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10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

5 February 1988

Dear Geoffrey,

NHS REVIEW

Next week's meeting of the Review Group will now take place on Monday 8 February at 1730 hours. I enclose two papers for discussion:

(i) a note co-ordinated by the Cabinet Office setting out suggestions for a work programme;

(ii) a paper by Sir Roy Griffiths on NHS costing estimates, which is particularly relevant to paragraph 6 of the Cabinet Office note.

I am copying this letter to Alex Allan (H M Treasury), Jill Rutter (Chief Secretary's Office), Jenny Harper (Minister of State, DHSS) and Sir Roy Griffiths, Sir Robin Butler, Richard Wilson and John O'Sullivan.

Yours,
Paul

PAUL GRAY

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

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Health 3

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From: R T J Wilson
5 February 1988

MR GRAY

cc Mr Monger

NATIONAL HEALTH SERVICE

As promised, I attach the paper for next Tuesday's meeting in final form. It has been cleared with the Chancellor of the Exchequer and the Secretary of State for Health.

RTJW.

R T J WILSON

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THE NHS

Note by the Cabinet Office

This note sets out some of the main questions that will have to be considered in the internal review of the NHS.

Scope and Objective

2. The objective is to devise a structure for health care which is responsive to the needs and wishes of patients and available to all, and at the same time cost-effective and efficient. The review will place special emphasis on the hospital service, but the latter cannot be considered in isolation from primary care and the private sector. The level of financing and resources can be considered later when Ministers have decided on a structure which will make best use of whatever resources are available from whatever source.

Problems

3. The fundamental problems are:

a. consumers have very little freedom of choice. Most patients have no say in when, where, how or by whom they are treated.

b. present cost controls are crude. Patients have no idea what it costs to treat them. Nor usually do those who treat them. Even if they do, they have no incentive to drive the costs down or to consider which course of treatment is the most cost-effective.

c. there is no means of channelling resources to the most efficient and cost-conscious units, eg the most efficient District Health Authorities (DHAs). Nor, unlike a business, can the most efficient and low-cost hospitals increase their share of the market (and hence their revenue) at the expense of the less efficient. As the Secretary of State's paper points out, hospitals are not rewarded for attracting patients but suffer financially for it.

d. the system is not good at dealing with mismatches between patient demands and available capacity (eg waiting lists) produced partly by institutional boundaries between public and private sectors, between GPs and the hospital service, and between health authorities.

e. there is insufficient management flexibility in the use of staff - from consultants down to the most junior grades - and in the method of determining their pay.

4. In short the NHS lacks a market mechanism under which the patient chooses, in full knowledge of the costs, who shall provide his health care, how, when and where, and resources are allocated to the hospitals, doctors and GPs who are most successful, again in full knowledge of the costs, in meeting the consumer's demands in the most cost-effective way.

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Suggested approach

5. We suggest that the Ministerial Group should approach this problem from three angles: facts, detailed investigation of selected aspects and options for changes in structure.

Facts

6. Ministers may wish to commission early factual papers on:

a. what public expenditure on the NHS buys, in terms both of inputs (eg pay, hospital buildings, drugs, information technology) and outputs (eg treatment of different illnesses, elective and non-elective, paediatrics, care of the elderly);

b. how far detailed information about costs in the NHS is already available, what it shows (eg regional differences) and progress with the Resource Management Initiative;

c. the comparison, on cost and other grounds, between the NHS and the private sector in this country (eg BUPA, and the experience of the 10 best hospitals), and between the NHS and other countries (e.g. New Zealand, West Germany and France, and the diagnostic-related groups set up to contain costs in the United States).

d. what is known about the way patient care is shared between different parts of the NHS, with particular reference to the need to avoid upward drift, and between the NHS and local authorities;

e. the terms and conditions of consultants' contracts.

Waiting time. -

Selected Aspects

7. The Group may also wish to commission papers discussing how the following aspects of the NHS's problems could be tackled. With the factual papers they might help build up a coherent picture.

a. The provision of up-to-date information in the NHS about unit costs, quality of output, use of resources and waiting lists. To be most useful this information needs to be systematically available to both users and health managers, and to be coupled with some form of competition.

b. The introduction of financial incentives and budgeting systems to encourage cost-effective decisions, and to ensure that resources are channelled to the most efficient hospitals and doctors.

c. The scope for more charging in the NHS, to increase awareness of costs and help moderate the 'all or nothing' choice between public and private sector provision.

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

e. How to develop the role of the private sector, both as provider of some services to the NHS and as providing care outside the NHS.

