PO-CH/NL/0102
PART C

Part. C.

SECRET

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Begins: 17/4/88
Ends: 22/4/88.

PO -CH /NL/0102

PART C

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Directions: 25 Years

[signature]
9/8/95.

PO -CH /NL/0102
PART C

Paul Gray,Esq.,
Private Secretary,
10 Downing Street,
SW1A 2AA.

17/4/88

Dear Mr Gray,

Thank you for your letter dated the 29th March,which I received recently.I have set out some comments below on the need for a reform of financing of health care and an outline of how it might operate.

Yours sincerely,
Michael Dutt.

Cllr Michael Dutt,MD MRCP,
St Albans City Hospital,
Herts.

INSURANCE BASED BRITISH HEALTH SERVICES

A).THE NEED FOR CHANGE.

1).Most current debate on the NHS focuses around arguments over increased efficiciency or more resources.Yet both of these produce the same result,increased output.The figures show clearly that the Government"s claims that output has increased already are true.Despite this,political criticism is effective on this issue,and unlikely to be solved by further increase in output alone,however achieved.

2).As Science and Medicine advance the potential demand for health services will grow among the public.This is fuelled by those in the medical and nursing professions who will point out that more and better treatment could be available.The Government relies on these same clinicians,with increased resources, to deliver the statistics on increased numbers of patients treated,who also indicate satisfaction with the service received according to opinion polls.Fundamentally it is likely that the criticisms of those working directly with patients will continue to carry weight with the public.It is most unlikely in my view that audit or changes in terms and conditions of service among doctors and nurses will refocus the debate on efficiency and away from the Government.Economic success and an aging population are further spurs to demand and public expectation.

3).It is a critical point that the NHS is tax funded and that as a consequence no one has any real sense of how much they spend on the NHS,and there is no individual choice from year to year over this spending.Against this background and one of

rising expectations,it is easy for the opposition or health service workers to auction up the demand for resources.

4).I suggest the objectives of any change should be to devolve the decision on spending from the Government to individuals to a greater degree,in order to bring home the costs of health care and to allow individual consumers to participate from year to year in setting the amount spent.

5).In discussion on reform,the U.S. system raises fears sometimes.The U.S. has an extreme free market system,which they have been forced to temper with schemes such as Medicaid.We have an extreme Socialist solution.The European systems are somewhere between the two.The Germans do not differ only by having greater spending on private insurance.They differ also,crucially,on the public side in having a series of statutory insurance schemes.These bring home the real costs in a more direct fashion than tax funding can.

B).THE PROPOSED CHANGE.

All Government regulated health spending should be separated from public sector spending.National insurance contributions would be abolished.

A State insurance company would be set up.This would offer insurance to everyone and would do so in relation to ability to pay.In the German system statutory health insurance schemes are similarly funded by policy holder premiums,but are not based on age or current health.Essentially,everyone pays the same percentage of income for insurance,so those who earn more pay more.

Each year the state company would set its premiums in consultation with subscribers.They would be invited to choose from a series of different rates and be given information on where the money might go.The state company would either set the following year's rate in relation to the responses received according to a statutory formula,or retain final discretion,having taken into account the views returned.

As a development of this ability to choose,the state company could be allowed to offer further specific benefits,(for example use of a side room when available),at an additional flat rate premium.

Private companies would be allowed to compete with the state company,provided they also offered insurance to all according to ability to pay.

Everyone would have to insure themselves with the state or an approved private company.This differs from the German system,where those above a certain income are left to make

their own arrangements though they may use the statutory schemes if they wish.By insisting that all use the state or an approved scheme one could be certain of meeting the criticism that young high earners might opt out and obtain cover at low premiums,thereby depriving the public system of their otherwise potentially high contributions.

There would be no cross subsidy whatsoever from taxation.All public health spending would be raised from state and approved private schemes.

C).SOME QUESTIONS ON THE PROPOSED NEW SCHEME.

1).What would happen if people chose premiums which totalled less than current spending?

It could be argued this was their choice but initially however it would be prudent politically for the Government to take the power to insist that the state and approved private sector had to set premiums to raise the current level of spending.

2).What would happen if people failed to make a choice over which scheme they would use for insurance?

They would be insured compulsorily with the state company at the minimum rate.

3).What would happen,if following consultation,the state company set the rates so high that higher income earners felt that in absolute terms they were making an excessive contribution.?

Given that lower income levels have to pay also this is unlikely.However this is why private companies would be encouraged to compete.To be approved they would have to accept everyone according to ability to pay and finance the health costs arising from that group of subscibers,but they could set for example a different per centage of income ,subject to the provisions of C 1 above.

4).Isn"t the consultation procedure a bit like a referendum and a major constitutional change?

Not really.If people choose between different motorcars they are making a choice in a virtually free market.There are particular reasons why the Government may need to be involved in the health insurance market,but anything which allows popular participation as well should be welcomed.

5).Wouldn"t health costs spiral upwards?

Spending would be separate from public sector spending.If people chose to spend more of post tax income on a service this would be up to them.When they actually had to finance the consequences of their decisions they might not do so.Similarly health professionals could ask for more spending but if the

public were not prepared to raise premiums their arguments would fall.

6).Doesn"t the system depend on financing from employers as in Germany?Haven"t employers in Britain voiced fears over this already?

No.This is not the German system.All funding would be direct from individual members of the public,so as to tighten the link between health spending and the individual.Current tax takes are not in marked pound notes,but it could be argued that a higher proportion of other public spending would be financed through company taxation while none would go to health.Income tax would be reduced by the equivalent of current NHS spending allowing for the abolition of national insurance contributions,to achieve a neutral effect overall.

7).Should or need the scheme cover the whole of NHS spending?

It could but it need not.Most of the political criticism centres around the hospital sector so the scheme could be introduced to cover the area of Hospital and Community Health Service spending of £11.328 billions.Traditional insurance principles work most easily in the acute sector with shorter hospital stays ,so the scheme could be further sub-divided to cover the acute hospital sector only.

8).What would be covered by the state and approved schemes?

Current NHS services to start with.Depending on the premiums chosen these might eventually cover private hospitals also,further blurring the distinction between public and private provision.

9).What about other private schemes?

People would of course be free to use these but only after they had insured themselves statutorily.The fact that the public system was clearly insurance based would probably accustom people to this type of system and lead them to insure privately or top up for increased benefits,without direct tax concessions.

10).What would happen to the current NHS structure?

This could be left as it is to start.Gradually however the influence of competing insurance companies would lead to a break up of the monopoly structure,with hospitals being owned by corporations or trusts.This would take politicians and civil servants out of running health insurance and health care and into a regulatory function which is more appropriate.

D).SUMMARY

The apparent advantages of the tax funded NHS;namely that all are covered according to ability to pay and that there is no payment at the point of delivery of the service,have mislead us

into constructing a Government near monopoly in both financing and delivery of health care.Real costs are not appreciated by the public.The desirable elements can be reproduced through a compulsory health insurance system constructed to bring home real costs,increase popular participation in the decision making and gradually take Government out of an activity in which it need not and probably should not be directly involved.

MICHAEL DUTT.

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CC51/EMC

18 April 1988

Mr P Gray
10 Downing Street
LONDON SW1A 2AA

Dear Mr Gray

Thank you for your letter of the 29th March.

I am sorry for the delay in my reply but I have been in Malaysia examining over the last two weeks.

I enclose with this letter a paper that I have written for the King's Fund College which discusses the Guy's experience. Section 3.3 and 4.3 relates to management budgeting.

I also enclose some notes on the National Health Service that I wrote following a meeting with the Centre for Policy Studies earlier this year. The section on management on page 2 deals with the management structure. I would particularly like to draw attention to the comments that I have made regarding the district health authority, as this is the level of which I have most experience.

Yours sincerely

PROFESSOR C CHANTLER MA MD FRCP LIHSM
CONSULTANT PAEDIATRIC NEPHROLOGIST

Enc

NOTES ON THE NATIONAL HEALTH SERVICE

PROFESSOR C. CHANTLER
CHAIRMAN
GUY'S MANAGEMENT BOARD

JANUARY 1988

GENERAL ORGANISATION

The first question and by far the most important for the service at the present time is whether or not we wish to continue with a health service funded out of taxation. We can either abolish the present service or else develop it. Before abolishing it we should reflect that whilst no other country has adopted it there are problems with all other systems in the developed world and it has proved better than all the competition in restricting expenditure on health care. Indeed a cynic might argue that the main advantage of the national health service has been to restrict expenditure to an extent which is now the envy of governments throughout the western world. In spite of claims to the contrary international comparisons concerning the quantity of care delivered and the quality of care and the ability to provide for all the population show that it is as effective as any other system that has been tried.

A fundamental change to a health insurance system, would be a massive undertaking and there is little evidence that the British people wish it, and certainly plenty of evidence that it would be less cost effective. One alternative that might be considered is to fund the NHS out of a state based insurance system funded as a separate tax, presumably progressive, and collected as part of the income tax. Thus it would be apparent what each individual was paying for health care and the level of this tax could be determined by parliament on a yearly basis with the hope that this might to some extent lead to a more rational debate about resources both in the country and in parliament.

It has to be recognised that a major defect of the national health service is that it does not provide choice for the customer and there are few internal pressures for efficiency. If as I believe a centrally funded service should continue then an expansion of the private sector is not only appropriate it is desirable as long as it is controlled.

FINANCE

The national health service is underfunded, this is a complex statement because it presupposes that overspending is not the reason for the deficits that many health authorities now have. The government's policies during the last few years have done much to increase the efficiency of the service and much remains to be done, however, again international comparisons suggest that the health service is no worse in terms of efficiency than other health care systems. The success of the service in introducing advances in medical technology and the improving health of the population have lead to rapidly increasing demands which have not been met by increased government expenditure. The gap however is not wide and a modest increase in government expenditure would do much to deal with present difficulties. The argument that it is a bottomless pit which emanates from Mr. Enoch Powell's tenure as Minister of Health is irrelevant. Many areas of expenditure particularly goverment expenditure could be so

described. This argument should not be used as an excuse for not spending enough. It is not possible to define sufficiency but it can be determined by comparisons with other systems and indeed that is the way the normality of most human activities is determined. On this basis an extra 1% of the gross domestic product spent on health care would bring us up to the regression line that determines the relationship between the size of the gross domestic product and the proportion spent on health.

MANAGEMENT

There have been considerable improvements in the management at the bottom end of the service following the Griffiths initiative. This has lead to increased efficiency which is apparent from most health service statistics and from the analysis of the cost improvement programmes. Those of us who work at the bottom end of the service do not feel that much has been achieved above. The lines of communication to the central management are too long and the awareness of central management to the management issues at the point of delivery of the service seems insufficient. There is a confusion at the District Health Authority level between representation and governorship and one propostion that should be examined is re-constituting Health Authorities' with executive directors, who would be the district officers, and non-executive directors chosen from outside because of their particular skills and interest. The Community Health Councils could be strengthened and two representatives say the chairman and secretary would sit on the newly constituted District Health Authorities with a purely representative role. At the centre consideration should be given to the NHS Management Board assuming a more involved management role using the corporate holding company model. Whilst accepting the need for a link at regional level again the regional directors should be partly the regional officers and partly non-executive directors chosen because of their interest but without representational responsibilities. According to this format the Ministry of Health would maintain a central directorate to advise the minister and to audit the activities of the NHS Management Board but many of the functions currently undertaken by the DHSS would be transferred to the NHS Management Board.

The efficiency of hospitals has improved with the Griffiths initiative but more needs to be done to involve professionals particularly doctors and nurses in management. The recognition that clinical freedom far from being compromised is actually enhanced by involvement in management and the importance of separating management accountability and professional responsibility and accountability in the management structure should lead to greater involvement of doctors in hospital management. Improved management is essential if outdated working practices are to be altered and efficiency increased. The involvement of the private sector and inter-hospital cost comparisons should continue to be promoted to stimulate efficiency.

An internal market in the health service is absolutely essential. It would be possible to introduce a simple scheme immediately and then to refine it as case-mix costing becomes more sophisticated. Such an arrangement between different

hospitals already exists in Sweden. Regular provision of information on waiting lists and waiting times to general practitioners and other hospitals could occur now.

Income generation for NHS hospitals has to be considered realistically. There is little point in hospital managers trying to set up businesses which they do not have the skills to create or manage. On the other hand actions such as the creation of amenity beds within NHS hospitals have much to commend them.

THE PRIVATE SECTOR

The private hospitals are necessarily more expensive than NHS hospitals (or at least should be) but their existence provides ideas for the health service and necessary competion. They provide an essential element of choice and it is realistic to suppose that further expansion in expenditure on private health will occur. Their contribution however is likely to be in relatively simple procedures particularly cold surgery rather than complex multi-system failure or the problems of old age. It is important that their expansion is controlled realistically so that for instance they are not able to attract essential staff from the NHS by financial inducements when NHS salaries are strictly controlled. It is also important to monitor and control any tendency for health service personnel to abuse their national health service contracts by working in the private sector during NHS time. The vast majority of clinicians work many hours of unpaid overtime in the national health service and even those with extensive private practices rarely fail to fulfill their NHS commitment. However some formal monitoring system of this is essential if public confidence is to be maintained. Adequate disciplinary procedures for those who abuse their privileges already exist and must be used.

The pay of low paid staff in the national health service, particularly nurses, therapists, secretarial and ancillary staff must be dealt with and the extra cost to the nation must be accepted. As far as nurses are concerned there is an immediate need to increase London weighting and to provide an extension of the salary scale for clinical nurses at sister level. An extension of the present salary scale from 5 years to 15 years with the eventual attainment of a salary equivalent to that of a senior registrar after 15 or 20 years service would do much to improve morale, keep people in the service, and attract back those who have left. A salary lead should be paid to those nurses with post basic qualifications at least while they are undertaking work where those qualifications are required. These three measures rather than a substantial overall increase in nurse salaries are recommended and would be less expensive.

CONCLUSION

The current problems of the NHS were predictable given the increasing prosperity of the country, the peoples increasing expectations, the changing age structure and medical advances. The problems are soluble and it is suggested that they should be dealt with not by changing the fundamental structure which by national comparisons has much to commend it. A modest

increase in resources to the health service, an expansion of the private sector, an improvement in management organisation, and the creation of competition within the service itself, are now required.

CC/JAG
25.1.88.

KING'S FUND COLLEGE INTERNATIONAL FELLOWSHIP

GUY'S HOSPITAL 1985 - 1988, A CASE STUDY

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1 INTRODUCTION

This case study analyses the experience at a major London teaching hospital over a three-year period, during which major management changes were introduced. It analyses the reasons the changes were thought to be necessary, the philosophy behind the changes proposed, and describes the results to date, in order to provide a basis for a preliminary examination of the lessons that have been learned.

1.1 Guy's Hospital - A Brief History

Guy's Hospital opened in 1726 in Southwark, a densely populated area of south London near to London Bridge. Southwark was then, and is now, an area of considerable inner city deprivation, and the first purpose of the hospital is to serve the local population.

Guy's Hospital, however, is a major London teaching hospital qualifying over one hundred doctors each year, about ninety dentists, a large number of nurses and people in allied health care professions. The hospital is situated next to London Bridge railway station, which is one of the busiest commuter stations in London and the centre of a network which extends out to the south coast providing public transport facilities into London to a population of over 3.5 million people. Thus, it is apparent that as well as providing hospital services to the local population, the catchment population of Guy's is much larger, and the hospital has an important role in the provision of tertiary referral services as well as for post-graduate teaching and research.

1.2 Guy's Hospital 1948 - 1974

The hospital was incorporated into the National Health Service in 1948. The board of governors had overall responsibility for the management of the hospital reporting via their chairman to the minister of health. The board of governors was serviced by the clerk to the governors who, with his staff, took overall responsibility for the administration of the hospital. The post of clerk to the governors was considered one of the most senior posts in hospital administration in the country.

The day-to-day responsibility for running the hospital was vested in the superintendent, who was always a clinician, and was responsible to the board. In effect, he, along with the clerk and the matron, shared this total responsibility.

In retrospect, the years 1948 to 1974 were "the years of plenty" and a steady expansion in the services provided by Guy's occurred over these years. The NHS was responsible for providing the money to run the hospital but the board of governors had access to the trust funds of Thomas Guy, which were used to fund new developments. Although the hospital endeavoured to stay within its financial allocation, it was not, in effect, cash limited, and thus legitimate demands for increased services could always be funded with the allocation adjusted at the end of each year, so the Government took over responsibility for items funded by the governors from trust funds in the previous year. In 1948, the board of governors assumed responsibility for the Evelina Children's Hospital situated about a quarter of a mile away from the main hospital and containing one hundred childrens' beds. Later, they assumed responsibility for St. Olave's Hospital and New Cross Hospital, both about two miles from Guy's. Thus by 1974 the Guy's Group of hospitals had access to about 887 beds on the main site, one hundred childrens' beds in the Evelina, the 234 beds in St. Olave's and the beds at New Cross making a total of 1,557 beds.

1.3 Guy's Hospital 1974 - 1982

In 1974 the board of governors were abolished. The community health services (not the family doctor services) and the hospital services were joined into the Guy's health district. This was joined with the St. Thomas' health district, the King's health district and Lewisham health district to form one Area Health Authority. The post of superintendent was abolished and the District Management Team was set up. The District Management Team worked by consensus between its various members and comprised: The chairman of the medical and dental staff committee at Guy's, a general practitioner, district treasurer, district administrator and district nursing officer. The two most significant changes as they affected Guy's were that the post of district administrator was far less senior in health service career terms than the previous post of clerk to the governors had been, the consensus management model was totally different from the old responsibilities held by individuals such as the superintendent, and finally, instead of Guy's Hospital reporting directly to the Minister, the reporting structure was through area to region to the DHSS.

In 1976 the then labour government introduced the concept of cash limits on public expenditure and these were applied strictly by the incoming conservative government of 1978. Cash limits laid an obligation on the Area Health Authority not to overspend, thus expense in the health service, having been to some extent demand led became strictly limited by the cash allocation irrespective of demand. It was, perhaps, inevitable that this change would lead to overspending and both the Guy's district and indeed the Area Health Authority's financial position rapidly deteriorated.

In 1978 considerable cutbacks in clinical services were proposed with an overall reduction at Guy's Hospital of 30%. These changes were resisted by the clinicians, who produced an alternative plan to close St. Olave's Hospital, and to accept a 10% reduction in clinical services as a result. This policy was eventually adopted but only after the government had replaced the Area Health Authority with commissioners. The final result, however, of the closure of St. Olave's Hospital was that the financial savings necessary were made.

1.4 Guy Hospital 1982 - 1985

A further reorganisation of the National Health Service took place in 1982 with the abolition of the Area Health Authorities. The Guy's health district and the Lewisham health district were joined as the Lewisham and North Southwark Health Authority reporting to the South East Thames Regional Health Authority. The District was broken into three separate units of management, namely, Guy's Hospital, Lewisham Hospital, and the Priority Care Community Care Services.

The overall responsibility for the district was held by the District Management Team reporting to the District Health Authority who were comprised of individuals representing various interests in the local community and headed by a chairman appointed by the secretary of state.

The new health authority decided on a radical plan to improve the provision of health care in the community and, in particular, the closure of long-stay large hospitals for mental handicap with the re-location of patients in small groups in the community. They determined to obtain the money for this plan by reducing expenditure in the two acute hospitals, i.e. Lewisham and Guy's Hospitals. In addition to these cuts, the South East Thames Regional Health Authority decided to reduce the allocation to Lewisham and North Southwark Health Authority by £12m per annum at current prices over a ten-year period (10% of allocation). To this reduction in allocation, other cuts have been added such as inflation shortfall, planned efficiency savings, etc., so that between 1982/83 and 1987/88 the District has suffered a loss of £12,430,000 per annum. The combination of Guy's share of this deficit and the re-distribution to the community has reduced the Guy's Hospital's budget by £10,235,000 in the five years 1982/87 leaving a budget of about £50m per annum.

The reductions at Guy's commenced in 1982/83 but the scale increased in 1983/84 and 1984/85. In January 1984 it was apparent that the hospital was going to overspend its allocation substantially, and the then District Management Team decided to close over one hundred beds to save money though a number of clinicians suggested at the time that the effect would not be as foreseen. During the two months following closure, throughput in the hospital increased to a level higher than in the same two months the previous year, and Guy's thus had the dubious distinction of being the first London hospital to spend more money by closing beds.

At this time the Griffiths' report was published and indeed clinicians and others at Guy's had discussions previously with the Griffiths' team suggesting that clinicians should be involved in the management of the hospital with their own budgets related to the clinical service provided and with a decentralisation of services, as far as practical.

The combination of increased demand for our services along with a reduction in our allocation and the imposed reduction in beds and other clinical services led to a crisis of management within the institution. Relationships deteriorated rapidly between different professional groups, not least between the clinicians and the administrators. The administrators felt the advice they were receiving from the medical advisory committee (based on a divisional "Cogwheel" representational system), was irresponsible because it took no account of the financial problems of the institution whereas the clinicians felt the administrators had lost their vision of the aims of the hospital to care for the sick.

Tensions were apparent at all levels of the institution, on the wards when doctors wished to admit patients to beds which were under-nursed because of reductions in the nursing service, within the nursing hierarchy itself, with their long line of communication imposed by the Salmon structure, and between different professional groups who sought to protect their particular service at a time of radical reductions in the provision of care. This then was the background to the debate which then took place concerning a new management structure which is discussed below.

2 ROLE OF CLINICIANS IN THE MANAGEMENT OF HOSPITALS

2.1 The Clinician's Perspective

It is often argued ('Lancet' PP 1398, June 23rd 1984) that clinicians should not actively participate in hospital management because a conflict of interest may arise between the allocation of resources and the needs of their own patients. It is important to recognise this dilemma; failure to do so may compromise the primary duty of a doctor to his patient or lead to resource allocations which are unfair to individuals whose needs are less acute or who are represented by less persuasive doctors.

However, clinical freedom is obviously restrained by lack of resource, and if clinical freedom is to be maximised, then it is important that clinicians have a voice in the debate on allocation of resources. The medical advisory committee system worked well in the days when the service was expanding and not cash limited, and works well in the private hospital where, in effect, the doctors are customers of the institution because they are the ones who introduce the patient who, in turn, pays the bills. In a cash limited system the position is different and no authority charged with maintaining financial stability will transfer responsibility for expenditure to any other group, such as clinicians, unless that group accepts the financial constraints within which they have to operate.

Clinicians in Britain guard their clinical freedom and all consultants in the NHS have equal status. The possibility that any individual clinician should have authority over others is properly resisted. Clinicians contemplating involvement in hospital management are also concerned about the time they will have to make available for the task, and fear that this will limit their clinical activities.

2.2 Service Perspective

Professional Health Service Administrators and Managers tend to have mixed feelings about the desirability of clinicians being involved in hospital management.

They are concerned that it is the clinicians who commit the resources but this is often without regard for the financial or organisational consequencies of decisions and it is they, the administrators, who have to cope with these consequences. They also feel that many clinicians have little knowledge of the complexity of the delivery of health care, the organisation of the hospital service, and of the National Health Service, and therefore tend to make irrational and uninformed decisions.

On the other hand, they recognise the clinicians are directly involved with the customer, that they tend to be semi-permanent in the organisation whereas the administrative staff move frequently as their career progresses, that clinicians are intelligent and have stamina, and that they tend to be responsible for many of the innovations in the Service (See Initiative and Inertia : Case Studies in the NHS by Barbara Stocking, Nuffield Provincial Hospitals Trust, 1985).

I believe that the balance of the argument is in favour of involving clinicians; both from the clinicians point of view because it helps to maximise their clinical freedom and, it is frustrating to be working in a service where one's capacity to influence it is limited. From the Service's point of view it is sensible to involve the most powerful professional group in the management of Hospitals in order to increase the efficiency of the organisation, However, certain principles and systems are necessary to avoid the conflict or confusion that may result.

3 PRINCIPLES AND SYSTEMS REQUIRED

3.1 Professional and Management Accountability

It is important to distinguish between professional accountability and management accountability. A clinician is professionally accountable to his patient and this accountability is audited in various ways, by the traditions of Hypocrates, by the various professional bodies, such as the Royal Colleges, by the General Medical Council, and by the law.

Although the remuneration of a clinician in the NHS comes from central government, it can be legitimately represented as coming from the patient from whom it is raised by taxation.

Hospitals are unusual in that they are staffed by professionals in a number of different fields, each of which has their own well-developed professional structure, for instance, in addition to doctors, there are nurses, engineers, physicists, medical scientific officers, etc. Management accountability can legitimately be separated from professional accountability and each individual in a hospital, irrespective of the job done, has management accountability to the health authority for the quantity and quality of service delivered and for the efficiency of the work carried out. Any management structure must take account of the difference between professional and management accountability and separate lines of accountability, not only serve to maintain professional freedom but also can act as a useful check or balance to the unrestrained use of authority. (See below).

3.2 Responsibility and Authority

Responsibility and authority must be co-terminus and commensurate. If the responsibility to provide a clinical service is to be taken by a group of clinicians with a clinical director, then the authority commensurate with the responsibility must be transferred to this individual. The dangers of authority without responsibility or responsibility without authority have already been referred to (section 1.4 & 2.1) but it is necessary to recognise the apprehension some clinicians will have about assuming responsibility for provision of service as opposed to individual patient care and the resistance that the administration will provide against the transfer of authority.

3.3 Management Budgeting

Traditionally, the National Health Service hospital service has operated on a functional budgeting system and whereas this works well in the Hotel and Support Services, it has little relevance in the clinical service where it is clearly impossible for one individual, such as the Director of Nursing, to be responsible for the day-to-day nursing expenditure in widely different areas throughout the hospital.

The result of the cumbersome functional budgeting system is that there is little commitment accounting, little knowledge of day-to-day expenditure, and little management control of the expenditure. The actual amount spent in the service is only known accurately at the end of each financial year, and it is hardly surprising that quite frequently an unforeseen over-expenditure is found when the final accounts are made. Only after they have been completed is it possible to determine exactly where the money was spent. This process is usually complete by mid-summer when the institution is well into the next financial year, so it is hardly surprising that hospital cuts tend to occur in the autumn year by year.

It is fundamentally important, in my view, that the National Health Service adopts management budgeting throughout the service, so that all expenditure is under the control of named individuals who receive their budgets in advance and can check expenditure at regular intervals taking action where necessary to adjust their programmes. Commitment accounting is an important component of such a system.

A decentralised clinical management structure needs to be served by a management (clinical) accountancy system. It is pointless to introduce clinical budgeting without a clinically based management structure because there is no point in having a budget if there is no one who accepts responsibility for it.

3.4 Part-Time Clinical Managers

If clinicians are to be involved in management, then they must be allowed to fulfil this reponsibility on a part-time basis. If it is a requirement that they devote a great deal of time to their management function, then they will cease to be clinicians and their unique perspective as clinicians will no longer be available to the hospital they serve.

If they are to fulfil their responsibilities on a part-time basis, then it should be recognised that their responsibility is for management and not administration. They need to be supported by able business managers, who may be drawn from the hospital administrative service, or other professional groups. They need to recognise that professional administrative skills are important and must be rewarded by paying attention to opinions expressed.

The emphasis is on a team approach and the basic team comprises the clinician, the business manager and the nurse manager working together. The other important component in allowing part-time clinicians to play a full part in management is that the organisation must be split up or decentralised so that the work can be shared amongst a number of clinicians, each of whom can commit a certain amount of time but not be overwhelmed by the management responsibilities.

4 GUY'S HOSPITAL 1985 - 1988

The historical review, the discussion on the role of clinicians in management and the necessary prerequisites for such arrangements dealt with in sections 1 - 3 were debated at Guy's in 1984-85. In the autumn of 1984, the medical and dental committee comprising all the consultants at Guy's voted to take part in an experiment based on these principles. A new hospital management board (board of directors) was formed and assumed responsiblity for the running of Guy's Hospital in April 1985.

4.1 Management Structure

The management structure introduced is shown as appendix 1. The chairman of the hospital management board is finally responsible for the performance of the hospital and reports directly to the district general manager and the District Health Authority.

He works closely with the chief executive, who is responsible for all the general management and overall objectives of the hospital. He also works closely with the director of nursing, and these three individuals carry the central responsibility for the performance of the hospital. They are assisted by a central team of the clinical superintendent, who is responsible for medical staffing, hospital development (we are planning a major capital development costing over £30m over the next five years), and who also chairs the quality committee, which reports directly to the Hospital Management Board. The central team also comprises the director of operations, who is responsible for the hotel and support services, the hospital finance director and his staff, and the personnel director and his staff.

Thirteen clinical directorates were established, each headed by a clinician assisted by a nurse manager and a business manager. The business managers were mainly chosen from professional hospital administrators but the business manager in one directorate is a nurse and in another a scientific officer. Obviously, arrangements differ in different directorates in that some directorates share a business manager, and for the laboratories the responsibility is shared between the director, the chief technician and a junior administrator/secretary.

It is fundamentally important to appreciate that management accountability is separate from professional accountability, so that the nurse-manager in a directorate reports directly to the director of nursing on professional matters, physicists report to the chief physicist etc. Although these professional lines of accountability have not had to be invoked because of serious management difficulties, they nonetheless exist for use, if required.

The chairman of the board is appointed by the district general manager but on advice from colleagues from within the Institution. It is obviously important that such an individual is acceptable to the authority and to his or her colleagues. It is also clear that if that individual lost the support of his board or of the medical and dental committee at Guy's, which represents all consultants, then he or she would have little choice but to resign irrespective of standing with the authority. Similar considerations have governed the appointment of clinical directors, who are not elected but appointed - again, however, on advice from colleagues and with regard to their management capabilities as seen by the chairman of the board and the district general manager.

4.2 Decentralisation

Having established the structure, it was then important to decentralise responsibility and staff to the directorates. Three years' later 1,838 out of a total staffing of 2,916 individuals in the hospital report within the decentralised directorates. These comprise doctors, nurses, clerical staff. scientific staff, etc. Centralised Outpatient appointing and management arrangements have been dismantled, and these responsibilities are now assumed in their entirety by their individual directorate for clinical firms. Similarly, admissions and the management of waiting lists have been largely decentralised to directorates. Bed allocations have been given to directorates with as few individual clinical teams as possible working out of any one ward. Rules for bed borrowing have been established and only the director of admissions, who is also the director of the accident and emergency department has the power to commandeer a bed. The authority of the ward sister or charge nurse over her or his ward has been re-established, and ward budgets, of which they are the budget holder, introduced.

4.3 Management Budgeting and Finance

A management budgeting system based on the Arthur Young model has been introduced and applied to clinical budgeting. We are now able to capture expenditure on staffing costs, radiology, pharmacy, and these are contained within the budget negotiated each year with each directorate. During the next financial year, we will add pathology costs, medical/surgical supplies and CSSD to these budgets. Performance by directorates is monitored at monthly intervals. Budgets are negotiated each year over the period October to December and then form an important component of the unit business plan presented in March to the board and the authority. (Appendix II).

This budget review process is an important component of our system in that it provides management appraisal where expenditure, quantity and quality of activity is formally examined. In the budget reviews just completed savings of £1.909,000 were extracted, and £1,122,000 of this saving was then re-applied to new developments out of a total budget for 1988/89 of £51.574m.

The board inherited a deficit from 1984/85 of £1.2m and an inherent overspend in 1985/86 of over £300,000 per month. In August 1985 it was apparent that the unit was heading for an overspend in that financial year of over £5m or over 10% of budget. In order to contain this overspend, it was decided to concentrate on staff costs rather than directly reducing clinical services as had been done previously. A strict manpower control system was introduced (previous to this, only very loose control had been exercised and, indeed, it was difficult to tell month-to-month exactly how many people were employed in the hospital).

By the autumn, the total staffing at Guy's had been determined, and individual managers, to whom the totality of staff reported, had been identified. It was determined to reduce the number of posts by 300 (about 10% by the end of the financial year, 1985/86 and this task was accomplished and at the end of the year the unit was overspent by £1.7m.

By the end of the financial year 1986/87 this deficit had been cleared and the unit was financially breaking even. This position has been maintained in the year 1987/88. The severity of the cuts is apparent in that since the beginning of 1984 the Guy's Unit has lost 28% of its beds (340). Manpower has been reduced by 17% (575 posts) and expenditure by £7.8m per annum, (15%).

4.4 Patient Services

The massive bed closures and financial reductions outlined above inevitably were associated with a fall in patient activity but inpatient throughput this year is only 6% less than the maximum achieved in 1982, and this year will number over 36,000 inpatient admissions. This represents an increase on last year of about 5%, and it is projected that it will rise another 5% next year. There has been a considerable increase in efficiency with length of stay and turnover interval declining sharply.

We have established an observation ward associated with the accident and emergency department to take the pressure off beds, and a five-day ward and a day surgery unit. Waiting lists rose inexorably between 1982 and mid-1987 but have now started to decline quite sharply in most areas.

The ranking of Guy's amongst London teaching hospitals has changed from being the most expensive on patient related cost per case in 1985/86 to being eighth out of eleven in 1986/87. With the increase in activity this year and the reduction expenditure, it is expected that the 1987/88 figures will show further improvements. In 1986/87 we saw 69,754 new Outpatients and the cost per patient for Outpatients was the lowest of the three teaching hospitals in our area of London.

Obviously, the quality of care is an important issue and we have not yet developed satisfactory outcome measures for this though we are concerned to do so. We do know that our re-admission rate has not increased and we have introduced a new system for planned discharges for the elderly or chronically disabled to the community with a reporting system to judge inappropriate discharges. As far as we can judge from these systems, the quality of care we are delivering has not deteriorated.

4.5 Quality Issues

It is an urgent priority for our institution to introduce clinical audit throughout the hospital and to look at outcome measures as discussed above. In the meantime, the quality committee has introduced codes of practice for customer relations such as outpatient waiting time, and these are being monitored.

An important issue in quality is the state of our buildings and medical and surgical equipment inventory. The works officer estimated in 1984 that there was a backlog of £12m on essential maintenance and we have begun to deal with this. In the last three years we have instituted a major lift refurbishment programme costing £370,000 over three years and this will continue in the future. We have spent £350,000 on replacing theatre cooling and air conditioning systems, £397,000 on a new incinerator, re-located and refurnished the blood transfusion unit, created an observation ward, and begun to improve the decorative state of the hospital - the roads and pavements in the hospital and major structural repairs to our buildings.

