PREM 19/2336

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# NHS Expenditure and Efficiency.

NHS REVIEW. COMMUNITY CARE REVIEW
In attached folder COPY of Ray Whitney MP's book
"NATIONAL HEALTH CRISIS."
② COMMUNITY CARE: AGENDA FOR ACTION

NATIONAL HEALTH

Part 1: May 1979

Part 10: February 1988

| Referred to | Date | Referred to | Date | Referred to | Date | Referred to | Date |
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PREM 19/2336

PART 10 ends:-

55/D455 to PM 29.2.88

PART 11 begins:-

JOHN O'SULLIVAN to PS 1.3.88

CONFIDENTIAL

Prime Minister

REVIEW OF COMMUNITY CARE

In December 1986, having consulted you and colleagues, Norman Fowler asked Sir Roy Griffiths to review the use of public funds to support community care, and advise on ways of improving effectiveness. I have received his report, and am circulating copies with this minute. Chapter 1 summarises his proposals.

The main issue facing Sir Roy was the disparate way in which public funds are currently committed to community care. Although the main statutory responsibilities, and much the greater part of the expenditure, rest with local authorities, social security entitlements for people in residential care have made a rapidly increasing and sizeable contribution, and some funds are available from NHS sources. Sir Roy has also had to grapple with the not always clear distinction between health and non-health care.

The current arrangements have prompted widespread criticism, from amongst others - the Audit Commission, the Social Services Committee and the Comptroller and Auditor General. Faced with how public funds could be managed to better effect Sir Roy has sought a solution that would concentrate responsibility at local level, while recognising multiple interests, and tighten accountability for plans and performance. He has concluded

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that, because of their primary existing role in this field, and the absence of more attractive alternatives, local social service authorities should be responsible for assessing the needs of people in their locality; taking a comprehensive view, in an enabling rather than a providing role, of the services that would most effectively respond to them; and arranging the delivery of suitable packages of care, through informal carers, voluntary and private bodies, and their own services. He proposes a central control and planning machinery, linked to the payment of specific grant, which he recommends should be used, amongst other things, to ensure that social service authorities make maximum use of the private and voluntary sectors, and improve consumer choice.

There is a great deal in the report with which I think we should all agree. The aims and objectives, from the point of view of effective management and delivery of policy, are entirely acceptable, and the package offers a valuable opportunity to bring expenditure on residential care within proper budgetary discipline.

We shall have to consider very carefully, however, the role he proposes should be given to local authorities. Although he sees this as enabling - in line with what Nicholas Ridley is seeking - I am far from sure that the arrangements which he proposes would ensure that local authorities dealt even-handedly with the private sector. There has been a welcome growth in private provision or residential care. We do not want to reverse that trend. And we need to do more work to turn Sir Roy's vision of a market for private non-residential care services into a reality.

More generally, we have to consider the reactions of our own supporters, many of whom are likely to be deeply sceptical of an enhanced role for local authorities. The available options will have, in my view, to be studied further.

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Other important and potentially controversial issues of substance include:

- changed social security entitlements for people in residential care;

- transfer of part of the Social Fund to local authorities;

- implications for the territorial departments.

We shall need to consider all the substantive issues collectively. Legislation would be required to implement the main changes. The resource and public expenditure implications need further analysis. Sir Roy had recognised that his proposals require further work. I am considering how this might best be organised to take account of departmental interests.

I have also received a report on residential care from a working party chaired by Lady Wagner, which was set up by the National Institute of Social Work, with Norman Fowler's support, in March 1986. That report is to be published by the Institute on 9 March. The proposals will need to be considered alongside those in Sir Roy Griffiths' report.

Against that background, I propose early publication of Sir Roy's report. Delay would stimulate speculation, and expectation of a more considered response than we shall be ready to make. I propose to make a short written statement on publication saying that the Government will be considering the proposals along with those in Lady Wagner's report; would take account of reactions; and would bring forward its own proposals in due course. A written answer to that effect is attached to this letter.

I hope it will be possible to publish on Wednesday 16 March. I have a number of Parliamentary questions asking about publication which have to be answered on 8 March. I propose to say in

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reply that I have received the report, and am arranging for it to be published on that date.

I invite agreement that:

- Sir Roy's report should be published and that I should say in answer to questions on 8 March that I have received the report, and that it will be published on 16 March;

- I should simultaneously make a statement as in the attached written answer;

- we should consider collectively the substantive issues, taking account of reactions, with the aim of reaching conclusions on a sensible and practical way forward.

Copies of this letter and the enclosures go to members of E(A) and Sir Robin Butler.

JM
29 February 1988

E.R.

DRAFT WRITTEN PQ ANNOUNCING PUBLICATION

Question: To ask the Secretary of State for Social Services when Sir Roy Griffiths' review of Community Care will be published, and if he will make a statement.

Suggested reply

Sir Roy Griffiths' report is being published today, and copies are being placed in the libraries of both Houses.

The report makes wide-ranging proposals affecting the responsibilities of local government; individuals' social security entitlements; central funding and control of community care services; and aspects of the Social Fund.

The Government will be considering the proposals, taking account of the report of the committee chaired by Lady Wagner on residential care, and of reactions to both reports; and will bring forward its own proposals in due course.

NAT HEALTH : Expenditure P1/2 . .

*[Mr. Greville Janner]*

because the matters raised in that written question are immensely important? The families of those commandos are still alive, and one of them wrote to me yesterday. They are extremely concerned. It is now clear that not only Waldheim, but his family, have been involved in those matters in a way that should be brought before the House in a statement, not in a written answer.

**Mr. Wakeham:** My right hon. Friend the Prime Minister has been forthcoming about the Government's attitude to these matters. I cannot promise a statement, but I shall refer the matter to my right hon. Friend.

## National Health Service (Charges)

3.37 pm

**The Minister for Health (Mr. Tony Newton):** With permission, Mr. Speaker, I should like to make a statement about voucher values for spectacles, blood glucose testing strips, and NHS charges from 1 April 1988.

First spectacle voucher values: Help with the cost of spectacles through the NHS voucher scheme is available to children under 16, full-time students under 19, people on low incomes and those needing complex lenses. The current voucher values were set when the voucher scheme was introduced on 1 July 1986. We have decided to increase them from 1 April 1988 so that, for example, the lowest voucher value will rise by nearly 9 per cent. from £14·25 to £15·50 and the highest voucher value by 28 per cent. from £66 to £85. In the hospital eye service there will be small increases in the maximum charges, which limit the charges to those requiring expensive lenses but not entitled to vouchers, and no increase in the charge for contact lenses.

In setting the new values we have sought to repond to the representations of the Royal National Institute for the Blind by making particularly large increases in vouchers for the more complex spectacles. We also propose a number of other changes to assist with special needs, on which representations have been made. Over and above standard voucher values, there will be a new supplement in the hospital eye service of up to £4 for people prescribed photochromic lenses for clinical reasons and a new supplement of £30 for those whose particular facial characteristics entail specially made frames. There will also be a new supplement of £30 for children who need exceptionally small glasses, available through the general ophthalmic service and the hospital eye service.

These voucher scheme is at present available for contact lenses only if they are prescribed for clinical reasons by the hospital eye service. We propose to end this restriction and to give complete freedom of choice at to whether vouchers are used for spectacles or for contact lenses.

These changes will increase expenditure on the voucher scheme by about £7 million in 1988-89, to a total of more than £65 million.

Secondly, Blood Glucose Testing Strips for Diabetics. We announced last November our intention to bring about a further improvement in services for diabetics by making such strips available on general practitioner prescription, following the similar action we took last year in respect of disposable syringes for those who need to inject insulin.

Discussions have now been held with the suppliers of the strips, and I am pleased to be able to tell the House that they will be made available on prescription from 1 June this year. Diabetics are, of course, exempt from prescription charges and will therefore receive their supplies free of charge. The cost of this measure in 1988-89 will be around £8 million.

Thirdly, prescription charges. We propose to increase prescription charges broadly in line with the increased cost of medicines. The item charge will rise by 20p from £2.40 to £2.60, an increase of around 8 per cent. The four-monthly season ticket will increase by £1 to £13.50, and the annual season ticket by £2.50 to £37.50. We estimate that the increases will yield over £10 million in 1988-89.

Over three quarters of all items will, of course, continue to be dispensed free of charge under the wide-ranging exemption arrangements, which cover children, those on low incomes, and everyone over retirement age. The House will also be glad to know that we propose to extend the exemptions for young people to include those under the age of 19 while they remain in full-time education.

Fourthly, dental charges. As the House knows, we have already announced our intention to move from the present complex and anomalous system of charging for dental treatment to a straightforward system of proportiionate charging set at 75 per cent. of the cost, subject to a maximum of £150. This new arrangement will apply to all routine dental treatment and crowns from 1 April 1988, and the charges for dentures and bridges will be set as fixed cash amounts at or about the same 75 per cent. level.

We estimate that the changes will yield additional income of about £17 million in 1988-89. However, as many people now pay the full cost of the more limited courses of routine treatment, the cost of many such courses will, in fact, fall. For example, the charge for a scale and polish and two small fillings will come down from £14.20 to £10.65.

We are retaining all the current exemptions — for children, young people aged 16 and 17, students under 19, expectant and nursing mothers and people on low incomes —which mean that nearly half of all courses of dental treatment atract no charge at all. In addition, we intend to bring forward a Government amendment at the Report stage of the Health and Medicines Bill to end the anomaly whereby some young people of 16 and 17, while exempt from charges for treatment, Nevertheless have to pay for dentures and bridges. the effect, if the House agrees, will be to exempt them from all dental charges.

In view of the changes to social security benefits that will come into effect on 11 April, I should make it clear to the House that, for the purposes of exemption from prescription and dental charges, of entitlement to spectacle vouchers and of reimbursement of expenses incurred in travelling to hospital for treatment, receipt of income support or family credit will qualify beneficiaries in the same way as supplementary benefit or family income supplement do now. There will also continue to be arrangements for assisting other people on low incomes, based on the new social security framework. Regulations will be laid before the House in due course to establish a single consolidated scheme, which will be both simpler and speedier than at the present arrangements.

Lastly, charges for private patients and overseas visitors. Increases in the central list of charges for private patients, averaging about 6·5 per cent., have already been announced. Charges for overseas visitors will also be increased for 1988-89, by 8·1 per cent. on average for in-patients and 6·5 per cent for out-patients.

Details of the proposed new spectacles voucher values, the prescription and dental charges and the charges for overseas visitors are available in the Vote Office. Regulations giving them effect will be laid before the House shortly. Equivalent measures will be taken by my right hon. and learned Friend the Secretary of State for Scotland and my right hon. Friend the Secretary of State for Northern Ireland.

**Mr. Robin Cook** (Livingston): I should like to give an unqualified welcome to two items in the statement—for both of which the Opposition have pressed. The first is that blood glucose testing strips will be available on prescription. This will be welcomed in all quarters of the House. The second is the announcement that there will be an additional exemption of dental charges for 16 and 17-year-olds, an issue which, the Minister will agree, my hon. Friend the Member for Peckham (Ms. Harman) and her colleagues have been pressing in Committee.

I should like to give a qualified welcome to the announcement on vouchers for spectacles. It is qualified, first, because, as the Minister knows, we are in this difficulty about more complex spectacles only because the Government privatised the entire optical service and, secondly, because the increase in the lower voucher charge is about £1·25, which, the Minister will admit, is less than the likely increase in the price of spectacles from the imposition of VAT, which is calculated to cost another £2 or £3 per pair of spectacles. If the Government intend to accept that European decision, the least that the House might have expected was that they would protect the poorest purchasers of spectacles from its effect.

The Minister will appreciate that his statement will be judged by the fact that this is the tenth increase in prescription charges since the Government came to office. The Minister attempted to defend the increase by saying that it represented the increase in the cost of medicines. Is he aware that the prescription charge is now 13 times the prescription charge of 1979—an increase wildly in excess of the increase in the cost of medicines in the intervening period?

Is the Minister aware that last year the Pharmaceutical Services Negotiating Committee estimated that, after last year's increase, one third of the items available on prescription cost less than the face value of the prescription charge? Will the Minister confirm that, as a result of the increase, many drugs will be cheaper to obtain at the retail price than on an NHS prescription? Does he agree that the exemptions to which he referred do not include chronic conditions, such as cystic fibrosis, asthma, Parkinson's disease, multiple sclerosis and schizophrenia, and that it is wholly wrong that people who suffer from chronic conditions which require significant medication should have to pay for their presccription charges?

I remind the Minister of the statement of the chairman of the Pharmaceutical Services Negotiating Committee that 2,000 people forgo part of their prescriptions every week because they cannot afford the charges. Is that not what the Minister would have expected, as an advocate of the law of supply and demand? Is it not precisely the effect that he would have predicted—people responding to an increase in prices by taking up fewer treatments? Is it not entirely wrong that they should be priced out of the treatment that they need?

The Minister concluded by referring to the 6·5 per cent. increase in charges for pay beds. Will he admit that the Government's policy on pay beds has been a commercial disaster? Is he aware that since 1979 the Government have increased the number of pay beds by one fifth—in sharp contrast to the cut in the number of NHS beds—and that the number of patients in pay beds has gone down by one third, while the bad debts from private pay bed patients last year alone reached £800,000? Against that background, is it not entirely fanciful for the Minister to suggest that the NHS can generate income from an activity that is a net loss to the service?

On the subject of charges to patients, will the Minister comment on the recent practice in Merton and Sutton

*Robin Cook]*

district health authority, which has introduced charges for mentally handicapped patients for music and speech therapy? Will he say whether he regards it as reasonable that long-stay mentally handicapped patients should generate income for their own treatment?

The whole House will be aware of the background to the statement. There is a massive surplus revenue in the Treasury which the Chancellor intends to give away in tax handouts in a couple of weeks' time. The money is there to fund a decent Health Service without charging the sick another £10 million for their prescriptions. The increases are unnecessary, unjustified and undesirable. When the orders are tabled, the Opposition will demand a debate on them and an opportunity to vote against them.

**Mr. Newton:** I thank the hon. Gentleman for his welcoming words about some aspects of the statement. I readily note that in committee his hon. Friends raised the issue of 16 and 17-year-olds, and I am glad that we have been able to respond in the way that we have.

I believe that the hon. Gentleman's remarks about prescription charges are exaggerated, especially when one considers that last year's increase of 20p was followed by the largest increase in the number of prescriptions dispensed for some years. There is no serious evidence of the deterrent effect to which the hon. Gentleman referred.

With regard to exemptions, the hon. Gentleman will know that my predecessor made it clear that the Government did not think it right to reopen the general list of exemptions, but rather to focus especially on ensuring that effective arrangements were available to those on low incomes. We have consistently sought to do that.

I believe that the hon. Gentleman is labouring under some misapprehension with regard to pay beds. It should be clear to the House that such beds are pay beds only when they are occupied by a paying patient. It other times they are available to, and are used by, the NHS. I readily accept that not as much income has been made from such beds as we would like. Indeed, one of the aims of the Health and Medicines Bill is to increase the capacity of the Health Service to raise additional sums from such beds, for the benefit of NHS patients. I see nothing wrong or foolish about that.

I shall look into the point that the hon. Gentleman has raised about Merton and Sutton, which is new to me, and write to him if necessary.

With regard to the hon. Gentleman's comments about revenue available to the Treasury, it should be remembered that the background to this statement is an increase of no less than 43 per cent., in real terms, in expenditure since 1978-79 on our primary care services and plans for substantial additional real spending over the next two to three years.

**Several Hon. Members** *rose*——

**Mr. Speaker:** Order. I am bound to have regard to the fact that this is an Opposition day, on which there are two important debates, and some heavy business after that. I shall allow questions to go on until 20 minutes past 4. I am sure that we shall return to this matter, and therefore I ask hon. Members to ask one question rather than several.

**Mr. Roger Sims** (Chislehurst): Is my right hon. Friend aware that his statement will be warmly welcomed on the Conservative Benches, especially in respect of spectacles and diabetic prescriptions? Is he aware that, every day, people pay, and expect to pay, enormous sums of money for toothpaste, ointments and a whole range of proprietory medicaments for which no prescriptions are required? Does that not put into perspective the reaction to charges for those items for which prescriptions are required? Indeed, as my right hon. Friend said, prescriptions are paid for by only a quarter of those for whom they are written.

**Mr. Newton:** I am grateful to my hon. Friend for his comments. I agree that more than 75 per cent. of items are dispensed without charge, and indeed approaching half the population are exempt from prescription charges. I believe that that puts the matter into perspective.

**Mr. Ronnie Fearn** (Southport): We welcome the initiatives on eye-testing, dental charges and blood glucose testing about which we are keen. Will the Minister clarify what he means by the increase in prescription charges of 8·3 per cent., which is above the rate of inflation? The phrase "the cost of medicines" is rather bogus, because 20p is way above what the pharmaceutical people believe the increase should be. Will pharmacists be advised to give the people the right formula; in other words, will they be told that they should be using the cheapest, but best, forms of medicine?

**Mr. Newton:** We would always hope that that principle would apply. Equally, if pharmacists are aware that an item that has been prescribed is available without prescription at a lower price, it is entirely reasonable to draw that to their customers' attention. Prescription charges are, necessarily, an averaging process, and I do not make any great apology for that.

It is true that the increase in prescription charges is greater than the general rate of inflation, but the price of medicines — partly because of advances — is rising somewhat faster, and the increase is in line with the rise in the cost of medicines.

**Mr. Jerry Hayes** (Harlow): I warmly welcome my right hon. Friend's enlightened statement on charges. However, will he accept that while the increase in the value of the spectacles voucher is also welcome it will not be of much benefit if, in a few months' time, he announces the abolition of the free eyesight check, because that will simply deter many people from getting their eyesight checked in the first place?

**Mr. Newton:** My hon. Friend and I discussed this matter at some length in Committee. I made the point then that nearly three quarters of those entitled to spectacle vouchers spend sums well in excess of £10 over and above the value of the spectacle voucher when purchasing their spectacles. As far as we can judge, they do that voluntarily, and that must cast some doubts on my hon. Friend's proposition about the alleged deterrent effect of our sight testing proposals.

**Mr. Max Madden** (Bradford, West): As my hon. Friend the Member for Livingston (Mr. Cook) said, there is a general welcome for parts of the Minister's statement. However, many members of the public will be extremely angry that the Minister has seen fit to increase prescription charges for the 13th time since the Government came into office, when the Chancellor of the Exchequer is sitting on a mountain of money. Does the Minister not recognise

that on this occasion he could have announced that there would be no increase in prescription charges? That would have been very welcome at a time when the vast majority of people want to make Budget day National Health Service day. Will the right hon. Gentleman give a clear undertaking that, as he has found it impossible to halt the increase in prescription charges, he has no intention of increasing any NHS charges for the remainder of the year?

**Mr. Newton:** We have made it clear that we have no plans of the kind that the hon. Gentleman adumbrated in the latter part of his remarks.

Prescription charges need to be considered against the background of the cost of drugs. These charges still raise a good deal less than 10 per cent. of the total cost of drugs, which has been increasing very rapidly. It is not an unreasonable policy to increase charges at least in line with the rise in the price of drugs.

**Mr. Robert McCrindle** (Brentwood and Ongar): Will my right hon. Friend accept that some of us who make no secret of our wish for additional funding for the National Health Service will nevertheless find it possible to accept the increase in prescription charges that he has announced? Whereas there are some things that only Governments can do — for example, authorising the building of new hospitals and meeting increased payments to nurses—there are some ways in which we can help ourselves. Therefore, for those of us able to afford it the additional 20p on prescription charges it is quite acceptable.

**Mr. Newton:** I am most grateful to my hon. Friend for his supportive remarks.

**Mr. Harry Ewing** (Falkirk, East): Opposition Members are concerned with those who cannot meet the additional 20p. The Minister said that his right hon. and learned Friend the Secretary of State for Scotland would make a similar announcement. Will that take into account the remarks of the Secretary of State in his commentary on public expenditure in Scotland the week before last, in which he showed clearly that Scotland still has the largest number of deaths from heart disease and cancer in the United Kingdom? Does the Minister honestly believe that increasing prescription charges will do anything to solve that very serious problem?

**Mr. Newton:** The generality of our plans for he primary health care services—which go much wider, although in some ways they are related to today's announcement—is directed at improving preventive measures, the early detection of ill health and early action to stop it getting worse. That entails the sort of moves that we plan for the development of general medical services, to which some of the proposals that I have announced will contribute.

**Mr. Peter Thurnham** (Bolton, North-East): Does my right hon. Friend agree that his proposals provide a welcome opportunity for diabetics to look after their own health more effectively and so improve the quality of their lives?

**Mr. Newton:** One of the purposes of last year's move on syringes and this year's move on blood glucose testing strips is to encourage diabetics to have more regular contact with their general practitioners, many of whom now run diabetic clinics. We are anxious to encourage that, and I am sure that that is in the general long-term interest of good health care for diabetics in this country.

**Mr. Dafydd Wigley** (Caernarfon): If the Minister is serious about preventing worsening health, surely he must think again about the charges for eye testing. May I press him for clarification on what he said about the transition from supplementary benefit to income support and family credit? Will there be any groups that could lose on benefit and be sustained by the guarantee that has been given by the Government? If that is the case, will that guarantee also operate on passporting for prescriptions?

**Mr. Newton:** There are two separate points. One concerns the move from supplementary benefit to income support and from family income supplement to family credit, where passporting will have the same effect as the transition itself. Of course, many more families will be in receipt of family credit than are currently in receipt of family income supplement. On the law-income scheme above those levels, the effect is more complicated. That is partly because it is extremely complex now and the scheme does not work very well. As I said in my statement, we shall try to bring forward a simpler and speedier scheme. It would be right for the hon. Gentleman to look at the details of that when my hon. Friends are able to bring it forward.

**Dr. Michael Clark** (Rochford): Is my right hon. Friend aware that the cost of the blood-testing strips was a burden on a considerable number of diabetic patients and that they will greatly welcome his statement? Will the availability of blood-testing strips on prescription apply to all strips, or just to a proprietary few? If the blood-testing strips are improved by advancing medical technology, will my right hon. Friend consider allowing those to be available on prescription without any delay?

**Mr. Newton:** I shall consider the point raised by my hon. Friend in the latter part of his question.

**Mr. Robert N. Wareing** (Liverpool, West Derby): Does the Minister agree that it is totally immoral to increase the tax on the sick, including those with multiple sclerosis and asthmatic diseases, just a fortnight before the Chancellor is planning a decrease in taxes on the very rich and often able-bodied people? When the Minister talked about an increase of 43 per cent. in real terms in spending on the NHS, is that in terms of the retail prices index, or of the actual cost to the NHS?

**Mr. Newton:** The figure is related, not to the NHS as whole, but to the family practitioner services, which are the primary focus of the statement. I do not agree with the hon. Gentleman's moral strictures. Indeed, they are absurd, when about half the population are exempt from prescription charges, over three quarters of all items dispensed are dispensed free, when there are expensive exemptions on medical grounds and when there are important season ticket arrangements, which help many of those who need regular prescriptions.

**Mr. Derek Conway** (Shrewsbury and Atcham): My right hon. Friend's £8 million announcement on glucose strips is as welcome as the statement last year on free syringes for diabetics. It will help to make their lives more liveable. So that we are not awash with crocodile tears when the orders are laid before the House, will my right hon. Friend reiterate that 75 per cent. of prescriptions are free, and that when the Labour party was propped up in power by the Liberals there was a charge, or as the Opposition put it, a tax, on sickness under that regime?

**Mr. Newton:** Yes. I can readily agree with my hon. friend.

**Mr. Kevin Barron** (Rother Valley): Will the Minister accept that the deterrent effect of charges on primary health care is likely only to put pressure on the acute services, which are already under-funded? Will he accept that the future of health care will look very grim until we stop charging for primary health care and do something about getting the nation's health into proper repair?

**Mr. Newton:** The whole programme put forward in the Government's White Paper on primary care and the generality of the measures being debated currently on the Health and Medicines Bill are designed to achieve precisely the significant further improvement in the primary care service that the hon. Gentleman wishes to see. We obviously disagree about whether it will bring about improvement, but my judgment is that it will, and the proof of the pudding will be in the eating.

**Mr. Chris Butler** (Warrington, South): My right hon. Friend will be aware that general practitioners and pharmacists often do not recommend to their patients that they can buy over the counter more cheaply than they can obtain some things on prescription. Will he consider encouraging pharmacists to issue a receipt showing the cost of the drugs dispensed to patients, so that they are able to make the decision themselves, and, in other cases, to enable them to adjudge the great value for money that they receive from the massive cost of the drugs that can be dispensed?

**Mr. Newton:** That is an interesting suggestion and I shall consider it. I would hesitate to go snap on it at the moment, in view of the possible administrative costs entailed.

**Mr. Martin Redmond** (Don Valley): Bearing in mind that a vast number of people are caught in the poverty trap and cannot afford today's prescription charges, what provision does the Minister intend to make to ensure that they receive adequate medicine free?

**Mr. Newton:** I have already referred to the Government's intention to bring forward proposals for a simpler and quicker low-income scheme for those above the direct passporting from income support or family credit, as it will be. We share the aim of avoiding the difficulty to which the hon. Gentleman referred, and I am hopeful that our proposals will do just that.

**Mr. John Marshall** (Hendon, South): Does my right hon. Friend agree that much of the indignation from Opposition Members is bogus and synthetic, as the increase is less than the cost of a bar of chocolate, and as Labour Governments have promised to abolish the prescription charge but have failed to do so? Is my right hon. Friend aware that many Conservative Members would contribute to a season ticket for the cure of verbal diarrhoea for the Leader of the Opposition?

**Mr. Newton:** I do not think that I would care to go down precisely the track advocated by my hon. Friend in the last part of his remarks. However, I endorse the first part of his question and would add that I am advised—this is against the background of the wide range of exemptions—that the average spending in this country on alcohol is now £8 per adult per week.

**Mr. Barry Jones** (Alyn and Deeside): Is it not unjust to put up prescription charges when the Government are putting through Parliament a measure such as the poll tax? Does the Minister know that under that tax as envisaged his grace the Duke of Westminster will be £7,000 per annum better of? Is it not unjust to announce higher prescription charges when the duke will not have any problem in paying the higher charges?

**Mr. Newton:** I have enough problems of my own, without getting into the poll tax.

**Mr. Rhodri Morgan** (Cardiff, West): I welcome what the Minister said about blood strips for diabetics, but how does he justify the increase in prescription charges for others who are chronically sick? This is perhaps one thing in life that I share with the Parliamentary Under-Secretary of State for Health and Social Security, who is sitting alongside the Minister. Many British holidaymakers have found that if they forget their inhalers they can obtain them more cheaply over the counter in France than they would in this country, with all the benefits of the NHS. With the latest increase in prescription charges, will the Minister tell the House how many countries in the EEC sell items such as asthma inhalers over the counter at a cost lower than they can be obtained on prescription in this country?

**Mr. Newton:** I am afraid that I cannot give the hon. Gentleman the information he seeks. However, I have said already that the prescription charge scheme is almost inescapably an averaging arrangement, and that implies that some people will receive their drugs more cheaply than they could in other ways, but others may find that they are a shade more expensive. I accept that.

**Mr. Tony Banks** (Newham, North-West): Will the Minister tell the House why the price of medicines has gone up so much? He announced an 8 per cent. increase in prescription charges, which is twice the rate of inflation, and he said that that was because of the increase in the price of medicines. Is that not indicative of the excessive profits being made by the pharmaceutical industry? Is it not true that if he took steps to prevent that industry from creaming off money from British taxpayers he would have more money at his disposal to devote to primary health care?

**Mr. Newton:** I have to say that, following the introduction of the new pharmaceutical price regulations scheme, I do not think that the hon. Gentleman's perception would be shared by the industry. Great sums of money are invested in drugs, but the cost of producing them does rise. We are anxious to keep costs under maximum control, but the price has risen by 8 per cent. and that is the background against which I have made the announcement.

**Mr. Dennis Skinner** (Bolsover): Does not the Minister's argument contain a curious logic? He said that when prescription charges are increased it will not be a deterrent to the sick who have to purchase various commodities. However, he uses the alternative argument—as his right hon. and hon. Friends will on Budget day—of saying that there is a deterrent for those in the higher income bracket who have to pay tax on 60p in the pound and that we should remove that deterrent so that they will work harder. The truth is that that curious logic has meant that the Minister has had to make this statement today so that

it is not made on Budget day, because the Government do not want the Budget to look really bad by increasing prescription charges while giving high rate taxpayers probably hundreds and hundreds of pounds per week.

**Mr. Newton:** I do not see any connection between the two lines of argument. The Government's taxation policies have contributed to the substantial increase in economic resources that are enabling us to sustain the services that we are discussing today. I do not believe that a charge of £2·60, levied, at most, on only half the population, will have a deterrent effect when people are ill, as the hon. Gentleman suggested.

*Following are the charges:*

*Optical voucher values and charges from 1 April 1988*

| | | *New values* £ | *Percentage increase* |
|---|---|---|---|
| (1) Single vision spectacles | | | |
| Voucher type | A £14·25 | 15·50 | 8·8 |
| | B £22·00 | 25·50 | 15·9 |
| | C £33·00 | 42·00 | 27·3 |
| (2) Bifocal spectacles | | | |
| Voucher type | D £27·00 | 29·50 | 9·3 |
| | E £42·00 | 50·00 | 19·0 |
| | F £66·00 | 85·00 | 28·8 |
| (HES only) | G £66·00 | 85·00 | 28·8 |
| (3) Amounts added to voucher value for clinically necessary: | | | |
| Prisms £3 per lens (single vision) | | 3·50 | 16·7 |
| £4 per lens (bifocal) | | 4·50 | 12·5 |
| Tints £3 per pair (single vision) | | 3·50 | 16·7 |
| £4 per pair (bifocal) | | 4·50 | 12·5 |
| (4) Complex lens vouchers for those not entitled to standard vouchers: | | | |
| Single vision | £2·00 | 3·00 | 50 |
| Bifocal | £14·00 | 17·00 | 21 |
| (5) Hospital Eye Service Maximum Charges: | | | |
| Single vision | £29·00 | 32·00 | 10 |
| Complex lenses | £50·00 | 52·00 | 4 |
| Contact lenses: charge per lens | £25·00 | 25·00 | — |
| *New Supplements* | | | |
| Supplement for children needing very small glasses | | 30·00 | — |
| Hospital Eye Service only: | | | |
| *(a)* Supplement for people needing specially-made frames | | 30·00 | — |
| *(b)* Supplements for people prescribed photocromic lenses for clinical reasons: | | | |
| (i) single vision | | 3·00 | — |
| (ii) complex lenses | | 4·00 | — |

*Prescription charges from 1 April 1988*

| *Charges proposed* | *Present charge* £ | *New charge* £ | *Percentage increase* |
|---|---|---|---|
| Charge per item | 2·40 | 2·60 | 8·3 |
| Season tickets: | | | |
| 4 monthly | 12·50 | 13·50 | 8·0 |
| Annual | 35·00 | 37·50 | 7·1 |

*Dental charges from 1 April 1988*

| | *Present charge* £ | *New charge* £ | *Percentage increase* |
|---|---|---|---|
| *Dentures* | | | |
| Metal based dentures having: | | | |
| 1-3 teeth | 50 | 64 | 28 |
| 4-8 | 42 | 69 | 33 |
| more than 8 teeth | 55 | 71 | 29 |
| Synthetic resin based dentures having: | | | |
| 1-3 teeth | 26 | 26 | — |
| 4-8 teeth | 28 | 34 | 21 |
| more than 8 teeth | 30 | 40 | 33 |
| *Maximum charges for more than one synthetic resin denture* | | | |
| Synthetic resin based full upper and full lower dentures | 47 | 59 | 26 |
| Any other combination of synthetic resin based dentures | 47 | 62 | 32 |
| *Bridges* | | | |
| An acid-etched retained bridge | 50 | 65 | 30 |
| Any other bridge | 50 | 150 | 200 |
| *Crowns* | | | |
| High gold alloy | 63 | [1]51 to 55 | −19 to −13 |
| Other alloy | 33 | [1]26 to 42 | −22 to +27 |

[1] Charges will vary depending on type of crown and materials used.

| | | | Percentage |
|---|---|---|---|
| *Other treatment* | Full cost up to £17: 40 per cent. of cost above £17 | 75 per cent. of cost | −25 to about +50 depending on cost |
| *Maximum charge for course of treatment* | £115 | £150 | 30 |

*Daily charges for services provided for overseas visitors as in-patients as at 1 April 1988*

| | *Class of hospital in which services are provided* | *Single room* £ | *Shared accommodation* £ |
|---|---|---|---|
| Class A | Long-stay hospitals | 93 | 84 |
| Class B | Psychiatric hospitals | 85 | 77 |
| Class C1 | Mainly acute and other hospitals in non-teaching districts | 149 | 136 |
| Class C2 | Acute and other hospitals in non-teaching districts | 170 | 154 |
| Class D | Hospitals in London teaching districts (other than hospitals in Classes A and B) | 231 | 210 |
| Class E | Hospitals in provincial teaching districts (other than hospitals in Classes A and B) | 185 | 168 |
| Class F | London Postgraduate Teaching Hospitals managed by Special Health Authorities except the Hospitals for Sick Children and the National Heart and Chest Hospitals | 253 | 230 |
| Class G | The Hospitals for Sick Children and the National Heart and Chest Hospitals | 392 | 357 |

*Charges for services provided for overseas visitors otherwise than as in-patients as at 1 April 1988*

| *Services provided* | *Hospital class A to E* £ | *Hospital class F and G* £ |
|---|---|---|
| 1. For a patient on each attendance at a hospital other than attendances directly associated with the procedures listed in paragraphs 4-12 following. | 14·50 | 21·50 |
| *Day Cases*[1] | | |
| 2. Charges per day exclusive of charges for procedures listed in paragraphs 4-12 following. | 28·50 | 29·50 |
| *Day Patients*[2] | | |
| 3. Charges per day exclusive of charges for procedures listed in paragraphs 4-12 following. | 34·00 | 35·00 |
| *Pathology* | | |
| 4. For each request. | 7·50 | 15·00 |
| *Radiodiagnosis, Nuclear Medicine and Ultrasound* | | |
| 5. (i) For each procedure listed in Appendix D (charge per Korner unit value). | 6·50 per unit for the first 6 units, 1·00 per unit thereafter | 9·00 per unit for the first 6 units, 1·25 per unit thereafter |
| (ii) CT Scanning. For all scans | 96·00 | 115·00 |
| *Radiotherapy* | | |
| 6. For treatment in any one day | 18·00 | 45·00 |
| *Physiotherapy and Remedial Gymnastics* | | |
| 7. Per attendance | 5·50 | 11·50 |
| *Occupational Therapy* | | |
| 8. For treatment in any one day | 8·50 | 10·00 |
| *Other Diagnostic Procedures* | | |
| 9. (i) Audiometry | 5·00 | 5·00 |
| (ii) Electrocardiography. For each testing session. | 9·50 | 17·50 |
| (iii) Electroencephalography. For each testing session | 38·50 | 83·50 |
| (iv) Electromyography. For each testing session | 24·00 | 50·50 |
| *Use of Operating Theatre Facilities* | | |
| 10. Operating theatre facilities booked as required: | | |
| (i) For less than 10 minutes | 22·50 | 28·00 |
| (ii) For 10 minutes to 30 minutes | 44·00 | 56·00 |
| (iii) For more than 30 minutes | 67·00 | 84·00 |
| *Dialysis* | | |
| 11. For haemodialysis or intermittent peritoneal dialysis: | | |
| (i) With training or routine at a hospital per session | 111·00 | 111·00 |
| (ii) Routine, at home—per session | 70·50 | 70·50 |
| (iii) Minimal Care Unit—per session | 90·50 | 90·50 |
| For continuous ambulatory peritoneal dialysis (including continuous cycling peritoneal dialysis)—per day. | 33·50 | 33·50 |
| *Supply of Drugs and Medicines* | | |
| 12. For the supply of a drug or medicine which is designed to eliminate, prevent the replication of, or in any way inhibit the mode of action of any Human Immunodeficiency Virus — for each quantity sufficient for one day's treatment. | 14·50 | 14·50 |

[1] For the purpose of this item a day case is a patient who attends as a non-resident patient for investigation, treatment or operation and who occupies a bed without staying overnight.

[2] For the purpose of this item a day patient is someone who attends regularly for a course of treatment without necessarily occupying a bed or staying overnight.

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10.

PRIME MINISTER

## THE NHS CRISIS: A PRIORITIES APPROACH

The NHS already operates a system of priorities. Accidents, emergencies and dangerous acute conditions will all receive immediate treatment. But this is not widely known. Press coverage, shroud-waving consultants, management failures, the mal-distribution of resources have all combined to give the impression that the NHS is in a state of chaos in which people in urgent need of life-saving care do not receive it. This is a key influence on public opinion. If a patient who needs a new hip thinks that he and a heart patient are being kept waiting (and dying) because of a mean-spirited Government, he will be angry. But if he realises that he is waiting so that heart patients can be treated promptly, he will be pacified.

Making priorities explicit leads to a proposal to tackle the waiting list problem by giving guaranteed maximum waiting times for certain treatments. If a patient's District Health Authority had not given him treatment when that time expired, he would receive a voucher for full-cost treatment at any hospital, NHS or private, in the country. Categories would therefore be expressed in terms of the waiting time guarantee as follows:

(i) Treatments requiring immediate assistance: this might include accidents, emergency admissions, coronary thrombosis, deep-vein thrombosis, pulmonary embolism, strokes (of various types), perforated ulcers, acute pancreatitis, meningitis and other infectious diseases, etc., etc.

(ii) Conditions requiring treatment within three weeks: e.g. all malignant disease, cancer of the colon, breast, stomach; etc., life-threatening diseases, e.g. investigation of haematuria; many

forms of chronic heart disease, TB.

(iii) Conditions requiring treatment within three months: e.g. conditions which are either painful, or interfering with the patient's life, or produce insomnia; enlarged prostate, hysterectomy for severe menorrhagia, etc.

(iv) Conditions which require treatment within six months: e.g. gall stones, haemorrhoids, hip replacements; conditions which, if untreated, would produce disability; some cataracts.

(v) Conditions which will receive treatment, but with no promise about timing: e.g. cosmetic surgery which is recommended for psychological reasons; minor orthopaedic disabilities; removal of benign skin conditions; uncomplicated varicose veins; persistent disc lesions.

(vi) Conditions which should be treated outside the NHS altogether: e.g. vasectomy, or reverse vasectomy; tattoo removals; sub-mucosal re-section; cosmetic operations; health promotion; alcoholism.

The above table is included for purely illustrative purposes. It would require a committee of doctors to draw up such a list in reality.

Consequences

A system which combines priorities and cash limits must have a "residual" category of treatments which loses resources to the priority treatments when they run up against the limits of their budgets. In the above list this is category (v).

In effect, operations for categories (ii), (iii) and (iv) will continue all year round without let or hindrance - eliminating incidentally the damaging practice described in an earlier DHSS paper in which specialist wards are closed and nurses let go because greater efficiency has resulted in

budgets being exhausted before the end of the financial year. This would happen, of course, in category (v) where at some point operations might cease in order to leave fungible resources free for elsewhere. But the rationale that such resources were being transferred to patients suffering from more serious conditions would be widely known.

A second problem is that new treatments emerge over time, often demanding more resources. These would have to be placed in one of the categories. To decide such matters, there would need to be a Standing Committee on Medical Priorities.

People's knowledge that they might have to wait three months, six months or for an indefinite period would markedly increase the incentive to take out "topping-up" insurance for such conditions. It would also induce private insurance companies to offer and market low-cost insurance schemes targeted to those same conditions. (There is at present an insurance company which offers treatment directly linked to the waiting list. If a patient has been on a NHS waiting list for more than six weeks, he can obtain treatment under the scheme for a low premium.)

It is, finally, worth noting that a system of priorities is compatible with <u>any</u> organisation of health care. If the Government were to adopt a HMO-based system, for instance, this categorisation of priorities would then become the basis of the "NHS minimum package".

<u>Advantages</u>

We can therefore sum up the likely results of a NHS priority system as follows:

(i) It reconciles patient choice with cash limits, and therefore makes a true internal market possible.

(ii) It re-assures the general public that life-threatening conditions will be promptly dealt with and that painful conditions will be dealt with in a reasonable specified time.

(iii) It makes the sacrifice of those queuing for category (v) treatments more acceptable to them by establishing clearly that it is the price for saving other people's lives.

(iv) It forces DHAs to face up to questions of allocating scarce resources, including the consultants' time, at the start of each financial year. It also gives DHA managers an incentive to "place" their patients with another authority before the guarantee expire and they have an obligation to fund an operation in the private sector.

(v) It increases the incentive to take out "topping-up" insurance for conditions that either carry an indefinite time limit in the NHS or are not provided by it at all.

(vi) It provides Ministers with arguments - based on need and social justice - which Socialist opponents will find hard to counter. the political equivalent of ju-jitsu.

Recommendations

I therefore recommend that you establish a Committee of Inquiry, composed of two doctors and one health economist, with the clear brief to report back in not more than six months on (a) health priorities in general, and (b) the establishment of categories of urgency for treatment based upon guaranteed maximum waiting times outlined in this paper.

JOHN O'SULLIVAN

(+ attachments HC 1-12) One paper

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PRIME MINISTER

NATIONAL HEALTH SERVICE
(Relevant Papers: Cabinet Office note on Issues for Meeting on 29 February; background papers HC1 to 12)

DECISIONS

1. The Group has before it twelve background papers which it commissioned when it last met, with a covering paper by the Cabinet Office. You may wish to concentrate on three main things.

2. First, you will wish to invite discussion on points of interest in the papers and commission further work as necessary. The Cabinet Office paper suggests some highlights. It will not be possible to go through all the papers in detail; but they are intended to provide a quarry of background information as the exercise develops.

3. Second, you may wish to take decisions on immediate issues which emerge from the papers. For instance:

i. consultants' contracts (paper HC3). The DHSS had been intending to open up a major initiative on consultants' contracts in the next few weeks. This is a key area which will certainly have to be tackled. The question is when. Should they wait until the work of the Group is further advanced?

ii. information about costs, budgeting etc. (paper HC6). The DHSS spell out their timetable for introducing pricing and budgetary controls. You may wish to urge them to speed it up;

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iii. audit (paper HC11). The Treasury have put in a paper on the scope for independent audit of efficiency in the NHS. The DHSS at official level do not agree the paper. Even so, do you want action to be put in hand on one of the three main options outlined?

4. Third, and most important, you may wish to set the Group's sights on longer-term reform of the NHS. The papers before the meeting deal with the NHS as it is. Analysing its present problems is clearly important. But it will also be very important to develop a view on where the NHS should be going in the long term and not get bogged down by immediate issues. The Cabinet Office paper proposes that officials should now concentrate on producing a paper on longer-term change: an outline is attached to the paper. You may wish to conclude the meeting by asking for this to be prepared for another meeting in 2 or 3 weeks' time.

ISSUES

5. We have pressed Departments to complete these papers as quickly as possible, so as to clear the way for the major work of the Group which is long-term reform of the NHS. Once it is clear where the NHS should be going in the long term, the immediate issues (eg consultants' contracts) can be dealt with in a manner which paves the way for long-term change. There is a risk that if the Group spends too long on issues such as budgeting and audit at this stage, it may end up with a modest refurbishment of the present NHS structure.

Points for immediate decision

6. You may therefore wish to deal with the papers reasonably briskly, concentrating on any issues where you wish to give an immediate steer to Departments. Possible points are:

a. consultants' contracts. The medical profession may well be one of the most difficult obstacles to NHS reform. Discussions with them when the review is complete will need careful

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handling. You may wish to consider whether DHSS should launch a major initiative on consultants' contracts straightaway or leave it until the Group has a clearer view of how the NHS should be reformed;

b. budgets and pricing. DHSS's timetable for introducing budgetary control in the NHS still seems very long: 1990 at the earliest (paragraph 10 of HC 6). Their emphasis on accurate apportionment of overheads suggests that they may be trying to achieve a perfect system which no private sector company could afford to wait for. Would it not be better to decide to introduce budgetary control with effect from, say, 1 April 1989 on the basis of whatever is the best information available by that time?

c. efficiency audit (HC 11). There is disagreement between the DHSS and Treasury about the scope for introducing an independent audit of efficiency. Paper HC 11 is not agreed by DHSS. The reasons for their opposition are unclear. You may wish to ask the Secretary of State for Health for his view. The case for extending the scope of the Audit Commission appears strong (although it would need legislation).

d. Scope for increased charging. (HC 12). The Treasury are still pressing strongly the case for increased charges. If the point is raised you may wish to say that this issue should be set aside and not brought back into discussion until the Review is much further advanced and there is a clear view on where the NHS should be going in the long term.

I agree that my parent department is unduly obsessed with this issue at present. PRCB.

## Options for long-term change

7. The Cabinet Office paper proposes that officials should now prepare a paper on the options for longer-term change. An outline is attached to the paper. It envisages three main sections:

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i. changes within the existing NHS. This will look at what could be done within the framework of the present system. It may well be relevant to deciding what steps can be taken now to prepare the way for longer-term change.

ii. new structures. This will be directed primarily at models based on Health Maintenance Organisations in the United States.

iii. changes in methods of finance. The main option here is likely to be transferring funding of the NHS from general taxation to National Insurance Contributions, or some similar contribution invented to cover health, with provision for contracting out..

8. We have prepared a note which goes over this ground, attached to this brief.

RTJW.

R T J WILSON

Cabinet Office
26 February 1988

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# Competition and patient choice in the NHS

This paper covers two of the subjects listed in paragraph 7 of the Cabinet Office note of 5 February:

- Ways of introducing greater competition into the NHS to promote the efficient allocation of resources.

