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NOTES ON THE NHS REVIEW

It is early days as yet but we seem to be moving towards a choice between two systems:

(1) Dedicated Health ~~Care~~ Tax plus total or partial "contracting out".

(2) Competitive Local Health Funds, financed by tax-based capitation fees and supplemented by "topping up" insurance.

Both have certain advantages in common (eg reducing the "cliff edge" of private insurance) and certain disadvantages in common (eg deadweight cost). But they also differ significantly:

1 Under scheme (1), the present NHS centralised structure of health provision would remain in being. Most patients would continue to rely on it; most forms of treatment would continue to be provided by it. Therefore, most of the present problems would remain - lack of sensitivity to patients, restricted choice, medical staff with an interest in attacking the system, constant political problems.

2 Both systems provide macro-cost-control. But a competitive LHF approach would also introduce micro-cost -control into the system.

3 A Health tax, rising with income, would lead to automatic increases in <u>public</u> spending on health, thus reducing the incentives for private care. LHFs, financed from general taxation but supplemented by topping up, could be run in such a way as to increase the incentives for private spending.

4 A Health tax, even if the upper income limit on contributing were removed, would be more regressive than finance from general taxation. It would inevitably lead to major demands for recasting income tax rates.

5 "Contracting out" is more open to the charge of "two standards of care" than topping up insurance.

6 Scheme (I) would not lead to changes in relationships with the medical and nurses professions. There would continue to be national bargaining on pay and work practices.

J. O'S.

JOHN O'SULLIVAN

LIST OF PAPERS

HC1	Spending on the NHS: inputs and outputs
HC2	What happens to patients
HC3	Waiting lists
HC4	Comparison between the private and public acute sectors
HC5	Manpower inflexibilities (consultants etc.)
HC6	Information for Management
HC7	NHS Budgeting and resource management
HC8	Health care systems in other countries
HC9	Greater competition in the NHS
HC10	Improving consumer choice
HC11	Scope for independent audit of efficiency
HC12	Scope for increased charging.

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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

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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.

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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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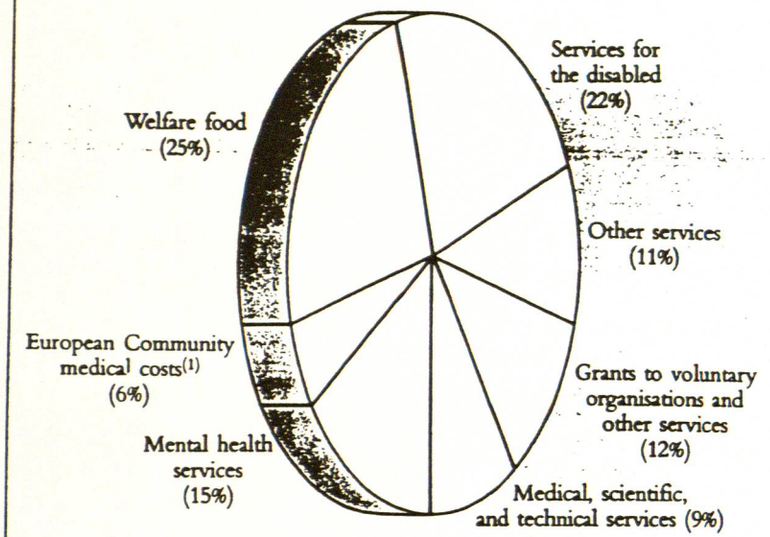
Annex A