Much still remains to be done but the board has managed in the last three years to protect the works department budget and increase it. Similarly, with regard to medical and surgical equipment, we have established an electrical and mechanical services unit and managed to increase the budget for replacement of equipment. Other initiatives being developed by the quality committee and the board with the clinical directors include the introduction of management appraisal, definite guidelines for directorate responsibilities, a five-year plan for objectives for the hospital, and new standards for communication, particularly with discharge summaries etc.

4.6 Personnel Issues

The massive reduction in employment obviously led to difficult personnel issues but most of the redundancies were dealt with by natural wastage and only 42 compulsory redundancies were required out of a total of 576 posts lost. Whilst the majority of these posts came from the ancillary services, no group was spared and the number of doctors and nurses employed had to be reduced. Further changes will be required in the future, and we are introducing a new system of private management for our domestic and portering staff though the individuals concerned will stay as employees at Guy's.

Perhaps the most important positive change that has come from our decentralised system has been the improvement in staff morale. Communications between different professional groups have improved with much more widespread appreciation of the essential contribution made by everyone concerned to the quantity and quality of health care. This has been particularly important with the decentralisation of the records department staff to work with individual clinical teams where recruitment has improved and turnover drastically reduced.

The improvement in quality is apparent in that it is relatively uncommon for a patient to attend without the notes and X-Rays being available whereas three or four years ago as many as one third of attendances were complicated in this way. We have worked hard at improving our communications and introduced a briefing system based on the monthly board meeting followed by a newsletter to all managers to discuss with their staff telling them of developments that are taking place in the hospital and problems that we are confronting.

4.7 Resource Management

The introduction of a management budgeting system has already been discussed. Guy's has been appointed a second generation "resource management" site as part of the experiment being conducted throughout the country by the NHS management board. As well as continuing to progress with our clinical budgeting system, we are also piloting the introduction of a new personnel system, and a nurse and theatre management system, all linked to a new patient administration system. We shall be looking to develop case-mix analysis and the production of average cost per case data over the next two years.

5 CONCLUSION

The experience at Guy's over the last three years has been positive and we believe that our approach to clinical management, certainly as far as this hospital is concerned, has much to commend it, and confirms the success of a similar system in the Johns Hopkins Hospital, Baltimore, USA (New England Journal of Medicine 310,1477, 1984). The extent to which a similar system would be advantageous to other hospitals is a matter for discussion and we would accept that an exact facsimile of our model probably would not be widely applicable but there are, however, certain principles which we would wish to insist on and they particularly relate to the proper involvement of clinicians in management, the decentralisation of authority and responsibility, and the development of team work between different professionals. This paper has necessarily concentrated on the role of clinicians but this should not be over-emphasised, and we believe that the development of the management skills of the administrative group (business managers and particularly the nurse managers) has been an important part of our success to date.

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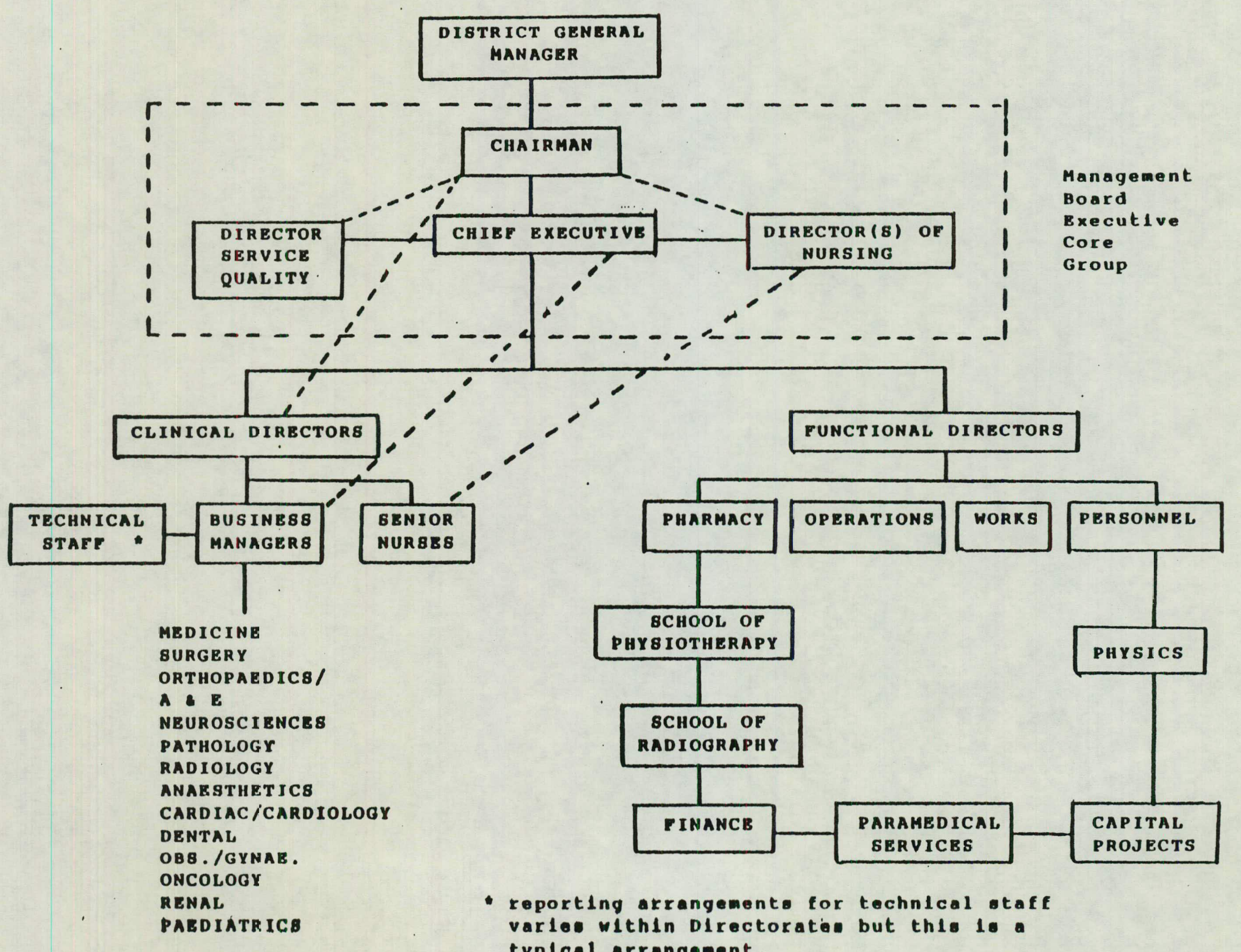

* reporting arrangements for technical staff varies within Directorates but this is a typical arrangement.

LEWISHAM AND NORTH SOUTHWARK HEALTH AUTHORITY

GUY'S HOSPITAL

BUSINESS PROGRAMME 1988/89

CONTENTS

PAGE

1. FOREWORD 1 - 5

2. FINANCIAL AND MANPOWER STATEMENT 6

3. UNMET NEED 7

4. SUMMARY OF DIRECTORATE PLANS 8 - 16

5. KEY OBJECTIVES 17 - 25

6. INCOME GENERATION 26 - 27

7. DISABLEMENT SERVICES CENTRE 28

8. RESOURCE MANAGEMENT 29

9. CAPITAL PROGRAMME 30 - 34

10. FIVE YEAR OBJECTIVES FOR GUY'S HOSPITAL 35 - 40

APPENDICES

APPENDIX I - 1988/89 ALLOCATION 41

APPENDIX 2 - 1988/89 REVENUE BUDGET 42 - 43

APPENDIX 3 - 1988/89 MANPOWER BUDGET 44 - 45

APPENDIX 4 - CAPITAL AND MAINTENANCE PROGRAMME 46 - 48

APPENDIX 5 - ACTIVITY FIGURES 1988/89 (to follow) 49 - 50

1. FOREWORD

This is the third Business Programme that we have produced for Guy's Hospital. The purpose of this is to set out our programme and budgets for the next year. These are based on the aims and objectives previously described in the Short Term Programme that we were required to produce in the summer for the Regional Health Authority. But we have set out in rather more detail what our budgets will actually be and how the resources available will be distributed within the hospital.

Each year we try to express our objectives in a more specific way so that we can keep these under review during the year and decide whether they are being achieved. This year for the first time much hard work and thought has gone into producing a statement of five year aims and objectives for Guy's. A statement of these is included in Section 10 of this Programme, and we have tried to reflect these in our proposals for next year. In some areas, for example, reducing waiting time in Outpatients and reducing cancelled admissions specific targets have already been set. In others, work is just beginning and we will need to give careful thought to work out the targets we set for future Business Programmes.

The present time is a very exciting and challenging one for Guy's Hospital. Much has been achieved over the last three years, and this is apparent from the way that Guy's goes about its business day to day. Our aim for 1988/89 and subsequent years is to build on the work that has already been done. We hope that the future will be less dominated by financial concerns so that we can devote more time and attention to the quality of service the hospital provides to the local community.

Increased Workload

During the last year we aimed to increase our workload to 35,204 admissions.

The latest available figures show that during the first nine months of the year we treated 26,922 patients compared with 26,577 for the same period in 1986/87. If these figures are projected forward for the entire year it seems likely that our caseload will be in the region of 35,896 cases, which is greater than the target.

Reaching our target represents a considerable achievement in view of the difficulties that have been encountered in recruiting nurses. Increasing the number of patients we treat was also dependent on making more sensible use of space and beds in the hospital and during the last year we have been able to:

(a) open the A & E Observation Ward.

(b) fund an additional paediatric intensive care cot in the Special Care Baby Unit.

(c) provide additional surgical beds on Patience Ward.

(d) provide additional beds for Renal patients in Astley Cooper Ward which was re-opened following a major upgrading in October 1987.

(e) open the Day Care Surgical Unit in June.

(f) carry out the closure of New Cross Hospital and the relocation of those services at Guy's Hospital, Lewisham Hospital and in the Community.

Greater Efficiency

For the second year in succession Guy's will have balanced its books. This represents a considerable increase in efficiency. Over the last five years Guy's has had its revenue allocation reduced by more than £7m per year. This represents a 14.5% reduction in expenditure. During the same period Guy's reduced its beds by 25%, its staff by 10%, but its caseload by only 6-7%, and there are signs this year that it is beginning to increase again. The cost accounts for London Teaching Hospitals for 1986/87 (the most recent available) show that Guy's has improved 8 places from being the most expensive teaching hospital in 1985 to one of the cheapest in 1987. As this year was one in which our case load was reduced because of the Theatre closures in the summer, it is likely that our cost per case will be even better in 1987 and 1988.

Nurse Recruitment

Nurse recruitment difficulties have affected most London Hospitals over the last year. There has been a shortage of specialist nurses at Guy's in care of the elderly, paediatrics, intensive care and theatres. But there are signs that Guy's is coping with this better than its neighbours. Our vacancy level (13.5%) is still too high, but it is one of the lowest in London and there is progress towards almost full recruitment in key areas such as the theatres. This is a tribute to the energy and determination of nurses at all levels throughout the hospital, but we will need to continue to pay attention to this and specific action is planned for 1988/89 which we believe will enable us to improve our recruitment of nurses.

Financial Prospects for 1988/89

Current revenue projections for the Guy's Acute Unit indicate that a "break-even" position will be achieved by the end of the current (1987/88) financial year and the Unit will, therefore, be able to plan for the 1988/89 Business Programme on the basis that there will be no recurring overspending, carried forward.

However, this position has only been achieved because of the following factors:-

(a) the DHA agreed non-recurring support of £215,000 which the Unit will need to call upon.

(b) the delay in opening the Observation Ward saved the Unit £150,000.

(c) the Ministerial announcement on cash limits in December will result in an additional £353,000 allocation, non-recurring.

(d) staff vacancy levels were higher than expected.

(e) whole wards were closed and on others there was a reduction in available beds due to short-term recruitment difficulties.

(f) British Telecom refund £138,000.

and despite the fact that the following reductions were made to the Guy's budget compared with the expenditure agreed in the Business Programme 1987/88:

		£000's
-	Multi-District Specialties Cost Improvement Programme.	35
-	Reduction in allocation to Renal Directorate	122
-	Shortfall in Learner Nurse allocation	570

None of the advantages listed as (a) to (f) above can be expected to re-occur in the coming financial year and must therefore be excluded when drawing up the 1988/9 Business Programme.

Budget Review

During the last three months considerable work has been undertaken within the Guy's Unit to review each individual budget in order that a realistic revenue budget can be arrived at for 1988/89.

This exercise has resulted in an internal redistribution of revenue to support underfunded services and thereby maintain the current level of service provided by the Unit.

Key Issues for 1988/89

The total running costs of Guy's Hospital for 1988/89 at March 1988 price levels has been costed at £51.574m as compared with £51.7m for 1987/88.

It must be emphasized that this costing allows for no growth whatsoever and has only been arrived at after the most rigorous examination of all current expenditure.

During our Budget Review Meetings we were frequently asked by Directorates and Departments alike to provide additional funds

for much needed projects. None of these have been included in our Business Programme for 1988/89. In our view none of the proposals submitted was frivolous or proposed anything other than sensible developments which the hospital will have to consider at some time or another. The total value of the bids that we did not include exceed £2.0m and for convenience a summary of these unmet needs are included elsewhere in the Business Programme.

Broadly, our Business Programme aims to:

(a) begin to achieve the aims and objectives of our 5 year plan (included later on) particularly in paying more attention the relationships between quantity and quality and the crucial need for all staff to be fully motivated to be more efficient.

(b) maintain caseload at least at 1987/88 levels with some increase in quality.

(c) live within budget.

(d) enable the re-opening of Charles Symonds Ward which is temporarily closed at present.

(e) enable the continuation of the Observation Ward and Day Care Surgery, for which full funding has not been received from the RHA.

The net recurring allocation for Guy's Hospital notified by the District is £49.879m for 1988/89, which after adjustment for learner nurse shortfall, the allocation agreed by the NHS Management Board for the Resource Management Project, and other adjustments, amounts to £51.466m. This compares with an expenditure forecast of £51.574m which leaves a marginal deficit of £108,000 which the hospital will address in discussion with members of the District Management Board during the year.

Phase III

The hospital has previously made a commitment to raise £2m towards the cost of the Phase III redevelopment. This would require a saving of roughly £350,000 a year which would transfer to our capital account. It has not been possible to allow for this in our 1988/89 budgets because to do so would have required a reduction in the services provided by Guy's Hospital.

Lewisham Hospital

The financial situation at Lewisham Hospital has been a cause of great concern to all the staff at Guy's. The plans set out in the Lewisham Unit Business Programme show that the hospital will have dealt with its recurrent overspending problems within the next two years. This will undoubtedly be a time of great stress for Lewisham, and Guy's has offered to do whatever it can to help. In particular there will be a joint approach to medical emergencies and it is suggested that the recent improvement in surgical waiting lists at Guy's might enable some more work to be done at Guy's, thus easing the pressure on Lewisham.

Pay Awards

It would not be possible for the hospital to absorb an underfunding for pay awards without reducing services. If we were required to fund the 1% shortfall (approximately £350,000 in 1988/89) this would be achieved by a reduction of 35 w.t.e. staff for a full year. This in turn would require the closure of 1.5 wards for all or part of the year.

Finally

The next year provides an opportunity for us to build on our past successes and to make progress on our aims and objectives for the next five years. This is very much dependent on continued financial stability and freedom from the ill effects of drastic centrally ordered changes to our financial baseline which come during the course of the year. Whilst 1988/89 remains a difficult one for Guy's Hospital we believe that with that stability we will be able to tackle the challenges with increasing confidence and success.

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2. FINANCE AND MANPOWER STATEMENT

This section sets out in more detail the financial situation for 1988/89 described in the foreword.

Details of the source of funds statement and proposed budgets for 1988/9 are shown on the attached Appendices 1 and 2.

Source of Funds

Using the latest issued draft allocation figure of £49,879,000. Appendix 1 identifies the anticipated additional allocation adjustments including the Evelina Appeal funding for nursing posts in the Paediatric Directorate. The total level of funding within which the budget setting process has taken place is £51,466,000. As part of the process, estimates have been made on the level of student nurse availability and the cost of replacement of any shortfall with trained staff. This exercise revealed a total requirement of £1.4m compared with an agreed funding level of £850,000. An additional £150,000 has therefore been included as a non-recurring addition but subject to confirmation of actual student numbers and additional expenditure incurred. The remaining balance of £400,000 has been found through internal redistribution.

1988/89 Budgets

An analysis of the Directorate and Residual Functional Budgets for 1988/89 are shown in Appendix 2. These total £51,574,000 and represents an overcommitment of £108,000 compared with the estimated available funding. In addition to providing for the full year effect of changes to the 1987/88 budgets these start figures incorporate £1,122,000 for new developments as detailed elsewhere in the plan, and further savings of £1,909,000 which have been extracted, as part of the budget reviews.

Manpower

The total manpower level within the hospital is planned to reduce during 1988/89 from 2915.99 w.t.e. to 2908.39 w.t.e. a reduction of 7.60 w.t.e. Details of the various movement between budgets and the actual 1987/88 and 1988/89 total manpower figures are shown in Appendix 3.

Vacancy Factor

A vacancy target of £385,000 has been set. As in 1987/88 fortuitous savings (i.e. normal turnover) accrued from vacancies will be deducted from Directorate and Departmental budgets.

Nuffield House

The provisional budgets set out at Appendix 2 do not take account of the income targets set by the District Health Authority, or the accumulated debt of £1.8m. Our proposals for dealing with this issue are described in Section 6, "Income Generation".

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3. UNMET NEED

During the Budget Reviews for this Business Programme the Unit noted a number of bids, for which it accepted the need, but was unable to fund in the coming financial year. Shown below is a summary by Directorate and Department of these bids. These only represent the tip of an ever growing iceberg, as a number of bids were not put forward by the respective managers as they knew there were no funds available to allow them to proceed.

The outstanding bids are summarised below. Staff, where requested have been identified separately, but the total value of the outstanding bids shown in the right hand column also includes requests for additional non-recurring funds.

None of the requests could be regarded as unreasonable. For example, the additional staff for paediatrics are nursing staff who are needed to support our present caseload and whose salaries are currently paid for by the Evelina Childrens Fund.

	W.T.E.	£
Directorate of Surgery	9.43	124,048
Directorate of A/E & Orthopaedics	6.50	85,600
Directorate of Medicine	6.00	130,400
Directorate of Neurosciences	1.00	38,800
Directorate of Paediatrics	30.05	369,000
Directorate of Obstetrics & Gynae	8.00	88,000
Directorate of Renal Services	2.00	107,000
Directorate of Cardiac Services	9.00	100,900
Directorate of Oncology	1.50	55,000
Directorate of Anaesthetics		30,000
Directorate of Radiological Sciences	0.39	23,300
M.S.S.E.		100,000
Drugs		100,000
Estate Management		7,500
Non Capital Programme		150,000
Maintenance and replacement Medical Equipment		500,000
	73.87	2,009,548

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4. DIRECTORATE PLANS

Introduction

The Directorate Plans for 1988/9 have been compiled as a result of an exhaustive programme of budget reviews which have been undertaken over the past three months. It was made clear to directorates that the 1988/9 budgets would be constructed on a zero based forecast and that any additional developments would have to be funded by savings and internal redistribution. As a result over 1% of revenue was identified for internal redistribution within the Unit and the Directorate Plans reflect this.

Surgical Directorate

(a) 1988/9 will see a full year's operation of the Day Surgical Unit and it is hoped that 1500-1800 cases will be treated.

(b) The Directorate is concerned with the increased growth of the waiting list and has therefore bid to the central waiting list fund to provide an additional 12 beds which would allow the treatment of an extra 840 cases in a full year at a cost of £288,000.

(c) The Directorate has reached an agreement with the London Bridge Hospital to use their Lithotripter for NHS patients. This will enable the Directorate to enclose the balcony on Martha Ward to gain an extra 4 beds. For this purpose and to enjoy a cash income the cross charging of other Districts has been agreed in principle with the RHA and will be introduced in 1988/9.

Accident and Emergency and Orthopaedics Directorate

(a) Although the RHA is only providing a proportion of the cost the Observation Ward will be funded at a full year cost of £274,570 in 1988/9 and it is hoped that in 1988/9 4,000 bed days on other wards will be saved. A recalculation of the original submission for transitional funding has been done but early indications are that the RHA will only provide funds at the level of the first submission. The discrepancy was a direct result of the very limited time allowed for the submission of bids.

(b) It has been possible to reinstate the Saturday mornings clerical cover in the A & E Department by the re-application of internal savings.

(c) A computerised A & E register will be established in 1988/9 at a non-recurring cost of £20,000.

(d) With the introduction of the ICL Patient Administration System it is intended that the decentralisation of admissions to individual Directorates will be completed.

(e) The management of the Hospital's Transport Department will be transferred to the Directorate.

(f) A bid to the central waiting list fund has been made for the enclosure of the two balconies on the orthopaedic wards creating an additional 8 beds. This bid should allow the treatment of an additional 300 orthopaedic and 250 plastic surgery cases in a full year, will reduce the waiting lists considerably and keep them at manageable levels. A total of £200,000 revenue and £90,000 capital has been requested.

(g) Joint Finance has been applied for in respect of the appointment of a Discharge Liaison Officer.

Medicine Directorate

(a) Following the considerable upheaval which accompanied the New Cross transfer, it is expected that 1988/9 will see a year of consolidation for the Medicine Directorate with caseload maintained at 1987/8 levels.

(b) A GP Direct Referral Service will be established in which special times are reserved to see patients on an out-patient basis. A direct line will allow GP's to discuss patients' symptoms and the service will hopefully reduce both out-patient waiting times and pressure on the A & E Department.

(c) It is hoped that recent recruitment initiatives will result in the re-opening of the Geriatric beds on Charles Symonds Ward.

(d) An SHO rotational scheme with Lewisham and Hither Green Hospitals will be implemented.

(e) A review of Dermatology out-patient scheduling will result in an increase in the number of new patients seen with a consequent reduction in both follow-up attendances and the waiting time for a first appointment which currently stands at 19 weeks.

(f) Conversion work on William Gull Ward has been funded by RHA AIDS money which will provide single room facilities for the possible treatment of AIDS patients. A further bid has been made to the District for 5 wte nurses to run this service. Notification of the 1988/9 Regional AIDS money is awaited.

(g) A bid has been made to the Strategy Group for the Provision of Services for the Elderly for pump-priming money to enable the appointment of a Discharge Liaison Oficer.

(h) Following a Consultant retirement, a bid has also been made to the RHA for the appointment of a Consultant Physician with an interest in Diabetes.

(i) It is anticipated that the recently completed refurbishment of the Lloyd Clinic will facilitate a general increase in activity in Genito-Urinary Medicine.

Neurosciences Directorate

(a) The appointment of a Senior Lecturer in Neurology and Rehabilitation has taken place and 2 NHS sessions will be funded by the Directorate.

(b) The Ward Receptionist on Bright Ward will be made up to full-time (+ 18 hours) thus improving admission and discharge arrangements.

(c) Discussions are at a preliminary stage on the possible transfer of the Pain Relief Service to this Directorate in 1988/9.

(d) Some additional funds were received in 1987/88, and a further application has been made to Region for increased funding for Plasma Exchange Services.

Paediatrics Directorate

(a) A complete review of the current nursing establishment has been undertaken but the increases recommended cannot be funded within the Unit's budget. The Evelina Appeal Fund will continue to fund 17.5 wte nursing posts within the Directorate.

(b) It is anticipated that there will not be an increase in workload during 1988/9 although the Directorate will be monitoring the effects of increased foetal cardiac work and changes in legislation.

(c) Bid for central waiting list funds have been submitted in respect of:

- an additional 400 paediatric surgical cases per annum with the re-opening of 4 beds on Ronnie MacKeith for 5 day operation and 2 beds on Borough for day cases at a cost of £181,000 per annum.

- an additional 96 paediatric cardiac cases on Russell Brock at a cost of £262,200 per annum.

(d) ENB approval has been given for the establishment of a post-registration nursing course in Paediatric Intensive Care in 1988/9.

Obstetrics and Gynaecology Directorate

(a) The creation of the private Nuffield Ward in the Tower will result in considerable ward movements for the Directorate involving Braxton Hicks, Lever and Blundell. There will be no significant reduction in NHS beds during the process although it will provide an opportunity for a review of bed usage.

(b) It is hoped that the regional standard obstetric computer system (Euroking) will be installed in 1988/9 if Regional funding is made available.

(c) The recently opened Day Surgery Unit will now accommodate the majority of TOPS work, thus reducing the reliance on fully staffed beds.

(d) The Directorate will continue to develop fertility services for District and Regional patients including IVF and GIFT.

(e) It is felt more appropriate to transfer the Cervical Cytology budget to the Directorate of Pathology (Histopathology). This will include £9,000 for the maintenance of the Radius Computer System.

(f) A waiting list bid has been submitted to the Region to address the increasing problem of patients needing urgent gynaecology treatment, particularly colposcopy. An additional 200 colposcopy and 50 gynaecology patients would be treated at a cost of £60,500 per annum.

(g) Additional space for colposcopy clinics will be made available at a cost of £2,000 for minor conversion work.

Oncology Directorate

(a) To comply with the Ionising Regulations 1985, lead shielding will be installed on the 8th floor of New Guy's House at a cost of £9,000.

(b) An increase of 2 wte staff nurses on Samaritan Ward will take place to reflect the increased level of workload.

(c) The possibility of recharging other Health Authorities for patients referred for Irridium treatment, will be investigated.

(d) Planning and enabling works will continue in 1988/9 in respect of the Radiotherapy Bunker with a view to commissioning the new LINAC at the end of 1988/9 and the consequential upgrading of the remainder of the Department.

Dental Directorate

Unlike the relationship between Guy's Unit and the Medical School, there is a totally different functional necessity between the Dental Hospital and School. This difference needs to be explained when considering dentistry in the Business Programme or with objectives outlined in forward planning.

Over 95% of the workload recorded for the Dental Hospital's 201,000 attendances in 1987 was carried out for patients by students in training. These patients could just as easily receive that treatment in a general dental practice outside the hospital. This contrasts sharply with the treatment for which patients are perforce referred to hospital by doctors. If treatment efficiency alone is the criterion, this would be dramatically improved by substituting the resource cost of students by a smaller cohort of qualified staff dentists.

The priorities for provision of care in the Dental Hospital need clearer definition in the future if understanding of its apparent costliness for consumables be judged in comparison with other directorates. There are three major considerations. First, there is a service commitment for the treatment of trauma and relief of pain for those without immediate access to a general dental practitioner. The Primary Treatment Unit exists to satisfy this important demand. Secondly, a specialist referral service must be provided for dental treatment and/or advice for residents of the District. Thirdly, by virtue of the £2.84m funding from the Region for Service Increment for Teaching (SIFT) there is a clear duty to make facilities accessible for training clinical undergraduate dentists. While training they will carry out routine dental procedures on suitable patients. Whether any of these service priorities constitutes a multi-district specialty for Lewisham and North Southwark Health Authority has not been confirmed.

If we are to remain the most prestigious Dental School in the UK, as well as the biggest, our aspirations to remain viable when the closure of further Dental Schools is considered, will depend upon our ability to continue producing adequately trained dentists. Sufficient resources to do this will be determined by manpower demands, which may well change. It is hoped to safeguard the likelihood of our survival as the Dental Teaching Hospital in the South by maintaining an expanded programme of post-graduate education which provides advanced forms of treatment.

Finally, there will be a high benefit to cost ratio for any support the hospital may give to the many research programmes continuously underway in the Dental Hospital and School.

The funding allocated to Dental Hospitals by the DHSS directly through Regional Supplies is essential for the maintenance of major dental equipment. Any Regional cuts in this funding would result in further financial burden upon the District.

(a) The Health Care Registration module of the ICL PAS system will be installed and the Directorate will be investigating additional computer applications such as chair booking, diaries and the coding and tracing of notes.

(b) The successful implementation of decentralised non-admin budgets to sub-specialties will continue in 1988/9.

(c) The policy of flexible admin and clerical gradings within total budget will be continued in 1988/9.

(d) The increased cost of consumables has been recognised by a £89,000 increase in the Directorate's non-pay budget transferred from savings in staffing.

Anaesthetics Directorate

(a) An additional Consultant Anaesthetist will be appointed in 1988/9 with 7 sessions at Guy's and 4 at Lewisham.

(b) A Consultant for the Intensive Therapy Unit will be appointed in 1988/9 and further discussions will take place on whether a separate ITU Directorate should be established.

(c) Development funds of £30,000 have been provided for equipment replacement.

Radiological Sciences Directorate

(a) A key objective for the Directorate is to make the new digital imaging installation in the link theatre fully operational and to introduce an efficient vascular service, responding to the increased level of demand expected from the District and other parts of the Region. In order to maximise the use of this equipment a proposal is under consideration to offer sessional use to selected Radiologists from other Districts on a fee basis.

(b) It is hoped to expand the computerised reporting system into out-patients and wards to reduce the time patients wait for results.

(c) No changes to the Directorate's budget or manpower figures will take place.

Pathology Directorate

(a) An additional Consultant Histopathologist will be appointed with the Hospital providing half of the revenue costs, (£16,500 p.a.) from savings on Medical Staffing within the Directorate. This sum has already been top-sliced by the District.

(b) An additional w.t.e Technician will be appointed in Histopathology from savings in junior medical staffing.

(c) The Directorate will investigate the feasibility of taking over the Pathology services required by the Drug Trials Unit which is a potential source of income.

(d) The budget for the phlebotomy service has been withdrawn and the Outpatient Phlebotomy Service will not be reinstated.

Renal Directorate

(a) Essential maintenance will take place in Bostock House to comply with Health and Safety regulations and the possibility of creating a waiting area/counselling room will be investigated.

(b) The Directorate has made a bid to the Region for £155,000 to purchase an additional dialysis machine and £5,500 for an extension to the existing computer system.

(c) 2 wte Ward Receptionists will be appointed for Bostock House and Astley Cooper Ward to ease pressure on the nursing staff and to aid recruitment.

(d) Negotiations will continue with the British Kidney Patients Association for the funding of a half-time Welfare Officer for an initial two year period.

(e) It is anticipated that the number of patients on the End Stage Renal Failure Programme will increase by 25-30 in 1988/9.

(f) An additional Consultant will be appointed in 1988/9 to meet the increased patient activity which is being funded by the Region.

Cardiac Directorate

(a) 2 wte Ward Receptionists will be appointed on the Medical and Surgical Intensive Care Wards to ease the pressure on nursing staff.

(b) Cross-charging will be introduced (on 1st April 1988) for open-heart surgery and angioplasties which will enable the increased level of patient activity to be maintained.

Central Services Directorate

Central Services provide a vital service to the hospital and it is essential that all who work in them feel part of the team and are aware of the objectives of Guy's Hospital and their potential contribution.

We intend to clarify our management arrangements by setting up a Central Services Directorate. It is intended that the Directorate should meet regularly and be similar to a Clinical Directorate in its relationship to its constituent specialties. It is also intended that the Directorate be represented on the Board and that some of the Managers of the larger Departments should be invited to attend Board meetings regularly.

The next year will be a challenging and exciting time for the Central Services Departments.

Our proposals include:

(a) Clinical Physics

It is proposed to transfer the management of Clinical Physics to the Medical School from April 1st 1988. This change will be accompanied by a separation of the maintenance work previously undertaken by Physics which will be transferred to the EBME service set up in 1987 as part of the Works Department. As a result a number of posts in Clinical Physics are under review.

(b) Works

The improved appearance of the hospital site and its buildings is one of the main features of our five year objectives. In the next year we will aim to identify an increased annual percentage to be spent on works and maintenance.
This in turn will enable a more extensive painting programme than is possible at the moment. We will also consider ways of strengthening works middle management so as to achieve this.

(c) Catering

It has been agreed with the Medical School that the hospital catering service should take over their responsibilities and provide a rationalised catering service for the whole site. This change will take effect from the new academic year in 1988.

A takeaway food outlet will open on the site of the present bakers shop in Spring 1988.

The programme developed in 1987 and as a consequence of the removal of crown immunity is now being implemented and this will continue throughout 1988.

d) Porters and Domestic Services

In accordance with the Health Authority's policy we are preparing specifications to submit the Domestic Department at Guy's Hospital to competitive tendering in accordance with Circular No. HC 83(18). We are also considering an alternative proposal which would involve contracting with a commercial organisation to take on the management of both the Domestic and Portering Departments at Guy's Hospital. Under this arrangement the management of the staff would be undertaken on contract with the private sector but the workforce in the Portering and Domestic Departments would retain their Lewisham and North Southwark contracts of employment. The successful Company will be required to demonstrate that specific standards can be achieved for a given cost, and that higher standards and efficiency savings through cost improvements can be attained. The emphasis of this contract is to define a standard, and performance will be measured against that standard which the contracting company will be expected to guarantee in both quality and cost terms.

It is anticipated that this contract will improve standards by approximately 5%, for example undertaking bed cleaning and remaking, thereby freeing nursing staff to concentrate more time in patient care.

(e) CSSD

This service transfers to the management of the District Headquarters on 1st April 1988. As far as Guy's Hospital is concerned the highest priority is the introduction of a formulary for equipment provided by the CSSD, which we believe will enable significant savings to be met in this area.

(f) Medical and Surgical Supplies

Supplies management transfers to the District on 1st April 1988. Like CSSD our priority for 1988/89 is the production of a formulary for Medical and Surgical Equipment.

(g) Telephones

The target date for the installation of the new Guy's Hospital switchboard is February 1989. An up-to-date directory will be published at the same time.

(h) Reception Staff

One of our most important aims is to set higher standards for the way that the public are welcomed to Guy's Hospital. Part of this approach involves refurbishing the public parts of the hospital. In addition we will be providing specialist training and support for all staff on reception duties to help them achieve this objective.

(i) Crown Immunity and Fire Precautions

The Guy's Unit is aware that the removal of Crown Immunity has widespread implications throughout the Unit, and all Departments are required to review their departmental health and safety policy and to conduct a health and safety audit. It is anticipated that the result of this audit may identify recurring and non-recurring expenditure that will require funding in the year 1988/89 and for this reason it has been necessary to allocate some minor block capital to address this problem, despite the growing problems of background maintenance.