- How to promote patient freedom of choice, both as a desirable end in itself and to promote competition.

The two subjects need to be considered together, since patient freedom of choice is an important part of competition.

## The problem

2. The problems are:

a. Most patients have no say in when, where, how or by whom they are treated.

b. In principle GPs already have freedom to direct patients to the authorities of their choice, but in practice do not always do so.

c. There are at present no routine patient or treatment related costing systems in the NHS, and so no way of choosing the authority or hospital providing the cheapest treatment for any particular illness. This is the subject of a separate paper.

d. There are no financial incentives on hospitals to attract more patients. Indeed, hospitals suffer financially if they do so.

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Internal trading in the NHS

3. One way of attacking thse problems would be to introduce more internal trading in the NHS. One authority could buy care from another, on repayment, if the costs of the second were lower. The repayment would provide the cheaper authority with the incentive to attract the extra work. For such a system to work, it would be necessary for more treatment-related cost information to be available.

4. This change might not by itself be very great. The bulk of health care would continue to be provided by the NHS, and the bulk of financing would continue to come from tax. Decisions about when and where to trade would be primarily for the authorities. But it would open the way to more far-reaching changes, for example by:

a. Extension of the same principle to hospitals rather than authorities so that hospitals which provided a particular treatment at relatively low cost could provide that treatment for other authorities or hospitals on repayment. This would require budgetting to be much more decentalised than at present.

b. Including the private sector in the arrangement, so that an independent hospital could provide services to the NHS on repayment. This is starting to happen already. If it happened more systematically it would lead to more competition, and cross-fertilisation between the public and private sectors.

c. Systematic competition between authorities, or between hospitals, with the patient or his GP making the choice between them. Such competition would mean a more radical change in the present structure of the NHS, and could take various forms. It is the subject of the following paragraphs.

Competition between authorities, or hospitals

5. The first step would be for District Health Authorities to compete for GPs to refer patients to them for individual courses of treatment and for their funding to be adjusted according to their success. Since GPs already have the freedom to direct patients to the authority of their choice, this would not in principle be an innovation. But in practice it would be, if applied on any scale, and would require a big psychological change on the part of GPs and authorities. Such a change would be encouraged, in the case of the authorities, by adjusting their funding to allow for their success in attracting patients. The possibility of some incentives for GPs might also be considered.

6. A further step would be for the District Health Authorities to act as Health Maintenance Organisations. HMOs, which were originally developed in the United States, contract to provide all necessary treatment for a fixed sum for a fixed period. Competition between the HMOs would then be to provide all necessary care for patients enrolled with them for a fixed period, rather than (as in paragraph 5) for individual courses of treatment.

7. The position of GPs in the new structure would require further thought. The assumption has been that it would be the GPs, rather than patients directly, who would refer them to DHAs. Since the choice of GP would be a matter for patients, this would be consistent with considerable freedom of choice. But another alternative would be for the GPs to be part of the HMO themselves, and for the patient to choose the HMO.

8. This form of competition would still be consistent with the NHS providing the bulk of health care, and being financed mainly from tax. Funding arrangements for the DHA/HMOs would also be essentially as at present, but with payments adjusted according to their success in attracting patients. Again, though, it would be possible to develop this model, if necessary gradually, in more radical directions. For example:

a. The DHA/HMOs could operate at arm's length from the hospitals. They would place patients on contract with the hospitals they judged most efficient. Hospitals would compete among themselves. This development could also be naturally combined with selling off individual NHS hospitals to charities or independent trusts or the private sector.

b. HMOs could be set up in the private sector, which could compete with the DHA/HMOs, for NHS as well as private patients. This would probably require some change in arrangements for paying for the care for the NHS patients. One possibility would be a health credit which would cover the cost of obtaining care at a specified standard for a specified period from an HMO. The patient could then use the credit to pay for his subscription to the HMO, public or private, of his choice. Difficult questions would arise in deciding what level of health care could be provided by the credit. Depending on the level, the patient might choose to top it up from his own funds. The level would also determine the effect on public expenditure, although the credit mechanism would in any event have important implications for present methods of expenditure control. This alternative could encourage both the provision of more care by the private sector and more financing from private funds. In the longer term it might be possible to privatise the successful DHA/HMOs.

Opting Out

9. Another possibility would be to transfer funding of the NHS from general taxation to either National Insurance Contributions (NICs) or a similar contribution specially created to cover health spending. There could be important distributional consequences which would have to be considered. This step would not in itself entail any change in the structure of the NHS, and

NHS spending would remain as public expenditure. Its significance is that it would make contracting out possible, which it is not while the NHS is financed mainly from tax. The contracting out could be either by the individual or by his employer and there would be a rebate on the contribution in respect of those contracted out. The approach would therefore be similar to that adopted by the Government for pensions. Further thought would need to be given to the extent of contracting out: whether for example it would be only for elective surgery or, at the other extreme, for a lifetime's health care. Ultimately the choice might be for the individual. In any case the rebate would be adjusted according to the extent of the contracting out. The pace of movement towards the new system would be determined by the rate at which the financing burden was shifted to contributions and contracting out was made progressively easier. The change could if necessary be made gradually.

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HC1

SPENDING ON THE NHS : Note by DHSS

A. Introduction

1. This paper considers what public expenditure on the National Health Service buys, both in terms of inputs and outputs, and the efficiency with which those outputs have been provided.

2. The National Health Service comprises:

* the Hospital and Community Health Services (HCHS), providing all hospital care and those community health services which are not provided by general practitioners such as district nursing and public health services.

* the Family Practitioner Services (FPS), providing medical, dental and dispensing services and some ophthalmic services, and covering the costs of medicines prescribed by general practitioners.

* Central Health and Miscellaneous Services (CHMS), a small number of services which need to be administered centrally eg European Community medical costs, welfare foods and special hospitals.

B. Inputs.

3. The NHS is financed primarily out of general taxation (85 per cent) with the remainder coming from National Insurance contributions (11 per cent) and general charges and receipts (4 per cent). The proportion of HCHS spending which is met from charges - 0.8 per cent - is relatively small, but is expected to increase to some 1.4 per cent by 1990/91 largely as a result of the income generation initiative. The remainder of this paper concentrates on HCHS spending.

4. Spending on the HCHS accounts for 73 per cent of public expenditure on the NHS (net of charges). Table 1, which compares the distribution of expenditure across major programmes for the years 1978/79 and 1987/88, shows that this percentage has fallen relative to the growth in FPS expenditure. (Annex A describes the breakdown of expenditure within each programme).

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Table 1: Distribution of (net) NHS Expenditure (England)

| | 1978/79 £m | % | 1987/88 £m | % |
|---|---|---|---|---|
| NHS | 6275 | 100.0 | 16646 | 100.0 |
| of which: | | | | |
| HCHS(total) | 4744 | 75.6 | 12214 | 73.3 |
| HCHS(current) | 4386 | 69.9 | 11374 | 68.3 |
| HCHS(capital | 358 | 5.7 | 840 | 5.0 |
| FPS(current) | 1369 | 21.8 | 3876 | 23.3 |
| CHMS(current) | 155 | 2.5 | 520 | 3.1 |
| Other NHS(capital) | 7 | 0.1 | 36 | 0.2 |

Hospital and Community Health Services

5. Some 93 per cent of net public spending on the HCHS represents current expenditure. Annex B shows where this expenditure goes now compared to 1978/79. Almost three quarters of gross current spending is accounted for by labour costs, of which expenditure on (NHS employed ) nurses accounts for a third of the total.

6. Table 2, which shows the change in numbers employed between 1978 and 1986 by main staff group, highlights the significant increases in those (doctors, nurses and professions allied to medicine [PAMs]) most closely associated with patient care.

Table 2: Growth in numbers of HCHS staff (000s)

| | 1978 | 1986 | % change |
|---|---|---|---|
| Total HCHS+ | 753.5 | 793.4 | 5.3 |
| Doctors | 37.8 | 43.2 | 14.3 |
| Nurses* | 351.0 | 402.7 | 14.7 |
| PAMs | 24.2 | 33.6 | 38.8 |
| Admin & Clerical | 100.3 | 111.4 | 11.1 |
| Ancillary** | 172.2 | 124.3 | -27.8 |

+ Figures for HCHS staff are based on whole time equivalents
* not adjusted for the reduction in contractual hours in 1981
** reduction in numbers primarily due to the 'competitive tendering' initiative

7. Capital expenditure represents some 7 per cent (£840 million) of net public spending. In 1987-88 this is expected to be supplemented by a further £200 million from land sales which health authorities retain.

C. Outputs.

8. Additional resources have bought still greater increases in patient activity as Annex C shows. Between 1978 and 1986 medical and nursing staff each treated 1.2 per cent per annum more inpatients and day cases.

9. In the acute sector ,which accounts for nearly half of all HCHS expenditure, this increase in activity has occurred across all ages but has particularly concentrated on the rising numbers of elderly and the very young ( Table 5 ). The former stems largely from an ability to carry out surgical and medical procedures that were previously not possible for older people. The latter reflects the increased ability of neonatal and maternity services to keep alive premature and low weight babies.

Table 5: Treatment rates (per 10000 population) by age group,acute sector.

| | 1978 | 1985* | % change |
|---|---|---|---|
| 0-4 | 1380.3 | 1554.2 | 12.6 |
| 5-14 | 575.9 | 644.7 | 11.9 |
| 15-64 | 797.6 | 862.7 | 8.2 |
| 65-74 | 1362.6 | 1668.6 | 22.5 |
| 75+ | 1736.5 | 2148.9 | 23.7 |
| All ages | 901.4 | 1032.7 | 14.6 |

* latest available data

10. This increase in treatment rates has occurred during a period when the number of available beds has been reduced in the process of rationalising services. While increased re-admissions account for a small part of the increase in activity, by far the greatest influence on the higher number of admissions has been a significant improvement in productivity reflected in such indicators as shorter average lengths of stay and turnover intervals. Table 6 illustrates these changes for the acute sector.

Table 6: Use of Facilities (Acute sector)

| | 1978 | 1986 |
|---|---|---|
| No. of available beds | 149913 | 131332 |
| Mean duration of stay (days)- all ages | 9.8 | 7.3 |
| Turnover Interval* | 3.6 | 2.5 |
| Throughput+ | 28.0 | 37.3 |

* Average length of time in days that a bed is unoccupied between the discharge of one patient and the admission of another.
\+ In-patient discharges and deaths per year per available bed

11. The 'final' output of the NHS should be a healthier and longer living population. Mortality rates across all age bands have fallen since 1978 and life expectancy increased as table 7a shows. Table 7b looks at the improvement in the standardised mortality ratios (which take account of changes in the age structure of the population) for a limited range of disorders where prompt medical intervention can often prevent death.

Table 7a: Mortality rates and life expectancy by age

| | 1978 | 1986 |
|---|---|---|
| Perinatal mortality* | 15.4 | 9.5 |
| Death rates:** | | |
| Males | 12.1 | 11.7 |
| Females | 11.4 | 11.4 |
| Life Expectancy:+ | | |
| At Birth | | |
| Males | 70.0 | 72.0 |
| Females | 76.2 | 77.9 |
| At 40 years | | |
| Males | 32.6 | 34.1 |
| Females | 38.1 | 39.4 |
| At 60 years | | |
| Males | 15.8 | 16.9 |
| Females | 20.4 | 21.5 |

* Per 1000 births
** Per 1000 population, all ages and from all causes
\+ In years, figures relate to triennial periods 1976-78 and 1984-86.

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Table 7b: Potentially avoidable causes of death (England & Wales)

| Cause | Age group | Percentage change in standardised mortality ratios 1978-1986 |
|---|---|---|
| Perinatal death | - | -38 |
| Tuberculosis[1] | 5-64 | -50 |
| Cancer of Cervix | 15-64 | -7 |
| Hodgkin's Disease | 5-64 | -22[3] |
| Chronic rheumatic heart disease | 5-44 | -76[4] |
| Hypertension/cerebrovascular disease | 35-64 | -30 |
| Surgical deaths[2] | 5-64 | -17[3] |
| Respiratory diseases | 1-14 | -58 |
| Asthma | 5-44 | -25[4] |

(1) Omits late effects of tuberculosis
(2) Appendicitis,choleolithiasis,cholecystisis and hernias
(3) 1979-85 percentage change shown as 1978 figures not available
(4) Figures likely to be distorted by revision of International Coding of Diseases.

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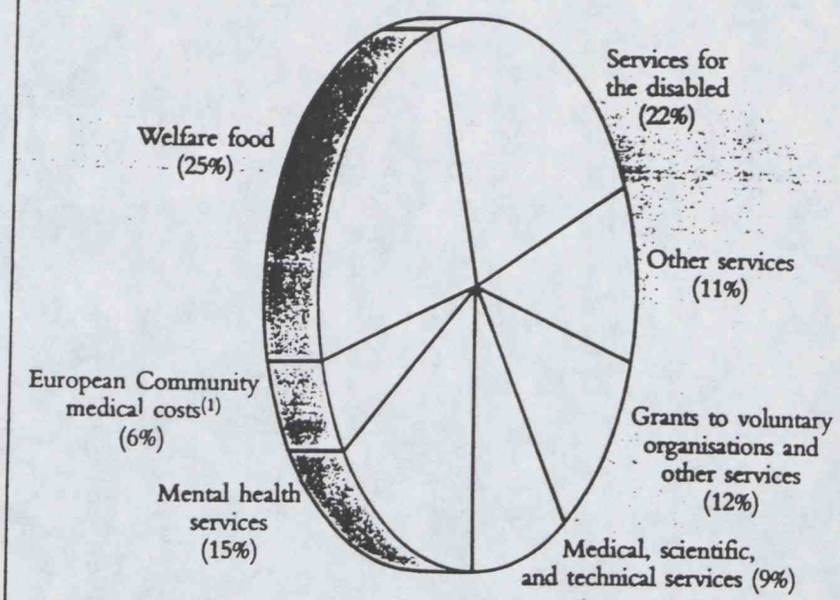
Annex A

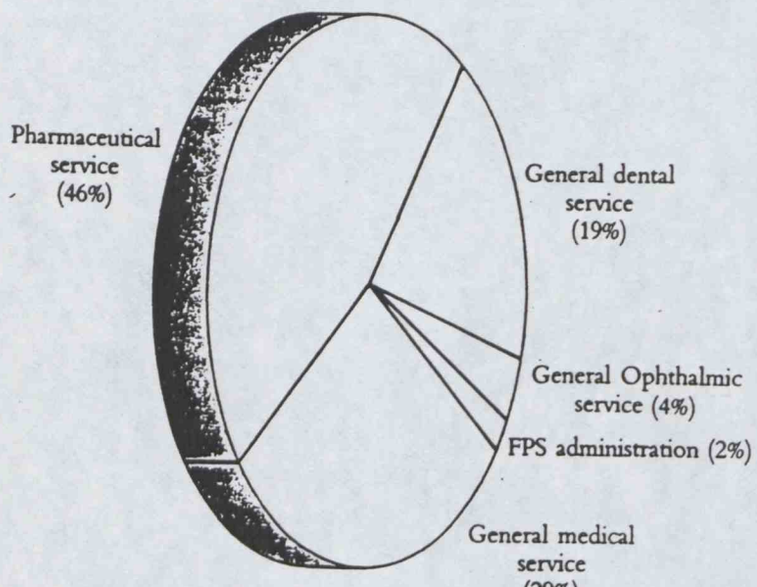
Distribution of NHS Expenditure

**Central health and miscellaneous services (gross expenditure) 1986–87**

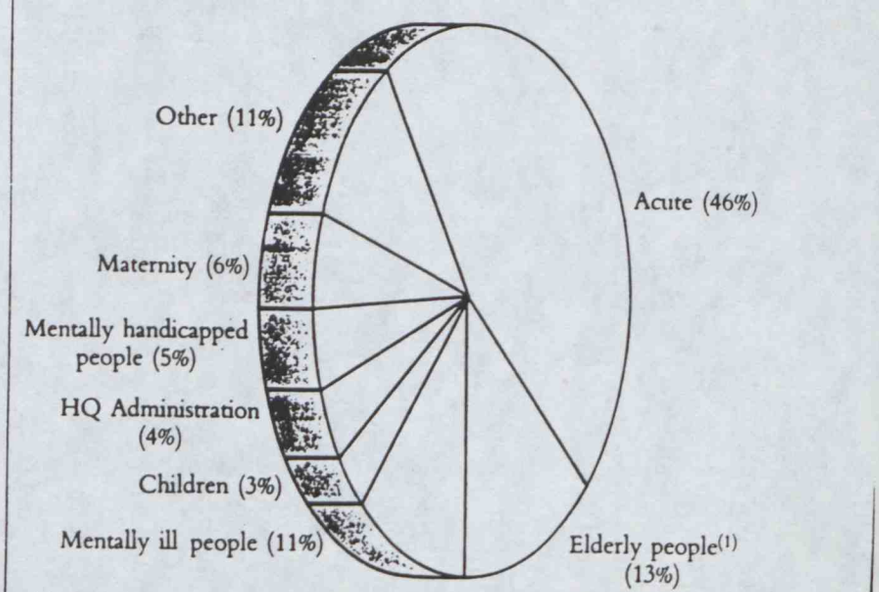



(1) *The costs of medical care provided by other EC countries to people from England. Neither this nor the Welfare Food Service are subject to a cash limit.*

**Family Practitioner Services (gross current expenditure) 1986–87**




**Health Authority gross current expenditure (excluding joint finance) by service group, 1985–86**




(1) *Excludes expenditure on acute services.*

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Annex B: Sources and uses of funds by health authorities

| | 1978/79 | | 1986/87 | |
|---|---|---|---|---|
| | £m | % | £m | % |
| Income: | | | | |
| Exchequer | 4347.4 | 98.3 | 10162.5 | 98.5 |
| Charges+ receipts | 35.0 | 0.8 | 91.0 | 0.9 |
| Decreases in working balances[5] | 24.0 | 0.5 | 68.6 | 0.7 |
| Central adjustments[6] | 15.1 | 0.3 | (-4.9) | (-0.1) |
| Total | 4421.5 | 100.0 | 10317.2 | 100.0 |
| Expenditure: | | | | |
| A.Staff | | | | |
| Medical + Dental | 391.6 | 8.9 | 1122.1 | 10.9 |
| Nurses | 1353.7 | 30.6 | 3495.2 | 33.9 |
| Other NHS staff | 1492.6 | 33.8 | 2917.7 | 28.3 |
| Non-NHS staff (agency etc) | 40.6 | 0.9 | 150.1 | 1.5 |
| Sub-total | 3278.5 | 74.1 | 7685.1 | 74.5 |
| B.Non-staff | | | | |
| Drugs | 128.1 | 2.9 | 318.2 | 3.1 |
| Medical+ surgical equipment[1] | 175.7 | 4.0 | 466.6 | 4.5 |
| Energy[2] | 144.1 | 3.3 | 239.4 | 2.3 |
| Provisions[3] | 132.1 | 3.0 | 189.1 | 1.8 |
| Rates | 55.3 | 1.3 | 166.7 | 1.6 |
| Other | 608.0 | 13.8 | 1458.3 | 14.1 |
| Sub-total | 1243.3 | 28.1 | 2838.3 | 27.5 |
| Direct credits | (100.2) | (-2.3) | (206.1) | (-2.0) |
| Total | 4421.5 | 100.0 | 10317.2 | 100.0 |

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1. Includes X-ray equipment and laboratory and occupational and industrial therapy equipment.
2. Fuel,light and power.
3. Includes contract catering
4. Includes net expenditure of services received from/ services provided to other authorities
5. eg running down of stocks, deferred payments to creditors
6. Includes advances to the Central Blood Laboratories Authority et al. and adjustments for supplies and equipment provided by the Department to health authorities without cash payments.

Note: In 1986-87 Health Authorities met some £150 million of expenditure from cash releasing cost improvements resulting from a more efficient use of resources.

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Annex C: HCHS Activity statistics (England) -thousands

| | 1978 | 1986 | % change |
|---|---|---|---|
| HOSPITAL | | | |
| Acute | | | |
| Inpatients[2] | 4204 | 4894 | 16.4 |
| Daycases | 542 | 1019 | 88.0 |
| Outpatients[3] | 6757 | 7776 | 15.1 |
| A&E cases | 13360 | 13776 | 3.1 |
| Maternity[1] | | | |
| Inpatients[2] | 731 | 862 | 17.9 |
| Outpatients[3] | 727 | 728 | 0.1 |
| Geriatric and younger disabled | | | |
| Inpatients[2] | 241 | 405 | 68.0 |
| Outpatients[3] | 37 | 59 | 59.5 |
| Daypatients[4] | 1363 | 1662 | 21.9 |
| Mental Illness | | | |
| Average daily no. of occupied beds | 78 | 62 | -20.5 |
| Outpatients[3] | 187 | 202 | 8.0 |
| Daypatients[4] | 3098 | 3834 | 23.8 |
| Mental Handicap | | | |
| Inpatient beds | 47 | 34 | -27.7 |
| Outpatients[3] | 3 | 3 | 0.0 |
| All specialties | | | |
| Inpatient & daycases | 5932 | 7464 | 25.8 |
| Outpatients[3] | 7711 | 8768 | 13.7 |
| A&E | 13360 | 13776 | 3.1 |
| Daypatients[4] | 4987 | 6108 | 22.5 |
| COMMUNITY | | | |
| Health visiting[5] | 3597 | 4129 | 14.8 |
| Home nursing[6] | 3158 | 3433 | 8.7 |

1. Includes GP maternity
2. Discharges and deaths
3. New outpatient attendances
4. Daypatient attendances
5. Persons visited
6. Persons treated

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HC2

WHAT HAPPENS TO PATIENTS : Note by DHSS

Introduction

1. This paper offers a summary analysis of the flow of patients into and through NHS hospitals.

Consultation and admission

Primary Care

2. Ninety per cent of patient contacts with the NHS are dealt with by primary care* services. Every year there are some 200 million general practitioner (GP) consultations (Annex, Table 1). Only a fraction of these consultations (see below) result in referral for secondary care+ in hospitals.

Access to Secondary Care: Acute Services

3. There are three main routes to admission for in-patient or day treatment[x] in hospital acute services[o]:

i. directly, via accident and emergency (A and E) departments.

ii. also as emergencies, but through referral by a GP or by another consultant.

iii. by GP referral for an outpatient appointment, followed by a decision by the consultant to admit for in-patient or day treatment as an "elective" patient (ie with no clinical need for emergency admission).

4. Overall, more than half of all acute in-patients are admitted as emergencies (2.6 million "immediate admissions" out of a total of 4.9 million in 1986 - see Table 1), ie through routes i. and ii. A relatively small proportion of A and E patients are subsequently admitted as in-patients - there were 10.5 million new A and E patients in total in 1986.

---

*"Primary care" services are those which are offered at the point of entry into the health service system. They provide simple diagnosis and treatment, preventive care, and referral of complex cases to secondary care.

+"Secondary care" consists of specialised services, provided on referral from primary care services, which offer care and treatment which is usually more sophisticated and complicated than could be handled by a GP.

x In-patient and day treatment both involve using a hospital bed, but day treatment does not involve staying overnight.

o"Acute" services are all hospital services other than maternity, geriatric, units for the younger disabled, mental illness and mental handicap services.

5. Route iii. is more complex. Of the 8.8 million new out-patients in 1986, (7.8 million of whom were in the acute specialties), about half were referred by their GP, the remainder either by one hospital specialist to another or as a follow-up to in-patient or day treatment. The majority of new out-patients are not subsequently admitted for inpatient or day treatment, but many return for subsequent out-patient appointments. Of the 2.2 million elective in-patients treated in 1986 (Table 1), 60% did not know the date of admission when the decision was taken to admit. Paper HC3 offers a fuller analysis of in-patient waiting lists and waiting times, including their distribution geographically and by speciality.

Non-acute services

6. Non-acute admissions - mainly maternity, mental illness, mental handicap and geriatric - are too varied for ready generalisation. Again, a substantial proportion of admissions (the exact figure is not known) are immediate - most maternity and mental illness admissions, for example. Some mentally handicapped and mentally ill people still reside in hospital, but many are admitted for short periods of observation, treatment or respite care. In 1986, 96% of mental handicap admissions and 74% of mental illness admissions were re-admissions.

Tertiary Care

7. "Tertiary care" is that which follows referral from one hospital - whose facilities are inadequate to care for a particular patient - to a specialist hospital or unit for more complex diagnosis and treatment (for example cardiothoracic or neurosurgery). These specialist procedures are usually expensive. Referrals of this kind may account for some 30-70% of admissions to postgraduate and other specialist teaching hospitals.

Decision points

8. Through the processes of consultation and admission, the key decisions - to the extent that there is real choice - are taken

* by patients, to consult their GP or to present themselves at an A and E department.

* by GPs, to refer to a consultant or to seek an immediate admission. (Rates of referral by GPs vary widely between individual GPs, Districts and Regions: the Group may like to have a fuller paper in due course on this issue and on the balance between general practice and out-patient hospital work.)

* by consultants, to admit a patient following an out-patient consultation.

* by consultants again, to refer on for tertiary care.

Care and treatment

9. The Annex as a whole gives some summary analyses of the pattern of care and treatment in NHS hospitals. Two of the more significant features are:

* acute services account for 77% of in-patient cases treated, but only 38% of occupied beds (figure A).

* people aged 75 or over accounted for 16% of all in-patients and 13% of acute in-patients in 1985, but for, respectively, 34% and 26% of beds used (Table 2). (Only 6% of the England population was aged 75 or over).

A fuller breakdown of acute and geriatric services by the main diagnostic categories is in Table 3, and by types of operations in Tables 4(a), and 4(b)

10. The figures in paragraph 9 reflect relative lengths of stay. For example, the average length of stay for acute patients aged 75 and over was 14.6 days in 1986, compared with 7.3 days for all ages. Lengths of stay obviously vary widely from condition to condition: for example, in 1985 the average length of stay for stroke patients - of whom 61% were aged over 75 (Table 3) - was 48.8 days.

11. Nearly 40% of the average 264,000 NHS hospital beds in use each day are occupied by mental handicap and mental illness patients, even though such patients account for less than 4% of admissions. A large part of the patient care now provided for these groups in the community is delivered by hospital based doctors and nurses.

Discharge

12. A decision to discharge is normally taken by the responsible consultant, often in consultation with colleagues in other professions. The decision on timing may depend on the availability of adequate community-based support. In 1986, 5.8 million in-patients were discharged home (Table 1); an unknown proportion of those concerned will have been among the 3.5 million people treated by home nurses and the 1.5 million adults seen by health visitors - many of the latter being the mothers of recently born babies.

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GP4/3

ANNEX

Table 1. Summary of patient flows, England 1986

| | Millions of persons/ attendances | |
|---|---|---|
| Family Practitioners Committee services | | |
| number of GP consultations (average 4 per head of population) | 200 | |
| number of prescriptions dispensed | 323 | |
| Hospital services | | |
| - Outpatient attendances | 37.7 | |
| (new outpatients) | (8.8) | |
| - Accident and Emergency attendances | 13.8 | |
| (new A and E patients) | (10.5) | |
| - Day cases | 1.05 | |
| of which operations | (0.80) | |
| - In-patient cases | 6.4 | |
| maternity | 0.9 | |
| psychiatric | 0.2 | |
| geriatric and units for younger disabled | 0.4 | |
| acute | 4.9 | |
| of which | | |
| Surgical | | |
| - immediate admissions | | 1.1 |
| - elective | | 1.8 |
| (of which booked/planned)(1) | | (0.60) |
| Medical | | |
| - immediate admissions | | 1.5 |
| - elective | | 0.4 |
| (of which booked/planned)(1) | | (0.29) |
| - In-patient operations | 2.6 | |
| - In-patients destination on discharge | | |
| - home | 5.8 | |
| - died in hospital | 0.3 | |
| - to another institution | 0.3 | |
| all in-patients | 6.4 | |

Note (1) Booked and planned admissions are elective (ie non-emergency) cases where the patient is given a date of admission at the time the decision is taken to admit.

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Figure A: Occupied beds and cases treated

1986, NHS Hospitals, England

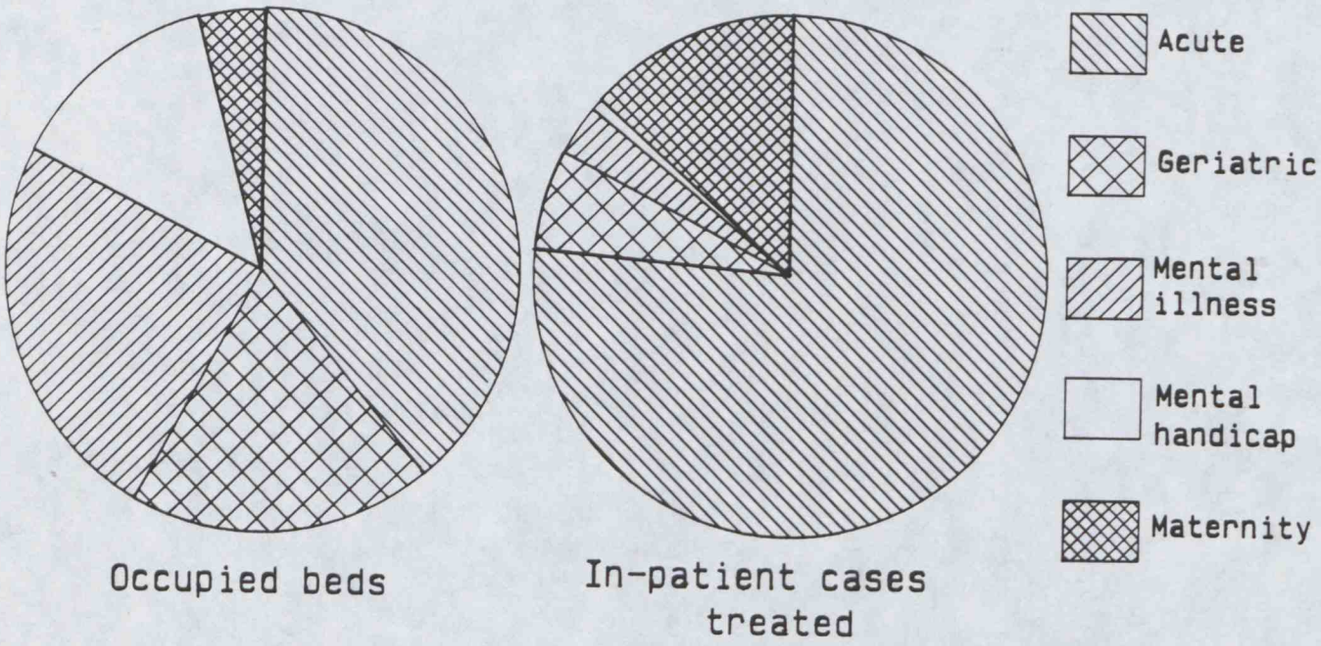

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TABLE 2 Estimated number of In-Patient and Day Cases treated, and average number of beds used daily, with percentage age distribution, NHS hospitals[1], England 1985

| | ESTIMATED NUMBERS[2] | | | | | AVERAGE NUMBER OF BEDS USED DAILY | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Percentage | | | | Total | Percentage | | | | Total |
| IN-PATIENTS | 0 - 14 years | 15 - 64 years | 65 - 74 years | 75 years & over | All ages | 0 - 14 years | 15 - 64 years | 65 - 74 years | 75 years & over | All ages |
| Mental handicap | 28 | 69 | 2 | 1 | 43,900 | 2 | 82 | 10 | 6 | 36,400 |
| Mental illness | 1 | 65 | 14 | 20 | 203,900 | 1 | 42 | 22 | 35 | 64,800 |
| Maternity | 0 | 100 | 0 | 0 | 851,600 | 0 | 100 | 0 | 0 | 10,800 |
| Geriatric | 0 | 1 | 19 | 80 | 382,200 | 0 | 2 | 19 | 79 | 50,000 |
| Acute | 17 | 55 | 14 | 13 | 4,865,100 | 10 | 44 | 20 | 26 | 100,700 |
| Units for the Younger Disabled | 0 | 96 | 3 | 0 | 7,300 | 0 | 99 | 1 | 0 | 1,300 |
| TOTAL | 14 | 58 | 12 | 16 | 6,353,800 | 4 | 44 | 18 | 34 | 264,000 |
| DAY CASES | | | | | | | | | | |
| Maternity | 0 | 100 | 0 | 0 | 18,800 | | | | | |
| Geriatric | 0 | 13 | 31 | 56 | 700 | | | | | |
| Acute | 11 | 71 | 11 | 6 | 937,800 | | | | | |
| TOTAL[3] | 11 | 72 | 11 | 6 | 957,200 | | | | | |

Source : Hospital In-Patient Enquiry
: SH3

[1] All Specialties
[2] Discharges and deaths
[3] In addition SH3 recorded 450 Mental handicap and 5,110 mental illness day cases

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TABLE 3 Estimated number of in-patient cases with main diagnosis as shown, and average number of beds used daily, with percentage age distribution, NHS non-psychiatric non-maternity hospitals[1], England 1985

| DIAGNOSIS | ESTIMATED NUMBERS | | | AVERAGE NUMBER OF BEDS USED DAILY | | |
|---|---|---|---|---|---|---|
| | Total | Percentage | | Total | Percentage | |
| | All ages | 0 - 14 years | 75 years & over | All ages | 0 - 14 years | 75 years & over |
| All Causes | 5,254,540 | 16 | 18 | 151,989 | 7 | 43 |
| Injury and Poisoning | 566,270 | 22 | 16 | 13,970 | 10 | 43 |
| Neoplasms (cancer) | 510,910 | 2 | 23 | 14,646 | 1 | 32 |
| Diseases of the Genitourinary System | 487,140 | 7 | 9 | 7,012 | 3 | 20 |
| Heart Diseases | 351,350 | 0 | 32 | 11,857 | 0 | 49 |
| Complications of Pregnancy, Childbirth and the Puerperium | 152,030 | 0 | 0 | 987 | 0 | 0 |
| Abdominal Pain | 133,030 | 17 | 8 | 1,388 | 10 | 19 |
| Diseases of the Circulatory System | 132,060 | 0 | 17 | 4,070 | 0 | 40 |
| Disorders of the Eye | 125,010 | 15 | 32 | 1,903 | 6 | 42 |
| Cerebrovascular Disease (stroke) | 123,030 | 0 | 50 | 16,180 | 0 | 61 |
| Diseases of the Nervous System | 106,940 | 12 | 22 | 8,548 | 5 | 41 |
| Hernia of Abdominal Cavity | 101,560 | 13 | 17 | 1,508 | 5 | 29 |
| Arthopathies including Rheumatoid Arthritis | 81,700 | 2 | 30 | 5,231 | 1 | 48 |
| Pneumonia, Bronchitis and Emphysema | 79,320 | 12 | 49 | 7,093 | 2 | 74 |
| Other | 2,304,190 | 26 | 15 | 57,598 | 13 | 40 |
| POPULATION - England 1985 | 47,111,700 | 19 | 6 | | | |

[1] Equivalent to Acute Sector plus Geriatric Depts plus Units for the Younger Disabled

Source : Hospital In-Patient Enquiry

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TABLE 4(a) Estimated number of in-patient operations performed, and average number of beds used daily, with percentage age distribution, NHS non-psychiatric non-maternity hospitals, England, 1985

| | ESTIMATED NUMBERS | | | AVERAGE NUMBER OF BEDS USED DAILY | | |
|---|---|---|---|---|---|---|
| | Total | Percentage | | Total | Percentage | |
| | All Ages | 0 - 14 years | 75 years & over | All Ages | 0 - 14 years | 75 years & over |
| Neurosurgery | 63,950 | 8 | 7 | 1,874 | 15 | 8 |
| Operations on eye | 115,480 | 16 | 31 | 1,720 | 7 | 38 |
| of which Operations on lens | 59,140 | 1 | 48 | 1,026 | 1 | 50 |
| Ear Nose and throat operations | 225,900 | 47 | 2 | 2,072 | 36 | 4 |
| of which Tonsils and adenoids | 81,820 | 72 | 0 | 685 | 65 | 0 |
| Oral Surgery | 86,730 | 15 | 2 | 664 | 13 | 5 |
| Cardio-thoracic surgery | 100,910 | 7 | 14 | 2,395 | 7 | 14 |
| Abdominal operations | 449,840 | 8 | 15 | 10,641 | 4 | 25 |
| Inguinal hernia operations | 65,780 | 15 | 13 | 890 | 7 | 21 |
| Urinary operations (inc male genital organs) | 233,780 | 16 | 20 | 4,017 | 7 | 29 |
| of which Cystoscopy (with destruction of lesion) | 87,170 | 1 | 28 | 1,229 | 1 | 37 |
| Obstetric & gynaecology operations (exc assisted delivery) | 426,460 | 0 | 2 | 4,826 | 0 | 6 |
| of which Hysterectomy | 68,170 | 0 | 3 | 1,898 | 0 | 5 |
| Dilatation, curettage and biopsy of cervix | 126,640 | 0 | 3 | 853 | 0 | 6 |
| Orthopaedic operations | 306,620 | 13 | 17 | 10,862 | 7 | 36 |
| of which Treatment of fracture by operations | 105,230 | 20 | 22 | 4,157 | 7 | 44 |
| Arthroplasty | 52,770 | 1 | 35 | 2,950 | 0 | 45 |
| Operations on arteries, veins and lymphatic system | 71,120 | 1 | 8 | 1,224 | 1 | 18 |
| Operations on skin (inc plastic surgery) | 100,380 | 20 | 9 | 1,967 | 12 | 20 |
| Other Surgery & procedures | 181,460 | 9 | 14 | 3,547 | 8 | 24 |
| All operations and procedures | 2,362,630 | 13 | 12 | 45,809 | 7 | 23 |

Source : Hospital In-Patient Enquiry

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TABLE 4(b) Estimated number of day case operations performed, with percentage age distribution, NHS non-psychiatric non-maternity hospitals, England, 1985

| | ESTIMATED NUMBERS | | |
|---|---|---|---|
| | Total | Percentage | |
| | All Ages | 0 - 14 years | 75 years & over |
| Gastric intubation | 119,560 | 1 | 10 |
| Excision and/or biopsy of superficial cyst, lesion or other skin growth | 79,080 | 6 | 5 |
| Cystoscopic operations and examinations | 69,840 | 2 | 14 |
| Ligation or excision of vas deferens (vasectomy) | 42,080 | 0 | 0 |
| Diagnostic dilatation and curettage of cervix | 37,800 | 0 | 0 |
| Sigmoidoscopy | 28,330 | 1 | 9 |
| Extraction of tooth, simple and surgical | 23,740 | 34 | 1 |
| Incision of ear drum | 22,750 | 87 | 0 |
| Incision or removal of nail | 19,600 | 16 | 3 |
| Arthrotomy and joint puncture of bone | 14,170 | 5 | 5 |
| Bronchoscopy | 11,040 | 1 | 13 |
| Spinal Puncture | 9,630 | 2 | 6 |
| Neuroloysis | 9,340 | 0 | 5 |
| Partial mastectomy | 9,000 | 0 | 2 |
| Preputiotomy & circumcision | 8,470 | 84 | 1 |
| Other day case surgery | 289,700 | 12 | 6 |
| All operations and procedures | 794,130 | 10 | 6 |

Source : Hospital In-Patient Enquiry

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HC3

HOSPITAL WAITING LISTS AND TIMES : Note by DHSS

Introduction

1. This paper is a background note on the composition of waiting lists and the extent of excessive waiting. The Group may wish to have a further paper in due course setting out the underlying issues and implications together with work now in hand to tackle them.

Trends since 1975

2. On 31 March 1987 the number of patients on the in-patient waiting list in England was 688,000, some 100,000 more than in March 1975 but 60,000 less than the March 1979 peak. Over the period the underlying trend has been an increase of 1.5% a year. Industrial action in 1975, 1979 and 1982 caused the waiting list to rise rapidly, followed by periods of recovery. In March 1986 the waiting list began to rise again, but not as a result of a strike. This continuing rise is a resumption of the national trend over the years which has been masked by the peaks caused by industrial action.

3. The gradual rise in the total waiting list has matched an associated rise in numbers of patients treated. As the volume of patients treated has risen so too have the numbers waiting. In fact the 1.5% average annual increase was slightly exceeded by an increase of about 1.7% a year in the number of acute inpatient cases treated. That has allowed waiting time, which is the relevant problem from the view of the patient, to remain constant over the period. In 1985 50% of all patients admitted from the waiting list were admitted in seven weeks or less. The corresponding figure for 1976 was eight weeks.

Extent of excessive waiting

4. At 31 March 1987 162,000 patients (23.6% of the total list) had been on the waiting list for more than 1 year. The proportion is the smallest since the statistic was first collected in 1975. Further, it overstates the extent of the problem because waiting list figures are collected at fixed points in time and therefore exclude people who have been on and come off the list in the intervening weeks.

5. Waiting lists consist almost entirely of patients waiting for surgery.* In 1985 nearly 3 million surgical cases were admitted to hospital. Of these, 1 million were admitted immediately and 550,000, or 18%, were admitted as booked patients. Of the remaining waiting list patients, 750,000 were admitted after waiting less than 3 months, and just 87,000 (3% of all surgical admissions) after waiting over 1 year. The relevant information is summarised in Chart A. A number (believed to be small) of patients on waiting lists do not, in fact, receive treatment.

* "Surgery" involves incision of the flesh. The "medical" specialties do not.

Composition of lists

6. Six surgical specialists (in order of magnitude: general surgery, orthopaedics, ENT, gynaecology, ophthalmology and oral surgery) account for some 85% of the waiting list. A high proportion of the patients are waiting for a small number of "popular" operations. A study of long waiting lists in West Midlands and Wales suggests that 46% of the total waiting list is accounted for by seven operations (varicose veins, hernias, hip replacements, arthroscopies (operating on a joint), tonsils and adenoids, sterilisations and cataracts). These results are broadly confirmed by a total census in Northern RHA of their waiting list at 31 January 1987, the results of which are summarised at Table A. In general the "popular" operations are even more prominent among patients waiting over a year.

7. For the most part, waiting list patients do not suffer from life threatening conditions, but many waiting list conditions lead to discomfort, increasing pain and disability.

Geographical variations

8. There is considerable variation in size of waiting lists between Districts and hospitals. There are 19 districts (10%) which have less than 100 patients waiting over 1 year. The lists in 20 districts represent 25% of the total national list.

9. Obviously differences in list size are affected by differences in catchment population and numbers of hospitals. However even when the length of the waiting list is related to the amount of activity in that district - in order to determine how many days' work the waiting list represents - there are still marked variations. The district with the largest population (Leicestershire) has few waiting list problems.

10. Regional comparisons tend to mask the widest variations, but even so show significant differences. Chart B shows the deviations from average in 1980. It is notable that the regions with the least problems were Northern, Yorkshire, and 3 of the 4 Thames regions. West Midlands had the worst problem. By 1986, Chart C shows that the position had changed. Northern and Yorkshire were still at the top of the league table but the worst problems were now to be found in 3 of the 4 Thames regions.

11. DHSS analyses has shown that in general there is no consistent relationship at district level between bed capacity or numbers of patients treated and either waiting lists or times. Similarly, the work of John Yates at Birmingham University using peformance indicators and activity figures has shown that the numbers of surgeons or operating theatres, absolute levels finance or efficiency (measured by operating rates per surgeon or the extent of cancelled operating sessions) are statistically unrelated to waiting lists or times at district level.

12. Experience has shown the need to look at waiting list problems and their causes individually and locally. The underlying cause of a problem list will be one or several of a range of factors, but determining which one needs local investigation. The solution will not necessarily be more money. For instance in looking at 30 of the longest lists John Yates found only one in which improvements depended on major capital work. In some places the problems lie in efficiency - a poor work rate, low throughput of beds, or inadequate discharge or admission procedures. Elsewhere the problem has been particular bottlenecks - shortages of staffing operating sessions, beds, anaesthetists or trained nurses.

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13. The waiting List Initiative has stimulated managers and clinicians in districts to identify the particular cause of their problem and the action needed to solve it, and then to put that action in hand (often supported from the waiting list fund). The aim is to develop locally accepted, achievable targets for improvements in waiting time.

