently under pressure from the Office of Fair Trading (OFT) to go further in the light of the Monopolies and Mergers Commission's pro-advertising reports. Advertising by doctors is a minefield because of the delicate relationship between patient and doctor and the profession is unhappy at going even as far as the GMC has allowed. Ministers have adopted a neutral position, being content to let the OFT fight the good fight.

We can explore the inclusion of list size on the FPC published medical lists, although such information may not be of much use to patients. A short list does not necessarily mean better service. Nor does a long list.

Paragraph 3.28

No 10

The proposal here is for a new allowance for doctors working in areas of deprivation. A high differential capitation fee might perform the same task more precisely since it would be targeted on deprived people rather than deprived areas.

DHSS response

An allowance is administratively much simpler than an enhanced capitation fee. There is a higher than average turnover of patients in inner cities. A capitation fee would have to be adjusted as patients moved in and out. This would create some instability of income for doctors which would work against our need to attract young doctors and their families into inner city areas. In addition an enhanced capitation fee would be expensive in FPC time without giving any benefits over a doctor-related allowance.

Paragraph 3.39

No 10

It appears from this paragraph that the General Practice Finance Corporation is to remain a statutory corporation, but be freed from restrictions on obtaining private finance. Why should it not be privatised outright?

DHSS response

Our objectives are:

- that Government should get out of the business of making loans to doctors.

- that we should deliver to Treasury, as agreed in the 1986 Survey, a once-off saving of £80m.

- that the sale of the GPFC should be in a form that is acceptable to the doctors who could otherwise scupper it (either by refusing to consent to have their loans transferred or through their opposition making it a commercially unattractive proposition).

After lengthy consultations with the GPFC and the profession, and with advice from Hambros, we now have a package that will meet the three objectives and will deliver savings of well over £100m. The proposed Corporation will, in all but name, be a company under the Companies Act: it is envisaged that a financial institution would subscribe 51% - 75% of the equity capital with the balance owned by a Trust for the benefit of the medical profession. Tony Newton is meeting the profession next Thursday to conclude this - in time for inclusion in the Bill. In short, we are privatising the GPFC, in a way that, we think, will meet all our objectives.

Paragraph 3.54
No 10

The White paper rightly points to over-referral by GPs as a major cost and efficiency problem for the NHS. But it offers no solution beyond "inviting" the offending doctor to discuss his referral patterns "with a view to..... making effective use of hospital care". This is weak. It would be preferable to try to build in financial incentives through capitation fees so that, for example, a GP would be expected to perform a wide range of tests and minor surgery as part of his normal duties. A referral of a patient to hospital for treatment from this recognised range would be billed against the doctor by the hospital. The capitation fee paid to the GP would be high enough on average to compensate.

DHSS response

Referral rates of doctors can vary at least fourfold but the reasons are not fully understood. It is much too soon to look for radical solutions. We need first to understand why some doctors refer more

than others. Research projects are under way. Where we have the information and can understand its significance we can seriously consider the No 10 proposal, which would of course have substantial implications for the financing of health care.

Making doctors pay for their patient's hospital treatment would probably result in their resisting taking on elderly or chronically ill patients.

CHAPTER VI

No 10

Under the new contract for community pharmacists introduced this year, the local FPC pays a grant to meet the fixed overhead costs of NHS pharmacists as well as their variable costs. Ideally, pharmacists would be paid per prescription handled. This would hurt some pharmacists in rural areas. A second best alternative would be for the local FPC to estimate how many pharmacists are necessary in a given area, and put the contracts out to tender.

DHSS response

What is proposed here is in fact already in operation. The new contract for pharmacists introduced in April 1987 made two main changes. First it did away with the basic grant to pharmacists (the basic practice allowance) which used to cover fixed overheads and some variable costs. In its place larger fees are paid for each prescription dispensed. Small isolated pharmacies receive a special extra grant, so that they stay viable. Second, the new contract set up controls for entry so that the local FPC can now decide whether a new pharmacy should be opened. We propose to review the new arrangements when we have had sufficient experience of them.

Paragraph 6.21
No 10

This rules out the expansion of the selected drug list, noting the willingness of the medical profession to employ economic prescribing by voluntary means. To rule out an extension of the selected list scheme may, however, be to deny a useful incentive.

DHSS response

Three points:

- What is said in the White Paper is no more than was said only a few months ago in the General Election, something which the Chief Secretary accepted made a significant extension of the Selected List impossible.

- A statement that we have no plans now does not inhibit us from formulating them later, and it wouldn't rule out considering at some future time the "modest" extensions discussed in the PES bilateral.

- But the positive objective which we are seeking by referring to the Selected List in the White Paper is the linkage of the statement about non-extension with the comment on the medical profession's willingness to achieve savings by voluntary means. This would be a clear and important signal to the general practitioners that the Government would have to reconsider its position on the Selected List if they didn't make improvements voluntarily. This will be emphasised by additional words to be inserted in the White Paper.

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JD

bc BG

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

26 October, 1987.

PRIMARY HEALTH CARE WHITE PAPER

The Prime Minister has seen your Minister's letter (undated) to which was attached a draft White Paper on primary health care.

The Prime Minister has a number of concerns about the draft, and in particular that it seems to mark a retreat from the Green Paper and its intended movement towards the creation of an "internal market" in the provision of primary health care. The Green Paper, for example, proposed that there should be an increase in capitation fees as a proportion of GP remuneration. Under the White Paper proposals, capitation fees, in contrast, would fall from 34.4% of income in 1984-85 to 31.2% in 1990-91. Very few sanctions are proposed which would be available to put pressure on less good GPs to improve their performance. Real spending on primary health care would rise by 12% over the next three years with very little concession from the doctors, except some modest monitoring and "voluntary peer review". There would be less reliance on incentives, by comparison with the Green Paper proposals, and more reliance on allocation of resources by the centre, in the form item-of-service payments and grants. The "good practice allowance" proposal in the Green Paper has been dropped.

The Prime Minister wishes to discuss the draft with your Minister and the Secretary of State for Health and Social Services.

I am attaching some more detailed comments.

A copy of this letter and its enclosure goes to Geoffrey Podger (Department of Health and Social Security), to Mike Eland (Lord President's Office) and to Sir Robert Armstrong.

David Norgrove

Miss Jenny Harper,
Office of the Minister for Health.

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MORE DETAILED COMMENTS

PARAGRAPH 3.22

The proposal to publish more information on individual GP practices, together with simplication of the right to change doctor is welcome. It would also be useful to propose giving doctors the right to advertise (as is proposed for dentists), and the information published by the FPC might include the current size of each doctor's list of patients.

PARAGRAPH 3.28

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PARAGRAPH 3.54

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enough on average to compensate.

CHAPTER VI

Under the new contract for community pharmacists introduced this year, the local FPC pays a grant to meet the fixed overhead costs of NHS pharmacists as well as their variable costs. Ideally, pharmacists would be paid per prescription handled. This would hurt some pharmacists in rural areas. A second best alternative would be for the local FPC to estimate how many pharmacists are necessary in a given area, and put the contracts out to tender.

PARAGRAPH 6.21

This rules out the expansion of the selected drugs list, noting the willingness of the medical profession to employ economic prescribing by voluntary means. To rule out an extension of the selected list scheme may, however, be to deny a useful incentive.

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CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street, SW1P 3AG

Tony Newton Esq OBE MP
Minister for Health
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
London
SE1 6BY

NBM.

26 October 1987

Dear Tony,

without

PRIMARY HEALTH CARE WHITE PAPER

Thank you for sending me a copy of your letter of 20 October, enclosing a copy of the draft White Paper.

The draft presents the improvements we have agreed upon, and the measures for paying for them, in a constructive way and in general, I find much to admire in your proposals. I do, however, have reservations in some areas. I refer in particular to what is said in chapter 3 about money for improving inadequate premises and about the future of the General Practice Finance Corporation; and the drafting of paragraphs 6.21 - 6.23 about measures to secure more economical prescribing.

Para 3.37 sets out proposals for improving practice premises. I am pleased that you have decided to be more selective and to target assistance from a cash limited fund only on those premises where exceptional assistance is necessary. It follows, I hope, that you will end the present arrangements for open ended access to the cost rent scheme (subject only to the suitability of the premises in question). Family Practitioner Committees could be given a quota for new entrants to the scheme, to be used selectively to support investment where it would not otherwise take place. I am doubtful too about the proposal to make improvement grants to upgrade unsatisfactory premises. Surely it would be better to offer assistance via loans (at subsidised interest rates if necessary), rather than via grants?