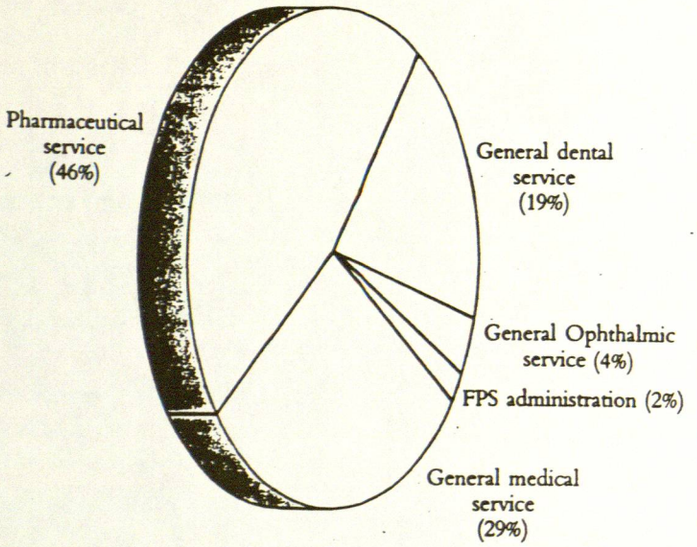
Distribution of NHS Expenditure

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

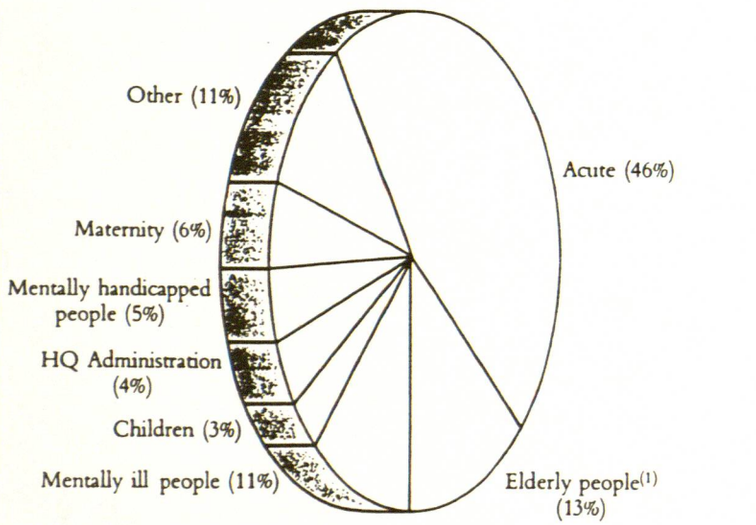


(1) *The costs of medical care provided by other EC countries to people from England. Neither this nor the Welfare Food Service are subject to a cash limit.*

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.

February 1988 DHSS

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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

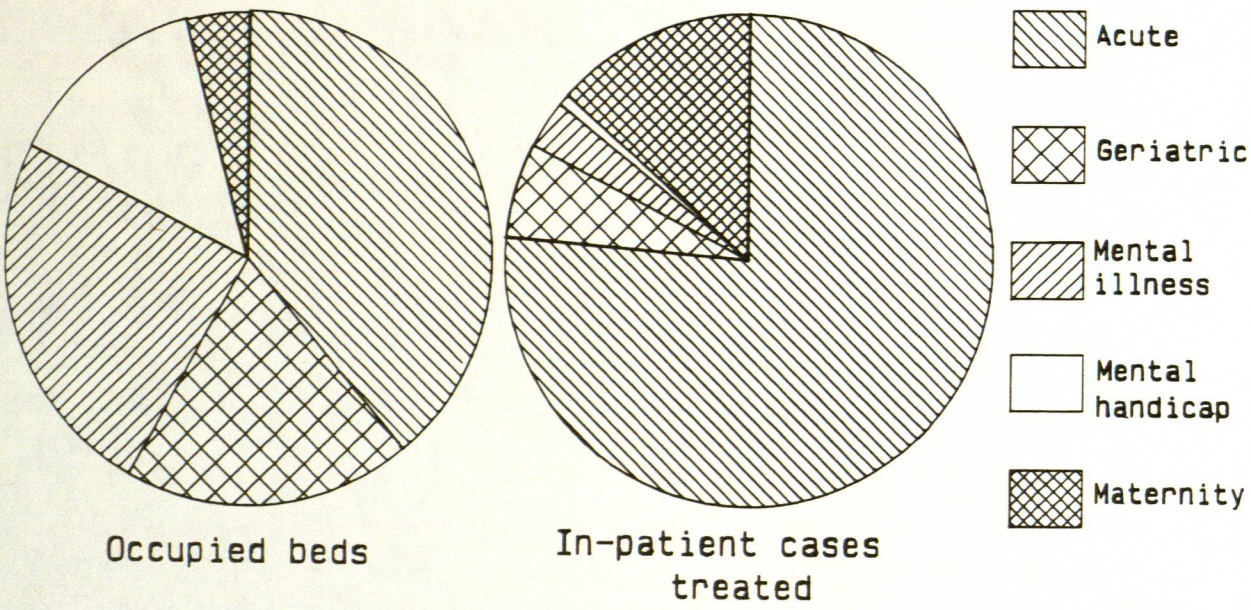

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TABLE 2 Estimated number of In-Patient and Day Cases treated, and average number of beds used daily, with percentage age distribution, NHS hospitals[1], England 1985

	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
Neurolysis	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.

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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.

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February 1988

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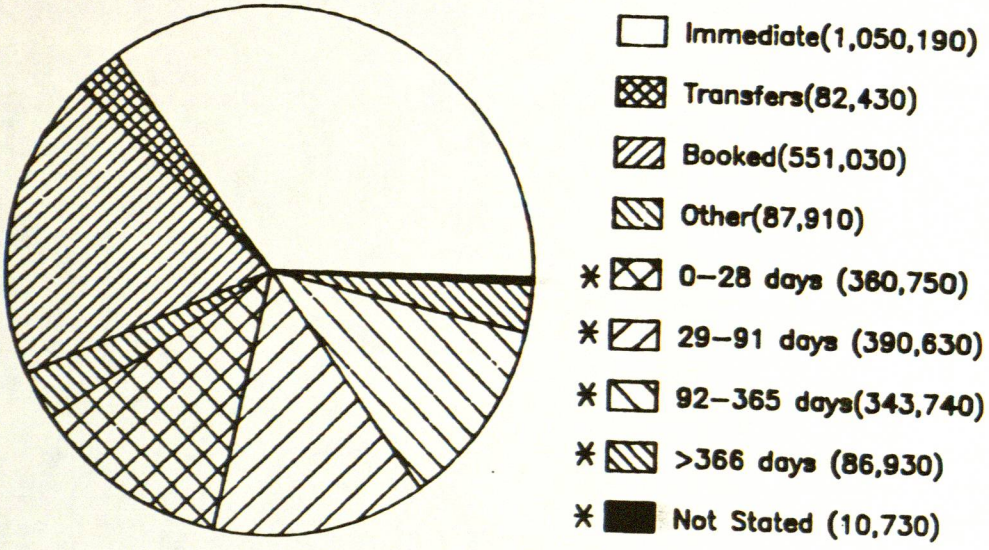
CHART A