DHSS

February 1988

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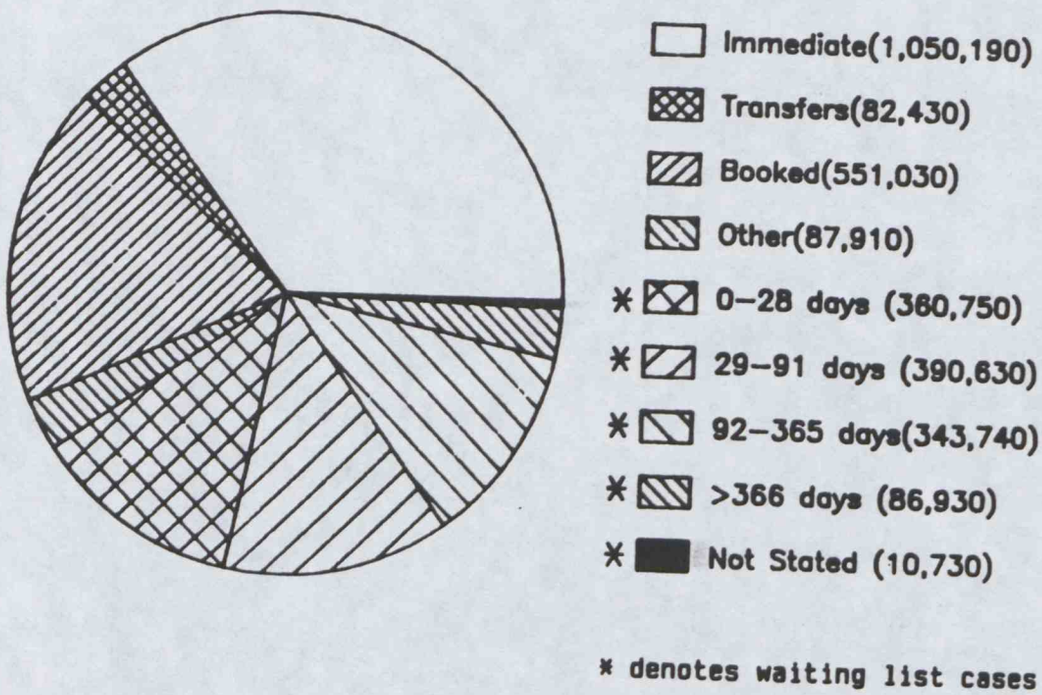
CHART A

# Cases Treated by Source of admission, 1985 Surgical Specialties, NHS Hospitals, England.




* denotes waiting list cases

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## TABLE A

## SUMMARY OF INPATIENT WAITING LIST DATA FROM NORTHERN RHA CENSUS

| Specialty | % on waiting list aged 65+ | % of patients waiting: 6 months or more | 1 year or more | main operation for inpatients on list, with % in brackets |
|---|---|---|---|---|
| gen surgery and urology | 23 | 37 | 21 | veins(20), cystoscopy(14), hernia(13), cholecystectomy(4), prostatectomy(3), sigmoidoscopy(3), circumcision(3). |
| Orthopaedics | 22 | 45 | 25 | total hip replacement(14), bunion(10), knee replacement(7), |
| Gynaecology | 5 | 25 | 10 | sterilisation(32), hysterectomy(16), dilation and curretage(13), repair of prolapse(8), examination under anaesthesia(2), termination of pregnancy(1). |
| ENT Surgery | 3 | 23 | 7 | tonsilectomy/adenoidectomy(37), incision of the ear drum(15) |
| Ophthalmology | 6 | 31 | 15 | cataract(75), squint(11). |
| all 5 specialties | 22 | 35 | 18 | |

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CHART B

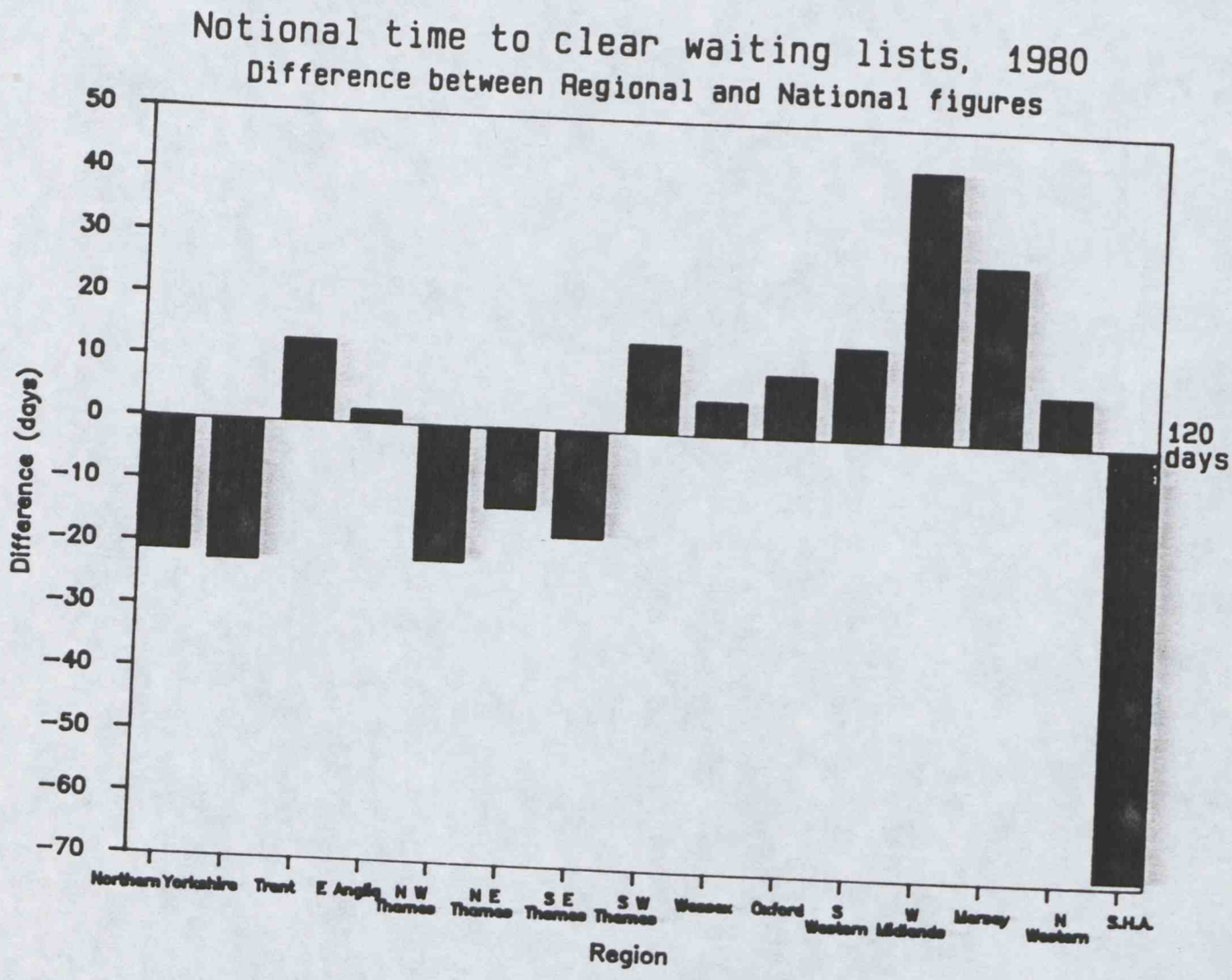

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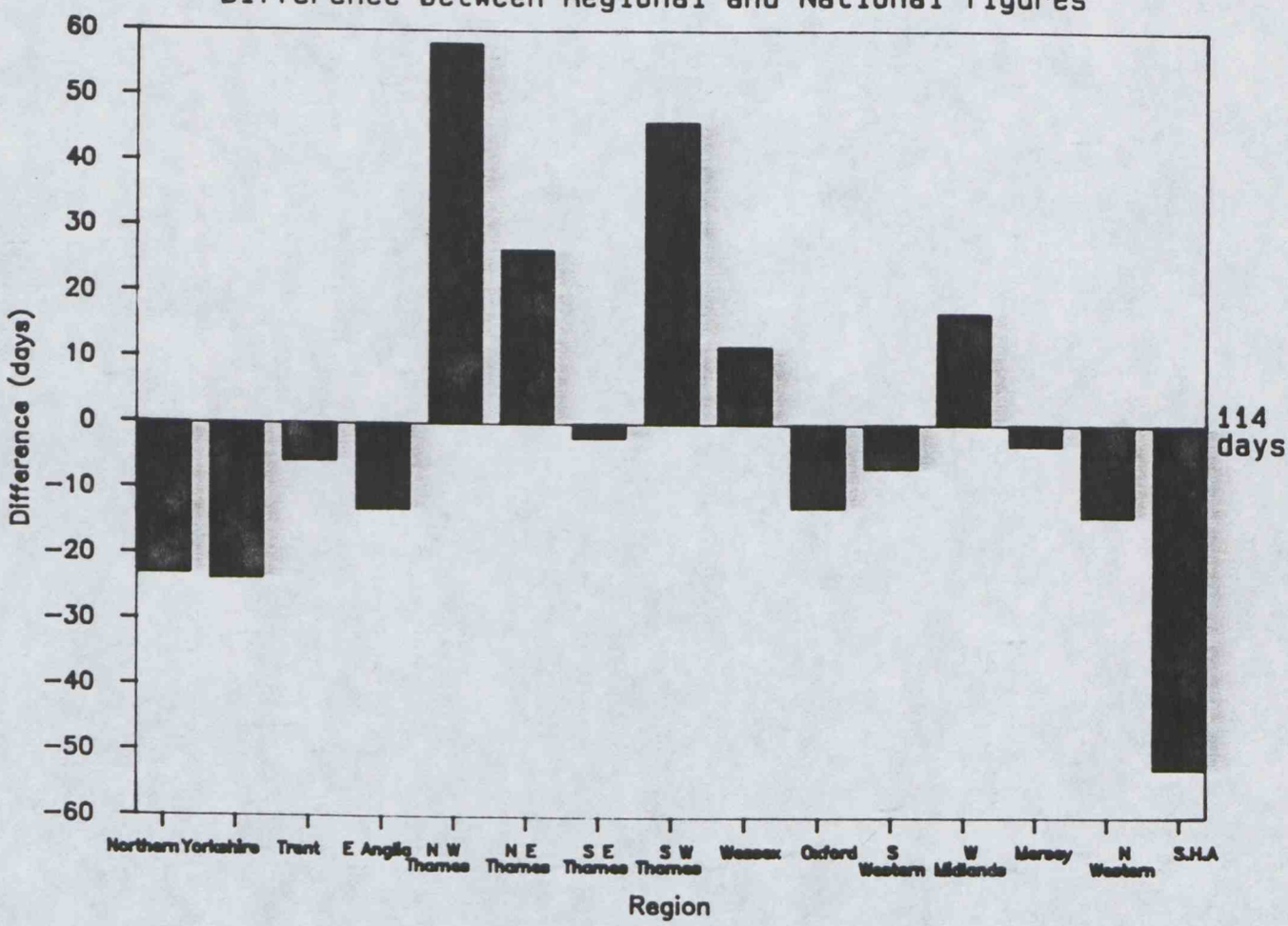
CHART C

# Notional time to clear waiting lists, 1986

## Difference between Regional and National figures



gjb23 HC4

# A COMPARISON BETWEEN THE PRIVATE AND PUBLIC ACUTE SECTORS IN THE UK

Note by DHSS

## Introduction

This paper summarises some key characteristics of the private acute sector, and compares these briefly with the NHS. It does not cover private nursing home provision, which the Group may wish to consider separately at some stage.

## Comparison

2. Comparative information is set out in tabular form as follows:

Annex A - is a summary overview of what the private acute sector is and how it operates, with the NHS equivalent information against each entry where appropriate.

Annex B - is a financial resume of the private sector, again showing NHS equivalents where appropriate.

3. There are a number of points of comparison which are worth highlighting, and which the Group may wish to pursue in more depth through later papers:

*There are obvious differences in the nature of the business. For example:

(i) the very different sizes of the average hospital (49 beds in the private sector against 233 in the NHS). Private units may find recruiting easier because they offer a friendlier, less stressed environment, and patients too may welcome this. On the other hand, in terms of the range of staff and equipment, and in training provision, the larger NHS units have advantages.

(ii) the differing range of work undertaken - private units concentrating on elective (pre-booked) acute surgery with the NHS tackling a much wider spectrum including accident and emergency care, intensive care and maternity care. Most people who go to the private sector for elective surgery will first have consulted their NHS GP.

(iii) differences in the characteristics of the insured and non-insured populations - in particular the fall-off in insurance cover for those over 65, caused by the high premiums (which reflect relative use of services).

*There are important differences in the businesses' relationship with their consumers. Whether the private sector's consumer is defined as the patient, the insurer, the GP or the admitting clinician, the private unit has to attract their business.

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*There is an important difference also in their relationships to consultants. NHS consultants have admitting rights to NHS beds, by virtue of their contracts. The private sector offers admitting privileges. Some private managers operate systems which measure each admitting consultant's use of the hospital's various clinical and support services. Those consultants who do not generate sufficient income for the unit, for example by using it for convalescence and not treatment or by cancelling theatre sessions at short notice, may have their admitting privileges withdrawn.

*Patterns of staffing differ. The majority of private acute hospitals now have some form of resident medical cover (although far removed from NHS standards of cover). On the other hand, consultants, who in their work in private units do not have supporting teams of junior staff, give much more direct patient care. The nursing pattern is not dissimilar: in the private sector nursing care is provided only by qualified nursing staff.

*Billing and costing systems differ in a number of respects (although there are some similar strengths and weaknesses as Sir Roy Griffiths' paper for the Group's last meeting suggested). The private sector's financial systems are designed to ensure overall cost recovery, and in general departmental cost recovery, via billing systems which divide costs across patients. These usually involve charging a calculated cost, plus a mark-up; the split of costs across patients may however be estimated rather than measured. The position in the NHS is described more fully in a separate paper. Financial information on the private sector, for example as in Annex B para 2 comes from insurers and therefore reflects the charges they bear rather than providers' costs. In particular charges may be adjusted to circumvent cost controls and maximise income.

4. The Group may wish to note this outline comparison pending consideration of some of the underlying issues in greater depth. Also attached, at Annex C, are some examples of co-operation between the NHS and the private sector.

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AN OVERVIEW

1. What it is:

Some 184 acute hospitals (including 16 termination of pregnancy clinics) in England with 9450 beds (425 beds) giving some 20 beds per 100,000 population.

The NHS equivalent: 131,000 acute beds or 260 per 100,000 population.

There are another 3000 pay beds in NHS hospitals, generally in the acute sector.

Roughly 45% of total private hospital beds are non-profit (religious or charitable) with 2/5th of the for-profit beds being owned by American groups. Over 50% of private hospitals are no more than 12 years old. Average size 49 beds.

Average size 233 beds (NHS acute and mainly acute hospitals).

2. Where it is:

Just over 50% of private beds (plus 47% of pay beds) are in the four (NHS) Thames Regions which have 30% of the England population; outside the Thames Regions, Oxford and Wessex have average levels of private beds, with the rest of England below average.

NHS policy of geographic and population-determined resource re-allocation aimed at giving broadly equal access to services.

3. What it does:

Primarily elective surgery, where including paybeds it covers 15-20% of the GB total. For some types of operation it meets a higher proportion, eg 25% of hip-joint replacement.

As well as elective surgery, the NHS provides accident and emergency services, medical and paediatric care, virtually all intensive care, primary and community care, and disease prevention progammes.

Roughly 25% of acute procedures in independent hospitals are performed as day care.

32% of elective surgery as day care in 1985. (NB. definitions may differ.)

Length of stay: a 1983/84 study of 1981 data found that, after controlling for age and case mix, lengths of stay in private hospitals were very comparable with those in NHS hospitals. (Pay bed lengths of stay were very much shorter.) This study is now being repeated; completion March/April 1988.

4. Occupancy:

Bed occupancy is variable, but generally low. BUPA estimated overall occupancy in 1986 at 51%; it is lower in London.
(NHS Pay-bed occcupancy - as pay-beds - was 32% in 1986.)

Occupancy in NHS acute beds was 75% in 1986 (which does not take account of the use of beds during the day for day cases).

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3. Cost Control Mechanisms

While private providers therefore seek to control their costs, their billing systems, coupled with patients' reliance on insurance, allow reasonable confidence of overall costs being recovered whatever level they reach. Cost control is largely an insurer function; the insurers therefore:

(i) have moved towards preferred provider systems - insurers (or companies providing cover for employees) steering patients towards particular hospital groups with whom they have preferential rates

(ii) have established negotiating teams aiming to ensure "their" patients get the optimum prices from providers

(iii) have applied cash limits to medical fee re-imbursement, based on a broad classification of operative procedures. (This classification is a system which has grown up over the years. It is not, for example, based on diagnosis related groups.)

A number of "third party administrators" have also appeared; their purpose is to administer insurance claims and potential claims with the aim of challenging unnecessary care and excessive billing.

The insurance industry is believed to be developing a variety of insurance plans to help control costs eg partial insurance.

4. Payment Patterns

25% of private acute treatment is paid for by the patient, the other 75% being a charge on insurance companies.

Average claim per person covered has increased from £53 per annum in 1979 to £98 in 1986 (all at 1986 prices).

Chart 2 shows the movement over time in the (real terms) average claim per person covered, with an NHS equivalent.

The average health insurance premium has increased from £165 per subscriber in 1979 to £250 in 1986 (1986 prices). Each individual subscriber covers an average of 2.15 people.

HCHS cost control operates

(i) via overall cash limit control

(ii) via centrally-run pay system - Review Bodies, Whitley. (NB. Private sector -except for medical fees - follows NHS rates.)

(iii) by paying staff salaries, not on an item of service basis.

N/A

NHS acute sector expenditure per head of England population was £112 pa - allowing a notional 20% for capital - in 1985, virtually the same in real terms as in 1979.

N/A

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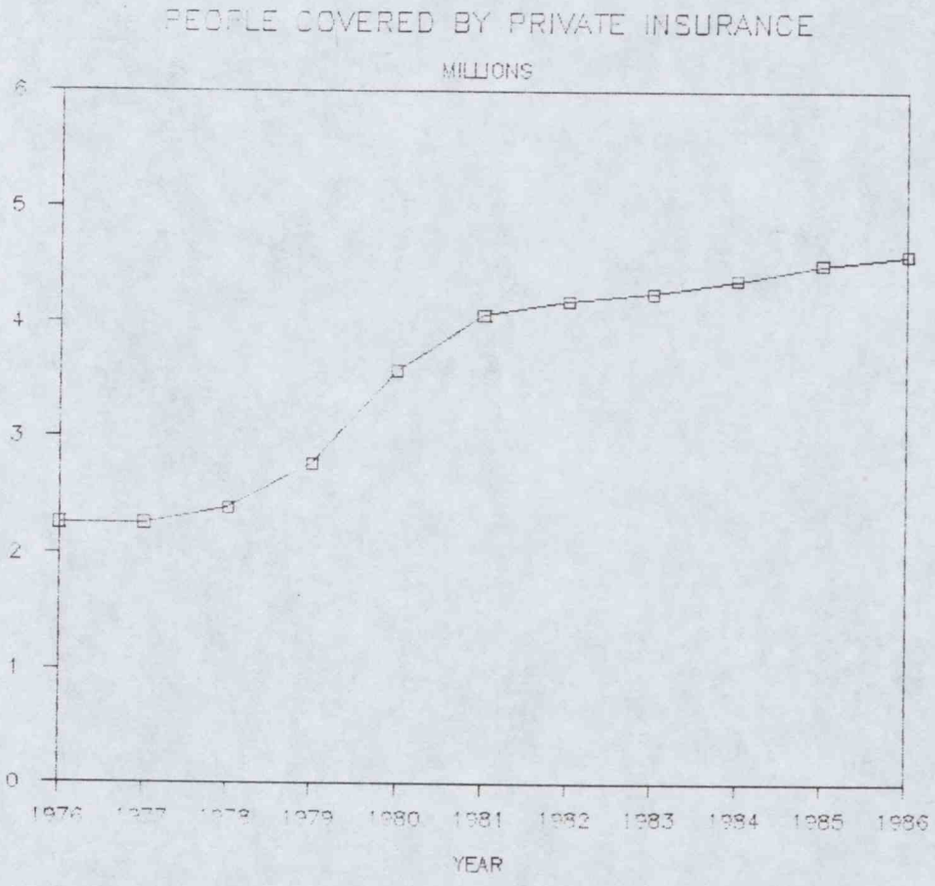
CHART 1



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ANNEX B

**A FINANCIAL RESUME**

1. What it spends:

Estimated 1986 UK spending on private non-psychiatric acute, in-patient and out-patient, care: £683m.
Breakdown: NHS Pay Bed charges £67m
Physicians and surgeons fees £310m
Medical/surgical hospitals and clinics £306m

The NHS equivalent for 1985-86 in England only was £5240m.
[NB This includes a 20% allowance for annuitised capital; revenue spending was £4370m].

The figures below are those available from insurance sources as typical charges for the procedure listed; for reasons set out in 3. below these billed figures, although designed to ensure a private unit recovers cost overall, may not represent true procedure costs.

NHS Procedure costs

Hip replacement £2100-£4200

£3960 (Updated 1984 central estimate)

Heart operation £4560-£6540

£3000-£3960 (£3,000 is Hillingdon Health Authority's costs based on average length of stay for NHS heart operations; £3,960 is based on a Trent Region study in 1987.

Hysterectomy £1320-£2880

£1440 (Updated 1982 study)

Duodenal ulcer £1220-£2280

N/A

Varicose veins £740-£1380

N/A

[NB NHS figures include notional 20% allowance for annuitised capital]

2. Cost Components:

BUPA has estimated that in-patient charges per patient treated rose by 77% over the period 1980/81 to 1985/86. (Charges have to cover the costs of capital investment. Trends in unit costs are not available.)

The equivalent NHS increase in in-patient cost per case for the period 1980/81 is 17%.

To maximise income and limit the impact of insurer-led cost containment, private providers tend to load price increases on to those items of cost that meet with least resistance - notably, in recent years, drugs.

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5. Who it employs:

| | |
|---|---|
| Registered Nurses: 7001 whole time equivalent(England December 1986) - 74 per 100 beds. | NHS Registered Nurses in acute sector was some 55,000, or about 43 per 100 beds. |
| Medical staff: There is no data available on the extent to which NHS consultant staff undertake private practice. Under their terms and conditions, 6,400 whole-time NHS consultants can earn up to 10% of their NHS salary through private practice; a further 5400 part-time NHS consultants face no earnings limit. | 6400 whole-time consultants, 5400 part-time. (Plus 800 wte staff with honorary contracts - principally academic staff. They may also undertake private practice). 23,700 wte other medical staff from senior registrar to house officer. [NB Medical staffing figures are not split between acute and other.] |
| Other Professional Staff) No data<br>Support Staff ) available | 355,700 wte other staff - across all sectors of NHS activity. |
| The sector relies on the NHS, providing only some limited nurse training, mainly post-qualification study for nurses. Attempts to establish medical training arrangements have not succeeded. | Virtually all basic nurse training (24,000 trained per year) and the great majority of post-basic training. All medical training. All other professional health training that is not in higher/further education sector. |

6. Who uses it:

Over 9% of the UK population have health care insurance, and are able to recover part or all of their costs when they use the private sector. (50% of insurance is company purchase, 20% is employer-based and 30% is individual or group.) Roughly 25% of private sector use is not covered by insurance.

Chart 1 attached shows the growth in health insurance coverage.

7. Consumer Protection

The operations of the insurers protect users' financial interests.

Financial discipline imposed by cash limits.

Their care interests are safeguarded by

(i) each unit's pride in its reputation

(ii) the requirements of the registration system

(iii) their right to report health professions to their professional machinery eg General Medical Council

(iv) their right to go to law.

The NHS' care standards reflect

(i) each unit's morale and ethics

(ii) the watch-dog role of Community Health Councils

(iii) the responsibility of Authorities, and ultimately Ministers

(iv) the input of the Ombudsman

(v) the role of MPs

(vi) health profession's machinery eg General Medical Council

(vii) a patient's access to law.

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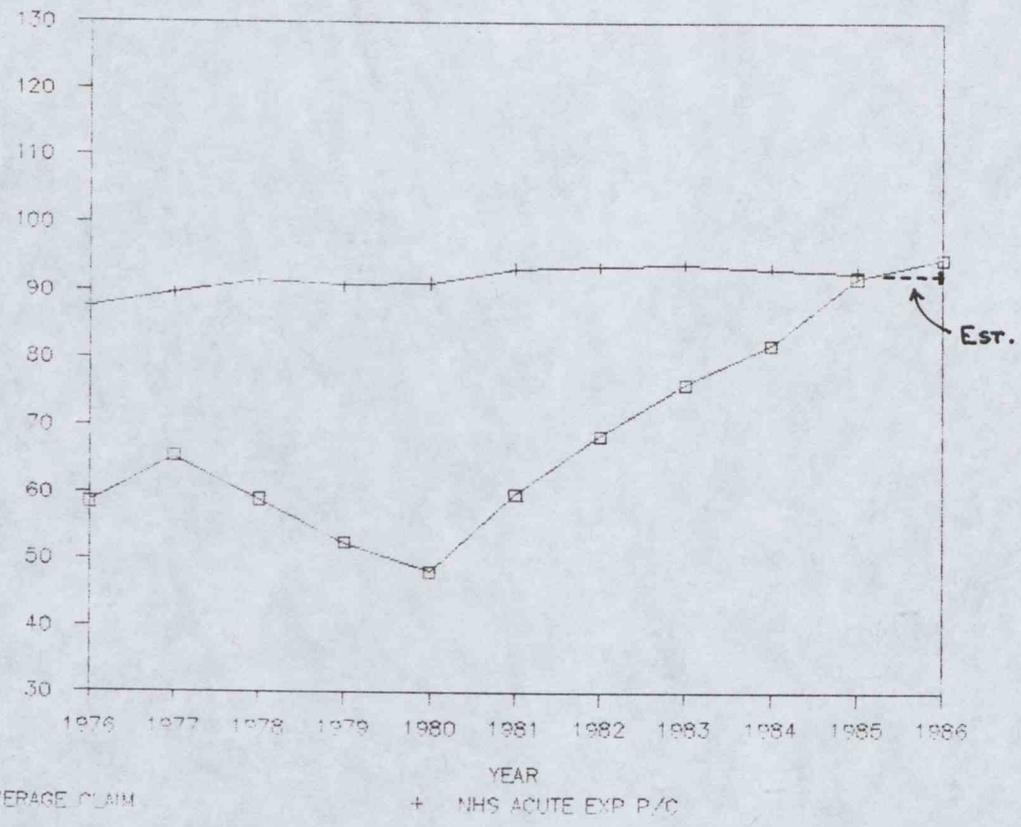
CHART 2

NHS ACUTE SECTOR REVENUE EXPENDITURE PER CAPITA (ENGLAND)/
AND AVERAGE CLAIM PER PRIVATELY INSURED PERSON (UK)
(CONSTANT PRICES)*




* In real terms using HCHS revenue deflator (£1985/86)

/ About 20% should be added to NHS expenditure to allow for annuitised capital expenditure.

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ANNEX C

COOPERATION BETWEEN THE NATIONAL HEALTH SERVICE AND THE PRIVATE SECTOR

1. This note briefly summarises the current range of projects involving the private sector and local health authorities. In 1986, the private sector provided treatment for 41,000 cases under arrangements involving 121 health authorities. The range is considerable and the number of projects has increased significantly recently, stimulated by central initiatives such as Ministers' drive to reduce waiting lists. As part of the waiting list initiative, over 35 district health authorities have reached agreements with the private sector for treating some 4,800 NHS patients in private hospitals for certain conditions at a total cost of over £2.3 million.

2. Examples of waiting list projects include:

| | |
|---|---|
| Portsmouth HA: | 100 hip replacements (£135,000) |
| Doncaster HA: | 100 general surgical operations (£40,000) |
| | 200 ENT operations (£100,000) |
| | 70 gynaecology operations (£30,000) |
| Burnley HA: | 181 ENT operations (£66,000) |
| | 77 hip replacements (£60,000) |
| Southend HA: | 240 gynaecology operations (£96,000) |

3. Other examples of projects involving the private sector can be sub-divided as follows:

a. <u>The provision of expensive, specialist equipment</u>

i. BUPA have paid another £1 million for a Magnetic Resonance Imaging Scanner at the National Hospital for Nervous Diseases, for use by both NHS and private patients;

ii. Installation of lithotripter at St Thomas' Hospital at a cost to BUPA of £1 million. About 1,000 patients treated each year, 75 per cent of which are NHS;

iii. NHS patients represent half the 2,000 annually using the whole body scanner in BUPA's London Medical Centre.

b. <u>Preventative medicine</u>

i. BUPA Hospital, Portsmouth is providing mammographic screening for between 5 and 8 NHS patients a week under a contractual arrangements with Chichester HA;

ii. BUPA Hospital, Norwich is providing mammography services to NHS patients. It has also made a joint appointment with Great Yarmouth and Waveney HA of a nurse tutor;

ii. In Barking, Brentwood and Havering HA, private sector heart screening takes place out of hours on NHS facilities. The HA receives 20 per cent of the gross income.

c. Innovative medicine

i. Joint venture with St Bartholomew's Hospital whereby American Medical International (AMI) Portland Hospital pays £80,000 pa for the provision of infertility services at St Bartholomew's for the treatment of 1,000 women (and some men), half of whom are NHS patients.

ii. Bioplan Holdings plc, a Hampshire - based health care company, is collaborating with Oxford and Salford Health Authorities in building joint NHS/private day surgery units.

d. "Priority care" groups

i. The NHS spends £5 million pa sending seriously disturbed young people to private psychiatric facilities, such as AMI's two units at Kneesworth near Cambridge and Langton House, Dorset;

ii. Bolton HA are holding discussions on a mixed NHS/private development of a new facility for 90 long-stay geriatric patients, 50 of whom will be from the NHS.

e. Management contracts

Guys Hospital is considering contracting out to Hospital Capital Corporation (HCC) the management of 47 paybeds in Nuffield House, its private patient wing.

f. "Priority acute" services

A number of the waiting list projects mentioned in paragraph 2 are targeted at diagnostic groups to which Ministers have asked health authorities to give priority. Other examples include:

i. East Suffolk HA have an agreement with Unicare Medical Services, a subsidiary of the US based Travenol, for the provision of renal dialysis services in Ipswich. At present, 10 NHS patients are regularly dialysing;

ii. Clwyd HA signed a contract on 19 November 1987 with AMI Manchester for the treatment of up to 20 cardiology and cardiac surgery patients to be referred each year by consultance physicians in Clwyd;

iii. Two subsidiary private renal units, managed on behalf of the NHS by Travenol and Community Dialysis Services at Bangor and Carmarthen, were opened in 1985 under a 7 year contract. The provision of two further subsidiary units at Cardiff and Merthyr Tydfil is under consultation.

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HC5

**MANPOWER INFLEXIBILITIES : Note by DHSS**

## Introduction

1. It is important to promote greater flexibility in the use and deployment of staff in the HCHS. Changes in the labour market, and in particular the prospect of a substantive decline in the number of school leavers, make this the more important.

2. Manpower inflexibilities are being tackled across all staff groups. The present paper deals primarily with professional staff. It

* summarises relevant work currently in hand in respect of (a) consultants, and (b) the non-medical, professional workforce;

* considers the relationship between this work and the review; and

* suggests some issues for further consideration in the context of this review.

## Work in hand

Consultants

3. The main work currently in hand which bears on flexibilities in the medical workforce is addressing three underlying problems:

a. the fact that the present consultants' contract seeks to cover a lifetime's work during which technology, practice and service patterns will change. Appended to this paper is a background note on the consultants' contract, and on the context in which the possibility of changing that contract is currently being addressed.

b. a lack of effective mechanisms, including sanctions, for resolving problems quickly at local level.

c. a lack of common understanding about the professional (service to patients) and the managerial (resource use) elements of a consultant's duties, and about the problems of reconciling the two in daily practice.

4. Two major initiatives are currently in hand. One is the Resource Management Project - with which the Group is already familiar. The other concerns disciplinary procedures: current disciplinary procedures for hospital and community doctors and dentists can use resources which would be better spent on patient care - the costs of lengthy suspensions on full pay, for example, and high legal costs. The DHSS is currently working with the profession on the first major review of these procedures, and a report is expected later this year.

5. Other work is at this stage internal to Government. Specifically the following proposals are under consideration, not all of which are addressed

exclusively to "inflexibilities" but which are interrelated in a variety of ways:

a. including in the existing contract references to subordinate documents such as a specific, reviewable job description.

b. providing for greater geographical mobility.

c. securing a sharper assessment of a consultant's management aptitude and attitude during the appointment process.

d. establishing a clearer role for Districts in monitoring consultants' activities, or even (despite its unpopularity with the profession) giving Districts the contracts themselves where they are currently held at Regional level (Appendix, paragraph 2).

e. tightening the rules to prevent private practice from distorting NHS commitments (for example, by delaying the start of NHS clinics).

f. promoting "best practice" in the management of professional work and in the exercise of managerial tasks and responsibilities.

g. reviewing the distinction awards system, for example to reward managerial as well as clinical excellence and responsibilities and to secure a fairer distribution of awards overall.

Other professions

6. Inflexibilities which arise with the other health professions - nurses, physiotherapists, radiographers, and so on - are being tackled on three main fronts:

(a) Greater flexibility between professional disciplines. There is potential for greater flexibility between professions; and in some cases within them. The "Project 2000" proposals for the reform of professional nurse education aim to maximise flexibility within the profession in the delivery of nursing care in and between both hospital and community settings. These aspects of Project 2000 are well accepted in the NHS and by the profession. Inter-professional flexibility is more sensitive. There are two approaches: to seek amalgamation of professions, and to seek flexibility of roles and common training. There has recently been only one successful example of amalgamation (physiotherapists and remedial gymnasts), although discussions are going on which could lead to eventual amalgamation of physiotherapy and occupational therepy. Flexibility of roles and common training are seen as a more immediately practicable approach, although still controversial with the professions. There have been some limited advances. DHSS are seeking to stimulate more.

(b) Skill mix. The potential for using vocationally trained "helpers" is recognised to varying extents by different professions. There is also varying appreciation of the extent to which recruitment problems at professional level will necessitate this approach. The Project 2000 proposals envisage a new but better prepared "helper" grade to replace

and enlarge the existing, limited numbers of nursing auxiliaries. Ministers are currently considering how to secure this necessary expansion. Some other professions (eg occupational therapy) are working positively to expand the role and use of helpers. Others are less advanced. DHSS policy is to promote the National Vocational Qualifications approach throughout the care sector (ie social services and private and voluntary sectors as well the NHS). This will involve both "career ladders" based on vocational qualifications, with access to professional training for the more able "helpers"; and the maximum degree of common training for all helpers, to promote flexibility. The NVQ approach is being backed up by a number of skill mix studies in individual professions.

(c) Conditions of service. Difficulties here include rigid grading definitions; collective agreements which stipulate triggers for the creation of extra posts; benefits which apply to certain grades only or which are different for each staff group; and allowances, for example for unsocial hours, which can inhibit flexible shift-working. A series of grading reviews now in progress should result in a more flexible recognition of skills and responsibilities. A wholesale review of conditions of service is also under way with a view to making them better suited to local management needs.

Wider review issues

7. The Group's work could clearly have a major impact on much of the work described in this paper. The review could, for example, have significant implications for both consultants' and general practitioners' contracts going beyond what is currently proposed, and it seems sensible to take no major new initiative with the medical profession on consultants' contracts for the time being. The Department will report as the review proceeds on any implications which may emerge from current developments.

8. There remain at least three key issues which are potentially fundamental to the review. Some if not all of these issues could usefully be illuminated by comparisons between the public and private sectors and/or between UK and overseas experience. They are:

(a) Self-regulation. Doctors are accountable to their patients for the service they give. Nurses and the other health professions are similarly responsible for the maintenance of professional standards, including safe practice and enhancing specialist knowledge. These responsibilities are underpinned by the regulatory activity of the relevant statutory bodies, in particular the General Medical Council, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the Council for Professions Supplementary to Medicine. The value of this self-regulation needs to be weighed against the need for flexibility and management control. The Group may find it helpful to have a fuller paper on this issue, and on related issues such as limitations on professional advertising.

(b) "Tenure". Models of health care delivery which imply a less monolithic organisation of supply will have implications for the tenure for life currently enjoyed by nearly all NHS staff, including hospital

consultants (Appendix, paragraph 2). The Group may wish to consider at a later stage whether current proposals for modifying the consultants' contract in a way which alleviates the effects of tenure - in particular 5 (a) and (b) above - will suffice (assuming that a nationally negotiated model contract remains the right approach).

(c) Skills supply. There is a major and growing problem of securing an adequate supply of many of the skills - especially nursing and some other non-medical skills - which will remain essential however health care delivery is organised. The Group may therefore wish to consider as their work progresses:

* the potential impact of different organisational models on the supply and costs of scarce skills; and

* how best to maintain the necessary "seedcorn" investment in professional and other skills training.

February 1988 DHSS

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APPENDIX

## Consultants' contracts

Background

1. In the 1970s, the Government and profession sought to negotiate a more work-sensitive contract for consultants. An impasse was reached over "pricing" the new contract, and it fell. Instead, in 1979, the present Government agreed and introduced the current arrangements for private practice and promulgated a new model contract (Annex A).

2. Background information about the basis on which consultants are employed is contained in Annex B. The key features are 24 hour responsibility for patients and permission to undertake private practice as well as NHS work. The majority of consultants are appointed to the grade (with tenure for life) in their mid to late 30s and remain in the same post until retirement. Consultants' contracts are held at RHA or Teaching District level, although many consultants work only in one District.

Objectives

3. In addressing the need for change, the NHS Management Board's aims are that consultants should

* be a well-motivated workforce, providing high quality, 24 hour care for their patients.

* provide maximum value for money and account for the resources they use.

* regularly evaluate their clinical practice.

* accept the need for the flexibility to meet changing clinical practices and service needs.

4. It is also important to secure the commitment of the consultant workforce to any changes proposed, recognising that

* it is difficult to provide effective services to patients without the commitment and goodwill of the consultant body.

* most consultants provide services in excess of their contractual commitments, and only a minority abuse their positions.

* many consultants are increasingly willing to participate in resource management initiatives, to secure improved efficiency, to co-operate fully with general management, and to promote more systematic clinical audit.

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ANNEX A

Annex D
(PM(79)11)

**RECOMMENDED FORM OF CONTRACT FOR CONSULTANTS**

Dear

APPOINTMENT OF CONSULTANT IN (SPECIALTY)

1. I am instructed by the (insert name) Authority to offer you an appointment of [whole-time] *, [maximum] *, [part-time] * consultant in (specialty) from (date) subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff and to the provisions as to superannuation from time to time in force.

2. The terms and conditions of the employment offered are set out in the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales) and General Whitley Council Conditions of Service as amended from time to time. Copies of these may be seen at the Authority's offices.

3. The appointment is superannuable. Unless within 13 weeks of starting your employment you are notified otherwise, you will be subject to the National Health Service Superannuation Scheme and will then be contracted out of the state pension scheme. A copy of the current regulations governing the scheme may be seen at the Authority's offices and a booklet about it is attached (NHS Superannuation Scheme (England and Wales); An Explanation).

4. Insofar as they are not already covered by the Terms and Conditions of Service mentioned above the following duties have been assigned to you for the purpose of providing health services under the National Health Service Acts in the following district(s): (insert names)

a. Diagnosis and treatment of patients at the following hospitals, health centres and clinics; (insert names). (Insert, for part-timers only, the number of notional half-days at each)

b. [Domiciliary consultations as may be required from time to time].

c. In addition to the duties mentioned above you may exceptionally be required to undertake duties for limited periods within the districts specified above.

d. The diagnosis and treatment of patients occupying accommodation made available under sections 58, 65 and 66 of the National Health Service Act 1977, insofar as such patients have not made private arrangements for such treatment under section 65(2) of that Act.

e. (insert as necessary)

f. Continuing clinical responsibility for the patients in your charge, allowing for all proper delegation to, and training of, your staff.

Subsequently, the duties and places where they are to be carried out may be varied by agreement between the Authority and yourself.

5. The arrangement of your duties will be such as may be agreed between the Authority and yourself from time to time. (Insert the following sentence for whole-timers and maximum part-timers). [It is agreed that any private practice you may undertake, whether limited or not by the Terms and Conditions of Service, will in no way diminish the level of service that may be expected from you by the authority in carrying out the duties specified above].* (Insert the following sentence for maximum part-time consultants only:) [It is also agreed that the duties specified above are regarded as requiring substantially the whole of your professional time, and that this will involve a minimum work commitment equivalent to 10 notional half-days a week].* (Insert the following sentence for part-time consultants only:) [The duties of the appointment offered to you are assessed as amounting to notional half-days a week].*

6. The salary of the appointment (exclusive of any distinction and meritorious service award payable to you) will be that appropriate to a [whole-time] * [MPT] * consultant appointment [assessed at notional half-days a week].* Your starting salary will be (insert commencing salary). Salary will be payable monthly/quarterly. Your incremental date will be

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7. For the purposes of section 1(2)(c) of the Employment Protection (Consolidation) Act 1978, your previous employment with (insert name of previous employer) does [not] * count as part of your continuous period of employment [and your continuous period of employment therefore began on (date)].* However, for the purpose of certain NHS conditions of service, previous NHS service, not treated as "continuous" under the provisions of the Employment Protection (Consolidation) Act 1978, may also be reckoned for those purposes, subject to the rules set out in the Terms and Conditions of Service.

8. The employment is subject to 3 months notice on either side but is subject to the provisions of paragraphs 190 to 198 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.

9. You are required to be fully registered with the General [Medical] * [Dental] * Council.

10. The authority requires you to be a fully subscribed member of a recognised professional defence organisation, or, if you have an objection to such membership on grounds of conscience or on some other grounds approved by the Secretary of State, to take out and produce to the authority an insurance policy covering yourself in respect of any liability arising out of or in connection with your duties hereunder, and to produce to the Authority forthwith the receipts of the payment or renewal of subscriptions or premiums as the case may be.

11. Your private residence shall be maintained in contact with the public telephone service and shall be not more than 10 miles by road from the (insert name) hospital unless specific approval is given by the Authority to your residing at a greater distance.

12. Arrangements for leave and other absences must be approved by the Authority [but shall in the first instance be made locally].*

13. The agreed procedure for settling differences between you and the authority where the difference relates to a matter affecting your conditions of service is set out in Section XXII of the General Whitley Council Conditions of Service.

14. In matters of personal conduct you will be subject to the General Whitley Council agreements on disciplinary and dismissal procedures. The agreed procedures for appeal against disciplinary action or dismissal are set out in Section XXXIV of the General Whitley Council Handbook and paragraph 190 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.

15. The authority accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to their officials for safe custody. You are therefore recommended to take out an insurance policy to cover your personal property.

16. If you agree to accept this appointment on the terms indicated above, please sign the form of acceptance at the foot of this letter and return it to me in the enclosed stamped addressed envelope. A second signed copy of this letter is attached and should be retained by you for future reference.

Yours sincerely

Signature
On behalf of

I hereby accept the offer of appointment mentioned in the foregoing letter on the terms and subject to the conditions referred to in it. I undertake to commence my duties on the

Signature

Date

This offer and acceptance of it shall together constitute a contract between the parties

Note: [ ] * denotes "delete as necessary".

SECRET

ANNEX B

MANAGEMENT OF CONSULTANTS IN THE NHS

Key facts

a. 14,000+ consultants (England and Wales).

b. Contracts held at Regional or Teaching District level (by District in Wales).

Can be appointed as:

| | Proportion |
|---|---|
| i. whole-time (equivalent to 11 half-days per week). Private practice must not exceed 10% of salary | 48% |
| ii. maximum part-time (equivalent to 10 half-days per week). Unlimited private practice | 32% |
| iii. other part-time | 9% |
| iv. honorary (normally University employees). | 11% |

c. Under his terms of service, a whole-time and maximum part-time consultant is "expected to devote substantially the whole of his professional time to his duties in the NHS".

d. Whole-time consultants' salaries start at £25,440 rising by four annual increments to £32,840. In addition, 36% of consultants receive a distinction award of between £5,790 and £29,550 p.a. 1% receive the highest award: their whole-time salary (on scale maximum) is £62,390. Some 68% of consultants are in receipt of an award when they retire.

e. Total HCHS medical and dental pay bill for 1987/88 estimated to be £1,516 million, including some £50 million for distinction awards.

f. In addition to their salaries - and depending upon the specialty - consultants can earn fees from domiciliary consultations (no more than approximately £10,000 p.a), category 2 work (providing reports for insurance companies etc) and family planning work.

SECRET

HC6

**INFORMATION FOR MANAGEMENT** : Note by DHSS

**Introduction**

1. This paper

(i) summarises recent and current developments in HCHS management information;

(ii) illustrates what health authority managers can now do with the better information which is coming on stream; and

(iii) examines in broad terms the timetable for future action based on DRG (diagnosis related group) costing. (A fuller paper is being prepared on this in accordance with the conclusions of the previous meeting of the Ministerial Group).

The paper is relevant both to strengthening the NHS in its present form and to the development of the systems that would be needed to underpin more radical options.

**Recent and current developments**

2. Current improvements in the range and quality of the information available to local management have come from two main initiatives:

(i) Korner: the Korner Steering Group identified a minimum range of compatible data to be captured in every District. Most of the Group's recommendations have been implemented by health authorities from 1987-88, and the remainder are due for implementation from 1988-89. The result has been a radical overhaul of the Service's information systems, the fruits of which are now beginning to emerge.

(ii) Performance indicators (PIs): the Department has developed a set of 450 PIs, covering a wide range of both inputs and outputs. Their purpose is to help management at all levels to identify variations in performance so that necessary management action can be taken. An updated package is due for publication by the end of March. An improved, Korner-based, set relating to the financial year 1987/88 is being developed for issue in January 1989.

3. The Korner recommendations were directed primarily to the needs of District management. The data to be submitted to the Department is obviously less detailed than that needed by Districts, and has been asked for less frequently (much of it quarterly, the rest annually) than it will be needed by local managers.

SECRET

**The uses of better information**

4. Timely, accurate, reliable and accessible information is needed by management

* to plan effectively, and to make difficult choices between competing needs, demands and solutions.

* to monitor the development of services and use of resources.

* to evaluate the use of resources and the quality and outcome of care.

With the implementation of Korner and the development of PIs, local managers now have powerful information tools at their disposal. Some brief illustrations show what is now becoming possible.

5. On hospital activity data, for example, figure 1 at Annex A shows for each of the Districts in a Region the average length of stay in hospital for patients who have had a heart attack. Figure 2 gives a similar comparison of operating theatre usage. At local level, analysis of this kind can be further broken down by individual consultant and valuable feedback given to consultants themselves. As a different example, figure 3 shows the variations across Districts in attendances at general surgery outpatient clinics. The main items of data available on hospital activity are listed at Annex B.

6. Information on costs is being significantly improved with Korner implementation, especially through the introduction of costing by specialty (for hospital services) and by programme (for community health services). Cost control through departmental budgeting is already commonplace - by way of illustration, an extract from one hospital's financial monitoring report is at Annex C. Since health authorities now have greater freedom to set charges for private patients, some have for that purpose established the average costs of particular operations in their hospitals (using much broader patient groupings than DRGs).