The Unit attaches considerable importance to this issue and we have already appointed a Hygiene Control Officer to the Catering Department who will assist Catering Managers throughout the Authority to set quality standards which will be closely monitored. In order to support this we are committed to a high level of hygiene training for food handling staff.

It is our objective to improve the standard of fire prevention and we have agreed to appoint an Assistant to the Fire Prevention Officer which will be joint funded with Priority Care, and this will enable more staff to be trained in fire prevention and closer monitoring of fire prevention procedures, e.g. ensuring fire doors are closed, and ensuring fire escape routes are kept free of rubbish and discarded furniture or equipment.

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5. KEY OBJECTIVES

Introduction

The following section outlines the way Guy's Hospital will approach the set of objectives laid down by the District for 1988/9. For ease of reference the numbering system relates to that used throughout the District's guidelines for the Business Programme. Much work has already been completed on the production of objectives for Guy's Hospital over the next 5 years. See Section 10.

(a) Objectives Relating to Planning for the future

Objective 1.1 - "To Progress Guy's Phase III to Budget Cost Submission"

The Projects Directorate will continue to progress the Phase III project during 1988/9 and are aiming towards a target of October 1988 for the formal Budget Cost Submission. Project Managers (CONSPECTUS) have been appointed by the Regional Health Authority and the Design Team of relevant building professionals has been established. Regular Project Team and Design Team meetings will be held during 1988/9 and smaller sub-groups will continue to look at capital costings and cash flow, revenue costs and manpower and enabling works. The Unit is achieving a very high programme for the preparation of briefing information.

(b) The Delivery of Services to our Patients and our Local Population - Acute Services

Objective 2.1 - "To identify the volume of activity which can be maintained without detriment to service quality"

Objective 2.4 - "To maintain the 1987/8 levels of caseload and patient activity"

These two objectives are taken together as they ae so inter-related.

The budget reviews that have taken place with each Directorate have been undertaken on the basis of zero growth of both revenue and caseload. It is, therefore, planned that the Guy's Hospital Unit caseload target will be 35,896 which is the current projection for 1987/89. Any additional caseload will be the result of successful bids for additional funding such as waiting list monies. If the Unit does not receive the revenue needed to run the Unit at this level or if there is an underfunding of pay awards then the contingency arrangements outlined in Section 2 of the Guy's Business Programme will greatly effect the caseload figures. In line with the development of resource management, with its emphasis on the integration of financial, manpower and activity at Directorate level, activity reporting on 1988/9 will be split by Directorate.

Objective 2.2. - "To identify specific quality targets for service provision"

The Quality Assurance Committee at Guy's will be building on the work carried out during 1987/8 and will be monitoring caseload levels and aspects of care such as the number of cancelled admissions, waiting times and waiting lists. In addition the Committee will be concentrating on improving the quality of service given to patients by our reception staff.

Objective 2.3 - "To maintain as first priority services to District residents"

For District Acute Specialties the Hospital now records waiting lists separately for District and Non-District patients and precedence is given to District patients whenever the minimum waiting time of 8 weeks for an out-patient appointment is exceeded.

Objective 2.5 - "To increase day case activity"

1988/9 will see a full year's running of the Day Case Unit, established using transitional funds in 1987/8. It is anticipated that 1500-1800 cases will be treated per annum in this Unit and will include TOPS cases previously dealt with through staffed beds.

Objective 2.6 - "To reduce the numbers of cancelled admissions"

The policy of decentralisation of admission procedures to Directorates, linked to the installation of the ICL Patient Administration System, should be completed in 1988/9 and will make the whole process more efficient and flexible. The Quality Assurance Committee will continue to monitor the number of cancelled admissions although it is difficult to foresee any marked reduction when bed occupancy across the Unit remains at such a high level.

Objective 2.7 - "To improve systems for planned discharges"

The major problems associated with this objective lie in the lack of notification to Community Services or insufficient notice of discharge. The Hospital has clarified responsibilities on the Wards and the creation of Ward Receptionist posts (continuing in 1988/9) will provide for better procedures and notification. Guidelines have been issued to medical staff from the Quality Assurance Committee and seminars held to stress the importance of planning discharges. A bid has been made to the Strategy Review Group for a Discharge Liaison Officer in Geriatric Medicine and to Joint Finance for a post in Orthopaedics where 24% of beds are blocked by non-acute cases. Monitoring will continue by the Quality Assurance Committee. If plans to reduce Hospital Social Work support are implemented by the London Boroughs of Southwark and Lambeth then the situation will get worse.

Objective 2.8 - "To reduce waiting times for first out-patient appointments"

The waiting times are monitored regularly by specialty, and Directorates are asked for explanations of high figures. Proposals for 1988/9 which will have an effect on waiting times include the review of Dermatology out-patient scheduling with greater concentration on new attendances within existing sessions and the GP telephone referral service in Medicine. The decentralisation of out-patient scheduling will improve the efficiency of the service and the Quality Assurance Committee has issued guidelines on good practice. New guidelines will be issued to all local GP's in 1988/9 and will not only include basic information on how to arrange appointments and the list of clinics, but will also give them waiting times for routine first out-patient visits and in-patient treatment split by District and Non-District patients.

Objective 2.9 - "To reduce waiting times in Out-patients and A & E"

Guidelines stipulate that 75% of patients should be seen within 30 minutes of their Out-patient appointment and no more than 3% should wait for more than one hour. The introduction of computers and the decentralisation of out-patient management, linked to realistic appointment scheduling should assist in keeping to these recommendations. Regular monitoring will be undertaken by the Quality Assurance Committee. In A & E it has been agreed that no patient for admission should wait for longer than 30 minutes. The introduction of a computerised register should assist in the monitoring process.

Objective 2.10 - "To improve the accuracy of recording hospital activity"

The forthcoming installation of the ICL PAS should greatly increase the accuracy of recording activity as should the A & E computer, obstetric system and the decentralisation of management of admissions and out-patients. The completion of discharge summaries, from which Korner data is compiled, are to be rigorously monitored and a suggested target of accuracy has been set at 85%.

Diagnostic Coding Backlog

To catch up on the backlog of coding resulting from staff shortages and turnover, the following steps have been taken to improve the situation:

- staffing establishment is now up to 4 w.t.e. and a bid for a 5th person has been made (the original staffing level was 5 w.t.e.).

- in order to cut turnover staffing grades have been assessed and have been increased from CO to HCO grade (this is the standard grade throughout the Region for coding posts).

- extra staff have been engaged on additional contracts to deal with the backlog.

Discharge Summary/Letter

A new Discharge Summary/Letter is being tried out by Renal, Gynaecology and part of Medicine for a two month period. This is to be reviewed in April and if successful should be extended across the Unit. The aims of this new form are as follows:

- These forms should contain sufficient information in order to code the discharge and thereby eliminate the need for the Diagnostic Coding Unit (DCU) to retrieve the casenotes. Retrieval of casenotes has been identified as both time consuming and ineffective in cases where the clinician retains the casenotes for follow-up treatment. There are instances when DCU are coding discharges which are 3 years old.

- The introduction of this form should bring about standardisation of the required information for coding purposes and thus quicken the coding process.

- We are also considering splitting the coding work in order that each member of the coding staff may gain an expertise in set specialties.

District Information System (DIS)

As far as Guy's Unit is concerned this has caused many problems. Firstly it is a duplication of the work already done by the Admissions Department and secondly access to the system has been plagued by downtime. All of this has therefore resulted in a backlog of work. Objectives relating to DIS are as follows:

- to deal with accrued backlog using extra staff in 1C where possible.

- once the ICL Inpatient Module is installed at Guy's, the DIS will be integrated so that Inpatient Activity is automatically transferred.

- Diagnostic Coding will be transferred from PRIME to DIS. This has been delayed in view of their backlog and the problems encountered with access to this system.

Data Capture

There are a number of areas (particularly Day Case Units such as Bostock House) which need to be brought in line and this should coincide with the implementation of the new PAS. They are being taken into account in procedures being drawn up but do pose a certain manpower problem where this will cause extra work for areas with little or no clerical support.

Operating Theatres

Information about activity within the theatres should improve with the introduction of FIP. It is not yet possible to say whether there will be any manpower implications of this.

(c) Multi-District Specialties

Objective 2.11

The Hospital was disappointed that Paediatric End Stage Renal failure was transferred from a Supra-Regional to a Multi-District specialty for 1988/9.

Although the specialties where de-classification has been accepted will continue at current levels of activity, these levels will be monitored and the Hospital will be agreeing with the Directorates concerned, longer term proposals which may include cross-charging. From 1st April 1988 cross-charging will definitely be inroduced for open-heart surgery and angioplasties.

The Hospital is awaiting the RHA's decision on those specialties where a case has been made for the retention of Multi-District status, i.e. paediatric surgery, paediatric burns and paediatric assessment.

In addition the Hospital will be pushing for Regional recognition of the Neonatology service at Guy's.

(d) Terminal Care Services

Objective 2.19 - "To maintain the existing level of Terminal Care Services and to provide secretarial support to the Consultant"

The Unit will be appointing a Secretary for the Consultant in Terminal Care and will be recruiting to vacant nursing posts in the Symptom Control Team. Continued emphasis will be put on communications with referring Clinicians and on enhancement of the teaching programme.

(e) AIDS

Objective 2.22 - "To provide appropriate services to AIDS patients"

HIV testing facilities and the counselling service, established in 1987/8 from Regional AIDS funding, will continue in 1988/9 in the recently refurbished Lloyd Clinic. In addition an upgrading programme of 5 single rooms is underway on William Gull Ward which will accommodate the in-patient treatment of AIDS patients if necessary. Capital has been provided from the RHA's AIDS fund and the Unit is waiting to hear if the 1988/9 allocation will enable the Unit to be staffed.

(f) Breast Cancer Screening

Objective 2.23 - "To implement, as appropriate to the District, the Forrest Report proposals on Breast Cancer Screening"

As part of the South East London Breast Screening service it is proposed that Guy's will provide an Assessment and Biopsy Unit for women who have had abnormal breast cancer screening tests. The cost of providing this service on the Hedley Atkins Unit is assessed at £55,899 per annum with £102,900 equipment and building works start-up costs. However, it is unlikely that the Region's plan will involve setting up this Unit before 1989/90.

(g) Cervical Cytology Call and Recall

Objectives 2.24, 2.25, 2.26 and 2.27

The Guy's Hospital cytology laboratory will be providing part of the smear testing service to assist with the implementation of a full call/recall system for 4 community patches in 1988/9. An additional Consultant and Technician will be appointed in Histopathology (half the cost of the Consultant will be funded by the Unit) and the cost of the maintenance contract on the Radius Computer (£9,000) has been included in the budgets.

(h) Health Promotion

Objective 2.28 - "To implement across the District the Authority's agreed Health Promotion policies"

The Unit has implemented the Authority's policies on No Smoking, Healthy Eating and Sensible Drinking and will be continuing to monitor their success in 1988/9.

(i) Services for Adults with Physical Disabilities

Objective 2.29 - "To develop an integrated District-wide plan for the provision of services to adults with physical disabilities"

he appointment of a Consultant Neurologist (Senior Lecturer) with an interest in this field will provide a much needed co-ordination of rehabilitation services including the in-patient rovision at Dunoran. The Guy's Unit will be funding 2 sessions of this post.

(j) Improving the Organisation

Revenue

Please see Section 2.

Staff

Objective 3.2 - "To identify and implement measures which are reasonably within the control of the Health Authority to increase levels of recruitment and retention of staff"

The Guy's Unit is currently experiencing serious difficulty in recruiting to posts in various professional groups including Psychiatric, Geriatric, Paediatric and ITU Nurses, MLSO's, OT's Speech Therapists, Pharmacists and Works Officers. In addition medical and general secretaries are difficult to attract because of the low levels of pay when compared to other employers in the vicinity.

In 1988/9 the Unit will be aiming to improve on its recruitment performance for these groups and to increase retention rates by:

- reviewing the Unit's advertising policy.
- the introduction of performance review.
- the introduction of a YTS scheme for clerical staff.
- introducing a rolling "Customer Relations Training Programme".
- improving links with local schools and colleges.
- expanding the joint management development initiative with the King's Fund.
- Developing within the workforce a common sense of purpose and identification with Guy's.

Particular attention will be paid to nurse recruitment by:

- the appointment of a nurse recruitment officer.
- the provision of additional clerical support on the wards to reduce the level of routine paperwork carried out by nurses.
- giving accommodation priority to nurses in "hard to recruit" areas.
- implementing parking concessions.
- increasing the ward work undertaken by ancillary staff, e.g. bed making.

Objective 3.3. - "To implement the management development programme District-wide"

Substantial progress was made in management development during 1987/8 with the establishment of the King's Fund College link and the appointment of a Field Fellow under the auspices of the Resource Management Project. It is hoped that in 1988/9 the programme will be extended to cover the Executive and Heads of Department. A detailed implementation programme for 1988/9 is now available.

A system of individual performance review will begin to be implemented in 1988/9. This will include:

- Chairman/Chief Executive and Central staff
- Clinical Directors
- Business Managers
- Senior Nurses
- Heads of Departments

The programme will take two years to implement fully, but it is anticipated that substantial progress on clarifying roles and setting objectives for the above groups of staff will have been made by the end of 1988/89.

Objective 3.5 - "To finalise the District's Equal Opportunities Policy and implement its recommendations"

Guy's Hospital will consider how best to implement the Authority's policy on Equal Opportunities when this has been agreed by the Authority.

Objective 3.6. - "To Implement Cashless Pay"

Although the lead role in the achievement of this objective will be taken by the District Payroll Department, the Unit will be assisting in the implementation of cashless pay. The Unit's allocation has already been "top-sliced" to provide for the incentives being offered to staff and it is hoped that the savings that accrue from the scheme will also be allocated to the Unit's at a later date.

(k) Capital Resources

Please see separate section.

(1) Information Systems

Objective 3.19 - "To implement the PAS system through installation of ward based terminals"

Guy's Hospital plan to install ward terminals by the end of March 1989. However, this will depend on resources being made available and obtaining the commitment of ward staff. It is also being considered that terminals should be provided in Bostock House for the recording of Day Case patients and in the Maternity Unit in order to deal with healthy babies.

Objective 3.21 - "To introduce the IPS system for staffing and manpower"

Detailed procedures for the collection of the data for IPS are currently being worked up and training of the "end-users" will take place before the system goes live in June 1988. The final stage of implementation will be completed when a direct link to the payroll computer is established. This will enable managers to input pay details on a weekly/monthly basis and will also provide financial information downloaded from the payroll to IPS. All Business Managers and Heads of Department will have access to a terminal and after the system goes live they will be responsible for maintaining the records of their staff and for inputing data on starters and leavers.

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6. INCOME GENERATION

Each year Guy's Hospital has a proportion of its allocation expressed as an income target. For 1988/89 this will be £1.36m. Of the total target of £1.36m approximately £360,000 will be accounted for by way of income that we will earn from receipts for road traffic accidents, prescription charges, and rents from the Guy's aerial farm.

It may be possible to earn additional income in 1988/89 by introducing more revenue generating schemes such as contracting out our incineration services to other organisations, greater sales to the private sector, and increased charges for the aerial farm. But these are unlikely to produce more than £100,000 and will thus have only a marginal effect on the hospital's target.

It is therefore proposed to re-introduce Section 65 private practice to the Guy's site.

This will be undertaken in two stages.

(a) Nuffield Ward

The creation of additional beds on the 16th floor of the Guy's Tower to provide a self-contained private unit of 12 beds. This will be achieved with no significant loss of beds elsewhere in Guy's by carrying out enabling alterations on 14th and 15th floors of the Guy's Tower. The total cost of all the necessary work has been offset against the likely income to be earned, and after paying for the conversions will generate a profit of approximately £100,000 clear in 1988/89.

In addition to the income the hospital will also gain the advantage of having refurbished wards on the 14th, 15th and 16th floors paid for from private patient income,and ultimately additional beds for the NHS when Nuffield House re-opens.

(b) Refurbishment of Nuffield House

It is proposed that the hospital should take over the project for the refurbishment of Nuffield House. A feasibility report has been prepared by Watkins Gray International, and Dauncey Lynde Mellstrom and Bass indicating how this could be done. The cost would be dependent on the level of refurbishment which could be met in full from the sale proceeds of Deptford Laundry. The Regional Health Authority have indicated that they would be prepared to release the full sale proceeds from Deptford provided that the funds are used solely for this purpose.

A forecast profit and loss account has been prepared showing the income that would accrue to Guy's Hospital. This indicates that it is possible to achieve a profit of £2m per annum at 70% - 75% occupancy which would be sufficient to (a) offset income shortfall, (b) repay the debts accumulated since 1986 and (c) provide additional funds for the NHS.

- For this project to succeed the hospital needs to be run day-to-day on a professional basis. It is proposed that Guy's Hospital recruit a Hospital Director for Nuffield House either directly or via a contractor who would be required to run the hospital in accordance with annual profit and service quality targets with Guy's assuming the role of the holding company.

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7. DISABLEMENT SERVICES CENTRE

The McColl Report on artificial limbs recommends devolution of this function to more local level. Early indications are that the Special Health Authority for artificial limbs will consider a bid to form such a local unit at Guy's with a patient workload of approximately 1200 cases per annum from Lewisham and North Southwark and the immediately surrounding Authorities. A bid is currently being presented to the Special Health Authority for conversion of part of an existing hospital building (Shepherd's House) to provide an immediate and interim solution. Discussions are also in hand with the London Docklands Development Corporation to include a GAIT Laboratory for disabled children in the Guy's area.

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8. RESOURCE MANAGEMENT

Guy's Hospital has been recognised as one of the five pilot sites participating in the NHS Management Board's National Resource Management Project. The programme for 1988/89 reflects our aim to consolidate and further develop our management structure and provide better information about clinical practice and performance. In 1988/89 it is planned to:

(a) Introduce guidelines for Clinical Directors, and agree objectives for Business Managers, and Senior Nurses, as well as in the Central Services, as the first stage in introducing a systematic review of the performance of all hospital staff.

(b) Identify what further training or development is needed and set out programmes for Clinical Directors, Business Managers and Senior Nurses.

(c) Achieve the above objectives as part of the Management Development project now being implemented in collaboration with the King's Fund College.

(d) Further refine and improve the financial information provided to Clinical Directorates to include additional reporting of variable costs, for example, Pharmacy, Radiology and Pathology.

(f) Develop Clinical Information Systems which classify patient episodes into clinical meaningfull groups, stimulate development of clinical peer review, and collect details of the resources consumed by clinical activities.

(g) To commission the FIP Theatre System and use this to improve the utilisation of theatre time.

(h) To commission the Ward based FIP system which links units of nursing time to patient dependancy and enables better planning and management of nursing resources.

A Resource Management Project Steering Group has been set up under the Chairmanship of Professor C. Chantler to review the progress of the project as a whole.

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9. CAPITAL PROGRAMME

(a) Progress Report on the 1987/8 Programme

During 1987/8 a total of 22 schemes were progressing (excluding New Cross schemes) within a total allocation of £1.637m. This allocation was provided from a variety of sources including the minor block allocation, The Special Trustees, land sale proceeds, The Friends of Guy's, Kidney Patients Association and Regional AIDS monies.

Although final figures are not yet to hand it is estimated that there will be an end of year overspend of approximately £58,000 with a carry over commitment of £83,000.

(b) Use of Capital Resources 1988/9

Major Schemes

(i) Replacement Switchboard

Following a detailed analysis of the Guy's Switchboard it has now been agreed that it should be replaced as a matter of urgency. This proposal has been supported by the Regional Health Authority and tender documents are currently being prepared for immediate implementation of the scheme.

In view of the urgency of the scheme, agreement has been reached with the Special Trustees for a loan of £1.2m which the Unit will repay from its Minor Block Capital allocation at a rate of £200,000 per annum for the next six years.

(ii) Radiotherapy Department

The Special Trustees have granted a sum of £1.267m for the Radiotherapy Department which will enable:

- the formation of a bunker for the new LINAC being purchased by the Region.
- works, such as road diversion, to be carried out before the formation of the new bunker.
- minor upgrading of the remainder of the Radiotherapy Department including a new air conditioning system.

Estimated expenditure in 1988/9 is £726,000 with an expectation that the new LINAC will be installed by November 1989.

(iii) Minor Block Capital

As stated in previous pogrammes the Guy's Unit is committed to using its minor block capital allocation to rectify its present and growing problems of backlog maintenance.

The formation of the Guy's Phase III Development will, with the consequent demolition of a number of its condition E buildings, have a significant effect on this declared aim. The Unit's first priorities for the 1988/9 financial year are therefore the enabling works which will free up the Phase III site.

The District Works Officer has identified the main areas where maintenance is urgently required. These fall into the following categories:

- airconditioning/replacement of lifts - continuation of a phased programme.
- structural repairs and building maintenance - continuation of a phased programme.
- maintenance of engineering infrastructure - continuation of phased programme.
- energy conservation schemes - continuation of a phased programme.
- health and safety - continuation of programme of remedial measures consequent upon removal of crown immunity.
- replacement of Tower refrigeration absorption plant.
- phased replacement of electrical distribution system.
- phased major redecoration/building programme.

The Unit has been notified that its Minor Block Allocation for 1988/9 will be £510,000 to which can be added the anticipated proceeds from the sale of the Dunoran Orchard, Deptford Laundry and the part of Nuffield House owned by the Hospital. (This sum will be used for upgrading work and Dunoran itself).

(c) Analysis of Objectives

Objective 3.12 - "To manage the District's Capital Programme as efficiently as possible"

The main procedures for managing the District's Minor Block Capital Programme were agreed in 1987/8 and are now in operation. The Head of District Planning co-ordinates these procedures and will be submitting her own paper on this objective as part of the District Headquarter's Business Programme.

However, there are certain points which the Guy's Unit would like to make on this objective:

(i) The management of individual schemes is the responsibility of the Units but monitoring and reporting procedures are confused because payments against job numbers/cost centres are made at a District level.

(ii) Delays in issuing cost centres/job numbers for schemes result in programming problems within the Unit Works Department. This has a "knock-on" effect on ensuring schemes are completed in the year of funding.

(iii) The Unit Works Department has set up a commitment accounting system for the management of the Guy's schemes. However, as progress is monitored on the basis of payments made, reconciliation is difficult. This is particularly important towards the end of the financial year when the projected out-turn and carry forward commitments need to be assessed.

To try and alleviate these problems it is proposed that:

1. the Guy's Unit should not only run and control each scheme but that the financial reporting should be undertaken by the Unit Finance Director, This would make the system more efficient and would allow closer control and monitoring of schemes.

2. when 1. is implemented a small Capital Monitoring Group would be established with representatives from Works, Finance and Projects Directorates. This small group would meet every month to analyse the progress and expenditure on each scheme. Reports to both the District Capital Planning Group and the Members Sub-Group would subsequently be more accurate.

3. computer links between the Works, Projects and Finance Departments should be investgated if 1. is accepted.

<u>Objective 3.13</u> - "To deal with maintenance needs in a planned and coherent way"

The Unit recognises the need for investment in backlog maintenance but the very scale of the problem (£17m to bring the District's building stock back to condition B) and competing priorties such as Crown Immunity, Lift Replacements and the Replacement Switchboard make anything but the minimum level of investment impractical. The scale of the problem is well known and attempts have been made in recent years, and will continue in 1988/9, to support small maintenance schemes from revenue allocations.

The continued implementation of the Works Information Management Systems (WIMS) and the Labour Management System will, in 1988/9, assist in the structured planning of maintenance.

The maintenace schemes that will be funded from the Minor Block Capital allocation in 1988/9 are included in Appendix 4.

It is also proposed that £300,000 revenue will be spent on minor schemes. However, this will have to cover all the following areas:

- backlog maintenance
- crown immunity
- health and safety
- fire precautions

Objective 3.14 - "To achieve the improvements required by the Environmental Health Officer in all areas, particularly kitchens, following the removal of crown immunity"

The Guy's Unit has had very good relationships with the EHO at Southwark for the last ten years and the problems resulting from the removal of crown immunity are not as acute as those at Lewisham. However, a great deal of work has been undertaken to satisfy the hygiene requirements and in 1988/9 the Unit will be:

- completing the work specified by the EHO in respect of the Tower kitchens and the Coffee Bar
- undertaking a major refurbishment of the main kitchens with money from both minor block capital and revenue sources
- commencing a rolling programme of ward kitchens upgrades with appropriate equipment replacement
- undertaking an extensive programme of food handler training to include not only catering staff but domestics and nurses as well (the regulations stipulate a minimum of 8 hours training per annum for each food handler)
- pursuing an in-house solution to pest control

Any further developments will be greatly affected by the central policy decision on the introduction of cook-chill across the District.

Progress throughout the year will be monitored by the EHO and his reports will provide the key quality indicator. The appointment of a District Quality Control Officer in the Catering Department in 1987/88 will provide a focal point for liaison with the EHO.

Expenditure proposals - £69,000 for Crown Immunity and fire precautions etc.

Objective 3.16 - "To invest in medical and scientific equipment"

The pressure on the Minor Block Capital allocation for the Guy's Unit because of:

- the need to top-slice the allocation to support the site strategy developments

- the extent of the demand for work on backlog maintenance and crown immunity

- the implementation of large schemes such as the switchboard replacement

means that no Minor Block Capital will be specifically allocated for medical and scientific equipment in 1988/9.

However, bids have been made to the RHA through the Short Term Programme mechanism for:

	No.	Total Cost (£000's)
Items over £20,000	55	1,527.7
Items under £20,000	62	60.3
	117	1,588.0

It is unlikely that the RHA's decision will be before June 1988.

An inventory of all medical and scientific equipment will be completed very shortly by the newly created EBME Department. This will allow rational decisions to be made as to what level of investment will be required in the future.

Objective 3.17 - "To invest in energy conservation/management"

No specific allocation has been made from Minor Block Capital for investment in energy conservation/management. In 1987/8 the Unit received £67,000 from the RHA towards the installation of a Heat Exchanger which had a total cost of £101,000 (£34,000 from Minor Block). It is expected that for 1988/9 the RHA will be again asking for bids for energy conservation projects. When notification is received from the RHA the Unit will be putting together bids to take advantage of the Regional funds. For 1988/9 the Unit will in addition be:

- aiming to make the maximum utilisation of energy, and

- taking a hardline in negotiations with public utilities on prices.

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10. FIVE YEAR OBJECTIVES FOR GUY'S HOSPITAL

Introduction

After nearly three years of the new management structure, Guy's is in a better state organisationally and financially than for many years. Yet many desirable changes have still to be achieved and this paper begins the process of defining the aims for the next five years. Once these overall aims have been agreed, each directorate and other unit should develop corresponding and more specific plans of their own. For this reason, this statement of aims will need to be debated and then refined. Ideally, the aims should be specific enough to give direction to our activities, without being so specific as to preclude genuine local interpretation at directorate and departmental level. At the end of this process, it should be possible to say "this is how we want our hospital to look in five years' time".

Pursuing Efficiency

Guy's exists to provide the best possible service to patients from its own district and from outside. Like any NHS hospital, it has to work within the constraints of governmental, DHSS, regional and district policies. Nevertheless, within these constraints, there are many opportunities and it is up to management at every level to make the most of them in striving for efficiency. Underlying all these efforts there will be an inevitable tension between the desire to treat as many patients as possible and awareness that when the system is overloaded, the quality of care falls. Another way to express this might be by the equation:

$$\text{Efficiency} = \frac{\text{Quality} \times \text{Workload}}{\text{Resources}}$$

The Aims

1. Patient Care

Within the overall aim of providing a service to all district patients and as many non-district patients as resources allow, we must achieve the highest possible quality of care. Quality here does not only mean good clinical diagnosis and treatment. It also means minimising delays or discomfort and giving each patient a sense of individual consideration by every member of the hospital staff whom he or she meets. This aim should inform every aspect of the hospital's work and will generate specific targets in different areas - for example, to reduce waiting time in outpatient clinics or eliminate cancelled admissions.

Like all those which follow, if these broad aims are to be achieved, it will be necessary to translate them into specific targets and to identify who will be responsible for achieving those targets.

2. **Personnel**

The hospital must set higher standards for all personnel and this may mean amended job descriptions and more extensive reviews of performance. On the other hand, it is a prime aim that all personnel shall feel:

(i) Proud to work for Guy's

(ii) Aware of their value to the hospital and their place in its working, i.e. to know what is expected of them and what constitutes good performance.

(iii) Confident that good work will be recognised and rewarded.

(iv) Confident that their voice will be heard by those senior to them.

(v) Clear as to their opportunities for improved training and for promotion.

(vi) Interested in and responsive to ideas as to how to do their job better.

3. **The Fabric of the Hospital**

The first aim must be that in five years, Phase III of the hospital's redevelopment will be well on the way to completion. In addition we must give a larger proportion of the hospital's finances to the maintenance and cleaning of the hospital buildings and grounds. Aims are:

(i) To improve maintenance of all buildings

(ii) To achieve efficient utilisation and conservation of energy.

(iii) To improve the standard of decoration and cleanliness of the environment. (One means to achieving this aim has been the allocation of responsibilities for specific areas of the hospital to the appropriate directorate or department.)

(iv) To speed the system of repairs and replacements.

4. **Equipment**

Well-designed, modern, user-friendly equipment helps to increase productivity and efficiency. We hope therefore, to allocate a regular slice of income for new equipment and its maintenance. The aims are:

(i) A full equipment inventory.

(ii) Replacement of sub-standard equipment by modern, reliable equipment.

(iii) Improved in-house maintenance with an agreed proportion of this work being carried out by outside firms.

5. **Communications and information**

These are vital both to the clinical and organisational running of the hospital. Specific aims are:

(i) Everyone in directorates and in other departments should be fully aware of the aims of and developments in the hospital.

(ii) Up-to-date, relevant and accurate information on financial and operational matters should be available so that all end of month data are available by the middle of the succeeding month.

(iii) Telephone and computer links within the hospital will be fully implemented and efficient. This will include a regularly updated telephone directory.

(iv) The critical importance of two way communication (e.g. between the executive and directorates) requires that all communications, of whatever kind, need to be expressed concisely and with clarity (a jargon-free hospital).

6. **Organisation**

Decentralisation has still some way to go. Aims here are:

(i) That directorates and other divisions assume full responsibility for their operations and budgets.

(ii) That a mechanism is found, in the larger directorates, for creating sub-directorate sections in which particular specialty groups can organise their work with as great as measure of independence as possible.

(iii) That business managers are all clear as to their roles and responsibilities and are fully supported by their clinical colleagues.

(iv) That the non-directorate sections and divisions o the hospital are similarly clear as to their role and responsibilities and feel fully involve^ in the hospital's working.

(v) The central hospital organisation and all directorates and other divisions should have produced handbooks defining their policies and practices.

(vi) That means be devised (eg incentives) to encourag individual directorates to adopt an 'entrepreneural' style of management both in relation to new clinical developments and in securing additional resources for the hospital. (Here the central organisation has to keep a balance between Directorates, ensuring that the activities of one do not harm the interests of another).

7. Teaching and Research

Guy's will not remain a first rank teaching hospital if it ceases to regard undergraduate ad postgraduate teaching and research as important. It is, however, essential that all aspects of quality of care and of management should come to be regarded as subjects for teaching and research, alongside the more familiar clinical topics. Suggested aims here would be:

(i) That staff and students of all kinds should learn from the example of those senior to them how to treat patients with courtesy and consideration, a well as efficiently and to demonstrate this to those junior to them.

(ii) That staff and students should be aware of the importance of good practices in the efficient running of their work whether in a clinical firm, a department or other section of the hospital, an that they should be interested to learn about management.

(iii) That relevant, effective programmes in these topics are available.

8. Training and Development

The provision of effective training and development is an integral part of our overall objectives. The aims are:

(i) That all staff should have access to training and development opportunities to enable them to make an effective contribution in the areas for which they have responsibility.

development should be renewed regularly and systematically by the individual concerned and their manager or supervisor.

(iii) That staff with management potential should be identified early on and provided with a structured learning and development programme.

(iv) That all managers should receive the necessary training and development to enable them to manage the organisation effectively.

9. **Support Departments**

These, from catering, stores and works, to theatres, pathology and imaging departments, provide services on which the throughput of patients depends. Their efficiency would be greatly increased if most of their work was scheduled and predictable. Aims here:

(i) Waste due to incorrect requisitioning of stores or catering supplies to be reduced below an agreed target.

(ii) Response time of the Supplies Department to be improved in accordance with an agreed target.

(iii) An agreed proportion of theatre cases to be booked in advance. Utilisation of theatre time during the working day to be increased to an agreed level.

(iv) A minimum of patients to be admitted purely for investigation: those who are so admitted have all investigations booked in advance.

(v) Investigative departments to have all reports or results on computer within an agreed time period of the tests being performed.

10. **Relations with the Community**

This includes patients, the community services and family doctors. The aims include:

(i) That residents of and G.P.'s in our district shall feel that Guy's is "their" hospital.

(ii) That communication and understanding between community and hospital services should lead to improved quality of care before, during and after visits to or stays in the hospital. To be specific, that admissions and discharges are planned in relation to home conditions and support services.

(iii) That family doctors receive an agreed proportion (95%?) of discharge summaries within a week.

(iv) To devise ways in which the work of social worker can be integrated with and where appropriate managed by, the hospital.

11. Relations with the District

(i) All clinical services should be co-ordinated within directorates across the district.

(ii) Information and record services should follow unified policies with a district patient number.

12. Relations within the NHS

(i) That Guy's must meet the statutory requirements for information from DHSS and Region, as funding allocations to Guy's are based on this data. Standards for accuracy and timeliness should be set and monitored for key reports (e.g. discharg summaries).

(ii) That Guy's must be able to respond to the initiatives of DHSS, Region and District and matc these to the priorities set within the hospital o be in a position to argue the case against. Again, accurate records of clinical activity and expenditure will be vital to pursue these objectives.

