From: The Rt. Hon. Kenneth Clarke, QC, MP

HOUSE OF COMMONS
LONDON SW1A 0AA

5 July 1989

Dear Colleague,

You will obviously by now be aware that the BMA's Conference of Local Medical Committees has rejected the new GPs' contract which their own leadership recommended to them. They will now go to a full ballot of their members, the result of which is uncertain and will not be known until the middle of July.

I am disappointed that the BMA leadership appear temporarily to have lost control of their GP members. They have encouraged widespread attacks on the Government's motives for change in the NHS and now cannot explain to their members why they should have reached any agreement at all with the Government over the contract. GPs have various complaints about items in the agreed contract, as you will know, but many of these are based on mistaken fears about the impact on individual incomes in good practices. Many GPs are dedicated and deliver a good service but unfortunately, in the real world, the quality of service varies too much across the country. The NHS will only deliver good quality primary care to all patients if the contract is based, like the remuneration of almost every other group of people, on workload and performance.

I see the forthcoming ballot of the GPs as a judgment by them on the skill of their own negotiators. If it rejects the new contract I think it will be rejecting a sensible package won by a good BMA team. I do not believe that those intending to vote against the package have any clear or consistent view amongst themselves of what they want instead. Any new proposals at this stage could only come from a cobbled-together coalition inside the profession as there is no open organised opposition to the BMA leaders.

The contract negotiations were very protracted over a hundred hours of discussion spread over more than a year. Both sides agreed on the need for a new contract which rewarded performance, and the resulting agreement was hard fought and involved a number of concessions on my part which I would not have made except for my desire to reach a reasonable compromise.

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* Basic Practice Allowances to be paid for lists of between 400 and 1200 patients, based on average list sizes within a practice and not personal lists. The concessions on these two points were very important in making sure that part-time women doctors continued to be attractive as potential principals in a partnership.

* Further talks relating to payments for GPs in rural areas were referred to a separate Committee for discussion with the existing system to remain in place meanwhile pending that review.

It is important to remember that a GP with an average list size (approx 2000) will not be under particular pressure to increase his list size. If he reaches the targets set out in the new contract he will be considerably better off than last year. GPs with smaller lists will wish to take on more patients and will be able to offer them more time and a better service than those GPs with a larger list. The argument about GPs having to have bigger lists and less time with patients is a total nonsense, raised as a negotiating ploy but now believed by too many doctors so that the BMA find it difficult to drop. The numbers of doctors in general practice is rising by 2% per annum whereas the general population is static.

From the Government's point of view the new contract is not about money, but about developing a better family service. The average remuneration of GPs is quite unchanged and the new contract does not save the Treasury a penny. It will encourage GPs to develop a wider range of high quality services to attract and retain patients. The promotion of health and the active prevention of disease will become a more central part of the GP's service. This is the first step towards raising the quality of service and value for money of the NHS generally as a result of wider reforms in which GPs will have a crucial role.

Among the direct benefits for patients from the new contract are:

* More regular assessment of the development of young children.

* Much more in the way of health promotion clinics and regular check-ups.

* Night visits being made more often by patients' own doctors or doctors they know.

* More protection from disease through immunization and screening.

* GPs doing even more to maintain the health of elderly patients and to keep in regular contact with them.

* More minor surgery on the doctors' own premises to save patients having to visit hospital.

* Improved services in deprived areas.

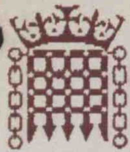
We are also pressing ahead with the White Paper, 'Working for Patients', and I think that it is fair to say that more people are now beginning to accept the need for reform of the NHS, rather than just calling for yet more funding. A recent poll in the 'Daily Telegraph' was particularly encouraging, as it showed that 80% of people felt that the Health Service was in need of some reform. In addition, recent Departmental figures show that if the worst performing NHS Districts were merely to become as good as the average, it could go a long way to eliminating the national waiting list.

The next step on the White Paper front is to develop further our policy for self-governing hospitals within the NHS. We have so far been notified of 178 expressions of interest in self-governing status, involving well over two hundred NHS hospitals and other units, as some expressions cover more than one unit. The timetable on this is flexible. Some hospitals will be ready to become self-governing in April 1991, the earliest date. I am not, however, working on the basis of any target numbers for either the first round in 1991, or for the ultimate total. I foresee a steady expansion in the number of self-governing units over the next few years, some from amongst the 178, and some who will come forward in the future.

With a view to making further progress on self-governing hospitals, I have published two short leaflets - one for staff at units which have expressed interest, and one for the general public. I am also repeating the successful exercise which we undertook at the launch of the White Paper, and holding a series of regional conferences to inform staff directly of our plans, and to explain and discuss the plans with a wide range of staff at interested units. We have already held a national conference in London for those who have expressed interest, and this was extremely constructive.