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

g. Ways of tackling consultants' contracts and tenure and other manpower inflexibilities.

h. The scope for introducing some form of publishable independent audit of efficiency, possibly on the lines of the Audit Commission.

Some possible structures

8. The common theme is the need to introduce a market mechanism. Various structural changes could be made to achieve this. The following are some possibilities. They are not exclusive, but they shade into each other. They could also be introduced on different timescales: it would be possible to start with one of the early options, and then develop the system gradually towards the later options. Running through all the options is the need to distinguish between those who buy health care and those who provide it.

Market mechanism within existing NHS structure

9. The first group of possibilities would introduce more market discipline into the existing NHS structure. This could be first by publishing more cost information and efficiency audit reports and by more decentralised budgeting to and within individual hospitals. Going beyond this, there could be more trading of services between authorities and sectors, so that Authority A, or indeed the private sector, could treat patients from Authority B on repayment if their costs were lower.

A new NHS structure

10. The second group of possibilities would introduce more competition in the NHS, involving radical changes in the existing NHS structure, while still leaving it mainly tax-financed.

11. One way to do this would be for District Health Authorities to compete for the allocation of patients by GPs and for their funding to be adjusted according to their success. GPs already have freedom to direct patients to the authorities of their choice, but in practice do not always do so, while authorities have little financial incentive to attract extra patients.

12. A further step down the same path would be for the Authorities to act as Health Maintenance Organisations. HMOs, which were originally developed in the United States, contract to provide all necessary treatment for a fixed sum for a fixed period. The DHA/HMOs could then place patients with hospitals, which in turn could compete among themselves. The DHA/HMOs could also compete with private sector HMOs.

13. Going still further the patient himself could be involved more directly in the choice of treatment and payment for it. There could for example be a system of health credits, by which the patient could receive a credit note covering the cost to the NHS of his treatment, which he could then use wherever he chose within the Service or, more radically, within the private sector. And there are systems in other countries which could be studied: for instance, those in France (where the patient pays the cost of his treatment and is then reimbursed, usually in full, by the State) and Germany. These ideas could however have important implications for present methods of expenditure control.

A greatly expanded private sector role

14. All the alternatives so far have been consistent with the NHS providing most of the health care and most of the funding continuing to come from tax. The last group of possibilities would increase both the role of the private sector in the provision of care, and the role of private finance in funding it.

15. At present, people can already choose to pay for private provision, normally for the less expensive or more optional treatment. This process could be encouraged by tax relief for private medical insurance premiums.

16. More radically, people could opt out for at least some of their medical care which they could then buy either privately or from the NHS. Opting out could be either by individuals or by employers. Those concerned would no longer pay the NHS for the cost of the treatment affected. It would not of course be possible to opt out of payment of tax, but if NHS care were to be financed through National Insurance Contributions, or some similar payment, established for health, there could be a gradual development of contracting out, similar to that decided on by the Government for pensions. Such a system would probably work most easily if the health care contracted out was of the less expensive or more elective kind. The more urgent or expensive long-stay treatment would probably have to stay within the NHS, and the size of the contribution rebate would have to allow for that.

17. The most radical solution of all would be to require all who could do so to provide for their own health care, probably by insurance, which could be arranged either individually or through employers' schemes. The State would still need to provide for the very poor or the uninsurable.

CONCLUSIONS

18. Ministers are invited to decide which specific aspects they wish to consider first.

Cabinet Office
5 February 1988

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CONCLUSIONS

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Cabinet Office
5 February 1988

NHS COSTING SYSTEMS

A note is attached as requested on the development of costing systems in the NHS. This puts into context the statements made last week on the progress of the Resource Management Initiative and also on the comparisons with the costing systems in the private sector. It is simply a brief situation report.

I would highlight the following points:-

a) The private sector knows its charges but these are not based on routine costing systems but rather on special costing exercises to ensure that the broad costs are taken into account along with market factors in fixing the tariffs. Neither the NHS nor the private sector, to our knowledge, has routine patient and treatment related costing systems.

b) The NHS does use the private sector, as in the Waiting List Initiatives of the past 18 months. This is not done because of the nicety of the NHS weighing the comparative costs of carrying out operations in the NHS as against the cost of buying in the services from the private sector. Essentially it is in those cases where the NHS does not have the capacity to do the work and goes to the private sector to reduce waiting lists etc. In these cases a discount from private sector normal charges is negotiated.

c) Two paragraphs in the attached note are particularly important in the light of the earlier discussion. Paragraph 9 sets out the good progress made with the Resource Management Initiative and the information which will be available routinely next year. The length of time involved (which when mentioned at the meeting did have a strong ring of eternity about it) in the full implementation of the Resource Management Initiative is not in the design of the system, but in getting doctors and nurses committed to understanding and to use the system. This is a much longer process and is detailed in paragraph 7.

d) The work being done on costing systems is realistic and will stand comparison with the public or private sector on an international basis. Together with the progress on the new management approach, it is vital to the implementation of any of the possibilities envisaged by the Review.