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A drafting note just before para 3.39 draws attention to the fact that the sections on the GPFC have been prepared on the basis that it will be reconstituted as a statutory corporation in the private sector. I have yet to receive firm proposals from you on this, but I should mention now that I shall take much convincing that this is the right course. I see the options as a straightforward sale of the GPFC to a private sector buyer; or retaining it in its present form (with a much reduced role, though one that could be made consistent with your wish to target assistance for premises where it is really needed) and selling much of its existing loan portfolio.

In the recent Public Expenditure Survey, it was agreed that a much more concerted effort should be made to improve the economy of GP's prescribing. You set yourselves a target of raising the level of generic prescribing from the present 39% to 50% over the Survey period. Paras 6.21 and 6.22 do insufficient justice to your new initiative. We need to demonstrate that we are serious in the quest for improving value for money here. I must also ask you, please, to remove the sentence recording that the Government has no plans to extend the selected list scheme, or to introduce compulsory generic prescribing or substitution. At the Health PES bilateral meeting on 25 September John Moore said that "whilst he stood fast against a significant extension, he was prepared to look again at the possibility of more modest extensions in future years". I do not believe we should cut out future options which we agreed might be worth pursuing.

I note that the draft is silent about the exact levels of the new fees to be charged. Is it your intention to make a separate announcement about these, and if so, when?

I am copying this letter to Willie Whitelaw and other members of H Committee, to John Wakeham, David Waddington, David Norgrove at No. 10 and to Sir Robert Armstrong.

Yours Ever,
John

JOHN MAJOR

NHS HEALTH: primary health care: march 86.

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Prime Minister

Prime Minister 23 October 1987

Draft White Paper on Primary Health Care

The White Paper is a near miss. It contains a large number of worthwhile reforms - for instance, requiring GPs to offer a wider range of medical services in return for the basic practice allowance (BPA); providing patients with more information about local GPs; making it easier for them to change their doctor; and easing the complaints procedure. Some of the chapters - notably those on the dental and opthalmic services - show a real commitment to patient choice in health. And because it promises increased resources, it is likely to receive a warm welcome from the medical profession.

These advantages, however, are set in an overall context not of liberalisation and patient power, but of greater efficiency achieved by tougher centralised management. In comparison with the Green paper it represents a move away from an "internal market" model of health care towards a more streamlined bureaucratic model. In political language, it is a Heathite document rather than a Thatcherite one.

SIGNS OF THE TREND

(1) This drift can be seen most clearly in the central chapter (Chapter III) on General Medical Services. Here there is an explicit retreat from the Green Paper proposal that we should increase capitation fees as a proportion of GPs increases (which would then function, in effect, as a portable health voucher for primary health care). Indeed, under the White Paper proposals, capitation fees as a proportion of doctors' gross incomes would actually fall

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from 34.4 per cent in 1984-85 to 31.2 per cent in 1990-91 (See Annex A).

This is the other major point.

(2) Partly as a result, GPs' remuneration is now more reliant than before upon a mixture of item-of-service payments and specific grants for improved practice. (Although the general "good practice allowance" is cast out of the White Paper, it reappears there in covert and disaggregated form as grants for postgraduate courses, additional payments for preventive health services, improvement grants for practice premises, etc). No doubt this is intended to give the NHS bureaucracy a battery of incentives to improve GP performance. In fact, it is unlikely to do so for three reasons.

First, item-of-service payment, though meant to encourage new medical treatments, remain on the books long after the services in question are part of every doctor's basic skills (e.g. vaccination). GPs then get paid twice for the same service, once through their Basic Practice Allowance, and a second time in the form of a special payment. A case in point is health promotion and prevention of ill-health activities. In the White Paper these are said (rightly) to be covered by the BPA, yet they also attract special payments. It is safe to assume that they will do so long after annual health checks are a regular and expected part of every patient's experience. In short, item-of-service payments should, if anything, be cut back; in the White Paper they proliferate.

Second, although we can measure the inputs for better standards easily enough, we must accept that they are a poor guide to whether higher standards have actually been achieved. How, then, do we measure the output - the quality of care. The White Paper suggests number of worthwhile ideas - consumer surveys; monitoring of rates of hospital referrals by Family Practitioner Committees; annual reports

to by GP practices to FPCs; and area studies of primary care standards by joint FPC-DHA teams. (Two such experimental studies are at present being conducted.) But it should be recalled that 50 per cent of FPC members in charge of the monitoring are themselves drawn from the medical profession and so likely to be indulgent critics of professional colleagues. (See the record of consultants in this regard). We don't really know how to improve GPs quality of service. In the absence of vigorous competition between GPs, each advertising a different range of medical services, we are unlikely to discover how to do so.

Third, even if we did know, there are few sanctions available to the NHS to improve the performance of backward and recalcitrant GPs. The White Paper suggests "experiments in voluntary peer review". That is a transparently feeble solution which suggests that poor performers may even keep such of the incentives to better practice as they manage to obtain.

What the bureaucratic model of primary care offers, then, is a donkey which can be offered carrots but never threatened with sticks. It has no equivalent of the market loss suffered by GPs who lose income when their patients depart with a large capitation fee on their backs.

(3) Except for the chapters on dental services and opthalmic services, and the proposals to make it easier for patients to change doctors, there is little in the White paper about encouraging competition or opening doors to the private sector. This is especially obvious in relation to promoting healthy living where the private sector has played a pioneering role. (Incidentally, the tone of some health promotion passages - that of an over-eager gym-mistress - will greatly irritate our more libertarian supporters, not least in the medical profession.)

Edwina's hand?

He won't Should we not consider, if the Chancellor will allow it, fiscal incentives for company-wide health schemes? Have we abandoned all interest in allowing patients to top up care with their own money - perhaps the payment of an additional fee for a personalised health promotion programme? Might it be possible, for instance, to hire commercial locum services to provide regular GP services to those inner city districts which remain under-doctored?

On such points, which were raised in response to the Green paper, the White paper is silent. (Further specific criticisms of the White Paper proposals are included in Annex B.)

The Choice

The costs of financing primary care development are substantial. It has received a 42% real increase in resources since 1978-79. But has output or productivity improved as a result? Certainly, the Government's popularity has not noticeably improved.

Under the White paper proposals, real spending on this sector would rise by 12% over the next three years. Some of the expenditure will be met from extended charges on sight testing and dental treatment - £20m, £110m and £140m in each of the next three years. In addition, there will be an Exchequer contribution of £194m, £207m, and £435m respectively. To justify this additional finance for a sector of health care which has already received generous treatment, we should be able to point to major steps in the right direction. Can we do so?

The doctors have made no sacrifices in return for this additional largesse - the most they will concede in return for the extra grants made available to them is some modest monitoring and "voluntary peer review". Nor has the

bureaucracy. We are actually confirming the present bureaucratic system in which officials move about large blocks of money to encourage whatever practices are currently favoured by the DHSS. This will inevitably mitigate against -- or, at the very least, fail to advance -- greater efficiency, patient satisfaction and the introduction of "best practice" techniques (all of which competition tends to promote). The reforms proposed under the general heading of the "internal market" (for which the existing capitation fee is ideally suited) have been sidetracked. And the genuinely useful reforms which the White Paper does include would fit just as comfortably into a more liberal, open system.

The question therefore arises: should publication of the White paper be delayed until these central flaws are examined and perhaps corrected.

The pressures for publication on the 17th November are essentially those of short-term parliamentary and political convenience. There is an early legislative slot which may not recur soon or easily. And publication would reveal that various financial benefits are proposed for the doctors and the NHS which will go some way to offset the unfavourable impact of the dental and opthalmic "cuts" whose financial consequences will be evident from the Autumn Statement.

We do not dismiss the significance of these factors. Against them, however, a White paper plus legislation now would determine the policy on primary care for a decade. It would be a policy of modest improvements in the present structure - a structure that delivers neither increased efficiency, high quality care or real patient choice. We would have rushed in - in order to tinker.

In these circumstances, delay and a rethink, even at some cost in political embarrassment, seems a wiser course.