GUY'S HOSPITAL

1988/89 BUSINESS PROGRAMME - ALLOCATION

	Recurring	Non Recurring	Total
	£'000	£'000	£'000
Start Allocation	49,860	19	49,879
1) Opthalmology to WLHA	(60)		(60)
2) 3 Sessions Dr Clarke	(8)		(8)
3) Radiotherapy to WLHA	(245)		(245)
4) New Cross FYE Reversal	21		21
5) Clinical Asst FYE	(6)		(6)
6) Learner Shortfall	700	150	850
7) Planned Addition		150	150
8) Resource Management		123	123
9) Caseload Preservation	150		150
10) Supplies Savings	10		10
11) Renal 1988/89 Activity		380	380
Total expected allocation	50,422	822	51,244
Other Funds :-			
Evelina Appeal Support			222
Total Available Funds			51,466

GUY'S HOSPITAL

1988/89 BUSINESS PROGRAMME - REVENUE BUDGET

	1987/88FYE ALLOCATIONS AT MARCH 1988	RECURRING ADJUSTMENTS	NON RECURRING ADJUSTMENTS	INITIAL 1988/89 BUDGETS
Clinical Directorates :-	£'000	£'000	£'000	£'000
Surgery	2,287	3	0	2,290
A&E/Orthopaedics	1,843	1	20	1,864
Medicine	3,258	(54)	0	3,203
Neurosciences	429	4	18	451
Paediatrics	2,858	103	0	2,961
Obs & Gynaecology	1,976	11	2	1,989
Renal	2,299	(29)	256	2,527
Cardiac Services	3,145	12	0	3,157
Oncology	701	18	9	728
Dental	3,126	(91)	0	3,035
Anaesthetics	1,055	68	0	1,123
Radiological Services	2,134	0	0	2,134
Pathology	2,298	(2)	0	2,296
	27,410	43	305	27,758
Poisons Unit	793	(18)	0	775
Regional Genetics	613	13	0	626
C.T. Scanner Exps	43	0	0	43
Total Directorates	28,859	38	305	29,202

Residual Functions :-	1987/88FYE ALLOCATIONS AT MARCH 1988 £'000	RECURRING ADJUSTMENTS £'000	NON RECURRING ADJUSTMENTS £'000	INITIAL 19 /89 BUDGETS £'000
Medical Staff Services	1,172	(51)	0	1,121
Nursing - Residual	995	(41)	0	954
MSSE - Central & Other	104	0	0	104
Theatre Function	1,381	0	0	1,381
Pharmacy & Drugs	3,230	165	0	3,395
C.S.S.D.	1,400	0	0	1,400
Clinical Physics	377	0	0	377
Administration	1,386	5	0	1,391
School of Radiography	245	(4)	0	241
School of Physiotherapy	367	(40)	0	327
Catering	1,692	(71)	14	1,635
Domestics & Portering	2,914	(85)	0	2,829
Linen Services	378	0	0	378
Estate Management	2,816	0	0	2,816
Energy and Utility	1,511	0	0	1,511
Rent & Rates	1,327	(52)	0	1,275
Medical School Charges	76	0	0	76
Losses & Compensations	75	25	0	100
Mortuary	21	0	0	21
Non Capital Programme	300	15	0	315
Telecommunications	620	20	0	640
Security	137	1	0	138
Accommodation Income	(379)	(60)	0	(439)
Personnel	236	(5)	0	231
Superintendants Office	137	0	0	137
Deptford Support Service	46	0	0	46
Finance Directorate	167	0	0	167
New Cross Hospital	618	(618)	0	0
Total Res Functions	23,350	(795)	14	22,569
Rerserves etc. :-				
Pay Award Reserve	188	0	0	188
Caseload Preservation	0	(0)	0	0
Renal Activity	106	(106)	0	0
Vacancy Contributions	(385)	0	0	(385)
87/8 Prices Reserve	225	(225)	0	0
Saturday Theatre	0	0	0	0
	134	(332)	0	(197)
Annual Revenue Budget	52,344	(1,089)	319	51,574

GUY'S HOSPITAL

1988/89 BUSINESS PROGRAMME - MANPOWER BUDGET

Clinical Directorates :-	87/88 W T E	Changes W T E	88/89 W T E
Surgery	149.75	1.50	151.25
A&E/Orthopaedics	120.45	0.30	120.75
Medicine	254.20	(3.00)	251.20
Neurosciences	25.88	0.35	26.23
Paediatrics	216.79	6.00	222.79
Obs & Gynaecology	152.93	0.56	153.49
Renal	96.09	2.50	98.59
Cardiac Services	157.54	3.50	161.04
Oncology	52.63	2.00	54.63
Dental	250.91	(16.14)	234.77
Anaesthetics	33.01	1.00	34.01
Radiological Services	113.51		113.51
Pathology	130.12	(0.73)	129.39
	1,753.81	(2.16)	1,751.65
Poisons Unit	47.34		47.34
Regional Genetics	37.52	1.00	38.52
C.T. Scanner Exps			
Total Directorates	1,838.67	(1.16)	1,837.51

Residual Functions :-	87/88 W T E	Changes W T E	88/89 W T E
Medical Staff Services	3.09	(2.00)	1.09
Nursing - Residual	84.50	(2.00)	82.50
MSSE - Central & Other			
Theatre Function	101.50		101.50
Pharmacy & Drugs	57.30		57.30
C.S.S.D.	41.80		41.80
Clinical Physics	22.00		22.00
Administration	81.09	(2.69)	78.40
School of Radiography	6.96	(0.25)	6.71
School of Physiotherapy	10.25		10.25
Catering	117.80		117.80
Domestics & Portering	336.89		336.89
Linen Services	12.75		12.75
Estate Management	141.83		141.83
Energy and Utility			
Rent & Rates			
Medical School Charges	3.00		3.00
Losses & Compensations			
Mortuary	2.00		2.00
Non Capital Programme			
Telecommunications	16.00	1.00	17.00
Security	5.56		5.56
Accommodation Income			
Personnel	14.00	(0.50)	13.50
Superintendants Office	10.00		10.00
Deptford Support Services			
Finance Directorate	9.00		9.00
New Cross Hospital			
Total Res Functions	1,077.32	(6.44)	1,070.88
Rerserves etc. :-			
Pay Award Reserve			
Caseload Preservation			
Renal Activity			
Vacancy Contributions			
87/8 Prices Reserve			
Saturday Theatre			
	0.00	0.00	0.00
Total W.T.E. (Contracted Hours)	2,915.99	(7.60)	2,908.39

UNIT:...GUY'S..............

1. SOURCE OF FUNDS	£	£	£	£	COMMENTS
MINOR BLOCK ALLOCATION..	510,000				
CARRY FORWARD 1987/88 (+/-)......	(58,000)				
SUB-TOTAL..................	452,000			452,000	
ANTICIPATED LAND SALES:					
a) Dunoran Orchard *		60,000			
b) Deptford Laundry **		1,200,000			
c) Nuffield House (Hospital owned - Part)		150,000			
d).....................................					
SUB-TOTAL............................		1,410,000		1,862,000	
AVAILABLE FROM OTHER SOURCES (PLEASE SPECIFY):					
a)...Special Trustees			726,000		
b) Regional Aids Funding			30,000		
c)...					
d)...					
e)...					
f)...					
SUB-TOTAL..................................			756,000	2,618,000	
GRAND TOTAL..				2,618,000	

* If the sale proceeds from the Dunoran Orchard accrue in 1988/9, the estimated £60,000 return will be spent on upgrading work at Dunoran itself.

** The sale proceeds from the Deptford Laundry have been 'ear-marked' for the necessary conversion work on Nuffield House which will be undertaken by the Special Trustees - the figure of £1.2m. is at present a rough estimate of these proceeds.

2. PLANNED EXPENDITURE

BRIEF SCHEME DESCRIPTION IN PRIORITY ORDER	PLANNED		CATEGORY (Please tick)						ANTICIPAT COST £
	START DATE	FINISH DATE	BACKLOG MAINT	CROWN IMMUNITY	H & S FIRE PR	MED/SC EQUIP	SAFETY/ STANDARDS	OTHER	
A Minor Block									
1987/8 Carry forward	April '88	March '89							83,000
Switchboard-Repayment to Trustees	April '88	March '89							200,000
Lifts-Phased Replacement Programme	April '88	March '89							200,000
Phase III Enabling Works	April '88	March '89							50,000
Crown Immunity/Health and Safety/ Fire Precautions	April '88	March '89							69,000
B. Special Trustees Funding									
Radiotherapy Bunker	Jan '88	1991							726,000
C. Other Initiatives									
William Gull Conversion (RHA AIDs funding)	March '88	May '88							30,000
* Dunoran Home Upgrading work	April '88	March '88							60,000
** Nuffield House Conversion - Repayment to Trustees	April '88								1,200.000
SUB-TOTAL									2,618,000

2. PLANNED EXPENDITURE (CONTD)

BRIEF SCHEME DESCRIPTION IN PRIORITY ORDER	PLANNED		CATEGORY (Please tick)					ANTICIPATED COST £
	START DATE	FINISH DATE	BACKLOG MAINT	CROWN IMMUNITY	H & S FIRE PR	MED/SC EQUIP	OTHER	
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SUB-TOTAL THIS PAGE								00
SUB-TOTAL PREVIOUS PAGE								2,618,000
GRAND TOTAL								2,618,000

3. ANTICIPATED REVENUE EXPENDITURE ON MAINTENANCE: (UNITS TO IDENTIFY CATEGORIES OF MAINTENANCE EXPENDITURE)	1987/88	1988/89	COMMENTARY
Small Schemes in the areas of:- - Backlog Maintenance - Crown Immunity - Health and Safety	300,000	300,000	

St. Mary's Hospital,
Praed Street, London W2 1NY
01-725 - 1200 [Direct Line]
01-725 6666 [Main Switchboard]

18.IV.88.

P. Gray, Esq.,
10 Downing Street,
LONDON, SW1A 2AA.

Dear Paul,

I have delayed writing until now because I wanted to up-date myself on the changes that ~~are~~ have taking ~~on~~ place in General Practice during the twelve years since I was principal, although I am still a member of that college.

When I was a trainee and then a principal in General Practice, '74 to 76, it was very evident to me then that ~~at the time~~ there was an enormous drive by the Government to encourage General Practitioners to take up family planning, and as a result very many of us ensured that we had done a Family Planning Course, so that we could qualify for the IUCD fee, which at that time was £10. I am surprised to see that it has actually risen more than three times to £33.15.

By comparison, the consultation and minor operations fee is £14.75. (This fee did not exist in 1976). This fee ~~would be~~ is appropriate for any non-emergency minor surgery, such as excision of a sebaceous cyst, treatment of an ingrowing toenail, removal of superficial lumps and bumps on the skin - (providing that there was no clinical indication that there was malignancy, and providing that all tissue excised was sent for histology). If the General Practitioner was available, there is no reason why he could not do the more simple emergencies, such as suture of simple lacerations and removal of a superficial foreign body in the eye.

Since these procedures would probably involve more than a comparable procedure of fitting an IUCD, (although the latter does involve also general family planning advice), I believe that at the very least this consultation and minor operations fee should be doubled or possibly trebled.

2/-

There are, of course, certain other problems which dampen incentives for General Practitioners to undertake work which they could do more cost-effectively than hospital emergency services:-

(1) Lack of provision of CSSD services - (Central Sterile Supply Department).

(2) Lack of appropriate premises for many inner city single-handed General Practitioners - (by comparison to Health Centres).

(3) Lack of nursing support - (even though there is a 70% re-imbursement of the nurse's salary by the FPC).

These problems would not be insurmountable providing there were sufficient incentives.

We in Accident and Emergency would be only too delighted to run courses on minor surgery for General Practitioners, and if those General Practitioners saw that there was appropriate remuneration, I believe the financial incentive would be sufficient to overcome difficulties. It could well be that once these difficulties were overcome, i.e. once a General Practitioner had his premises, a nurse and appropriate skills, over a period of years the fees for minor surgery could proportionately be reduced from the initial *pump priming* that would probably be necessary.

+CSSD equipment supply

It must be remembered that General Practitioners are answerable to Family Practitioner Committees who are answerable to the DHSS, whereas Community Services are (including District Nurses), are answerable to the District Health Authorities, whilst personalized social services, e.g. Meals-on-Wheels, Home-Helps, come from local authorities. If these three were under one Community Health Service, I believe it would be easier to provide the necessary support to the General Practitioners to make use of their minimum of nine years' training. (Five years as a Medical Student, one year as a Houseman, three years as a Vocational Trainee). In addition, remembering that there is a block in certain grades in certain

specialities, e.g. Registrars in General Surgery, there would be an incentive for General Practices to appoint partners who had a specific surgical expertise, and could train other members in the practice. Again, the financial incentive would need to be sufficiently high initially to enable this to come about. (in addition to the necessary vocational training)

The local Accident and Emergency Departments would be supportive of their local General Practitioner colleagues, such that if a wound dehisced - (broke open), bled or a procedure they were carrying out went wrong, then that local Accident and Emergency Department would be there to provide a 24-hour emergency service back-up. By giving the patients this service, they would give the General Practitioners the support that they needed in order to have the courage to proceed.

I believe that these problems will become more acute as the population ages and the post-war baby boom becomes a retirement bulge. Then it will be of enormous importance to keep patients out of hospital and in the community.

A large number of vocational trainees in General Practice spend six months of their three years in Accident and Emergency, and in Accident and Emergency they learn basic surgical procedures. Although we do not deal primarily with cold minor surgery, I do not in point of fact turn such patients away, as they are very useful teaching material for our junior Senior House Officers who can carry out minor operations under supervision.

We all know now how the career pendulum has swung, i.e. towards general practice as a popular option, such that there is enormous competition for good practices. Vocational trainees who have a practical surgical training, as part of their vocational training, would ~~have~~ increase ~~d~~ their financial worth to a practice, and therefore ~~those~~ trainees would have a great incentive to develop a surgical expertise in the future. Thereby minor surgery-type patients would be removed from waiting lists.

I should also say that simple superficial abscesses could also be incised by General Practitioners, as they are far too often treated with antibiotics without surgical intervention at the cost to the patient

cause antibiotics do not dissolve pus, only create sterile abscess.

ally, developing what I have said above for a oup Practice, there is everything to be said for member of that practice to have a surgical ertise just as perhaps another one might have an esthetic expertise, and so on through the practice. ll hospitals could provide a community a cottage pital service, but the large district general pitals serving populations of 300,000 +, with ident and Emergency Departments seeing 50,000 or e patients a year, would be the trauma centres the future, perhaps being on-call for trauma in ation with other large district general hospitals, that surgical teams were readily available for or trauma. (This is another topic I know, but which is increasingly going to be discussed as a ult of what is happening at the College of Surgeons England).

in, developing the theme of my earlier letters, ey would follow ~~the~~ patients, and the General ctitioners who provided these services for ients would be paid on an item of service basis. In a pital setting, again, money would follow the ient, such that those departments which provided cost services would receive more patients and ereby more money. This would provide the petition that would be necessary to keep costs down. However, money ld not follow the patient in district general pitals for those services which the DHSS deemed ld be more appropriately carried out in General ctice. The only rider here is that Teaching pitals would perhaps receive a small fee so that y could train their junior staff in treating minor gical problems, remembering that in a strictly gical sense there is no minor surgery; only minor geons.

eral Practitioners, being self-employed, have ays been an entrepreneurial breed, and also some- t more individualistic than their hospital leagues, who are more institutionalized. Therefore, extrapolation of the item of service payments tem would find fertile ground in General Practice.

5/-

I hope what I said is both pertinent and relevant, and thereby helpful.

Yours sincerely,

Robin

Robin Touquet, RD, FRCS, MRCGP.
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From the Private Secretary

19 April 1988

FURTHER COPY OF DOCUMENT CIRCULATED 19/4

NATIONAL ASSOCIATION OF HEALTH AUTHORITIES

Mr Philip Hunt, the Director of the NAHA, has written to the Prime Minister forwarding the Association's Evidence to the NHS Review. I have acknowledged receipt of this material. But your Secretary of State may like to see the document which I enclose.

I am copying this letter and enclosure to Moira Wallace (HM Treasury), Jill Rutter (Chief Secretary's Office), Jenny Harper and Sir Roy Griffiths (Department of Health and Social Security) and Richard Wilson (Cabinet Office).

Paul Gray

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

THE NATION'S HEALTH

- A WAY FORWARD

NAHA'S EVIDENCE TO THE PRIME MINISTER'S

REVIEW OF THE NHS

NATIONAL ASSOCIATION OF HEALTH AUTHORITIES
GARTH HOUSE, 47 EDGBASTON PARK ROAD
BIRMINGHAM B15 2RS

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ISBN 0 946832 46 3

THE NATION'S HEALTH

- A WAY FORWARD

CONTENTS

		page no
	KEY POINTS	i
I	**AN ASSESSMENT OF THE NHS**	1
	Recent Achievements	2
	Issues to be tackled	3
II	**THE NHS IN CRISIS?**	5
	Inflation	5
	Demand	7
III	**FUTURE FUNDING/PROVISION OPTIONS**	10
	The alternatives - Primary Sources of funding	12
	- Secondary Sources of funding	16
	Distribution of Finance	19
	Other major funding/provision options	23
	Alternative funding - conclusion	27
IV	**ROLE OF THE PRIVATE SECTOR**	28
V	**ROLE OF TEACHING AND RESEARCH**	30
VI	**AN NHS FOR THE 1990s**	32
	Contract with the customer	32
	Accreditation	34
	Organisational Recommendations	35
	- National NHS Management Agency	38
	- Regional Health Authorities	40
	- District Health Authorities	41
VII	**SUMMARY OF KEY POINTS AND RECOMMENDATIONS**	49

KEY POINTS

(i) In this paper, the Association gives a wide-ranging assessment of the achievements and performance of the NHS.

In particular, it stresses that:

* The provision of equal access to health care irrespective of means, free at the point of delivery, has relieved people from worry about the personal costs of being ill.

* The effectiveness of the NHS planning system has avoided wasteful duplication of facilities.

* Polls show a high degree of satisfaction amongst those who have either received treatment recently or have had a close member of their family receive treatment.

* In the 1980s the NHS has increased the number of in-patients, out-patients and day cases treated, as well as developing community care, achieving substantial savings and introducing general management.

GOOD FOUNDATIONS MUST NOT BE UNDERMINED

(ii) Whilst acknowledging that the NHS is facing several difficult challenges, the Association argues that they do not amount to a justification for undermining the good foundations which have been laid by the NHS over the last forty years. These challenges do, however provide an exciting agenda for the NHS in improving the nation's health in the years leading up to the end of the century.

NO ADVANTAGE IN SWITCHING TO ANOTHER FUNDING SYSTEM

(iii) NAHA believes that, measured against objective criteria, there is very little advantage in moving to an alternative to the current system of funding. However, in arguing for the continuation of general taxation as the primary source of funding, the Association also believes it to be essential that:

* the NHS is allocated sufficient funds to meet inflation and legitimate patient demand and other agreed developments; this amounts to some 2% real growth in funding per year;

* there should be sufficient buoyancy to provide incentives for efficient health authorities.

ACTION ON 'EFFICIENCY' INCENTIVES

(iv) NAHA has called for the rectification of what it calls 'perverse incentives' to greater efficiency. It draws attention to the fact that, by an efficient use of resources health authorities have reduced the average costs per case - by treating more patients in fewer beds - yet have increased total expenditure by overall expansion of services. Cash limiting of budgets then penalises those who have improved their performance in this way.

OTHER FACTORS

(v) Among the other factors NAHA has highlighted:

* the need to reverse the recent abolition of the facility by which health authorities can carry over a proportion of their budgets from one year to the next;

* the possibility of a system under which a pre-set, percentage bonus could be given to districts over-achieving agreed activity levels within agreed budgets;

* the desirability of trials of 'internal markets' to work out problems before the concept is widely adopted within the NHS.

THE ROLE OF THE PRIVATE SECTOR

(vi) Any expansion of the private sector will, the Association believes, have consequences for the NHS. It could, for example:

* increase NHS costs by introducing competition for the recruitment of doctors, nurses and other professions;

* exacerbate the nurse shortage problem already being experienced by the NHS;

* lead to the NHS becoming a 'second class service' as a result of the private sector taking on much more of the acute health care.

(vii) In view of these potential problems the Association believes that it will be very important to ensure that an expansion of the private sector does not lead to a lowering of standards of provision in the NHS.

THE ROLE OF TEACHING AND RESEARCH

(viii) The Association believes the NHS crucially depends for the quality of its care on the high standards and excellence of basic and clinical research and training.

Therefore NAHA call for:

* reversal of the increasing reliance by universities on 'soft money' for academic medical posts, following the reductions in UGC grants;

* formal compensation by the private sector for the benefits it receives from the teaching and research activities carried out in the NHS.

AN NHS FOR THE 1990's

(ix) NAHA sees the necessity for organisational and attitudinal changes if the NHS is to cope with the challenges it faces ahead in the 1990's. It sets out a number of ideas in the paper.

CONTRACTS WITH THE CUSTOMERS

(x) Such a contract between a DHA and the users of its services would specify:

* the kind of service people could expect;

* the maximum periods people could expect to wait for treatment for a particular condition, either within the district or in a private hospital or another district depending on agreements reached through an internal market trading mechanism.

NATIONAL HEALTH ACCREDITATION AGENCY

(xi) This would assess the standard of service being provided by DHAs and might follow the model of the Joint Commission on the Accreditation of Hospitals in the United States, which sets standards for:

* medical staff organisation and functioning;
* nursing;
* anaesthesia;
* out-patients;
* medical records;
* laboratories;
* physical plant design, structure and functioning;
* quality assurance;
* outcome measurements.

THE DISTRICT HEALTH AUTHORITY

(xii) DHAs, as the 'pivotal tier' of NHS management, will need to ensure that clinicans are brought into the mainstream of resource management. A number of other important steps should be taken:

* consultants to be employed by DHAs;

* district general managers to take part in the interview and appointment of consultants in order to assess managerial performance;

* consultants to undergo peer-group reviews of clinical performance.

LOCAL PAY DETERMINATION

(xiii) The present centralised system of pay determination is largely outdated and should be replaced by a much more flexible one. The problem of 'leapfrogging' is exaggerated - the regional review system and cash limits will provide sufficient controls.

PRIMARY CARE SERVICES

(xiv) The division of responsibility between FPCs and health authorities is illogical. All primary health care services should be brought within the jurisdication of DHAs.

(xv) GPs should be brought more into the managerial and planning process. New contracts should be drawn up which set the objectives of a practice for a specified term and detail the obligations of both sides to that contract.

NHS MANAGEMENT AGENCY

(xvi) A radical shake up is needed at the centre. Looking back at the NHS over the last 40 years, NAHA concludes that the relationship between Ministers and their agents - the health authorities - has been one of confusion with too much interference and wasteful energy devoted to bureaucratic procedures governing that relationship. This has, in turn, undermined the confidence of local managers to be dynamic, thrusting and entrepreneurial.

(xvii) Establishing the NHS Management Board as an agency outside the structure of the DHSS would provide enormous benefits in improved management, effectiveness and efficiency, and in producing the permanent and easily identifiable leadership which the Service at present lacks.

(xviii) Such an agency would contract with health authorities for districts to deliver on a number of key policy objectives - a contrast to the present situation in which health authorities face an enormous number of competing health policy priorities.

Section I

AN ASSESSMENT OF THE NHS

1. It would be wrong and misleading to allow the present financial crisis and uncertainty facing the NHS to understate the achievements of the Service. During the lifetime of the NHS, there have been significant improvements in the health of the population. The provision of equal access to health care irrespective of means, free at the point of delivery, has relieved people from worry about the personal costs of being ill. The effectiveness of the NHS planning system has avoided wasteful duplication of facilities and the comprehensiveness of the service covering long-term ill, elderly, people with mental illness and people with mental handicap, as well as acute care, are notable features.

2. A particular strength of the NHS is the primary care system dealing as it does with 90% of medical episodes. General Practitioners effectively act as 'gatekeepers', ensuring that patients do not enter the more expensive hospital system unnecessarily and they provide a very good level of health care in conjunction with the community health services.

3. The standing of British medicine is high and the NHS has been able to provide comprehensive district services whilst maintaining high quality teaching and research. This has been achieved despite the relatively low level of resources devoted to the NHS as compared to health care systems in other countries, thus testifying to its efficiency and tight cost control.

4. The NHS is an extremely popular institution. Opinion polls in the last few months have confirmed the findings of previous polls conducted by Marplan for NAHA and the Health Services Journal. These show a high degree of satisfaction amongst those who have either received treatment recently or who have had a close member of their family receive treatment. The bond of loyalty

which exists between the NHS and its staff and customers is one not to be lightly tossed aside.

RECENT ACHIEVEMENTS

5. In the 1980s, the NHS has a number of achievements to its credit including the following:

* In terms of hospital services, between 1980 and 1986, in-patients cases increased by 17%, day cases increased by 57%, regular day attendances increased by 15% and out-patient cases increased by 7%.

* Both the community based services and the hospital sector have responded to the significant increase in the proportion of elderly people in the population.

* The imbalance in resources between regional health authorities has been substantially redressed.

* Large savings on revenue budgets have been generated by health authorities and capital expenditure has been enhanced through sales of land and buildings no longer required by the Service.

* In collaboration with local authorities and voluntary agencies, health authorities have worked to expand the provision of care within the community rather than in large unsuitable institutional settings.

* General management has been introduced and this has led to a much more efficient management system.

* Management costs have been rigorously controlled and as a percentage of revenue expenditure are now down to below 4.5%.

ISSUES TO BE TACKLED

6. The Association is not, however, complacent. There are a number of problems and important issues, set out below, which need to be tackled:

i) The present system of funding is outside the control of the NHS and is determined by competing national political priorities rather than by the legitimate requirements of the service. Thus health authorities are now having to restrict the level of work they can do.

ii) Within the NHS, there is a very definite feeling of frustration, along with loss of confidence, over the ability of the service to match reasonable public expectations. Furthermore, in addition to the service pressures which are being recognised (eg through lengthy waiting lists) and in many cases inadequately met, there is evidence of further unmet needs in the community.

iii) The relationship between government and health authorities is unsatisfactory. Too many bureaucratic controls, financial restrictions and unfocussed priorities have served to undermine the confidence and ability of health authorities to act in a dynamic, innovative and effective way.

iv) The present system of allocating resources to health authorities from the Government is not sufficiently related to the relative effectiveness and efficiency of each authority.

v) The NHS needs to become more responsive to patients' needs and feelings and to provide a greater element of choice. At the same time, medical peer group review along with general standard setting and monitoring of the quality of services needs greater emphasis and development.

vi) Performance in both clinical (including waiting lists) and non-clinical areas is variable between health authorities and this cannot always be explained satisfactorily by local conditions and circumstances.

vii) Financial and other information systems need further development in order that the fullest information can be made available to clinicians and managers to help them make effective decisions.

viii) Health authorities need greater freedom to negotiate on pay and conditions with their staff in order to compete in local labour markets.

ix) Improvements in health care are likely to depend considerably on changes in personal behaviour and in the social and economic environment. The NHS needs to give greater emphasis to the promotion of health, the prevention of disease and co-operation with other sectors to improve the general environment.

7. These issues which we have identified do not amount to a justification for undermining the good foundations which have been laid by the NHS over the last forty years. They do, however, provide an exciting agenda for the NHS in improving the nation's health in the years leading up to the end of the century.

Section II

THE NHS IN CRISIS?

8. One of the major causes of stress and serious concern facing the NHS centres around the Service's financial state. It is clear that - for health authorities - this issue has not been unexpected: the funding 'crisis' has been building up over a number of years. Whilst the NHS has benefitted from a relatively high rate of increase in expenditure in comparison with many areas of the public sector, a number of growing pressures on this expenditure can be identified.

INFLATION

9. When set against the rises in pay and prices experienced by the hospital and community health services (HCHS), the 49% cash increase between 1980/81 and 1986/87 falls to a real rise of just 3.2%, or just over one half of one percent per year. The table overleaf shows how the level of expenditure in cash and real terms has changed from year to year.

10. The difference in expenditure changes between the cash-limited hospital and community health services and the largely demand led family practitioner services (FPS) is quite marked. Indeed, had the 80% cash growth experienced by the FPS applied to the HCHS then HCHS cash limits would have been £12,598m in 1986/87 - 20% more than it actually received.

11. In recent years, the underfunding by the Government of pay awards has had serious effects on the careful and finely balanced financial planning undertaken by health authorities. Government underestimates of the pay inflation element of authorities' cash limits has reduced the effects that cash-releasing cost improvements have had on service development. NAHA's Autumn 1987 financial survey of health authorities revealed that the full year

costs of the 1986 pay awards in 1987/8 plus the 1987/8 awards resulted in a shortfall of about 1.21% of the total revenue cash limit for 1987/8. This is almost exactly the amount that new cash-relating cost improvements programmes are estimated to realise in 1987/8.

Table: Resources available to the NHS 1980/81 to 1987/88

ENGLAND	1980/81	1981/82	1982/83	1983/84	1984/85	1985/86	1986/87	1987/88 Estimates)
HCHS Current								
Total Spending (£m)	6,999	7,720	8,284	8,709	9,205	9,699	10,421	11,427 b
Cash Increase (%)	-	10.3	7.3	5.1	5.7	5.4	7.4	9.7
Inflation Rate (%)	-	8.2	6.5	5.1	5.8	5.2	6.9	8.3 a
Purchasing Power (%)	-	2.0	0.8	0.0	- 0.1	0.2	0.5	1.4
FPS Current								
Total Spending (£m)	2,173	2,504	2,894	3,110	3,419	3,600	3,908	4,269
Cash Increase (%)	-	15.2	15.6	7.5	9.9	5.3	8.5	9.2
Inflation Rate (%)	-	12.9	11.6	5.4	6.9	6.1	6.0	7.2 c
Purchasing Power (%)	-	2.0	3.6	2.0	2.8	- 0.7	2.4	2.0
NHS Total								
Total Spending (£m)	9,971	11,182	12,195	12,919	13,870	14,675	15,811	17,208
Cash Increase (%)	-	12.1	9.1	5.9	7.4	5.8	7.7	8.8
Inflation Rate (%)	-	9.0	7.4	5.0	5.9	5.4	6.5	7.7 c
Purchasing Power (%)	-	2.9	1.5	0.9	1.3	0.3	1.1	1.1

Note: the figures for NHS total spending include both capital and central health and miscellaneous service expenditure, therefore these figures will not equal the sum of HCHS and FPS expenditure.

(a) Estimated (b) Public Expenditure White Paper Allocation plus £75m; less £30m transfer to capital
(c) NAHA estimates

Source: Social Services Committee, session 1985/86 Public Expenditure on the Social Services HC 387 and DHSS memorandum to Social Services Committee, session 1986/7 Public Expenditure on the Social Services HC 413.

DEMAND

12. Although the cumulative real increase in resources between 1980/81 - 1986/87 for the NHS as a whole (+8%) and its two components, the HCHS (+3.2%) and the FPS (+12.7%), suggest that the Service had room for expansion and/or improvement in service quality, these resource rises should be compared with the change in demand placed upon the NHS. These particular pressures on resources have been identified by NAHA and others as follows:

* Demography
* Medical Technology
* Government Policies/Priorities

13. The table below shows the estimated percentage increases in funding over and above inflation - required to respond to these pressures.

Table: Demand pressures on HCHS: 1980/81 - 1987/88

%	1980/81	1981/82	1982/83	1983/84	1984/85	1985/86	1986/87	1987/88
Demography 1	1.1	0.4	0.4	0.5	0.6	1.3	1.0	1.0
Medical Technology 2	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Policies/Priorities2	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Total	2.1	1.4	1.4	1.5	1.6	2.3	2.0	2.0

1 Source: King's Fund Institutes Briefing Paper 4 1988
2 'Best Guess' Estimates

14. In no year, from 1980 onwards, were the real increases in HCHS expenditure high enough to cover the combined effects of a population which is growing older, of medical advances increasing the range of conditions that can be treated as well as the need to fulfil important central government policies.

15. As the figures used here are national averages, it must be remembered that they can disguise considerable variations between authorities. The growth in the elderly population is not uniform across the country

nor are advances in medical technology immediately available to all health authorities. Together with the effects of RAWP at a time of virtually static increases in real resources, these differences have lead to differing experiences of the past six years' financial situation. For those authorities 'over target' the combination of increased health care demands together with a budget falling in real terms has produced exceptional difficulties and serious implications for existing services, let alone new developments.

16. If health authorities had been fully funded for inflation and had been allocated a 2% development addition per year, the NHS would not be in its current financial crisis. There is, therefore, very little evidence that the current method of funding the health service is in some way fatally flawed and that the NHS as a whole is in need of a complete change, for example along the lines of the US system of health care. This conclusion is lent credence by the experience of other western countries operating largely private and/or insurance based health care services. Additional expenditure on health care within <u>these</u> types of systems has not automatically secured a proportionate level of improved health care, although waiting lists are less of a problem.

17. For example, the USA spends about twice as much on health care as the U.K. Yet its state of health is not significantly better. It fails to provide adequate health care to some of the most needy people in US society, although it isarguably over-provided with hospitals and has levels of medical staffing and sophistication in medical equipment which far outreach those in the UK. In West Germany, where higher proportion of GDP is spent on health care, there is great concern about expenditure rising out of control. In fact experience in the USA, West Germany and in other countries suggests that extra spending by society on these other systems of health care sometimes results in a disproportionate rise in the income of health care providers, or in the provision of underused or inefficient facilities and services.

18. The experience of other western countries in providing health care does not suggest that a perfect model exists which can simply be taken off the shelf and applied to

the UK. Unquestionably extra funding for health is required, and the NHS has a sufficient track record to suggest that it is the most appropriate vehicle for ensuring that it is spent effectively; provides value for money and can be successfully integrated into an overall strategy for improving the nation's health.

Section III

FUTURE FUNDING/PROVISION OPTIONS

19. NAHA believes that one principle should be cardinal: a high standard of health care should continue to be available to all, free at the point of delivery. This has been a tenet of the NHS since its formation and is a major factor in the continued public esteem in which the NHS is held. In addition to this, any future options for funding need to be judged against the following criteria:-

* Total Resources: Generate sufficient resources to meet public expectations on services.

* Effectiveness: Produce positive benefits in terms of improving the health of the nation.

* Efficiency: Provide health care in an efficient way.

* Consumer Choice: Be responsive to the needs of patients in their role as consumers of health care; respecting their dignity, personal freedom (including GP advice and referral functions) and choice.

* Economy: Minimise administrative and clerical bureaucracy.

* Geographical Equity: Ensure equality of access and care in different parts of the country.