7. Local managers can now construct a wide range of indicators of performance by relating costs to activity or manpower. Examples of indicators which local managers can construct from Korner data on acute services, services for the elderly, and diagnostic and other clinical support services, are at Annex D.

**Further improvements**

8. We are building on these foundations to secure further improvements. For example, it is important that measures of the outcome of treatment are developed to complement indicators of activity and efficiency. Work on outcome measures is in progress within the Department, and a further note on this can be provided if the Group so wishes.

9. Another key area for further improvement is information on costs. Korner-based specialty costing is a valuable planning and monitoring

tool, the more so when combined with the detailed activity data which is available locally. But, as explained in Sir Roy Griffiths's paper for the last meeting of the Group, it does not by itself allow for the wide variety of conditions and procedures encompassed by a single specialty. We are tackling this for two main purposes:

* "pricing", the broad determination of the resources absorbed by given patient "case-mix" workloads;

* control, the more precise monitoring of performance on a local, hospital-specific, basis.

10. To be acceptable, information for control purposes must be based on a combination of

* patient activity data in which local managers and doctors have a high degree of confidence; and

* a system which

  - attributes to individual patients and/or DRGs a significant proportion of their actual costs (such as drugs and medical tests), and

  - apportions all other costs (such as clinicians' time, theatre use, hotel and overhead costs) in accordance with an agreed standard approach which offers acceptable accuracy without detailed and expensive data collection and allocation processes.

One of the objectives of the resource management project is to provide output costs on this basis both by individual patient and by DRG. Such information will be available for several of the pilot sites by 1989, but it will be at least 1990 before comparably good information will start becoming available on a wider basis.

11. It should be possible, using estimates, to develop more quickly DRG-related information which is adequate for pricing purposes (although accelerating progress would carry resource implications). There are four options:

option A - take pre-Korner 1986-87 cost account and activity data and apportion all costs largely on the basis of US experience. In this way broad average DRG costs could be computed by about Easter 1988 on a national and Regional basis.

option B - as for option A, but using (post-Korner) 1987-88 data. On this basis results could be available by October/November 1988, provided that the problems arising from the transition to Korner data prove manageable.

option C - use 1987-88 data, but apportion all costs on the basis of costing samples taken from, say, 20 UK hospitals together with the experience of several of the existing resource management sites. This could offer results by about January 1989.

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option D - as for option C, but allowing time for the development and evaluation of the resource management project to provide a more robust and acceptable database. This approach should allow well-researched DRG standard costs to be generated by January 1990, using 1988-89 data.

12. The problem with both option A and option B is that, because US and UK clinical practice is not the same, the use of unevaluated US cost weightings would be open to legitimate challenge. Option C does not face the same problem, but would be subject to two major risks:

* there are bound to be teething troubles with 1987-88 data, as the first following Korner implementation; and

* it may be more difficult to obtain the acceptance of DRGs and other resource management developments if we proceed without the evaluation provided for by option D.

13. The paper promised in paragraph 1 (iii) above will examine the timetable for further action in more detail. It will consider in particular:

* how critical it will be, in the light of the development of the Group's work, to have DRG information at least by 1989;

* the balance of advantage between, on the one hand, introducing the DRG changes quickly and, on the other hand, introducing them more slowly but after full evaluation and consultation;

* whether it would be desirable to discuss option C with the medical profession; and

* the scope for early trials of pricing and control systems.

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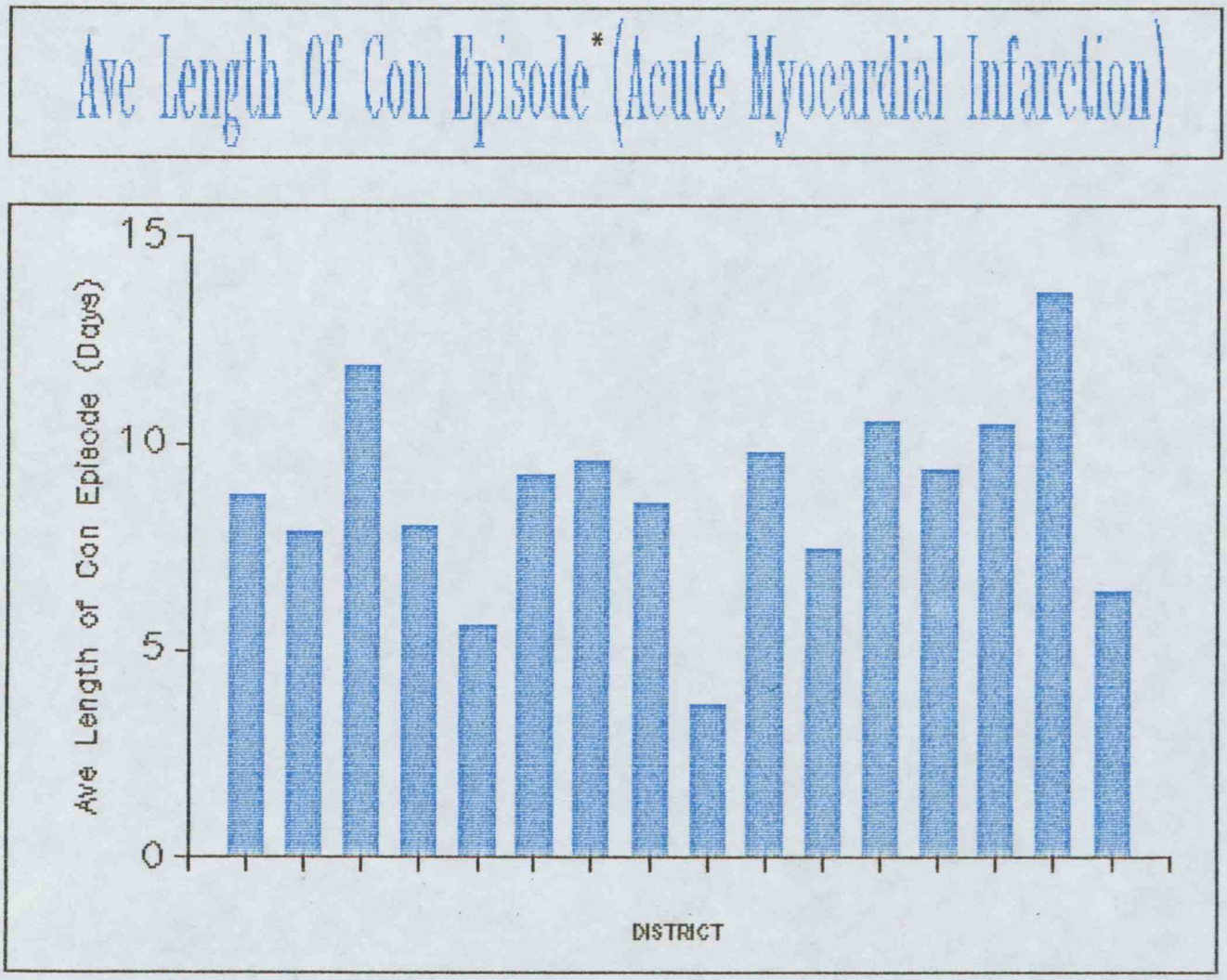
ANNEX A

Figure 1




* A period spent under the care of an individual consultant (A continuous spell of treatment may comprise more than one consultant episode).

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Figure 2

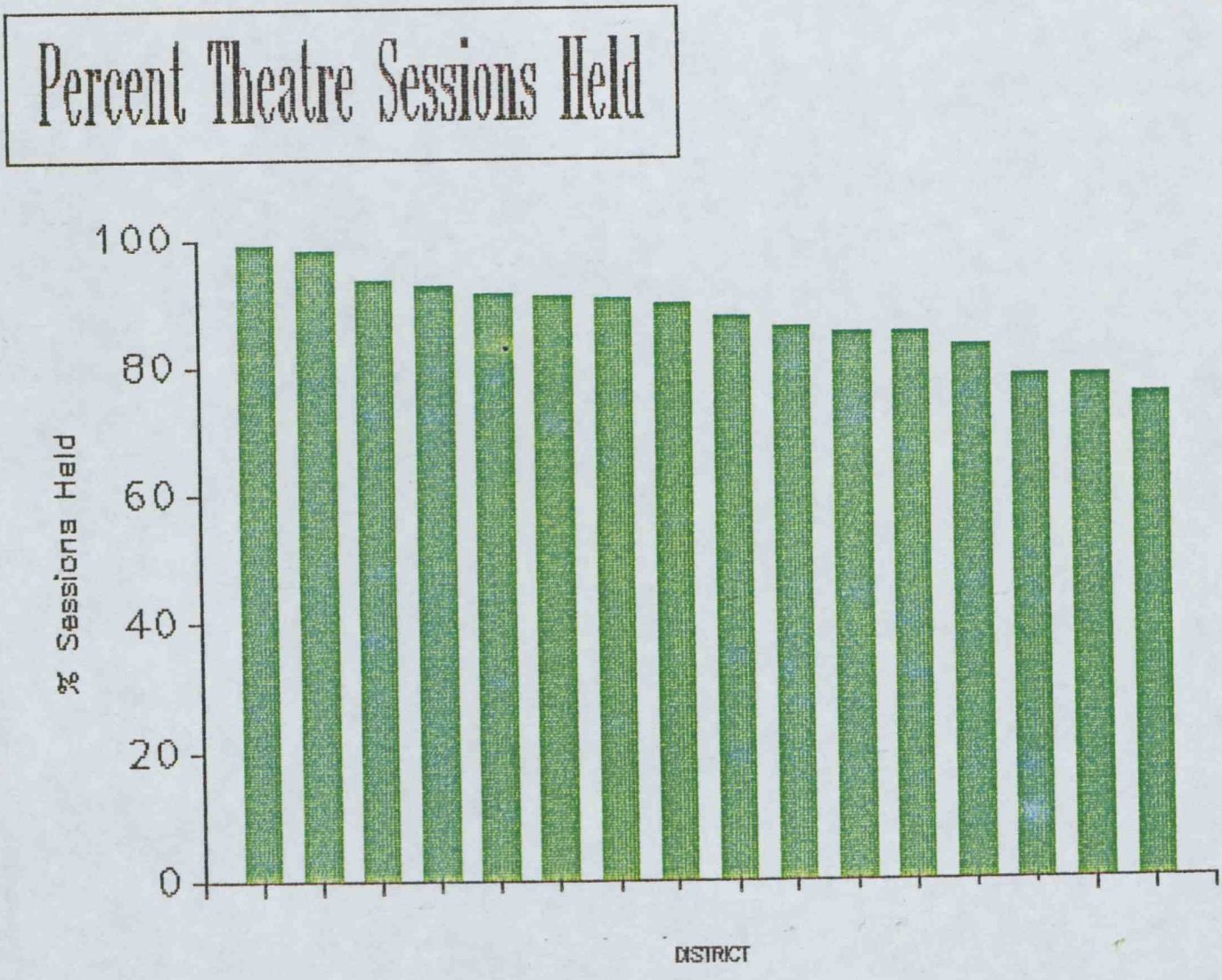

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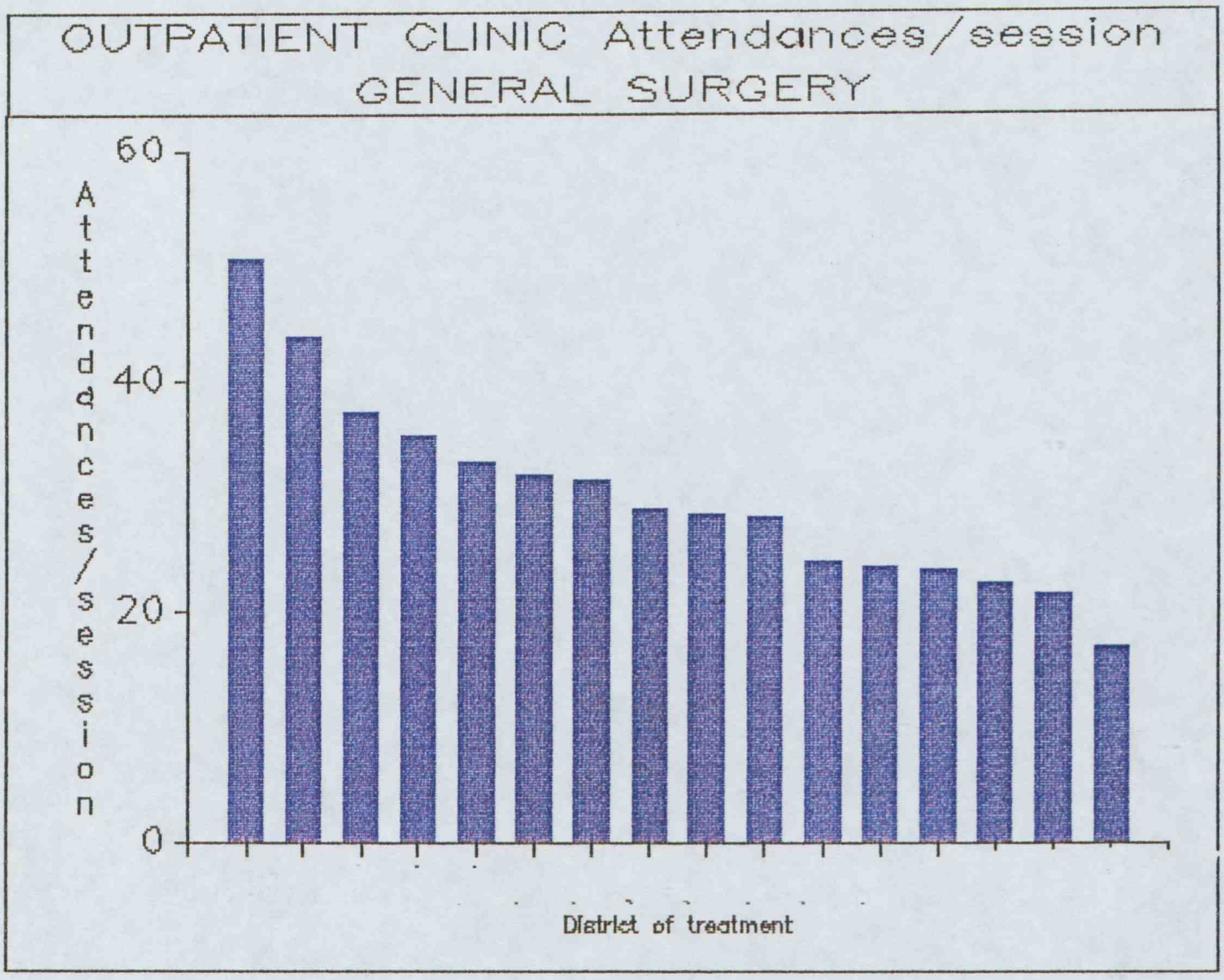
Figure 3



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Annex B

Examples of hospital patient activity data available (at consultant level where applicable)

Number of consultant episodes by diagnosis
Length of stay
Bed turnover interval
Bed occupancy
Bed throughput
Number of cases operated upon
Number of outpatients per clinic
Number of day cases
Waiting lists and waiting times
Accident and emergency cases
Numbers of laboratory requests
Numbers of diagnostic procedures eg. Xray, ECGS.

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ANNEX C

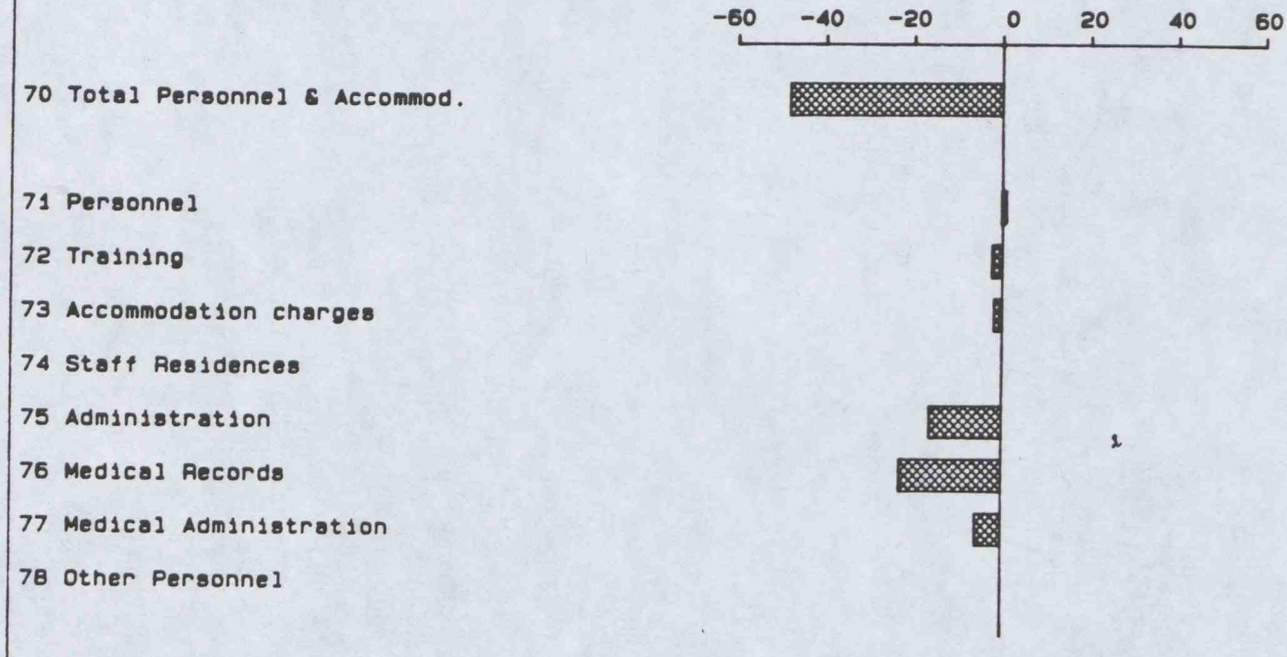
RESOLVE
21:17 22nd Dec 87

Variance on Budget - year to date

222 20 70

£000

Personnel
Variance on Budget - 7 months to Oct.87



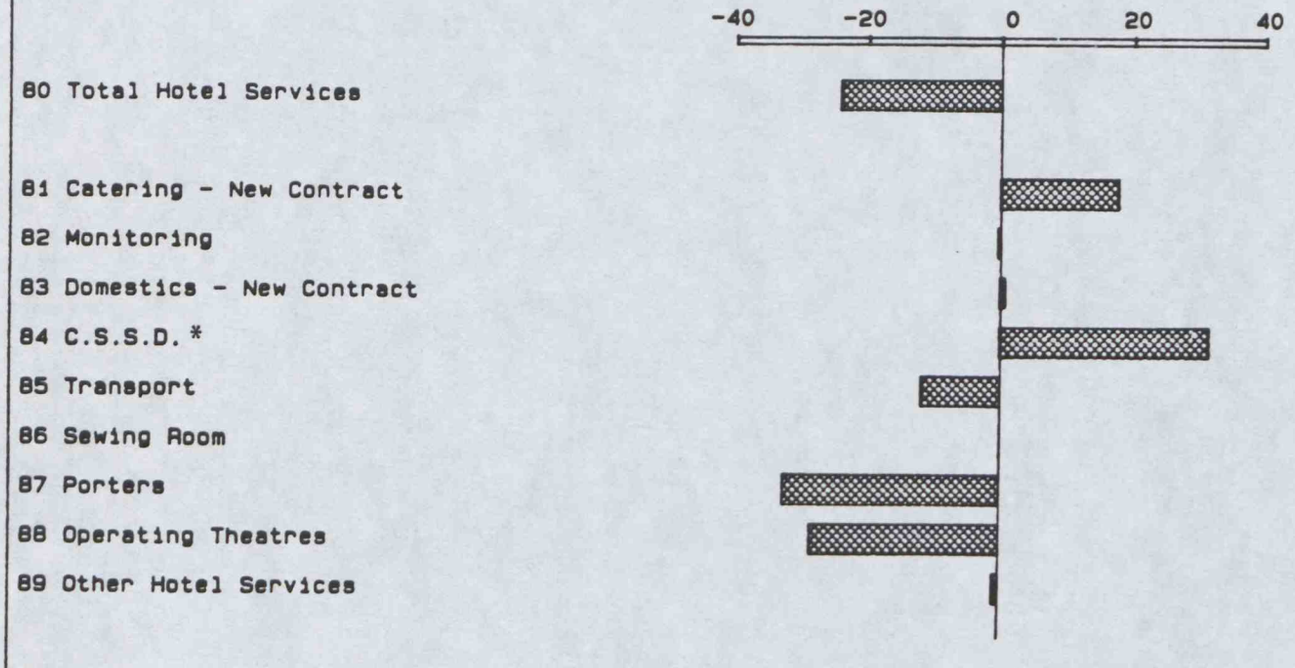

RESOLVE
21:19 22nd Dec 87

Variance on Budget - year to date

222 20 80

£000

Hotel Services
Variance on Budget - 7 months to Oct.87




* Central Sterile Supplies Department

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ANNEX D

| PROGRAMME | DESCRIPTION OF INDICATOR | TYPE |
|---|---|---|
| ACUTE SERVICES | | |
| Patients using a bed | Actual cost per consultant episode by acute specialty | Efficiency |
| Day care patients | Actual cost per attendance (day care patients) by acute specialty | Efficiency |
| Out-patients | Actual cost per out-patient attendance | Efficiency |
| Accident and Emergency Department | Accident and emergency cost per attendance - Accident and Emergency department | Efficiency |
| SERVICES FOR THE ELDERLY | | |
| Patients using a Bed | Actual cost per occupied bed day - geriatric specialty | Efficiency |
| Out patients | Actual cost per attendance (out patients) - geriatric specialty | Efficiency |
| Day Care patients | Actual cost per attendance (day care patients) - geriatric specialty | Efficiency |
| Manpower/ Community | Total annual staff costs of District Nursing staff related to the resident population aged [65+] | Efficiency/ Provision |
| Chiropody Services | Total staff cost (chiropody staff) related to the resident population aged 75+ | Access |

SECRET

| PROGRAMME | DESCRIPTION OF INDICATOR | TYPE |
|---|---|---|
| DEPARTMENTS | | |
| Pathology | Total cost related to unweighted requests for each pathology specialty | Efficiency |
| | Total staff cost (pathology staff) related to unweighted requests for each pathology specialty | Efficiency |
| Radiology | Total cost of radiology services related to 100 weighted requests | Efficiency |
| | Total staff cost (radiology staff) related to 100 weighted requests | Efficiency |
| Radio-therapy | Total radiotherapy costs related to exposures - Radiotherapy departments | Efficiency |
| Nuclear Medicine | Total cost (nuclear medicine) related to weighted requests | Efficiency |
| Medical Physics | Medical physics revenue expenditure per number of courses of radiotherapy given | Efficiency |
| | Medical physics revenue expenditure per 1000 unweighted radiology requests | Efficiency |
| | Medical physics revenue expenditure per 1000 weighted nuclear medicine | Efficiency |

SECRET

| PROGRAMME | DESCRIPTION OF INDICATOR | TYPE |
|---|---|---|
| Pharmacy | Total staff cost (pharmacy staff) related to occupied bed days | Efficiency |
| | Total staff cost (pharmacy staff) related to consultant episodes | Efficiency |
| | Qualified pharmacists (WTE) related to total drugs expenditure | Workload |
| | Total pharmacy staff (WTE) related to total drugs expenditure | Workload |
| Operating Theatres | Total cost of Operating Theatres related to operating hours | Efficiency |
| | Total staff cost (theatre staff) related to occupied surgical bed days | Efficiency |
| Chiropody | Total cost (Chiropody services) related to 1000 resident population | Efficiency |
| Dietetics | Total cost (Dietetics services) related to 1000 resident population | Efficiency/ Provision |
| Occupational Therapy | Total cost (occupational therapy services) per 1000 resident population | Efficiency/ Provision |
| Speech Therapy | Total cost (speech therapy services) related to 1000 resident population | Efficiency |
| Catering | Total cost (patient catering) per occupied bed day | Efficiency |
| Domestic/ Cleaning | Total cost (domestic services) per 100 sq metres cleaned | Efficiency |
| Portering | Total staff cost (portering staff) related to 100 weighted bed days | Efficiency |

SECRET

HC7

NHS BUDGETING AND RESOURCE MANAGEMENT : Note by DHSS

Introduction

1. This paper offers a factual summary of current developments in budgeting within the NHS. It complement paper HC6 on "information for management".

Background

2. Since the 1974 reorganisation of the NHS there has been a considerable sophistication of financial reporting within the Service. The extension of the management accounting function within finance departments has improved the content and timeliness of budget reports. Increasing computerisation has facilitated better workload statistics and manpower reporting as part of overall financial management. In the majority of Districts, managers can expect to receive payroll based reports within 10 days of the month end; some managers will be receiving weekly activity and cost reports.

Links to Planning

3. It is a truism that "a budget is a costed plan", and the necessary preliminary to the budget setting cycle should be the planning cycle. In most health authorities, however, only plans for new services or curtailment of existing services have an impact on budgets, whilst cost improvement programmes tend to be finance-driven and not seen as part of the service plan. The implementation of general management, together with a sharpening up of the planning process in the past two or three years, have stimulated greater integration. But the focus of budgeting still tends to be on marginal change to existing functional budgets rather than on a fresh look at output plans.

Current Budgetary Practice

4. There is no statutory or defined cost centre structure in NHS hospitals for budgetary reporting. Given that hospitals have different management structures, there will continue to be local variations. But there are a number of natural cost centres. Typically, budgets will be set, and individuals held accountable, for:

(i) major diagnostic departments such as radiology, chemical pathology and pharmacy.

(ii) other medical and para-medical services such as physiotherapy and psychology.

(iii) ancilliary services such as domestics/cleaning, portering, transport and estate management.

5. Although in some areas - physiotherapy for example - budgets will tend to be just a financial reflection of a manpower quota, most cover workload as well as resources. Many hospitals have undertaken detailed costing and budgeting studies in departments like radiology. In addition, the competitive tendering programme has ensured cost centres such as catering have had their budgets more carefully scrutinised.

6. More variation is found in the cost centres associated with nursing staff and medical and surgical equipment. Many (but not all) hospitals have set up wards, operating theatres, out-patient clinics and so on as cost centres. But there have been technical difficulties associated collecting data routinely on, for example, the use of consumables by a ward; and also problems of responsibility, for instance agreeing locally who is accountable for the operating theatre budget.

Input Budgeting

7. The well established systems for monitoring actual against expected financial performance have served the NHS well in supporting strong financial controls. But current practice remains directed primarily at controlling inputs. A classic illustration of the problem this poses is the accountability of the budget holder of (say) radiology. Whilst he can be expected to run his department efficiently and produce each X-ray with the minimum labour and materials consistent with quality, he cannot be expected to control the volume of X-ray requests. Establishing this aspect of budget setting in turn requires information systems which can relate patient activity to inputs in the ways described in paper HC6.

Output Budgeting

8. There have been a number of local experiments in the development of budgets which are better related to outputs. These have often been in teaching hospitals, frequently centred around "high-tech" specialties such as renal medicine. The nature of this and similar specialties - high cost, low patient volume, expanding, and relatively discrete in costing terms - meant that budgets could be constructed around forecast patient numbers and agreed treatment protocols.

9. Attempts to develop this process on a comprehensive basis across a hospital were formalised with the management budgeting experiments which preceded the current Resource Management Project. Despite a number of weaknesses in these first experiments, they did provide systems which could be used to start the budget setting process with forecasts of patient numbers and to provide a much stronger link to the planning process.

10. There are probably now some 50 hospital sites in the UK with at least a rudimentary form of output-driven budget setting. The timetable for developing a more sophisticated approach based on "diagnosis related groups" (DRGs) is discussed more fully in paper HC6.

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HC 8

HEALTH CARE SYSTEMS IN OVERSEAS COUNTRIES : Note by DHSS

1. Attached are a set of notes on the delivery and financing of health care systems in a selection of OECD countries, namely:

| | |
|---|---|
| Australia | (A) |
| Canada | (B) |
| Denmark | (C) |
| Finland | (D) |
| France | (E) |
| Germany | (F) |
| Netherlands | (G) |
| Sweden | (H) |
| New Zealand | (I) |
| United States | (J) |

The notes are intended to be brief and for information only. The Ministerial Group may wish to explore individual systems in more detail at a later date.

2. The Group may also find it helpful to have a fuller comparison, including parameters additional to those in the attached notes and covering, for example

* differences in total health expenditure
* a breakdown of health expenditure between different health care sectors and within sectors, including the efficiency with which resources are used
* comparisons between tax based and non-tax based systems, including the impact on people's incomes, administrative costs, and so on
* output comparisons
* differences in health status.

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B:DC2.2.3

SECRET

AUSTRALIA

A

Administrative Organisation

The federal government has legislative powers over the provision of pharmaceutical, hospital and sickness benefits and medical and dental services.

The supply of health care facilities and the operation of health services is shared between the state governments and the private sector.

Local authorities have limited powers and responsibilities for the protection and promotion of public health.

Coverage

A universal health insurance scheme (Medicare) operates throughout Australia with residency as the sole eligibility criterion.

Medicare reimburses in full the cost of inpatient and outpatient treatment and accommodation in public hospitals. Patients contribute towards drug prescription costs with a flat rate fee per item.

Medicare does not cover dental services, home nursing, physiotherapy and chiropracters.

Individuals can upgrade the basic Medicare service through private insurance/ out-of-pocket payments.

Delivery of service

Primary care

As in the UK the general practitioner acts as the gatekeeper to the health service.

Of the 90 per cent of practitioners in private practice 40 per cent are GPs and the rest are specialists who hold part-time salaried hospital posts with (limited) rights of practice.

Secondary care

About 80 per cent of general short-stay hospital beds are in public hospitals and the relatively high bed to population ratio means that waiting lists are virtually non-existant. Private hospitals, which tend to be owned by doctors, are licensed by the state health authority with responsibility for standards of accommodation, staffing, facilities and records.

Patients on admission (either by referral or through the A&E department) elect to be treated either as a 'hospital' or 'private' patient. The former are treated by hospital clinical staff and the cost reimbursed by Medicare. The latter are treated by the doctor of their choice and must pay a user fee.

Source of funds

Medicare is financed from general taxation and by an earmarked levy of 1.25 per cent of taxable income (from all sources) over and above specified thresholds. There are exemptions for pensioners and social security beneficiaries.

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State governments provide the major share of capital funds for public hospitals. In addition individual hospitals may raise bank loans guaranteed by the state health authority._

Hospital/ Doctor reimbursement

Public hospital operating costs are reimbursed by the federal and state governments. There are no government subsidies for private treatment and patients pay the full cost.

General practitioners are paid on a fee-for-service basis. Full-time hospital doctors are salaried, the awards set by an independent wage fixing tribunal.

# SECRET

B

CANADA

Administrative organisation

The Department of National Health and Welfare administers national programmes, monitors provincial compliance with conditions of legislation and provides provinces with technical, consultative and co-ordinating services.

Provincial health care systems are self-contained. Each authority administers its own health insurance plan, assesses hospital and medical claims, pays providers and monitors all aspects of the programme.

Coverage

Each province runs a universal medical insurance scheme which is portable from province to province. Coverage is compulsory but some opting out is permitted in Ontario and Alberta. Services covered vary between provinces but typical exclusions are cosmetic surgery, prescription drugs for those under 65, external appliances and ambulance transport.

Delivery of service

Primary care

All providers are autonomous. Some 70 per cent of practitioners are in office-based ( as against hospital ) private practice but with hospital privileges to admit and treat/ supervise the treatment of their patients.

Secondary care

Over 90 per cent of beds are in nonfederal hospitals of which just 2 per cent are in proprietory institutions. A further 2 per cent of beds are in federal hospitals and the remainder are in provincial mental institutions. Hospitals are owned mostly by communities or by charitable institutions.

Sources of funds

The bulk of the cost of the Canadian health service is met from provincial general revenues. The Federal government makes contributions to the provinces through block grants, conditional on the provinces meeting federal programme requirements. Employer/employee contributions vary between provinces as do user charges. Physician services tend to be re-imbursed in full.

Hospital/ Doctor reimbursement

Hospital operating costs are met from annual prospective global budgets controlled by the provincial government. Capital budgets are granted separately on specific approval of the proposed investment.

Doctors are reimbursed either on a fee-for-service basis if self-employed (in either the primary or secondary sector) or an a salary if employed by a hospital or health centre.

SECRET

DENMARK

C

Administrative organisation

The State lays down the legislative framework and undertakes supervision and control of the health programme.

County councils with responsibility for hospital services, and the National Health Insurance scheme are responsible for curative health services. Preventive medical services fall to the municipalities.

Coverage

As in the UK all residents are guaranteed the right to free medical care irrespective of income.

Delivery of service

Primary care

Primary health services are organised on a similar basis to the UK. Patients are treated by general practitioners in private practice with access to a wide range of community health services. If appropriate patients are referred to specialists outside the hospital system. This group of practitioners provides most services traditionally supplied in the UK by outpatient facilities.

Patients can choose between two types of GP service:

-free treatment by a GP of their choice with whom they agree to stay for at least one year. 95 per cent of the population opt for this.

-unrestricted access to any GP or specialist with the patient paying the practitioner's fee and part of the cost of treatment.

Secondary care

Almost all the hospitals are publicly owned. Treatment is free and patients are admitted on referral by GP or through A&E service. A few private hospitals exist but are almost 100 per cent subsidised by local authorities and subject to the same regulations as public hospitals.

Source of funds

Almost the entire cost of the Danish health system is borne by the local and state government out of general taxation and rates.

In addition charges are levied on

-medicines (upto 50 per cent of their cost)
-adult dental care
-physiotherapy
-spectacles

with exemptions for patients on low incomes.

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Hospital/ Doctor reimbursement

Doctors are under contract to local government and are paid either on a straight capitation fee (Copenhagen) or by capitation plus fee -for-service (rest of the country). Specialists are paid on a fee-for-service basis and where employed by hospitals can engage in private practice outside normal working hours either on their own premises or at the hospital. If the latter there are regulations as to the time, extent and user payments to the hospital for facilities, staff and instruments.

Hospitals are financed by local government.

FINLAND SECRET D

Administrative Organisation

The Ministry of Social Affairs and Health supervises three National Boards of of Health, Social Welfare and Labour Protection. The provision of health services falls directly to the municipalities, or communes, which effect delivery either singly or in combination with other communes.

Coverage

All residents are covered by a predominantly public financed system.Private insurance schemes exist but these are mainly involved in compulsory accident insurance which covers the cost of health care resulting from work or traffic accidents.

Delivery of service

Primary care

The basic unit of health care is the health centre run by a commune or federation of communes. The health centre is a functional medical unit which may have more than one physical location. The services provided cover basic GP care, school health, dental care, and vetinary services. Almost all have some beds, X-ray and laboratory facilities.

One fifth of physician services in the primary sector are private. Health centre doctors may treat private patients but not in the health centre.

Secondary care

Virtually all hospitals are public hospitals owned by a federation of communes in each of 21 central hospital districts. Some 5 per cent of hospitals are private and may or may not be subsidised. In addition state hospitals can have upto 10 per cent of its beds designated as private.

Sources of funds

Health services are funded from general taxation levied at central and/or local level. Gross hospital costs are shared between State and commune, the richest receiving a subsidy of 30 per cent and the poorest a subsidy of 70 per cent. (Similar arrangements apply to health centres).

Hospital/ doctor reimbursement

Less than 10 per cent of hospital costs comes from co-payments. These are levied on outpatient visits and inpatient admissions as a day fee for stays of less than three months in hospital.

Hospital doctors are salaried as are health centre practitioners.

FRANCE

SECRET

E

Administrative organisation

There is considerable central regulation of hospital planning and spending with regional governments in control of administration and funding.

Coverage

The national social insurance system is virtually universal.

Delivery of service

Primary care

Medical care is dispensed by general practitioners and specialists in private practice. There is no limit on access to, nor prescription of care by, the practitioners and no referral by GPs to specialists.

A small but growing number of health centres have been established in recent years managed by community groups and friendly societies. The centres are officially recognised by the sickness insurance funds and medical personnel work on a contract basis.

Secondary care

Some 70 per cent of beds are in publicly owned (mainly by local government) hospitals. Some private owned hospitals are authorised to operate as part of the public system accepting an obligation to treat patients round-the-clock.

Most private facilities are used for maternity and elective surgery and are about 12 per cent voluntary and 18 per cent proprietory.

Sources of funds

Health care expenditure is financed from:

-employee/employer social security contributions (which cover cash benefits too)

-patient charges. These cover roughly 25 per cent of doctors' and dentists' fees, 20 per cent of hospital treatment costs plus a small 'hotel' charge and between 30 and 60 per cent of the cost of prescribed medicines. (Social assistance beneficiaries are exempt as are consumers of essential care for serious and long term illnesses, maternity and neo-natal services).

-government contributions from the proceeds of automobile insurance premiums as well as a tax on pharmaceutical advertising costs,alcohol and tobacco. In addition the government pays lump sum subsidies towards hospital capital and operating costs.

Hospital/doctor reimbursement

Hospitals receive about 20 per cent of their operating costs direct from the patient and the rest from the sickness insurance funds by way of prospectively set global budgets.

Capital costs are recovered in part through amortisation allowances in the per diems and charges. The balance of costs are financed through subsidies from the central and local governments.

In the primary sector practitioners receive a state approved fee-for-service (health centre physicians are salaried). In the hospitals doctors are paid a salary in the public sector and receive a fee-for-service in the private sector.

GERMANY

SECRET

F

Administrative organisation

Central government is responsible for overall supervision of the social insurance system and health matters in general but it is the state governments (Lander) that determine hospital capacity and have executive and legislative powers to fix hospital per diems, capital expenditure etc.

Coverage

Some 90 per cent of the population is covered by the sickness insurance scheme. The remaining 10 per cent (mostly high earners and the self-employed) are covered by private insurance.

Delivery of service

Primary care

Primary health services tend to be delivered by general practitioners in private practice, but as in France, since patients can consult specialists directly, GPs do not have a monopoly on primary care.

All social insured patients gain access to the health system either through a GP or specialist who must be a member of a physicians' organisation or panel. Outpatient services are provided by 'polyclinics', outpatient clinics (establishments with at least 3 specialised departments), doctors practices and district nurses.

Secondary care

The hospital sector is confined almost exclusively to inpatient services. Except in an emergency, admission is on referral by a panel doctor. The doctor's referral must be submitted in advance to the sickness fund for approval of cost, otherwise the patient must pay in full.

Over half the hospitals are publicly owned by the local communities. Some 35 per cent are private non-profit making and the remainder are proprietory.

Source of funds

Health service expenditure is financed from:

-employer/employee social security contributions with an upper earnings limit. As a result of measures introduced last year (primarily increased charges and reduced coverage for 'inessential treatment') these contributions will be reduced in the future.

- patient charges eg prescriptions (with exemptions for children,pensioners, the disabled and expectant mothers), 'hotel' charges for the first fourteen days in hospital and transportation charges. New or increased charges have been announced for prescriptions, spectacles ,hearing aids and dentures.

-government subsidies for particular occupation schemes and grants for hospital capital expenditure.

SECRET

Hospital/Doctor reimbursement

Hospitals are under contract to the sickness funds. Basic operating costs are reimbursed through prospective (hospital specific) per diem rates negotiated between the hospital and the regional sickness fund. These rates are subject to approval by states governments. For optional extras such as single room accommodation and treatment by a particular doctor the patient is charged directly.

Capital costs are financed by federal, state and local authorities directly out of taxation.

Regional physician panels contract with the sickness funds to provide care for the insured on an annual lump sum basis. The lump sum is then apportioned among participating doctors on a fee-for-service basis. Hospital doctors are salaried.

NETHERLANDS

Administrative organisation

Both national and regional government have responsibility for health sector planning and the construction of facilities and the acquisition of major items of medical equipment require a government issued licence.

Coverage

Social insurance with an approved sickness fund is compulsory for all employees under retirement age and earning less than a fixed amount. Individuals remain compulsorily insured post retirement, as do social security beneficiaries and all dependents. This covers some 70 per cent of the population. The remainder are covered by private insurance.

The 'Exceptional Medical Expenses' scheme covers the cost of medical care in cases of prolonged illness or disability requiring hospitalisation of more than a year or nursing home care for the elderly or chronic sick. It is compulsory for all residents.

Delivery of service

Primary care

Patients register with a general practitioner contracted to the social insurance scheme who either treats the patient directly or refers him to a specialist operating in private practice from the outpatient department of a hospital.

Increasingly GP services are being provided in health centres alongside dentists and dispensing chemists.

Secondary care

Some 90 per cent of hospitals are privately owned and run on a non-profit bais by local communities and religious orders. The remainder are owned by the municipalities. Hospitals maybe further classified according to whether they are 'open' or 'closed'. In the former the patient is free in the choice of specialist who in turn has right of access to the hospital. In the latter, there is a contract with a team of specialists the members of which treat patients to the exclusion of all other specialists.

Admission to hospital is via GP or specialist referral.

Sources of funds

Health service expenditures are financed from

-equal employee/employer percentage social security contributions for ordinary care but with additional employer contributions for the 'Exceptional Medical Expenses' scheme

- patient charges for prescriptions, some dental treatments and artficial limbs and appliances

- annual lump sum government subsidies for the 'Exceptional Medical Expenses' scheme.

SECRET

Hospital/ Doctor reimbursement

Hospital and doctors contract to the social insurance scheme and are paid directly by the sickness funds.

GPs are paid a capitation fee, however, the size of the fee is related to the number of sickness fund patients registered with him. Compensation for the fixed costs of practice are paid out to some maximum number of registered sickness fund patients. In addition GPs with privately insured patients receive payment on a fee-for-service basis, direct from the patient who is subsequently reimbursed by the insurer.

Specialists are paid on a fee-for-service basis and on a scale agreed with the sickness fund (for sickness fund patients). Hospital doctors are salaried.

SWEDEN

SECRET

H

Administrative organisation

The Ministry of Health and Social Welfare determines policy. An independent supervisory body, responsible to the government (not the ministry) is the main enforcement and planning agent but executive responsibility for all public medical services falls to the 23 counties and 3 municipalities.

Coverage

The national health insurance scheme is compulsory for all who live and work in Sweden. It provides protection against loss of income due to illness, injury, disability or childbirth.

Benefits include part of the costs of primary care services, outpatient services in hospitals and consultations for inpatient treatment. Dental services are free upto the age of 19. Sickness benefits under the scheme amount to 90 percent of income upto some fixed maximum.

Delivery of service

Primary care

'Family' doctors are employed by the counties/municipalities as district health officers providing community care in health centres. However, the use made of primary care facilities is remarkably low due in part to an 'over-investment' in hospital (including outpatient) based services to which patients have direct access without the need for GP referral. Currently only a third of all ambulatory physician visits are to district physicians (as against 50 per cent at hospital outpatient clinics).

Some 5 per cent of doctors are in private practice. They can opt to be affiliated to the public insurance system, in which case the patient pays a higher fee and the fund reimburses the doctor at the agreed rate.

Secondary care

Only 6 per cent of hospitals are privately owned and there are no private facilities in public hospitals. Most hospitals are owned by the counties/ municipalities.

Highly specialised hospital care is provided by six health care regions and is regulated by agreement between the county councils.

Sources of funds

Some 65 per cent of Sweden's health care service is financed from employers' contributions. A further 15 per cent comes from state grants and the rest from patient charges.

SECRET

Hospital/doctor reimbursement

Hospital operating costs are met from annual budgets controlled by the local community councils. Capital costs are community financed by means of a specific appropriation voted by the community councils.

Doctors in the public sector receive a fixed salary for a fixed number of working hours and are prohibited from receiving direct patient fees for inpatient or outpatient services.

SECRET



NEW ZEALAND

Administrative organisation

The Department of Health defines sector wide priorities and funds and oversees:

(1) Hospital boards (and the area health boards that are gradually replacing them). These plan and control public hospitals and (in the case of health boards) public health.

(2) Health benefits that subsidise privately provided general practitioner services, pharmaceuticals, laboratories and private hospitals.

Coverage

Health care is available to all residents. The cost of hospital care in public hospitals is borne entirely by the state. Patients contribute to the cost of primary care and some 30 per cent of the population has private insurance to cover these charges. Free dental services are limted to those under 16 years old.

Delivery of service

Primary care

Primary health is delivered by private practitioners in a contractual arrangement with the State. Patients do not have to register with any particular doctor. For access to specialist and hospital care general practitioner referral is usual; it is obligatory if health benefits are to be claimed. Choice between public hospital specialist services (for which there is no charge ) and private specialist services (for which patients pay at a subsidised rate ) is determined in part by assessment of waiting times, convenience of location and flexibility of appointment systems.

Secondary care

Private hospitals account for about 14 per cent of surgical and medical beds, 55 per cent of geriatric beds and 21 per cent of all hospital beds. Hospital care is subsidised in the private sector and provided free of charge in the public sector. A high proportion of pathology and radiology is done privately, is free or heavily subsidised to the patient, and is used extensively by the smaller hospitals on a contractual basis.

Sources of funds

The public sector meets over 80 per cent of the total health care cost financed primarily from general taxation (with minor exceptions funded directly from the Accident Compensation Commission). A further 15 per cent represents out-of-pocket payments to meet the costs of GP visits (the State meets only half these costs) and pharmaceuticals (prescriptions are subsidised with larger subsidies available for children and elderly).

Hospital/Doctor reimbursement.

Public hospitals are funded through budgets allocated on a RAWP type basis to Hospital Boards. Private hospitals receive subsidies in the form of a per diem payment equal to 50 per cent of the full charge

SECRET

General practitioners and specialists receive from the State a flat rate fee for items of service performed during normal hours. This is enhanced for night,holdiay and week-end work and for treating certain categories of patients eg the elderly, children and chronically infirm.