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

Notional time to clear waiting lists, 1980

Difference between Regional and National figures

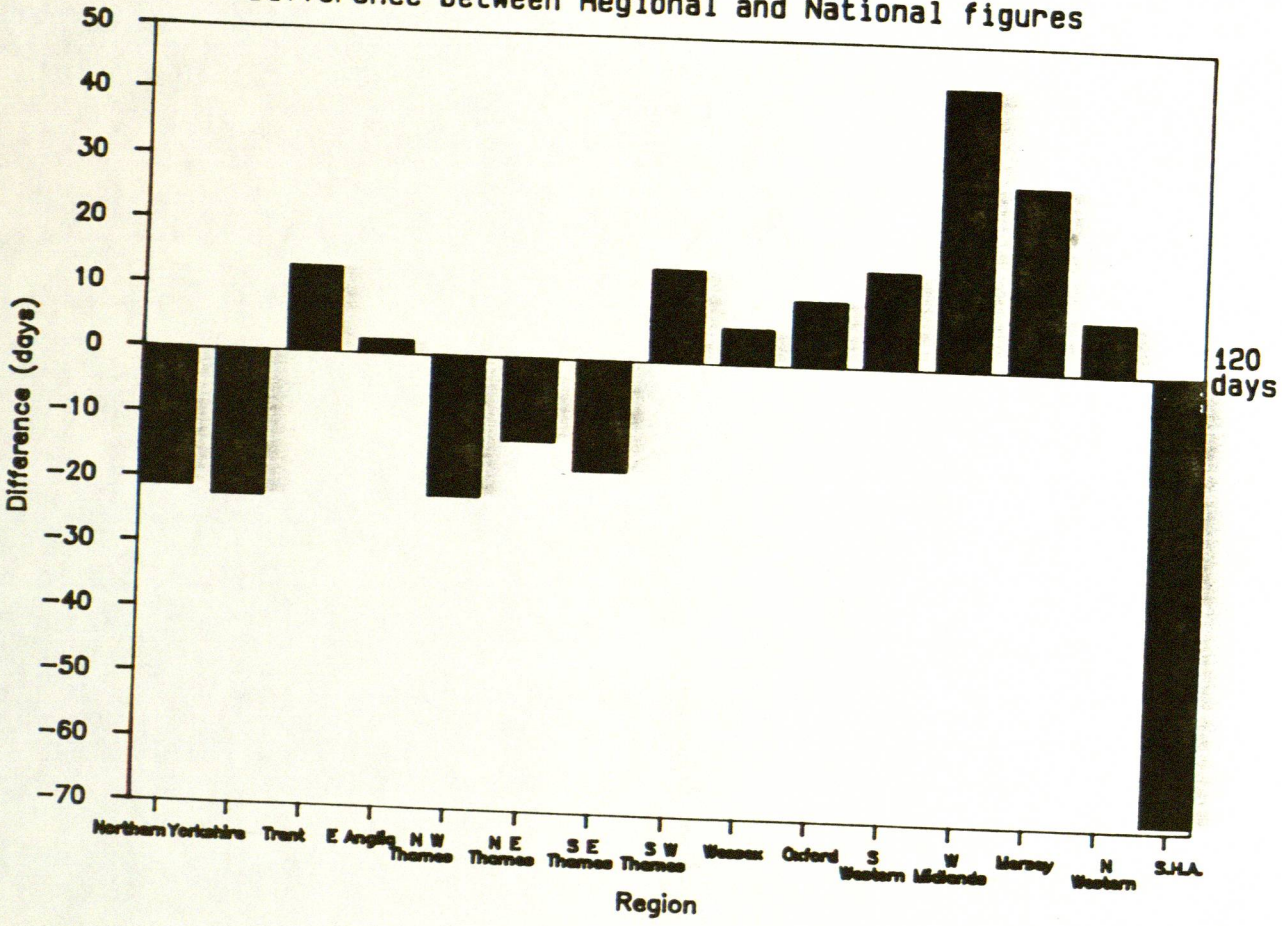

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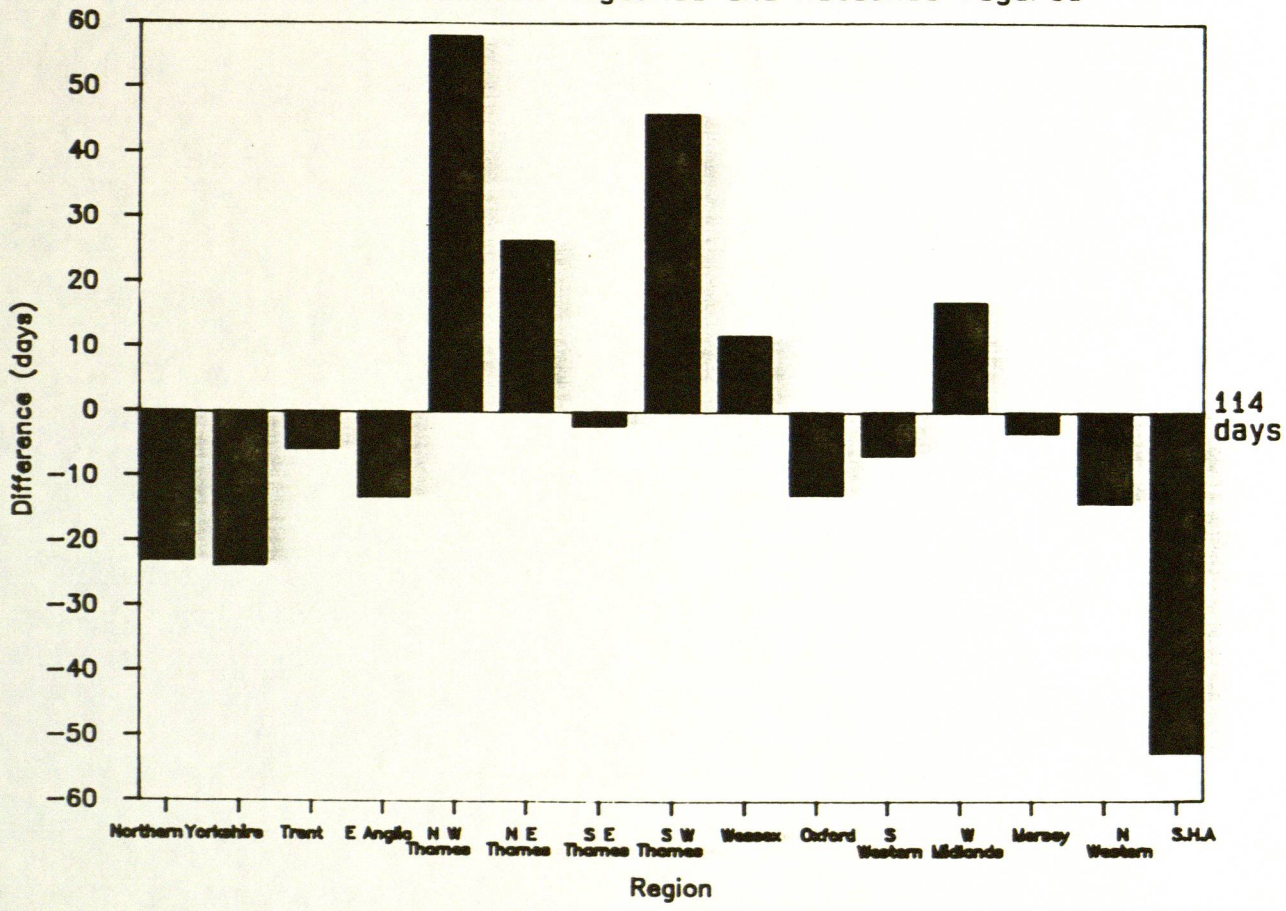
CHART C

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.

*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.

February 1988 DHSS

ANNEX A

SECRET