* Equity of Medical and Social Need:	Ensure comprehensive and good quality care to people with a mental and/or physical handicap, people who are old and other groups at special risk or socially deprived.
* Equity between Generations:	Ensure proper and adequate care for the old and the young.
* Financial Equity:	Provide care and treatment unrelated to a person's ability to pay.
* Community and Family Practitioner Services:	Ensure a close relationship between the hospital services and primary health services.
* Teaching and Research:	Ensure that the long-term requirements for a well-trained medical workforce, together with appropriate and high quality research facilities and opportunities, are maintained.
* Public Commitment:	Ensure that it is held in high esteem by the public.
* NHS Morale:	Ensure that the morale of staff is high.
* Health Promotion:	Provide comprehensive health promotion services to the entire population.

20. In addition to these criteria, the recommendations of the recent Acheson Inquiry into public health raises important issues with respect to the vital role any health care system must play in terms of:

* Population medicine (ie epidemiological studies, health monitoring/target setting);

* Prevention, health surveillance and control of communicable disease and infection;

* Inter-authority and inter-agency co-operation on health promotion.

21. Furthermore, the need to pursue the World Health Organisation's goals of Health for All by the Year 2000, and in particular the 38 regional targets adopted by the member states of the European region of WHO, must be recognised.

THE ALTERNATIVES

PRIMARY SOURCES OF FUNDING

22. Three major alternatives for raising funds are considered below. Many variations on these alternatives have been put forward but in essence they tend to fall in one of three categories: an earmarked national health tax; a social insurance scheme; private health insurance.

Earmarked National Health Tax

23. Increases in income tax rates, or taxes such as VAT or National Insurance could be 'earmarked' for the exclusive use of the NHS. For example, a very substantial increase in VAT (presumably roughly matched by some reduction in income tax) might cover the cost of the NHS together with

providing some margin for NHS growth and a linking with both inflation and general growth in the economy. NHS funding from taxation would thereby be protected from the competition for funds from other Government departments.

24. However, the earmarking of taxes for specific uses runs contrary to British political traditions because it removes public spending decisions from the arena of Government and Parliament. It is unlikely that any Government would guarantee funding for the NHS from an earmarked tax without intervening to set the tax to produce a particular level of total funding which, in the Government's judgement, the NHS should receive. Therefore if an earmarked tax was introduced for NHS funding the rate applied would probably be a matter for annual political review. Moreover few, if any, forms of earmarked tax could produce a predictable level of income. For example, a tax set as a particular percentage of VAT would yield an income variable plus or minus some million pounds depending on the performance of the economy in a particular year; this could destabilise firm resource allocation and budgeting much more than the present system of funding.

25. Although it is argued that such a tax would strengthen the relationship between the payment for, and cost of, health care, any earmarked tax would only do this in a very general way; the actual costs of care received by any particular individual would rarely, if ever, reflect that person's 'earmarked tax' contributions. Furthermore, the promotion of health care cost awareness amongst patients misses those groups who actually demand care on behalf of patients and who have some control over costs - e.g. GPs, nurses, clinicians and managers.

Social Insurance

26. Such a scheme would probably be part of the national insurance system and would provide funding for health care to contributors on an income-related basis within a scheme established by Government. The cost of contributions would be shared between employer and employee and would probably be limited to funding

services for the working population. The non-working population would need to be covered by the Government, probably through tax funding.

27. The main disadvantages include increased cost of collection and unpredictability of year to year income. If national insurance is used in its present form (but increased to meet funding of the NHS), then this would be a regressive step in taxation terms. Also, as employers currently contribute to employees NI, increasing NI would increase employers on-costs. To get round this (and the regressive taxation problem) national insurance would have to be restructured, along the lines of income tax with the NHS part of the tax paid solely by employees. The effects of such changes would be merely to duplicate income tax, but at considerable additional cost. Major organisational problems would be encountered in relation to people who contracted out of the social insurance system and opted for a private insurance scheme and then needed to switch back to state support if they became unemployed or suffered long term illness.

<u>Private Health Insurance</u>

28. Private Health Insurance (PHI) as here defined is a wider concept than existing UK PHI schemes. With the exception of those groups of people who qualify for free health care (eg children, the elderly, people with handicaps and the chronic sick) everyone could be required by law to insure themselves and any family members not covered by free health care, by paying premiums to PHI.

29. Persons insured under PHI would have access to private hospitals as well as the NHS. Organisations providing PHI cover would negotiate prices for their members direct with the NHS and with private hospital chains.

The main advantages include: greater choice, sensitivity and closer relationships between service provision and demand (albeit demand based on ability to pay). Main disadvantages include: an inequitable, 'two tier' health care system would inevitably result with a large increase in indirect (ie non treatment) costs to administer private health insurance schemes; 'opting out' could become a serious problem for the NHS as it is likely that those choosing to opt out would be the relatively affluent, relatively healthy middle classes, leading to a reduction in income for the NHS while not reducing NHS workload commensurately. 'Opting out' also raises problems of subsequent 'opting in': if 'opting in' is to be allowed then the NHS could face very serious, if not insurmountable, problems of trying to maintain a high quality, comprehensive service on funding reduced due to people initially 'opting out'.

Major Funding Alternatives Versus General Taxation

30. NAHA believes that, measured against the guidelines criteria outlined in paragraph 19, there is very little advantage in moving to an alternative from the current system of funding health care. Private health insurance systems are inevitably partial in their coverage. For access to health care to be rationed on the grounds of ability to pay contravenes one of the central criteria by which any health care system should be judged. Social insurance would not offer any advantages over funding by general taxation, indeed it would have to closely resemble the current form of funding (but at additional cost) if the problems of unequal access and unequal quality of care were to be avoided. Although earmarking a tax for specific use by the NHS could theoretically protect NHS funding from other public spending, in practice the level at which the tax would be set would be determined annually, by government - not unlike the current way of funding the NHS, but with little discernable additional benefits.

31. Having evaluated the present system of funding and the various well-publicised alternatives against the identified essential criteria, NAHA is strongly of the opinion that the present system of funding by general taxation is the most appropriate, the most cost effective and the most socially acceptable and should not be abandoned.

32. However, as was intimated earlier in the paper, it needs to be recognised that one major disadvantage of general taxation is that the amount of funding is wholly outside the control of the NHS and is not directly related to the volume of patient demand on the NHS. Instead the level of funding is determined by competing national political priorities, including policies on the reduction of public expenditure and taxation. In arguing for the continuation of general taxation as the primary source of funding we believe it to be essential that the NHS is allocated sufficient funds to meet inflation, legitimate patient demand and other agreed developments and has sufficient buoyancy to provide incentives for efficient health authorities.

SECONDARY SOURCES OF FUNDING

33. In addition to the above 'primary' sources of funding, 'secondary' sources have also been considered by the Association.

Part-Pay and Hotel Charges

34. 'Part-pay' charges could be used to raise a portion of revenue from patients treated, and also to bring home to patients and the public that health care is not a 'free good'. Charges can be at a minimum flat rate, a flat rate per day, or a percentage of estimated total cost of treatment. Persons excused from prescription charges could also be excused from these hospital charges. 'Hotel' charges are a variant on the foregoing where the charge rate is linked to the cost of non-clinical services provided during care.

35. Major problems are envisaged in operating such a system. If such charges are set too low, the costs of collection will outweigh revenue; if they are set too high they could deter the less well off from seeking care, ultimately to the detriment of their health. In addition, scarce and valuable managerial time and effort could be diverted from the main task of organising and providing health care to operating a costly bureaucratic system with all the administrative problems of billing and exemptions etc.

Amenity Charges

36. There is a long tradition in the NHS of providing amenity beds. Often these do not appear to have been actively developed or promoted to earn extra NHS income. Many NHS hospitals would have to raise the standards of patient amenity in order to compete with private hospitals. However, it is possible that significant income could be gained from increased amenity charges even after paying back the interest and principal on additional capital obtained by external borrowing or internal brokerage loan funds provided from within the NHS.

Paybeds

37. Beds for private patients could bring health authorities a small sum of additional funds although it is likely that there is a considerable geographical variation in the level of demand. During the last ten years the number of paybeds has declined and there has been a large expansion of private hospitals; it is therefore difficult to assess how well NHS hospitals would fare if they attempted to increase their funds by encouraging the development of paybeds.

Sponsorship

38. The NHS, by comparison with the Arts, Sport or even the Universities, has not done as much as it could do, to

involve industry and commerce in the funding, or part-funding, of new developments, new buildings etc. Of course, it is important that sponsorship funding should cover all or part of the running costs of new developments for a period of years and not just the initial capital cost of some headline-grabbing new development such as a scanner.

Sale of Surplus Land and Buildings

39. Selling surplus land and buildings has now become normal practice in most health authorities, subject to delays over planning permissions and the transfer of long-stay patients into community care. These sales release capital funds for better re-investment, but they do not normally do anything to enlarge revenue funding because the NHS is not allowed to invest funds for future income.

Income Generation

40. Over and above those mentioned above, the NHS has embarked upon an income generation initiative with schemes expected to raise £20m in 1988/89 rising to £70m in 1991/92. This can range from the letting of shop outlets in hospitals to selling services to the private sector.

Secondary Funding - A Limited Resource

41. Many of the secondary sources of funding are in fact already being used by health authorities. However, the scope for providing any more than a small supplement to authorities' main incomes is limited. It would be unwise to rely too heavily on this source.

42. One income generation scheme which many health authorities feel should be considered is the ability for authorities to borrow on the money market. Obviously such a new possibility needs careful checks and balances to ensure that health authorities avoid getting into a downward 'creative accounting' spiral. However, the possibility exists for the NHS collectively to negotiate favourable loan terms, enabling it to pursue particular, targetted, developments requiring pump-priming revenue funds. Furthermore, the possibilities of lease-back, whereby surplus land/buildings are used as collateral to secure loans, should be investigated.

DISTRIBUTION OF FINANCE

43. Whatever method is used to fund the NHS, the distribution of finance is just as important an issue. Three distributional methods have been considered by NAHA in relation to the current method of allocation to health authorities.

* RAWP

  These are the current population, SMR based formulae for redistributing finance between health regions. The logic and equity of the current formulae at sub-regional level is doubtful, however, especially at a time of stagnation of resources.

* Central Regional Funding of Agreed Services Plans

  The RAWP system implies the distribution of available funding according to notional needs of the local population. This in turn implies endorsement of local self-sufficiency in health care delivery, other than for the specialised and often expensive treatments which must be concentrated in a few regional or national centres. An alternative policy

for sub-regional funding (and which is in partial use in some regions) is to agree that the full implementation of RAWP must be deferred until some future time of more rapid resource growth. Instead, priority should be given to requiring health districts and units to plan resource use and care delivery to maximise the outputs of existing facilities in a manner to share their resources and strengths to compensate for shortages and weaknesses in neighbouring or nearby localities. This is the principle of maximising the output at the margin of all existing resources. One way to seek to achieve this is by determining funding allocations to districts only after agreeing that their service plans allow for maximum patient access to all specialties, inclusive of cross-boundary admissions from other districts.

In theory, this approach should bring into use all spare capacity within the NHS acute services <u>and</u> provide equality of access (though not necessarily 'local access') for all patients. A practical problem, however, is that under current arrangements financial compensation to districts receiving patients from other districts is dealt with by funding adjustments to RAWP for cross-boundary flows, which are typically more than a year in arrears. This does not provide a great financial inducement to seeking out, or even welcoming, inflows of patients from other districts to fill any spare capacity available from time to time in particular specialties.

* Central or Regional Funding of 'Costed Workloads'

For the funds distribution method described in the preceding paragraph, there is no real need for detailed knowledge of the unit costs of hospital treatment, or 'workloads', since the system involves working from existing total costs to make adjustments at the margin (upwards or downwards) to reflect the relative merit of different districts'/hospitals'

agreed annual service plans. However, the introduction of DRGs (Diagnosis Related Groups - classifications of patient conditions and relative costliness) offers the ability within two or three years to have fairly accurately estimated national standard average costs of treatment for acute hospital patients. This opens the possibility of constructing the acute care component of district funding allocations by costing the workloads. The use of costed-DRGs for funding would increase the pressure on acute hospitals to be efficient and to maximise the use of any spare capacity. Funding allocations could be based on agreed plans for the coming year's DRG casemix and volume. It should be possible to determine provisional hospital funding allocations on the above basis, and then to adjust the actual final funding allocation up or down by quarterly monitoring of the <u>actual</u> DRG workload provided by each hospital.

44. NAHA supports the idea that a RAWP-type system of finance distribution (that is, one based on population size and the <u>need</u> for health care) is the best way of allocating money to different areas of the country. The problems associated with RAWP and low or no real resource growth, are best solved by ensuring adequate resourcing for the NHS. However, the Association does recognise particular difficulties and problems with the current RAWP formulae which need adjustment to allow for:

* Speedier reimbursement for cross boundary flows.

* More accurate approximations for or direct measurement of, morbidity.

* An efficiency incentive mechanism.

45. The trade-offs and conflict of objectives between the efficiency incentive mechanism and the equity thrust of RAWP/population/needs - based allocation system obviously needs careful balancing. Whilst the Association notes much valuable work in this area within the NHS; for example, performance related pay and especially the refinement of objectives/outcomes, without which measuring efficiency is problematic, it is still the case that, at the minimum, perverse incentives to greater efficiency should be rectified.

46. The drive for efficiency in the acute sector has been responsible, in part, for the financial problems of health authorites. The average length of time patients stay in hospital as inpatients has decreased by nearly 21% and the number of inpatient cases per available bed has increased by 24% during the 1980s. Therefore by an efficient use of resources, health authorities have reduced the average cost per case yet increased total expenditure by the overall expansion of services.

47. For example, the growing trend amongst health authorites (in the face of cash limited budgets) to restrict catchment areas can lead to the unnecessary duplication of services: districts outside redrawn catchment areas have to develop their own services to meet needs traditionally met by neighbouring authorities. The recent abolition of the facility to allow health authorities to carry over a proportion of their budgets from one year to the next should be reversed. Furthermore, an increase in the proportion of their budgets which authorities are allowed to carry forward should be introduced. This would help reduce poorly planned and inefficient year-end spending. Consideration should also be given to positive incentives for greater efficiency. For example, within the district/region contractual arrangement noted elsewhere in this paper, provision could be made for a pre-set, percentage bonus to districts overachieving agreed activity levels within agreed budget levels.

48. OTHER MAJOR FUNDING/PROVISION OPTIONS

The categorisation we have used to group alternative funding methods ('primary', 'secondary', 'distribution' etc) has tended to cut across some types of funding/provision systems. In particular, the generic 'internal market', health maintenance organisations (HMOs) and health care vouchers are three related ideas which have received much attention recently and which are commented on below.

Internal Markets

49. The NHS currently operates as a co-operative confederation of districts, with both formal and informal cross boundary flows of patients and services. Proponents of 'internal markets' suggest that great benefits, as they see it, in terms of efficiency gains, from the use of 'spare' capacity, could be realised through a greater formalization of this inter-district co-operation with intensive buying and selling between districts and the private sector.

50. NAHA is in general sympathetic to the aims of internal markets but would strongly emphasise the practical and theoretical problems associated with the implementation of a formal or compulsory market for health care within the overall structure of the NHS. The onus is on the proponents of this system to firstly demonstrate rather than simply assert the merits of the internal market, and secondly to explicitly state the probable ramifications of internal markets:

For example, will they:

* Result simply in a transfer of the burden of some health care costs to patients in terms of increased travel time, loss of earnings etc?

* Reduce consumer choice by transferring a greater proportion of health care supply decisions up the line from GPs to district health authorities (a reduction in the freedom to refer)?

* Lead to a distortion in management priorities as districts seek to compete for patients and hence survival?

* Reduce wages for NHS employees - many of whom are already low paid relative to the private sector?

* Require complex cost recording and billing systems and increase administrative bureaucracy?

* Mean the end to equalisation of access to services through the incremental RAWP procedure?

51. The Association welcomes the proposal for a regional trial to see how exactly these problems work out before the concept is widely adopted within the NHS. This would be particularly relevent in relation to regional specialities.

Health Care Vouchers

52. Under this system funding travels with the patient. Health care vouchers (HCVs) would be issued to every member of the population to be exchanged for NHS (or private) health care. Although the idea behind HCVs is to provide a degree of consumer power over the providers of health care, there are considerable problems associated with such a system. Not least is the problem of deciding what value of HCV to issue to each individual given the age, sex, geographical, social class and other factors influencing the amount of health care each person consumes. The problem of what to do when a patient uses up his/her voucher is very substantial.

53. If HCVs are to be used in a more indirect way, with districts receiving funding according to the number of patients/vouchers they attract, then this is in essence no different from the current RAWP cross boundary flow compensation and, as such, would suffer from the same technical problems of tardiness and inaccurate costing data, both of which, in the view of the Association, could and should be improved within the RAWP formulae.

54. It is highly unlikely that HCVs would extend the patient's choice of health care any further than currently exists with the freedom of GPs to refer their patients to any consultant or service willing to accept them.

Health Maintenance Organisations

55. Health Maintenance Organisations (HMOs) have been in existence in the USA for nearly forty years and much of the evidence for their success at reducing costs of care, while still providing a quality service, comes from their comparison with the US fee-per-item of service system. Although different forms of HMOs exist, all retain essential characteristics. For a standard fee, a person can become a subscriber to an HMO (a health business), which will provide a set package of care which may include major surgical procedures. An HMO may well sub-contract work to specialist organisations/hospitals - for example pathology services or hi-tech medical treatment.

56. As with internal markets, the onus is on the proponents of HMOs as a substitutue/complement to the NHS to provide hard empirical evidence for their worth in a British setting. To date, one of the striking aspects of the arguments put forward in favour of HMOs is the similarity between HMOs and the NHS which could be described as a co-operative confederation of HMOs. At present there is little to stop private health providers or groups of doctors setting up their own HMOs, attracting flat-rate paying subscribers and offering high quality

comprehensive health care to their members. The sole experiment in HMOs in the UK so far has been the Harrow Health Care Centre. Although its supporters claim it as a medical success, nonetheless it has suffered financially due to its inability to attract the 'critical mass' of subscribers which would enable it to spread its risk (as do insurance companies). (For further information on the Harrow Health Care Centre see Michael Goldsmith and David Willetts, 'Managed Health Care: A New System for a Better Health Service'; Centre for Policy Studies, February 1988).

57. The common characteristic linking the many variants of HMOs (eg health management units (HMUs) managed health care organisations (MHCOs)) is the conjunction of financial and health care provision responsibilities. However, NAHA would point to the considerable amount of work that has already been carried out in the NHS, from resource management to DRGs, which is likely to produce the effect of health care provision linked to financial responsibility that characterise HMOs - but without recourse to overhauling the entire structure of the NHS.

58. The ability of general practitioners to refer freely on behalf of the patient may be severely curtailed by the introduction of HMOs. Serious consideration should be given to the restrictive consequences HMOs will have on this most basic of clinical and indeed patient freedoms.

59. Geographical and demographic differences (eg rural/urban, elderly/young populations) will necessarily lead to differences in premiums for different HMOs reflecting different demand for health services, but which will not be related to ability to pay. This is a very serious criticism of HMOs and one which could only be avoided by a complicated and costly 'topping up' or national

redistribution of HMO premiums to even out health care costs to patients. A further possibility would be for the state to provide a health care service for all those unable to pay HMO subscriptions. Such a two-tier health care system would, in the view of NAHA, be unjustified and unnecessarily divisive.

60. The Association believes, therefore, that whether HMOs are organised around GPs or DHAs, their introduction as a substitute for the NHS is unwarranted and inconsistent with the basic evaluation criteria set out earlier in this paper.

61. ALTERNATIVE FUNDING: CONCLUSION

The NHS has achieved much in the last few years. However, the demographic inflationary and development pressures it has had to face have been a considerable additional burden for which health authorities have not been adequately compensated. There should be little mystery about our present problems. If, during the 1980s, the NHS had been fully financed for inflation and given sufficient additional funding for demographic change, medical advances and government priorities, health authorities would now be financially robust.

62. In the view of the Association, the funding of the health service from general taxation is both efficient in tax collection terms and is seen by the public as one of the most equitable ways of financing a free at the time of need health service. Although the formalising of the present co-operative provision of health care by many health authorities (internal markets) may bring some additional benefits hard evidence is needed before embarking on major reorganisation. The immediate need is for the NHS to be funded for inflation and specified developments.

Section IV

ROLE OF THE PRIVATE SECTOR

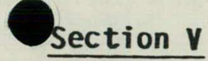
63. A comparatively low proportion of British GDP is devoted to private health care spending. However, the private sector of the UK health care industry has been expanding for some years and this trend is likely to continue. Whilst this may lead to more resources being spent on health care in the UK, there are some by-products and consequences of such an increased take-up for the NHS.

64. The first point to be made is that the private hospital sector, whilst relieving some burden on the NHS, does not in any sense provide a comprehensive service. Rather it is to be seen as providing a 'topping up' service, mainly in relation to routine surgical procedures in the acute sector. It is noticeable that whilst some of the prominent private sector insurance organisations have now developed plans for elderly people, the scope of their cover is inevitably limited.

65. Secondly, as the private sector grows, it will be competing with the NHS for scarce staff resources. This is likely to be exacerbated by demographic changes in the 1990s reducing the supply of potential nurses. So one of the unintended consequences of a greatly expanded private sector, could be additional costs for the NHS if the private sector becomes the market leader in the pay field. If the NHS is not able to compete effectively with the private sector on pay it would then be weakened by a diversion of staff from NHS to private hospitals. Private hospitals would utilise staff and provide equipment for the more routine procedures, but highly complex procedures would still be referred to NHS hospitals. However, the absence of experience and staff in providing total care would ill-equip NHS hospitals for carrying out this function.

66. Thirdly, the prospect of the NHS becoming a 'second class service' is one which is viewed with considerable apprehension. This arises from the consequences of the private sector taking on a considerable proportion of the acute health care for the middle classes and the more wealthy members of society.

67. The Association believes that in these circumstances, it will be essentail that the NHS continues to provide services of the highest quality and is funded appropriately in order to do this. Equally, it is accepted that as the private sector expands, close co-operation and collaboration with the NHS is desirable and that in the planning of services health authorities need to take account of present and potential private sector provision. However, public and professional acceptance of a mixed health economy would be more easily maintained on the basis of a genuine partnership which can demonstrate direct benefits to NHS patients. As the private sector expands, it must be expected to play its part in contributing to the essential health care infra-structure and in relation to the training of professional staff, make appropriate contributions towards the cost.



THE ROLE OF TEACHING AND RESEARCH

68. The NHS, indeed any health care system, depends crucially for the quality of its care on high standards and excellence in basic and clinical research and training. Nursing and medical training and research provide one of the key investments in health care. They provide the route to increasing medical knowledge as well as ensuring wide dissemination of new forms of care and new methods of treatment, apart from training new generations of health workers.

69. The NHS provides mainly, though not exclusively, through Teaching Authorities and the London SHAs an invaluable environment in which to conduct medical research and training. Whilst not without its faults the opportunities afforded by the NHS for doctors to observe and practice on a wide range of patients and illnesses are second to none. The Association sees a number of problems, however, if the current symbiotic relationship between academic medicine and training on the one hand and NHS health care provision on the other, is changed too much.

70. It should be recognised that training and research in health care requires both long term commitment as well as adequate financial resources. For these reasons, teaching districts/hospitals are inevitably more expensive in financial terms (eg cost per case) as well as in terms of patient activity (eg average length of stay, throughput per bed). Alternative funding systems such as health care vouchers or the internal market would have to recognise these essential differences between teaching and non-teaching districts. However, such recognition would come at a cost in terms of additional complications and bureaucracy for these two systems of funding.

71. It is the view of the Association that, given the central, long term role played by medical training and research to the success of the NHS, this area of health service work should be retained and developed within the public sector. In terms of financing teaching and research, NAHA believes that the increasing reliance by universities on 'soft money' for academic medical posts, following the reductions in UGC grants, is detrimental in the long term to the quality of medical teaching and research and hence the NHS, and should be reversed. This would restore some of the balance of priorities in teaching, and especially in research - which can all too easily be diverted to more commercial ends to the possible detriment of the ethos of NHS health care. Given the private health care sector's use of and benefits from, the teaching and research activities carried out in the NHS, arising from the long term investment by the taxpayer in NHS buildings, equipment and staff, the Association believes that some formal compensation would not be inappropriate. This particular issue would become especially crucial if the level of competition between the private and public health care sectors were to increase.

72. However, the Association recognises that the current structure of teaching and research, involving many different groups (NHS regions & districts, DES, UGC, MRC etc) funded in different ways, with often conflicting objectives, pressures and planning horizons, needs to be carefully examined.

Section VI

AN NHS FOR THE 1990's

73. If the NHS is to meet the challenges identified in paragraph (6) and to cope effectivly with many of the issues already raised in this paper, a number of changes need to be made to the way it operates. Firstly, we deal with the NHS's relationships with the general public. It is here that the most crucial challenge of all is to be faced and it is upon our success in this area that the future well-being of the NHS rests.

CONTRACT WITH THE CUSTOMER

74. The whole endeavour of the NHS must be directed towards the end product: good quality service to members of the public. Since the publication of the NHS Management Inquiry Report, health authorities have developed a number of techniques for improving the sensitivity of their services. These have included:

* Surveys of patient attitudes and opinions.

* Development of quality assessment and quality circle programmes.

* Establishment of consumer panels.

* Literature and information for patients and visitors have been made user friendly.

* Staff training programmes for dealing with the public have been established.

* Health Authority newspapers are delivered regularly to people living in a number of districts.

75. The Association believes that we need to build upon this by the establishment of a contract between district health authorities and the users of their services. Such a contract would specify the level of service people could expect and the maximum periods they might have to wait for treatment for a particular condition, either within the district or in a private hospital or another district depending on agreements reached through an internal market trading mechanism. The contract would be readily available to members of the public and widely publicised. We have noted suggestions that if a health authority fails to deliver on such a contract, patients would themselves have the right to shop around for a specified treatment and expect their local health authority to pick up the bill. There is clearly some attraction in such a concept but the Government would need to recognise that this would inevitably require more exchequer support for the NHS and be very expensive to administer.

76. Complementing the contract, would be a package of measures to make services more user orientated. These would include:

i) All staff, including clinicians, to receive training on good practice in dealing with the public.

ii) The public must be more involved in their own treatment and this means that professionals must be more ready to share information with them and discuss options available.

iii) A more speedy, sensitive and responsive complaints system should be established.

iv) Performance review systems must provide more emphasis on the quality of service provided and should involve the public in this assessment. Regular and systematic peer-group review by clinicians of their clinical performance would be a major element in this process as a mechanism for quality control.

ACCREDITATION

77. In order that a reliable audit of the quality of service is maintained, the Association proposes that a National Health Accreditation Agency should be established. This would ensure that a good standard of service was being provided by district health authorities. Hospitals are already inspected by the Health and Safety Executive, fire officers, environmental health officers and professional bodies including the Royal Colleges and national nursing boards. However, the efforts of these bodies are un-coordinated and take in a narrow range of activity such as physical standards and the professional training of staff.

78. We think that the USA model of accreditation is one which could well be looked at. The Joint Commission on the Accreditation of Hospitals sets various standards to be achieved by a hospital's governing body and management: for medical staff organisation and functioning; for various hospital services - nursing, anaesthesia, out-patients, medical records, laboratory and the like; for physical plant design, structure and functioning. The Commission also specifies the need for a comprehensive quality assurance programme and various outcome measurements.

79. It is noticeable that through the registration procedures in the Registered Homes Act, independent hospitals and nursing homes are required to reach certain standards. We think it anomalous that NHS hospitals are not covered by a systematic inspectorial procedure which applies certain explicit standards and closely examines the outcome of a DHA's activity. The advantage to the public is that they can be guaranteed that all NHS hospitals will meet the required standard. For health authorities and staff, a national inspectorate could help ensure that the NHS did not slip into providing what we have earlier described as a second class service. For the Government, too, there are a considerable number of benefits. The main one being an assurance that it can afford to delegate much more responsibility to health authorities because our proposed National Agency can ensure that agreed standards are being adhered to.

ORGANISATIONAL RECOMMENDATIONS

80. The NHS has been through a number of re-organisations in the last four years and we do not believe that a further major structural change would be in its best interest. There are, however, a number of organisational matters which need attention, not least in terms of the NHS's relationship with the Government. We believe that at national level a radical shake up is needed if the NHS is to provide the required dynamic management in the years leading up to the year 2000.

81. It is worth reflecting that the present Government review of the NHS is the fifth major review or organisational change of the NHS to have taken place in the last fifteen years. (1974 Re-organisation; Royal Commission on the NHS and Patient First - 1979; NHS Management Inquiry Report - 1983). That it has been necessary for successive Governments to do this indicates a general unhappiness with the organisation of the NHS. Aside from the funding issue, a recurring theme has been the unsatisfactory relationship between Government and the NHS stemming from the Secretary of State's accountability to Parliament and the role of health authorities as his agents.

82. We acknowledge that ministers have to respond to criticism in Parliament about various aspects of the running of the NHS. A constant theme of reports from Parliamentary Committees has been for the need for tight central control over health authorities and this has been reinforced by the actions of individual MPs who have made representations to Ministers about specific decisions made by local health authorities. Additionally there has been frustration on the part of Ministers, and indeed Parliament, that important policy priorities established for the NHS have not been implemented as quickly or as fully as desired.

83. For health authorities, the frustrations have been no less. Interference by Ministers and officials has been a constant theme. Flavour of the month policies have abounded and health authorities have been frustrated due to the numerous policy guidelines, directions, controls and instructions which have emanated from the

Government, sometimes conflicting with each other and hardly ever distinguishing as to the priority to be accorded to each one or as to their priority over other areas.

84. Looking back at the NHS over the last 40 years, the Association concludes that the relationship between Ministers and their agents, the health authorities, has been one of confusion with wasteful energy devoted to bureaucratic procedures governing that relationship. This, in turn, has undermined the confidence and ability of local managers to be dynamic, thrusting and entrepreneurial.

85. It is of little surprise that in the NHS Management Inquiry Team Report, led by Sir Roy Griffiths, so much attention was paid to the role of the DHSS and its relationship with the NHS. The report stressed that it was not for the centre to engage in the day to day management of the NHS and stated that as a coherent management process is developed of planning, implementation and control, the DHSS should vigorously prune many of its existing activities. The Report stated that the requirement for central isolated initiatives should disappear once a coherent management process is established. Most importantly, the Inquiry Team recognised that a real demonstration of management will was required if the NHS was to break free from the present top-down approach to detailed management and yet be held to proper account for performance and achievement.

86. To what extent has this been achieved? A considerable strength of the original Inquiry Team report was that it was not very prescriptive. It contained a small number of key recommendations along with a critique of NHS management and could be seen in many respects as an 'agenda for action' rather than as setting out in close detail every facet of the NHS that needed to be changed. This meant that health authorities had considerable latitude in deciding how to interpret Griffiths and in

deciding what action to take. This is evidenced most clearly by the enormous variations in management structures introduced by health authorities to suit local circumstances. However, in his paper entitled 'The Future of NHS general management: Where Next?', Gordon Best, Director of the King's Fund College, has argued that following the initial stages of introducing general management, there is now to be seen a trend towards greater centralisation. In particular, he suggests that a number of developments indicate that the DHSS - consciously or otherwise - is engaged in a process of 'repossessing' general management. We share his view and conclude that the original hope of the NHS Management Inquiry Team for a more constructive relationship between the DHSS and health authorities themselves has not been fully realised.

87. Our view has been confirmed very recently by the House of Commons Social Services Committee which drew attention to this matter in their paper on NHS Resources, (1st Report 1987/88 Session - 264-1), when it noted that the long list of priorities and targets set for the NHS goes far beyond the list of "central initiatives" and the Committee wondered if the word "priority" was not seriously devalued by so many priorities. It said 'we are seriously concerned by the apparent absence of any sort of relationship between "priorities" set by the government and the system of budgetary planning in the NHS.' The Social Services Committee referred to the NHS Management Inquiry Report and said that in contrast to the recommendation on cutting down central initiatives:

'To date, what seems to have happened is that management has been required to cope with an ever increasing number of central, isolated initiatives within increasingly tight cash limits'.

THE NATIONAL NHS MANAGEMENT AGENCY

88. We share the Committee's view. We do not believe that the necessary pruning of DHSS activities, as recommended by the Inquiry Report, has taken place and propose that a radical change be made in relation to the central management of the NHS by establishing the NHS Managment Board as a management agency outside the DHSS. The NHS Management Agency would effectively provide a focus for the leadership of the NHS and negotiate a contract with Ministers to provide a given level of service in return for an agreed allocation of resources. Such a contract would be very much focussed on key national policies and priorities as laid down by Ministers and would be subject to questioning and debate in Parliament.

89. The Association would put forward three main arguments for the establishment of a management agency. First, despite some notable achievements, it believes that the NHS Management Board is less effective than it could be by being placed within the DHSS. Secondly, there is very little indication that under present arrangements, the DHSS is able to resist the temptation to interfere in the activities of health authorities. Thirdly, we believe that the recent report of the Efficiency Unit to the Prime Minister on improving management in government indicates a way forward. (Improving Management in Government: The Next Steps-Report of the Efficiency Unit - 1988 under the supervision of Sir Robin Ibbs).

90. The report recommended that agencies should be established to carry out the executive functions of Government within a policy and resources framework set by a department. The report says that an agency of this kind might be a part of Government, or it may be more effective outside Government.

91. The report stated that:

> "These units, large or small, need to be given a well defined framework in which to operate, which sets out the policy, the budget, specific targets and the results to be achieved. It must also specify how politically sensitive issues are to be dealt with and the extent of the delegated authority of

management" ... "The framework will need to be set and updated as part of a formal annual review with the responsible Minister, based on a long term plan and an annual report. The main strategic control must lie with the Minister and Permanent Secretary. But once the policy objectives and budgets within the framework are set, the management of the agency should then have as much independence as possible in deciding how those objectives are met" ..... "The presumption must be that, provided management is operating within the strategic direction set by Ministers, it must be left as free as possible to manage within that framework. To strengthen operational effectiveness, there must be freedom to recruit, pay, grade and structure in the most effective way ....."

92. The report concludes by saying:

"The substantial gain we are aiming for is the release of managerial energy. We want to see managers at all levels in the public service:

- eager to maximise results,
- no longer frustrated or absolved from responsibility by central constraints,
- working with a sense of urgency to improve their service."