ANNEX A

[Two objections are generally raised to greater reliance on capitation fees. It is said, first, that they might result in GPs recruiting more patients than they can adequately treat. If this were so, it could be easily dealt with by imposing a limit of, say, 3,000 patients per doctor. But it isn't so. Scandinavian GPs, working in the health teams favoured by the White Paper, treat as many as 5,000 patients.

The second objection is that some GPs might deliberately recruit from the healthy sectors of society, getting a high income for little work. Again, that could be easily dealt with by providing priority groups and inner city inhabitants with generous differential capitation fees. (The elderly already receive them). Anyway, with the increased responsibility for health checks and advice on healthy living, GPs are likely to find the 20-45 year olds much less passive patients than they have been till now.

In short, neither objection is convincing; both objections exhibit a bureaucratic suspicion of markets and consumer competence.]

ANNEX B

Paragraph 3.22 and following. The White paper promises much more published information on individual GP practices together with a simplification of the right to charge one's doctor. This is excellent, but it should surely be more effective if accompanied by the doctor's right to advertise his services - a right the White paper recognises in relation to dentists. Also, the information published by the FPC might include the current size of each doctor's list of patients.

Paragraph 3.28. The proposal here is for a new allowance for doctors working in areas of deprivation. Surely a high differential capitation fee would perform the same task more precisely since it would be targetted on the deprived people rather than areas.

Paragraph 3.39. It seems from this paragraph that the General Practice Finance Corporation is to remain a statutory corporation, but to be freed from restrictions on obtaining private finance. Why should it not be privatised altogether?

Paragraph 3.54. The White Paper rightly points to over-referral by GPs as a major cost and efficiency problem for the NHS. But it offers no solution beyond "inviting" the ofending doctor to discuss his referral patterns "with a view to ... making effectuve use of hospital care." That leads nowhere.

What is needed, of course, is a financial incentive for good behaviour. Under a system of high capitation fees that might be provided as follows: The GP would be expected to perform a wide range of tests and minor surgery as part of his normal duties. Were he to refer a patient to hospital for treatment from this recognised range, therefore, the

hospital would send him a bill for it. This would also provide the financial incentive for GPs to carry out minor surgery called for in Paragraph 3.39. It might, finally, act as an incentive to group practice which the White paper favours throughout.

Chapter IV, covering the dental services, both suggests a major reliance on capitation fees for children's dental care and supports a move to allow greater freedom for advertising.

Chapter V, covering General Opthalmic Services, is able to report a general success for the policy of ending the optician's monopoly, removing the general provision of spectacles from the NHS, and providing vouchers to meet the needs of those who cannot afford to purchase them privately.

This policy is now extended in two ways:

(a) sight testing is now removed from the NHS (with the exceptions of the usual suspects amounting to 30% of those tested).

(b) Sight testing will be separated from the provision of spectacles. The White Paper would prohibit an optician from offering sight tests only on the condition that spectacles were purchased.

These are excellent proposals and a reminder that in politics courage often pays.

Chapter VI. Under the new contract for community pharmacists introduced this year, the local FPC pays a grant to meet the fixed overhead costs of NHS pharmacists as well as their variable costs. To prevent public expenditure rising uncontrollably, the NHS controls entry by contract. New pharmacies will only get an NHS contract if the local

FPC considers that they are either necessary or desirable.

An alternative market approach, of course, would be to end the reimbursement of fixed costs and simply pay them per prescription handled. We would then be able to control public expenditure without restricting the number of pharmacies in a dirigiste fashion. This was rejected, however, because it would hit small pharmacists in rural areas.

There is, however, some scope for a second best market solution. The local FPC would estimate how many pharmacists are necessary in a given area and put them out to tender. It is a pity, therefore, that this chapter rules out any major changes to the new contract.

Paragraph 6.21. Is it necessary to rule out any intention of expanding the selected list, which has cut the cost of drugs to the NHS by £75 million in its first year of operation, to other therapeutic areas? The reason given is that the Government has noted the willingness of the medical profession to employ economic prescribing by voluntary means. But by ruling out extending the selected list scheme, it perhaps deprives itself of a useful incentive.

Otherwise this chapter has excellent suggestions - in particular, that pharmacists should be able to delegate to trained assistants some of their present responsibilities in dispensing. This would free them for a wider role in health promotion.

Chapter VIII contains an excellent strengthening of the patient complaints procedure.

John O'Sullivan

JOHN O'SULLIVAN

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CCBC 3

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522

From the Minister for Health

The Rt Hon The Viscount Whitelaw CH MC
The Lord President
Privy Council Office
68 Whitehall
London SW1A 2AT

Dear Willie,

PRIMARY HEALTH CARE WHITE PAPER

Cabinet considered our proposals for primary health care on 10 September. The proposals were approved subject to some expenditure points which have since been resolved with the Chief Secretary. The way is now clear to publish the White Paper. A copy of the draft is enclosed. — in attached folder.

It might be helpful to H Committee colleagues to whom the draft is copied, if I highlight the main points. The thrust of the document is health promotion and the prevention of ill health - hence the title "Promoting Better Health". This is brought out in particular in chapters 1 and 3. The resources implications need careful presentation in view of our plans to raise income from new charging arrangements. This is done in chapter 2. Much is made of recent and planned expenditure. I would also draw attention to chapter 9 on Inner Cities.

Our plans for launching the White Paper are currently being worked up. The White Paper contains many proposals which will be widely welcomed and we must make the most of them.

As to the publication date, we favour a date a few days after the Autumn Statement, and no later than 17 November. The Bill for the related legislation will be published at the same time. With John Moore's agreement I am seeking H Committee clearance by correspondence, since the proposals closely follow the principles considered and agreed by colleagues at earlier stages. In the circumstances I shall be glad of a reply by 26 October. We shall assume colleagues are content if I do not hear from them by that date.

Copies of this letter go to all members of H Committee, the Leader of the House, the Chief Whip, No 10 and Sir Robert Armstrong.

Yours ever,
Tony.

TONY NEWTON

Enc.

YdS/D.12

SECRET

SECRET

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON
SW1P 3AG

17 September 1987

NBPM

In the margins of our Public Expenditure bilateral on 14 September we discussed the outcome of the Primary Health Care discussion at Cabinet on 10 September, in the light of the minute recording Cabinet's decisions circulated by Sir Robert Armstrong. I confirmed that it was our joint understanding that we had agreed the increases proposed for dental charges in my Paper (C(87)15) and that there would be a package of Primary Health Care improvements, the exact cost and composition of which would be for discussion between us in the forthcoming PES round.

I am copying this minute, for the record, to the Prime Minister and to Sir Robert Armstrong.

JOHN MOORE

SECRET

10 DOWNING STREET

Prime Minister

You will want to emphasise the need to keep this discussion confidential.

JHW
9/9.

Pr. Health Care -
encouraged expenditure.

9 out of 10 - PHC.

£3

Agriculture

L-C

Parl Sec

Welsh

Chief Sec

Chancellor of the Duchy

Sc. Sec

H. Secretary

For. Sec

Gen. Fin. Corpn.

Optical Charges

Ref. A087/2565

PRIME MINISTER

PRIMARY HEALTH CARE
(C(87)15)

DECISIONS THAT ARE REQUIRED

1. The main decision that is needed is whether the forthcoming Primary Health Care Bill should contain provisions to enable charges to be made for dental examinations, as well as treatment.

2. If the main decision is in favour of such a charge, you may also wish the Cabinet to confirm that the speed at which improvements in primary health services can be financed and introduced is a matter that must be resolved in the public expenditure round, in the normal way.

BACKGROUND

3. On 10 March 1986 (CC(86)14:4) the Cabinet agreed the then Social Services Secretary's proposals for a discussion document on primary health care, which has since been subject to a good deal of public discussion and consultation with the professions. Mr Fowler stated than that his key objects were to raise standards, to make the services more sensitive to consumers, to promote health care and to pursue value for money: the doctors' contract should be revised to encourage better performance, and there should be far more emphasis on preventive medicine. Mr Fowler also said that the discussion document was intended to open up debate on the whole question of charges.

4. In July of this year the present Social Services Secretary came to H Committee with a paper (H(87)27) seeking approval for the contents of the Primary Health Care Bill, which needs to be introduced in November. The contents he proposed were for the most part a miscellaneous collection of provisions needed to make

promised PES savings in this field, or to meet technical legal points.