Patients pay the excess direct to the GP upto a maximum charge set by an independent body. Full-time hospital doctors are salaried.

UNITED STATES

SECRET

J

Administrative organisation

The Federal government's direction of the health service is limited to the provision of monies tied to specific legislation and the regulations that flow from that legislation.Planning is undertaken at state and local levels. Licensure of both practitioners and hospitals falls within the powers of the state government.

Coverage

US health care systems combine public and private interests and institutions. Some 90 per cent of the population is protected by private health insurance or a government programme or a combination of both.

The two main governemnt programmes, Medicare and Medicaid account for about 30 per cent of health care spending. Medicare is run by the Federal government for the elderly (over 65); Medicaid is a federal/state funded programme covering the needy, regardless of age. Many Medicare patients take out 'top up' insurance to cover charges (mostly physician fees) not fully reimbursed by the scheme. Service coverage for Medicaid is wider than for Medicare but usually excludes dental services,prescribed drugs, eyeglasses and intermediate care facilities.

Delivery of service

Patients have a significant amount of freedom to select the physician of their choice and the hospital in which care will be provided. The principal constraint is whether or not the chosen physician has the privilege of admitting patients to the hospital of the patient's choice

Primary care

Most physicians are in private practice and there is no clear demarcation between the role of the general practitioner and the specialist.Patients have direct access to both, who will then refer to a specialist /other specialty service as appropriate. Physician practice is office based -house calls are very rare.

An increasing number of physicians -approximately 25 per cent - now practice in single or multi-specialty groups. Health Maintenance Organisations (HMOs), where the emphasis is on prevention, tend to be large multi-specialty groups which contract with a population (usually an employee group) to provide comprehensive health services in return for regular payments, irrespective of whether the enrolled use service or not.

Secondary care

Over 60 per cent of all hospital (and nursing home ) beds are privately owned of which some 85 per cent are in non-profit making institutions. The rest are federal (intended for the armed forces, veterans and American Indians and not accessible by the general public) state and locally owned.The latter have provided a charitable 'last resort' function and their importance is diminishing.

Access to private hospitals is by the referring physician with rights of practice, who personally provides /supervises hospital care and determines when to discharge the patient.

SECRET

Sources of funds

Federal and local/state government monies together account for just over 40 percent of direct total health expenditure. The remaining 60 per cent divides equally between direct out-of-pocket payments and third party (insurance) payments. Medicare is a social insurance programme. One part covering hospital,nursing home and home care is financed through the social security system by compulsory salary deductions. The second part covering physicians services is financed by general taxation and voluntary contributions. Medicaid is a non-contributory programme financed from general taxation.

Hospital/doctor reimbursement.

Since 1984 the Federal Medicare programme has reimbursed hospitals on the basis of prospectively established payments per case (diagnostic related groups (DRGs)). Individual state Medicaid systems and private insurers use a variety of approaches, predominantly retrospective cost or charge based.

Capital reimbursement tends to be included in the payment rate,however, fixed.Principal government subsidies for capital are through the tax exemption of financing instruments for health care institutions.

Patients pay on a fee-for-service basis in the primary sector but doctors may be reimbursed in a variety of ways ranging from fee-for-service to salary to percentage of group income (for group practices and HMOs).Hospital doctors are either paid on fee-for-service basis or a salary.

11.2.2

SECRET

**GREATER COMPETITION IN THE NHS** **HC 9**

**Note by HM Treasury**

1. The NHS is an administered rather than market-based system. There is little effective competition between suppliers and little financial incentive to attract customers. This has led outside observers to discuss the "internal market" and other means of introducing market forces.

2. The essence of a market-based system is a distinction between buyers and suppliers. At present patients do not act as buyers, as they do not pay directly for services; there is little charging for services; and there is little competition between alternative suppliers. Many possible models can be envisaged, for example:

Within hospitals: hospital managers as buyers, clinical teams as suppliers.

Between hospitals: districts or GPs as buyers, hospitals (public or private) as suppliers.

Between districts: one district as buyer, another as supplier.

For all health services: amalgamated district/FPC as buyer, contracting GPs, hospitals etc as suppliers.

We do not need yet to construct detailed models. But we need to identify the conditions which must be fulfilled if an element of competition is to be introduced into the NHS. This paper should be read in parallel with that on providing consumer choice; it should be noted that the objectives of choice and efficiency do not always coincide.

3. If suppliers are to be able to compete with each other in a way which improves overall efficiency:

- they need financial incentives to attract customers;

- buyers need information on which to base their decisions and budgets to encourage cost-effective choice.

Without all these, there is a danger that competition would be solely in terms of quality of service, and hence generate further cost pressures. Choices in the system need to be reinforced by financial transactions which determine resource allocation: in other words, the money should follow the patient.

4. This brings us up against a fundamental problem: service delivery is organised in a completely different way from the allocation of resources.

5. Service delivery is dealt with by the medical profession. It starts with the patient approaching his GP. Two distinct stages follow: diagnosis and treatment. The GP may do both himself (eg by writing a prescription for an antibiotic). Alternatively the diagnosis may be clear, but he needs to refer the patient to a hospital consultant for treatment. A third possibility is that the patient is referred to a consultant for diagnosis, and perhaps onwards within the hospital system several times before eventual treatment. In the course of treatment, the consultant and his team will call upon a number of specialist services: radiology; pathology; physiotherapy; occupational therapy; and so on.

6. Resource allocation is largely separate from this process. Funds are allocated by districts to hospitals, and within hospitals, on the basis of an overall assessment of needs. Efforts are of course made at all levels to accommodate clinical requirements. But the structure - from PES to RAWP to day-to-day decisions in hospitals - is quite different from the clinical decisions described above. Thus, the level and quality of service

has little bearing on resource allocation and, conversely, there is little resource incentive to improve performance. Indeed there exist perverse incentives not to improve efficiency. A surgical team that improved its efficiency and so was able to treat more patients in a year would, as a result, also have higher costs and so would risk coming up against its budget limit before the year end, as may have been happening in the current year.

7. Even within the present organisation of the NHS, competition could be introduced into at least some of these decisions. One form of the "internal market" - with districts trading with each other and the private sector on the basis of comparative cost - could be introduced once the better costing information now in the pipeline starts to come through. Clinical budgets, with medical support services as cost centres, offer the prospect of competitive tendering for pathology, etc. Good progress has been made in competitive tendering for ancillary services, with cumulative savings now over £100m a year, but no steps have yet been taken to introduce it into clinical areas.

8. In considering specific options for changing the future structure of the NHS, the following criteria need to be met if the result is to be improved competition:

a. Does the new structure clearly distinguish buyer and supplier?

b. Is the buyer in a position to make informed choices?

c. Do resource allocation decisions match up with clinical decisions?

d. Is the good supplier thereby better rewarded than the less good?

e. Are there incentives for suppliers to maximise their efficiency?

**CONSUMER CHOICE**

**Note by H M Treasury**

**Objectives and scope**

There are two main objectives in extending consumer choice in health care:

(a) the ability to exercise choice is desirable in itself; and

(b) choice stimulates competition among the suppliers of health care and so encourages greater responsiveness to consumer demands.

Moreover, if associated with appropriate financing mechanisms, choice enables individuals to decide for themselves how much they want to spend on health care. In this connection, it is important to be clear about the appropriate role of the state - see Annex.

2. There are, however, a number of potential constraints:

- it is not generally realistic for consumers to exercise choice over <u>clinical</u> decisions. This would be impossible in relation to, for example, much casualty work. But there is greater scope for patient choice in other areas (eg maternity) and more generally giving patients more <u>information</u> about the clinical alternatives;
- consumer choice may in some circumstances conflict with efficiency. For example, an internal market under which health authorities traded with each other (and with the private sector) would imply <u>directing</u> patients to particular hospitals and so overriding consumer choice;

- if health services are provided free at the point of use, consumers have no incentive to be cost-conscious; allowing more choice is thus likely to put upward pressure on expenditure, as patients would generally choose on the basis of quality rather than cost.

If steps were taken to introduce greater choice, therefore, it would need to be clear that the benefits outweighed the costs inevitably associated with it.

3. Leaving aside clinical decisions, where the scope is limited as explained above, the main areas for the exercise of consumer choice are as follows:

(a) choice of doctor (GP and consultant);

(b) choice of place of treatment (eg choice of hospital);

(c) choice of timing of treatment;

(d) choice of optional extra (eg better hotel services in hospital); and

(e) choices in financing (eg in insurance-based systems consumers may be able to choose between alternative levels of cover according to the premiums paid.

**Present system**

4. In principle, NHS patients already have the right to choose their GP and also the NHS hospital and consultant from whom they are to receive their health care. In practice these choices appear to be little exercised: very few people change their GP except when moving to a different locality; and most people rely on the GP to refer them to a consultant. One major reason is lack of readily available information on the services available.

5. Little choice is offered by NHS hospitals over the timing of treatment, eg out-patient consultations or non-urgent operations. Nor do patients have any choice over the standard of hotel services. The one optional extra available in NHS hospitals is use of an "amenity bed" in a separate room, on payment of a relatively small charge; but take-up of this option is low.

6. These limitations in the NHS mean that the main route for patients wishing to have more choice is to go private, usually by joining a private health insurance scheme. But this is a costly decision, as it effectively means paying twice for part of their health care. And it is only by going private that patients are able to exercise any choice over the financing of health services, as there is no scope under the NHS either for opting out (ie providing for ones own care in return for reduced contributions to the state system) or for topping up (ie paying at the margin for extra services).

**Options for increasing choice**

7. Some steps are already being taken to extend the scope for consumer choice in the NHS. For example, the 1987 White Paper "Promoting Better Health" has as an objective "to give patients the widest choice in obtaining high quality primary care services". To this end it is proposed:

- to improve the availability of information on local health services, including discussion with the General Medical Council of the removal of the ban on advertising by GPs;
- to make it easier to change doctor; and

- to raise the proportion of GPs' incomes accounted for by capitation payments, so as to provide a greater financial stimulus for GPs to be responsive to patients' wishes.

8. Other options within the present structure include:

(a) improved provision of information, along the lines of the primary care White Paper but extended to the whole range of health services. This might involve improved communication between GPs and hospitals on the hospital services and specialists available and on waiting times in different locations;

(b) more choice over the timing of hospital treatment, for example by requiring hospitals and consultants to offer alternative appointment dates and the option of short-notice cancellation bookings for out-patient attendances and elective surgery;

(c) increased provision of optional extras in NHS hospitals, available for a fee. As well as separate rooms, these might include special menus, accomodation for visitors and facilities such as private telephones and TVs.

9. When more radical options for the future of the NHS come to be considered, further ways of improving consumer choice will open up. Structural changes within the NHS - for example, if we went down the road of competing Health Maintenance Organisations - might enable patients to choose between different methods of providing health care. And financing changes (for example, allowing people to opt out of certain types of NHS care in return for paying a reduced contribution) may make the alternative of private care the more

real choice for many people than it is at present. Such options will need to be considered in the next stage of the Group's work.

ANNEX TO HC10

## THE ROLE OF THE STATE

1. In considering the question of choice in particular, but also other questions (eg of competition), the role of the state needs to be considered.

2. The state's primary role is to ensure that everyone has access to adequate health care at a price they can afford.

3. For that purpose, it is not necessary for the state to provide the care itself. At present the state does provide most of the health care of the nation. There is some private sector provision, part of which is purchased by the state and part of which is bought directly by the patient (or via an insurance company). But that is comparatively small (and the state even sells some of its provision to the private sector).

4. It would be possible to move, gradually or quickly, to a system where most health care services were provided by private sector organisations, competing with each other to a greater or lesser extent. The process might be fastest with hospitals, where private sector provision has already made the greatest inroads, but could also include primary health care.

5. The State would be left with an enabling and regulatory role. As regards the enabling role, there are various ways in which people could be enabled to finance their purchase of health care, and these can be considered in the further work to be done.

**SCOPE FOR INDEPENDENT AUDIT OF EFFICIENCY** **HC 11**

Note by HM Treasury

1. There is at present no systematic attempt to carry out studies which would enable the efficiency of different parts of the NHS to be compared, so that best practice may be easily established and disseminated and poor performance highlighted. Experience suggests that a valuable way of doing this would be to build on the collection and analysis of information by auditors.

2. The objectives would be to use the information systems now being developed in order to produce deeper efficiency and value-for-money (VFM) studies across a broader range of NHS acticity. The reports need to be demonstrably independent. They also need to be published regularly and widely in order to stimulate public interest and discussion.

Current Structure

3. There are currently three layers of audit function in the NHS:

(a) Internal audit within individual health authorities and family practitioner committees.

(b) The main statutory external audit of individual authorities and FPCs carried out by DHSS.

(c) Audit by the NAO of the summarised accounts for the hospital and family practitioner services as a whole and of the Appropriation Accounts for the relevant Votes.

Other VFM work under existing arrangements is carried out by the Health Advisory Service, which promulgates good practice in community care, and through efficiency scrutinies by regions.

4. At present none of these audit tiers carries out systematic service-wide VFM audit. It is a function which could fall to either NAO or DHSS in the present system. The NAO have begun to do more comparative VFM work - the recent report on operating theatres is a good example - and this is to be encouraged. But NAO

(and PAC) are not best placed to take on the more wide-ranging role envisaged in paragraph 1. The DHSS statutory audit teams have begun to give greater priority to VFM work, and 30 studies are currently in progress.

Possible Options

5. Most of the suggestions for change have focussed to some extent on the analogy of the Audit Commission, following the techniques which it uses in its audit of local authorities. In many cases, the auditors themselves are private firms, but all report to the Commission and are paid for by the authorities. The Commission instructs these auditors in the course of their audit to gather figures for specific activities. The Commission then assembles and compares these figure and produces models of best practice. A report is produced for each authority, comparing their performance with best practice, and the auditors are instructed to follow up the authorities' progress in improving performance.

6. In its VFM studies, the Commission uses maximum publicity, and threats to expose bad practice, in order to force councillors to agree to efficiency improvements rather than face questions from their electors. Much is achieved by appealing to the professional pride of chief officers, but ultimately the accountability is to local councils.

(i) Improve existing arrangements

7. This could be done by a variety of measures, including greater outside recruitment into the DHSS Audit Directorate; more exchanges of staff with the private sector and the Audit Commission; contracting more audits out to private sector firms (15% of health authority audits are already contracted out but the Audit Commission proportion is 30%); and introducing multi-disciplinary audit teams which included doctors and non-clinical professionals as well as accountants. The statutory audit branch might be given a quasi-independent status within DHSS, reporting direct to the NHS Management Board, and charged with producing more wide-ranging VFM reports.

8. The advantages of this approach are that it would be readily accepted by the parties presently involved (Parliament, NAO, DHSS, and NHS staff) and would build on the progress now being made. It is also likely to be less expensive than alternative options involving organisational change. The disadvantages are that it would provide less initial impetus than the other options, and that the process would not be wholly independent of Government and the NHS.

(ii) A new independent audit authority

9. A second option would be to hive off the DHSS' statutory audit service with an independent role and strengthened staffing. This would follow the precedent of the Audit Commission, which was originally set up from the former District Audit Service of the DOE. For individual health authorities, the new body would provide statutory audit reports as they do now. Wider studies on value for money and efficiency on a national basis could also be prepared for the NHS Management Board or for publication generally. An annual report would be laid before Parliament.

(iii) Give statutory audit to Audit Commission

10. A further option would be to remove the audit function from DHSS completely and give it to the Audit Commission instead of setting up a new, and to some extent rival, body. DHSS audit staff would then transfer across to the Audit Commission. The NAO would continue to audit the consolidated accounts, so that the PAC retained its role in relation to the large sums of voted money which go to the NHS.

11. The advantage of this option would be that responsibility would fall to a body with proven expertise. In contrast, there would inevitably be a period of uncertainty while the new NHS audit body suggested under (ii) above established a track record for itself. Given the links between health authorities and local authorities, it might be thought logical to have one body dealing with the two.

12. There are however constitutional difficulties. The Audit Commission reports to local authorities, who are in turn responsible to their electorates, subject to a statutory power of surcharge where defined rules are broken. The NHS, on the other hand, is a part of central government, with a Minister responsible to Parliament. The lines of accountability are quite different. If the Audit Commission became responsible for NHS external audit, it would have to become responsible to DHSS Ministers (either directly or through health authorities), which would represent a major change in its hitherto independent constitution.

13. There is also a possibility of conflict with the NAO who, as mentioned above, have the right to conduct VFM studies in the NHS and do so. The NAO might resent the intrusion of another audit body into what they may consider as their territory and this would require careful handling.

Conclusions

14. The pros and cons of the three options for achieving this may be summarised as follows.

(i) Beef up DHSS statutory audit. The least disruptive option, and much could be done; but lacks the impetus that would be given by a new organisation, and a question mark would remain over its independence and capacity for publicising reports.

(ii) Create a new, hived-off audit body, similar to the Audit Commission. Greater independence and relatively few constitutional problems; but the new body would have to prove itself and might find itself in competition with the Audit Commission and the NAO, with increased risks of duplication and overlap.

(iii) Give statutory audit to the Audit Commission. Enables Commission's prestige and track record to be tapped, provides some consistency in treatment

of local authorities and health authorities, and avoids proliferation of bodies in this field. But there could be constitutional problems in the Audit Commission reporting to DHSS and there might well be tension created with the NAO.

15. Under all these, the PAC would continue its oversight, with NAO retaining its present audit responsibilities. This is inevitable, given the large amount of voted money going to the NHS. But it will be important to ensure that the NAO and the statutory auditors work together rather than in competition. And changes should be made only after first discussing them with the C & AG.

11.2.1

**SECRET**

HC 12

**SCOPE FOR INCREASED CHARGING**

**Note by HM Treasury**

1. NHS charges potentially serve important functions in any structure of health care.

a. They act as a price mechanism and hence as regulators of demand on the system. They are the only price mechanism in a largely free service to consumers.

b. They lower the cliff edge between free public services and full-cost private services.

2. Most charges arise on the Family Practitioner Service - prescription, dental and ophthalmic charges. But since the FPS is frequently the point of entry into the system, the benefits of improved charging mechanisms there should be felt throughout the NHS.

Prescription charges

3. About 75% of prescriptions are free. Most of these (45% of all prescriptions) are to pensioners, who have a blanket exemption. This means that

- the economic benefits of prescription charges are largely blunted because only 25% pay them

- where demand is highest (among the elderly) the price mechanism is entirely absent.

An obvious first step would be to remove the exemption for pensioners over income support level, thus putting them on the same footing as those below pension age. Because of their greater needs, however, there may be a case for mitigating this, perhaps by a reduced "season ticket" rate, or providing that prescriptions after the first, say, half dozen were free. Even so, this change would raise perhaps £100m a year. The same principle - exemptions only for lower income groups - could be extended to children under 16, who at present account for 10-15% of prescriptions.

4. Prescription charges are a flat rate, currently £2.40. This means that the only incentives to cost effective prescribing, apart from exhortation, are the dissemination of cost information to GPs (which FPCs are increasingly doing) and the requirements, through the limited list, to prescribe generic equivalents. Significant savings have been achieved in this way. But more would be possible if prescription charges were put on a cost-related scale , subject to some maximum (say £10 a prescription). There would then be pressure from patients for doctors choose the cheapest drugs wherever close substitutes were available.

Charges for visits to GPs

5. While GPs are an important filtering system, they are undoubtedly subjected to many unnecessary consultations. Their only means of discouraging this are limited and fully booked surgery hours, and determined receptionists. A small charge per consultation - say £2 - would help to discourage unnecessary visits. Again, there would be exemptions, and perhaps "season ticket" arrangements. On the present prescription charge

exemptions, a £2 charge would raise £100m a year. If exemptions were limited to low income groups, the revenue would be £240m. But the more important gains from this would be:

a impressing on the public that health care has to be paid for;

b reducing unnecessary demands on GPs' time (including provision of 'medical certificates' requested to justify absence from work for whatever reason).

Hospital hotel charges

6. While in its full form this has been ruled out, it might be worth considering charging for extras - TV, private room, telephone, better food, etc. The present amenity bed scheme is not popular, possibly because the standard of accommodation is relatively poor for the money (which is also one of the common criticisms by patients who use pay beds to get private treatment). Nor is this being pursued under the income generation scheme as yet, mainly because of difficulties in defining the "basic" service and what it would be reasonable to charge for additionally.

Outpatient visits

7. If charges were introduced for GPs, there would be a case by analogy for introducing them for outpatient clinics. A £2 charge might raise £25-50m, depending on the scope of exemptions.

Accident and emergency departments

8. It might be possible to make a charge for visits to casualty departments, provided this was done after the event.

Administration

9. If new charges were introduced, provision would be needed for their collection. This would involve some extra administration and cost, and should clearly be integrated from the start into new budgetting systems which may follow the resource management initiative. While this paper has been drafted in terms of the patient paying, there are other possibilities (like insurance, employer or local authority billing) which can be considered later in discussion of financing.

Pledges

10. The 1987 Conservative Manifesto did not refer to NHS charges. The Campaign Guide however said

> "The Conservative party has always maintained that those who can afford to should make a fair contribution to the costs of the NHS and thus to the overall resources available for spending on health. Revenue from charges contributes to the development and extension of medical services, from which everyone can benefit."

The Prime Minister has ruled out hotel charges (which we take to mean "basic" charges, rather than charges for optional extras) for the duration of this Parliament.This was most recently reaffirmed in an exchange with Mr Kinnock at oral questions on 28 January this year - the relevant Hansard extract is attached. The only other reference we have found is an oral answer by the Prime Minister in January 1980 ruling out charges for visits to GPs. This does not appear, however, to have been repeated subsequently.

**Mr. Kinnock:** Does the Prime Minister recall saying, just five weeks ago, on 21 December, that charges for patients in National Health Service hospitals:

"could not possibly come in during the lifetime of this Parliament because I remember very vividly during the election I confirmed we would rule it out. We have introduced extra charges which we think people can afford but we are not talking about extra charges beyond those which we have introduced."

Does the Prime Minister still stand by those words?

**The Prime Minister:** Yes, of course. I already made that clear when I was asked a similar question in the House but a short time ago.

**Mr. Kinnock:** Is the Prime Minister saying — it is important that she make a formal announcement about this — that there is no possibility in this Parliament of direct or indirect charges for visits to the doctor, for hospital visits, for family planning services or anything else? If she is—and it is what she said in the election—will she be good enough to make a formal announcement, instead of letting it seep out through Bernard Ingham?

**The Prime Minister:** I have been asked this question about board and lodging charges in this House, and I have answered it in this House. The statements made during the general election stand. I have said so before, and I say so again. They stand for the lifetime of this Parliament. By the time the next Parliament comes we shall have completed the internal review. We shall then make our promises, which will stand for the following Parliament.

HANSARD 28 JANUARY 1988 COL 477

cc BWP

HC 13

SECRET

# REVIEW OF THE NATIONAL HEALTH SERVICE

## ISSUES FOR MEETING ON 29 FEBRUARY

### Note by the Cabinet Office

1. At its last meeting on 8 February, the Ministerial Group commissioned papers on twelve topics. These are attached.

**What the papers show**

2. The papers are intended primarily as a quarry of background information and analysis.

3. The first eight papers are mainly factual but illuminate some important points about the way the National Health Service (NHS) is working at present.

For instance:

i. spending on the NHS (paper HC1). Between 1978 and 1986 manpower in the Hospital and Community Health Services increased by 5 per cent. This concealed a decrease of 28 per cent in ancillary staff (largely because of contracting out) and an increase of 14 per cent in doctors and nurses. Over the same period, inpatient and day cases increased by 26 per cent, drawn particularly from the elderly and the young. Life expectancy increased across all age bands.

ii. what happens to patients (paper HC2). Patients have very little real choice within the NHS at present. The main decision they have to take is whether to consult their GP or present themselves at an accident and emergency department. All other decisions are taken by GPs and consultants.

iii. waiting lists (paper HC3). There were 688,000 people on waiting lists last March, of whom 162,000 had been waiting for more than a year. Almost all were waiting for surgery. Nearly half are thought to have been accounted for by only seven operations. Waiting times have remained broadly constant since 1975. There are considerable regional variations in the length of waiting lists with the Northern and Yorkshire regions consistently the best, and some Thames regions switching from being the best to the worst in the last eight years. There seems to be no single explanation for the length of lists. Would the Group like to have a further paper on practical ways of shortening waiting times?

iv. Comparison between the public and private sectors (paper HC4). The private sector concentrates primarily on elective surgery: that is, surgery for conditions which if not treated may cause discomfort but not death. It accounts for 15-20 per cent of total operations of this kind but plays little part in the treatment of geriatric and mentally ill or handicapped cases, two of the biggest demands on the NHS which cannot be covered by insurance.

A second point is the cost-comparison in Annex B which, if correct, seems to suggest that unit costs in the private sector have increased much more sharply than those of the NHS in recent years.

v. manpower inflexibility (paper HC5). A combination of restrictive practices, tenure and self-regulation backed by statute may well be one of the main obstacles to reform. The Department of Health were planning to open up a major initiative on consultants' contracts in the next few weeks. Would the Group wish them to defer this initiative until its work is further advanced, but instead provide it with a paper on more radical ideas for possible change? and on ways in which the self-regulation of entry qualifications by nurses could be altered?

vi. information about costs, budgeting and resource management (papers HC6 and 7). Local hospital managers already have considerable information about hospital activity (eg length of stay for particular illnesses, operating theatre usage) and about some costs. The next step is to develop a sufficiently accurate approach to apportioning overheads to enable cost information to be used for the purposes of pricing (setting budgets) and control (monitoring actual against expected costs). Depending on the approach, the NHS could be in a position to price the treatment of individual patients at any time between Easter 1988 and January 1990; but using this information for control purposes nationally is not expected on present plans until at least 1990. Further papers about this timetable and about clinical audits will be coming forward for the next meeting of the Group.

vii. overseas practice (paper HC8). This is a first shot. A further summary of both financing and provision in other countries will be coming forward for the next meeting of the Group.

4. The remaining four papers contain some preliminary analyses of issues identified at the last meeting.

viii. Papers HC9 and 10 on competition and consumer choice suggest criteria for decisions on future structures. The Annex to HC10 on the State's role draws an important distinction between providing health care and financing it.

ix. Paper HC11 suggests changes in the present arrangements for auditing the NHS. Decisions will be needed on whether changes should be made and, if so, which of the options to adopt.

x. Paper HC12 suggests ways of extending charges, as a means not simply of raising revenue but of introducing financial discipline into the present system and lowering the cliff-edge between free public services and full-cost private services.

Options for longer-term change

5. These papers inevitably have a short-term bias. The Group may therefore wish to commission further work on the options for longer-term change. The attached annex outlines a possible paper which officials could be asked to prepare for the next meeting of the Group, setting out the main options for reforming the NHS. More detailed assessment of selected individual options and their implications could then follow.

Conclusion

6. The Group is invited:

i. to note the background papers attached, and to commission any further work on them which it may wish to have;

ii. to commission a paper on the options for longer-term change on the lines of the Annex attached.

Cabinet Office

SECRET

# OPTIONS FOR THE NHS

Outline of official paper

1. There are three broad approaches which could be adopted. They are not mutually exclusive. Some of the ideas under different headings could be combined. For instance, changes within the existing NHS could be made at an early stage as the first steps towards a more radical structure; and changes in management structure could be combined with changes in methods of financing.

## Changes within the existing NHS

2. One approach would be to concentrate on refurbishing and improving the NHS without changing its basic concept. Possible options include:

i. decentralised budgeting, with many more decisions, (for instance, about priorities) being taken locally at or below hospital level;

ii. introducing an "internal market", in which District Health Authorities, hospitals and support services would trade and compete with each other;

iii. contracting-out hospital care to public or private sector providers. District Health Authorities, or perhaps hospitals would be responsible for ensuring that care and treatment were available;

iv. encouraging more personal and occupational provision eg through fiscal incentives and/or the extension of charging. Most health care would still be financed by tax.

## New Structures

3. Among new structures one possibility would be to establish Local Health Organisations, similar to Health Maintenance Organisations in the United States, based on District Health Authorities or GPs or a combination of both. They would be funded partly by a transferable capitation fee and partly by topping up. Competition from the private sector could be introduced over time. So too could an element of employer-based health provision. The possibility of abolishing Regional Health Authorities would need to be examined.

## Changes in methods of Finance

4. Changing the method of finance (which is a different issue from the level of finance) is another approach to reform. There are at least three different possibilities under this heading:

i. health credits/vouchers. The individual would receive the money and buy care himself. There would be maximum individual choice;

ii. social insurance with or without opting out. This could be either a new system or built on existing social security arrangements;

iii. compulsory private health insurance. There would be a safety net for those on low incomes.

Conclusion

5. The aim would be to set out these options clearly, with a succinct indication of the main advantages and disadvantages, including the public expenditure and fiscal implications, of each approach, without any recommendation as to which should be adopted. The next step would be to do a more detailed assessment of the implications of individual options selected by the Group.

cc DOP

8.

PRIME MINISTER

26 February 1988

## KEEPING NHS REFORM ON THE RAILS

I am in almost total agreement with Richard Wilson's paper which accompanies the DHSS and Treasury briefs. It may be useful therefore if, instead of repeating his analysis, I concentrate on analysing the attitudes underlying some of the departmental approaches.

At the last ministerial meeting, the decisions reached were:

(a) to obtain greater information on the NHS;
(b) to examine selected aspects of health care, in particular charging;
(c) and to postpone discussion of structural reforms.

This led us down a false trail. "Without theory the facts are dumb." And without clear aims to determine what is relevant, the mere collection of data will lead to delay, loss of momentum and the accumulation of much material that is useless. In the uncertainty created, officials will tend to reflect the established interests and attitudes of their departments.

In the Treasury's case, the strongest instincts are those of a Ministry of Public Finance or watchdog of public spending. It naturally aims to maintain its centralised control of the system, to hold down public spending, and to seek greater efficiency within the system by means of external audit.

Inspired by these aims, the Treasury is waking up to the fact that the National Health Service is good at controlling its total cost (even if poor at micro-cost control). It fears that any other system will lead to runaway public spending -

especially one in which decisions over financial control are distributed outwards. And it therefore sees reform of the NHS as a synonym for charging. While the Treasury's attitude is ideal for the annual public expenditure round, it is less suited to devising fundamental reforms.

The DHSS has quite a different set of incentives. It wishes, first, to see a method of finance which makes the cost of health care visible and which is tied to rising incomes. It also has an interest in not disturbing the medical and other pressure groups of which it is the sponsoring Department. These lead it to favour financing reform over structural change - in particular, the "SERPS solution" of a dedicated health tax with contracting out.

Neither the Treasury nor the DHSS, on this analysis, have a deep interest in money following the patient, introducing the stimulus of private sector competition, getting to grips with inefficient practices on the ground, or structural solutions like Health Maintenance Organisations. And indeed the Departments have both expressed serious reservations about them, the Treasury stressing the problem of deadweight cost. They objected to a Cabinet Office paper which examined HMO reform in detail (and which now appears as an annex to Richard Wilson's brief for you.) And the Treasury papers, which are in general more opinionated than the DHSS submissions, tend to be somewhat negative in tone towards patient choice.

There is also emerging what looks like a (distinctly fragile) alliance between the two Departments in favour of a dedicated health tax plus contracting out. Some Treasury officials have dropped strong hints in favour of this, others seem to be against it. This ambiguity has given heart to the DHSS.

To put the argument in italics, the two Departments are instinctively suspicious of structural change. If structural

change is disposed of, they may well fall out over the SERPS approach which, if the Treasury opposed it strongly, would presumably then perish in its turn. And that would leave us with the present NHS system with charges - the worst of all possible worlds.

To prevent these developments and to keep NHS reform on the rails, I suggest that you adopt the following position in Monday's meeting:

1. Keep all the options for reform open - including structural change in which money follows the patient between competing providers.

2. Commission two papers:
   (a) on the options for structural and financing reform
   (b) the steps required to get there

3. Resist a general policy of "more information" for the group unrelated to solving particular problems. With Roy Griffiths' reading list and the DHSS papers we already have as much information as we can reasonably digest. We also have the examination of options that will direct our attention to such relevant information as we do not now possess.

4. Express deep scepticism about charging on the grounds of unpopularity and poor revenue raising. You might, however, grudgingly concede the possible application of charging in the context of major NHS structural reform.

5. Refuse to spend too much time on the dispute between the Treasury and the DHSS about an external audit for the Health Service. The Treasury is almost certainly right on this and will win in the end. But it is a second order question in the context of Monday's meeting and

should not be allowed to obstruct more important discussion.

6. Commission a study of guaranteed maximum waiting times as outlined in the enclosed minute. The DHSS paper contains a wealth of interesting information on waiting times. But we need to know such things as: how large is the residual category of treatments as a percentage of all treatments? And what percentage of patients in each category of treatment has to wait beyond the guaranteed maximum waiting time? The answers to these questions would enable us to calculate whether (or, more precisely, at what lengths of waiting time) we could finance the guarantees.

7. Kick two questions firmly into touch:
   (a) deadweight cost in relation to either contracting out or allowing private sector HMOs to compete for capitation fees. We have asked the Treasury for a paper on this and will respond to it later in the week.
   (b) Treasury rules on unconventional financing which at present obstruct the entry of the private sector into the building and operation of hospitals for NHS patients. Again, the Policy Unit is working on this and will raise it with the Treasury in the near future.

overstated!
PRG

John O'Sullivan

JOHN O'SULLIVAN

cc PS

MES

cc PS I

**DEPARTMENT OF HEALTH AND SOCIAL SECURITY**

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

***From the Minister for Health***

MBR

CONFIDENTIAL

Andy Bearpark Esq
Private Secretary
10 Downing Street

26 FEB 1988

Dear Andy,

NHS CHARGES

I enclose a draft of the statement the Minister for Health will be making on Monday. The statement will cover increased voucher values for spectacles and the introduction of blood glucose testing strips for diabetics, as well as changes to dening and prescription charges.

Copies go to Alison Smith (Lord President's office), Colin Phillips (Chief Whip's office), Jill Rutter (Chief Secretary's office), David Binnie (Michael Forsyth's office), Jan Dominguez (Ian Grist's office) and Aileen Porter (Richard Needham's office).

Yours,

Jenny Harper

MISS J M HARPER
Private Secretary

KW/DNo.25

VOUCHER VALUES FOR SPECTACLES, BLOOD GLUCOSE TESTING STRIPS AND NHS CHARGES FROM 1 APRIL 1988

With permission, Mr Speaker, I should like to make a statement about voucher values for spectacles, blood glucose testing strips, and NHS charges from 1 April 1988.

First, Spectacle Voucher Values: Help with the cost of spectacles through the NHS voucher scheme is available to children under 16, full-time students under 19, people on low incomes and those needing complex lenses.

The current voucher values were set when the voucher scheme was introduced on 1 July 1986. We have decided to increase them from 1 April 1988 so that, for example, the lowest voucher value will rise by nearly 9% from £14.25 to £15.50 and the highest voucher value by 28% from £66 to £85. These changes will increase expenditure on the voucher scheme by about £7 million in 1988/89, to a total of more than £65 million.

The new voucher values will apply both in the General Ophthalmic Service and in the Hospital Eye Service. At the same time, there will be small increases in the maximum charges in the Hospital Eye Service, which limit the charges for those requiring expensive lenses but not entitled to vouchers. There will however be no change in the charge for contact lenses prescribed through the Hospital Eye Service. /Patients with a clinical need for contact lenses can already obtain them with vouchers issued by the Hospital Eye Service. For other patients, we do not think it is reasonable to restrict their choice to spectacles only, if they prefer to use their vouchers for contact lenses. We will be changing the regulations from 1 April to allow them this greater freedom of choice./

In setting the new values we have sought to respond to the representations of the Royal National Institute for the Blind by making particularly large increases in vouchers for the more complex spectacles. We also propose a number of other changes to assist with special needs on which representations have been made. Over and above standard voucher values, there will be a new supplement in the Hospital Eye Service of up to £4 for people prescribed photochromic lenses for clinical reasons and a new supplement of £30 for those whose particular facial characteristics entail specially-made frames. There will also be a new supplement of £30 for small children who need exceptionally small glasses, available through the General Ophthalmic Service and the Hospital Eye Service.

Secondly, Blood Glucose Testing Strips for Diabetics: We announced last November our intention to bring about a further improvement in services for diabetics by making such strips available on general practitioner prescription, following the similar action we took last year in respect of disposable syringes for those who need to inject insulin.

Discussions have now been held with the suppliers of the strips, and I am pleased to be able to tell the House that they will be made available on prescription from 1 June this year. Diabetics are of course exempt from prescription charges and will therefore receive their supplies free of charge. The cost of this measure in 1988/89 will be around £8 million. /About £10 in a full year./

Thirdly, Prescription Charges: We propose to increase prescription charges broadly in line with the increased cost of medicines. This means that the item charge will rise by 20 pence from £2.40 to £2.60, an increase of around 8%. The four-monthly season ticket will increase by £1.00 to £13.50, and the annual season ticket by £2.50 to £37.50. We estimate that these increases will yield over £10 million in 1988/89.

Well over three-quarters of all items will of course continue to be dispensed free of charge under the wide-ranging exemption arrangements, which cover all children, those on low incomes, and everyone over retirement age. The House will also be glad to know that we propose to extend the exemptions for young people to include those under the age of 19 while they remain in full-time education.

Fourthly, Dental Charges: As the House knows, we have already announced our intention to move from the present complex and anomalous system of charging for dental treatment to a straightforward system of proportionate charging set at 75% of the cost. This will apply to all routine dental treatment and crowns from 1 April 1988, and the charges for dentures and bridges will be set as fixed cash amounts at or about the same 75% level. As has also been announced earlier, there will be an increase in the maximum charge for a course of treatment from £115 to £150.

We estimate that these changes will yield additional income of about £15 million in 1988/89.

Since many people now pay the full cost of the more limited courses of routine treatment, the cost of some 6 million such courses will in fact fall. For example, the charge for a scale and polish and two small fillings will come down from £14.20 to £10.65.

We are retaining all the current exemptions - for children, young people aged 16 and 17, students under 19, expectant and nursing mothers, and people on low incomes - which mean that nearly half of all courses of dental treatment attract no charge at all. In addition we intend to bring forward a government amendment at the Report Stage of the Health and Medicines Bill to end the anomaly whereby some young people of 16 and 17, while exempt from charges for treatment, nevertheless have to pay for dentures and bridges. The effect, if the House agrees, will be to exempt them from all dental charges.

Low Incomes

/Mr Speaker, in view of the changes to social security benefits which will come into effect on 11 April, I should make clear to the House that, for the purposes of exemption from prescription and dental charges, of entitlement to spectacle vouchers, and of reimbursement of expenses incurred in travelling to hospital for treatment, receipt of Income Support or Family Credit will qualify beneficiaries in the same way as receipt of supplementary benefit or Family Income Supplement does now. There will also continue to be arrangements for assisting other people on low incomes, based on the new social security framework. Regulations will be laid with a single consolidated scheme which will be both simpler and speedier than at present. Regulations will be laid before the House in due course./

Charges for Overseas Visitors

I should also briefly mention charges for overseas visitors. These charges - for people not ordinarily resident here - are inclusive amounts based on the costs of providing patient accommodation. For 1988/89 they will increase by 8.1% on average for in-patients and 6.5% for out-patients.

Details of the proposed new spectacles voucher values, the prescription and dental charges, and the charges for overseas visitors are available in the Vote Office and I shall, with permission circulate them in the Official Report. Regulations giving them effect will be laid before the House shortly. Equivalent measures will be taken by my rt hon and learned Friend the Secretary of State for Scotland, and my rt hon Friend the Secretary of State for Northern Ireland.

YdS/D.25

PAUL GRAY

24 February 1988

ROY GRIFFITHS' REPORT ON COMMUNITY CARE

I have seen your note to the Prime Minister and the Prime Minister's letter. I entirely agree with your advice, but I would prefer to push the Ministerial meeting on Community Care to eight or ten weeks rather than the six you suggest. It is not yet clear that the NHS review is making such fast progress as to make possible a useful discussion on community care in the shorter time scale.

JOHN O'SULLIVAN

copy to Mr. Gray

# The National Union of Conservative and Unionist Associations
## Western Provincial Area

D

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*President:* DAME MARY BRIDGES, DBE
*Chairman:* MICHAEL CARTER, CBE
*Hon. Treasurer:* PETER HODGSON, OBE
*Hon. Secretary:* PETER GOWER, CBE

22nd February 1988

Rt. Hon. Margaret Thatcher, FRS, MP,
10 Downing Street,
London SW1

Dear Mrs Thatcher

At the National Union dinner I promised to let you have the information on a well-managed and positively run Health Authority. I enclose press cuttings and a short paper which I hope you will find interesting and, also, heartening. I feel there are many Authorities in the country that are similarly well-managed. It is, therefore, unfair that those which are efficiently run are lumped together with the ones which are badly run in a general and, very often, ignorant condemnation of the NHS. I have noticed over recent months that the louder some Authorities shout "cuts", the greater their managerial incompetence.

The Authorities which are currently short of funds have not suddenly arrived in their current predicament. This is the consequence of years of mismanagement. Extra funds would just cover up inefficiencies and sins of omission. If extra funds are available, they should be targeted to specific projects which are easily monitored for performance. The Somerset Health Authority is not demoralised and has an active and dynamic management, with many new ideas on how to run the service for the benefit of the patients.

/cont.....2

If you would consider allowing my Chairman, Mr. Ward and the District General Manager, Mr. Smith and myself to come and see you for half an hour or so, we would be pleased to do so. I think on questioning us, you would discover new and interesting insights into the workings and otherwise of the NHS from, so to speak, the factory floor.

Yours sincerely

Michael Carter

Michael Carter, CBE
Chairman, Western Area

Batcombe House,
Batcombe,
Shepton Mallet,
Somerset.

# SOMERSET HEALTH AUTHORITY

## 1. PROFILE

Somerset Health Authority provides health services to a population of 361,000. It has 27 hospitals, 6 day hospitals and a total of 3,086 beds. The acute services are based on a District Hospital at Taunton and a District Hospital at Yeovil. It manages its own Ambulance Service. It is one of the larger health authorities in the country.

## 2. FINANCIAL STATUS

The basic cash limits for Somerset Health Authority for 1987/88 are:

| | |
|---|---|
| Revenue | £76 million |
| Capital | £1 million |
| Joint Funds | £1 million |
| TOTAL | £78 million |

The Authority over the years has accumulated revenue reserves. This has been done by not committing to the service all the revenue funds allocated by government but rather putting some by regularly each year in order to meet the running costs of future proposals and capital schemes. These monies have been used on a non-recurring basis year by year to augment the Authority's spending usually on capital projects. This reserve currently stands at £2.6 million. It will be used in the future to fund the revenue costs of the second stage of redevelopment of the District General Hospital which will be completed in 1994 and to augment the cost of the community based strategy for services for the mentally handicapped and the mentally ill.

Apart from allowing the Authority to augment its major capital programme this strategy also puts the Authority in a good position for any "fine tuning" which may be required during the course of the year.

## 3. CAPITAL

A selection of major capital works in the period 1985/86 to 1994/95 is shown below. They have been funded from the normal capital allocation as well as by the use of the reserve fund referred to above.

continued

| Schemes Completed 1985/86 to 1987/88 | | £ million |
|---|---|---|
| Musgrove Park Hospital (Acute Services) | Pathology Facilities) Mortuary ) | 1.4 |
| | ENT Theatre and Dept | 0.8 |
| | Maternity Unit | 0.6 |
| | Phase I Redevelopment | 9.5 |
| | CT Scanner | 0.2 |
| | Intensive Care Unit | 0.6 |
| Burnham EPD Unit | Mental Illness | 0.6 |
| | | 13.7 |

| Schemes Planned to 1984/95 | | |
|---|---|---|
| Musgrove Park Hospital | Phase II Redevelopment | 18.8 |
| Yeovil Hospital | Radiology Department) CT Scanner ) | 2.0 |
| (voluntary subscriptions involved) | | |
| Glastonbury/Street Community Hospital) Priory Hospital Redevelopment ) | | 3.3 |
| Williton Hospital | Elderly Services | 2.2 |
| Mental Illness Community Facilities | | 10.4 |
| | | 36.7 |

## 4. HOSPITAL ACTIVITY

Between the years 1982/83 and 1986/87 there has been an increase in health activity, for example, in acute hospitals inpatient cases have increased by just over 11% during this period. There has been a drop by 10% in the length of time that the average patient has stayed in hospital. The number of day cases has increased by 9%. The average number of attendances by outpatients has increased by 7%. The Accident and Emergency departments have dealt with an increase of 10% in patients. Increases have also taken place in performance in the long stay hospitals, hospitals for the mentally ill and the mentally handicapped.

## 5. INCREASED EFFECTIVENESS

The Authority has pursued rigorous cost effective programmes resulting in, for example, a saving of £1 million per annum recurring through the competitive tendering exercise for hotel services in hospitals. This was undertaken within the time-table laid down by the government ending in 1986. Since that time a regular cost improvement programme of just over 1% per annum has been achieved each year.

continued

## 6. INTRODUCTION OF GENERAL MANAGEMENT

The introduction of General Management has been a great success in Somerset. High calibre managers have been recruited to whom clear responsibilities have been delegated and powers of decision given. Unnecessary bureaucracy has been eliminated and accountabilities are quite clear. Functional management has been eliminated cutting out unnecessary professional hierarchies. The ethos of general management is widely accepted within the District even by the consultants despite their contracts being with Region. Clinicians are also much keener to play a role in management and over the years good working relationships have been established with the consultants.

## 7. WAITING LIST INITIATIVES

Two waiting list reduction schemes have been successfully achieved.