93. The Association believes that an NHS Management Agency would provide such a focus for the NHS and provide enormous benefits in improved management, effectiveness, efficiency and in producing the permanent and easily identifiable leadership which the Service at present lacks.

REGIONAL HEALTH AUTHORITIES

94. There has been some debate about the future role of RHAs. The Association believes that a regional structure is required within the NHS. It is very unlikely that our proposed Management Agency could directly allocate funds to 190 DHAs and negotiate a seperate contract with each one. There are a number of essential functions which need to be done at a regional level. These include the overall allocation of resources to districts; review of their performance; strategic planning over a region; manpower planning; the co-ordination of supra-district services. NAHA is less sure of some of the service functions of RHAs. These include ambulance services, works, computers, management services and related areas. It would be perfectly possible for these to be controlled by DHAs, acting on a consortium basis.

95. In many cases, it is the blurring of these two areas of RHA activity which is the cause of much of the contention between RHAs and DHAs, and we consider it vital that any duplication of responsibilities should be eradicated. If it is accepted that RHAs will be confined in future to a more strategic role, then it would be advantageous if the present boundaries of RHAs could be reviewed to ensure that they are consistent with present day circumstances.

96. The Association would prefer this regional tier to be run as part of the NHS, as now, staffed by NHS officers and under the control of a health authority rather than as regional outposts of the Management Agency. In essence, we would argue for the Management Agency to contract with RHAs. Each RHA would agree to provide a negotiated level of service centred around a limited number of key priorities. They would be funded on that basis and be given incentives for efficient performance along with maximum freedom to carry out their responsibilities.

97. DISTRICT HEALTH AUTHORITIES

The Association sees the district health authority as the pivotal tier of NHS management around which services will be planned and provided in conjunction and in close co-operation with neighbouring districts. In addition, the DHA will have crucial public health responsibilities in relation to the health of the population for which they are responsible.

Maximum Decentralisation

98. In our earlier comments, we have remarked on the introduction of a limited internal market mechanism, along with the need for health authorities to be provided with incentives for efficient performance and to be given financial freedom to borrow capital. We accept that there are further opportunities for efficiency and rationalisation in relation to the establishment of uniform information systems and in such areas as procurement policy. But in the crucial management and policy making area, we would argue for considerable freedom to be given to district health authorities to manage their own affairs. As we see it, the district health authority would contract with the regional health authority to provide a certain level of service. This contract would very clearly set out the main short-term and long-term priorities for each health authority. These key objectives must necessarily be both limited and prioritised; they must be achieveable and would include an assessment of the service's performance in relation to the users as explained earlier in this paper. It must also be a key component of such a contract that health authorities have sufficient resources to carry out the contract.

99. In return, health authorities would be under an obligation to deliver on the key objectives set out in the contract. We believe that the contract should be very widely publicised so that the staff and population of the district know very clearly what is expected of the

health authority. Those authorities who exceed their targets should be rewarded with additional finance, whilst those authorities who do not deliver without good reason will be called to account. We believe that such an approach would create the kind of dynamic, innovative and thrusting authorities which will be required.

100. For district health authorities there are a number of pre-conditions which need to be established before they could be expected to take on such a role effectively. First and foremost is the relationship between clinicians and health authorities.

Relationships with Consultants

101. Health authorities will be required more than ever before to explain variations in clinical and other, performance relative to other districts. This is entirely reasonable but represents a considerable challenge.

102. We believe that in any future funding system, it will be essential to develop clinical budgeting across every district in the NHS and to ensure that clinicians are brought into the mainstream of resource management. This should be linked with a system of clinical audit and might also include creation of specific incentives to encourage clinicians to take an interest in the costs of their activity.

103. It is our belief that the results of the current work on resource management in the pilot districts will not be readily transferred and beneficial to other authorities unless there is a structured managerial framework within which such concepts can be applied. The concept of clinical divisions could be formalised as a managerial entity. This would allow the appointment of clinical directors who would have real authority, in a managerial sense, over consultant colleagues to a degree which would allow them to have effective control over any budget

allocated to the specialty concerned. The creation and appointment of clinical directors would also provide an impetus to the process of clinical audit, quality control and outcome measurement etc. This, however, is only to be considered as a model since we are strongly of the view that management arrangements are for local determination.

104. Arising from the 'Achieving a Balance' initiative, registrar contracts are in the process of being transferred from DHAs to RHAs. Whilst this will allow for more effective career planning, this will entail regionally controlled manpower planning for relatively junior doctors. It is essential that this is balanced by a move towards DHA employment of consultants. The Association has consistently argued that all DHAs should employ consultants, since the present arrangement makes it very difficult for non-teaching authorities to enforce conditions of service and work agreements. We also consider that to a doctor pursuing a career in hospital medicine, having a career goal of a consultant status contract with a DHA would benefically affect that doctor's relationship with DHAs throughout his/her career.

105. The Association considers that district general managers should take part in the interview and appointment of consultants. The district general manager has overall responsibility for meeting the objectives of the health authority. The obligation to deliver on the part of general managers means that they must have greater influence on how money is spent, and how resources are used. Consultants have a crucial effect and influence on the control of NHS resources, including staff. It is important, therefore, that an assessment should be made, at the time of their appointment, of the consultant's managerial ability as well as their clinical capability. In assisting with the selection of a consultant, the general manager would be solely concerned with a potential appointee's managerial performance and would not, in any way, be involved with an assessment of their clinical performance.

106. On making consultant appointments, health authorities and the appointee should have a very clear idea of what is required of the consultant, including expected workload and the effect the appointment will have on the overall objectives of the health authority. The contract should allow for flexibility in working practices, and take account of the changing needs of a particular district. Appropriate reference should be made to the consultants' accountability for resources. This would be particularly relevant where a consultant held the budget for a department.

107. The Association also considers that just as general managers are regularly reviewed, the same process should apply to consultants. It is stressed that reviews of clinical performance should be by their peers. However, there should also be an opportunity for management and consultants to consider both their present working relationship and whether any improvements could be made. The possibility of relating an element of consultants' pay to performance, should be considered, in relation to a review of the present merit awards system. Also worthy of debate is the nature of the contract to be negotiated and whether they should be subject to renewal from time to time, rather than being seen to be tenured for the consultant's working life.

108. Local Pay Determination

The present centralised system of pay determination is largely outdated and indeed, given the difficulties the NHS faces in recruiting sufficient professional staff, can be a positive barrier to effective management. Although a number of moves have been made recently to introduce flexibility, the present national system is too restrictive and inflexible. This is largely due to the number of tightly defined grades; this causes problems for managers seeking to use their workforce more flexibly to recruit in areas of local shortage and to introduce new posts with mixed duties. Reports by NAHA and the King's Fund have pointed the way to a much more flexible and dynamic approach.

109. We recognise that a major anxiety about allowing local flexibility is that wage costs might soon spiral due to 'leapfrogging', with districts overspending their budgets and forcing other districts to follow suit. We believe this problem is exaggerated and that the regional review system and the use of cash limits offer sufficient controls to prevent this.

Primary Care Services

110. It is our understanding that the Government's review is primarily directed towards the Hospital and Community health services and our submission is directed towards that end. However, an undoubted strength of the NHS is the standard of primary care services. Paragraph 3.61 and part of paragraph 10.10 of the recent Government White Paper 'Promoting Better Health' makes the following comments on hospital referrals which are very apposite.

Paragraph 3.61

> "Health Authorities incur a very substantial cost through family doctor's decisions to refer patients to hospital and through their use of hospital diagnostic and treatment facilities. It is important that expensive hospital facilities are used in the most cost-effective way, and the wide variation in referral rates suggests that this may not always be the case. Family doctors (who have no information about the costs) have little reason to examine their criteria for referral. While in some circumstances a higher than average referral rate may be justified, a minority may refer substantially more patients to hospital than the requirements of the individuals concerned merit. Patients whose doctors make fewer than average referrals may not benefit fully from the hospital facilities available for their conditions. The Government therefore welcomes the work being done in some areas by family doctors and specialists to examine the criteria used in making referral decisions, a type of decision about which more needs to be known."

Paragraph 10.10

> "**Hospital Referrals:** FPCs and DHAs should act to ensure that the use of hospital facilities achieves the maximum benefit for patients and that services are used to ensure quality of care in a cost-effective way. FPCs will therefore be required to obtain independent professional advice on how to improve services in this important but difficult area."

111. We believe, and we must acknowledge that we are speaking here on behalf of health authority members of NAHA, that the division of responsibility between FPCs and health authorities is illogical and we would argue that all primary health care services should be brought within the jurisdiction of DHAs. We also believe that GPs need to be brought more into the managerial and planning process. We therefore propose that new contracts should be drawn up between health authorities and GPs which set the objectives of a practice for a specified term and detail the obligations of both sides to that contract. An effective primary health care system can absorb and cushion demands which would otherwise be made on the more expensive hospital service. Collaboration between the two sectors is therefore vital and the unification of such services under the district health authority would enhance such collaboration. This view is one not shared by our FPC members.

Health Authority Members and Chairmen

112. The role we have suggested for district health authorities is crucial; not the least of their responsibilities will be their effective relationship with the community that they are there to serve. In this respect we believe that health authority members have a major part to play in ensuring that the decisions of health authorities are sensitive to local circumstances, whilst in keeping and consistent with the overall priorities of the NHS. It is also important to recognise that the involvement of local people in health authority

management ensures public confidence in the decisions made. Often, however, the potential of members is not fully exploited; partly because insufficient attention has been paid to their selection, training and support, and partly due to lack of clarity as to their role. At a time when major changes are likely to occur in the NHS, it is particularly important that the contribution of members to health care should be evaluated and re-stated.

113. If our proposal to give more authority to district health authorities is accepted, it will be more important than ever to ensure that we have effective health authority members. To do this, we would commend the proposals made in our earlier report entitled 'Acting with Authority', ('Acting with Authority' - A consultative paper on the appointment, training and work of DHA members', NAHA 1986) This report makes a number of key recommendations designed to ensure that members' potential is fully exploited in the future. These include:

i) Drawing up a job specification for members.
ii) Improving recruitment and appointment procedures.
iii) Providing better training and support.

114. It will also be essential that DHA chairmen, who have such a major role to play, receive sufficient training and support. It is noticeable that a recent survey by the Association of DHA Chairmen indicated that the great majority devoted a considerable amount of time each week to their work. We envisage that even more demands will be placed upon Chairmen of DHAs in the future.

115. <u>Service Funding and Service Provision</u>

It is accepted that there is an important distinction to be made between the role of a DHA as funder of services and its role as a provider of services. It would be perfectly possible for DHAs to be the funding,

regulatory, planning and public health agency within their locality, whilst the actual management of hospitals could be undertaken by voluntary, charitable or commercial organisations.

116. The comments of Sir Roy Griffiths in his report 'Community Care : Agenda for Action' are particularly relevant. In discussing the role of social services authorities, he makes the point that ".... The role of the public sector is essentially to ensure that care is provided. How it is provided is an important, but secondary consideration and local authorities must show that they are getting and providing real value." He emphasised that "..... it was the responsibility of the social services authorities" ....." to ensure that these services are provided within the appropriate budgets by the public or private sector according to where they can be provided most economically and efficiently. The onus in all cases should be on the social services authorities to show that the private sector is being fully stimulated and encouraged and that competitive tenders or other means of testing the market, are being taken."

117. Up to this point, we have assumed that the district health authority would continue to be the a major provider of services. It is recognised, however, that there could be developments along the lines described by Sir Roy. The key-point for the Association is the necessity of there being a statutory health body at local level responsible for monitoring the health of the population and for taking steps to improve that level of health. Such a position must entail the ability of district health authorities to direct services to that end.

Section VII

SUMMARY OF KEY POINTS AND RECOMMENDATIONS

(i) The NHS is a popular and successful organisation which has provided a high standard of service to the public for forty years. (section I, para 1-5)

(ii) If the NHS had been fully compensated for the cost of pay awards and price inflation and received a 2% development addition each year for demographic pressures, medical technology and key government priorities, the NHS would not be in its present crisis. (section II, para 8-16)

(iii) The nation must continue to have an equitable health service, free at the point of delivery. (section II, para 18)

(iv) There is a need for greater incentives towards efficiency and the development of limited internal markets. (section III, para 47)

(v) The development of internal markets is supported but a regional trial is welcomed as a way of exploring a number of identified problems. (section III, para 51)

(vi) Expansion of the private sector may lead to the NHS becoming a 'second class' service. (section IV, para 63-67)

(vii) The NHS needs to be reorientated towards the users of its services. This should be symbolised by the establishment of a contract between each DHA and its local population. (section VI, para 74)

(viii) A National Health Accreditation Agency should be established to monitor and assess the standard of service being provided by the NHS. (section VI, para 77-79)

(ix) The NHS Management Board should be established outside the DHSS. (section VI, para 88)

(x) The present bureacratic and wasteful controls placed on health authorities should be removed. (section VI, para 98)

(xi) RHAs to be retained on basis of slimmed down functions but with a more dynamic relationship with DHAs and the proposed NHS Management Agency. (section VI, para 94-96)

(xii) DHAs will be the pivotal tier of NHS management responsible for the planning and management of services and the development of a public health function. (section VI, para 97)

(xiii) Consultants to be brought more into the management process and to be employed by DHAs. (section VI, para 101-107)

(xiv) Local pay flexibility to be introduced. (section VI, para 108-109)

(xv) DHAs to administer family practitioner services. (sections VI, para 110-111)

(xvi) Role of health authority members to be strengthened. (section VI, para 112-114)

(xvii) The teaching and research capacity of the NHS should be adequately funded. (section V, para 68-72)

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Mr. Paul Gray,
10, Downing Street,
London SW1A 2AA

20th April 1988

Dear Mr. Gray,

I must apologise for the slight delay in replying to your letter of the 29th March. In that letter you ask me to expand upon my comments on the development of more centrally-determined cost norms and formularies to improve NHS cost efficiency. May be I can preface my remarks by a few observations before getting down to detail.

Approximately 3 years ago when I took over the Chairmanship of our local Medical & Surgical Equipment Advisory Committee, we established a new central warehousing store for this district. An exercise was therefore undertaken to collect stocks from all the wards and determine what was obsolete, what was wanted and what was still usable. Regrettably, in that exercise, no less than £80,000 worth of redundant and obsolete equipment was discovered. This can only be described as a terrible waste and would not be allowed to occur in any rationally run private enterprise. Why did the waste occur? It has occurred because clinicians wanted, say, various forms of endotracheal tubes whereas, in fact, they only used one or two. Different consultants insisted on different types of endotracheal tubes without rationalizing why. Then as staff changed, their own preferences came in with little scientific reasoning and hence more wastage. Many forms of bladder draining bags were available. Some had previously found favour, then had been superceded, new ones brought in without old stock being used up. An array of intravenous lines, intravenous needles, cannulae, were also found sitting on shelves not being used. A whole range of various dressings for a variety of skin wounds were found. No less than 64 different types of wound dressing and skin fixatives were found in this district. I might add the list has now been pruned to only 10 with no deterioration in quality of patient care. When one looked at masks for delivering oxygen therapy, a whole range of these were found sitting on shelves which had been bought in according to the whims of individual consultants, not necessarily on the efficacy of the product. It was at that time I decided, therefore, to embark upon a system of developing a District Equipment Formulary in exactly the same way as we have District Drug Formularies which, in turn, have derived guidance from the black list of drugs.

I fully realise there must be some competition in the market to ensure that good products are being produced and no monopoly situation arises but, nevertheless, I feel there are far too many.

continuation sheet .....

In the U.K. the quality of medical practice is sufficiently standard that we do not need a wide array of different equipment for the same treatment. As one who examines at a number of Medical Schools I can say, without reservation that the students emerging from the different Medical Schools are, indeed, very similar. This cannot always be said for other European countries.

Furthermore, the Regional Authorities have the ability, after discussions with representatives from districts, to award large contracts to Companies for a given product, thereby ensuring large discounts. Therefore, it seems reasonable to me that one should be able to come to agreements at largely a national level for many items such as the following, e.g.:

1. Wound drainage systems
2. Urinary bladder drainage systems
3. Intravenous lines
4. Angio access ports
5. Syringes and needles
6. Surgical gloves
7. Various types of endoscopes, e.g., upper gastrointestinal, lower gastrointestinal, bladder, bronchoscopy, etc.,
8. Haemodialysers.
9. Artificial kidneys

The list could be exhaustive but the above are just simply some ideas. Since the practice for which these items are used does not differ widely I cannot see why a limited national formulary for such equipment cannot be agreed upon, a limited number of firms able to compete for this type of work and, therefore, ensuring standard national costs for such items which, indeed, can be passed down to regions and all districts benefit by such arrangements.

Such arrangements would not lead to stasis of thought in equipment development. Indeed, if better equipment does come to the surface, then it should be the norm for every District Hospital to use up existing stocks before new stock of a new type can be bought. This sort of thinking should be directed from central Government then all senior clinicians would understand they have a responsibility in behaving in a fairly standard manner and not continue with the present free for all approach.

Again, when talking of developments in therapeutics, stricter guidelines from Region, maybe emanating from central Government, should be enforced, otherwise we have strange situations where, for example, say, in Radiotherapy a new drug may be recommended, e.g. Carboplatin in place of Cisplatin, at what might be an extra of £40,000 - £50,000 per district but with very little improvement in quality of patient care. We see things happening with gold therapy in rheumatoid arthritis now this is becoming available as an oral preparation. In other words, what I am suggesting is that, with some of these treatments, which are not just district based but have

national application, one has to think very carefully before new treatments should be recommended or, if they are, they must be planned for in a suitable way. There is far too much adding on to Formularies with respect to drugs and not deleting old and outdated ones. In my view (I am Chairman of the local Drugs & Therapeutics Committee) every effort should be made to make sure that if clinicians want something new there is usually something that can be deleted in its place. Again, the phenomenon of something new must be better irrespective is something to be resisted and this is done more effectively in private practice, as it happens, than in the National Health Service.

Another very good example is the cost of home total parenteral nutrition, albeit this is a small field. In this sector, a number of commercial firms supply the treatment at £30,000 per year but we have shown, for example, at our hospital, that we can treat patients for around £19,000 per year and achieve exactly the same result. Therefore, it seems to me that if one had national guidelines on this type of thing then the National Health Service could benefit from those areas who can produce the treatment at a fraction of the cost of commercially available ones.

Of course, the converse can hold true and in the last one year I have, as it were, gone private on my home dialysis delivery service, saving £50,000 on my budget per annum.

There are a number of Committees that now sit with respect to drugs, i.e., A.C.D., A.C.B.S. (I am Chairman of the latter Committee) which determine what drugs and what borderline substances can be prescribed to patients. Hitherto, no such fundamental control has taken place over medical and surgical equipment which, after revenue consequences of personnel salaries, is the second biggest drain on resources. Therefore, I feel that central DHSS should take a stronger lead in defining what is available and most effective in the delivery of medical treatment. There should be a degree of discussion but after that there should be enforcement and I am sure you would be surprised that with such a firm line, often colleagues will settle down and accept what has been stated, rather than just saying 'no' for the sake of it.

Another implication in national norms concerns the cost of various treatments in different regions. Thus, if we look at such treatments as chronic ambulatory peritoneal dialysis, regular haemodialysis treatment, coronary artery by-pass grafting, hip replacements, to name but a few, there are very considerable cross-regional differences in cost of the treatment. Now, why should that be when we are concerned with a National Health Service? The doctors salaries are the same, the nurses salaries are the same, most of the supportive technical staff salaries are the same. If, then, we rationalize on the type of equipment and drugs used, there can be no reason why there can be cross-boundary differences of even up to 400% for the same treatment. That, in my mind, is not a National Health Service, it is regional service which does not always justify the big differences in cost.

continuation sheet .....

Now, to make many of the things I have mentioned above possible, we need to have a good management structure. The one thing one has to admire the private sector for is their accounting system and their very limited formularies on both drugs, dressings, equipment, which many of the same medical personnel operating in the private sector would not accept (for no good reason) in the National Health sector. However, the private sector spends between 10% and 11% of its income on good administration, whereas in the National Health Service it is something around 3.7%. I am, therefore, suggesting that a little more money spent or redistributed on good management which could bring about these changes could rationalize the delivery of medical and surgical treatment and allow money left over for other development.

A lot of what I am suggesting, therefore, does away with this issue of so-called doctors clinical freedom. However, is it clinical freedom to say I must have irrespective of efficacy or of costs involved? I do not believe this is so.

I personally am a budget holder (£3.4 million per year) which covers personnel, consumables, drugs, ancillary staff, and have not found having to think about what I do is in any way curbing my clinical freedom. Indeed, by being more cost effective, because I now realise better what goes on, I have been able to develop certain things which would not have been possible in the past.

Again, the medical phenomenon of never being able to say 'no' is something we must skirt around. Never being able to say no means you are always saying 'yes', yet not always constructively measuring why the response has been given.

In conclusion, I believe by having national guidelines and formularies re drugs, borderline substances, medical and surgical equipment and cost of specific treatments standardized, much money could be saved for the National Health Service and I would not see this in any way as curbing clinical freedom. Yes, the medical profession will get up and shout, but that is no reason for not going along these particular lines. the BMA, for example, is bound to resist but I do not think that really matters for there is a lot of common sense in going along the lines I have suggested above.

In my reasoning above, I have simply given some outline ideas but if you would like me to specify more clearly, if you found this of any interest, I would be happy to do so.

Finally, I personally believe it is unwise to overfund any service but I think the National Health Service should be kept slightly hungry. By that I mean that in the so-called hungry situation, all clinicans, managers, nurse managers, will be a little sharper in deciding what priorities they give to treatment, rather than assuming everything is available for everybody. Some support for this can be seen in the supplier induced

continuation sheet .....

demand phenomenon now seen widely in the United States and some parts of Europe. Because there are many cardiac surgeons available to do coronary artery by-pass surgery in America, many operations are still being done even at a time when it is well known the coronary artery disease rate in the United States is actually falling. Likewise, more lumpectomies are done in the States than over here because there are too many surgeons waiting around to do such operations in private practice. This is something I feel we must strongly guard against in our country and a rationalization and keeping resources limited to a certain degree is important to achieve this.

With kind regards,

Yours sincerely,

H.A.Lee
Professor of Renal Medicine

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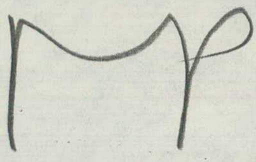


Attached are

(a) General Briefing

(b) Main points/bull points on NHS groups and financing.

(c) Fuller brief on NHS financing.

(d) Details of past RB decisions.

Questions on Review Bodies generally and on the Senior Civil Service should be addressed to HM Treasury; questions on the judiciary to the Lord Chancellor's Department; on the Armed Forces to the Ministry of Defence; and on the NHS Groups to DHSS.

HM TREASURY
21 APRIL 1988

Tuesday **9th February 1988**

(Answered by the Prime Minister on Thursday 21st April)

UNSTARRED No. Mr Edward Leigh: To ask the Prime Minister if she will make a statement on the latest report by the Review Body on Doctors' and Dentists' Remuneration.

THE PRIME MINISTER [Pursuant to her reply of 9th February 1988, col 135]:

I am now in a position to make a statement on the latest Reports of the Pay Review Bodies. The 1988 reports of the Review Bodies on the pay of Nursing Staff, Midwives and Health Visitors, and Professions Allied to Medicine, the Doctors and Dentists, and the Armed Forces, and of the Top Salaries Review Body, have been published today. Copies are now available in the Vote Office. The Government are grateful to members of the review bodies for these reports and the time and care which they have put into their preparation.

The following table shows the increases in pay rates recommended by the review bodies, and their cost:

Review Body Reports	Average increase per cent	Range of increase per cent	Cost (1) £ million
Nurses, midwives and health visitors	15.3	4.2-33.6 (2)	803
Professions allied to medicine	8.8	7.6-9.5	45

Doctors and dentists	7.9	7.3-8.1 (3)	318
Armed Forces	6.4	2.5-7.3	232
Top Salaries			
Senior civil servants and senior officers of the armed forces	5.4	5.2-5.5	5.5
Judiciary	7.4	5.3-11.9 (4)	

(1) UK public expenditure cost including employers' national insurance and superannuation contributions, where appropriate. Figures include cost of additional payments to staff working in the London area, where appropriate. The figure for doctors and dentists includes payments for GPs' expenses and hospital doctors' insurance, not counted as pay.

(2) The recommendations include implementation of a new clinical grading structure. Most increases fall within the range shown. Increases could be up to 60 per cent for some nurses. No nurses will receive less than 4 per cent.

(3) About 95 per cent of staff fall within this range. The remainder get higher increases up to 14.5 per cent and in a few cases possibly more.

(4) Most increases fall within the range shown, although in six cases the increase will be 23.7 per cent. The upper end of the range reflects structural changes for certain groups.

The increases recommended for nursing staff, midwives and health visitors include implementation in the Autumn of a radical new grading structure to provide more attractive career prospects and proper recognition of qualifications, skills and responsibilities for staff directly involved in patient care. The Review Body's recommendations are on the basis that there should be an immediate interim payment of 4 per cent from 1 April 1988 and that once the new structure has been introduced, consequential pay increases would be backdated to 1 April 1988.

The Government have decided to accept in full the Review Body's recommendations on nursing staff, midwives and health visitors. They have also decided that the increases recommended by the Review Bodies on the pay of Professions Allied to Medicine, Doctors and Dentists and the Armed Forces should be paid in full from 1 April 1988. The recommendations of the Top Salaries Review Body will be implemented as to 4 per cent from 1 April 1988, with the balance from 1 October 1988.

The full cost of the awards for the Armed Forces Pay Review Body and Top Salaries Review Body groups will be met from within existing public expenditure programme totals for this year. In the case of the health service groups the Government have decided that the cost in excess of the allocation already made for this year should be met from the Reserve. They will provide an extra £749m from the

Reserve within the planned total of public expenditure for this year, of which £683m will be added to health authority cash limits. The remaining £66m is for the Family Practitioner Services. Together with the increases in allocation already announced, the increase in provision for the National Health Service in 1988-89 over 1987-88 will therefore be £1,852 million.

The pay rates and scales resulting from the decisions will be promulgated as soon as possible for all the groups concerned. Pensions will be based on the salaries actually in payment in accordance with the principle set out in my written answer of 13 April 1984, at column 383.

Personal Secretary £ per annum	Staff Nurse £ per annum
8,134	8,230
8,399	8,490
8,664	8,750
8,986	9,010
9,373	9,270
	9,530

The scales include inner London weighting of £1,527 per annum for personal secretaries, and London weighting of £930 per annum for nurses. Both groups are eligible for various other payments including overtime, which are excluded from the scales quoted above. Personal secretaries can receive proficiency allowances depending on skill and a special pay addition of £400 based on recruitment and retention needs. Nurses are eligible for various leads and allowances, including special duty payments of up to 60 per cent. of basic pay for working unsocial hours on top of any overtime payments.

Surplus Industrial Capacity

Mr. Austin Mitchell: To ask the Prime Minister whether the Government will provide funds for surplus industrial capacity to be set aside for use in times of war; and if she will make a statement.

The Prime Minister: We have no plans to do so.

Doctors and Dentists (Pay)

Mr. Leigh: To ask the Prime Minister if she will make a statement on the latest report by the Review Body on Doctors' and Dentists' Remuneration.

The Prime Minister: I have received the review body's report on the proposed new hospital staff grade, which is being published this afternoon. Copies will be available in the Vote Office. The Government are grateful to the chairman and members for the speed and thoroughness of their deliberations. The salary scale they have recommended is from £13,720, progressing by six equal increments to £20,470. The Government propose to accept the review body's recommendation. There will be further discussions with the profession's representatives to finalise detailed arrangements with the aim of introducing the new grade in the spring.

Engagements

Mr. Harry Greenway: To ask the Prime Minister if she will list her official engagements for Tuesday 9 February.

Mr. Ieuan Wyn Jones: To ask the Prime Minister if she will list her official engagements for Tuesday 9 February.

Mr. Wigley: To ask the Prime Minister if she will list her official engagements for Tuesday 9 February.

Mr. Pike: To ask the Prime Minister if she will list her official engagements for Tuesday 9 February.

Mr. Stern: To ask the Prime Minister if she will list her official engagements for Tuesday 9 February.

Mr. Janner: To ask the Prime Minister if she will list her official engagements for Tuesday 9 February.

The Prime Minister: This morning I had meetings with ministerial colleagues and others. I attended the memorial service for Lord Duncan Sandys at St. Margaret's, Westminster. In addition to my duties in the House, I shall be having further meetings later today. This evening I hope to have an audience of Her Majesty the Queen.

DEFENCE

AIDS

Mr. Butler: To ask the Secretary of State for Defence, pursuant to his reply of 14 December 1987, *Official Report*, column *415*, if he will give his reasons for not testing all Army recruits for HIV status.

Mr. Freeman: The scale of the AIDS problem is such that we see no need at present for general compulsory screening. The MOD policy not to test all Army recruits for HIV status is in accordance with Government policy on employment. Within the service, those who consider themselves to have been at risk are encouraged to undergo voluntary screening and to seek immediate confidential advice from their unit medical officers.

Service Personnel (Electors)

Mr. Nicholas Bennett: To ask the Secretary of State for Defence if he will list the total number of service personnel in each branch of the armed forces who are registered as electors for the latest year for which statistics are available; and what is the percentage these figures represent of the total manpower in each service.

Mr. Freeman: The statistics requested are as follows:

As at 31 December 1987

	RN-RM	Army	RAF
Numbers registered as electors	51,684	103,480	50,855
As percentage of strength	79	65	54

All figures exclude service spouses also registered under the service voters provisions.

Nuclear Weapons (Transportation)

Mr. Hood: To ask the Secretary of State for Defence how many nuclear weapons have been transported within or through the Clydesdale constituency since 1979.

Mr. Ian Stewart: It has been the practice of successive Governments not to give details of the movement of nuclear weapons.

HOME DEPARTMENT

South African Embassy (Incident)

Mr. John Carlisle: To ask the Secretary of State for the Home Department if he has received reports from the Commissioner of Police of the Metropolis of an incident that took place outside the South African embassy on Tuesday 19 January which resulted in injury to a superintendent of police.

Mr. Douglas Hogg: My hon. Friend may be referring to an incident which took place at the Strand entrance to Charing Cross underground station on 19 January. I understand fronm the commissioner that a police superintendent was pushed down the underground stairs and assaulted. The assailant ran off before help could be summoned and to date has not been identified. Police inquiries into the incident are continuing.

ANNEX I

DRAFT OF 20 APRIL

Q AND A BRIEFING

DECISIONS

1. **What did the Review Bodies recommend?**

Review Body		Average Recommendation (%)	Range (%)	Cost (1) (£m)
Armed Forces		6.4	2.5-7.3	232
Doctors & Dentists		7.9	7.3-8.1	318
Nurses & Midwives		15.3	4.2-33.6(3)	803
Professions Allied to Medicine		8.8	7.6-9.5	45
TSRB	**Civil Service**	5.4	5.2-5.5)	
	Senior Armed Forces	5.4	5.2-5.5)	5.5
	Judiciary	7.4(2)	5.3-11.9)	

(1) The figures for public expenditure cost differ from those in the review bodies' reports. The review bodies' figures do not include some costs which count as public expenditure.

(2) The TSRB's recommendations for the judiciary provide for increses of about 5.4 per cent for most members of the judiciary. The higher increases shown above reflect structural recommendations for certain groups. In half a dozen cases the increase will be 23.7 per cent.

(3) Most nurses and midwives would fall within this range. At extremes the Review Body suggest that some staff could get up to 60 per cent.

[see also footnotes to Prime Minister's written answer].

2. **What is being awarded?**

All recommendations are being implemented in full from the due date, except that the TSRB group's increases are being staged, with 4 per cent from 1 April and the balance from 1 October.

Point to Make

All the above increase compare with an increase in the Retail Price Index of 3.5 per cent and in Tax Price Index of 1.6 per cent in the 12 months to March 1988. [The Tax Price Index, or TPI, measures the average increase in gross taxable income needed to compensate taxpayers for any increases in retail price index after taking account of changes to direct taxes and employee National Insurance Contributions].

GOVERNMENT RECORD

3. **Nurses/Professions Allied to Medicine**

Table below sets out record over various time periods:(Source: DHSS)

Pre-1988 RB Awards (Real Changes in Pay Rates)

	Nurses	PAMs	Staff Nurse (max)	Ward Sister (max)
1974-79	-21.2	-21.2	-17.1	-21.0
1979-1987	+29.1	+34.1	+28.7	+38.3
1983-1987	+15.5	+20.0	+18.2	+24.1

Post-1988 RB Awards (Real Changes in Pay Rates)

	Nurses	PAMs	Staff Nurse (max)	Ward Sister (ma
1974-79	-21.1	-21.2	-17.1	-21.0
1979-1988	+43.8(average)	40.1	+33.0 to 53.9	+39.2 to 55.1
1983-1988	+27.8(average)	26.1	+22.2 to 41.5	+24.9 to 39.1

Note Figures are percentage changes in pay rates from pay round to pay round (1 August to 31 July) deflated by the RPI increase over the same period. The numbers in the first table are the most recent published numbers on the respective records of the Administrations; the second table brings the earlier table up to date following the 1988 award. [It assumes an increase in the RPI of 3.5 per cent in the year to July 1988].

4. Government kept faith with nurses

Government has:

(a) Implemented pay increases lifting nurses pay by 43.8 per cent in real terms since 1979;

(b) Established Review Body to determine their pay in 1983 and implemented all awards 28.7 per cent real terms increase has resulted since 1983.

(c) Reduced working week by 2½ hours in 1980;

(d) Since end-1978 nurses and midwives increase 62,800; (of which 29,200 reflects 1980 reduction in working hours.) Increased numbers of nurses and midwives by 33,600 after compensating for reduction in hours.

5. Nurses' Earnings

As well as increases in basic pay rates nurses are eligible for additional payments (mainly for unsocial hours and overtime). Currently average earnings (excluding London Weighting) of full-time staff in the main nursing grades are estimated to vary by between 12 and 24 per cent more than basic pay. It is estimated that, an enrolled nurse (on maximum) will after implementation of the increases and regrading would typically carry £188 to £208 per week, a staff nurse (on maximum) £206 to £236 per week and a sister (on maximum about £273 to £304 per week. The exact figure will depend on his or her grading in the new structure. (These figures exclude London Weighting and the new London pay supplements recommended by the Review Body which together are worth up to £1888 a year.)