COSTING HOSPITAL OUTPUTS IN THE NHS - THE MOVE TOWARDS BEST PRACTICE STANDARDS

Introduction

1. This paper summarises the present and prospective situation regarding the costing of patient and treatment related hospital "outputs" in the NHS. It is supported by an Appendix and a technical annex which set out details of the NHS Management Board's Resource Management Project.

The NHS and Private Health Organisations

2. The costing systems currently operated by NHS hospitals have similar strengths and weaknesses to those operated by private health organisations in the UK. More specifically:

(1) both sectors have well-established, and similar, systems for monitoring "inputs" - for example actual as against planned financial performance.

(2) NHS hospitals have recently introduced systems for costing "outputs" by specialty. Such systems are unusual in private hospitals. However, the costing of "outputs" in medical support areas like pathology and x-ray is more widespread in the private sector.

(3) neither sector has routine patient and treatment related costing systems. This reflects the difficulty and expense of setting up and running such systems and, in the case of private hospitals, a past lack of perceived need for such systems.

(4) ad hoc "output" costing exercises are undertaken in both sectors but are more common in the private sector where there is a commercial need, regularly, to check individual treatment costs against patient charging tariffs.

(5) certain (and different) costs are omitted from each sectors systems. These costs are, in the case of the NHS, capital servicing costs and, in the case of the private sector, the fees of clinicians. — only because they submit their accounts separately. AR 6/12

3. The private sector operates well publicised charging tariffs based principally on what the market will bear. These tariffs can sometimes create the false impression that such hospitals also have detailed treatment costing systems.

Developments in Private Health Organisations

4. The larger US owned private sector groups, such as AMI, are now beginning to invest heavily in developing better "output" systems. These developments involve the introduction of procedures that have recently been successfully introduced in North America. They reflect the fact that there is no obvious, or simply applied, blueprint for the 1990's but that American models look promising as long as they are appropriately adapted to UK circumstances.

Developments in the NHS

5. The NHS Management Board's current initiative in this area is the resource management project. It involves major management and information experiments at five hospitals.

6. In the middle term this project is aimed at facilitating a hospital management process which will set new international standards and build on recent post-Griffiths achievements in the management and information area; in the shorter term it is seeking a solution to the lack of patient and treatment related "output" costs for use in monitoring effectiveness and efficiency and supporting the development of an internal market.

7. Getting better output information is not enough in itself. For this reason the resource management project is, additionally, directed towards ensuring:

(1) both that doctors and nurses are committed to using the data and the systems, not least to support better patient care;

(2) and that hospital management structures and processes encourage doctors to exercise responsibility, and accept accountability, in return for their decisive influence over the use of resources.

Hence the emphasis of the new hospital management structures which are emerging at several of the experimental sites like Guy's Winchester and Newcastle.

8. The project has the formal support, nationally, of hospital doctors through the Joint Consultants Committee and the Central Committee for Hospital Medical Staff. It also has the support of the great majority of doctors, nurses and managers at each of the five scheduled sites. This is crucial as the experience of earlier pilot projects showed that failure to secure the involvement and commitment of the doctors at all levels is a crippling handicap.

9. Progress is good. In the case of four sites, developments will reach an experimental operating stage during 1988 and provide a basis for assessment and evaluation from late 1988 onwards. It is hoped these developments will demonstrate the practicality of costing inpatient treatment outputs at all acute hospitals at regular intervals well in advance of implementing other parts of the overall project, with the first results available in the early part of 1989.

10. Success on the costing front would facilitate a number of potential, additional, developments. They include:

(1) privatising parts of NHS hospital activity;

(2) encouraging an internal market;

(3) the introduction of a voucher system;

(4) the introduction of insurance-based systems.

It would also highlight areas which, given existing activity levels, were over or under funded.

DIRECTOR OF FINANCIAL MANAGEMENT
NHS MANAGEMENT BOARD

output/4/2

APPENDIX

THE RESOURCE MANAGEMENT PROJECT - ITS PURPOSE, PROGRESS AND PROSPECTS.