(i) East Reach Hospital Taunton

This hospital had been vacated following the transfer to purpose built facilities at the new District General Hospital. It was proposed to re-open the hospital for a limited period to carry out 400 operations in a period of two months. The estimated cost was £300,000.

The project team was set up in January 1987. By the 1 March 1987 it had set up the initiative and recruited all the necessary medical and nursing staff on fixed term contracts. Other services were provided from the District General Hospital. Some new equipment, totalling £25,000, was purchased.

The initiative was a success. 479 operations were carried out on 410 patients; the actual cost was £214,000 funded by

| | |
|---|---|
| DHSS Initiative Monies | £100,000 |
| DHA Monies | £114,000 |

Prior to expiry of contracts nurses were assessed, interviewed and where appropriate all available nurses were offered permanent posts within the Unit. All purchased equipment has been fully utilised within the Unit since the end of the project.

(ii) Yeovil District Hospital

The waiting list initiative is taking place at Yeovil District Hospital and aims to reduce the waiting list in Gynaecology, General Surgery and Orthopaedic Surgery by 800. The estimated cost is £90,000 which is being funded by the Authority. The initiative started on 1 April 1987 and is planned to continue until 31 March 1988. Staffing is mainly from within existing establishments. Additional equipment, mostly prostheses, is estimated at £28,000. As at 31 January 1988 the initiative has exceeded its target with 813 operations as follows:-

332 Gynaecology;
356 General Surgery; and
125 Orthopaedic.

There are still two months for this scheme to run.

8. CURRENT PROBLEM

Somerset, like all other health authorities, faces uncertainty with regard to the level of funding for pay awards (particularly the review body awards relating to doctors, dentists, nurses and professions allied to medicine) for 1987/88 and for 1988/89. It will not be possible to implement the Authority's developments for 1988/89 and 1989/90 as planned unless the government fully funds, on a recurring basis, the cost of the 1987/88 pay awards and future awards. If, however, the recurring under-funding of the 1987/88 pay and price increases continues into 1988/89 and there is a fall-short of actual costs by, say, 1% then the total deficit for the Authority will be £800,000 in 1988/89 which has to be added to the £400,000 in 1987/88 giving a total funding deficit of £1.2 million.

The Authority is preparing a contingency plan for this eventuality which involves looking at its current services in order to see whether some of the unsophisticated health care in, for example, the long stay services can be left to the private sector or voluntary sector so that funds can be spent on that part of the Health Service for which it is best equipped and does best. The Authority is also looking at bringing forward cost improvement programmes and is satisfied that it will be able to find another 1% improvement in efficiency in the next two years. This will involve the closure of small, less economic hospitals.

9. KEY ISSUES

(a) Consultant Contracts

The single most important change that would have widespread positive effects on the Health Service is to put consultant contracts with District Health Authorities. The contractual situation at the present time with the exception of teaching hospitals is that the contracts lie with Region. Consultants under these circumstances have loyalties neither to Region with whom they rarely come into contact nor to the District with whom they work but feel no ties of contractual loyalty. Professional independence is inculcated in the medical educational system and the contractual arrangements within the NHS serves only to reinforce that independence. The reality of the employer/employee relationship between health authority and consultant would introduce an important psychological change and a significant sanction for health authorities in a hiring and firing capacity. This sanction does not need to be used to be an important weapon in operational management terms.

continued

The District General Manager of health authorities must be seen as the ultimate Manager. He is in a position to appraise consultant performance although it would be wise for him to be professionally advised in order to do this effectively.

The ultimate aim should be short term contracts for consultants with agreed work loads accountable through District General Managers to District Health Authorities.

Consultants with large private practices, and they are likely to be surgeons and anaesthetists, can earn more working a shorter period in the private sector than they can within the NHS. There is an unhealthy temptation, therefore, to give priority to private work. A contract with greater remuneration for an agreed work load would be mutually attractive.

(b) Restriction of Service Provision

There are a number of clinical conditions which should not be an NHS responsibility, for example,

cosmetic surgery;
invitro fertilisation;
treatment of minor ailments; and
chiropody (except for medical conditions).

These services could be provided on a fee paying basis.

(c) Private Patients and Income Generation

There is a growing demand for private practice. Many health authorities could meet this but are currently restricted by regulations relating to the number of private beds they are allowed. This Authority would like to increase the number of private patients by the provision of a small private wing. An increase in private patient beds can only be granted where a clear demand is not being fully met within existing allocated beds. This does not allow health authorities to anticipate the demand. Somerset consultants would be prepared to support the building of a small private patient unit which would generate a significant amount of income for the Health Authority. It may be, of course, that the New Medicines Bill will address this.

(d) Influence of Professions and Other Organisations

The influence of the professions and particularly the medical profession, and statutory bodies such as the English National Board and other organisations like Royal Colleges have enormous influence over the way that the NHS is run. It is highly questionable whether or not private institutions, commerce and industry, would be so dominated by such professional bodies. The Health Authority and the General Manager can find themselves having to meet stringent conditions which these bodies can impose on threat of withdrawal of recognition. Examples can be the Royal Colleges insisting on time-tables for consultants which do not give adequate NHS service. Recently

the UKCC (National Body for Nurse Training) have recommended a completely new training scheme for nurses (Project 2000) which replaces the present Health Service orientated training programme by a more expensive and broader based educational scheme centred on education institutions. The current "apprenticeship" training for nurses has served the NHS well. Its elimination will take the nurse further away from the patient bedside where she learns her skills and will have the same adverse effect on nursing which its demise had for industry and commerce.

(e) NHS Relationship with Consumer

A free Health Service at the time of need is a laudable ideal. Unfortunately, it clouds the relationship between the consumer (patient) and the supplier (Health Authority) and raises expectations without identifying the implications. What is required is a mechanism for sharpening-up the accountability of the supplier to the consumer and the consumer's appreciation of the value of the service being provided. The most effective way of achieving this is through a contribution for services given. This would not have to be a large amount, but it should be sufficiently large to be economic to collect. It could be insurable. If this charge was related to hotel services it would have the advantage of not impinging on clinical services, would give an income to the Authority which was easily identifiable, would enable the Health Authority to use that income to improve services and particularly hotel services which in turn would create an internal market for consumers to exercise some choice. At present referrals to hospital are made at the discretion of general practitioners with little involvement of the patient. Although clinical considerations would still be important this change would ensure that they would not be the only ones to influence the patient.

T A WARD
Chairman

I N SMITH
District General Manager

M. J. F. CARTER
Member

February 1988

87?

Dec/77

# WAITING LISTS FALL

The Government have congratulated Somerset Health Authority on its £222,000 scheme to reduce hospital waiting lists in the county.

The scheme was carried out at the 195-year-old East Reach Hospital, Taunton, earlier this year and as a result 479 operations were carried out on 410 patients within 43 days.

In a letter, the Department of Health and Social Security say: "We regard this as an excellent example of good practice."

Mr. Ian Smith, the Authority's General Manager, said all the staff were to be congratulated on achieving excellent results.

He said that in Somerset this year there had been a 20 per cent reduction in hospital waiting lists.

This had been achieved by the East Reach facilities and other schemes, including a highly successful one at Yeovil District Hospital where the staff were already ahead of their own target.

A report shows that between December and June, the lists in Somerset dropped by 1,113 to 3,995.

2

Mr. Smith paid tribute to the medical, nursing and other support staff whose hard work and dedication had produced such good results.

Mr. Smith pointed out that there had been a shortening of queues for many types of operation, including general surgery, gynaecology, ear, nose and throat surgery, oral surgery and orthopaedics.

The exception was eye surgery where there had been a slight rise from 342 to 403 because the move to Musgrove Park Hospital from East Reach Hospital had caused some disruption.

Reduction in the lists are: West Somerset: General Surgery down from 1,355 to 1,104; Gynaecology down from 638 to 396; ENT Surgery down from 414 to 309; Oral Surgery down from 794 to 635; Orthopaedics down from 1,565 to 1,148 and Ophthalmology up from 342 to 403.

East Somerset: General Surgery down from 462 to 378; Gynaecology down from 532 to 440; ENT Surgery down from 91 to 76; Oral Surgery down from 209 to 181; Orthopaedics down from 237 to 206.

# Shorter wait for surgery the aim

**SOMERSET Health Authority is hoping to be allowed to spend an extra £375,000 to reduce hospital waiting lists.**

The authority will decide whether the money should be spent as part of a special fund set up by the Government to reduce the numbers of people waiting for operations.

In the past year Somerset has reduced the waiting lists by 20 per cent, through extra operating sessions at Yeovil and keeping East Reach Hospital, Taunton, open after the move to Musgrove Park Hospital.

In Yeovil 725 additional operations have been performed, compared with a target of 600.

The chairman of the authority, Mr Tom Ward, said on Friday that Somerset was doing "exceptionally well", in spite of the crisis in funding the national health service.

"We are by no means complacent, but we have been able to stay within our cash limit during the current financial year.

"As a result, our basic services have not been affected, while at the same time we have introduced a number of new initiatives."

Jan 88

# Patients gain from energy savings

The Authority is to launch a major campaign to reduce the cost of heating and lighting at its 28 hospitals and other healthcare buildings in the county.

The Authority spends more than £2 million every year on energy — twice the amount it spends on drugs.

Over the last 10 years the Authority has reduced its energy bill by over 25 per cent but Mr. Roger Tanner, Director of Estate Management, is convinced that further savings of up to 30 per cent can be achieved by new initiatives in this area.

A small team of energy specialists has been set up to investigate and advise on how these savings can be achieved.

Work has already started on energy surveys of the major hospital sites and these will analyse in detail how and what energy is being used on each site.

Detailed plans will also be drawn up for improving the energy performance by improving insulation, and using the latest computerised control systems, heat recovery equipment and low energy lighting schemes.

The Authority recently installed one of the country's first "zero fuel" incinerators at Tone Vale which is now incinerating waste from all the West Somerset Hospitals without using any fuel.

The campaign will also concentrate on "good housekeeping", such as switching off unwanted lights, closing doors and windows to avoid losing heat and generally making sure that energy is not wasted.

To promote this "energy conscious" environment in all its hospitals the Authority is to introduce an Energy Newsletter, an Energy Handbook for all new employees and an Energy Saving Suggestion Scheme with cash prizes, said Mr. Tanner.

He added: "Our objective is to make Somerset Health Authority the most energy efficient Authority in the NHS.

"If we can achieve our target of 30 per cent reduction in our annual energy bill then this will release more than £0.5 million every year for improving patient services.

"One of the good things about saving energy is that not only does it save money but it usually results in better standards of comfort for patients and staff who work in our buildings."

The Authority's Chairman, Mr. Tom Ward, has hosted a series of early morning 'Energy Breakfasts' when senior managers were told of the effects of saving energy and asked to actively support the campaign.

# Better health service from cash savings

SOMERSET Health Authority announced this week that patients are to benefit directly from efficiency savings of £1.6 million over the next two years.

The introduction of competitive tendering, new switchboards and savings in energy cost have helped to release the cash.

Mr Ian Smith, the authority's new general manager, said developments in the service would increasingly depend on making better use of existing money.

Among the projects to benefit is the first phase of Musgrove Park Hospital, Taunton, due to be completed next year.

Yeovil District Hospital will gain a new orthopaedic outpatient department while improvements at South Petherton Hospital include new outpatients facilities an occupational therapy department and updated physiotherapy and X-ray rooms.

The authority plans to appoint a new consultant in paediatrics specialising in the care of the handicapped as well as junior posts to help in general and acute services.

More community midwives will be appointed to cope with the expected 25 per cent increase in births over the next ten years.

There are plans to help pay for a medical director at St Margaret's Hospice and to give money towards setting up a counselling service for AIDS sufferers.

Wells is to get an extra consultant psychiatrist while the Kenneth Bailey Day Hospital in Yeovil will be opening five days a week rather than the present three.

Top priority for the mentally ill is the development of psychiatric services in North Somerset by the provision of locally-based units near the people they will serve.

## Fire at laundry

AN electrical fault sparked a small fire in a dryer at the laundry in Parkmead Road on Monday.

CONFIDENTIAL

file DA
cc BG

10 DOWNING STREET

LONDON SW1A 2AA

*From the Private Secretary*

22 February 1988

Dear Geoffrey,

SIR ROY GRIFFITHS' REVIEW OF COMMUNITY CARE

The Prime Minister was grateful for your Secretary of State's minute of 17 February with which he forwarded Sir Roy Griffiths' report on community care.

The Prime Minister agrees that the report gives rise to major difficulties, in particular the role proposed for local authorities. She accepts that it would be difficult to do other than arrange for early publication of the report, in parallel with the report of Lady Wagner's working party on the role of residential care. But she has commented that it is necessary to consider precisely what should be said about the Griffiths report at the time of publication; vague generalities could arouse the wrong expectations. The Prime Minister would therefore be grateful if your Secretary of State could now propose the precise terms of an announcement to accompany publication of the Griffiths report.

I am copying this letter to Alex Allan (HM Treasury), Roger Bright (Department of the Environment) and Jill Rutter (Chief Secretary's Office).

Yours,
Paul

(PAUL GRAY)

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

CONFIDENTIAL

PA

THE SUNDAY TIMES 21 FEBRUARY 1988

# Hospital teams think small to combat NHS 'mayhem'

by Neville Hodgkinson
Medical Correspondent

SENIOR consultants at one of Britain's top teaching hospitals have staged a managerial revolution which they claim could provide a model for a more efficient NHS.

A pioneering deal struck three years ago at Guy's Hospital in southeast London, giving consultants the right to manage the hospital providing they agreed to live within their resources, has now borne fruit.

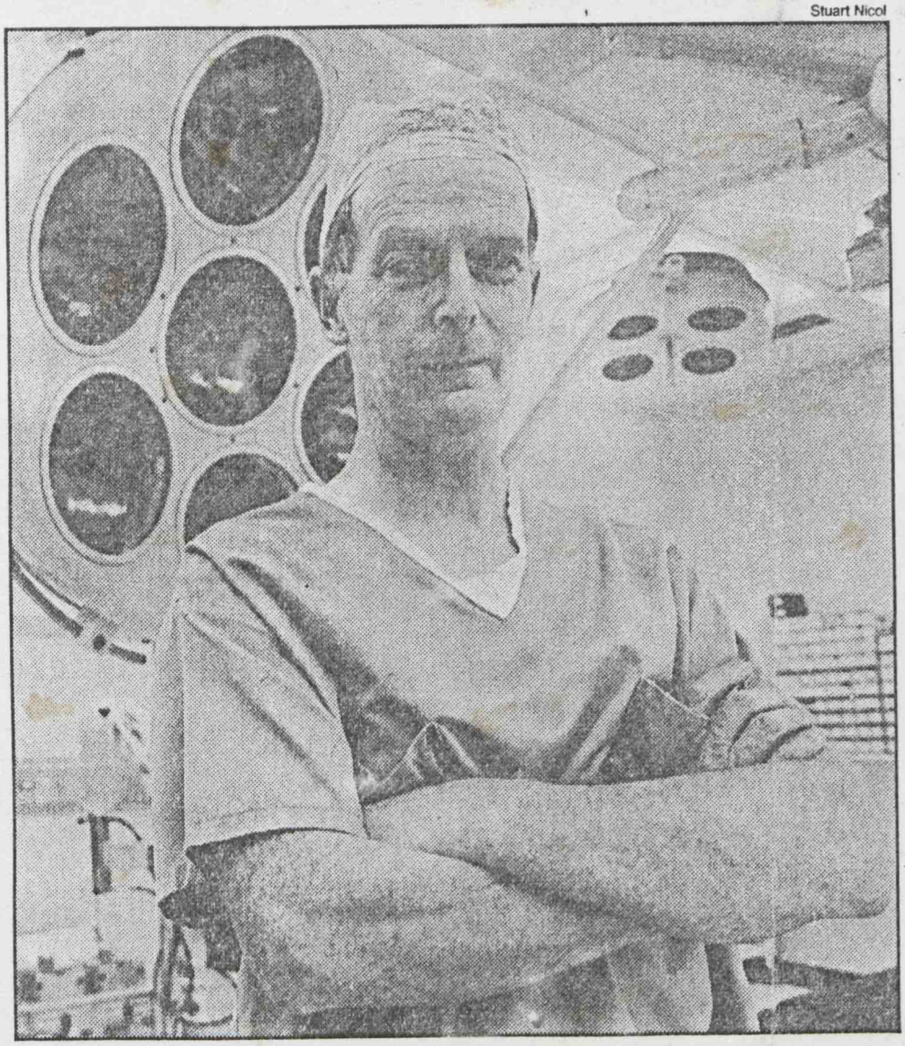
The result, say the doctors, is that the hospital has been able to meet government economies while minimising the harm to patients. There have also been dramatic benefits, they claim, including:

- A better day-by-day service to patients, with easier admissions, better control over medical records, and cleaner wards.
- Greater continuity between out-patient treatment and in-patient care.
- Much higher morale among staff, because they are better informed and more involved.

The secret of success, says Professor Ian McColl, one of the driving forces behind the change, has been to think small. He believes poor management arising from unwieldy hospital structures, rather than lack of money, is responsible for what he describes as the "mayhem" in the NHS.

"Guy's has nearly 3,000 employees, making it far too big to run as a single hospital," he said. "So we have split it up into smaller, clearly identified units. You then have loyalty within the group, and everyone matters. People here used to feel terribly isolated and had the feeling that nothing mattered. They are now taking a great interest in how the hospital is progressing."

Stuart Nicol



**Managerial surgery: McColl in a theatre at Guy's where a revolutionary deal is succeeding**

Although a single doctor is in overall charge, the hospital is run as 13 units, rather than one big one. Each relates to a particular medical speciality such as surgery, radiology, neurosciences and so on. A senior consultant in the field heads each directorate, helped by a chief nurse and a business manager. Because the units are relatively small, the consultant and nurse continue to practise on the wards.

McColl, the director of surgery, says that means they are better able both to "find out what the troops want, and cut through the red tape".

One Friday night he operated on an 86-year-old woman with a life-threatening hernia by himself, having been told there were not enough theatre staff to admit her. He smuggled the woman into the hospital and operated with a local anaesthetic, by-passing four sets of hospital workers.

Nurses the next day filed a complaint. But it was a "storm in a teacup", McColl says, and he is now exploring ways of simplifying a wide range of operations.

He believes doctors should be more ready to operate in people's homes and recalls the case of a 94-year-old woman with a breast tumour who refused to go into hospital. She argued that at her age she was unlikely to come out.

"I said to her, 'You know, you are probably quite right. How would you like your operation here in your own bed?' Yes, she said, any time I liked. With an assistant I did it at her home under local anaesthetic. She never turned a hair!"

Doctor-managers are not fooled by their colleagues' arguments about why they should always get more money. As a result, Guy's, in making ends meet, is rare among the teaching hospitals of the Thames health regions, which have been losing millions of pounds through redistribution of NHS resources to traditionally less well provided parts of the country.

The hospital has had to save about £7,700,000 a year, a cut of 13% on its previous budget. It has also been attending to long-standing neglect of its buildings. With a sister hospital in the Guy's group, it has lost 346 beds – a reduction of 28% – and 576 posts, a cut of 17%. The number of patients treated has also fallen, by 8%, but is currently rising again.

Despite the real hardship involved in such cuts, some of the savings have come easily. Lynn Farr, who was appointed by McColl as both senior nurse and business manager in the surgical directorate, found a cache of 2,000 pairs of paper knickers on one of the wards – for men. "Nobody ever questioned what was being bought or stocked," she said. "This was how the health service started overspending. Nobody was accountable to anybody."

NT.
CBG.

PRIME MINISTER

NHS REVIEW

This note covers three issues - an initial reading list, state of play on papers for the Ministerial Group, and arrangements for the Chequers seminars.

Reading List

DHSS have now supplied a reading list as you requested at the last meeting. I have not had a chance during the day to go through it all, but there looks to be an interesting range of material which you might like to glance at this weekend. At this stage Sir Roy Griffiths has - sensibly I think - focused mainly on analytical rather than prescriptive material. Each of the nine sections in the folder is summarised in the opening contents page.

If you want an early sight of material with a stronger focus on solutions I will get DHSS to put it together.

Further Papers

I gather from Richard Wilson that good progress is being made with the first batch of papers commissioned at the last meeting. These will be finalised next week and I will put them to you next weekend prior to a meeting of the group on 29 February.

Chequers Seminars

You endorsed the idea of two separate Chequers seminars on 27 March and 24 April. We now need to consider just what form they should take and who should come.

I attach a list of possible names that John O'Sullivan has put

together following discussion with Tony Newton. You will want to consider the mix of people for the two occasions. The prior question is what should be the topics for discussion.

For 27 March I suggest:

i) the measurement of costs and performance in the NHS, introduced an NHS manager

ii) budgeting systems, financial incentives and the implications for terms of employment for NHS professionals introduced by a doctor

For 24 April I suggest:

i) development of competition and freedom of choice for patients, introduced by a 'thinker'

ii) development of the role of the private sector and its links with the public sector. Various different models e.g. HMOs. Introduced by a private health person.

Although the suggested topics for the meetings are different I think there is a good case for having a similar mix of people on the two occasions. You might like to consider an external guest list of twelve people each time comprising:

i) 1 GP
ii) 2 consultants
iii) 1 nurse
iv) 2 NHS managers
v) 2 NHS chairmen
vi) 2 private health
vii) 1 think tank
viii) 1 expert

In addition I suggest three Ministers - yourself plus the Chancellor/Mr Newton at one meeting and Mr Moore/Chief Secretary at the other. Officials at each meeting might be Richard Wilson, John O'Sullivan and myself. That would make eighteen in all.

If you are content with that broad approach I should be grateful if you could look at the names in John O'Sullivan's note. If there are people you definitely would not want to attend either seminar I suggest you put a cross against their names. If there are others you would definitely want to come please put a tick.

You will also want to consider the timing of the meetings. I assume you would want to offer lunch. The two main options would then be:

i) convene at lunch-time and talk for 1½ hours after

ii) convene at 11 or 11.30, have the opening presentations and initial and discussion before lunch and wind up after lunch.

The latter option might be preferable.

Content for me to:

i) proceed to set up the 27 March and 24 April seminars?

ii) invite twelve guests for each meeting on the pattern described above and reflecting your preferences on individual names?

iii) tell participants the proposed main items for discussion and invite two individuals at each meeting to make introductory talks?

iv) invite the Ministers and officials as suggested

above? Do you want any others?

v) convene the sessions at 11 a.m.?

Paul Gray

19 February 1988

MJ2CAE

PRIME MINISTER

## ROY GRIFFITHS' REPORT ON COMMUNITY CARE

Mr. Moore has now forwarded to you Roy Griffiths' report on community care with his minute of 17 February. The Policy Unit have commented in their note of 18 February.

As predicted, Sir Roy has proposed an enhanced role for local authorities in the coordination of community care. As Mr. Moore points out, this presents a major dilemma; there is much internal logic in Sir Roy's package but it gives rise to clear political difficulties.

As a piece of analysis I think Sir Roy's report is a good one. He has made a compelling case for the need for more effective coordination of community care at local level. Chapter 4 of the report (pages 30-34) highlights just how many different bodies and institutions are involved in this area.

While Sir Roy stresses the need for more local coordination he is also at pains to stress the need for substantial central government control. He proposes a system of specific grants (which will not please the Treasury) and an enhanced Ministerial role in DHSS. The way through this may be along the lines Mr. Moore suggests of emphasising the purely enabling role of local authorities and tightening up the central framework within which they would operate. In parallel with that there seems a lot to be said for building on the part that family doctors could play in coordinating and directing community care provision (see paragraph 4.16 and the Policy Unit note).

The main issues are:

- should the report be published?
- how do you want to take Government consideration of the subject forward?

Although community care is an important issue that needs to be tackled, and a growing one given the demographic trends, I would have thought the key priority at present is pressing ahead with the NHS review, concentrating on the hospital service. Given the slow start that exercise has made, we do not now want significant DHSS resources to be diverted on to community care.

Would you therefore be content:

(i) To agree to early publication of the Griffiths Report on the basis proposed by Mr. Moore and the Policy Unit?

(ii) To meet Sir Roy Griffiths and a small Ministerial group in about six weeks' time to discuss the handling of community care (by which time Sir Roy should be back in action and a good deal of the initial work on the NHS review should have been done)?

RACG.

We need to know precisely what we are going to say about it — before publication. Vague generalities could arouse the wrong expectations

PAUL GRAY

19 February 1988

VC4AUK

**DEPARTMENT OF HEALTH AND SOCIAL SECURITY**

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

*From the Secretary of State for Social Services*

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1A

18 February 1988

RA

Dear Paul,

NHS REVIEW

Your letter of 9 February recorded Sir Roy Griffiths' undertaking to circulate a reading list to members of the Prime Minister's Group. Sir Roy thought that it would be most convenient for the reading material itself to be circulated, and I enclose a binder of material accordingly. The list itself, together with a brief summary of each item, is included at the front of the binder.

Sir Roy took the view that it would be most helpful at this stage for the reading list to focus mainly on analysis rather than prescription, and in particular to offer a balanced range of authoritative analyses of the nature of the health care market. The material offered has been selected on this basis, and a number of the items included were suggested by Sir Roy himself. Further reading can be suggested, with a stronger focus on solutions, as the Group's work progresses.

I am copying this letter and enclosure to private secretaries to the Chancellor and Chief Secretary.

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

NAT HEALTH:
Expenditure Pt 10

CONFIDENTIAL

PRIME MINISTER

18 February 1988

THE GRIFFITHS' REPORT ON COMMUNITY CARE

A quick reading of Roy Griffiths' Report shows that it has a number of attractive features. It would introduce budgetary constraints for residential care which has grown rapidly from £23 million in 1981 to £459 million in 1986. It is based on a sensible mix of public and private provision. And it would establish clear lines of responsibility for help to the mentally ill, the elderly and those needing long-term care.

But it also has serious drawbacks. It seems an overly bureaucratic approach, reminiscent of the Seebohm Report. It might, as John Moore warns, discourage the further growth of private sector care. And it concentrates too much power in the hands of local authorities which have notably failed to handle their housing, education or, indeed, their social service functions at all satisfactorily.

But we might well graft some of Sir Roy's ideas onto our internal review of the NHS. For instance, if we want DHAs to become health funding and procurement bodies, they might fulfil the same role in relation to community care. Paragraph 4.16 is interesting here, pointing out that family doctors could have an enhanced role as the point of first contact for community care services.

So we strongly support John Moore's conclusion that the Report should be published and welcomed as an important contribution to the debate, but then shelved until we are ready to come up with our own proposals. These will draw heavily upon Roy Griffiths's ideas but are also likely to differ substantially from them.

John O'Sullivan

JOHN O'SULLIVAN

J.O'S.

pp. PETER STREDDER

CONFIDENTIAL

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cc BG

PRIME MINISTER

## SIR ROY GRIFFITHS' REVIEW OF COMMUNITY CARE

You will recall that in December 1986 Norman Fowler, after consulting you and colleagues, asked Sir Roy Griffiths to review the use of public funds to improve the effectiveness of their application to community care.

Sir Roy has just completed his report and submitted it to me at the weekend. I am sure you will wish to see the report straightaway. A copy is attached. Chapter 1, pages 20-23, summarises the proposals.

We gave Sir Roy a formidable task. The Audit Commission and the Social Services Committee had been critical of the effectiveness of community care, and especially of the application of public money to it from a variety of sources. Our invitation to Sir Roy to look at the problem was our response to this. The criticisms have since been echoed by the NAO, who expected that he would have to consider "fairly radical solutions" in his review.

He has brought to the work the logic and penetration that one would expect. But he has inevitably been confined by the fact that local authorities have a major place in the provision of community care. He has sought a solution that would spell out responsibilities and insist on performance and accountability. This has led him to the conclusion that local social service authorities should assess the community care needs of people in their locality, and should take a comprehensive view, in an enabling rather than a providing role, of these needs and the services that should respond to them.

CONFIDENTIAL

This is an understandable response to the task he was set. But I think that, from a broader point of view, he has reached some wrong conclusions. There has been a welcome growth of private sector provision of community care. I do not believe that local authority "enablers" who are themselves providers of competing services would deal even-handedly with the private sector. More generally, I doubt whether our supporters would understand a policy which would steer vulnerable members of the community more firmly towards the local authorities, of whose record we are highly critical.

So we have a dilemma. Sir Roy's report recommends a logical way of tackling the diffusion of responsibility for community care which nevertheless takes us in the wrong direction politically. There may be ways round this, for example by emphasising the purely enabling role of local authorities, cutting back their responsibilities as providers and tightening up the framework within which they would operate while at the same time encouraging the private sector alternatives. But all this will need time and thought. Meanwhile, we have the Griffiths report, which is widely anticipated, and must decide what to do with it.

The report is one of two we have been expecting which will touch on community care. The other will be from Lady Wagner's working party on the role of residential care. Her work was commissioned in March 1986 by the National Institute of Social Work, with Norman Fowler's support, and the report is being published next month. The handling of that report is for the Institute, but they are certain to publish and I believe we have no choice but to do the same with the Griffiths report. My preference would be to publish it soon, saying only that this is an important contribution to the debate on community care which we shall consider alongside Wagner. We could add that we would be bringing forward our own proposals on community care in due course, in the light of these reports. We should emphasise that Sir Roy's proposals are primarily concerned with non-health services. Although they do not have a direct bearing on the review of the NHS the two are certainly relevant to one another.

CONFIDENTIAL

A number of colleagues will be interested in the Griffiths report and I had been planning to write to colleagues in E(A) about publication and handling. But given the political sensitivities, I suggest you might want to hold a smaller meeting of Ministers to discuss the immediate problems. I am therefore at this stage copying this minute and the report only to Nigel Lawson, Nick Ridley and John Major.

JM

17th February, 1988

File. A.

7

SUBJECT cc MASTER

10 DOWNING STREET

LONDON SW1A 2AA

*From the Private Secretary*

9 February, 1988.

Dear Geoffrey,

**NHS REVIEW**

The Prime Minister yesterday held a meeting to discuss the review of the National Health Service (NHS). Those present were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. John O'Sullivan (No.10 Policy Unit). The meeting had before it a note by the Cabinet Office on the work programme of the group, and a paper by Sir Roy Griffiths on the NHS costing systems.

In discussion the following were the main points made:

a. Thinking needed to start with the fundamentals. What was the State's responsibility for ensuring that health care was available when needed? If it had such a responsibility how was it best discharged? It did not necessarily follow that the State itself should provide the treatment. Considerable thought had been devoted to these questions among those interested, both in this country and abroad, and Sir Roy Griffiths undertook to provide the group with a reading list.

b. Ideas for an internal market in the NHS needed to be treated with caution. Markets usually worked because participants were motivated by the desire to make profits and create wealth. For a market approach to be effective, a major change in attitudes by those working in the NHS would be needed. One of the key issues was how this change of attitude could be brought about.

c. The resource management project in the NHS was of major importance. What took time was not so much the construction of the new management systems as the process of involvement and commitment by NHS staff. But even if for this reason it was bound to take time to implement the new system, it should be possible to evaluate the project earlier than was now proposed. It would be useful for the group to consider a paper setting out the

lessons - however tentative - which had been learned already and reviewing the timetable for evaluation and implementation. It would be desirable for some evaluation of the project to be ready by July this year if possible.

d. All the work suggested in paragraphs 6 and 7 of the Cabinet Office note was worth undertaking. It would also be useful to add to the list in paragraph 6 a paper on waiting times, and to extend the scope of the paper in paragraph 6(e) to cover the monopoly position of other providers of health care.

e. While radical change was very desirable in the long term it was not realistic to expect it to be fully brought into effect during this Parliament. The group might therefore also consider what practical steps could be taken in the shorter term. For this purpose, a distinction might need to be made between changes that would require legislation and those that would not. It was, however, essential for any medium-term measures to be compatible with the desired longer term direction of change.

f. It was probably too soon for the group to consider possible structures for a reformed NHS. The choice of a structure was, however, the most important and difficult question it would face, and should not be deferred too long. As a first step, it would be greatly helped by having a full description of the structure of health care in selected other countries (e.g., the United States, Germany and New Zealand).

g. A programme of informal discussions might be arranged with those who could provide helpful comment and information, both from this country and abroad. These discussions would need to take place privately, and to be handled with great care, since those who were not consulted must not feel left out, and no indication could be given at this stage of the Government's own views.

The Prime Minister, summing up the discussion, said that the Cabinet Office should now arrange for work to be set in hand on all the papers described in paragraphs 6 and 7 of its note. Two papers should be added: one describing the structure of health care in selected countries abroad, and one on waiting times. The paper on consultants' terms and conditions (6e) should be extended to cover other monopoly suppliers of health care. The group would not consider structures further until this work had been done. The Secretary of State for Social Services should arrange for a paper to be prepared on any lessons so far learned from the resource management project, and on possibilities for accelerating its timetable. Sir Roy Griffiths had undertaken to circulate a reading list. The Minister for Health and Mr. O'Sullivan should make suggestions as to individuals who might be consulted informally. The group recognised that it would take some time for all this work to be completed, but a

first batch of papers should be circulated in about a fortnight, for a meeting in three weeks' time.

I am sending a copy of this letter to the Private Secretaries of the Ministers at the meeting, and also to the others present.

Yours,
Paul.

Paul Gray

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

E

PRIME MINISTER

The Cabinet Office paper on NHS reform is in general a very clear guide. I would add just three points:

(i) We should be clear that some systems of finance cannot easily be reconciled with some structures of health care. For instance, a dedicated health tax with "contracting out" is hard to combine with competing HMOs financed by full cost capitation fees. In such a system, the consumer has little incentive to contract out. He would get a better bargain by keeping his full capitation fee and adding "top up" insurance to it. Equally, partial "contracting out" under the present NHS structure would tend to undermine the existing private insurance market.

(ii) The term HMO is used in the paper, as in our previous discussions, to denote both of two slightly different institutions:

(a) Health Maintenance Organisations (HMOs proper) which contract to provide all necessary treatment for a fixed sum for a fixed period from their own hospitals employing their own doctors;

(b) Preferred Provider Organisations (PPOs) which contract to provide all necessary treatment for a fixed sum for a fixed period, but purchase this treatment from independent hospitals and doctors, using their bulk buying power to hold down costs.

There is also a third such institution - Health Management Units (HMUs) which combine features of both the above, employing GPs directly on an HMO basis but purchasing treatment from hospitals as PPOs do.

(iii) In paragraph 7, it is proposed to study how certain NHS problems might best be tackled. The list omits the problem of NHS priorities, in particular those relating to waiting lists. Since explicit priorities of urgent and non-urgent treatment provide an incentive for certain forms of health insurance, I would include this topic in the list.

John O'Sullivan

JOHN O'SULLIVAN
7 February 1988

DS2AFJ

PRIME MINISTER 5 February 1988

## VISIT TO BARTS: SOME OBSERVATIONS

We spent half a day at Barts Hospital yesterday at the invitation of Trevor Clay, talking to nurses in the intensive care, cardio-thoracic and general surgery wards and to nurses, nursing management and the RCN over lunch. The visit was helpful in illustrating some of the issues relevant to nurses pay and training.

### Impressions

On our tour of the wards we gained a number of impressions:

- That nursing is becoming increasingly highly skilled, particularly in areas such as intensive care and post-operative nursing. These jobs require the nurse to give constant attention for an 8-hour shift and to make life or death decisions about administering drugs - for example, to regulate blood pressure or to increase sedation.

- Because patients are discharged much earlier than previously, on average they are more seriously ill whilst in hospital. They also require more attention than in the past when some of those about to be discharged could even help with simple tasks, such as distributing the tea.

- Both these factors combine to require a higher number of trained nurses to maintain an adequate level of care than in the past. They also make nursing more stressful.

- Nurses in the most skilled and stressful jobs and those who perform particularly well in the job are paid no more than any other nurse in the grade. It has become

increasingly difficult to fill these key posts, since many nurses stay only for a short time using their qualification as a way of getting a preferred but less stressful job.

- In all the cases we saw, wards had been closed not for lack of funds but because of a lack of available nursing staff. Overall, Barts are short of 100 out of 600 posts for trained nurses. We saw equipment costing £30,000 in a two-bedded intensive care ward lying idle because no nurses were available despite £100,000 being available to fund the 10 posts required. The ratio of 5 staff per bed illustrates the labour intensive nature of this kind of care.

- Because of shortages of skilled nurses much more had to be left to students who sometimes had to take decisions for which they were not properly trained.

Staffing

On staffing, we concluded that:

- It is clear that there is a genuine shortage of nurses. As far as we could judge, there is no scope for more efficient use of nursing staff in the areas we visited.

- However, one cannot be sure that the shortage of staff is as great as might appear by comparing the actual numbers in post with establishment because, as yet, there appears to be no proper system of staff inspection. We were told that the complement was largely historical but that there was an initiative to provide much better information about the requirements for staff. However, the shortfall on one ward we visited, 10 out of a complement of 22 nurses, seemed strong evidence that there was an unavoidable shortage.

- On pay, it is clear that the remuneration system needs to be changed to reward staff who work in more difficult or stressful jobs, who have additional relevant qualifications or on the basis of exceptional personal performance.

- There is also a particular need to pay higher salaries in London where the difficulties in recruiting and retaining staff appear to be primarily related to the high cost and lack of availability of suitable housing.

The new salary structure currently being priced by the Review Body will allow these changes to be made. It has a new grading structure which will enable nurses in the more demanding jobs to be rewarded. It will also have an element of flexibility to allow local managers to increase pay rates for particular groups of staff where there is a shortage. This ought to satisfy the RCN since they seem willing to accept local flexibility but not rigid regional differentials.

Recruitment and Training

On recruitment and training the conclusions were:

- The present system of relying on high levels of recruitment with a high wastage rate and limited scope for entry after the age of 25 or flexibility to accommodate married women wanting to return to the profession involves considerable wastage of resources. Because of demographic changes, with many fewer young women being available to train for nursing, changes will need to be made to widen entry into the profession. The RCN seem ready to accept this.

- A number of changes can be made to widen entry into nursing. More effort could be made to attract men, those who have had another first career and those with lower

academic qualifications. The emphasis in future should be on ensuring standards of achievement during training. Equally, the NHS could be much more flexible in keeping in touch with and accommodating the particular requirements of women who had left to have families but want to return, perhaps on a part time basis.

- There is a similar waste of resources in more advanced training, for example, the six months intensive care course, since many nurses use their training for only a relatively short period. The Sister in charge of the intensive care unit told us that none of her contemporaries on her intensive care course were still working in intensive care.

- Although nursing is now highly skilled in certain areas, by no means all of a nurse's duties require high levels of skill. There seems to be scope for creating a new type of 'nursing assistant' who would take over the less skilled aspect of nurses work and the duties of auxiliaries. Unlike auxiliaries, who work as part of the ward team, the nursing assistant would work under the supervision of a specific nurse and with the patients for whom she was responsible and have some training. This would mean that wards could be staffed with fewer qualified nurses without any reduction in the quality of care. It would be cheaper because nursing assistants would be much less fully trained and would be paid less than nurses. And because they would be working under the supervision of a registered nurse, this would appear to be acceptable to the RCN.

John O'Sullivan Peter Stredder

JOHN O'SULLIVAN PETER STREDDER

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PRIME MINISTER

**HEALTH**

**Meeting of Ministers 8 February 1988**
**Note by the Cabinet Office, 5 February**

**DECISIONS**

This meeting is to discuss how to take forward the review of the NHS. The main purpose is to take decisions not on substance, but on the immediate programme of work for the Ministerial group.

2. In particular you may want to commission papers for the next meeting. The Cabinet Office note suggests possible further work on:

- facts about what the NHS provides, its efficiency, comparisons with the private sector and other countries;

- particular problems, such as how to get more information about costs, and how to introduce more competition and patient freedom of choice;

- possible structures designed to introduce more competition into the NHS. The Cabinet Office note sets out some options, broadly in order of the degree of innovation which they would entail.

**BACKGROUND**

3. At the last meeting on 27 January it was agreed that the group should take a fundamental look at the National Health Service and health care. The issues to be considered first were those related to costs, structure and the medical profession. Increases in financing could not be considered until there was confidence that

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the system was cost-effective. You asked the Cabinet Office to co-ordinate a note for the next meeting proposing how the group should proceed in tackling the issues. The note of 5 February is the result. It has been cleared with the Chancellor of the Exchequer and Mr Moore.

Flag A

**ISSUES**

**What the problem is**

4. The Cabinet Office note outlines the main problems of the NHS which the Group intends to tackle. You may wish to check that there is general agreement with this summary.

**Factual papers**

5. The Cabinet Office note goes on to suggest that the group might commission factual papers on the matters listed in paragraph 6. These are preliminary pieces of work, aimed at finding out:

a. what expenditure on the NHS actually buys;

b. what information is available about NHS costs and what differences within the NHS it discloses;

c. what can be learned from comparisons with the private sector and other countries;

d. how division of patient care is divided up between the different parts of the NHS, and between the NHS and local authorities;

e. what consultants' contracts say.

Numbers etc Professional ambitions

6. You will probably want to commission factual papers on all these aspects, and any others suggested by members of the group. The papers might be prepared by the DHSS, but co-ordinated by the Cabinet Office. It would be helpful to have any guidance which the Group can offer on priorities. For instance, the paper

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Sir Roy Griffiths' paper (Flag C) is a helpful start on this. PRCB.

setting out what information is available about NHS costs seems fundamental to the exercise and you may want to ask for it to be one of the items discussed at the next meeting.

**Particular aspects of NHS problems**

7. Building on these factual papers, the Cabinet Office note suggests that Ministers might consider papers discussing how particular aspects of NHS problems could be tackled. None of these papers on their own will provide a complete answer to the problems of the NHS, but by looking at them from different angles they may help Ministers to put together a coherent approach. The particular topics suggested are:

a. the provision of information to patients and health managers;

b. the introduction of financial incentives and proper budgeting;

c. the scope for more charging;

d. ways of introducing greater competition

e. ways of developing the role of the private sector;

f. how to promote patient freedom of choice;

g. what should be done about consultants' contracts and other restrictive practices.

8. Here again, the papers could be prepared by Departments and be co-ordinated by the Cabinet Office. They represent a substantial volume of work which cannot all be completed for the next meeting and the Group may wish to consider which papers should have priority. This will depend on how the discussion goes; but if there is general agreement with the theme of the paper, which is

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the need for some form of market mechanism, you may wish to commission papers for the next meeting on:

- ways of introducing greater competition into the NHS;

- how to give patients greater freedom of choice.

**Some possible structures**

9. Finally, looking at the picture as a whole, the note suggests some possible structures for the NHS to give effect to the need for the introduction of market disciplines. They are grouped into three broad categories:

a. those that would introduce more market mechanism into the existing structure;

b. those that would make radical changes in the existing structure, while still leaving the NHS mainly tax-financed; and

c. those that would give a greatly expanded role to private care and private finance.

I think it might be better to focus on the para. 5 + 7 issues first. PR 16.

10. The structures described are only examples, and it may be too early for the Group to consider them. You will want to judge how to deal with this in the light of the discussion.

a. One possibility would be to ask for a particular structure to be worked out in more detail in order to help focus discussion (eg the concept of Health Maintenance Organisations in paragraph 12 of the note).

b. Another approach would be to ask for a paper illustrating what might be achieved within different timescales. As the note indicates, there are changes which could be made now within the existing structure of the NHS, which could pave the

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way for more radical changes later. You might find it helpful to have this set out rather more fully.

Timing

11. You might suggest another meeting of the group in about a fortnight, and ask for papers to be prepared to fit in with that timetable.

12. You will probably want to postpone, until the picture becomes clearer, any consideration of the timetable for the exercise as a whole and of how the outcome should be made public.

R T J WILSON
Cabinet Office
5 February 1988

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PERSONNEL MEMORANDUM

PM(79)11

1

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities )
Area Health Authorities ) for action
Boards of Governors )

Community Health Councils - for information

November 1979

PAY AND CONDITIONS OF SERVICE

CONTRACTS OF CONSULTANTS AND OTHER SENIOR HOSPITAL MEDICAL AND DENTAL STAFF

## SUMMARY

**This memorandum notifies arrangements for introducing amendments which have been agreed to the contracts of consultants and other senior hospital medical and dental staff, and modifications to the distinction awards system.**

### GENERAL

1. The Joint Negotiating Committee for Hospital Medical and Dental Staff(and in the case of paragraph 17 the Joint Negotiating Body for Doctors in Community Medicine and the Community Health Service) have agreed that the changes set out in this circular shall take effect from 1 January 1980 ('the effective date').

The principal changes are (subject to the further provisions of this memorandum):

i. maximum part-time consultants to be paid 10/11 of the whole-time salary;

ii. whole-time consultants to have an opportunity to engage in a limited amount of private practice; and

iii. the 9-session part-time contract to be reintroduced.

### MAXIMUM PART-TIME CONTRACT

2. As hitherto, consultants who are appointed to whole-time posts will be able to exercise the option of a maximum part-time contract, on the terms agreed between the Government and the Joint Consultants' Committee in 1955 and 1961 (Appendix to HM(66)14 attached at Annex A).

From the effective date:

i. all future holders of maximum part-time contracts will receive 10/11 of the whole-time salary on the basis that their NHS commitment will occupy substantially the whole of their professional time and that they will undertake a minimum work commitment equivalent to 10 NHDs; and

ii. all existing maximum part-time consultants will qualify for the 10/11 payment if the authority are satisfied that the consultants are already undertaking such a workload, or they agree to do so.