5. The two provisions that most attracted H Committee's interest were those to enable charges to be made for dental examinations (as opposed to treatment) and for sight tests. Mr Moore recognised that these were contentious proposals, but he made it clear that he hoped to be able to balance their reception by simultaneously announcing various improvements in the primary health care field, which he would present as being funded by the savings made by the new charges. The Chief Secretary, Treasury did not accept that hypothecation of savings.

6. H Committee was prepared to accept the proposed sight test charge, but was unable to agree the charge for dental examinations. Mr Moore was invited to consider whether he could meet his objectives by loading more of the charges onto treatment, and leaving dental examination free as at present. He concluded, however, that this was not practicable and brought the matter back to a meeting of H Committee on Tuesday of this week (H(87)13th meeting). Although a majority of the Committee supported the Social Services Secretary, several senior Ministers registered grave anxiety and a number of those who supported the proposal saw it as a watershed decision of great political importance. The Lord President therefore considered that the matter should be taken to Cabinet as soon as practicable.

MAIN ISSUES

i. The nature of the proposed charge

7. The existing dental charges do not apply to examinations but require the patient to pay the first £17 plus 40% of the balance of the cost of treatment, up to a maximum of £115. What is now proposed is a charge of 75% of the cost, including examination, up to a maximum of £150. The cost of an examination only would be just under £3, and small courses of treatment, such as an examination and a couple of fillings, would probably be slightly

cheaper under the proposed arrangements than the present ones. The significant increases in cost come at the top end of complicated treatment. Under the present exemption arrangements, which would be continued, 47% of dental patients are exempt in any event.

8. The proposal to charge for a simple examination raises two separate issues. Some Ministers see it as an issue of principle, since medical and dental examination under the NHS has hitherto been completely free. Other Ministers at H Committee were just as concerned about the difficulty of squaring the proposed new charge with the emphasis that the Social Services Secretary wishes to put on preventive medicine. Mr Moore argues that there is no evidence from earlier occasions that the level of demand for dental services has been permanently depressed by charges. But some Ministers will argue that this misses the point. They will say that dental health in this country is poor because people only visit the dentist when their teeth hurt: what is needed is to encourage people to go for frequent check-ups, and this will be made very difficult by a charge at the point of access.

9. On the point of principle, you will wish to consider how a controversy on this particular charge, and so soon after the General Election, might affect subsequent debate on charging the health services, and in particular whether it might push the Government into limiting its future room for manoeuvre. Some Ministers at H Committee thought that the politics of a controversy on health service charges at this moment would be extremely difficult to handle. Others thought that the whole question of health service charging needed to be opened up; that this was a modest and sensible proposal with which to start; and that the announcement of the charge should be accompanied by a clear statement of the Government's strategic intentions towards finding resources for the escalating cost of the health services.

ii. The PES dimension

10. As you know, Mr Moore is having considerable trouble in meeting his inherited PES commitments both on Health Service expenditure and on Social Security (on which you intervened recently to stop further work on a proposal affecting widows' benefit). Mr Moore had planned to meet £75 million of his commitment by removing the exemption from prescription charges for the elderly, but you indicated that you did not want that option pursued. Thereafter, a difference of view developed between the Treasury and DHSS which is summarised on the attached sheet, agreed between the two Departments at official level. DHSS are attempting to argue that they no longer have to find the £75 million that would have been secured from prescription charges on the elderly. Even though they make lower assumptions than the Treasury about the yield of sight test fees and dental charges, they therefore conclude that they have £3m-£52m-£87m to meet new expenditure. The Treasury, however, are naturally adamant that the £75m must still be found.

11. You will certainly not wish Cabinet to get drawn into this detailed figuring. But you will wish to bear in mind that the improvements in primary health care that the Social Services Secretary wishes to announce to balance the new charges have not been included in the DHSS bids for health and personal social services in this year's survey. Those bids are for £1021m/£1454m-/£2280m and, crudely stated, the Treasury argument is that the Social Services Secretary is trying to do a deal on the side by isolating the primary health care sector from the public expenditure round and hypothecating particular savings to finance improvements within it. The Chancellor and the Chief Secretary will certainly argue very strongly that this simply cannot be allowed.

iii. Implications for the Star Chamber

12. The timing of this imbroglio is particularly sensitive. Spending Ministers will certainly follow it with the closest attention, and will look for signals about the forthcoming Star Chamber.

13. Theoretically, at least, the matter could be resolved in one of the following ways -

a. Deciding that the timing and nature of the present charging proposal was not right for opening a debate on resources for the health service, and that the proposal should be vetoed. This would dispose of the immediate problem, but it would represent the third recent occasion on which a proposed saving device from Mr Moore had been blocked; and turning down a viable saving would send all the wrong signals for the Star Chamber.

b. Agreeing to the charge in principle, but on the condition that it was balanced by significant improvements in primary health care. This would be enough to win over some anxious colleagues. But it would be at the cost of damaging the PES discipline and the credibility of the Star Chamber.

c. Agreeing that the charge was probably acceptable, but making a final decision conditional on the shape of the overall package that emerged from the Star Chamber. This would totally destroy the locus of the Star Chamber, which exists to settle disputes of this kind.

14. Although not all colleagues will find it easy to accept, therefore, there is only one decision that does not damage the discipline of the public expenditure round in one way or another. This is that the proposed charge is acceptable in principle:

provision should be taken for it in the Primary Health Care Bill; and that the question of any improvements in the primary health care services, and how they might be financed, must be remitted to the public expenditure discussions in the usual way. The Chancellor and the Chief Secretary will argue strongly for nothing less than this.

iv. Views of Ministers

15. The Welsh Secretary is an unqualified opponent of the proposal, both on the issue of principle and on the problems caused for encouraging preventive medicine. The Scottish Secretary is extremely anxious, but only on the preventive medicine point (dental health in Scotland is apparently worse than in England). The remaining Health Minister, the Northern Ireland Secretary, is, however, in general support of the Social Services Secretary.

16. The Home Secretary is very worried about the politics of an announcement at this time. He would argue both for balancing improvements in primary health care and for a statement about the Government's attitude towards resources for health spending generally. The Lord Chancellor will probably simply say that the political row is not worth the money at issue.

17. The Environment Secretary, the Transport Secretary, the Employment Secretary and the Chancellor of the Duchy will all support Mr Moore's proposals, though the latter two may put some emphasise on the presentational advantages of simultaneously announcing improvements in primary health care services.

18. The Education Secretary supports Mr Moore's proposals, but on the footing that they will provoke a heated political debate about funding the health service, for which the time is now ripe. At H Committee Mr Baker described the issue as "a watershed decision".

19. The Chief Secretary is bound to reserve his position in the public expenditure discussions, as indicated above. I understand, however, that he is sympathetic to the political need for some balancing improvement in the primary health care services, and would endeavour to meet it if that can be done in the proper way, within the public expenditure discussions as a whole.

v. Parliamentary Problems

20. Finally, you will wish to note that the proposed new charge might well excite opposition from the medical profession, and would certainly add to the problems of handling the legislative programme in the House of Lords. The Lord President does not, however, believe that the Lords would try to block an essentially financial provision of this kind at the end of the day, and he does not think that the business managers' problems should be taken into account in deciding the matter.

HANDLING

21. You will wish to invite the Social Services Secretary to introduce his paper, and you might then invite the Lord President briefly to give the background from the point of view of H Committee.

22. You will then wish the Chief Secretary to reply to the paper, and you might then invite comments from the regional Health Ministers.

23. The Home Secretary will certainly wish to speak, and you may wish to invite comments from the Employment Secretary, as Mr Moore's precedessor.

24. Other members of the Cabinet may have general political comments to offer.

RA

ROBERT ARMSTRONG

9 September 1987

Family Practitioner Services: Treasury and DHSS positions on use of savings from sight test fees and dental charges

	Treasury			DHSS		
	1988-89	1989-90	1990-91	1988-89	1989-90	1990-91
Inherited PES Commitment	87	128	128	87	128	128
Income from sight test fees & dental charges ("Best Case")	30	140	140			
Less Mr Moore's bid for restoration of savings on prescription charges				75	75	75
	-57	12	12	12	53	53
Contribution from other savings to be identified	57					
Income from sight test fees and dental charges (DHSS assumption)				15	105	140
Balance to meet PES 87 bids	-	12	12			
Balance to meet new expenditure (not PES 87 bids)				3	52	87

This is now coming to Cabinet on Tuesday.

