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C(87) 15 COPY NO 32

9 September 1987

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PRIMARY HEALTH CARE

Memorandum by the Secretary of State for Social Services

I have proposed a substantial redirection of primary health care priorities for two important reasons. First, last year's Primary Health Care Review showed the need to reform primary care - the family doctor service in particular. We need good doctors in all areas, but particularly in the less attractive inner cities and in remote rural areas. There has to be greater emphasis on prevention, with more vaccination, immunisation, cervical cytology and screening for heart disease and hypertension. Services have to be better targetted at the vulnerable, eg children and the elderly. The worst surgeries in inner cities are appalling and must be upgraded. The key to improvement is a performance-related remuneration system designed to encourage doctors to provide better services, more competition between doctors by giving patients a more informed choice and more effective Family Practitioner Committees. Expectations that we will act to improve primary care are high following last year's Review and the Bill will give the necessary powers.

2. Secondly, there are Public Expenditure Survey (PES) considerations. I have agreed with the Chief Secretary, Treasury to raise £80 million next year by selling off the loan portfolio of the General Practice Finance Corporation and to take action to meet my other substantial inherited commitments from earlier surveys. This means that it will not be possible to leave things just as they are in the field of patient charges. There is no realistic possibility of raising additional revenue outside the dental and optical areas (prescription charge exemptions will be examined separately in my PES negotiations with the Chief Secretary, Treasury). To raise patient charges merely to meet my existing PES commitments would be seen as essentially negative, leaving us open to accusations over National Health Service (NHS) financing and failure to act on the Primary Care Review.

3. My proposal is to raise £140 million per annum by ending the free NHS sight test for those who can afford to pay; by introducing a charge for dental examinations, currently free for everyone; and by moving to a 75 per cent proportional charge basis for NHS dental examination and treatment. The effects of the proposed dental charges are given in Annex 1. The new charges would not be applied to those at present entitled to free dental treatment (nearly half - see Annex 2) or spectacle

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vouchers. But those who can afford to pay would do so. New revenue from patients would allow me to meet my existing PES commitments and to deliver highly desirable primary care changes. Annex 3 lists a range which we believe should be achieved. These could not be afforded otherwise - I would not feel justified in bidding for new money, given the demands of hospitals, for AIDS etc.

4. The Home and Social Affairs Committee (H) discussions have focussed on the proposed charge for dental examination. The ending of free sight tests for those who can afford to pay has not presented colleagues with similar difficulties. But charges for dental work are well established and the increasing emphasis on preventive dentistry means that the boundary between examination and treatment will become increasingly blurred in the future. Moreover, the proposed examination charge is very low. At under £3, its effect on demand must be expected to be slight and short-lived. Last time dental charges were substantially increased there was a short-term drop in demand, which recovered quickly. Moreover, dental health has improved substantially in recent years and this is due not just to dental care but to improved nutrition, dental health education and flouride. Nevertheless, I accept that some will seek to present a charge for examination as a change of principle, affecting access to NHS treatment. I believe that it will be essential, therefore, to present the new charge pattern in the context of a consumer-related package of primary care reforms, and for that we need to raise enough from patients to deliver change without further call on the Exchequer. The presentation will have to be very positive highlighting the benefits to the public. Nine out of ten contacts with the NHS are with the primary care services and the average patient sees the family doctor about four times a year. Improvements in this area will be very visible politically and welcomed. I intend to publish a White Paper at the same time as the Bill and will be circulating a draft to H Committee colleagues in due course.

5. I invite colleagues' agreement to this package of primary care changes.

J M

Department of Health and Social Security

9 September 1987

ANNEX 1

EXISTING (1987/88) AND PROPOSED NEW DENTAL CHARGES

Treatment	Existing Charges	75% Charge
Examination only	free	£ 2.93
Examination, scale and polish	£ 5.40	£ 6.97
Examination, scale and polish, plus two small fillings	£14.20	£ 13.57
Examination, scale and polish, two x-rays, plus two large fillings	£22.20	£ 25.42
Examination, scale and polish, two x-rays, four large fillings plus one root treatment	£46.60	£ 71.17
Examination, scale and polish, two x-rays, one root treatment, plus one gold crown	£92.00	£ 93.67
Examination plus full dentures		
(i) plastic	£47.00	£ 61.42
(ii) metal	£98.00	£122.92

Notes (a) Existing charge for routine treatment is 'first £17 plus 40 per cent of balance'.

(b) Crowns, bridges and dentures currently charged at various levels - plastic dentures artificially depressed; proposal is for general 75 per cent charge, but variation possible, eg for plastic dentures used by elderly;

(c) Examinations free under existing rules, included in 75 per cent proportional charge under new proposals;

(d) Existing maximum charge £115 per course of treatment; proposed new maximum £150.

ANNEX 2

EXEMPTION AND REMISSIONS FROM CHARGES

A. Dental Charges

1 Treatment is free for:

- those under 18 (except that those over 16 and not in full-time education pay for dentures);
- those under 19 in full-time education;
- expectant mothers and those with a baby under one year;
- low income groups, defined in terms of Supplementary Benefit or Family Income Support levels (Income Support or Family Credit from 1 April 1988).

2 Those close to the low income level can apply for free treatment or help with charges - individual assessments are made.

3 About 46 per cent of courses of treatment are provided free under these arrangements.

4 All these groups would continue to get free examinations under the proposed arrangements.

B. Optical Charges

1 Free NHS spectacles were replaced by vouchers in July 1986. Voucher values are fixed at levels which allow the patient to obtain basic spectacles without further payment (a more expensive selection can be made if the patient pays the excess).

2 Those entitled to vouchers are:

- children under 16;
- those under 19 in full-time education;
- low income groups (as for dental charges);
- users of certain complex lenses, eg high power, prismatic form.

3 Those close to the low income level may apply for assessment for full- or part-value vouchers.

4 Vouchers cover about 27 per cent of patients needing spectacles.

5 Those who do not pay for spectacles at present would continue to get free NHS sight tests under the proposed arrangements, as would the registered blind, the partially sighted and war pensioners with optical disabilities.

ANNEX 3

Proposed Improvements in Primary Health Care

1	GPs' pay to be related to meeting targets for vaccination, immunisation, cervical cytology. Special payments for surveillance of vulnerable groups, eg children and the elderly. More health education sessions for consumers.	£30m
2	More services to patients (eg physiotherapy, counselling, chiropody, dietary advice). Inadequate surgeries up-graded. More doctors in deprived urban and rural areas. Minor surgical operations by GPs.	£30m
3	Performance-related pay designed to encourage greater commitment by doctors. Consumer awareness. More choice for patients.	£15m
4	Dental health campaign; more fluoridation; dentists into under-dentisted areas; protected NHS sight-tests for war pensioners, blind and partially sighted; spectacle repairs for handicapped; domicilliary sight-tests for housebound poor; patient counselling role for pharmacists.	£12m