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PARLIAMENTARY BRIEFING

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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

CLAUSES 13, 14, 15 AND 16

The major proposal in clauses 13 to 16 relate to the idea that GP practices should be able to apply to have their own budgets for buying a range of services direct from hospitals. When the White Paper was published it was suggested that this would initially apply to practices with more than 11,000 patients (these cover about a quarter of the population) but the limit could be reduced in due course. Coupled with the change in the GP contract whereby doctors' remuneration will be based more on list size than hitherto, it has been suggested that this will lead to upward pressure on list sizes, as GPs seek to qualify for practice budgets. This goes against the long-term trend for list sizes to fall which has, in theory at least, enabled GPs to devote more time to each of their patients.

Practices, who wish to join the scheme, will apply to the RHA and will be set an overall budget, subject to an upper limit on the cost of hospital treatment for any one individual that can be charged to the budget. Budgets will also reflect the number of elderly patients on the practice's list and will exceptionally take account of the costs of other 'expensive' patients. It is not clear, however, what these exceptions will cover. For example, will people with Downs Syndrome, with diabetes or with sickle cell anaemia be covered? Similarly, will special account be taken of the number of heavy smokers? In any event, it seems unlikely that the scheme for allocating budgets will be particularly sensitive to variations in individual needs. The major fear is that this may mean that such practices will be

reluctant to take on to their lists patients who may be more expensive than the norm and that such patients may be more prone to being struck off.

The White Paper suggested that, if a practice overspent against its clinical budget, the overspend will be recovered from the following year's allocation. Moreover, if the practice overspent by more than 5% in two years in succession, then the practice would be subjected to a "medical audit" and might lose its right to hold its own budget. On the other hand, if a practice underspent, then it would be allowed to keep the underspend and use it within the practice. It is not clear what restrictions there will be on the use of the underspend and how such decisions are to be scrutinised. No details are contained in the Bill. Presumably clear guidance will be needed to avoid underspends being used to purchase a practice Porsche or other items irrelevant to patient care - Clause 14(6)(b) allows the Secretary of State to make regulations on this.

The effect of these proposals is that practices will be operating within a cash limit. The constraints imposed by this may well have the effect of compromising the clinical freedom of the GP concerned. Doctors will no longer decide where their patients should be referred solely on the basis of the patient's needs, but will now have to take account of the cost of that treatment in the light of the practice's budget. Even if doctors do not compromise their clinical decisions as a result of cost concerns, patients may still perceive that this has happened and there must be a concern that people will not have the confidence they previously had in their GP.

Moreover, the details of the proposals, given in the White Paper and the Working Paper, raise additional concerns about how the budgets will operate. Diagnostic tests will be charged to the practice budget on a fixed cost basis. This may act as a disincentive for patients to be sent for diagnostic tests by their GP. Whilst nobody would wish to see unnecessary tests carried out, there is in fact little evidence that this is currently a significant problem compared with overseas. If, however, a patient has been referred for a test, the cost paid from the GP's budget will remain the same whatever additional diagnotic procedures may be carried out at the hospital: the cost of extra tests will be borne by the hospital and not reimbursed by the practice making the referral. This will mean that there will be a disincentive for hospitals to carry out additional tests. The concern must be that patients may in future either not get or feel they are not getting the diagnostic tests they need.

A different procedure will apparently follow when a patient is referred to a hospital for treatment. In this case the GP practice budget will bear the cost of whatever treatment is deemed to be necessary by the hospital consultant (subject to the

overall individual maximum). Thus the budget holder will have no control over the charge to be made to the budget following referral and this may lead to referrals to consultants known to pursue only limited or less-costly courses of treatment. There may also be anomalies in respect of patients who refer themselves to accident and emergency departments. Indeed there will now be an incentive for GPs to encourage their patients to do just that, as the costs of treatment will not be borne by the GP's budget.

It is difficult to see how the proposals will improve patient choice. The choices that are exercised will be exercised by doctors, Moreover, if it is cheaper to send a patient to a particular hospital, then presumably that is where most GPs will refer the patient. This may mean longer and more difficult journeys for patients to reach hospitals which offer a marginally cheaper deal to the GPs. Again the pressure will be to reduce the costs, possibly at the expense of quality and convenience of service. The only option available to patients if they are unhappy about their doctor's choice of hospitals, will be to change doctors, if there is a suitable practice which will take them and if they are prepared to undergo the change which many may feel is daunting and traumatic.

There will undoubtedly be extra administrative costs associated with these proposals and these will have to be found from GP practice budgets. GPs will have to place and negotiate their own contracts with hospitals in their area and around the country. It is not at all clear that this is a reasonable extra burden to impose on already over-stretched GPs.

ACHCEW is deeply concerned about the implications of the proposals for GPs. The arrangements are likely to impose a significant cost constraint on medical treatment and diagnosis and this will be to the detriment of the patient. At the same time there may well be a lessening of trust by patients in their doctor, who may no longer feel that they are receiving the treatment they need rather than the treatment that the GP can afford.

There are also major concerns about the accountability of GPs who have opted to hold their clinical budgets. There will be no CHC access to the decisions made by doctors as to which contracts to place or the content of such contracts. It will be difficult for CHCs to monitor the quality of care given, as this will be the responsibility of individual GPs. Complaints procedures and systems of redress will need to be redefined if patients are to have any degree of protection and CHCs will need to be given explicit power to monitor the way in which the GP budgets operate. In this context, it is very important that practice accounts are published and are subject to scrutiny.

This briefing is prepared by the Association of Community Health Councils for England and Wales (ACHCEW). ACHCEW was set up in

1977 to represent the consumer of health services at national level and to provide a forum for member CHCs. 194 CHCs out of the 215 CHCs in England and Wales are members of the Association. ACHCEW is mainly funded by subscriptions from individual CHCs, but also receives grants from the Department of Health and a number of other bodies.