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.

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.

4. Payment Patterns

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

N/A

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

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.

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.

N/A

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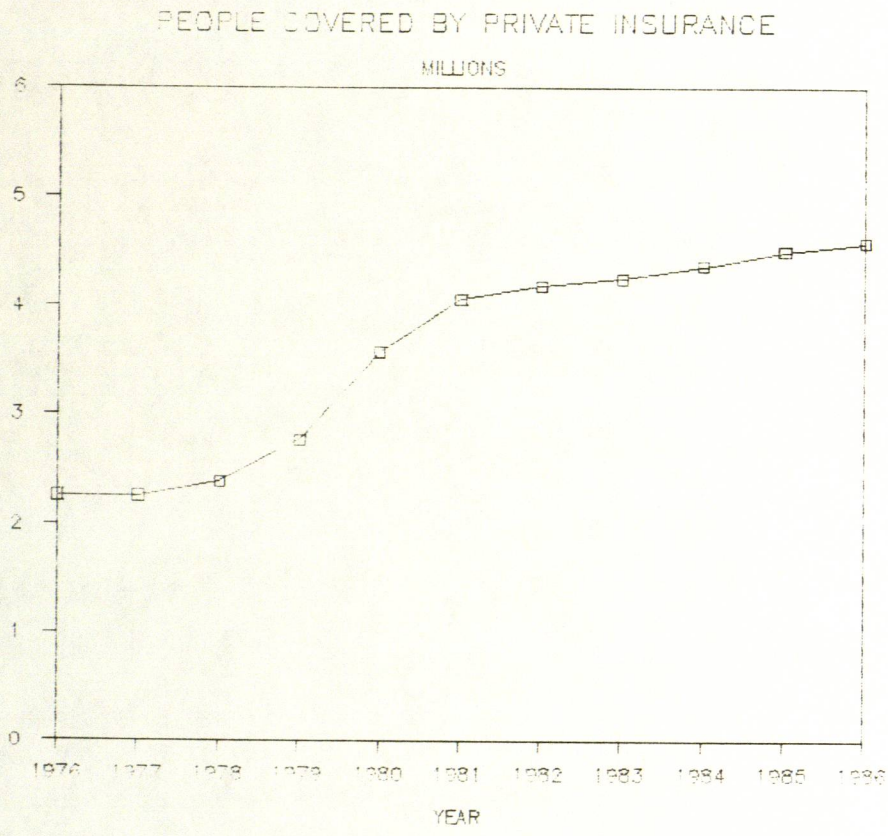
CHART 1