1. There is continuing interest in the resource management project and in the potential contribution it can make to the management of change in the NHS. Two particular questions being asked are the extent to which, given time, it can contribute significantly to the better use of resources and whether, within a much more urgent timescale, it can provide the better costing of hospital "outputs" that is required. The objective of this note is to summarise the purpose, progress and prospects of the programme and to discuss shorter-term possibilities and opportunities.

Background

2. There has been considerable debate over many years about how best to cost the "outputs" of acute NHS hospitals. This has taken place against the background of a financial planning and control tradition within which managers maintain records of the costs of all primary cost centres (covering functions and departments like nursing, pathology, catering, finance and works) and annually budget and plan financial performance on the basis of resource "inputs".

3. The above process has served the NHS well over many years. However, it has never provided an analysis of costs according to patient or treatment "outputs" or generated information of any real relevance or value to doctors and nurses in their capacity as the hospital product managers.

4. This limitation was addressed by the Korner Committee (1982-1984). After considering what it saw as the merits and demerits of speciality costing, diagnostic group costing, clinical team costing and patient costing, the committee recommended the adoption of speciality costing.

5. Speciality costing consists essentially of disaggregating and allocating costs to the different respective specialities (general surgery, general medicine, obstetrics, orthopaedics etc) and determining the average patient treatment costs of each speciality. It has the merit of simplicity. It is also the essential first step towards patient or treatment related "output" costing.

6. Such costing was introduced with effect from 1st April 1987 as part of the Korner implementation programme. It is the basis of a new generation of periodic in-year returns for unit and district management and an annual, national, summary for use at NHS Management Board level.

7. The introduction of speciality costing is enabling general financial reporting standards to be improved at all levels. However, it provides only the most generalised basis for relating "output" costs to patient care activity data. In particular, it does not allow for the wide variety of conditions and procedures encompassed by a single specialty. For example the resources needed to treat any two general surgical cases might, depending on the complexity of the procedure or the severity of the patients condition, vary by a factor of 10 or more. As a result it is of limited value to doctors and other managers as a resource management and decision support tool. Its capacity to influence clinical behaviour is similarly limited.

8. Health service managers still have little information about how much it actually costs, let alone should cost, to treat patients with similar medical conditions. In consequence, management is significantly handicapped when deciding how best to distribute resources at sub-unit level, trying to identify efficient and inefficient clinical and nursing practices or determining whether given levels of patient activity are over or underfunded.

9. Beneath the current lack of information about treatment costs lie equally important if not more fundamental challenges. At most NHS hospitals:

(1) the doctors, nurse managers and ward sisters feel uninvolved in (and in some cases alienated from) the local unit management process despite exercising the major influence over activity levels, service quality and resource use. The experience of earlier pilot projects showed that failure to secure the involvement and commitment of doctors and nurses is a crippling handicap.

(2) the doctors lack confidence in the basic activity data which must form the foundation of any credible clinical and output cost information system

(3) the nurse managers (nurse directors, officers and ward sisters) possess inadequate systems with which to plan and manage the nursing workforce which accounts for up to 40% of hospital costs.

PURPOSE

10. The purpose of the resource management programme is to overcome these problems by demonstrating, at 5 reference sites, by mid to late 1989 at the latest:

(1) how doctors and nurses can be involved such that they are committed to the management process, responsible for their use of resources and able to take better decisions regarding patient care.

(2) the practicability of operating accurate and medically credible systems for collecting patient activity data.

(3) the value of effective management information systems for nurses and departments like

pathology, radiology and pharmacy

(4) the feasibility of running, at an acceptable cost, costing systems which are closely linked to (2) and (3) above; which reflect the impact of variations in the kinds of conditions dealt with; which attract the support and confidence of doctors; and which actually get used.

11. The ultimate aim of the experiment is to enable hospital doctors, nurses and managers throughout the NHS to adopt similar practices everywhere..

12. The programme represents an ambitious challenge to existing attitudes and to the need to improve further activity and output cost information. It has the formal support, nationally, of hospital doctors through the Joint Consultants Committee and the Central Committee for Hospital Medical Staff. It also has the support of the great majority of doctors, nurses and managers at each of the reference sites.

PROGRESS

13. The five sites are the Freeman Hospital in Newcastle upon Tyne, The Royal Infirmary in Huddersfield, The Royal Hampshire County Hospital in Winchester, Guy's Hospital in London and Arrowe Park Hospital near Birkenhead. Work at these sites started in the period October 1986 to July 1987. In the case of Newcastle, Huddersfield and Winchester it will reach an experimental operating stage during the spring and summer of 1988 and these sites plus Guy's (which is about 4 months behind) will provide a basis for assessment and evaluation from late 1988 onwards. Progress is being widely publicised

14. Development work covering the four components of the programme listed in paragraph 10 above is common to all five sites. Differences of emphasis and approach include:

(1) The precise nature of the sub-unit organisation structures. Guy's and Winchester have adopted the most radical approach by creating clinical directorates whilst Huddersfield has made very little formal change to date to its traditional structures.