Over the next few months we will also be carefully considering these expressions of interest with the Regions, to identify those candidates who are likely to be front runners. I should emphasise, however, that the majority of the 178 are unlikely to be ready for self-government in 1991 and that we will have to make a careful selection of those units which will be capable of running their own services and working up the details of successful self-government with us.

Viable front runner candidates will be asked to establish a small team to take things forward, and work up the application and the service development plan that I will need to make my decision as to whether the unit is capable of self-government, once the necessary legislation has been passed. My decision in the end will depend on one judgement, and that will be whether the change will be in the interests of the NHS, the hospital, and above all the patients.



Inevitably the new GP contract and the White Paper have, in the short term, caused us political problems which have been reflected in your post bag. We will continue to do our utmost to develop and improve the presentation of our policies. It has to be recognised that the NHS is an area where people tend not to give us the benefit of the doubt and where it is easy to arouse emotions and fear about any suggested changes. Only when the reforms are in place will some of the doubts be calmed.

Fortunately we are making good and rapid progress on the implementation and planning of the new financial management systems, contractual arrangements and management changes which arouse very little public controversy but are actually the back-bone of the whole reform from a bureaucratic administered system to a managed patient-orientated one. I am sure that the reforms will actually be put in place over the next two years and be a "fait accompli" by the time of the next election.

I am more confident that ever that our proposals will be of immense benefit to the NHS and its patients, and are worth the political effort involved. I am equally convinced that, as with so many of our reforms over the past decade, people will look back in future years and see that they were sensible, and wonder what all the fuss was about. Meanwhile we must maintain the positive promotion of the merits and purpose of what we are doing.

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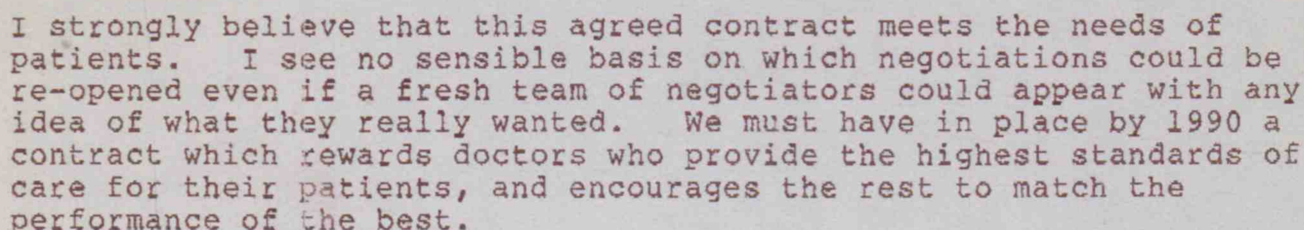

I strongly believe that this agreed contract meets the needs of patients. I see no sensible basis on which negotiations could be re-opened even if a fresh team of negotiators could appear with any idea of what they really wanted. We must have in place by 1990 a contract which rewards doctors who provide the highest standards of care for their patients, and encourages the rest to match the performance of the best.

In order to have a new contract of any kind in place I have to lay regulations before Parliament in the Autumn to bring the new contract into effect. I intend to continue with that course along the lines I agreed with the BMA negotiators and have every intention of implementing the contract next year.

It may be helpful if I briefly recap the history of the contract and its importance. The new contract had its origin in a Green Paper dating back to 1986, which was followed by an 1987 White Paper. We had been engaged in confidential negotiations for nearly a year when the BMA suddenly decided last February to lobby their members and organise local meetings, resulting in the row which I am sure you remember well. In my opinion the BMA provoked this row because we had just published our NHS Review White Paper and they wished to use the GP's contract as a weapon in their campaign against that. You will recall again the difficulty we had in sorting out arguments about pay from our proposals for NHS reform. Despite this, I was able to reach agreement on 4 May with Dr Michael Wilson, the Chairman of the BMA's GMSC, and he agreed to commend the new contract to all of his members.

The main new features of the settlement arising from the final negotiations with the BMA are:

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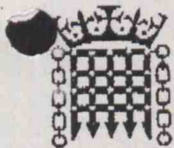

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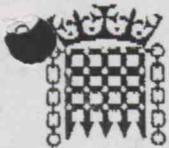

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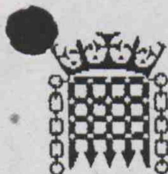

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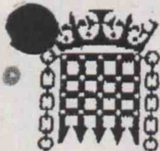

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