3. i. Exceptionally, those existing maximum part-timers who do not wish to take on such an extra commitment should be able, if they give notice within 3 months from the effective date, to change to a 9 session part-time contract.

ii. Existing holders of 9 session part-time consultant contracts whose present work commitment (apart from the obligation on the maximum part-timer described in para 3 of Annex B) satisfies the revised criterion (para 4 below) for a maximum part-time contract or who are prepared to increase their work commitment to satisfy it, may if they give notice in the same period of 3 months change to a maximum part-time contract.

iii. Thereafter any change as at 3(i) and (ii) above would be a matter of agreement between the consultant concerned and his employing authority, subject to the needs of the service.

iv. Any practitioner holding a maximum part-time contract on 31 December 1979 may if he wishes retain it on the personal basis of 9/11 of the whole time salary in payment from time to time.

4. Authorities are accordingly asked to review the contracts of all existing maximum part-time and 9-session part-time consultants in consultation with them on the basis of paragraphs 2(ii) and 3 above. In assessing the work commitment of maximum part-timers and 9-session contract holders wishing to change to maximum part-time they should continue to follow the principles set out in Mrs Castle's letter to Dr Stevenson of 17 April 1975 (copy attached at Annex B). The maximum part-time contract should however incorporate a minimum work commitment equivalent to not less than 10 notional half days covering all the duties of the post and customarily assessed in the flexible way provided for in the terms of service. The process of review will in the majority of cases simply amount to checking readily ascertainable facts. It should be completed so far as practicable by the effective date; where however this is not possible the change should be backdated to the effective date, save only that where an increased work commitment is made by a consultant wishing to change to a 10/11 maximum part-time contract, the increased payment shall be made from a current date.

WHOLE TIME CONTRACT

(a) *Private Practice*

5. The obligations of the whole-time consultant will remain as at present in respect of commitment and work done. It has been agreed however that from the effective date whole time consultants should be able to undertake a limited amount of private practice, receiving professional fees up to a limit in gross annual earnings from it of 10% of their gross whole time salary (including any distinction award, if applicable) for that financial year. The calculation of the 10% shall exclude any charge payable by a patient to a health authority for the use of NHS facilities.

6. The private practice may be undertaken, within the agreed limit,

i. in the NHS hospitals at which they are contracted to provide a service, on the same terms as those applying to part-time consultants; and

ii. outside those hospitals but in such a way that significant amounts of the consultant's time will not be taken up in travelling to and from private commitments.

7. Whole-time consultants who undertake private practice will accept that their NHS work should receive priority at all times (subject to the consultant's ethical obligation to all his patients when emergencies arise) and that health authorities are entitled to expect no diminution in the level of service to NHS patients as a result of this arrangement. The representatives of the professions have accepted that this extended right to private practice should not be exercised in such a way as to damage working relationships with other NHS staffs. They have formally accepted that the agreed changes relating to whole-timers and maximum part-timers should not bring about any reduction overall in the commitment of consultants to the NHS or in the work done.

8. At the end of each financial year, whole-time consultants will be asked to submit a return indicating that their annual gross income from private practice has not exceeded the 10% limit in that year. Detailed accounts will not normally be required since such a system will work most satisfactorily on the basis of a large measure of trust and confidence between employing authorities and consultants. Exceptionally, however an employing authority considering that they have grounds for seeking fuller information will be entitled to call for and to receive fully audited accounts.

9. Whole-time consultants exceeding the 10% limit for two consecutive financial years will be automatically regraded as maximum part-time at the end of the third year unless, by that time, they can show that they have taken effective steps to reduce their private practice commitments, and this is confirmed by the next earnings return. When a consultant has been regraded in this way he will not be able to exercise an option to return to whole-time status until two consecutive years have passed in which he can show that his private practice earnings have not exceeded the 10% limit. A consultant so regraded will not be eligible to contract for an extra paid session (paragraphs 10/11 below) and if he holds a contract for such a session at the time of regrading it shall be terminated in accordance with paragraph 10 below.

b. *Extra paid session*

10. Whole-time consultants may be contracted for not more than one extra non-superannuable session, paid at the rate of 1/11 of their whole-time salary (excluding merit award if any), the session to be offered at the discretion of the authority in the light of service needs and to be the subject of a separate letter of appointment, subject to review not less often than annually and terminable at three months' notice on either side without formality (ie without recourse to paragraph 190 of the Terms and Conditions of Service).

11. The extra session should be available only in exceptional circumstances and should be in respect of work which is not part of a consultant's normal contractual duties (including his obligations under para 110(a) of the Terms and Conditions of Service) and can be clearly distinguished from them. Examples of such exceptional circumstances might include covering part of the workload arising from the prolonged and unexpected absence of a colleague or a sudden increase in the overall workload. The cover of annual and study leave of colleagues would not count as an exceptional circumstance.

## PART-TIME CONTRACT

a. *9-session contract*

12. Following the revised definition of the maximum part-time commitment (paragraph 4 above), it has been agreed that authorities should be able to offer part-time contracts up to and including a total of 9 notional half-days.

b. *Extra paid sessions*

13. The part-time consultant with a contract or contracts for nine sessions or fewer may take on extra paid sessions, permanently up to a total of nine and exceptionally a further session to a total of 10 on the same basis as would apply to a whole-time consultant.

## ADVERTISEMENT OF CONSULTANT POSTS

14. From the effective date, consultant posts should be advertised in such a way that candidates unable for personal reasons to work full-time should be able to apply.

## STARTING SALARIES

15. In addition to existing provisions, authorities may advertise a consultant post at the maximum of the consultant scale if it has been vacant for at least a year and has been unsuccessfully advertised at least twice. Other consultants whose principal commitment is in the same hospital and specialty as the principal commitment of the advertised post will be entitled when such an appointment is made to be placed upon the maximum of the consultant scale (if they have not yet reached it) from the date of the relevant appointment.

## OTHER CAREER GRADES

16. Whole-time staff in the grades of medical assistant, assistant dental surgeon and senior hospital medical and dental officer may (i) engage in private practice up to the limit of 10% (Paragraphs 5 to 8 above) and (ii) contract for an extra paid session, on the same basis as whole-time consultants (Paragraphs 10-11 above). If in any financial year a practitioner has exceeded the 10% limit he will be required thereupon to take effective steps to reduce his private practice commitments to within the 10% limit. Part-time staff in these grades with a contract or contracts for 9 sessions or fewer may take on extra paid sessions, permanently up to a total of 9 and exceptionally a further session to a total of 10 on the same basis as whole-time staff (cf Paragraph 13 above).

## DISTINCTION AWARDS

17. From the effective date, a number of modifications to the distinction awards system will be introduced. Details are at Annex C, but the main provisions are:

i. Awards will in future be known as distinction and meritorious service awards for consultants, and community physicians.

ii. Awards will be made in such a way as to achieve a more equitable distribution both between regions and specialties.

iii. The criteria for making awards will be clarified, and they will make it clear that outstanding service contributions alone can be sufficient reason for recommending an award.

iv. The Central Advisory Committee on distinction awards will be enlarged by the inclusion of additional members representing the general body of consultants.

v. The Chairman of the Advisory Committee will consult regional health authorities to ensure that employing authorities are able to put forward recommendations for the consideration of his Committee.

vi. The confidentiality of the system will be modified to allow the names of holders to be made available to consultants generally within their region.

## MAXIMUM PART-TIME AND 9 SESSION PART-TIME CONSULTANT CONTRACTS: CONSULTATIVE MACHINERY

18. The Department consider that employing authorities may find it helpful to establish a joint consultative group to consider and give guidance to employing authorities and consultants on any contentious matters of fact or interpretation arising in the changes (paragraphs 2(ii) and 3 above) affecting holders of maximum part-time and 9-session part-time contracts. This group should be available as an informal point of reference for consultants and the authority, and will not be an appeal body, for which see paragraphs 20/21 below.

19. The group should consist of broadly equal numbers of representatives of the employing authority and the Regional Committee for Hospital Medical Services. It will be for employing authorities to decide who should represent them, but there is clear merit in using the expertise of their medically qualified staff as far as possible.

## APPEALS

20. Where consultation has been exhausted and disagreement persists between the authority and the consultant on the work commitment of a contract, the consultant may use the appeals machinery provided for in Section XXII of the General Whitley Council Terms and Conditions of Service if there is dispute as to whether his existing work commitment satisfies the revised criterion (para 4 above) for a maximum part-time contract.

21. If on appeal the consultant establishes that his workload satisfies the revised criterion for a maximum part-time contract, the authority will pay the 10/11 salary. If he does not establish this point, the authority will pay the 10/11 salary provided he is prepared to make an appropriate additional work commitment. If he was a maximum part-time contract holder on 31 December 1979 he may change to a 9-session part-time contract, or retain a personal 9/11 maximum part-time contract, as provided in paragraph 3 above.

## MODEL FORMS OF CONTRACT AND JOB DESCRIPTION

22. Attached at Annexes D and E are draft forms of contract for the career grades to replace those in HM(69)88. Authorities are asked to follow these closely in drawing up future contracts and, where appropriate, in amending existing contracts. Also attached (Annex F) in a model form of job description which authorities may find useful for advertising a vacant consultant post.

## AMENDMENTS TO TERMS AND CONDITIONS OF SERVICE

23. Amendments to the Terms and Conditions of Service are attached at Annex G.

## REVIEW

24. This agreement will be reviewed jointly by the Health Departments and the professions three years after the effective date.

## APPROVAL

25. This agreement has been approved by the Secretary of State under Regulation 3 of the National Health Service (Remuneration and Conditions of Service) Regulations 1951 (SI 1951 no 1373) and 1974 (SI 1974 no 296).

## ACTION

Authorities are asked to put the provisions of this memorandum into operation from the effective date.

**From:**
**NHS Personnel Division 1A**
**Eileen House**
**80-94 Newington Causeway**
**London SE1 6EF**
**Tele No. 01-703 6380 Ext 3780/3710**

**B(3)/C175/083**

**Further copies of this Memorandum may be obtained (by written request wherever possible please) from DHSS Store, Scholefield Mill, Brunswick Street, Nelson, Lancs BB9 0HU. Tel. Nelson (0282) 62411/2 Ext 17, quoting code and serial number appearing at top right-hand corner.**

Annex A
(PM(79)11)

(Appendix to HM(66)14)

## THE WHOLE-TIME/MAXIMUM PART-TIME OPTION

The following statement was agreed between the Ministry of Health and the Joint Consultants Committee in 1955:

> "The Joint Consultants Committees have had recent discussions with the Ministry of Health and the Department of Health for Scotland about whole-time and maximum part-time service for consultants in the National Health Service, and the following is an agreed statement of the position.
>
> It is recognised that some consultants, while prepared to devote substantially the whole of their time to hospital work and to give it priority on all occasions, would prefer a maximum part-time to a whole time contract. Ever since 1948 it has been the Ministry's view that, subject always to the needs of the hospital service, employing Boards should in this matter take into account the circumstances and preferences of the consultants concerned. While there has been no previous statement on this point as regards Scotland the practice in that country has been similar.
>
> Where a new appointment is being made this means that except where the Board decides that the needs of the hospital service (considered in conjunction with those of the local health services where the consultant is to undertake duties on behalf of a local authority) demand a whole-time appointment, the competition should be thrown open to all applicants who are prepared to give substantially the whole of their time to the post, whether they prefer a whole-time or maximum part-time contract. In such a case the successful candidate should not be asked to state his preference until after he has been selected for appointment.
>
> Similarly, if a consultant who is already employed in a whole-time post wishes to transfer to a maximum part-time contract, or vice versa, the Board should before reaching a decision take his circumstances and preferences into account, again subject to the overriding needs of the hospital service.
>
> This statement does not, of course, deal with the many cases where the services of a consultant are needed in the aggregate for only a limited volume of work, and where therefore a part-time appointment would in all cases be appropriate".

The following statement was issued by the Joint Consultants Committee in 1961:

> "The Joint Consultants Committee has again discussed with the Ministry of Health the agreement reached a number of years ago that hospital boards should, at the time of making a whole-time consultant appointment, normally offer the option of a whole-time or maximum part-time. The option was agreed on the understanding that consultants so appointed would be "prepared to devote substantially the whole of their time to hospital work and to give it priority on all occasions". By hospital work is meant, of course, all duties that arise from an officer's contract. It is important that the right to exercise this option continues and the Joint Committee reminds consultants of their obligation under it. A hospital board has a right to advertise for a whole-time post without the option, but the board should have adequate reasons for so doing. Under the agreement it can expect as much from him on a maximum part-time contract as on a whole-time contract.
>
> This is a valuable privilege for consultant applicants and, to safeguard its continuance, the Joint Consultants Committee reminds consultants of its terms and their obligation under it.
>
> The same obligations apply to a whole-time consultant who applies in due course to become maximum part-time".

Annex B
(PM(79)11)

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
ALEXANDER FLEMING HOUSE
ELEPHANT AND CASTLE LONDON SE1 6BY
TELEPHONE 01-407 5522

Dr Derek Stevenson
British Medical Association
BMA House
Tavistock Square
LONDON
WC1 9JP

17 April 1975

Dear Dr Stevenson,

I refer to our previous correspondence about the existing agreements on the filling of those consultant posts in which the consultant, after appointment, has the option of accepting either a whole-time contract or what is known as a maximum part-time contract.

I have already confirmed - and am pleased to reiterate - that I do not seek to disturb this option agreement made in 1955 and re-affirmed in 1961 and 1969. For my part I am prepared for it to continue to be operated on the basis which has been practised over the years and has been continued without interference during the past year.

My understanding of the long-established practice, which you sought in your letter of 14 March and which I said in my reply I would be prepared to discuss with you, takes account of the reasons underlying the introduction of the agreement in 1955. It is accepted that it represented and still represents a compromise to meet the needs both of the employing authority and of the consultant. The former needs to secure substantially the whole of the consultant's professional time, and the latter accepts this obligation and that of giving priority to his NHS duties on all occasions. However, in interpreting this latter obligation I accept that it can only operate in the light of the consultant's ethical obligation to all his patients when emergencies arise. The other part of the compromise is the need of the maximum part-time consultant to enjoy - within the exercise of his professional judgment - sufficient flexibility in making arrangements to allow him to carry on private patient practice, a right to which the option entitles him (and in return for which he foregoes a part of the aggregate whole-time salary).

The application of this compromise means that a consultant, after accepting a post advertised as "whole-time with the option of maximum part-time" - whichever way he opted to work - agreed with his employing authority the definition of his NHS work. For the maximum part-time contract holder this has incorporated a basis of not less than 9 notional half days customarily assessed in the flexible way provided for in the

terms of service as regards travel time and emergencies - together with additional work which has not always been defined in the same detail. The maximum part-time contract has been expressed in a variety of ways, and in a number of cases it has not been agreed in terms of notional half days. Where it has been so agreed it has normally been 9, but occasionally 10 or 11. The process of assessment should be conducted flexibly so as to provide both that the consultant will give substantially the same service and time overall as he would have done had he opted for a whole-time appointment, and also to allow him to accommodate his other work. Because of a consultant's continuing ethical commitment to his patients it is not customary to define or limit this in terms of a fixed number of hours; thus the consultant's obligation cannot be discharged merely by working a fixed number of hours in a week.

To summarise my view I would endorse that of the then Chairman of the Central Consultants' and Specialists' Committee who wrote in 1955 "the spirit of the agreement is that the difference between a maximum part-time and a whole-time consultant is not the amount of work that either does but the difference of legal relations .... a difference which should normally be determined solely by the wishes of the consultant concerned". Because the former has been, and is, entitled to undertake private patient practice in his case the full programme of his NHS duties has been drawn up more flexibly to meet the needs both of himself and his employing authority. It is my view that in reaching their agreement the parties should not be restricted in considering all the circumstances. For example, the employing authority should not automatically assume that the consultant would necessarily wish to agree to carry out his NHS work in the same way as any previous holder of the same post. Moreover, should the circumstances change it is open to either party to propose a reconsideration of the programme of work within the spirit of the option agreement.

For completeness sake I should remind you that it is also accepted that an NHS authority has the right, where on occasion the needs of the hospital service so require, to advertise a whole-time post without an option, but when so doing it must have adequate reasons. Merely to state that the post requires the whole of the consultant's time is not an adequate reason and I would expect that before considering an advertisement on these lines the authority would discuss the matter with the appropriate representatives of its consultant staff (usually the Regional Committee for Hospital Medical Services).

In conclusion, I hope you will agree that I have correctly set out the present practice and that in the interests of both the NHS and the profession all consultants and employing authorities should continue to have full regard to it when settling the terms of individual contracts under these present arrangements, and in fulfilling their respective obligations. As I have indicated earlier in my letters of 11 February and 20 March, if we come to consider possible modifications of the contract some practical alterations may be necessary to take account of heavy workload and possibly of other factors, but the spirit of the option agreement should, in my view, be upheld.

Sincerely,

Barbara Castle

## DISTINCTION AND MERITORIOUS SERVICE AWARDS FOR CONSULTANTS AND COMMUNITY PHYSICIANS

1. The following changes will be introduced in the present system of making awards to consultants for distinction and meritorious work in the NHS. The Advisory Committee on Distinction Awards under its Chairman, will remain as hitherto solely responsible for advising the Secretary of State on awards to be given. Reference in this document to consultants should be taken as including community physicians also.

### I. A AND A+ AWARDS

2. No changes will be made in present arrangements for the consideration of candidates for A and A+ awards; these will be given wherever sufficient distinction is found irrespective of considerations of specialty or geographical distribution. While it is expected that the highest awards will continue to be given to consultants with major academic or clinical research achievements to their credit, it will be made clearer that service contributions to the NHS should be given their proper weight and that outstandingly meritorious service alone can, exceptionally, qualify a consultant for the very highest award.

### II. B AND C AWARDS

a. *Regional Distribution*

3. The existing informal quota system for the distribution of available awards between regions will be formalised in consultation with the Chairman of the Awards Committee. Regional quotas will be broadly pro rata to the number of consultants employed save that in the first few years it may be necessary to weight them slightly in order to remove the remaining fairly minor discrepancies between regions. It will still be open to the Central Advisory Committee to override these quotas if for instance, particularly deserving cases come forward at a later stage or on appeal, but as now it is expected that the number of cases where this occurs will be so small as not significantly to affect the overall regional balance.

b. *Distribution by Specialty*

4. The Chairman and his Committee will keep a careful watch on the distribution of awards between specialties. The Chairman during his visits to regional committees will give guidance on the distribution of awards between specialties and set guidelines on targets to be achieved in the medium term. Regional Committees, in making recommendations to the Chairman, will be invited by him to take account of these guidelines. It is accepted that awards can be given only where there is merit either in terms of academic or clinical distinction or of outstanding service contributions and so there may be occasions when regional committees cannot make progress as fast as was hoped towards a redistribution of awards because insufficient suitable candidates have been identified.

### III. CENTRAL ADVISORY COMMITTEE

5. The Advisory Committee on Distinction Awards will be enlarged to include three members representing the general body of consultants holding A+ or A awards. Nominations for these seats will be made by the Chairman of the Central Committee for Hospital Medical Services after consultation with the Chairmen of the Central Advisory Committee, the Joint Consultants Committee, and the Community Medicine Consultative Committee.

Similar arrangements will be made for representation from consultants in Scotland.

### IV. THE ROLE OF THE EMPLOYING AUTHORITIES

6. Hitherto the Chairman of the Advisory Committee, when he visits a region, has normally sought informal advice through the RMO or a nominated AMO. It is proposed that this process of consultation with employing authorities should be formalised, to the extent that the Chairman will ensure that the authorities are able to put forward for consideration their recommendations based on knowledge of the service contributions of individuals. Such recommendations will be formulated in confidence and without public discussion by the authority in accordance with normal personnel practice. They will then be considered by the regional advisory committees for awards along with advice from other sources in the normal way. The final decision on which names should be put forward to the Secretary of State will, as now, be for the Chairman and members of the Central Advisory Committee.

7. The structure of the NHS in Scotland and Wales will not make it feasible for health authorities to participate in precisely the same way as in England, but it is proposed that broadly similar principles should apply.

## V. CONFIDENTIALITY

8. It is agreed that the confidentiality of the awards system, should be maintained, subject only to the names of award holders being available in confidence to consultants generally within their region on request to the Regional Medical Officer, who will keep a list of the holders of awards (with the class and date of their awards) within his region. (Similar arrangements will be made in Scotland and Wales).

## VI. OTHER ASPECTS OF THE AWARDS SYSTEM

9. In all other respects the awards system will remain as it is now.

**RECOMMENDED FORM OF CONTRACT FOR CONSULTANTS**

Dear

APPOINTMENT OF CONSULTANT IN (SPECIALTY)

1. I am instructed by the (insert name) Authority to offer you an appointment of [whole-time] *, [maximum] *, [part-time] * consultant in (specialty) from (date) subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff and to the provisions as to superannuation from time to time in force.

2. The terms and conditions of the employment offered are set out in the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales) and General Whitley Council Conditions of Service as amended from time to time. Copies of these may be seen at the Authority's offices.

3. The appointment is superannuable. Unless within 13 weeks of starting your employment you are notified otherwise, you will be subject to the National Health Service Superannuation Scheme and will then be contracted out of the state pension scheme. A copy of the current regulations governing the scheme may be seen at the Authority's offices and a booklet about it is attached (NHS Superannuation Scheme (England and Wales); An Explanation).

4. Insofar as they are not already covered by the Terms and Conditions of Service mentioned above the following duties have been assigned to you for the purpose of providing health services under the National Health Service Acts in the following district(s): (insert names)

a. Diagnosis and treatment of patients at the following hospitals, health centres and clinics; (insert names). (Insert, for part-timers only, the number of notional half-days at each)

b. [Domiciliary consultations as may be required from time to time].

c. In addition to the duties mentioned above you may exceptionally be required to undertake duties for limited periods within the districts specified above.

d. The diagnosis and treatment of patients occupying accommodation made available under sections 58, 65 and 66 of the National Health Service Act 1977, insofar as such patients have not made private arrangements for such treatment under section 65(2) of that Act.

e. (insert as necessary)

f. Continuing clinical responsibility for the patients in your charge, allowing for all proper delegation to, and training of, your staff.

Subsequently, the duties and places where they are to be carried out may be varied by agreement between the Authority and yourself.

5. The arrangement of your duties will be such as may be agreed between the Authority and yourself from time to time. (Insert the following sentence for whole-timers and maximum part-timers). [It is agreed that any private practice you may undertake, whether limited or not by the Terms and Conditions of Service, will in no way diminish the level of service that may be expected from you by the authority in carrying out the duties specified above].* (Insert the following sentence for maximum part-time consultants only:) [It is also agreed that the duties specified above are regarded as requiring substantially the whole of your professional time, and that this will involve a minimum work commitment equivalent to 10 notional half-days a week].* (Insert the following sentence for part-time consultants only:) [The duties of the appointment offered to you are assessed as amounting to notional half-days a week].*

6. The salary of the appointment (exclusive of any distinction and meritorious service award payable to you) will be that appropriate to a [whole-time] * [MPT] * consultant appointment [assessed at notional half-days a week].* Your starting salary will be (insert commencing salary). Salary will be payable monthly/quarterly. Your incremental date will be

7. For the purposes of section 1(2)(c) of the Employment Protection (Consolidation) Act 1978, your previous employment with (insert name of previous employer) does [not] * count as part of your continuous period of employment [and your continuous period of employment therefore began on (date)].* However, for the purpose of certain NHS conditions of service, previous NHS service, not treated as "continuous" under the provisions of the Employment Protection (Consolidation) Act 1978, may also be reckoned for those purposes, subject to the rules set out in the Terms and Conditions of Service.

8. The employment is subject to 3 months notice on either side but is subject to the provisions of paragraphs 190 to 198 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.

9. You are required to be fully registered with the General [Medical] * [Dental] * Council.

10. The authority requires you to be a fully subscribed member of a recognised professional defence organisation, or, if you have an objection to such membership on grounds of conscience or on some other grounds approved by the Secretary of State, to take out and produce to the authority an insurance policy covering yourself in respect of any liability arising out of or in connection with your duties hereunder, and to produce to the Authority forthwith the receipts of the payment or renewal of subscriptions or premiums as the case may be.

11. Your private residence shall be maintained in contact with the public telephone service and shall be not more than 10 miles by road from the (insert name) hospital unless specific approval is given by the Authority to your residing at a greater distance.

12. Arrangements for leave and other absences must be approved by the Authority [but shall in the first instance be made locally].*

13. The agreed procedure for settling differences between you and the authority where the difference relates to a matter affecting your conditions of service is set out in Section XXII of the General Whitley Council Conditions of Service.

14. In matters of personal conduct you will be subject to the General Whitley Council agreements on disciplinary and dismissal procedures. The agreed procedures for appeal against disciplinary action or dismissal are set out in Section XXXIV of the General Whitley Council Handbook and paragraph 190 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.

15. The authority accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to their officials for safe custody. You are therefore recommended to take out an insurance policy to cover your personal property.

16. If you agree to accept this appointment on the terms indicated above, please sign the form of acceptance at the foot of this letter and return it to me in the enclosed stamped addressed envelope. A second signed copy of this letter is attached and should be retained by you for future reference.

Yours sincerely

Signature
On behalf of

I hereby accept the offer of appointment mentioned in the foregoing letter on the terms and subject to the conditions referred to in it. I undertake to commence my duties on the

Signature

Date

This offer and acceptance of it shall together constitute a contract between the parties

Note: [ ] * denotes "delete as necessary".

Annex E
(PM(79)11)

**RECOMMENDED FORM OF CONTRACT FOR MEDICAL ASSISTANTS AND ASSISTANT DENTAL SURGEONS**

Dear

I am instructed by the (insert name) Authority to offer you an appointment as a [whole-time] *, [part-time] * practitioner in (specialty) from (date) in the grade of [medical assistant] *, [assistant dental surgeon] *

2. The appointment is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales) and General Whitley Council Conditions of Service as amended from time to time. Copies of these may be seen at the Authority's offices.

3. The appointment is superannuable. Unless within 13 weeks of starting your employment you are notified otherwise, you will be subject to the National Health Service Superannuation Scheme and will then be contracted out of the state pension scheme. A copy of the current regulations governing the scheme may be seen at the Authority's offices and a booklet about it is attached (NHS Superannuation Scheme (England and Wales); An Explanation).

4. Insofar as they are not already covered by the Terms and Conditions of Service mentioned above the following duties have been assigned to you for the purpose of providing health services under the National Health Service Acts in the following district(s): (insert names)

a. The Authority will nominate from time to time the consultant or consultants to whom you will be responsible and your duties will be such as he or they shall designate to you. Your normal hours of duty will be agreed between yourself, the consultant to whom you are responsible and the employing authority and will be notified to you in writing by the Authority but these will be subject to any additional requirements of your post. Initially, you will be responsible to (insert name) and your duties will be at the following hospitals, health centres or clinics (insert names). (Insert, for part-timers only, the number of notional half-days at each).

b. In addition to the duties mentioned above you may exceptionally be required to undertake duties for limited periods elsewhere within the districts specified.

c. (Insert as necessary)

d. Continuing clinical responsibility to the consultant(s) nominated by the Authority for the patients in your charge, allowing for all proper delegation to, and training of, junior staff.

The Authority reserves the right to make changes in your place of work and in the consultant(s) to whom you are responsible subject to your agreement, such agreement not to be unreasonably withheld.

5. The arrangement of your duties will be such as may be agreed between your consultants and yourself from time to time. (Insert the following sentence for whole-time practitioners). [It is agreed that any private practice you may undertake will in no way diminish the level of service that may be expected from you by the authority in carrying out the duties specified above] *. (Insert the following sentence for part-time practitioners only:) [The duties of the appointment offered to you are assessed as amounting to notional half-days a week] *.

6. The salary of the appointment will be that appropriate to a [whole-time] * appointment in the grade of [medical assistant], [assistant dental surgeon] [assessed at notional half-days a week] *. Your starting salary will be (insert commencing salary). Salary will be payable monthly. Your incremental date will be

7. For the purposes of section 1(2)(c) of the Employment Protection (Consolidation) Act 1978, your previous employment with (insert name of previous employer) does [not] * count as part of your continuous period of employment [and your continuous period of employment therefore began on (date)] *. However, for the purpose of a number of NHS conditions of service, previous NHS service, not treated as "continuous" under the provisions of the Employment Protection (Consolidation) Act may also be reckoned for those purposes, subject to the rules set out in the Terms and Conditions of Service.

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because 10% limit
included in 2

30th
April
MGR/5/4
Replaced

8. The appointment is for one year in the first instance unless previously terminated by three months' notice on either side. At the expiration of one year the appointment, unless terminated, may be renewed without any limitation of time, and shall then be subject to three months notice on either side and to the provisions of paragraphs 190 to 198 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.

9. You are entitled to the minimum periods of time off duty set out in paragraph 118 of the Terms and Conditions of Service of Hospital Medical and Dental Staff: if this entitlement cannot be accorded, you will be entitled to extra duty allowance under the conditions set out therein.

10. You are required to be fully registered with the General [Medical] *[Dental] *Council.

11. The authority requires you to be a fully subscribed member of a recognised professional defence organisation, or, if you have an objection to such membership on grounds of conscience or on some other grounds approved by the Secretary of State, to take out and produce to the authority an insurance policy covering yourself in respect of any liability arising out of or in connection with your duties hereunder, and to produce to the authority forthwith the receipts of the payment or renewal of subscriptions or premiums as the case may be.

12. Your private residence shall be maintained in contact with the public telephone service and shall be not more than 10 miles by road from the (insert name) hospital unless specific approval is given by the Authority to your residing at a greater distance.

13. Arrangements for leave and other absences must be approved by the Authority [but shall in the first instance be made locally] *.

14. The agreed procedure for settling difference between you and the authority where the difference relates to a matter affecting your conditions of service is set out in Section XXII of the General Whitley Council Conditions of Service.

15. In matters of personal conduct you will be subject to the General Whitley Council agreements on disciplinary and dismissal procedures. The agreed procedures for appeal against disciplinary action or dismissal are set out in Section XXXIV of the General Whitley Council Handbook and paragraph 190 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.

16. The authority accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to their officials for safe custody. You are therefore recommended to take out an insurance policy to cover your personal property.

17. If you agree to accept this appointment on the terms indicated above, please sign the form of acceptance at the foot of this letter and return to me in the enclosed stamped addressed envelope. A second signed copy of this letter is attached and should be retained by you for future reference.

Yours sincerely

Signature
On behalf of

I hereby accept the offer of appointment mentioned in the foregoing letter on the terms and subject to the conditions referred to in it. I undertake to commence my duties on the

Signature

Date

This offer and acceptance of it shall together constitute a contract between the parties.

Note: [ ]* denotes "delete as necessary".

## I. RECOMMENDED FORM OF JOB DESCRIPTION FOR ADVERTISING A VACANT CONSULTANT POST

### 1. HOSPITAL(S) AND CLINIC(S) WHERE SERVICES ARE TO BE PROVIDED

The District(s) and within the District(s), the hospital(s) and clinic(s) and any other premises for which the post carries a regular commitment, including function, size and relationship to other hospitals, medical schools etc. Opportunities of the post; any likely developments in the service.

### 2. THE WORK OF THE DEPARTMENT

A brief description of the work of the department including the number of consultants; the number of junior staff; principal relationships with other specialties; administrative relationships with other specialties eg the Cogwheel Division. Facilities available - accommodation, diagnostic facilities, etc. Any other relevant information.

### 3. POSITION OF CONSULTANTS UNABLE FOR PERSONAL REASONS TO WORK FULL-TIME

Any consultant who is unable for personal reasons to work full-time will be eligible to be considered for the post; if such a person is appointed, modification of the job content will be discussed on a personal basis, in consultation with consultant colleagues.

### 4. THE JOB ITSELF

a. its title;

b. relationships:

i. name of employing authority or authorities;

ii. names of consultant members of the department;

iii. numbers and grades of members of the firm;

c. duties of post:

i. clinical - details of all clinical commitments;*

ii. teaching - undergraduate/postgraduate duties (other than those remunerated by a university or by fees in accordance with paragraph 172 of the Terms and Conditions of Service), including an assessment of the likely time involved;

iii. any research activities which are an inherent part of normal clinical duties;

iv. administrative duties including those associated with care of patients and the running of the department. (It will not usually be possible to include much information in this section at the time of advertising a post);

d. weekly provisional timetable of duties, including the location(s) at which they are to be performed; any duties which take place less frequently than once a week should be included with an indication of their average frequency.

e. For part-time posts, other than maximum part-time posts, an assessment, in accordance with paragraph 61 of the Terms and Conditions of Service of the average time required by a consultant in the specialty to perform the defined duties of the post. The assessment should *exclude* those duties which are otherwise remunerated;

***There should be an indication of any requirement to advise on, undertake or participate in termination of pregnancy, in accordance with the Chief Medical Officer's letters of 19 February 1975 and 16 July 1979 to Regional Medical Officers.**

f. statement that the consultant has a continuing responsibility for the care of patients in his charge, and for the proper functioning of his Department;

g. statement that the consultant will undertake the administrative duties associated with the care of his patients, and the running of his clinical department.

5. MAIN CONDITIONS OF SERVICE

i. that the post is covered by the terms and conditions of service;

ii. if he chooses to contract on a whole-time basis, that his gross income from private practice must not exceed 10% of his gross NHS income (including distinction award if applicable);

iii. any requirement as to residence, medical examination etc;

iv. salary scale.

6. DATE WHEN POST IS VACANT

## AMENDMENTS TO THE TERMS AND CONDITIONS OF SERVICE REQUIRED TO IMPLEMENT THE NEW ARRANGEMENTS FOR CONSULTANTS ETC

14 Renumber 14(a)

15 Renumber 14(b)

BASIS OF CONTRACT

CAREER GRADES

15. a. Where a whole time consultant appointment is made in the National Health Service, it may be filled by a consultant on either a whole-time or a maximum part-time basis. A consultant who opts for the maximum part-time contract is, like a whole-time consultant, expected to devote substantially the whole of his professional time to his duties within the NHS. Subject to any controls that may be exercised from time to time by the Health Departments, employing authorities may offer part-time appointments in the career grades.

b. A maximum part-time consultant is paid 10/11 of the whole-time salary set out in Paragraph 2 and of a distinction award if applicable; save that any such consultant in post on 31 December 1979 electing to do so may retain a personal maximum part-time contract paid at 9/11 of the whole-time salary.

c. A part-time consultant is paid on the basis set out in paragraphs 61-69.

TEMPORARY ADDITIONAL SESSION

16. In exceptional circumstances, an authority may, at their discretion, enter into a separate contract with a consultant (other than a maximum part-time consultant) a senior hospital medical or dental officer, medical assistant or assistant dental surgeon for an extra notional half-day to undertake work which is not part of his normal contractual duties (including his obligations under paragraph 110(a). Such contracts shall be reviewed not less often than annually and will be terminable at 3 months' notice on either side without formality. The provisions of paragraph 190 and 191 do not apply to notional half-days contracted for under these arrangements. The notional half-day shall be remunerated at the rate of one-eleventh of the appropriate whole-time salary.

61. Add to the end of the last sentence ", and any time contracted and remunerated separately under the provisions of paragraph 16".

69. Last sentence to read - "this maximum shall not include payments made for an additional notional half-day contracted under paragraph 16, or in respect of exceptional consultations etc etc".

71. Add to the existing sentence a new sentence: "A notional half-day arising from an additional session contracted under the terms of paragraph 16 shall not be included in the calculation".

78. Insert after "whole-time employment" in the first sentence the following "(excluding any notional half-day contracted under paragraph 16)".

PRIVATE PRACTICE

159. Delete existing paragraph.

158. a. The term "private practice" includes work in the General Ophthalmic Service, general practice under Part II of the National Health Service Act 1977 (except in respect of patients for whom a hospital medical officer is allowed a limited "list", eg members of the hospital staff) and the diagnosis or treatment of patients by private arrangements under section 65(2) or 66(1) of the National Health Service Act 1977, but does not include work of the kind referred to in paragraph 162. No fees may be charged by either a whole-time or a part-time practitioner to a patient who has elected to receive services under section 65(1) of the National Health Service Act 1977.

b. All practitioners may undertake private practice, subject to the limits set out in paragraph 159 below, provided that practitioners in the training grades may undertake it only outside the hours for which they are contracted to an employing authority.

## LIMITATION OF PRIVATE PRACTICE

159. a. A whole-time practitioner in one of the career grades must certify annually (if his employing authority request this, by the production of fully audited accounts) that his gross income from private practice (excluding any payments made by patients for the use of NHS hospital facilities) does not exceed 10% of his gross salary (including any distinction award, but excluding any other fees, whether payable under these terms and conditions of service or otherwise);

b. Where a whole-time consultant's certified private practice income exceeds 10% of his gross salary (as defined) for two consecutive years ending 5 April, his contract will automatically be deemed to be a maximum part-time contract and his remuneration adjusted accordingly, with effect from 1 April in the year following, unless by that date he can show that he has taken effective steps to reduce his private practice commitments to enable him to comply with paragraph 159(a) above, and this is subsequently confirmed by his earnings return due at that time.

c. When a consultant has been regraded under (b) above, he will not be able to exercise an option to return to whole-time status until two consecutive years have passed in which he can show that his private practice earnings have not exceeded the limit of 10%.

d. A whole-time practitioner in one of the career grades (other than a consultant) whose certified private practice income exceeds 10% of his gross salary (as defined) in any year ending 5 April shall thereupon take effective steps to reduce his private practice commitments to enable him in his next earnings return to comply with paragraph 159(a) above.

d. Where private practice is undertaken by a whole-time practitioner outside the NHS hospitals where he is contracted to provide a service, it shall be so limited that significant amounts of his time are not taken up in travelling to and from private commitments.

Provisions of paragraphs 160-169 are subject to further negotiation.

297. c. Revise as follows: "Where a consultant moves to take up a maximum part-time contract he shall be reimbursed ten-elevenths of the normal expenses to which a consultant appointed to a whole-time post would be entitled under paragraphs (c) or (d) above. Where such a whole-time consultant changes to a maximum part-time contract within two years of taking up his appointment he shall be required to refund one-eleventh of the expenses paid".

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PRIME MINISTER

NHS REVIEW: MEETING ON 8 FEBRUARY

Flag D - consultants' contracts

Flag E - comments on summary paper by J. O'Sullivan

I attach three documents for Monday's meeting:

Flag A - A summary paper coordinated by the Cabinet Office of the main issues to be considered;

Flag B - A handling brief from the Cabinet Office;

Flag C - A paper by Sir Roy Griffiths on NHS costing systems.

The papers at A and C have been circulated to those attending the meeting.

Given the diary constraints there is only one hour for the meeting. I suggest you focus on organising the work programme for the group and identify the key pieces of work which should now be put in hand. If time permits you might want to have some brief discussion of Sir Roy Griffiths' paper although the area this covers will need to be considered again when other factual pieces of paper are available.

We are now putting in hand the organisation of regular fortnightly meetings of the group. But you may also want to consider convening other types of meetings. There are perhaps four other groups of people it would be worth involving in the discussions over the next few months:

- selected NHS managers
- a selection of consultants
- private sector operators, eg BUPA etc.
- a selection of "thinkers".

Meetings involving these groups could take one of two forms - either presentations or seminars. As a first step you might

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like to consider having a presentation by selected NHS managers of how the hospital system actually works.

You might then want to convene one or two seminars. These could either be just with one of the four groups on their own or involve a selection of people from the four groups. The latter might be more useful. You will want to consider whether to arrange such occasions at No. 10 or at Chequers.

You should also be aware of Sir Roy Griffiths' movements. He will be present at Monday's meeting. But at the end of next week he is going into hospital for a heart by-pass operation and will be out of commission for about five weeks. He does not want knowledge of the operation to be widely known and you should not mention it at Monday's meeting. But you may want to bear in mind that he will not be available for the next two or three meetings. Given pressures on your diary next week, I think any private chat you wanted to have with him will have to wait until he is back in action again.

PRCG.

PAUL GRAY

5 February 1988

P.S. At Flag D is some detailed material on consultants' contracts which you might want to glance at over the weekend.

PRCG.

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10 DOWNING STREET

LONDON SW1A 2AA

*From the Private Secretary*

5 February 1988

Dear Geoffrey,

**NHS REVIEW**

Next week's meeting of the Review Group will now take place on Monday 8 February at 1730 hours. I enclose two papers for discussion:

(i) a note co-ordinated by the Cabinet Office setting out suggestions for a work programme;

(ii) a paper by Sir Roy Griffiths on NHS costing estimates, which is particularly relevant to paragraph 6 of the Cabinet Office note.

I am copying this letter to Alex Allan (H M Treasury), Jill Rutter (Chief Secretary's Office), Jenny Harper (Minister of State, DHSS) and Sir Roy Griffiths, Sir Robin Butler, Richard Wilson and John O'Sullivan.

Yours,
Paul

**PAUL GRAY**

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

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Health 3

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From: R T J Wilson
5 February 1988

MR GRAY

cc Mr Monger

NATIONAL HEALTH SERVICE

As promised, I attach the paper for next Tuesday's meeting in final form. It has been cleared with the Chancellor of the Exchequer and the Secretary of State for Health.

RTJW.

R T J WILSON

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# THE NHS

## Note by the Cabinet Office

This note sets out some of the main questions that will have to be considered in the internal review of the NHS.

## Scope and Objective

2. The objective is to devise a structure for health care which is responsive to the needs and wishes of patients and available to all, and at the same time cost-effective and efficient. The review will place special emphasis on the hospital service, but the latter cannot be considered in isolation from primary care and the private sector. The level of financing and resources can be considered later when Ministers have decided on a structure which will make best use of whatever resources are available from whatever source.

## Problems

3. The fundamental problems are:

a. consumers have very little freedom of choice. Most patients have no say in when, where, how or by whom they are treated.

b. present cost controls are crude. Patients have no idea what it costs to treat them. Nor usually do those who treat them. Even if they do, they have no incentive to drive the costs down or to consider which course of treatment is the most cost-effective.

c. there is no means of channelling resources to the most efficient and cost-conscious units, eg the most efficient District Health Authorities (DHAs). Nor, unlike a business, can the most efficient and low-cost hospitals increase their share of the market (and hence their revenue) at the expense of the less efficient. As the Secretary of State's paper points out, hospitals are not rewarded for attracting patients but suffer financially for it.

d. the system is not good at dealing with mismatches between patient demands and available capacity (eg waiting lists) produced partly by institutional boundaries between public and private sectors, between GPs and the hospital service, and between health authorities.

e. there is insufficient management flexibility in the use of staff - from consultants down to the most junior grades - and in the method of determining their pay.

4. In short the NHS lacks a market mechanism under which the patient chooses, in full knowledge of the costs, who shall provide his health care, how, when and where, and resources are allocated to the hospitals, doctors and GPs who are most successful, again in full knowledge of the costs, in meeting the consumer's demands in the most cost-effective way.

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**Suggested approach**

5. We suggest that the Ministerial Group should approach this problem from three angles: facts, detailed investigation of selected aspects and options for changes in structure.

**Facts**

6. Ministers may wish to commission early factual papers on:

a. what public expenditure on the NHS buys, in terms both of inputs (eg pay, hospital buildings, drugs, information technology) and outputs (eg treatment of different illnesses, elective and non-elective, paediatrics, care of the elderly);

b. how far detailed information about costs in the NHS is already available, what it shows (eg regional differences) and progress with the Resource Management Initiative;

c. the comparison, on cost and other grounds, between the NHS and the private sector in this country (eg BUPA, and the experience of the 10 best hospitals), and between the NHS and other countries (e.g. New Zealand, West Germany and France, and the diagnostic-related groups set up to contain costs in the United States).

d. what is known about the way patient care is shared between different parts of the NHS, with particular reference to the need to avoid upward drift, and between the NHS and local authorities;

e. the terms and conditions of consultants' contracts.

Waiting time. -

**Selected Aspects**

7. The Group may also wish to commission papers discussing how the following aspects of the NHS's problems could be tackled. With the factual papers they might help build up a coherent picture.

a. The provision of up-to-date information in the NHS about unit costs, quality of output, use of resources and waiting lists. To be most useful this information needs to be systematically available to both users and health managers, and to be coupled with some form of competition.

b. The introduction of financial incentives and budgeting systems to encourage cost-effective decisions, and to ensure that resources are channelled to the most efficient hospitals and doctors.

c. The scope for more charging in the NHS, to increase awareness of costs and help moderate the 'all or nothing' choice between public and private sector provision.

d. Ways of introducing greater competition into the NHS to promote the efficient allocation of resources.

e. How to develop the role of the private sector, both as provider of some services to the NHS and as providing care outside the NHS.

f. How to promote patient freedom of choice, both as a desirable end in itself and to promote competition.

g. Ways of tackling consultants' contracts and tenure and other manpower inflexibilities.

h. The scope for introducing some form of publishable independent audit of efficiency, possibly on the lines of the Audit Commission.

**Some possible structures**

8. The common theme is the need to introduce a market mechanism. Various structural changes could be made to achieve this. The following are some possibilities. They are not exclusive, but they shade into each other. They could also be introduced on different timescales: it would be possible to start with one of the early options, and then develop the system gradually towards the later options. Running through all the options is the need to distinguish between those who buy health care and those who provide it.

**Market mechanism within existing NHS structure**

9. The first group of possibilities would introduce more market discipline into the existing NHS structure. This could be first by publishing more cost information and efficiency audit reports and by more decentralised budgeting to and within individual hospitals. Going beyond this, there could be more trading of services between authorities and sectors, so that Authority A, or indeed the private sector, could treat patients from Authority B on repayment if their costs were lower.

**A new NHS structure**

10. The second group of possibilities would introduce more competition in the NHS, involving radical changes in the existing NHS structure, while still leaving it mainly tax-financed.

11. One way to do this would be for District Health Authorities to compete for the allocation of patients by GPs and for their funding to be adjusted according to their success. GPs already have freedom to direct patients to the authorities of their choice, but in practice do not always do so, while authorities have little financial incentive to attract extra patients.