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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 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	The NHS' care standards reflect
(i) each unit's pride in its reputation	(i) each unit's morale and ethics
(ii) the requirements of the registration system	(ii) the watch-dog role of Community Health Councils
(iii) their right to report health professions to their professional machinery eg General Medical Council	(iii) the responsibility of Authorities, and ultimately Ministers
(iv) their right to go to law.	(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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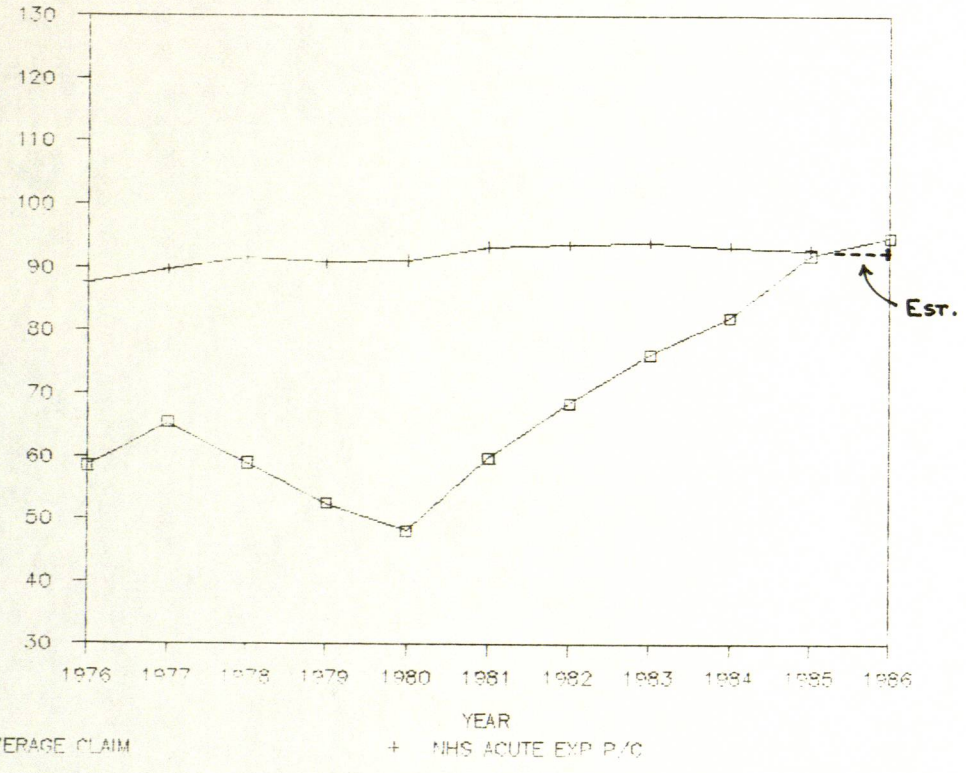
CHART 2

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.

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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".

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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.

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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.