2

PRIME MINISTER

DLW 8/9.

8 September 1987

PRIMARY HEALTH CARE: DISCUSSION AT 'H' TODAY

The Lord President decided to refer the proposal to introduce charges for basic dental check ups to full Cabinet.

John Moore was absolutely insistent that without the new money that these charges would bring in, he could not present or pay for his primary health care proposals. Moreover, the sting that was attached to this new proposal would be removed by the benefits in his package of proposals.

The Chief Secretary together with Norman Fowler, John Wakeham, Kenneth Baker, Paul Channon and DTI backed John Moore. Vulnerable members of the community would be exempt. There is no evidence that raising charges deterred the use of these services. A major point was made that there is currently a huge growth industry in the private sector among individuals, companies and trade unions who pay for health checks from BUPA and PPP. The hundreds of pounds that BUPA charge for health testing does not deter health checks and the £2.90 that the National Health dental charge would be, should not deter people who can afford to pay it.

Against this came Peter Walker who was adamant that more frequent visits to the dentist should be encouraged and that the only way to do this was to maintain free dental checks. Michael Havers said we should certainly forego the £40m that these charges would bring in. Malcolm Rifkind was unhappy and said that it would be difficult to sell in Scotland because it might be seen as a blow against preventive medicine. Lord Denham said we might lose this proposal in the House of Lords.

Willie Whitelaw did not express a view, but took up a comment by Kenneth Baker that this was a watershed decision on the future of the NHS. He and the other members thought that it would be politically difficult, but said that we mustn't run scared of either houses if what we think we are going to do is right!

HB.

HARTLEY BOOTH

cc DN
TF
Press
PM
PIC

STATEMENT ON PRIMARY HEALTH CARE: MONDAY 21 APRIL 1986

With permission, Mr Speaker, I should like to make a statement about primary health care services.

These are the services provided outside hospital by family doctors, dentists, pharmacists and opticians and by the community nursing and other related services. They have never been comprehensively reviewed in the forty years since the 1946 National Health Service Act. Yet they account for nearly a third of total spending on the health service and over a million people use the services every day.

The Government is now carrying out a comprehensive review of primary health care. With my rt hon Friends the Secretaries of State for Wales, Northern Ireland and Scotland I am today publishing a discussion document which will form the basis for extensive consultations throughout the country. The Government's main objectives are to raise standards of care and to make services more responsive to the needs of the public. The document we are publishing discusses a number of ways of achieving those objectives.

So far as family doctors are concerned, the introduction of a Good Practice Allowance would reward both those doctors providing the highest standards of care and provide an incentive to others. This is in line with proposals made by the Royal College of General Practitioners. An allowance on these lines might recognise such features as the range of services provided, including preventive activities; the doctor's personal availability to his patients; and the achievement of particular targets for the levels of services such as vaccination.

The Government also believes that the public is entitled to more information about the different types of services that doctors provide to enable patients to make better choices when seeking a general practitioner. Together with arrangements that would make it easier for patients to change doctors, this would further help to raise standards and make the services more responsive to the needs of the public. This process would be assisted if - as is also discussed in the document - more emphasis was placed on capitation payments in the doctor's remuneration system, so as to increase the financial value to the doctor of the individual patient.

Among other proposed changes is a new flexible retirement system which would mean that as now doctors could retire at 60 but with a compulsory retirement age of 70. It is also proposed to end the 24 hour retirement rule where doctors are able to retire and rejoin the health service 24 hours later, collect a lump sum payment and in some cases draw both pension and pay in full.

One effect of these changes would be in inner cities where there is a disproportionately high number of elderly doctors. Although there is some outstanding work already done there, it is particularly important to raise standards in inner cities. This will entail attracting some younger doctors and to help achieve this the discussion document suggests the possibilities of providing financial incentives within the remuneration system; of adjusting the allowances paid to doctors for practice premises in order to compensate for the higher cost of accommodation in inner cities; and of experimenting with different forms of contract.

As regards dental services, the discussion document outlines ways in which patients could be more sure of getting the full range of National Health Service treatment. To help patients choose their dentist it suggests that the restrictions on advertising might be further relaxed and to improve value for money the Government will act upon the recommendations of the committee which it set up to consider the problem of unnecessary dental treatment. The discussion document also examines ways in which greater emphasis could be placed on preventive measures, and it outlines retirement arrangements similar to those discussed for doctors.

The Government also believes that pharmacists could and should play a larger part in the provision of comprehensive primary care services. The Nuffield Foundation recently published the report of an enquiry which shows some of the ways this can be achieved. Much has changed since the pharmacist's main function was to make up medicines himself, and he should now be enabled to make better use of his skills in advising patients and doctors on the use of medicines.

Among other matters dealt with in the document are ways of improving the procedures for dealing with complaints against family practitioners and the extension of informal conciliation arrangements for dealing with less serious complaints. The document also proposes an independent study of the quality of primary care services in England initially in one or two areas.

I am also publishing today the report of a review of community nursing services in England carried out by a team led by Mrs Julia Cumberlege, Chairman of the Brighton Health Authority. Among the matters on which the team has made recommendations are the establishment of neighbourhood nursing services; ways of making better use of nursing skills; and the training of community nurses.

The Government intends that there should now be wide consultation on the discussion document and the Cumberlege Report, taking account also of documents published by other bodies such as the Royal College of General Practitioners and the Nuffield Foundation. We want to hear the views of all those who are interested in raising the standards of primary care whether as providers or users of the service. To carry forward the review Ministers will be holding a series of consultation meetings not only in London but in several major cities outside like Birmingham, Manchester and Newcastle. We will be inviting to these meetings the professional bodies like the British Medical Association, the British Dental Association and the Pharmaceutical Society. But we also want to take evidence from voluntary organisations, the statutory health service agencies, and organisations concerned with the interests of consumers.

These proposals have been put forward for discussion and the consultations will last until the end of the year. At this stage, therefore, final decisions have not been taken. Many of the primary health care services are already provided to a high standard but the Government believe that further improvements are possible. It is for this reason that we have embarked on the first overall review of these services for forty years.

CCB/YP

PRIME MINISTER 9 April 1986

PRIMARY HEALTH CARE CONSULTATION DOCUMENT

Health, like education, fails three key tests:

i. Efficiency. Spending on the Family Practitioner Services has gone up from £2bn in 1979 to about £4bn in 1984-85 - a real increase of about 24%. It is not clear if output or productivity have improved as a result. No wonder the message on higher spending is not getting across - on the GP side, nobody can see what we've bought for our money.

ii. Choice. We are notionally free to change our GPs, but the culture does not encourage it. Because GPs don't advertise and don't set up directly in competition with each other, this right is in practice worth about as much as rights under the Soviet constitution.

iii. Standards. There are GPs practising today who have received no training for the past 30 years. There is no system of HMI-type inspection of their medical competence.

If health and education are to stop being such big losing issues for the Government, we must develop practical proposals for pursuing these three themes. This Consultation Document is an opportunity to set out ideas which can eventually go

into the Manifesto. Norman Fowler may even wish to legislate in 1987-88, though there is no need to commit ourselves at the moment.

Norman Fowler's draft successfully steers a path between:

- A document so anodyne and tame that it muffs your one great opportunity of reforming a distinctively British institution - Socialist interventionism mixed with professional cartels.

- A radical alternative system that would look fine as an IEA Occasional Paper, but would cause such an uproar in the medical profession that we would end up having to back down and disavow any plans for reform.

The paper is quite a meaty agenda for consulting the profession, without being suicidally controversial. It deserves a welcome. A guide to the document is in the attached Annex.

There are two different approaches to improving health care, just as there are in education:

- tougher central control;
- liberalisation and patient power.

The draft is a surprisingly effective compromise between them.

Tougher control

Under the current system, the cost of the FPS is above all determined by the number of GPs. So the Green Paper points to controlling GP numbers, getting rid of the duds who tend to be the older ones, and supervising the quality of the remaining GPs more aggressively. Assessing and rewarding the best GPs need not be bureaucratic (because we already assess GPs to decide which can be trainers) nor expensive (we can reward those who save money by modest drug prescribing). We have the power to do this because we have a contract with them (through our FPCs). If it works, that approach gives you a better managed service with higher quality GPs working harder and probably earning more.