Government responding to strike action earlier this year by nurses?

No. New grading structure proposed and agreed before then. Review Body simply asked to price it.

6. Doctors

The table below sets out the record over various time periods:

	(1) 1974-79	(2) 1979-87	(3) 1979-88
House Officer (max)	-16.8	+29.6	+35.4
Consultant (max)	-24.6	+34.1	+40.0
General Practitioner (average)	-15.8	+29.7	+34.5
Average	-23.7	+32.5	+38.2

Note Figures are percentage changes in pay rates from pay round to pay round (1 August to 31 July) deflated by the RPI increase over the same period. Column 1 is the record of the Labour Government; Column 2 is the position up to and including implementation of the 1987 award; Column 3 is the position after implementation of the 1988 award, (assuming an increase of 3½ per cent in the RPI in the 12 months to July 1988).

7. Junior Doctors Earnings

Average salary for house officers was £14,458 in 1987, will become an estimated £15,637 in 1988

8. Doctors Numbers

At September 1986 nearly 14,000 more doctors and dentists (GB) than September 1978.

9. Armed Forces

Government has honoured Manifesto commitments to restore and maintain comparable salary levels for the Armed Forces with civilian earnings. All AFPRB recommendations have been implemented.

10. TSRB

Benefitted from major restructuring three years ago, and senior civil service grades 2 and 3 have benefitted from performance pay opportunities introduced last October. Staging? Special case, because of relationship with Civil Service pay. Staging of military and judges generally maintains relativities recommended by TSRB.

Squeeze on Defence Budget?

This award can be contained within the cash limit.

Running cost implications of TSRB?

Tiny. Will be financed within existing running cost limits.

PAY POLICY

Why no staging for anyone besides TSRB?

Government implementing what Review Bodies recommended. TSRB a special case because of links with other civil service pay.

Implications of nurses award for others eg. NHS non-Review Body groups, civil service

Each group's pay is determined according to what is necessary to recruit, retain and motivate and what can be afforded. Inevitably this will mean different increases for different groups.

How does Government justify 15.3% for nurses, while calling for lower settlements for others?

Review Body makes out the case for nurses' award: increasing recruitment/retention problems, need to make nursing more attractive career to recruit enough school leavers in 1990s when numbers declining; plus cost of important and radical clinical grading review. Does not invalidate argument for lower general settlement levels to improve competitiveness and create jobs.

Access to Reserve for third successive year. Makes nonsense of claim that pay/price increases will be financed within cash limits?

It was not possible for Health Authorities to meet the full cost of the Review Body recommendations from within their won resources without reducing services unacceptably. The decision to add to cash limits reflected the wholly exceptional circumstances created by the Review Body recommendations and in particular the cost of the clinical grading review for nurses. That should not be regarded as creating a precedent. Certainly does not mean pay increases for others will be financed this way.

CONFIDENTIAL

(b)

NHS FINANCIAL ASPECTS: BULL POINTS

- additional provision for 1988-89 announced today is £747m (UK) (£596m (England) - £542m (English health authorities))

- total cost of awards £1166m (UK) - £923m (England)

- total cost of Review Body awards fully funded by Government

- new UK total net expenditure (current and capital) on NHS in 1988-89 is £22,567m (£22.6 billion); £18,131 (England)

- cash increase in UK (net, current and capital) over last year is £1852 (nearly £2 billion); £1485m (England)

- cash increase in UK health authorities gross current expenditure over last year isn 5.3%

- annual amount spent on NHS per family in 1988-89 will be £1650 (UK)

- total cost of nurses pay award this year £803m (UK), £633m (England) fully funded by Government

- total cost of PAMs pay award £45m (UK), £35m (England) fully funded by Government

- total cost for doctors and dentists is £318m (UK), £255m (England) fully funded by Government

- extra £45m to meet the new London pay supplement for nurses and PAMs.

…KPN

…RSES PAY AWARD: BULL POINTS

- Highest ever real terms pay - higher than Halsbury (1974) and Clegg (1979).
- 43.8% real terms increase since 1979
- 28.7% real terms increase since 1983.
- Government has set up independent Review Body, implemented all five of their awards and funded over 90% of the cost of those awards.
- New clinical grading structure biggest shake-up in grading since 1948. Major opportunity to establish worthwhile career progression for nurses who wish to remain in clinical work.
- Will play vital part in overcoming recruitment and retention problems by giving significant pay increases to staff in shortage specialties associated with advanced skills.
- London pay supplements will mean that, with the increase in basic pay this year, increases for staff nurses and sisters in Inner London will be in the range of £27-£57 per week.
- starting pay for a staff nurse in Inner London is now £9,677 and for a sister it is £12,048 - in each case this is more than the previous maximum basic pay for the grade.

Staff Nurse

- Pay on qualification now over £8,000 (£8,025), and increase of almost 10%;
- the maximum for the basic grade of staff nurse (D) goes up by 7%; now paid around £2,280 more in real terms than in 1979;
- maximum for staff nurses with extra skills and responsibilities (paediatric intensive care, theatres etc) now £10,650 - an increase of over £2,000 a year (£2050) or almost 24%.

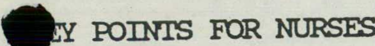
Sister

- Starting pay on promotion now £10,200 - an increase of 13%.
- maximum for sister on an acute ward now £13,925, an increase of 16%. This latest award means that she will have had a real terms increase in pay of 55% or £4,945 since 1979.
- lowest increases (4.2%) for some sisters not on acute wards or in teaching areas but they all stand to benefit from better career prospects.

Labour's record

- Under Labour, nurses received pay increases of less than the rate of inflation 3 years running.
- In 1976/77, Labour cut nurses' pay by over 10% in real terms.
- In the 5 years between 1974/75 and 1978/79 Labour cut nurses' pay in real terms in 4 of them.
- Nurses pay fell by 21% in real terms in the 5 years to 1979.

4KPN



KEY POINTS FOR NURSES

Average Award

- Overall increase in paybill 15.3% or £633m in England (£803m UK)

Basic Pay

- Large range of increases: 4.2% to 33.6% and more in some cases.

- Biggest increases for new clinical grades, for example

  Staff nurses in Scale E = 23.8%-26.0%
  Sisters in Scale G = 16%-33.6%

  Smaller increases for:

  Staff nurses in Scale D = 7.0%-9.9%
  Sisters in Scale F = 4.2%-=13.3%

- 4% payment on account for clinical grades, pending regrading. (Deadline for regrading 31 October 1988.)

- Increases for staff not covered by new clinical grades of:

  Senior nursing grades = 5.1%-8.5%
  Students = 6.3%-7.8%

London Pay Supplements

- Supplements of:

  9% for qualified staff in Inner London (up to max of £958 pa)

  5% for all other staff in Inner and Outer London (up to max of £532 pa)

  2.5% for all staff in Fringe Zone (up to max of £266 pa)

- All supplements payable in addition to London weighting, but abated as with London weighting for staff in residential accommodation.

- All supplements payable from 1 April. Those for clinical staff to be based on present pay plus 4% payment on account.

Leads and Allowances

- Special Duty Payments: rates unchanged but maximum basic salary to attract such payments imposed at £12,500.

- Small increase in psychiatric lead (to £220), no increase in geriatric lead.

- Small increases in stand-by and on-call and a number of smaller allowances.

DDRB 1988 REPORT
KEY POINTS

1. Average increase 7.9%, 8.1% for HCHS grades, 7.3% for gps.

CONSULTANTS

2. Scale maximum increased from £32,840 to £35,500. Distinction awards up 8.1%; value of A and A+ awards up 9.2% and 14% respectively. Top earnings for consultants therefore £69,220.

JUNIORS

3.1 General increase of 8.1%. Average salaries at scale maximum therefore

	Current	Recommended
House Officer	14,458	15,637
Senior House Officer	17,668	20,235
Registrar	21,275	22,993
Senior Registrar	24,140	26,081

3.2 pay supplements for juniors with longest contracted hours (104+) doubled.

3.3. additional point added to SHO scales

OTHER GRADES

4. All other grades get 8.1%, except gps holding hospital appointments (7.3%).

GENERAL PRACTITIONERS

5. Average net intended remuneration for gmps increased from £26,840 to £28,800 and target average net income for gdps from £23,200 to £24,92^ (7.3%). Fees and allowances for gps take account of overpayment of £61 in 1985/86. The average expenses provision for gmps is set at £13,480.

DEFENCE SOCIETY SUBSCRIPTIONS

6. The DDRB recommends that $^{2}/_{3}$ of cost of subscriptions for HCHS grades (full-timers plus part-timers working solely for NHS) be directly reimbursed. This amounts to £720 for those paying the full rate.

Distinction Awards

7. DDRB recommends review of distinction awards system, particularly noting criticism of secrecy, lack of management input, age at which awards are made and the fact that they are not subject to review.

NHS FINANCING (C)

What will it cost?

Total UK cost in 1988-89 of awards is £1166 million. Inflation factors built into existing NHS provision cover £417 million of this. Remaining £749 million will be met from Reserve.

Health expenditure in 1988-89

NHS net current expenditure in UK will be increased by £749 million to £22,567 million. This is £1,852 million more than the estimated outturn for 1987-88. Gross current spending by UK health authorities will be over 10% higher than last year - an increase of well over 5% in real terms. When the proceeds of their cost improvement programmes and income generation schemes are taken into account, resources available to health authorities in England will be nearly 7% higher in real terms, with large increases also in Scotland, Wales and N Ireland.

[See attached table]

This year NHS will spend around £400 for every man, woman and child in the country, or £1650 per family.

Will Scotland, Wales, N Ireland increases give what is needed, or only formula increases?

Increases in Scotland, Wales and N Ireland are calculated as what is necessary to fund the pay awards.

What about future years?

Provision for 1989-90 onwards will be reviewed in the public expenditure survey. Decisions will be announced in the Autumn Statement.

More money needed this year to prevent cuts in services?

Health authorities were getting significant real terms increases even before this announcement. Any uncertainty they may have had over the financing of review body awards is now removed.

Further increases to meet other NHS pay settlements?

No. Cost of pay awards to other groups (a significantly smaller proportion of the pay bill than doctors and nurses) will have to be met from cash limits, like other price changes.

What if nurses clinical grading review turns out to cost more than suggested by review body?

Government believe this announcement will give health authorities ample funds with which to carry out regrading. Health authorities will obviously have to have regard to cost in implementing the new arrangements, and will need to keep within their new cash limits.

NHS review

A separate matter from these decisions. Government is conducting a wide ranging and fundamental review of the NHS. Proposals will be made in due course.

NHS EXPENDITURE 1987-88 AND 1988-89

	1988-89 increase £m	New 1988-89 provision	1987-88 est outturn £m (3)	New year -on-year incr £m	Real terms(1) % increase(2)
NHS (UK) - net	749	22,567	20,715	1852	4.25% (5.0%)
NHS England - gross current	596	17,902	16,265	1637	5.3% (6.3%)
HCHS England - gross current	542	12,633	11,473	1160	5.4% (6.7%)

Notes

1. Real terms increase measured against GDP deflator of 4.5%.

2. Figures in brackets take account of new cost improvement (£143m) and income generation (£20m) savings in 1988-89.

3. Estimated outturn for 1987-88 includes 16 December 1987 announcement, plus £44 million carried forward underspend adjustment.

Increases in each territory

£m 1988-89	HCHS	FPS	NHS
England	542	54	596
Scotland	86	6	92
Wales	34	4	38
N Ireland	21	2	23
UK	683	66	749

126/3/tr/2

(d)

Review Body Recommendations and Awards 1971-87

	RPI	TPI	AFPRB	DDRB	NPRB nurses	NPRB pams	TSRB senior civil service & senior military	TSRB judiciary
1971	9.4	n/a						
Recommendation			-	8%	-	-	-	-
Implemented			-	8%	-	-	-	-
1972	6.3	n/a						
Recommendation			10%	8%	-	-	6.8%	6.8%
Implemented			10%	8%	-	-	6.8%	6.8%
1973	9.2	n/a						
Recommendation (a)			6.5%	4.5%	-	-	£250 pa	£250 pa
Implemented			6.5%	4.5%	-	-	£250 pa	£250 pa
1974	15.2	n/a						
Recommenation (a)			13%	7.4%	-	-	£350 pa	£350 pa
Implemented			13%	7.4%	-	-	£350 pa	£350 pa
1975	21.7	26.2						
Recommendation			29.5%	30% (b)	-	-	(c)	(c)
Implementated			29.5%	15%	-	-	(c)	(c)
1976	18.9	21.0						
Recommendation (a)			£6 pw	£6 pw	-	-	£6 pw	£6 pw
Implemented			£6 pw	£6 pw	-	-	£6 pw	£6 pw
1977	17.5	16.3						
Recommendation (a)			5%	£208 pa (2½%)	-	-	£208 pa	£208 pa
Implemented			5%	£208 pa (2½%)	-	-	£208 pa	£208 pa
1978	7.9	2.1						
Recommendation			32%	10%	-	-	35%	35%
Implemented			13% (d)	10%	-	-	10%	10%
1979	10.1	12.3						
Recommendation			32.5%	25.7%	-	-	23.2%	22.9%
Implemented			32.5%(e)	25.7%(f)	-	-	13.4%(f)	12.5%(f)
1980	21.8	18.4						
Recommendation			16.8%	31.4%	-	-	38.2%	35.7%
Implemented			16.8%	31.4%	-	-	12.3%*	12.1%*

* Abated

	RPI	TPI	AFPRB	DDRB	NPRB nurses	NPRB pams	TSRB senior civil service & senior military	TSRB judiciary
1981	12.0	15.7						
Recommendation			10.3%	9%	-	-	23.0%	21.1%
Implemented			10.3%	6%	-	-	7.0%	7.0%
1982	9.4	9.7						
Recommendation			6.1%	9%	-	-	19.4%	24.3%
Implemented			6.1%	6%	-	-	14.3%	18.6%
1983	4.0	3.5						
Recommendation			7.2%	9.7% (b)	-		11.7% (b)	11.7% (b)
Implemented			7.2%	7.7%	-	-	5.8%	4.5%
1984	5.2	4.1						
Recommendation			7.6%(b)	6.9%(b)	7.5%	7.8%	6.5%(b)	6.5%(b)
Implemented			4.9%	4.6%	7.5%	7.8%	4.5%	4.5%
1985	6.9	6.4						
Recommendation			7.1%	6.3%(b)	8.6%(b)	12.1%(b)	12.2%(b)(g)	16.3%(b)
Implemented			7.1%	5.3%	5.6%	5.6%	7.1%	
1986	3.0	1.2						
Recommendadtion			7.46%(b)	7.6%(b)	7.8%(b)	8.2%(b)	6.5%(h)	6.7%(i)
Implemented			5.6%	5.7%	5.85%	6.15%	3.0%	3.1%
1987	4.2	2.5						
Recommendation			5.96%	7.7%	9.5%	9.1%	4.8%(b)	4.8%(b)
Implemented			5.96%	7.7%	9.5%	9.1%	4.25%(b)	4.25%(b)

Notes

a. Review Body recommendations and awards restricted to those allowed under pay norms.

b. Staging reduces in-year cost. Full recommended rates paid by year-end.

c. A second TSRB report in 1974 recommended increases of 28.8%. The Government implemented increases varying between 14.4% and 28.8% for individuals on 1.1.75 and announced an intention to pay the second stage on 1.1.76. However, the second stage was not paid because of pay policy.

d. 10% pay policy norm plus 3% for introduction of the 'x' factor.

e. Labour Government implemented 24.2% increase just before May 1979 election. Incoming Conservative Government implemented a further 8.3% to restore fully comparable salaries.

f. Implemented by the Conservative Government.

g. Figure is for senior civil service. Senior military recommendations were 17.6 per cent. Award was 7.3 per cent in-year.

h. Recommendations reduced to 4.0 per cent and staged to reduce in-year cost to 3.0 per cent.

i. Recommendations reduced to 4.1 per cent and staged to reduce in-year cost to 3.1 per cent..

st2.28

BF 5/5 pmp.

FROM: R C M SATCHWELL
DATE: 22 April 1988

This is a useful summary of NAHA's views, and I hope provides some relevant briefing for the sort of views which will emerge on Sunday.

1. MR PHILLIPS
2. CHIEF SECRETARY

cc Chancellor — 2.
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Griffiths
Mr Sussex
Mr Tyrie
Mr Call

HP. 22/4

Encouraging. 1 should be grateful if the CST could let me have a note of the main pts of Sunday's mtg.

NHS REVIEW: NAHA'S EVIDENCE

We have just received the National Association of Health Authorities' ("NAHA") evidence to the review of the NHS (summary of key points attached for copy recipients). Some of their ideas may well come up at the Prime Minister's meeting with health authority representatives on Sunday.

2. NAHA's earlier offering "Funding the NHS" (summarised in my minute of 13 April) was a rather limp effort, which basically called for more money. Its one major recommendation was the introduction of flexed budgets, a bad idea from our point of view, since it would almost inevitably lead to a serious erosion of control over expenditure. However, the new document "The Nation's Health: a Way Forward" is much better. Although there is still a fair amount of special pleading, much of it is in return for changes within the existing structure, some of them interesting, some of them welcome. And flexed budgets have been discreetly dropped.

3. NAHA's assessment of the NHS and its current problems (section I) is pretty fair. They highlight its strengths (comprehensiveness, popularity and perceived equality of access,

490

and tight cost control) and point to a number of major achievements in the last decade, notably the introduction of the new management structure and the large increases in patient throughput. Nevertheless, according to NAHA, there is a strong feeling of frustration among the staff, the system is seen as unresponsive to the needs and feelings of patients, and there are both severe rigidities (notably on pay and the cliff edge) and wide variations in performance between individual authorities. Unfortunately, NAHA then digress in Section II into a long discussion about "cumulative underfunding" which has little to do with the problems which they have just identified.

4. Section III briefly discuses the various options for funding (tax, insurance etc) but comes down firmly in favour of the existing system. They support the idea of supplementary sources of income (such as the sale of surplus land and buildings) which are already in place. But they also feel that health authorities should be freed from existing borrowing constraints. Your recent exchanges with Mr Newton over this issue mean that you should not be surprised by this.

5. Section III also looks at the distribution of finance within the system, and highlights the advantages and disadvantages of RAWP, particularly the disincentive to greater efficiency caused by greater through put at the margin resulting in increased costs within a fixed budget. NAHA are against HMOs and vouchers. But they are "in general sympathetic" to the notion of an internal market, though worried about some of its aspects, particularly the effect on the patient (whose choice might be reduced). They would therefore welcome a regional experiment.

6. Section IV, on the role of the private sector, is very short. NAHA are worried that an expanded private sector will lead to a "second class" NHS dealing with the poor, the elderly and the disadvantaged, as scarce staff resources are attracted by higher private sector wages paid for by the fitter and wealthier sections of society. They are also concerned about the effects on teaching and research (section V), nearly all of which is currently funded by the public sector.

7. Finally section VI lists some of their proposals for "an NHS for the 1990s" Some of these we would support; for instance, the amalgamation of FPCs and DHAs, more decentralised management, particularly over pay, and the greater integration of medical staff in the management process. Other suggestions raise issues of cost control, notably the guaranteed "maximum waiting time" for operations (which is potentially open-ended), part of the patient/ DHA contract designed to make health services more responsive to patients' needs.

8. NAHA also put forward a number of interesting ideas where it would be useful to have some feedback from Sunday's meeting. One is the proposed Contract between GPs and newly merged DHAs/FPCs, which would "set the objectives of a practice for a specified term and detail the obligations of both sides to that contract". This is obviously a contentious issue within NAHA, since the unification of primary care services under one authority is a view "not shared by our FPC members". The second is an independent "National Health Accreditation Agency" to draw up and monitor standards in both medical and non-medical (eg equipment design) fields. This has implications for the audit function within the NHS, and also for the role of DHSS Ministers.

R. Satchwell.

R C M SATCHWELL

Section VII

SUMMARY OF KEY POINTS AND RECOMMENDATIONS

(i) The NHS is a popular and successful organisation which has provided a high standard of service to the public for forty years. (section I, para 1-5)

(ii) If the NHS had been fully compensated for the cost of pay awards and price inflation and received a 2% development addition each year for demographic pressures, medical technology and key government priorities, the NHS would not be in its present crisis. (section II, para 8-16)

(iii) The nation must continue to have an equitable health service, free at the point of delivery. (section II, para 18)

(iv) There is a need for greater incentives towards efficiency and the development of limited internal markets. (section III, para 47)

(v) The development of internal markets is supported but a regional trial is welcomed as a way of exploring a number of identified problems. (section III, para 51)

(vi) Expansion of the private sector may lead to the NHS becoming a 'second class' service. (section IV, para 63-67)

(vii) The NHS needs to be reorientated towards the users of its services. This should be symbolised by the establishment of a contract between each DHA and its local population. (section VI, para 74)

(viii) A National Health Accreditation Agency should be established to monitor and assess the standard of service being provided by the NHS. (section VI, para 77-79)

(ix) The NHS Management Board should be established outside the DHSS. (section VI, para 88)

(x) The present bureacratic and wasteful controls placed on health authorities should be removed. (section VI, para 98)

(xi) RHAs to be retained on basis of slimmed down functions but with a more dynamic relationship with DHAs and the proposed NHS Management Agency. (section VI, para 94-96)

(xii) DHAs will be the pivotal tier of NHS management responsible for the planning and management of services and the development of a public health function. (section VI, para 97)

(xiii) Consultants to be brought more into the management process and to be employed by DHAs. (section VI, para 101-107)

(xiv) Local pay flexibility to be introduced. (section VI, para 108-109)

(xv) DHAs to administer family practitioner services. (sections VI, para 110-111)

(xvi) Role of health authority members to be strengthened. (section VI, para 112-114)

(xvii) The teaching and research capacity of the NHS should be adequately funded. (section V, para 68-72)

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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From the Secretary of State for Social Services

CH/EXCHEQUER
REC. 22 APR 1988
ACTION Mr Saunders
COPIES TO CST, PMG, Sir P Middleton, Sir T Burns, Mr Anson, Mr Phillips, Miss Peirson, Mr Culpin, Mr Saunders, Mr Parsonage, Mr Turnbull, Mr Grieve, Mr Griffiths, Mr Call, Mr Mcintyre

FIRST MOORE PAPER ON BUYERS

SECRET

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

Ch/ Might like a look at final version. Bids are at para 16. MPW 22/4

22 April 1988

Dear Paul,

NHS REVIEW

I attach a copy of my Secretary of State's Paper for the NHS Review meeting on 27 April.

Copies of this letter and its attachment go to the Private Secretaries to the Chancellor and to the Chief Secretary, to Professor Griffiths and Mr O'Sullivan (Policy Unit) and to the Private Secretaries of the Minister for Health and Sir Roy Griffiths in this Department and to Mr Wilson (Cabinet Office).

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

NHS REVIEW: CHARTING THE WAY AHEAD HC 18

NOTE BY THE SECRETARY OF STATE FOR SOCIAL SERVICES

Introduction

1. Our work so far has identified three main elements of a health care system:

- buying health services
- providing health services
- financing these transactions

My paper focuses primarily on the first two elements. It deals with the third only where it is directly relevant to the other two.

Summary of approach

2. The table below summarises the key aims I believe we have agreed on and the key changes which I consider would enable us to achieve those aims.

Key aims for improving NHS	Key changes to achieve aims
1. More choice and competition.	A. Self governing hospitals.
2. More flexible, less monolithic system, with more freedom for hospitals.	B. Separation of buying and provision. 'Buyer' contracts with GPs and hospitals, public or private, for provision of care.
3. Better incentives for good management and effective cost controls and better quality services, applying to both administrators and professionals.	C. Buyers responsible for service needs of population.
4. Encourage people to spend more of own money on health care.	D. Providers compete to deliver health care itself and to contain costs.
5. Well accepted mixed economy of public and private health care.	E. Retain expenditure control through cash limits on buyers for hospital and community health expenditure.
	F. Cost control supported by a tariff of standard reference prices based on DRGs.
	G. Fiscal incentives to take out health care insurance.
	H. Better information about services, especially for GPs.

Self governing hospitals

3. Annex A summarises what the central proposal, the separation of the buying and provision of health care, might mean in practice. In broad terms hospitals would be able to run themselves, while responsibility for ensuring

that health care was available would rest with statutory "buyers". In effect the functions currently performed by health authorities would be split and, in the case of the provision of services, dispersed.

4. The buyers would be funded by, and accountable to, Government for:

* securing comprehensive health services for their resident population in accordance with the Government's policies and priorities for better health and health care services. We shall need to give further thought to the most sensible size of population for the buyers to cover.

* ensuring that these services gave the best value for money for public funds. In particular, buyers will need to take full account of the actual health benefit to patients and the public of the services provided.

To these ends they would invite tenders which covered between them all the necessary services, placing contracts - wherever possible on a competitive basis - with whichever providers of health care could deliver most acceptably. The contracts would need to cover family practitioner, community, public and preventive health services, as well as hospital services.

5. These contracts between buyers and providers would be central to the whole approach. Each contract would specify both the price and the quality required for each service. The form of contract would need to vary from service to service, in a way which was sensitive to the needs of that service and which struck an acceptable balance between entitlement to treatment, expenditure control and the need, in some cases, for money to follow patients; some possibilities are discussed in Annex B. It might be helpful to establish a range of standard reference prices, based on DRGs, (diagnostic related groups) but subject to variation in the light of local market conditions (for example to reflect any regional or local variations in pay levels).

6. We need, correspondingly, to open up the provision of health care by encouraging more diversity and greater local autonomy. The emphasis will be on local management and responsibility; this is the best way of releasing the enthusiasm and enterprise of the people who provide services. The present NHS hospitals and other service units would remain public sector bodies, but they would be competing on equal terms both with each other, and with private sector providers, for contracts from the buyer. Public sector service providers would also be free to compete for the business of the private sector buyers of health care such as individuals, insurance companies, or employers. We would thus be giving considerable impetus to a health care "mixed economy". ← why? ✓

7. There are more than 1,800 NHS hospitals, varying in size from around 20-30 beds to over 1,000. It would not make practical sense for every one of these hospitals to be "self-governing" and responsible for its own contracts. A better starting point would be the 600 or so management units into which hospitals and community health services are currently grouped, although most of these units would contract separately for different groups of services, and often with different buyers.

8. Each providing unit would be autonomous, employing directly the staff necessary for their business. They would have considerable freedom to determine what kinds of service they should offer to buyers. This greater autonomy raises a number of issues to which we would need to give further thought. For example:

(i) We would need to ensure that adequate mechanisms were in place to manage capital assets and capital investment. We would not want providers to duplicate facilities extensively in an attempt to compete; nor - conversely - buyers to find themselves unable to secure adequate local services because of a failure by providers to invest in good time. To ensure that public providers offered fair competition and that all costs were properly allowed for, the cost of servicing capital would have to be met through contract prices.

(ii) We would also need mechanisms for securing an adequate, but not over-sufficient, supply of doctors, nurses and other skilled manpower, and for meeting the overhead costs of in-service training incurred by teaching hospitals and other service providers. Some of these aspects inevitably involve long lead times - for example the training of consultants.

(iii) Autonomy implies not only the employment of staff but also - at the very least - greater flexibility over pay and conditions of service. We should need to address the implications of such further relaxation of central control.

9. An important corollary of this approach is that some hospitals may fail to secure sufficient contracts to remain viable, either for the whole of their services or for a substantial sub-set. Each buyer would need to ensure that its population had adequate access to local services where such access was important, but politically sensitive closures of public sector hospitals or wards could result nonetheless. We shall need to consider how far it would be feasible in practice for Ministers to distance themselves from such decisions under the approach I envisage.

10. The position of GPs under the new arrangements would be crucial, both as providers of services themselves and as "gatekeepers" to hospital and other services. As providers GPs could remain contractors as now, but with the new buyers taking over the functions of Family Practitioner Committees. As gatekeepers GPs would retain their right of referral, but the freedom to refer wherever they wished could in practice be constrained by the relevant buyer's decisions on the placement of contracts. It would be essential to ensure that such constraints did not limit unreasonably the GP's - and hence the patient's - choice. For example:

* the range of contracts needed to secure adequate choice would need to be discussed between buyers and "their" GPs;

* each buyer would need to make some budgetary provision for GPs to make referrals additional to those contracted for, either to the same or to different providers; and

* the necessary contractual and budgetary arrangements could usefully be supported by peer review of referral practices and, perhaps, of difficult individual cases.

Still not much control

11. We shall want to bear in mind the parallel between what is said here about the buying and provision of health care and the proposals Roy Griffiths has made about the buying and provision of community care services.

Financing health care

12. We will be in a better position to reach decisions on the financing of health care when we have settled the main structure of buying and providing care. But the elements are closely interlinked:

first, because we can only go so far in developing competition and choice through internal restructuring we need a better mixed economy. To achieve that we need a better means of encouraging more people to put more of their own money into health care, particularly those aspects where personal choice can be an important element like elective surgery. In my judgement, to make a real impact on this we need to introduce more fiscal incentive for individuals.

second, the cost of health care needs to be better understood not just by those buying and providing it but by those receiving it. One way of doing this is for people to know how much they are contributing to the cost of health care.

13. Taken together, these factors underline the advantages of paying for health care through a modified version of the national insurance scheme, which includes a rebate for those who contract out of certain NHS services into an approved private or occupational health care scheme. The existing national insurance arrangements would not be entirely suitable. We would have to look in particular at the contribution structure so that it did not worsen work incentives, especially for the lower paid, or add significantly to the burden on employers; and also at the rebate arrangements, so that they were fair to older as well as younger people. But the overall attraction of this approach remains.

14. Contracting-out would apply only to certain services - for example to elective surgery, the area in which waiting lists build up most heavily. Buyers would continue to place contracts for such services, for those who do not contract out. But those who contract out would have an opportunity of greater choice and could elect to spend more of their own money than the buyer would have spent on their behalf.

Implications of the new structure

15. We should not under-estimate the scale of the changes implied by the model I have described. The NHS would look much the same to the patient, who would continue to go to the GP and hospital for free treatment, but the structure underlying it would be very different. The present hierarchical structure would go. The basis of employment would change. And the introduction of contracts and competition would make life look very different from the inside. All in all, the changes would be much greater than any of the reorganisations since 1949. As such they would attract opposition from those working in the NHS at all levels who felt threatened by those changes or who simply disagreed with them.

16. I feel bound to say, too, that I would expect the upward pressure on public expenditure on the NHS to be, if anything, increased by these changes. By forcing buyers to make explicit what services they judge their

population to need, any gaps between those judgements and the services available would become more open and measurable. The better information which would be essential to make the system work could supply ammunition to those who believed their services to be inadequate. Some spare capacity might be needed for competition to work effectively and for money to follow the patient. And competition and greater autonomy among providers could drive up labour costs. We shall need to look carefully at ways in which we can offset the effects of such pressures: for example, by developing more incentives to greater efficiency and cost-effectiveness.

17. The role of Government would change, but not fundamentally. We would still set the policy objectives and strategic direction within which we expect buyers to operate, and would still allocate their revenue. Buyers would be accountable to us for their purchasing decisions, and hence for the quality, comprehensiveness and cost-effectiveness of the services contracted for. Under the new structure, the Government would need to secure effective means for regulating and auditing health care services, both public and private sector. Government would also need to ensure the quality and quantity of education and training for medical, nursing and paramedical professions. In all these areas, accountability to Parliament would continue.

Approach to change

18. Overall a health care system along the lines sketched out in this paper would be fundamentally different from the present one. The changes involved would have to be phased in over a period of years. We would need to move towards our goals in a way which

- is incremental, so that we are able to modify our approach as we go
- minimises the impact on patients, so that they do not feel they are losing what is now valued in the NHS, especially the ready access free of charge
- recognises and seeks to reduce as far as possible the concern about turbulence that will be felt by those working for the NHS.

19. These factors all point to an approach which opens up the NHS to organic change. We need a rolling programme of improvement which leaves scope for adjusting the detail of longer-term changes as we learn from experience. Pushing down budgetary responsibility, and making related changes in information systems, is one example of an essential early reform. We must also seek ways of testing out key aspects of our reform proposals where existing experience - here or overseas - is an inadequate guide to how they will work out in practice. The timing of any organisational change - notably to the present health authority structure - would need careful thought, but we could fairly present our proposals as a continuing process of consultation and change, allowing reform to be taken at an acceptable pace.

Conclusions

20. My objective in this paper has been to carry forward our thinking, particularly in giving hospitals greater freedom to run themselves, in introducing more scope for competition and choice in developing a better mixed economy of health care, and in involving doctors more in the management of resources.

21. The model that has been set out is not intended to be a full or final blueprint, but to give us an opportunity to gauge the strengths and weaknesses of the general approach. We shall clearly need to do more work on the detailed implications. We shall also want to compare the pros and cons of this approach to the other approaches set out in the HC 15, particularly the "NHS refurbished" model.

22. If colleagues are content with the general approach I have outlined, I will put the follow up work in hand. I will also arrange for the approach to be compared to the other models we have considered.

April 1988

ANNEX A

SELF-GOVERNING HOSPITALS

How it might work

1. Patients would in general see an unchanged, though improved, NHS. In particular they would continue:

- to be entitled to a comprehensive range of health care, free at the point of use.
- to have access to the system mainly through GPs and specialists.

2. Buyers would

- be responsible and accountable to Government for

  a. ensuring that the service needs of their resident population were adequately met, and

  b. staying within cash-limited revenue allocations.

- put each service, or group of services, out to tender.
- contract with providers, including GPs, for particular services over a specified period.
- monitor the providers' performance.

3. GPs would

- retain full clinical responsibility for their patients.
- remain as independent contractors to the buyers, providing a primary health care service.
- continue to act as "gatekeepers" to specialist services through their referral of patients to specialists.
- discuss with buyers the range of referral choices open to them.

4. Consultants would

- retain full clinical responsibility for their patients.
- be either full or part-time employees of hospitals or clinics.
- be able to assemble "service packages" for their hospitals to offer to buyers.

DC1.8/9

5. Hospitals and clinics would

- be self-governing, with a management board, individually or in groups.
- employ professional and lay staff.
- seek to attract services for their local communities.
- offer specialist facilities to other providers on a sub-contract basis.