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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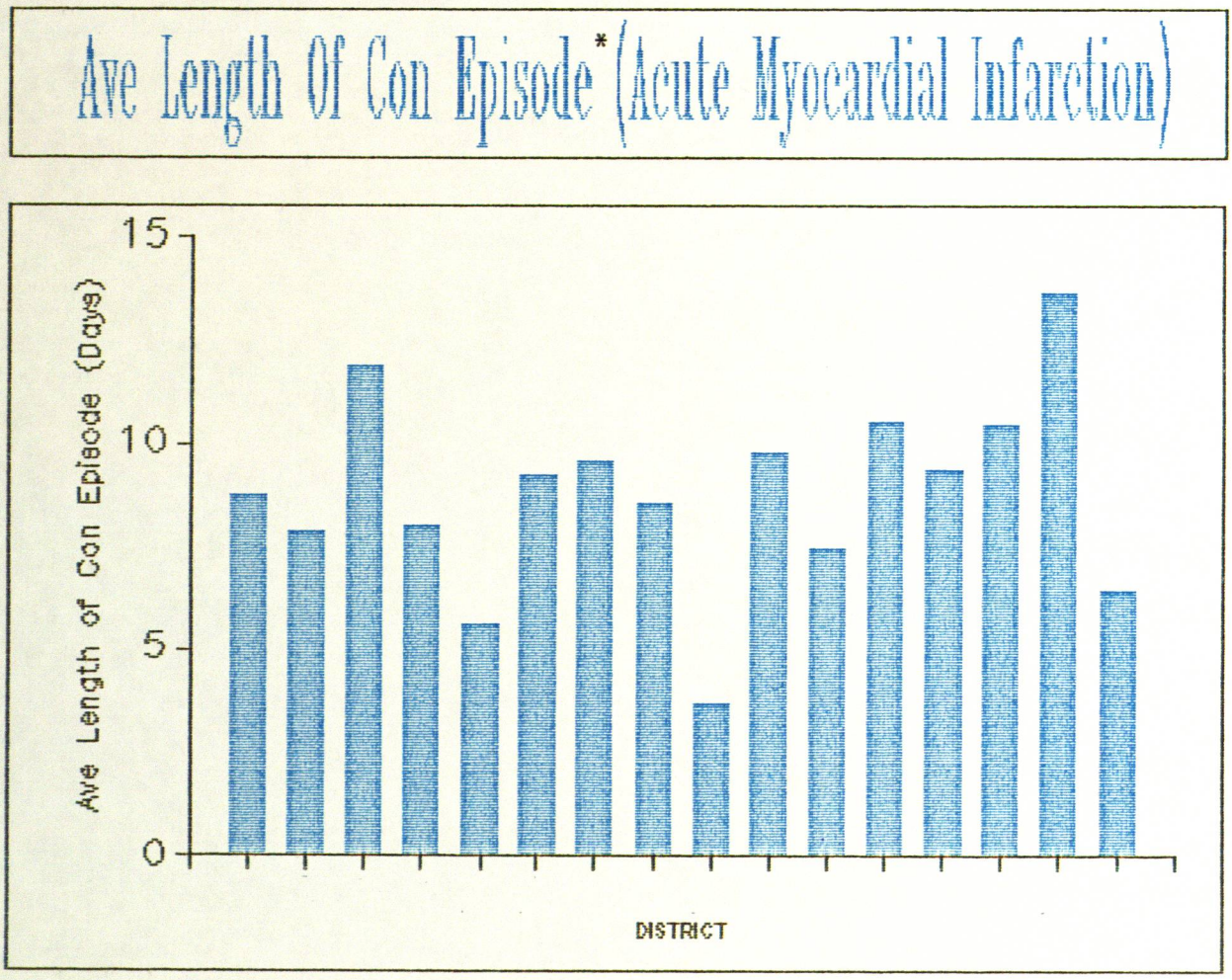
ANNEX A