Liberalisation and patient power

The patient power approach opens up primary care by increasing the size of the capitation fee as a percentage of GPs' remuneration, and allowing people to spend it wherever they wish. They should be able to take it to the private sector and top up with their own money. GPs would be free to advertise and set up in practice wherever they wished, so the bad ones would be driven out by competition. GPs would have a greater financial interest in running a large list and attracting customers. This portable capitation fee is in effect a health voucher for primary care.

Norman Fowler has gone quite a long way towards this free market model. The Green Paper proposes increasing capitation as a percentage of GPs' income; that the quality payment should be on a per capita basis; that it should be easier to change your GP; and that doctors should be allowed to give much more information to actual and potential patients.

Drugs

In 1984-85, the FPS spent £1,5 billion on drugs, and another £0.4 billion on the cost of dispensing them - almost one half of all expenditure on Family Practitioner Services. You asked Norman Fowler to investigate drug budgets, and he has agreed to look at "incentives for cost-effective prescribing". By this he means that if doctors cut their prescribing costs, they should be able to keep part of the savings to spend on local health care. You could make it clear to him that we need to cut the cost of drugs.

The Political Opportunity

Sometimes Ministers seem to be on the defensive - as if their jobs are a succession of problems interrupted by crises. The FPS consultation document is an opportunity to go onto the offensive. Its positive features are these:

- The themes of efficiency, standards and choice.

- We have a public agenda and should not be ashamed of it. It should kill any pre-Election talk of a secret agenda, at least for the FPS.

- Freedom. The document is not a miserable attempt to stop doctors doing things or to take rights away from them. It is intended to expand the range of options for financing or practising health care.

- Better use of public money.

Norman Fowler and his Cabinet colleagues should be urged to go out and spread the word. Admittedly, some GPs will be wary or downright hostile. But this can be overcome if:

i. Norman Fowler stays in close touch with the BMA and the Royal College of General Practitioners, so they feel their views matter.

ii. We publish a lively layman's guide (I believe Norman Fowler has this in mind). It could be available in GPs' surgeries as part of a wider public consultation exercise.

iii. MPs with an interest in health are contacted individually shortly before the Green Paper is published.

David Willetts

DAVID WILLETTS

ANNEX

PRIMARY HEALTH CARE CONSULTATION DOCUMENT: SELECTED HIGHLIGHTS

Chapter 1:

Paras. 8-10 Introductory statement of objectives

Chapter 2:

Paras. 5-23 Description of present financial arrangements

Paras.24-25 Very important suggestion of experimenting with private providers (such as the Harrow Health Centre)

Paras.26-28 Giving GPs a boost by saying some hospital tasks can go back to them

Chapter 3: The core of the paper.

Paras. 6-11 A good practice allowance (on a per capita basis). If some of the sillier items of service payments are abolished, and sensible drug prescribing encouraged, this should have little cost.

Paras.12-14 Increasing proportion of a GP's income from capitation fees.

Para. 15	More information (though the term "advertising" is not used).
Para. 16	Making it easier to change GPs.
Paras.17-21	Better complaints procedures.
Paras.24-26	Obliging doddery GPs to retire (76 GPs are aged over 80).
Paras.27-28	Better relations with hospitals.
Paras.31-33	More preventive medicine.
Chapter 7	The Treasury ghetto, where all the hard financial facts are to be found. Drug costs and charges are discussed in paras.17-24.
Chapter 9	Measures to help inner cities.
Chapter 11	Summary of conclusions. Important summary of proposals on page 78.

Ref. A086/1071

PRIME MINISTER

Primary Health Care

Flag A (C(86) 13)

BACKGROUND

The Secretary of State for Social Services has been reviewing primary health care with the intention of producing a discussion document, promised now for over two years. The draft attached to his memorandum deals mainly with the Family Practitioner Services (FPS) which are the services provided by general practitioners, dentists, pharmacists and opticians. H Committee endorsed the document on 19 March, but you thought that a social policy issue of this broad nature ought to be considered by Cabinet.

The SoS has now circulated a summary (at the back of the folder)

2. The impetus behind the review is the need for control of expenditure on the FPS. In 1983, the chartered accountants Binder Hamlyn were invited to examine the possibility of cash limiting the FPS. (The hospital side of the National Health Service (NHS) is already cash limited.) Their report concluded that it was not realistic to cash limit the FPS, but recommended other methods of control, including restrictions on the numbers of doctors and dentists by the implementation of a common retirement age and restrictions on entry into the profession. Potential savings from these proposals were written into the 1984 PES settlement and would have resulted in a reduction of £40 million in 1987-88. These savings cannot now be made from that source.

BRIAAG

3. Mr Fowler's objective now is to float some of the more controversial ideas for controlling the expenditure on the FPS in the context of other proposals which will be seen to render it more sensitive to the needs of the public and to improve standards of service. These include:

a. Providing more information to patients to enable them to choose the doctor who best meets their needs.

b. Extending the complaints procedures and making them easier to use and generally making it easier to change doctors.

c. Increasing the proportion of doctors' remuneration paid by way of capitation fees, rather than charges for specific services.

d. Making higher payments to doctors who provide the best standards of care.

e. Compulsorily retiring those doctors and dentists who are beyond the age when they could be expected to meet the demands of modern practice.

f. Experimenting with a monitoring service to assess the quality of primary care services in particular localities.

4. The discussion document is in the form of an agenda for discussion rather than a blueprint for action. It draws on the publications of other bodies, including the Royal College of General Practitioners. Mr Fowler will follow publication of the document with the wide-ranging consultation exercises of the kind employed in the Social Security review, and he explained to H Committee that he would not allow himself to be locked into bilateral negotiations with the professions until the discussion had built up momentum in this way.

BRIAAG

5. Although the main impetus behind the proposals is to reduce the projected rise in the costs of the FPS, Mr Fowler does not suggest any particular target figure. The main means by which costs will be controlled is the reduction in the number of practitioners and proposals to limit expenditure on drugs. In addition, the whole issue of charges for prescriptions etc and exemptions from those charges will be opened up for discussion.

6. Mr Fowler wishes to publish the discussion paper as soon as possible and to complete consultations by the end of the year. Legislation would be needed for some elements of a potential package but QL specifically rejected this for 1986-87 and H Committee noted that legislation of this kind of topic was best done early in the life of a Parliament.

7. There is a further political consideration. The Doctors' and Dentists' Review Body is about to submit its report for 1986. Both it and the Nurses and Midwives and Armed Forces Pay Review Bodies seem likely to come up with recommendations which are uncomfortably high, both in terms of repercussions elsewhere (the Chancellor hopes to get away with 6 per cent for the Civil Service) and in terms of cash limits. The Government may want to stage the implementation of the Review Body recommendations so as to keep within cash limits for 1986-87. The Cabinet will wish to consider the political risks of issuing a Green Paper which some doctors will see as a threat and at the same time or very soon after cutting back on staging a recommendation on their pay.

MAIN ISSUES

8. There is not likely to be any question of the need in principle to sharpen up the delivery of primary health services and to inject more competitive spirit into them. The overriding general assessment, however, is whether an initiative of the kind now proposed goes sufficiently far to produce a worthwhile pay-off without antagonising the medical professions to an

unacceptable degree during the run-up to a General Election. As the draft document points out, 650,000 people visit their family doctors every working day, and there would be a clear political penalty if doctors' waiting rooms were turned into centres of opposition to Government proposals that would be presented as expenditure cuts. H Committee thought that Mr Fowler had got the balance about right.

9. More specifically, you told the Secretary of State for Social Services, through your Private Secretary, that, while you generally welcomed his H paper, you had seven particular points to make where you thought the document might go further, or the presentation be sharpened. The reply from Mr Fowler's office (copies of the exchange of letters are attached) sets out how Mr Fowler intends to meet these points. Mr Fowler's response goes some way to meet the issues you had identified. If you want to pursue any of these points further, it might be simplest to note them as matters of detail to be settled in correspondence after the meeting.

Flag B

HANDLING

10. The Secretary of State for Social Services will be opening the discussion with a presentation of the consultation document, with visual aids. You may wish to indicate at the outset how much time he will have available for this: he has been told that the whole item might last for up to an hour.

11. You might then wish to ask the Lord President of the Council, as Chairman of H Committee, to add any points he wishes to make about that Committee's perception of the exercise, and the Chancellor of the Duchy of Lancaster to comment on the political and presentational aspects.