6. Providers generally would

- offer to provide particular services, or groups of services (not necessarily based wholly within a hospital or clinic), to NHS buyers.
- be free also to bid for private sector business.
- buy in any additional facilities they needed from other NHS hospitals and clinics or from the private and voluntary sectors.
- be accountable through contracts with buyers for meeting cost, volume and quality standards.
- bid for capital investment from public funds.

7. The DHSS would

- work primarily through buyers in setting policy objectives, allocating revenue and securing accountability.
- encourage development of clinical audit (including peer review).
- ensure that adequate capital funds were available (see below).
- publish DRG-based costs for contract pricing purposes.
- ensure effective regulatory and audit arrangements.

8. In addition, mechanisms would be needed to

- look after capital assets and capital investment matters, and in particular to:

  - be responsible and accountable for funding short-term and long-term investment plans, eg buildings and equipment.
  - acquire, hold and dispose of capital assets, consistently with public policy and accountability.

- ensure that there were adequate levels of trained manpower, and that the professional training overheads of providers (including those of teaching hospitals) were funded.

- ensure that service and resource plans were properly integrated.

Annex B

CONTRACTS BETWEEN BUYERS AND SELF-GOVERNING HOSPITALS

1. All services would be procured under contracts which explicitly set out the services and standards to be delivered and the mechanisms for cost control and quality assurance. Contracts would not necessarily be with hospitals, but with other providers or consortia of providing units. In this way contracts could be secured to provide integrated hospital and community services where appropriate. Competitive tendering would not be feasible in many parts of the country, for some services: a buyer will often be faced with only one provider for large parts of its population; and a provider with only one customer for its services.

2. To provide stability for both the hospital and the buyer, contracts would need to span a reasonable period of time and a clearly defined range or type of service. Three basic approaches to pricing the services under a contract are used:

Average cost - charges to the buyer would be raised on each patient served, priced according to DRGs. The provider would need to know expected volumes during the contract period before fixing the average cost, and the contract could be subject to an overall volume limit. The contract could also contain agreed prices for units of service beyond the volume initially contracted for.

Retainer plus marginal cost - the buyer would pay a retainer fee to ensure that a facility of a given size was kept available, and would pay the marginal cost of each patient treated in it, priced according to DRGs.

Capitation - the buyer would pay the provider a set annual fee for the number of patients expected to use the services offered by the provider, regardless of whether the patient actually uses these services. This is effectively an extreme case of the "retainer" type contract, where the population to be served is known, and their costs are sufficiently uniform to be rolled together.

3. There are three policy objectives which will help determine the choice of contract method:

Money following patient - money would follow patients as a group, in the long term, if the buyer places the service contract with another provider. In the short term, and in relation to the individual patient, it is achieved only by the average cost contract. This is because the whole amount of the money passes with the patient.

Expenditure control - requires that the maximum possible expenditure under a contract be known in advance. Thus capitation provides control, but a contract with a variable cost element would also need to be subject to a volume limit.

Immediate entitlement to treatment - this cannot be achieved if there is any volume limit on the contract such that a patient may have to wait, or simply not get service. However, any contract with a variable cost element and no volume limit allows no expenditure control. Capitation would provide both for immediate entitlement, and for expenditure control.

4. Possible contract regimes for each of the main services are described in the following paragraphs.

Family practitioners

5. GPs already work along the lines of the model: they are independent contractors to Family Practitioner Committees, which act as "buyers". This relationship would continue, but the FPCs would be replaced by the buying authorities. The buyers would contract with such practitioners as were conveniently located to serve the buyer's resident population (not necessarily practitioners located within the buyer's boundary). Buyers would need to include in their contracts with at least some practitioners a provision for treating visitors from other areas, such as holidaymakers, migrant workers, etc.

6. As the main access point to health services, GPs should be under a contract which ensures immediate entitlement to service. Contracts for GPs' services would therefore continue to be on the basis of capitation. If it is not intended to disturb the patient's view of the GP service, it might be appropriate also to continue to provide for certain specified services (such as family planning) to be contracted on the average cost basis. Dentists' and opticians' services would continue to be purely on the average cost basis.

Accident and Emergency

7. Each buyer would need contracts for the provision of accident and emergency services, even though the patients concerned might live outside the buyer's area. One approach might be for a buyer to make contracts with each of the hospitals to which a patient injured within that buyer's area might be taken. These would not necessarily be hospitals within the buyer's area. The contract would need to specify the range of conditions to be dealt with, so that only genuine accident cases were charged to the buying authority. But the contract would also need to preserve the "open door" policies of A & E departments, without encouraging over-use.

8. The hospital would pass an invoice for the additional patient charges to the buyer responsible for the area in which the emergency originated. The buyer would either pay, or refer the invoice on to the patient's home buying authority. Buyers could make reciprocal agreements to absorb such invoices on a "knock for knock" basis.

9. Patients referred on from A & E for immediate admission, together with other emergency cases referred by GPs (which may or may not enter hospital via the A & E department), would be treated under the contracts for the specialties concerned.

10. Both these types of admission must be provided on the basis of immediate entitlement. If demand within a buyer's area were sufficiently predictable, contracts could be on a type of capitation basis. This approach would give complete control of expenditure. Further consideration would be needed as to whether it would be realistic for buyers and providers to negotiate contracts on this basis. If not, and the variability of demand were too great, leading to an excessive fixed charge, the contract could be on the basis of a retainer plus the marginal cost of individual patients. For most emergency referrals these additional charges would be based on the DRG(s) applicable for each case referred.

Outpatients

11. Provision would be needed for immediate entitlement to an out-patient appointment where the GP considers this to be necessary. As with A & E, a type of capitation might be appropriate; otherwise, according to the economics of the situation, either an average cost contract, or a retainer plus marginal cost contract, neither with volume limits, would apply. GPs might be given incentives to reduce unnecessary referrals to outpatient departments and to provide directly treatment which is given unnecessarily in outpatient clinics. The contract pricing would need to cover the cost of any diagnostic services used.

Diagnostic services

12. GPs could arrange their own contracts (provided they were given their own budgets), or call off services under global average cost contracts arranged by buyers, for diagnostic services provided by hospital departments (eg radiography, pathology), which did not require referral to a consultant.

Elective admissions

13. Non-urgent cases are also referred to the hospital by the GP, usually for surgery, but sometimes for medical treatment. These cases would be subject to waiting list arrangements specified in the contract. These procedures need not be uniform across all services or treatments. This is discussed further in paragraph 22.

14. For these services, immediate entitlement is not relevant, but it is desirable for money to follow the patient. This points to a contract on the average cost basis, with charges according to the DRG of the patient. The contract would specify precisely which procedures and treatments were covered, and the maximum number of patients to be handled during the contract period. Contracts might encourage day- rather than in-patient procedures wherever possible.

Maternity

15. The volume requirement for maternity services is fairly predictable, and the services should be subject to immediate entitlement. However, individual costs vary according to the nature of

each case (eg straightforward delivery, caesarian, etc), so that a capitation approach might not be easy to negotiate. Maternity is also a service in which it may be desirable for money to follow the patient. Since demand is relatively predictable and inelastic, the risk to expenditure control in adopting an average cost contract without volume limit might be acceptable.

Other non-acute

16. Some "acute" episodes of mental or geriatric illness would logically fall under the equivalent of the emergency arrangements described in paragraph 10, or those for elective admissions in paragraph 14.

17. Other mental illness, mental handicap and long-stay geriatrics are relatively predictable, inelastic in demand and uniform in cost. There is little alternative to immediate entitlement. It would be desirable for money to follow the patient, but any movement would take place on a slow timescale in any event. A capitation contract might therefore be appropriate for these services.

Community services and public health

18. Community services are less subject to the requirement of immediate entitlement. Money could, to a limited extent, follow the patient. Capitation might therefore be inappropriate, and it should be possible for these services to be contracted on the basis of average cost. The main constraint on expenditure would not so much be a formal volume limit in terms of patients served, as a limit on overall resources available; the contract could limit the number of staff available.

19. Services which were not patient-specific, such as general prevention and public health, could be contracted on a fixed capitation type basis.

Expenditure control

20. Expenditure control is easiest where costs are fixed in advance, and do not vary with patient throughput. Hence capitation contracts offer the buyer greatest certainty. Where volume limits can be applied, as for elective surgery and non-urgent general medical cases, expenditure is equally firmly fixed. Contracts providing a retainer plus marginal cost charges are less controllable, and open-ended average cost contracts, least of all. Lack of a volume limit is less important for some services such as maternity, where demand is relatively predictable and inelastic. In others, the main constraint will be the waiting list for in- or day-patient services, and the simple rationing of visits for community services (as in paragraph 18).

21. Where expenditure control is firm, the task of control of costs falls squarely on the provider. Where expenditure control is imperfect, buyers might need to rely on the audit (clinical and financial) of a random sample of individual cases. Buyers could maintain a small professional staff to carry out the audit process, perhaps with access to medical records.

22. Waiting lists would be an essential part of expenditure control in non-urgent services. The maintenance of an agreed waiting list regime might be included in the contract for the relevant services. For example, the contract might provide for the buyer to direct the hospital as to the rate of flow of waiting list cases, within set limits.

23. Most expenditure on family practitioners has hitherto been demand-led. Under the contracting regime proposed the presumption might appear to be that it would be cash-limited, but there should be no difficulty in principle in releasing that tranche of buyers' expenditure from cash limits.

Quality control

24. Quality control would be an essential feature of the contract. It would be enforced by clinical audit procedures, and by the discipline of the eventual removal of the contract. In some cases, contracts could provide incentives for improving quality of service.

Penalties

25. The main penalty for failure by a buyer to meet contract conditions would be loss of the contract when renewal is due. However, in addition, particularly where there is little or no competition, financial penalties under the contract might be appropriate. Ways of dealing with contract failure without detriment to patient services require further thought.

Annex 3

Patient and GP Choice

1. The "self-governing hospitals" model implies no change in a patient's treatment in an emergency, but it would have an impact on the way in which a patient and his or her GP would exercise choice over non-immediate referrals to a specialist. This note illustrates that impact by reference to a fictitious patient, Mrs Smith, and her GP, Dr Jones. It assumes that Mrs Smith has already chosen Dr Jones as her GP, is satisfied with the service he offers, and trusts his advice. It also assumes that the "self-governing" hospitals model has been in operation for around 3-4 years.

2. Mrs Smith is a widow aged 65. She lives alone in the suburbs of a large provincial town. She sees a lot of two friends who live in her street, and has a son, daughter-in-law and grandchildren who live two or three miles away. She is physically mobile, but is partially sighted and has a history of eye trouble, including a hospital admission five years previously for a cataract removal. She has recently developed mild diabetes. She has no private health insurance.

3. Mrs Smith's eyes are troubling her again. She hesitates to consult her GP because she is afraid of the consequences: she did not like her previous stay in hospital, and does not want to repeat the experience; and she is afraid of losing her sight. Nonetheless, encouraged and reassured by her friends and family, she makes an appointment to see Dr Jones.

4. Dr Jones is unable to make a firm diagnosis. Given Mrs Smith's history, though, he knows that the problem is not straightforward and suspects strongly that an operation will be needed. He reckons that this would involve a stay in hospital of about a week followed by two or three follow-up out-patient attendances. He also suspects, but cannot be sure, that Mrs Smith's condition will deteriorate quite quickly if not attended to.

5. Dr Jones explains all this to Mrs Smith and advises strongly that she should see a specialist, initially for an out-patient consultation and diagnostic tests. He reviews the three main options:

i. Mr A is the consultant at the district general hospital in the town. This is the hospital to which Mrs Smith was previously admitted, and to which she is therefore not well disposed. But the consultant is now different: Mr A was recruited by the hospital's management 18 months previously to revive a flagging opthalomology department and standards have improved dramatically. The available evidence, together with Dr Jones's own experience, suggests that Mr A deals admirably with relatively routine cases, but his department is not well equipped for more complex problems and so Mrs Smith might have to be referred on to a more highly specialised unit. An outpatient appointment could be arranged quickly, but pressure on operating theatres has recently extended ophthalmology waiting times to an average of 4 months: Mrs Smith might rate a high priority on Mr A's waiting list, but Dr Jones cannot be sure. The hospital holds the main contract for providing ophthalmology services for the local health agency's residents: the terms of the contract are adequate to cover Mrs Smith's out-patient, diagnostic and in-patient needs, although the relatively low price negotiated by the agency could encourage Mr A to refer Mrs Smith elsewhere for treatment.

ii. Mr B is a consultant at a provincial teaching hospital 50 miles away. The ophthalmology department there is strong, and both well equipped and well staffed to deal with complex cases. Dr Jones has a generally high opinion of Mr B, although Mr B's ratio of operations to patients seen is high and Dr Jones knows that Mrs Smith would prefer not to face an operation unless it was really necessary. Also, some of Dr Jones's patients have in the past found the hospital to be rather impersonal. An out-patient appointment could be arranged as quickly as one with Mr A and in-patient waiting times are substantially shorter - about a month on average. The local health agency's only other ophthalmology contract is with this hospital: the agency decided two years previously to increase from 10% to 20% the proportion of its

committed ophthalmology budget devoted to this contract, partly to put pressure on the district general hospital to improve its performance and partly in response to the changing preferences of its GPs. The agency has nonetheless asked its GPs to minimise the referral of relatively routine cases to this hospital as its prices are higher, reflecting its more specialised nature.

iii. Mrs C is a consultant at Moorfields Eye Hospital in London, 150 miles away. Dr Jones has occasionally referred difficult cases to Mrs C in the past, and has total confidence in her and the hospital's ability to deal with them. An out-patient appointment would take a little longer to arrange than one with Mr A or Mr B. In-patient waiting times average three months - shorter than those for the DGH, but Mrs Smith would be much less likely to rate a high priority on Mrs C's list than on Mr A's. The local health agency has no contract with Moorfields, but it does have a reserve budget to cover referrals without existing contractual cover, subject to peer review. Moorfields's prices are the highest of the three hospitals, but Dr Jones is satisfied that he could make a strong case for financial cover from the reserve budget. It could take up to three weeks to receive a reply to such a bid.

6. Having gathered all the relevant information Dr Jones discusses these options thoroughly with Mrs Smith. His advice is a referral to Mr B. Although he believes that a referral to Mrs C would be justified on clinical grounds, he is concerned about the length of time that would elapse before a diagnosis is made and, if necessary, an operation performed; and he is worried about how Mrs Smith would react to being so far from home. On the other hand, he believes that the history and potential complexity of Mrs Smith's condition makes a referral to Mr B clinically justifiable by comparison with a referral to Mr A.

7. Mrs Smith has only one doubt about agreeing to this: she feels she would cope much better with a spell in hospital if she could be visited frequently by her family and friends. In other respects her natural inclination to follow Dr Jones's advice is reinforced by her strong desire - having steeled

herself to consult him - to wait the shortest time possible for any necessary hospital treatment. For herself she sees the time to be spent travelling to out-patient appointments as a price worth paying for a shorter waiting time.

8. Mrs Smith discusses the position with her son and her friend. They work out between them how at least one of them can visit her every day, usually with a grandchild, if she is admitted to the teaching hospital. She telephones the surgery to ask Dr Jones to go ahead with the referral to Mr B.

-- And they all lived happily ever after.

004/4212

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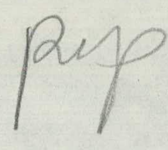

cc:
PS/Chancellor
PS/PMG
Mr Anson
Mr H Phillips
Mr C W Kelly
Mr Turnbull
Miss Peirson
Mr Gieve
Mr Saunders
Mr A M White
Mr Griffiths
Mr Call

Treasury Chambers, Parliament Street, SW1P 3AG

The Rt Hon John Moore MP
Secretary of State for Social Services
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1A 2NS

22nd April 1988

Dear John,

ADDITIONAL PROVISION FOR THE NHS IN 1988-89

Thank you for your letter of 18 April which we discussed the other night in the House.

I have considered the proposal you have put very carefully and discussed it with the Chancellor. Although I understand your concern I do not think I can agree that it is a practical proposition now to put in more funding while we are still in the middle of the Review. It would be difficult to present and run counter to the line we have been taking that funding decisions should be taken in the light of the Review and not in advance of it.

I would be happy to discuss this with you and Tony if you wish.

Yours Ever,

John

JOHN MAJOR

mjd 3/120m

SECRET

Treasury Chambers, Parliament Street, SWIP 3AG
01-270 3000

CC-CST, AMG, Sir P Middleton
Mr Anson, Sir T Burns
Mr Phillips, Miss Peirson
Mr Saunders, Mr Parsonage
Mr Riley, Mr Turnbull
Mr Culpin, Mr Kuczys (IR)
Mr D Griffiths Mr Call
22/4/88.

PRIME MINISTER

A SCHEME FOR CONTRACTING OUT OF THE NHS

I attach the paper on contracting out of the NHS which was commissioned from the Treasury at our last meeting.

The paper concentrates on developing and analysing an option which seems to be the most promising if this line were pursued. Its main features are as follows:

- A significant increase in the NHS element of national insurance contributions with an offsetting increase in the Treasury supplement to the National Insurance Fund and no change in tax or NIC rates.
- A rebate payable to those who "contracted out" by taking private health insurance cover satisfying some minimum requirements.
- Those who contracted out would not formally give up their rights to NHS treatment; rather they would undertake to pay for all treatment within the terms of the insurance policy, even where it is provided in NHS hospitals.
- The rebate would be a flat rate of perhaps £50 a year per head.
- Since the rebate would not be available to the elderly, who do not pay NICs, they would instead be entitled to tax relief on premiums paid to private health insurance schemes.

The main alternative to a scheme on these lines would be one simply based on tax relief for private health insurance premiums. The case here is strongest for the elderly. This has already been

advocated by a substantial group of our supporters in the House, led by Sir Phillip Goodhart. A case could be made for extending it to company health schemes (by exempting employer-paid premiums from tax as a benefit in kind), but there would be strong pressures then for a corresponding concession in respect of all premiums, however paid.

However, there are significant drawbacks about introducing tax relief to promote private health care. Our general policy is to widen the tax base in order to be able to reduce tax rates, so as to leave people with more of their own money and the freedom to choose how to spend or save it. I am therefore most concerned that we should not do anything to reverse the progress we are making in simplifying and streamlining the tax system. Moreover, the introduction of tax relief for private health care would make it more difficult to justify the absence of tax relief for private school fees. And many of the arguments against an NIC rebate (see below) would apply equally to a tax relief.

Returning to the NICs proposal, the financial implications of contracting out are discussed at the end of the paper. The calculations are necessarily a bit speculative, but the message is disturbing. There is a significant initial cost in paying the rebate to those who already have private insurance. This would at once reduce <u>net</u> private funding. A lot more people would need to contract out and top up from their own resources to make good this loss. But the rebate is unlikely to be large enough to attract additional people into taking out private insurance in sufficient numbers. Thus, there would be higher costs to the public purse without any assurance of an increase in the amount of private money going into health care. It must therefore be doubtful if this is the most cost-effective means of devoting additional public funds to the NHS.

There is moreover a major distributional point. The first beneficiaries of such a scheme would inevitably be those who alredy pay for private health care, who tend to be the better off section of the population. This would be particularly difficult to defend after the present controversy over the social security changes and the community charge. Moreover, one of the reasons people would subscribe to private health care with these incentives would be to get what they perceive as better or more timely treatment. We would have to be prepared to deal with accusations that we were providing tax relief to help the better off to jump the queue. Again, if we are going to spend an additional sum of public money on health, is this the best way?

I am forced to the conclusion that contracting out is on balance unattractive and should not be pursued on this occasion. It has too many problems for too few (and uncertain) rewards.

I am copying this minute and attachment to John Moore, Tony Newton, Sir Robin Butler and Sir Roy Griffiths.

Moira Wallace

pp **NL**
22 April 1988
(Approved by the Chancellor and signed in his absence.)

A SCHEME FOR CONTRACTING OUT OF THE NHS

Note by the Treasury

1. At present, the NHS is overwhelmingly free at the point of use, whereas fees and charges for private health care reflect the full cost of the service. The NHS is financed out of general taxation (including that paid by those who choose not to use it), while the private sector is paid for by its customers. There is therefore a financial disincentive to make use of the private sector, and hence a major obstacle to the development of private health care, which might otherwise provide a means of easing the pressure on the NHS.

2. One obvious way to reduce this "cliff edge" between the public and private sectors would be wider use of charging in the NHS. Those who chose the private sector would then avoid that expense. Otherwise, there are two broad ways in which the problem might be tackled:

   a. Some form of tax relief for the cost of private health care.

   b. Some form of remission from national insurance contribution for those who chose to contract out, in some sense, of the NHS.

3. These options are by no means mutually exclusive. Indeed, it is possible to combine elements of each within one package: for example, a rebate of national insurance contributions for those in

work, tax relief for the elderly, and more use of charging in the NHS. This paper deals mainly with the option of remission for those who contract out. But the issues raised by the idea of tax relief are also germane, and these are considered first.

A tax relief

4. The most frequently canvassed option is to give tax relief for private health insurance premiums. A parallel option would be to exempt premiums paid by employers under a company scheme from taxation as a benefit in kind in the hands of the employee. An alternative approach might be to allow tax relief for money spent in paying directly for treatment. Total private health insurance premiums were just over £600m in 1986. Direct expenditure on uninsured private health treatment was a further £500 million.

5. Bills for medical treatment tend to be unpredictable and large. If private health provision is to be encouraged, people will need to be encouraged to take out insurance. It would seem preferable therefore, if there is to be any form of tax relief, to concentrate that relief on insurance rather than direct payments for private treatment. This would also avoid the need for the Inland Revenue to vet claims for individual payments according to whether or not they were medically necessary, with Ministers having to defend the resulting decisions. As well as being contentious, this would need substantial extra staff.

6. Any relief on premiums could be targetted on those who find it most difficult or expensive to obtain private health insurance. At present, the most heavily discouraged group is the elderly.

About 170,000 policyholders (15% of those not in company schemes) are over 65. But most schemes will only take on new customers over 65 with limited cover, and those who are already in the scheme face steep increases in their premiums. This effect would be even more pronounced for those previously in company schemes whose premiums had been paid wholly by their employers. Tax relief would mitigate the increase experienced on reaching the age of 65. It might also encourage insurance companies to begin offering more comprehensive schemes for the elderly. On the other hand, around two thirds of pensioner households pay no income tax, and so could not benefit from a new relief.

7. The other possibility would be to encourage the growth of company schemes by exempting premiums from the benefits in kind legislation. Such a step might trigger a further significant spread of company schemes, and encourage firms to extend to all the workforce those schemes presently confined to managers.

8. It might however be difficult to justify a relief for company schemes but not for premiums paid by small businesses, the self-employed, and individuals. There would be pressure to extend tax relief to all private health insurance premiums. This would in turn lead to pressure for concessions in other areas - for example, those who opt out of state education by educating their children privately, or those who pay for child care when at work, which would substantially undermine the Government's policy of simplifying the tax system and reducing special reliefs. A special relief from the benefits-in-kind charge would also be counter to the changes made in the last Budget. A relief confined to the elderly would be less liable to give rise to problems of this sort.

9. There would be an initial "deadweight" cost because those who already insure themselves would get the new relief. Tax relief for private health insurance premiums would cost £230m a year initially, made up of £80m for exempting employer-paid premiums from the benefits in kind charge, £130m for relief for premiums paid by individuals of working age, and £20m for the cost of tax relief for pensioners. The cost of any relief could be expected to increase subsequently as more people took it up.

A rebate for contracting out

10. The most obvious option here is to use the existing national insurance system. Part of the revenue from national insurance contributions is already allocated by statute to the NHS, as the attached table shows.

11. In 1988-89 total NHS contributions will be some £3.3bn, or about 16% of net NHS expenditure. This would be insufficient to underpin a viable contracting out scheme, since acute services (which are what private insurance would presumably cover) account for around a third of NHS expenditure. If the NHS element of NICs were increased, the income of the National Insurance Fund would fall. The shortfall could be made good by increasing the Treasury Supplement from general taxation to the Fund, thus leaving overall tax and NIC rates unchanged. The supplement is currently 5% of gross contribution to the NI Fund, but was 18% as recently as 1979. The Annex illustrates how this might be done: the Treasury supplement is increased to 17½%, still just below the 1979 level.

12. Contracting out of the NHS might be seen as analogous to contracting out of SERPS. In return for giving up a right to certain categories of treatment under the NHS, individuals could make their own arrangements and receive a rebate as a contribution towards the cost.

13. The analogy could not however be pressed too far. In its most rigorous sense, contracting out would imply that the individual formally relinquished rights to certain precisely defined categories of treatment which the state would no longer be obliged to provide for him. He would however continue to receive other types of treatment under the NHS, which were not available in the privately insured sector - probably primary, geriatric, chronic disease, other long stay care, maternity care where complications do not arise, and so on. This would bring the state directly into decisions about whether particular individuals at particular times fell on the NHS or contracted-out side of the line. There would be highly contentious individual cases, with the prospect of political controversy and litigation. Private health schemes would have to be heavily regulated to ensure that they continued to offer adequate cover so that the NHS did not have to step into the breach. Individuals might feel obliged to carry some form of identification indicating whether their health cover was public or private sector. These are not very attractive features.

14. There are however other ways of approaching this. The rebate could be conditional on two slightly looser requirements: that the insurance scheme met a certain minimum level of cover, and that those who took private insurance undertook to pay the full cost of

any treatment within the terms of their policy which they received from NHS hospitals. Systems would need to be set up to ensure that insurers were billed for any treatment provided in NHS hospitals. Responsibility for assessing individual cases would rest with the insurer, and not with the state. Where a case was not covered, for example on grounds of cost or length of stay in hospital, the excess would be provided under the NHS. Where cover was refused on grounds that the particular procedure was not medically necessary, it would, as now, be for the individual to meet the cost himself.

15. Individuals who contracted out would receive a rebate of some or all their NHS contributions. This would further complicate the national insurance system. (A further question would be whether rebates in respect of those in employer-paid company schemes should be paid to the employer, to the employee or split between the two.)

16. Those who did not pay NICs, notably the elderly, could not benefit from contracting out. Yet the elderly are proportionately the biggest users of the NHS. To encourage them also to take out or continue private insurance, therefore, NIC rebates might have to be supplemented by a tax relief for the elderly along the lines discussed in paragraph 6. There would be pressure to extend this to others who do not pay NICs, including for example non-working widows and those who have taken early retirement (although those who had done so on health grounds might be unable to obtain private insurance in practice).

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Structure of the rebate

17. The first main alternative would follow SERPS by providing a percentage contribution rebate for those contracted out. This would have the merit of relative simplicity for both the DHSS and employers. But it also has problems:

a. In both state and contracted-out pension schemes the benefits are earnings-related, so an earnings-related rebate is appropriate. This is not the case for health care.

b. Higher earners would get bigger rebates. The rebates might even exceed the cost of private health insurance, so that they made a profit by contracting out. On the figures suggested in the Annex, the annual NHS contribution by those at or above the earnings limit (£15,860 a year) would be £380. Somebody on £50 a week by contrast would pay an NHS contribution of £62 a year, and would hence get a rebate of only one-sixth that of the higher earner.

18. The other alternative would be a flat rate rebate payable weekly or monthly. This would be in some ways analogous to a voucher scheme.

19. Under a flat rate rebate scheme, rebates could in principle be payable in respect of both individuals and their non-working dependants. This would, of course, increase the number of cases in which the rebates would exceed what individuals paid in NHS contributions or even total NICs. In such cases, the excess of rebates over NHS contributions would score as public expenditure, in the same way as payments to non-taxpayers under the mortgage interest relief scheme.

20. How big should the rebates be? The average cost per head of the NHS is at present around £375 a year, of which some £120 is for acute hospital services. But there is wide variation with age, as illustrated by the following table of very approximate projections for 1988-89:

	All NHS services	Acute hospital services
age 0-4	£350	£150
age 5-15	£220	£55
age 16-64	£230	£65
age 65-75	£650	£250
age 75+	£1500	£550

The average private health insurance premium was some £120 per head in 1986; extrapolating from past trends (under which the average premium has been growing in recent years at about 10-12% a year, reflecting both increasing medical costs and a changing age structure of the insured population) the figure is likely to be nearer £150 per head in 1988.

21. In considering the appropriate rebate, the following factors are relevant.

a. Insurance cover for primary care and geriatric, chronic and other long stay treatment is unlikely to become available in the short term. The second column of the above table is the more relevant comparison with the cost of private insurance.

b. There would inevitably be "adverse selection" - the tendency for any choice to be taken up wholly or mainly by those with most to gain from it. Thus, those who contracted out would tend to be the younger, fitter and better off who already have private insurance or who would be charged the lowest premiums by private insurers. Those who contracted out would tend to cost the NHS less than the average, while those who stayed behind would be more expensive.

c. The option of contracting out would be available only to those in work who, as the above table shows, cost less than the national average.

22. Taking all these factors into account, and including a loading for adverse selection, a contracted out rebate of around £50 a year per head would probably be appropriate. (This is probably around one-third the average insurance premium per head.)

Financial implications

23. It is difficult to quantify with any certainty the financial consequences of a scheme on these lines. This would depend on the amount of the rebate, on the extent to which it is passed on in the form of lower premiums and on the numbers taking advantage of it who would not otherwise have taken out private health insurance. Take-up is obviously related to the size of the rebate; but it is very difficult at this stage to assess the likely size of the effect. Such research as has been done (mainly in the USA)

suggests that demand for private health care rises by about ½% for every 1% fall in the cost of premiums. But this may not be a good guide to the consequences of introducing a major new scheme of the sort discussed in this paper.

24. <u>Exchequer costs</u> would increase by the cost of the rebate, less any reductions in expenditure on the NHS. The deadweight cost of a £50 rebate to the 5½ million people already covered by private health insurance would be just under £300m. As more people took advantage of the rebate and contracted out, the cost would rise. The suggested rebate of £50 a year would reduce the cost of insurance premiums by about one-third. If the elasticity suggested above is correct, there would be a further 1 million people contracting out, at an additional cost of £50m. If the effect was in fact greater, with, say, 3 million more contracting out, the cost would rise to £450m.

25. In the short term, it is unlikely that NHS costs would fall significantly from what they would otherwise have been. While the higher numbers contracting out would reduce the pressure of demand on the NHS, this would be likely to be reflected in shorter waiting lists or other improvements in service.

26. In net terms <u>private resources</u> going into health care would in the first instance decline, because £300m would be met from public funds rather than private hands. Again, however, the picture would change as more contracted out. Assuming a £50 rebate and an average premium of £150, net private sector payments for health care would rise by £100m for every further million people who contracted out. It would however need 3 million more to contract out (a relatively high elasticity of demand) before <u>net</u> private sector resources even got back to their present level.

27. There would be other cost pressures over time. Some of the rebate might feed through to higher costs rather than increased private sector activity. And there would be strong pressure for annual uprating of the rebate.

28. The result would be an overall increase in the resources, both public and private sector, devoted to health care as more people contracted out. But, unless the response to the new rebate was very big indeed, the increase in total health expenditure might be <u>less</u> than the increased cost to the public purse. Even on optimistic assumptions about people's response, the <u>proportion</u> of health care financed privately would probably be less than it is now.

HM Treasury
April 1988

Rates of Class 1 contributions for 1988-89

	Primary contribution (employee)			Secondary contribution (employer)	
	Standard rate		Reduced rate for married women and widow optants	Not Contracted out rate	Contracted out rate††
	Not Contracted out rate	Contracted out rate††			
	%	%	%	%	%
National Insurance Fund					
Weekly Earnings					
£41.00 - £69.99	4.05	2.05	2.90	4.20	0.40
£70.00 - £104.99	6.05	4.05	2.90	6.20	2.40
£105.00 - £154.99	8.05	6.05	2.90	8.20	4.40
£155.00 and over†	8.05	6.05	2.90	9.65	5.85
National Health Service†	0.95	0.95	0.95	0.80	0.80
Total					
Weekly Earnings					
£39.00 - £64.99	5.00	3.00	3.85	5.00	1.20
£70.00 - £104.99	7.00	5.00	3.85	7.00	3.20
£105.00 - £154.99	9.00	7.00	3.85	9.00	5.20
£155.00 and over†	9.00	7.00	3.85	10.45	6.65

Notes: † The contribution rates apply to earnings up to the upper earnings limit for employees and to all earnings for employers.

†† Applies only to earnings between the lower and upper earnings limits. The corresponding not contracted-out rate applies to earnings below the lower earnings limit and, for employers, to earnings above the upper earnings limit.

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ANNEX

NATIONAL INSURANCE FUND AND NHS FINANCING 1988-89

The table below sets out the present flows of NIC and general taxation revenue into the NIF and NHS this year, based on GAD figures for national insurance and PEWP figures for the NHS. All figures are GB. The NHS figures are net of charges. It shows for comparison an alternative model under which the NIC element of NHS funding is increased from £3.3bn to £6.7bn to cover the cost of acute hospital services, with the resulting shortfall in the NIF met by an increased Treasury supplement. It is assumed that the increased NHS allocation is provided by doubling the contribution by the self-employed, and raising the balance largely from employees. The scope for increasing employer contributions is limited by the very low NIC rates payable for some employees. There are of course other possible combinations. This one is set out simply to exemplify the principle.

	Present position		Alternative	
	£ bn	rate	£ bn	rate
NIF income				
Employees	11.9	2.05-8.05%	9.3	0.6-6.6%
Employers	14.3	0.4-9.65%	13.6	0-9.25%
Self employed	0.7	£3.42+5.15%	0.6	£2.80+4%
Treasury Supplement	1.6	5%	5.0	17.5%
Total	28.5		28.5	
NHS income				
Employees	1.7	0.95%	4.3	2.4%
employers	1.5	0.8%	2.2	1.2%
self employed	0.1	£0.63+1.15%	0.2	£1.25+2.3%
general taxation	17.8	-	14.4	-
Total	21.1		21.1	
NICs				
Employees	13.6	3-9%	13.6	3-9%
Employers	15.8	1.2-10.45%	15.8	1.2-10.45%
Self employed	0.8	£4.05+6.3%	0.8	£4.05+6.3%
Tax contribution to:				
NHS	17.8		14.4	
NIF	1.6		5.0	
Total	19.4		19.4	