12. A further step down the same path would be for the Authorities to act as Health Maintenance Organisations. HMOs, which were originally developed in the United States, contract to provide all necessary treatment for a fixed sum for a fixed period. The DHA/HMOs could then place patients with hospitals, which in turn could compete among themselves. The DHA/HMOs could also compete with private sector HMOs.

13. Going still further the patient himself could be involved more directly in the choice of treatment and payment for it. There could for example be a system of health credits, by which the patient could receive a credit note covering the cost to the NHS of his treatment, which he could then use wherever he chose within the Service or, more radically, within the private sector. And there are systems in other countries which could be studied: for instance, those in France (where the patient pays the cost of his treatment and is then reimbursed, usually in full, by the State) and Germany. These ideas could however have important implications for present methods of expenditure control.

**A greatly expanded private sector role**

14. All the alternatives so far have been consistent with the NHS providing most of the health care and most of the funding continuing to come from tax. The last group of possibilities would increase both the role of the private sector in the provision of care, and the role of private finance in funding it.

15. At present, people can already choose to pay for private provision, normally for the less expensive or more optional treatment. This process could be encouraged by tax relief for private medical insurance premiums.

16. More radically, people could opt out for at least some of their medical care which they could then buy either privately or from the NHS. Opting out could be either by individuals or by employers. Those concerned would no longer pay the NHS for the cost of the treatment affected. It would not of course be possible to opt out of payment of tax, but if NHS care were to be financed through National Insurance Contributions, or some similar payment, established for health, there could be a gradual development of contracting out, similar to that decided on by the Government for pensions. Such a system would probably work most easily if the health care contracted out was of the less expensive or more elective kind. The more urgent or expensive long-stay treatment would probably have to stay within the NHS, and the size of the contribution rebate would have to allow for that.

17. The most radical solution of all would be to require all who could do so to provide for their own health care, probably by insurance, which could be arranged either individually or through employers' schemes. The State would still need to provide for the very poor or the uninsurable.

**CONCLUSIONS**

18. Ministers are invited to decide which specific aspects they wish to consider first.

Cabinet Office
5 February 1988

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SECRET

**THE NHS**

**Note by the Cabinet Office**

This note sets out some of the main questions that will have to be considered in the internal review of the NHS.

**Scope and Objective**

2. The objective is to devise a structure for health care which is responsive to the needs and wishes of patients and available to all, and at the same time cost-effective and efficient. The review will place special emphasis on the hospital service, but the latter cannot be considered in isolation from primary care and the private sector. The level of financing and resources can be considered later when Ministers have decided on a structure which will make best use of whatever resources are available from whatever source.

**Problems**

3. The fundamental problems are:

a. consumers have very little freedom of choice. Most patients have no say in when, where, how or by whom they are treated.

b. present cost controls are crude. Patients have no idea what it costs to treat them. Nor usually do those who treat them. Even if they do, they have no incentive to drive the costs down or to consider which course of treatment is the most cost-effective.

c. there is no means of channelling resources to the most efficient and cost-conscious units, eg the most efficient District Health Authorities (DHAs). Nor, unlike a business, can the most efficient and low-cost hospitals increase their share of the market (and hence their revenue) at the expense of the less efficient. As the Secretary of State's paper points out, hospitals are not rewarded for attracting patients but suffer financially for it.

d. the system is not good at dealing with mismatches between patient demands and available capacity (eg waiting lists) produced partly by institutional boundaries between public and private sectors, between GPs and the hospital service, and between health authorities.

e. there is insufficient management flexibility in the use of staff - from consultants down to the most junior grades - and in the method of determining their pay.

4. In short the NHS lacks a market mechanism under which the patient chooses, in full knowledge of the costs, who shall provide his health care, how, when and where, and resources are allocated to the hospitals, doctors and GPs who are most successful, again in full knowledge of the costs, in meeting the consumer's demands in the most cost-effective way.

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**Suggested approach**

5. We suggest that the Ministerial Group should approach this problem from three angles: facts, detailed investigation of selected aspects and options for changes in structure.

**Facts**

6. Ministers may wish to commission early factual papers on:

a. what public expenditure on the NHS buys, in terms both of inputs (eg pay, hospital buildings, drugs, information technology) and outputs (eg treatment of different illnesses, elective and non-elective, paediatrics, care of the elderly);

b. how far detailed information about costs in the NHS is already available, what it shows (eg regional differences) and progress with the Resource Management Initiative;

c. the comparison, on cost and other grounds, between the NHS and the private sector in this country (eg BUPA, and the experience of the 10 best hospitals), and between the NHS and other countries (e.g. New Zealand, West Germany and France, and the diagnostic-related groups set up to contain costs in the United States).

d. what is known about the way patient care is shared between different parts of the NHS, with particular reference to the need to avoid upward drift, and between the NHS and local authorities;

e. the terms and conditions of consultants' contracts.

**Selected Aspects**

7. The Group may also wish to commission papers discussing how the following aspects of the NHS's problems could be tackled. With the factual papers they might help build up a coherent picture.

a. The provision of up-to-date information in the NHS about unit costs, quality of output, use of resources and waiting lists. To be most useful this information needs to be systematically available to both users and health managers, and to be coupled with some form of competition.

b. The introduction of financial incentives and budgeting systems to encourage cost-effective decisions, and to ensure that resources are channelled to the most efficient hospitals and doctors.

c. The scope for more charging in the NHS, to increase awareness of costs and help moderate the 'all or nothing' choice between public and private sector provision.

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d. Ways of introducing greater competition into the NHS to promote the efficient allocation of resources.

e. How to develop the role of the private sector, both as provider of some services to the NHS and as providing care outside the NHS.

f. How to promote patient freedom of choice, both as a desirable end in itself and to promote competition.

g. Ways of tackling consultants' contracts and tenure and other manpower inflexibilities.

h. The scope for introducing some form of publishable independent audit of efficiency, possibly on the lines of the Audit Commission.

**Some possible structures**

8. The common theme is the need to introduce a market mechanism. Various structural changes could be made to achieve this. The following are some possibilities. They are not exclusive, but they shade into each other. They could also be introduced on different timescales: it would be possible to start with one of the early options, and then develop the system gradually towards the later options. Running through all the options is the need to distinguish between those who buy health care and those who provide it.

**Market mechanism within existing NHS structure**

9. The first group of possibilities would introduce more market discipline into the existing NHS structure. This could be first by publishing more cost information and efficiency audit reports and by more decentralised budgeting to and within individual hospitals. Going beyond this, there could be more trading of services between authorities and sectors, so that Authority A, or indeed the private sector, could treat patients from Authority B on repayment if their costs were lower.

**A new NHS structure**

10. The second group of possibilities would introduce more competition in the NHS, involving radical changes in the existing NHS structure, while still leaving it mainly tax-financed.

11. One way to do this would be for District Health Authorities to compete for the allocation of patients by GPs and for their funding to be adjusted according to their success. GPs already have freedom to direct patients to the authorities of their choice, but in practice do not always do so, while authorities have little financial incentive to attract extra patients.

12. A further step down the same path would be for the Authorities to act as Health Maintenance Organisations. HMOs, which were originally developed in the United States, contract to provide all necessary treatment for a fixed sum for a fixed period. The DHA/HMOs could then place patients with hospitals, which in turn could compete among themselves. The DHA/HMOs could also compete with private sector HMOs.

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**A greatly expanded private sector role**

14. All the alternatives so far have been consistent with the NHS providing most of the health care and most of the funding continuing to come from tax. The last group of possibilities would increase both the role of the private sector in the provision of care, and the role of private finance in funding it.

15. At present, people can already choose to pay for private provision, normally for the less expensive or more optional treatment. This process could be encouraged by tax relief for private medical insurance premiums.

16. More radically, people could opt out for at least some of their medical care which they could then buy either privately or from the NHS. Opting out could be either by individuals or by employers. Those concerned would no longer pay the NHS for the cost of the treatment affected. It would not of course be possible to opt out of payment of tax, but if NHS care were to be financed through National Insurance Contributions, or some similar payment, established for health, there could be a gradual development of contracting out, similar to that decided on by the Government for pensions. Such a system would probably work most easily if the health care contracted out was of the less expensive or more elective kind. The more urgent or expensive long-stay treatment would probably have to stay within the NHS, and the size of the contribution rebate would have to allow for that.

17. The most radical solution of all would be to require all who could do so to provide for their own health care, probably by insurance, which could be arranged either individually or through employers' schemes. The State would still need to provide for the very poor or the uninsurable.

**CONCLUSIONS**

18. Ministers are invited to decide which specific aspects they wish to consider first.

Cabinet Office
5 February 1988

NHS COSTING SYSTEMS

A note is attached as requested on the development of costing systems in the NHS. This puts into context the statements made last week on the progress of the Resource Management Initiative and also on the comparisons with the costing systems in the private sector. It is simply a brief situation report.

I would highlight the following points:-

a) The private sector knows its charges but these are not based on routine costing systems but rather on special costing exercises to ensure that the broad costs are taken into account along with market factors in fixing the tariffs. Neither the NHS nor the private sector, to our knowledge, has routine patient and treatment related costing systems.

b) The NHS does use the private sector, as in the Waiting List Initiatives of the past 18 months. This is not done because of the nicety of the NHS weighing the comparative costs of carrying out operations in the NHS as against the cost of buying in the services from the private sector. Essentially it is in those cases where the NHS does not have the capacity to do the work and goes to the private sector to reduce waiting lists etc. In these cases a discount from private sector normal charges is negotiated.

c) Two paragraphs in the attached note are particularly important in the light of the earlier discussion. Paragraph 9 sets out the good progress made with the Resource Management Initiative and the information which will be available routinely next year. The length of time involved (which when mentioned at the meeting did have a strong ring of eternity about it) in the full implementation of the Resource Management Initiative is not in the design of the system, but in getting doctors and nurses committed to understanding and to use the system. This is a much longer process and is detailed in paragraph 7.

d) The work being done on costing systems is realistic and will stand comparison with the public or private sector on an international basis. Together with the progress on the new management approach, it is vital to the implementation of any of the possibilities envisaged by the Review.

# COSTING HOSPITAL OUTPUTS IN THE NHS - THE MOVE TOWARDS BEST PRACTICE STANDARDS

## Introduction

1. This paper summarises the present and prospective situation regarding the costing of patient and treatment related hospital "outputs" in the NHS. It is supported by an Appendix and a technical annex which set out details of the NHS Management Board's Resource Management Project.

## The NHS and Private Health Organisations

2. The costing systems currently operated by NHS hospitals have similar strengths and weaknesses to those operated by private health organisations in the UK. More specifically:

(1) both sectors have well-established, and similar, systems for monitoring "inputs" - for example actual as against planned financial performance.

(2) NHS hospitals have recently introduced systems for costing "outputs" by specialty. Such systems are unusual in private hospitals. However, the costing of "outputs" in medical support areas like pathology and x-ray is more widespread in the private sector.

(3) neither sector has routine patient and treatment related costing systems. This reflects the difficulty and expense of setting up and running such systems and, in the case of private hospitals, a past lack of perceived need for such systems.

(4) ad hoc "output" costing exercises are undertaken in both sectors but are more common in the private sector where there is a commercial need, regularly, to check individual treatment costs against patient charging tariffs.

(5) certain (and different) costs are omitted from each sectors systems. These costs are, in the case of the NHS, capital servicing costs and, in the case of the private sector, the fees of clinicians. — only because they submit their accounts separately. AR 6/12

3. The private sector operates well publicised charging tariffs based principally on what the market will bear. These tariffs can sometimes create the false impression that such hospitals also have detailed treatment costing systems.

## Developments in Private Health Organisations

4. The larger US owned private sector groups, such as AMI, are now beginning to invest heavily in developing better "output" systems. These developments involve the introduction of procedures that have recently been successfully introduced in North America. They reflect the fact that there is no obvious, or simply applied, blueprint for the 1990's but that American models look promising as long as they are appropriately adapted to UK circumstances.

Developments in the NHS

5. The NHS Management Board's current initiative in this area is the resource management project. It involves major management and information experiments at five hospitals.

6. In the middle term this project is aimed at facilitating a hospital management process which will set new international standards and build on recent post-Griffiths achievements in the management and information area; in the shorter term it is seeking a solution to the lack of patient and treatment related "output" costs for use in monitoring effectiveness and efficiency and supporting the development of an internal market.

7. Getting better output information is not enough in itself. For this reason the resource management project is, additionally, directed towards ensuring:

(1) both that doctors and nurses are committed to using the data and the systems, not least to support better patient care;

(2) and that hospital management structures and processes encourage doctors to exercise responsibility, and accept accountability, in return for their decisive influence over the use of resources.

Hence the emphasis of the new hospital management structures which are emerging at several of the experimental sites like Guy's Winchester and Newcastle.

8. The project has the formal support, nationally, of hospital doctors through the Joint Consultants Committee and the Central Committee for Hospital Medical Staff. It also has the support of the great majority of doctors, nurses and managers at each of the five scheduled sites. This is crucial as the experience of earlier pilot projects showed that failure to secure the involvement and commitment of the doctors at all levels is a crippling handicap.

9. Progress is good. In the case of four sites, developments will reach an experimental operating stage during 1988 and provide a basis for assessment and evaluation from late 1988 onwards. It is hoped these developments will demonstrate the practicality of costing inpatient treatment outputs at all acute hospitals at regular intervals well in advance of implementing other parts of the overall project, with the first results available in the early part of 1989.

10. Success on the costing front would facilitate a number of potential, additional, developments. They include:

(1) privatising parts of NHS hospital activity;

(2) encouraging an internal market;

(3) the introduction of a voucher system;

(4) the introduction of insurance-based systems.

It would also highlight areas which, given existing activity levels, were over or under funded.

DIRECTOR OF FINANCIAL MANAGEMENT
NHS MANAGEMENT BOARD

output/4/2

APPENDIX

## THE RESOURCE MANAGEMENT PROJECT - ITS PURPOSE, PROGRESS AND PROSPECTS.

1. There is continuing interest in the resource management project and in the potential contribution it can make to the management of change in the NHS. Two particular questions being asked are the extent to which, given time, it can contribute significantly to the better use of resources and whether, within a much more urgent timescale, it can provide the better costing of hospital "outputs" that is required. The objective of this note is to summarise the purpose, progress and prospects of the programme and to discuss shorter-term possibilities and opportunities.

### Background

2. There has been considerable debate over many years about how best to cost the "outputs" of acute NHS hospitals. This has taken place against the background of a financial planning and control tradition within which managers maintain records of the costs of all primary cost centres (covering functions and departments like nursing, pathology, catering, finance and works) and annually budget and plan financial performance on the basis of resource "inputs".

3. The above process has served the NHS well over many years. However, it has never provided an analysis of costs according to patient or treatment "outputs" or generated information of any real relevance or value to doctors and nurses in their capacity as the hospital product managers.

4. This limitation was addressed by the Korner Committee (1982-1984). After considering what it saw as the merits and demerits of speciality costing, diagnostic group costing, clinical team costing and patient costing, the committee recommended the adoption of speciality costing.

5. Speciality costing consists essentially of disaggregating and allocating costs to the different respective specialities (general surgery, general medicine, obstetrics, orthopaedics etc) and determining the average patient treatment costs of each speciality. It has the merit of simplicity. It is also the essential first step towards patient or treatment related "output" costing.

6. Such costing was introduced with effect from 1st April 1987 as part of the Korner implementation programme. It is the basis of a new generation of periodic in-year returns for unit and district management and an annual, national, summary for use at NHS Management Board level.

7. The introduction of speciality costing is enabling general financial reporting standards to be improved at all levels. However, it provides only the most generalised basis for relating "output" costs to patient care activity data. In particular, it does not allow for the wide variety of conditions and procedures encompassed by a single specialty. For example the resources needed to treat any two general surgical cases might, depending on the complexity of the procedure or the severity of the patients condition, vary by a factor of 10 or more. As a result it is of limited value to doctors and other managers as a resource management and decision support tool. Its capacity to influence clinical behaviour is similarly limited.

8. Health service managers still have little information about how much it actually costs, let alone should cost, to treat patients with similar medical conditions. In consequence, management is significantly handicapped when deciding how best to distribute resources at sub-unit level, trying to identify efficient and inefficient clinical and nursing practices or determining whether given levels of patient activity are over or underfunded.

9. Beneath the current lack of information about treatment costs lie equally important if not more fundamental challenges. At most NHS hospitals:

(1) the doctors, nurse managers and ward sisters feel uninvolved in (and in some cases alienated from) the local unit management process despite exercising the major influence over activity levels, service quality and resource use. The experience of earlier pilot projects showed that failure to secure the involvement and commitment of doctors and nurses is a crippling handicap.

(2) the doctors lack confidence in the basic activity data which must form the foundation of any credible clinical and output cost information system

(3) the nurse managers (nurse directors, officers and ward sisters) possess inadequate systems with which to plan and manage the nursing workforce which accounts for up to 40% of hospital costs.

PURPOSE

10. The purpose of the resource management programme is to overcome these problems by demonstrating, at 5 reference sites, by mid to late 1989 at the latest:

(1) how doctors and nurses can be involved such that they are committed to the management process, responsible for their use of resources and able to take better decisions regarding patient care.

(2) the practicability of operating accurate and medically credible systems for collecting patient activity data.

(3) the value of effective management information systems for nurses and departments like

pathology, radiology and pharmacy

(4) the feasibility of running, at an acceptable cost, costing systems which are closely linked to (2) and (3) above; which reflect the impact of variations in the kinds of conditions dealt with; which attract the support and confidence of doctors; and which actually get used.

11. The ultimate aim of the experiment is to enable hospital doctors, nurses and managers throughout the NHS to adopt similar practices everywhere..

12. The programme represents an ambitious challenge to existing attitudes and to the need to improve further activity and output cost information. It has the formal support, nationally, of hospital doctors through the Joint Consultants Committee and the Central Committee for Hospital Medical Staff. It also has the support of the great majority of doctors, nurses and managers at each of the reference sites.

PROGRESS

13. The five sites are the Freeman Hospital in Newcastle upon Tyne, The Royal Infirmary in Huddersfield, The Royal Hampshire County Hospital in Winchester, Guy's Hospital in London and Arrowe Park Hospital near Birkenhead. Work at these sites started in the period October 1986 to July 1987. In the case of Newcastle, Huddersfield and Winchester it will reach an experimental operating stage during the spring and summer of 1988 and these sites plus Guy's (which is about 4 months behind) will provide a basis for assessment and evaluation from late 1988 onwards. Progress is being widely publicised

14. Development work covering the four components of the programme listed in paragraph 10 above is common to all five sites. Differences of emphasis and approach include:

(1) The precise nature of the sub-unit organisation structures. Guy's and Winchester have adopted the most radical approach by creating clinical directorates whilst Huddersfield has made very little formal change to date to its traditional structures.

(2) The processes adopted for ensuring that the local doctors and nurses significantly influence future information outputs. At one extreme Newcastle invested heavily at the outset in defining its clinical data base. At the other, Huddersfield is "prototyping" towards final data base decisions over a 12 to 18 month period.

(3) The range of computer software and hardware being deployed. A relatively large choice of software and hardware is being piloted.

15. At a technical level the three most important components of the experimental programme involve developing and maintaining an accurate and credible clinical data base, establishing a case-mix classification system for recording patient treatment and cost data and implementing effective nurse management systems. More information on these components is set out in the technical annex attached to this Appendix.

Evaluation

16. An important aspect of the original agreement with the JCC was that the programme should be experimental. Once the initial development and implementation period is concluded, both sponsoring parties (the JCC and the Management Board) are committed to commissioning as full and objective an evaluation of the results as is practical and reviewing the results of that evaluation before any decisions are taken about how best to encourage implementation by the rest of the service.

17. A first evaluation report will be produced in October 1988. It will discuss the progress at each site and how successful each site has been in implementing its plans on schedule. It will be co-ordinated by the JCC and the Management Board.

18. A more detailed evaluation report, which measures the impact on service quality and costs of the new organisational and information arrangements in their first full year, will be prepared in October 1989. A parallel "external" evaluation, aimed at providing an outsiders view of the potential cost benefit and value will be undertaken by staff from Brunel University in 1989/90.

Current position regarding other sites

19. As mentioned above, recommendations regarding how best to extend the new processes will be based on the 1988 and 1989 conclusions of the joint JCC/Management Board evaluation group. In the meantime other NHS districts and units anxious to make progress on the organisation and information front are being advised to concentrate on getting their basics right in preparation for implementing the resource management processes from 1989 onwards.

20. In advising these districts and units, emphasis is being given to the importance of:

(1) Introducing sub-unit arrangements which involve doctors and nurses in the local management process.

(2) Capitalising on the opportunities provided by Korner data for more informed local decision making. This applies, in particular, to the new activity and specialty costing data that is now becoming available.

(3) Establishing effective management and financial systems for nursing and service departments like pathology and using the specialty costs to give clinicians a preliminary feel for the level of expenditure associated with their activities.

21. Such districts and units are being discouraged from attempting to implement clinical data bases and/or case-mix management systems until more is understood about how best to proceed in these areas.

A BROADER PERSPECTIVE

22. The purpose of the resource management programme was defined in paragraph 10. Underlying this purpose is the aim of providing NHS management with the means of making the best possible use of limited resources and encouraging better and more cost effective treatment. Much is expected as consultants start comparing their performance with colleagues - first within hospitals, then across districts and finally, as the system spreads through the NHS, nationally and internationally.

23. A successful outcome to the experiment will raise a range of possible broader uses for the new activity and costing information and influence a number of potential developments. For example the information could:

(1) facilitate the privatisation of large parts of NHS hospital activity or complete hospitals. At a less radical level it could support an internal market within which hospitals or authorities shopped around for services amongst themselves and/or in the private sector. Authorities/hospitals could become purchasers of services rather than providers.

(2) open the door to a voucher system under which the government might provide a basic sum to be spent in NHS or private hospitals which individuals could then top up.

(3) ease the introduction of an insurance-based system where the state reimburses individuals for care wherever it is given.

24. It might also indicate that the NHS, in certain areas at least, is significantly over or underfunded. This would be highlighted not by crude measures of international spending but by comparison between the costs of individual treatments across countries or between NHS costs and the costs of private health providers.

APPENDIX
Technical Annex

SOME TECHNICAL ISSUES

Clinical data base

1. Much of the pioneering work on establishing how best to develop an effective and accurate clinical data base has taken place in Newcastle. It has involved:

(1) Recognising existing problems. They include the fact that in most hospitals (i) the current medical coding process is in arrear, (ii)conscientious but medically untrained coding officers and clerks are left to interpret what are often complex and ambiguous medical files without medical oversight or audit and (iii) the resultant data is largely discredited in the eyes of the doctors and rarely used.

(2) Reviewing existing and available diagnostic and operation coding classifications and selecting the most suitable for future purposes

(3) Determining, with clinicians, what information would be of future value to them in their clinical and clinical management roles, This covers defining the nature and content of the clinical data base and discussing how it might be used to inform peer-review processes.

(4) Deciding how best, reliably and with a minimum of effort, to collect the new diagnostic and operation data and feed it into the data base (collection points, encoding techniques, staffing and validation arrangements, and so on).

2. The results of this work have been made available to all the other sites.

Case-mix classification systems

3. As mentioned in paragraph 7 of the main appendix, the major limitation of speciality costs is that they pay no regard to the impact of variations in case-mix on levels of resource utilisation. Under speciality costing each case would normally attract the same average cost calculated by reference to total resources utilised and number of patients handled.

4. Because case-mix analysis data lies at the heart of any effective patient treatment costing system, considerable emphasis is being put on how best to group the large number of medical conditions and treatments which characterise existing activity coding systems. The resource management programme is experimenting with a US based "grouping" system which consolidates the 20,000 plus medical classifications that represent the latest (ICD 9 CM) codes used in North America into 467 resource homogenous diagnostically related groups (DRGs). This grouping has won widespread acceptability amongst doctors in North America.

5. DRGs represent a classification of inpatients which reduces data volumes to manageable proportions. The classification is considered to be medically meaningful, comprehensive and unambiguous, obtainable from existing data and (in North America at least) consistently able to delineate groups of patients with similar patterns of resource use. This covers use of operating theatres, medical time, medical tests, drugs, length of inpatient stay (nursing and hotel services) and costs.

6. NHS hospitals use an earlier and less detailed version of the ICD code referred to above rather than the latest (ICD 9 CM) version on which DRGs are based. In consequence, the resource management programme is currently:

(1) Assessing whether existing UK ICD 9 based HAA data can be translated into ICD 9 CM equivalents without unacceptable compromises in reliability and accuracy. This involves using "mapping" programmes developed by Yale University which originated the DRG system.

(2) Determining whether the US developed DRGs adequately reflect UK hospital treatment practices. Part of this involves establishing whether the application of DRG groupings in England produce data clusters which have medical validity and cover cases which absorb broadly similar amounts of resource.

(3) Assuming affirmative answers to the above questions (and the early evidence is encouraging), testing the US DRG based cost model to establish whether it is suitable (with or without modification) for English hospital circumstances.

(4) Developing suitable software to run the cost model on micro as well as main-frame computers.

7. Good progress is being made in the mapping and validation activities described above using 1985 NHS HAA data covering hospitals in Mersey, Northern and Yorkshire regions. The early evidence suggests that UK data can be successfully grouped into DRGs and that the resultant groups will be medically valid and resource homogenous. A definitive report on all these issues will be available in late March/early April.

8. Work is also being undertaken to test the potential suitability of the US DRG cost model and to explore the practicability, or otherwise, of implementing a system of DRG costing throughout the NHS from 1 January 1989, in advance of other parts of the resource management project. A report on the results of these tests will also be available in late March/early April.

Nurse management

9. The third major component of the work at all 5 reference sites concerns nurse management. Currently no widely respected computer based nurse dependency or management systems are being used within NHS hospitals despite the fact that any improvements in this area will have an immediate impact on quality of care. Better information is needed urgently about the effectiveness with which nursing time is managed and the extent to which they may over recent years have become diverted into "non-nursing" duties unrelated to patient care.

10. A range of nurse management systems is being implemented at four of the sites. They are aimed at helping ward sisters and nursing officers to assess the individual nursing needs of patients so that nurses can be deployed accordingly. They are also aimed at helping nurse managers to monitor service quality, maximise the amount of time nurses spend providing direct patient care and measure the nursing resource used in looking after individual patients.

GM1864p

**DEPARTMENT OF HEALTH AND SOCIAL SECURITY**

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

*From the Secretary of State for Social Services*

Paul Gray Esq
Private Secretary
10 Downing
LONDON
SW1A 2AA

5 February 1988

Dear Paul

**CONSULTANTS CONTRACTS**

I understand that, in the context of the NHS review, you have asked to see the form of NHS consultant contracts.

I enclose a copy of the relevant material. The model contract is at Annex D, and a recommended form of job description at Annex F.

I am copying this letter and enclosure to Richard Wilson at the Cabinet Office.

Yours ever

Flora

FLORA GOLDHILL
Private Secretary

RA Health

**DEPARTMENT OF HEALTH AND SOCIAL SECURITY**

**Richmond House, 79 Whitehall, London SW1 2NS**

**Telephone 01-210 5166/7/8**

***From Sir Roy Griffiths***

5th February, 1988

P. Gray, Esq
10 Downing Street
LONDON
S.W.1.

Dear Paul,

I enclose 12 copies of a note on Costing Systems, as requested. It is extremely hurried and I hope it fits the bill.

Yours sincerely,

ROY GRIFFITHS

Enc.

Jan. 4, 1987.

# GERMAN HEALTH SERVICE UNDER REVIEW

This background paper on the health service in the Federal Republic of Germany examines the likely effect of reforms envisaged in the Health Expenditure Law expected to reach the statute book in Bonn this summer:

The health service is not suffering from shortages but from oversupply, which means that it is running short of money. The Federal Republic of Germany already has 165,000 doctors, 35,000 dentists and 18,000 pharmacies with 47,000 pharmacists and totals keep rising. The hospitals have 50,000 beds too many.

The Federal Government has therefore decided that everyone must economise: the doctors and dentists, the pharmaceutical industry and the manufacturers of medical equipment.

Not all Germans are equally affected by this. Under regulations of 1911, the basic elements of which are still valid, the health insurance system is divided into two categories: employees with a monthly income of up to DM 4,275 (DM 4,500 in 1988) must be insured under one of the statutory health insurance schemes -- a variety of local, company and wage-earners' schemes.

Anyone whose earnings are above this ceiling can opt for exemption from the insurance liability and join one of the 49 private schemes, where premiums are generally higher but the policies are geared to individual requirements and kept within limits by the insured paying part of the medical expenses involved. At present 5,200,000 people are privately insured.

In recent years, the spending of the statutory health insurance schemes for 37 million members and their families has risen sharply due to better medical care and longer life expectancy. In 1960 this spending amounted to only DM 9.5 bn., but it has now reached DM 108 bn. -- DM 8 bn. more than revenue from contributions.

This expenditure requires contributions averaging 12.6 per cent of the gross earnings of the insured. Schemes with many "bad risks" must levy up to 14 per cent. Employees and employers each have to pay a half; the workers notice the impact on their purchasing power, and the firms on labour costs, with the result that the investment capacity of companies is reduced and they become less willing to take on more staff.

REPORT FROM THE FEDERAL REPUBLIC OF GERMANY
EMBASSY: 23 BELGRAVE SQUARE LONDON SW1X 8PZ TELEPHONE 01-235 5033

Structural reform

The proposed new structure guarantees health care for the population, but the insurance schemes must pay only for what is medically necessary. More extensive benefits, such as expensive dental work, medicines and sanatorium and hospital treatment not considered absolutely essential, must be paid for by the patient.

The health insurance schemes are also to be relieved of costs not really regarded as being part of their field of responsibility. For instance, death benefits amounting to as much as DM 6,000 at present will no longer be granted. For a transitional period, patients will also have to bear a sizeable share of the cost of medicines (up to 20 per cent or DM 10), medical aids (up to 40 per cent), and hearing aids, for which only a basic sum of DM 800 will be refunded. Those requiring spectacles will in future get only the cost of lenses reimbursed.

All these limitations are to exist only for a transitional period until the expenditure and revenue of the statutory health insurance schemes are once again in balance.

Prevention features prominently in the new Health Expenditure Law to be adopted in mid-1988. This begins with regular health education at school. Anyone going for a medical check-up will be allowed to pay a smaller share of the medical expenses. This is likely to be of particular advantage in the case of dental treatment. The cost of plasters, skin ointments and headache remedies must in future be met by the patient.

DM 14 bn. savings

Under the new legislation the Federal Government hopes to reduce the bill of health insurance schemes by DM 14 bn. Half of this will go straight back to the insured through a one per cent cut in contributions. The Federal Government will devote the other DM 7 bn. saved to remedy a long-criticised shortcoming in health policy: the money will go to the relatives who look after 630,000 severely handicapped people at home. In future, these relatives will -- at the expense of the statutory health insurance schemes -- be able to take an extra four weeks' holiday a year on top of their normal entitlement and have a nurse replace them for one hour a day.

With this reform plan, Chancellor Kohl's administration has tackled one of the two major problems in the social sector at present. The other is the old-age pension insurance scheme, but this still has sufficient resources for the next few years until the 1990's.

Nat Health

10 DOWNING STREET
LONDON SW1A 2AA

*From the Private Secretary*

**SIR ROBIN IBBS**

The Prime Minister was most grateful for your minute of 29 January and for your comments on the possibility of a scrutiny.

The Prime Minister has noted the possibilities and will want to consider this further when the work programme for the overall NHS review is a bit clearer.

I am copying this minute to Sir Robin Butler.

**PAUL GRAY**

**4 February 1988**

js/1818p

CBG

**DEPARTMENT OF HEALTH AND SOCIAL SECURITY**

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

*From the Secretary of State for Social Services*

PO1/1694/500

Mark Addison Esq
Private Secretary
10 Downing Street
LONDON
SW1A 2AA

4 February 1988

Dear Mark

Thank you for your letter of 26 January about perinatal mortality. ~~January~~ Jan + Feb

I attach a revised table for perinatal mortality rates which has been compiled by OPCS mostly using the WHO and UN Demographic Yearbook. This is the latest data available from the WHO and the table updates the previous WHO information we have given you. The most notable difference is the rate for the Federal Republic of Germany. This is because the figure previously quoted was in fact the figure for the East Germany. The figures for <u>both</u> countries are now shown.

For the longer term, I have asked OPCS to let us know the reasons for the disparities between the WHO statistics and those used by the CSO.

I hope this all puts us on a somewhat firmer footing.

Yours ever

Flora

FLORA GOLDHILL
Private Secretary

PERINATAL MORTALITY INTERNATIONAL COMPARISONS WHO STATISTICS

| COUNTRY | YEAR | RATE |
|---|---|---|
| England and Wales | 1984 | 10.1 |
| Austria | 1984 | 10.2 |
| Belgium | 1984 | 11.3 |
| France | 1984 | 11.2 |
| Germany Federal | 1984 | 8.6 |
| East Germany | 1984 | 10.6 |
| Greece | 1984 | 16.5 |
| Republic of Ireland | 1983 | 13.7 |
| Italy | 1981 | 16.7 |
| Netherlands | 1984 | 10.0 |
| Luxembourg | 1984 | 8.8 |
| Spain | 1980 | 14.4* |
| Switzerland | 1982 | 9.0 |
| Denmark | 1984 | 8.4 |
| Finland | 1984 | 7.6 |
| Norway | 1984 | 8.9 |
| Sweden | 1984 | 7.3 |
| Japan | 1984 | 8.7 |
| Canada | 1983 | 9.5 |
| USA | 1981 | 15.6 |

The year is the latest given by the majority of countries to WHO. Perinatal mortality includes live and still births but countries do not have a common baseline for registration of births which in the UK is 28 weeks gestation or any child which has shown any sign of life.

The statistics for 1984 indicate that fewer babies died here than in France, Belgium, Austria, Greece, Italy, Republic of Ireland, Spain and USA.

* EEC Eurostat Annual Returns and used by WHO.

4 February 1988

PA.
Note Spoke R Lodge and told him to proceed as here then.
RRCG 4/2

Prime Minister
You may like to glance at this work in progress. Sir Roy Griffiths is also working on a note for the weekend.
RRCG 3/2

2

SECRET

P 03005

From: R T J Wilson
3 February 1988

MR GRAY

cc Sir Robin Butler

NATIONAL HEALTH SERVICE

1. Following the Ministerial meeting on 27 January the Cabinet Office was asked to co-ordinate a paper which proposed how the group should proceed in tackling the issues.

2. I attach a draft of such a paper. It is being shown to the Chancellor of the Exchequer and the Secretary of State overnight to check that they are content with it as a basis for discussion. The draft is similar to the one you saw yesterday but reflects comments from the Treasury and DHSS.

3. The draft sets down some preliminary thoughts about the problems which the group will have to analyse and ways in which they might be approached. We will be suggesting in our brief for the Prime Minister for the next meeting what follow-up action she may wish to commission. It is already clear that the problem is going to be how to inject a practical flavour into a subject where there is no end to the ideas which in theory might be explored. We have tried to angle the paper to help deal with this.

4. I would be grateful if you could confirm that the paper is on the right lines, subject to any comments which the Chancellor and Mr Moore may make. We will then let you have it in final form for circulation to the Ministerial Group on Friday.

5. I have pressed the DHSS to let us have a copy of the terms and conditions of consultants' contracts rapidly, hopefully today. I will forward it to you when I get it.

RJW

R T J WILSON

P.S. Mr Moore has now seen this paper and is content with it.
RJW.

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1

# THE NHS

## Note by the Cabinet Office

This note sets out some of the main questions that will have to be considered in the internal review of the NHS.

## Scope and Objective

2. The objective is to devise a structure for health care in this country which is responsive to the needs and wishes of patients and available to all, but at the same time cost-effective and efficient. The review will place special emphasis on the hospital service, but the latter cannot be considered in isolation from the primary care sector and the private sector. The level of financing and resources can be considered later when Ministers have decided on a structure which will make best use of whatever resources are available from whatever source.

## Problems

3. The fundamental problems are:

a. there is very little consumer freedom of choice. Most people who are ill have little or no say in when, where, how or by whom they are treated.

b. present cost controls are crude. Patients have no idea what it costs to treat them. Those who treat them have no incentive to drive down costs or to consider which course of treatment is the most cost-effective.

c. there is no mechanism for ensuring that most resources go to the most efficient and cost-conscious units, eg the most efficient District Health Authorities (DHAs). Nor, unlike a business, can NHS hospitals increase their funding by increasing output. As the Secretary of State's paper points out, hospitals are not rewarded for attracting patients but suffer financially for it.

d. the system is not good at dealing with mismatches between patient demands and available capacity (eg waiting lists) produced partly by institutional boundaries between public and private sectors, between GPs and the hospital service, and between health authorities.

e. there is insufficient management flexibility from consultants down to the most junior grades, as regards either the use of staff or the method of determining their pay.

4. In short the NHS lacks a market mechanism under which the patient chooses, in full knowledge of the costs, who shall provide his health care, how when and where, and resources are allocated to the hospitals, doctors and GPs who are most successful, again taking account of the costs, in meeting the consumer's demands.

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Suggested approach

5. We suggest that the Ministerial Group should approach this problem from three angles: facts, detailed investigation of selected aspects and options for changes in structure.

Facts

6. At an early stage Ministers may wish to commission factual papers on such matters as:

a. what public expenditure on the NHS actually buys, in terms both of inputs (eg pay, hospital buildings, drugs, information technology) and outputs (eg treatment of different kinds of illnesses, elective and non-elective, care of the elderly);

b. how far information about costs in the NHS is already available, what it shows (eg regional differences) and the present state-of-play on the Resource Management Initiative;

c. the comparison, on cost and other grounds, between the NHS and the private sector in this country (eg BUPA, and the experience of the 10 best hospitals), and between the NHS and other countries (e.g. New Zealand, and the diagnostic-related groups set up to contain costs in the United States).

d. what is known about the way patient care is shared between different parts of the NHS, and between the NHS and local authorities;

e. the terms and conditions of consultants' contracts.

Selected Aspects

7. The Group may also wish to consider papers discussing how particular aspects of the NHS problems could be tackled. These papers of their own will not suggest a complete answer, but coupled with factual material they might help build up a coherent picture.

a. Provision of information. Information is an integral part of the market mechanism. In the case of the the NHS, up-to-date information is needed about unit costs, quality of output, use of resources and waiting lists. To be most useful it needs to be coupled with some form of competition and to be available to both users and health managers.

b. Introduction of financial incentives and effective budgetary procedures to encourage cost-effective decision-taking, and to help ensure that resources are channelled to the most efficient hospitals and doctors.

c. Ways of introducing greater competition into the NHS, again to promote the efficient allocation of resources.

d. Ways of developing the role of the private sector, both as provider of some services to the NHS and as providing care to its own patients.

e. What more might be done to promote patient freedom of choice, both as a desirable end in itself and as a way of helping to promote competition.

f. Ways of tackling consultants' contracts and tenure and other restrictive practices in the medical field.

g. The scope for introducing some form of publishable independent audit of efficiency, possibly on the lines of the Audit Commission.

Some possible structures

8. The common theme is that more might be done to introduce a market mechanism. There are various structural changes which could be made to achieve this. The following are some possibilities. They are not exclusive, in the sense that they shade into each other, and it would be possible to start with one of the early options, and then develop the system gradually towards the later options. Running through all the options is the need to distinguish between those who buy health care and those who provide it.

Market mechanism within existing NHS structure

9. The first group of possibilities would introduce more market discipline into the existing NHS structure. This could be first by means of provision of more cost information, publication of efficiency audit reports and making individual hospitals cost centres. Going beyond this, there could be more trading of services between authorities, so that Authority A could treat patients from Authority B on repayment if its costs were lower. Consultants' contracts and pay mechanisms more generally could be reviewed.

A new NHS structure

10. The second group of possibilities would introduce more competition in the NHS, involving radical changes in the existing NHS structure, while still leaving it mainly tax-financed.

11. One way to do this would be to provide for District Health Authorities to compete for the allocation of patients by GPs and for their funding to be adjusted according to their success. GPs already have freedom to direct patients to the authorities of their choice, but in practice may not always use it fully, while authorities who are successful in attracting patients do not receive extra funding.

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12. A further step down the same path would be for the Authorities to act as Health Management Organisations, HMOs, which were originally developed in the United States, contract to provide all necessary treatment for a fixed sum for a fixed period. The DHA/HMOs could then place patients with hospitals, which in turn could compete among themselves. The DHA/HMOs could also compete with private sector HMOs.

13. Going still further, steps could be taken to involve the patient himself more directly in the choice of treatment and payment for it. There could be ways of achieving this, even within a largely tax-financed system by for example:

- the French system under which the patient at first pays the cost of his treatment, and is then reimbursed, in most cases in full by the State. This system brings home to the patient the costs of the treatment;

- a system of health credits, by which the patient could receive a credit note convering the cost to the NHS of providing the treatment he needed, which he could then use wherever he chose within the Service or, more radically, within the private sector.

**A greatly expanded private sector role**

14. All the alternatives so far have been consistent with the bulk of health care continuing to be provided within the NHS, and the bulk of the funding continuing to come from tax. The last group of possibilities involve both increasing the role of the private sector in the provision of care, and the role of private finance in funding it.

15. At present, people can already choose to pay for private provision, normally for the less expensive or more optional treatment. This process could be encouraged by tax relief for private medical insurance premiums.

16. More radically, people could opt out for at least some of of their medical care which they could then buy either privately or from the NHS. Opting out could be either by individuals or by employers. The essence of this system is that those concerned would no longer pay the NHS for the cost of the treatment they would seek outside. It would not of course be possible to opt out of payment of tax , but if NHS care were to be financed through National Insurance Contributions, or some similar payment, established for health, it would be possible to contract out from their payment. There could be a gradual development of contracting out. The system would be similar to that decided on by the Government for pensions. Such a system would probably work work most easily if the health care contracted out was of the less expensive or more elective kind. The more urgent or expensive long-stay treatment would probably have to stay within the NHS, and the size of the contribution rebate would have to allow for that.

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17. The most radical solution of all would be a system under which all who could do so would be required to provide for their own health care, probably by insurance, which could be arranged either individually or through employers' schemes. The State would still need to make arrangements for the very poor or the uninsurable.

18. These are only illustrations of possible options on which Ministers may wish to commission further work.

**CONCLUSIONS**

19. Ministers are invited to decide whether they wish to proceed on the above lines and which specific aspects they wish to consider first.

Cabinet Office
3 February 1988

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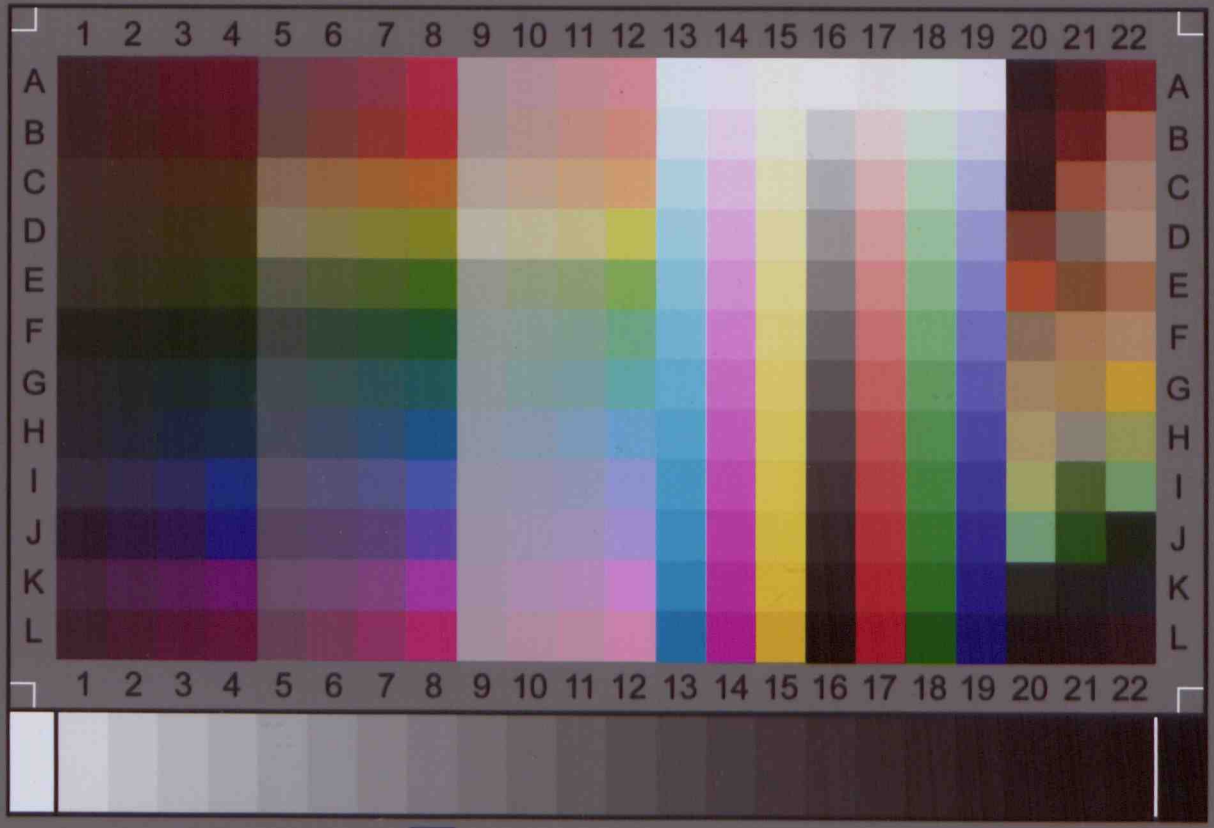
PART 10 ends:-

R Ibbs to Pus 29/1

PART 11 begins:-

RWilson to PGray 3.2.88.

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