12. You may wish to say that you assume that the endorsement of H Committee implies that the Treasury and the territorial

Ministers are content with what is proposed. Subject to that, you might invite the comments of Ministers generally.

CONCLUSIONS

13. You will wish Cabinet to agree on -

a. Whether the discussion document should now be published as soon as possible in the form that Mr Fowler puts forward.

b. Whether the consultative exercise should be conducted on the lines that Mr Fowler has described.

c. Whether the timetable (ie consultation up to the end of this year, but no legislation until after a General Election) is appropriate.

RA

ROBERT ARMSTRONG

9 April 1986

010

cc BG

THE PRIME MINISTER

In Nick's absence I am writing to signify our general agreement to the proposals made by Norman for publishing the Discussion Document on Primary Health Care which will be discussed at Cabinet tomorrow. In so doing I can confirm that we have seen the recent exchange of correspondence between your Office and Norman's and are content with Norman's ideas for presenting the further points you have raised.

... I am copying this to other members of the Cabinet and to Sir Robert Armstrong.

9 April 1986

W R

CONFIDENTIAL

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DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Secretary of State for Social Services

David Norgrove Esq
Private Secretary
10 Downing Street

9 April 1986

Dear David

PRIMARY CARE

As you know, the consultation document will be discussed at Cabinet tomorrow.

I enclose a leaflet which we propose to publish simultaneously with the main document. Apart from a summary of the paper, it comprises most of the text of Chapter 11 (Conclusion) which may be useful as an aide-memoire for the discussion.

I am copying this to Private Secretaries to Cabinet members and to Michael Stark.

Yours sincerely

Jane

Jane McKessack
Private Secretary

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DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Mark Addison Esq
Principal Private Secretary
10 Downing Street

27 March 1986

Dear Mark,

PRIMARY HEALTH CARE

My Secretary of State is grateful for the Prime Minister's response to the discussion document on primary health care and proposes to meet the particular points she raised as follows:

(i) Smaller lists and quality of care

We will bring out in Chapter 2 the fact that there is little evidence of a direct link between doctors' list sizes and quality of care and that consequently there is little to indicate what might be an optimum list size.

(ii) Financial effects of GP referrals

The discussion document refers to the need for general practitioners to be supplied with information about their referral rates and how they compare with other doctors. The intention is to improve GPs' performance in this important part of their job. The funding of hospitals to take account of the numbers of patients referred to them is a rather different matter which might in the first place be examined by the NHS Management Board.

(iii) Topping up

The best way of getting this on to the primary care agenda would be by a reference to the recently restated BMA proposal that doctors should be able to charge their patients for providing routine medical checks where patients want them but where there are no clinical indications that an examination is necessary. When this idea was previously considered it was turned down because of the possibility of

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discouraging some people from getting the screening which they ought to seek and receive under the NHS and because of the extra demands on NHS diagnostic facilities likely to result. But the discussion document could invite comments on this sort of approach in an open-ended way.

(iv) Competition between medical practices

We intend to insert in Chapter 3 an invitation to comment on whether the restrictions on doctors entering practice unduly limit competition.

(v) Drug budgets

We would certainly like to find a way of introducing some discipline in doctors' prescribing. Drug budgets as such involve substantial presentational and technical difficulties, and it is highly desirable at the moment to avoid any statement that might prejudice the chances of reaching a satisfactory agreement with the pharmaceutical industry on drug pricing. We therefore propose to insert a statement that once better information on individual doctors' prescribing patterns is fully available the possibility of using this information to increase the incentives for cost-effective prescribing will be explored. This will provide a peg on which to hang discussion of drug budget-type arrangements during the consultation process. What we hope to do is devise an experiment in one or two family practitioner committee areas in which we would agree with the doctors collectively that they could keep part of the savings that they made in their area's prescribing costs as a fund for the Family Practitioner Committee to disburse on local primary health care developments. This would be in addition to the experiments already referred to in the discussion document for contracting with a private health care provider for the delivery of primary care services in return for no more than the cost to the NHS of both services and drugs under normal arrangements.

(vi) Community hospitals

We intend to refer to the case for small community hospitals, where these are cost-effective.

(vii) Summary list

We will sharpen up the summary list.

I am copying this letter to Joan MacNaughton (Lord President's Office), Colin Williams (Welsh Office), Jim Daniell (Northern Ireland Office), Robert Gordon (Scottish Office), Jill Rutter (Chief Secretary's office) and Michael Stark (Cabinet Office).

Yours sincerely

A Laurance
Private Secretary

NAT. HEALTH: Primary Health Care: Mar 1984

DCABBH

PRIME MINISTER

PRIMARY HEALTH CARE

Mr. Fowler was somewhat discountenanced by your suggestion that Cabinet should consider the consultative document on primary health care, which was discussed at H this afternoon. He believes that this would delay publication and he may feel that Cabinet may dilute the recommendations. He may therefore try to buttonhole you at Cabinet tomorrow to persuade you that the document need not be discussed by Cabinet, and that instead he should have a bilateral with you to satisfy you that he has taken account of your points.

My understanding is that you wanted Cabinet to discuss the document not so much because of your own concerns, but because you thought that this was an important document of social policy which merited the kind of political discussion which only Cabinet could provide. A bilateral discussion with Mr. Fowler would not meet that objective.

If Mr. Fowler presses very strongly for an early Cabinet discussion, I suppose that you could tell him that you would summon a special Cabinet next Tuesday for this purpose (since Cabinet is not meeting on Maundy Thursday). This would provide cover for the discussion on Leyland. A bit of an obvious tactic, and one which may lead Mr. Fowler to think he had been "set up" - hardly putting him in the right frame of mind for the Leyland discussion. But you might want to consider the tactic, and perhaps mention to the Lord President if you thought it worth pursuing. Obviously, it would not run unless Mr. Fowler pressed for it.

N.L.W.

(N.L. WICKS)

19 March 1986

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bc D. Willetts.

10 DOWNING STREET

From the Private Secretary

17 March 1986

PRIMARY HEALTH CARE

The Prime Minister has seen your Secretary of State's minute of 6 March, and the discussion document on primary health care. She has noted that H Committee are to discuss the paper this week.

The Prime Minister welcomes the paper and the opportunity it offers to consider improvements to the efficiency and effectiveness of the primary health care services. She believes, however, that it might go further in one or two areas:

(i) The document could challenge more directly the idea that the quality of care depends on a shorter list - in other words more doctors. She understands, for instance, that in Scandinavia GPs in health teams commonly care for 5,000 patients.

(ii) She agrees that better links between GPs and hospitals are important, but believes that the best arrangements might be to allow GPs to select services for their patients from hospitals of their choice, and for the DHA's funds to follow.

(iii) The Prime Minister welcomes the references to experiments with private care. She suggests, however, that the document should canvas the possibility of patients being able to top up care with their own money. This might be particularly relevant in the area of preventive medicine.

(iv) The arrangements for controlling new doctors wanting to establish themselves in competition with existing practices should be scrutinised with a view to relaxing their restrictive aspects.

(v) The document should consider the idea of giving GPs a fixed drug budget to help contain drug costs.

(vi) The document could usefully refer to small community hospitals, which are run by GPs, and which appear to offer popular and cost-effective treatment.

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(vii) The summary list of proposals on page 78 of the document could usefully be sharpened up and made to sound more down to earth.

I am copying this letter to Joan MacNaughton (Lord President's Office), Colin Williams (Welsh Office), Jim Daniell (Northern Ireland Office), Robert Gordon (Scottish Office), Jill Rutter (Chief Secretary's Office, H.M. Treasury) and Michael Stark (Cabinet Office).

MARK ADDISON

Tony Laurance, Esq.,
Department of Health and Social Security.

Prime Minister.

CC/30

H discuss the draft consultative document on Wednesday. You may wish to discuss with the Lord President on Tuesday.

If you have any views at this stage (and this Policy Unit note is a helpful prompt) we shall ensure they are passed on to Mr Fowler on Monday. MLEA 14/3

To

PRIME MINISTER

14 March 1986

PRIMARY HEALTH CARE CONSULTATION DOCUMENT

Health, like education, fails three key tests:

i. Efficiency. Spending on the Family Practitioner Services has gone up from £2bn in 1979 to about £4bn in 1984-85 - a real increase of about 24%. It is not clear if output or productivity have improved as a result. No wonder the message on higher spending is not getting across - on the GP side, nobody can see what we've bought for our money.

ii. Choice. We are notionally free to change our GPs, but the culture does not encourage it. Because GPs don't advertise and don't set up directly in competition with each other, this right is in practice worth about as much as rights under the Soviet constitution.

iii. Standards. There are GPs practising today who have received no training for the past 30 years. There is no system of HMI-type inspection of their medical competence.