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

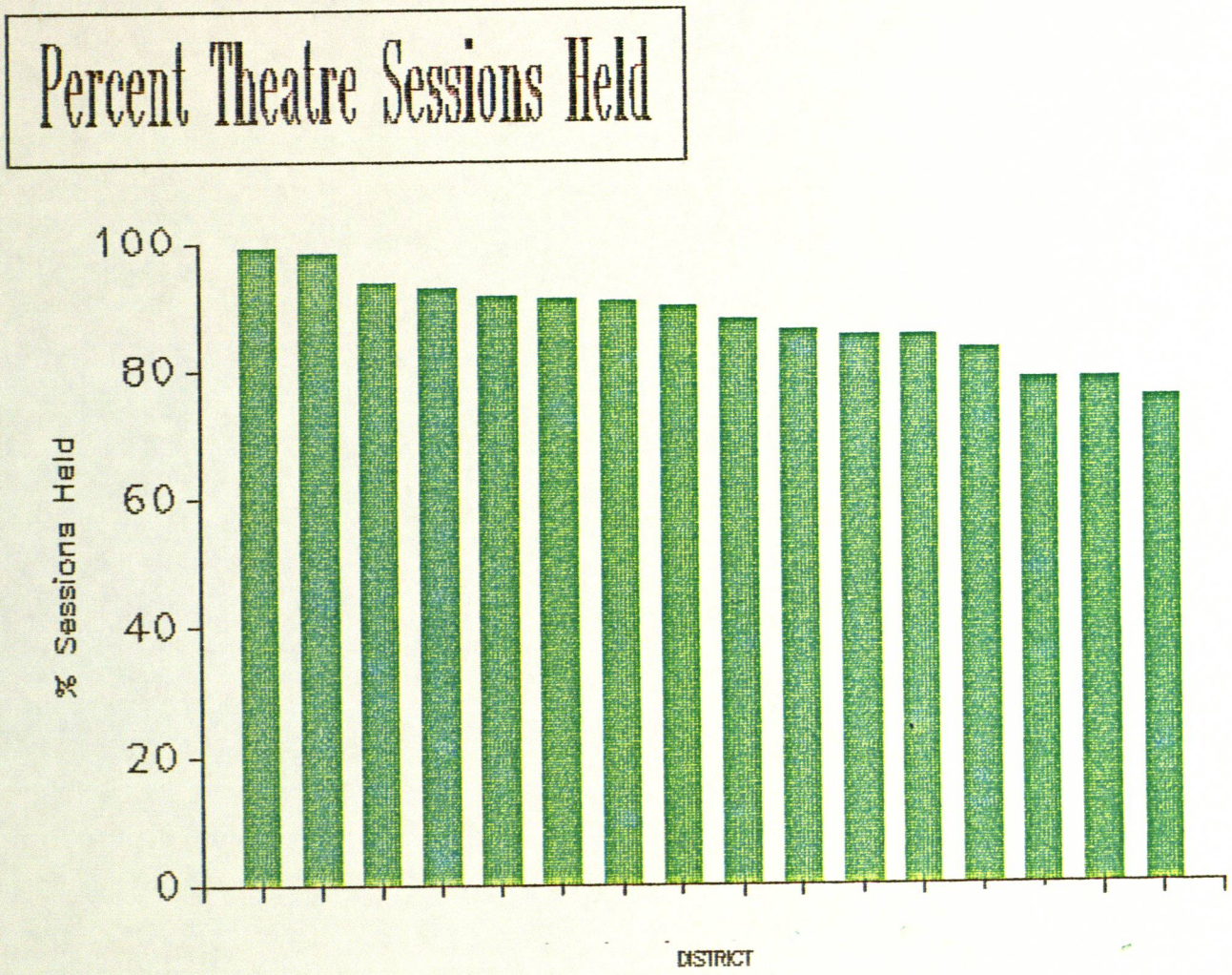
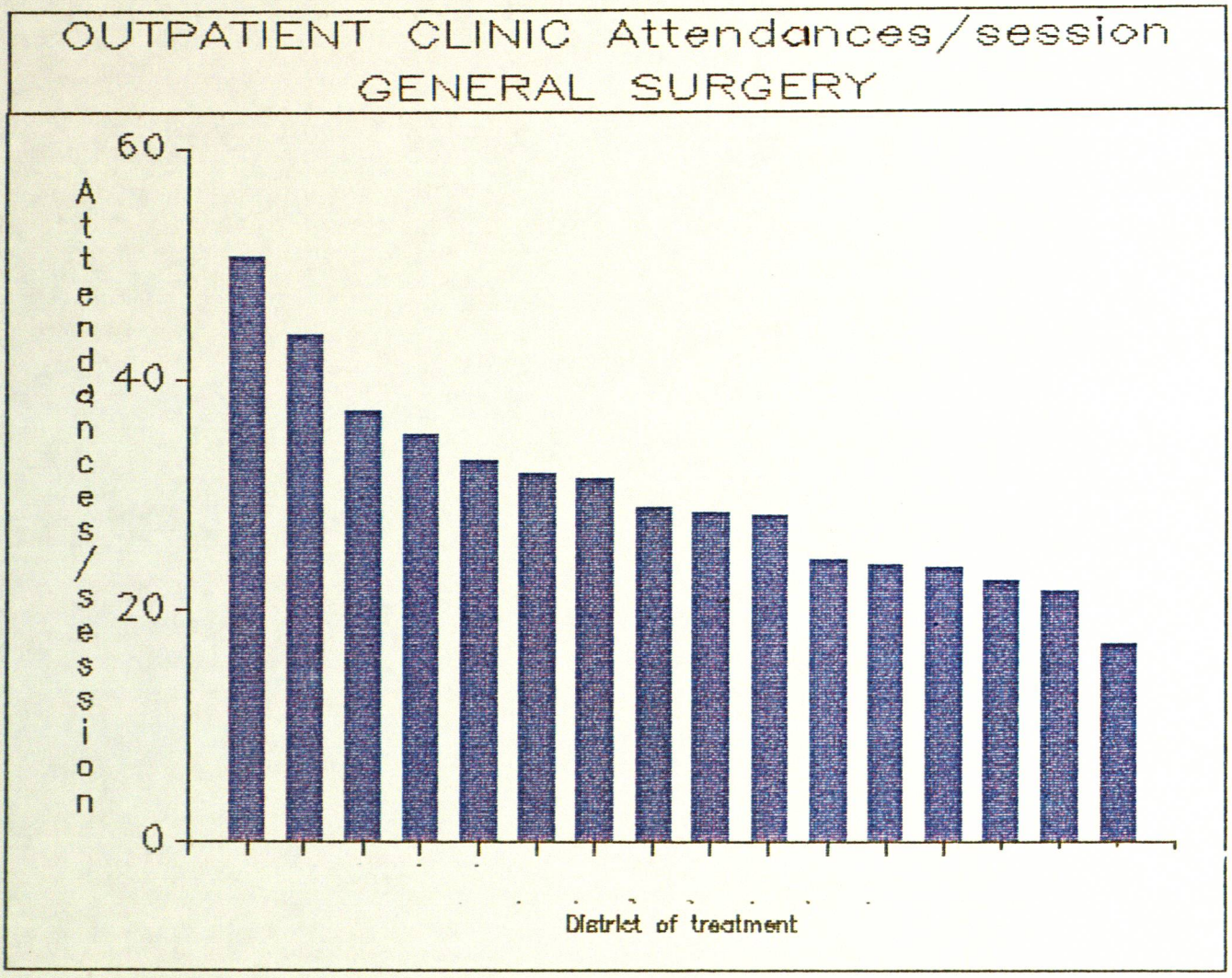