If health and education are to stop being such big losing issues for the Government, we must develop practical proposals for pursuing these three themes. This Consultation Document is an opportunity to set out ideas which can eventually go

into the Manifesto. Norman Fowler's draft successfully steers a path between:

- A document so anodyne and tame that it muffs your one great opportunity of reforming a distinctively British institution - Socialist interventionism mixed with professional cartels.

- A radical alternative system that would look fine as an IEA Occasional Paper, but would cause such an uproar in the medical profession that we would end up having to back down and disavow any plans for reform.

The paper is quite a meaty agenda for consulting the profession, without being suicidally controversial. It deserves a welcome. A guide to the document is in the attached Annex.

There are two different approaches to improving health care, just as there are in education:

- tougher central control;
- liberalisation and patient power.

The draft is a surprisingly effective compromise between them.

Tougher control

Under the current system, the cost of the FPS is above all determined by the number of GPs. So the Green Paper points to

controlling GP numbers, getting rid of the duds who tend to be the older ones, and supervising the quality of the remaining GPs more aggressively. Assessing and rewarding the best GPs need not be bureaucratic (because we already assess GPs to decide which can be trainers) nor expensive (we can reward those who save money by modest drug prescribing). We have the power to do this because we have a contract with them (through our FPCs). If it works, that approach gives you a better managed service with higher quality GPs working harder and probably earning more.

Liberalisation and patient power

The patient power approach opens up primary care by increasing the size of the capitation fee as a percentage of GPs' remuneration, and allowing people to spend it wherever they wish. They should be able to take it to the private sector and top up with their own money. GPs would be free to advertise and set up in practice wherever they wished, so the bad ones would be driven out by competition. GPs would have a greater financial interest in running a large list and attracting customers. This portable capitation fee is in effect a health voucher for primary care.

Norman Fowler has gone quite a long way towards this free market model. The Green Paper proposes increasing capitation as a percentage of GPs' income; that the quality payment should be on a per capita basis; that it should be easier to change your GP; and that doctors should be allowed to give much more information to actual and potential patients.

Possible changes to the paper

Norman Fowler could go further:

i. The document needs to attack more forthrightly the idea that quality of care depends on a shorter list (para.5 on page 19), ie yet more doctors. GP numbers have already shot up from 26,345 in 1979 to 29,137 in 1984 - an increase of 11%. We must not make the same mistake as we made by focussing just on pupil:teacher ratios. If a GP is well-organised, uses his nurses well, and has financial incentives to work hard, he should be able to increase his list size over the 2,000 average. In Scandinavia, GPs in health teams commonly care for 5,000 patients. Increased capitation payments give GPs more incentive to work efficiently and look after more patients.

ii. It is all very well to talk about better links between GPs and hospitals, (para.28 on page 29) but we don't just want more committees. The best arrangement would be to allow GPs to select services for their patients from hospitals of their choice, and the DHA's funds should follow. Cash should follow patients. The paper should hint at a genuine internal market for health care.

iii. The references to experiments with private care are helpful (paras.24-25 on page 14). But the document

carefully avoids stating whether people will be able to top up with their own money. This thought should be added to the discussion of preventive medicine (para.33 on page 31). As well as buying healthy food, why can't we buy extra check-ups from our own GP?

iv. There is a special Quango - the Medical Practices Committee - which controls new doctors wanting to set up in competition with existing practices. It is hardly compatible with free competition between doctors. The discussion of the number of practitioners (paras.14-16 on pages 57-58) should hint at relaxing this restrictive practice.

v. The discussion of drug costs in Chapter VII (paras.17-24 on pages 59-61) is not as radical as you proposed at your meeting on the FPS last year. Norman Fowler is afraid that we will have to disavow any plans for extending charges well before the next Election. But at the very least the idea of giving GPs a fixed drug budget should be mentioned.

vi. Small community hospitals, run by GPs, are not mentioned anywhere. But GPs love them. They come cheap. And they are a way of preserving popular old cottage hospitals. They're worth a mention.

vii. The list of proposals on page 78 should be sharpened up: they need to sound more down-to-earth, more attractive and less bureaucratic.

I recommend that if you agree, you write to Lord Whitelaw before the H Meeting making these points.

David Willetts

DAVID WILLETTS

Yes please do.

ANNEX

PRIMARY HEALTH CARE CONSULTATION DOCUMENT: SELECTED HIGHLIGHTS

Chapter 1:

Paras. 8-10 Introductory statement of objectives

Chapter 2:

Paras. 5-23 Description of present financial arrangements

Paras. 24-25 Very important suggestion of experimenting with private providers (such as the Harrow Health Centre)

Paras. 26-28 Giving GPs a boost by saying some hospital tasks can go back to them

Chapter 3: The core of the paper.

Paras. 6-11 A good practice allowance (on a per capita basis). If some of the sillier items of service payments are abolished, and sensible drug prescribing encouraged, this should have little cost.

Paras. 12-14 Increasing proportion of a GP's income from capitation fees.

Para. 15	More information (though the term "advertising" is not used).
Para. 16	Making it easier to change GPs.
Paras.17-21	Better complaints procedures.
Paras.24-26	Obliging doddery GPs to retire (76 GPs are aged over 80).
Paras.27-28	Better relations with hospitals.
Paras.31-33	More preventive medicine.
Chapter 7	The Treasury ghetto, where all the hard financial facts are to be found. Drug costs and charges are discussed in paras.17-24.
Chapter 9	Measures to help inner cities.
Chapter 11	Summary of conclusions. Important summary of proposals on page 78.

10 March 1986

PRIME MINISTER

FAMILY PRACTITIONER SERVICE: MEETING WITH VISCOUNT WHITELAW

The Lord President may raise the draft consultation document on the Family Practitioner Services at his meeting with you tomorrow. After the rows on deputising services and the limited drugs list, he may be worried about a third dispute with the profession. These fears may be exaggerated as:

i. The previous rows were caused because the DHSS acted without consulting the profession. But this is a consultation document. There is no question of immediate legislation to implement the proposals.

ii. The more radical ideas in the document which find favour could then go into the next Manifesto. Publishing them now removes the risks of stories of a "secret agenda" for family doctors which the Government is afraid to publish. If we produce a completely bland document, people will suspect that there is a more radical one behind it.

iii. Many of the ideas in the document will be welcomed by the more progressive parts of the profession, such as the Royal College of General Practitioners, which represents about a third of GPs.

Viscount Whitelaw may want to delay publication. This would itself risk a row because:

i. It has been expected for the last 18 months. Much more delay, and the Government will look indecisive and weak.

ii. It will probably leak anyway.

iii. Outside reports on community nurses and on pharmacists will be published in the next month. Some sort of Government response will be needed anyway.

David Willetts

DAVID WILLETTS

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cc DW.

Prime Minister

This is an important, and long awaited document. H are likely to discuss next week. You may like to discuss with the Lord President on Thursday. David Willetts has done a useful note at 'A'.

MEA 7/3

PRIME MINISTER

PRIMARY HEALTH CARE

You will wish to be aware that I am today circulating a copy of the Discussion Document on Primary Health Care to H Committee. I enclose a copy. The concluding chapter contains a summary of the main proposals.

The aim of the document is to provide a basis for wide consultation before the Government gets into direct negotiations with the individual professions. This seemed to me, and to the Secretaries of State for the other Health Departments, the best way of handling what are sensitive issues for the professions. Doctors in particular will oppose many of the proposals in the paper. I believe that if we are to make ground with the profession we must first win the public debate. To this end I propose to hold a series of meetings to which we shall invite not just the professional negotiating bodies but also those who can be expected to bring other views to bear, including organisations representing the interests of the consumers, progressive bodies like the Royal College of General Practitioners and those engaged in health care. This would not only put pressure on the professions but it would also be a means of getting rather more radical options on the agenda. I hope you will be content with this approach.

I am copying this minute to Nicholas Edwards, Tom King and Malcolm Rifkind.

6 March 1986

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