Figure 3



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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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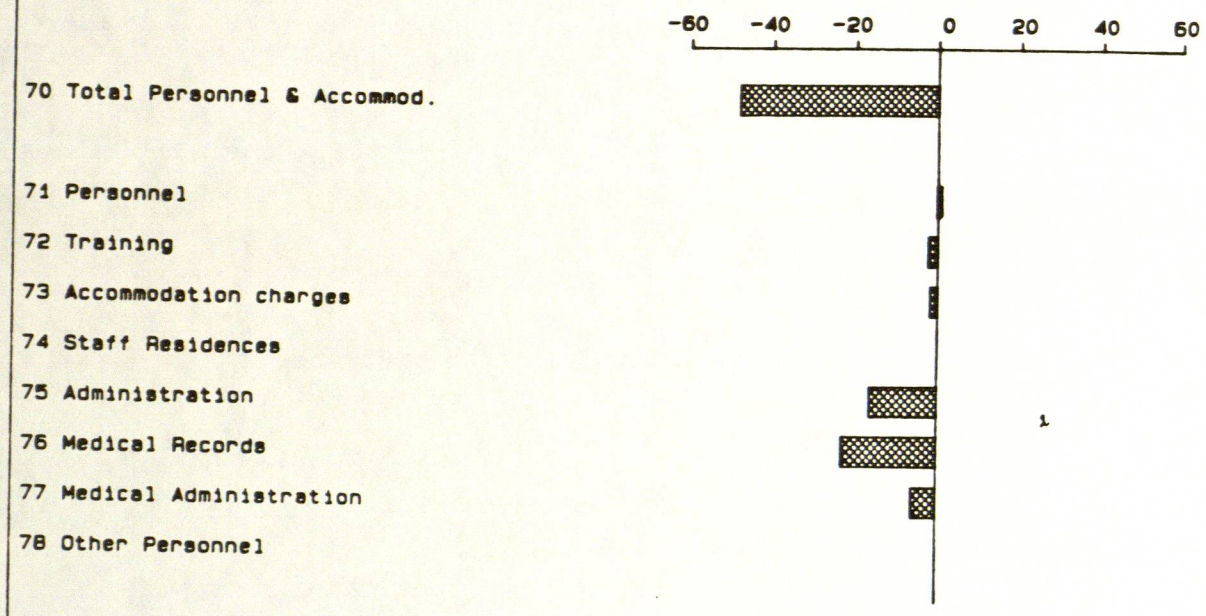
ANNEX C

RESOLVE
21:17 22nd Dec 87 — Variance on Budget - year to date — 222 20 70

£000

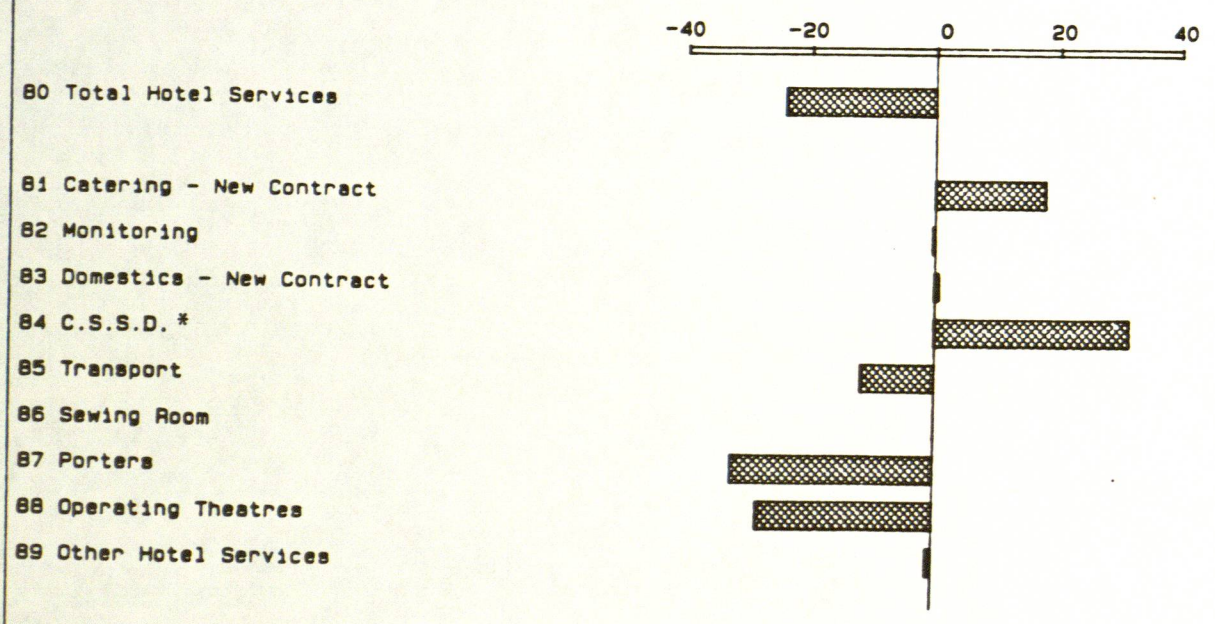
Personnel
Variance on Budget - 7 months to Oct.87



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

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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

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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

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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.

February 1988 DHSS

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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.

February 1988

DHSS

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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.

SECRET

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.

SECRET

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.

SECRET

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.

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.

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.

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

I

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

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 clinical 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 information 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 directing 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.

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.

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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.

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