(2) The processes adopted for ensuring that the local doctors and nurses significantly influence future information outputs. At one extreme Newcastle invested heavily at the outset in defining its clinical data base. At the other, Huddersfield is "prototyping" towards final data base decisions over a 12 to 18 month period.

(3) The range of computer software and hardware being deployed. A relatively large choice of software and hardware is being piloted.

15. At a technical level the three most important components of the experimental programme involve developing and maintaining an accurate and credible clinical data base, establishing a case-mix classification system for recording patient treatment and cost data and implementing effective nurse management systems. More information on these components is set out in the technical annex attached to this Appendix.

Evaluation

16. An important aspect of the original agreement with the JCC was that the programme should be experimental. Once the initial development and implementation period is concluded, both sponsoring parties (the JCC and the Management Board) are committed to commissioning as full and objective an evaluation of the results as is practical and reviewing the results of that evaluation before any decisions are taken about how best to encourage implementation by the rest of the service.

17. A first evaluation report will be produced in October 1988. It will discuss the progress at each site and how successful each site has been in implementing its plans on schedule. It will be co-ordinated by the JCC and the Management Board.

18. A more detailed evaluation report, which measures the impact on service quality and costs of the new organisational and information arrangements in their first full year, will be prepared in October 1989. A parallel "external" evaluation, aimed at providing an outsiders view of the potential cost benefit and value will be undertaken by staff from Brunel University in 1989/90.

Current position regarding other sites

19. As mentioned above, recommendations regarding how best to extend the new processes will be based on the 1988 and 1989 conclusions of the joint JCC/Management Board evaluation group. In the meantime other NHS districts and units anxious to make progress on the organisation and information front are being advised to concentrate on getting their basics right in preparation for implementing the resource management processes from 1989 onwards.

20. In advising these districts and units, emphasis is being given to the importance of:

(1) Introducing sub-unit arrangements which involve doctors and nurses in the local management process.

(2) Capitalising on the opportunities provided by Korner data for more informed local decision making. This applies, in particular, to the new activity and specialty costing data that is now becoming available.

(3) Establishing effective management and financial systems for nursing and service departments like pathology and using the specialty costs to give clinicians a preliminary feel for the level of expenditure associated with their activities.

21. Such districts and units are being discouraged from attempting to implement clinical data bases and/or case-mix management systems until more is understood about how best to proceed in these areas.

A BROADER PERSPECTIVE

22. The purpose of the resource management programme was defined in paragraph 10. Underlying this purpose is the aim of providing NHS management with the means of making the best possible use of limited resources and encouraging better and more cost effective treatment. Much is expected as consultants start comparing their performance with colleagues - first within hospitals, then across districts and finally, as the system spreads through the NHS, nationally and internationally.

23. A successful outcome to the experiment will raise a range of possible broader uses for the new activity and costing information and influence a number of potential developments. For example the information could:

(1) facilitate the privatisation of large parts of NHS hospital activity or complete hospitals. At a less radical level it could support an internal market within which hospitals or authorities shopped around for services amongst themselves and/or in the private sector. Authorities/hospitals could become purchasers of services rather than providers.

(2) open the door to a voucher system under which the government might provide a basic sum to be spent in NHS or private hospitals which individuals could then top up.

(3) ease the introduction of an insurance-based system where the state reimburses individuals for care wherever it is given.

24. It might also indicate that the NHS, in certain areas at least, is significantly over or underfunded. This would be highlighted not by crude measures of international spending but by comparison between the costs of individual treatments across countries or between NHS costs and the costs of private health providers.

APPENDIX
Technical Annex

SOME TECHNICAL ISSUES

Clinical data base

1. Much of the pioneering work on establishing how best to develop an effective and accurate clinical data base has taken place in Newcastle. It has involved:

(1) Recognising existing problems. They include the fact that in most hospitals (i) the current medical coding process is in arrear, (ii)conscientious but medically untrained coding officers and clerks are left to interpret what are often complex and ambiguous medical files without medical oversight or audit and (iii) the resultant data is largely discredited in the eyes of the doctors and rarely used.

(2) Reviewing existing and available diagnostic and operation coding classifications and selecting the most suitable for future purposes

(3) Determining, with clinicians, what information would be of future value to them in their clinical and clinical management roles, This covers defining the nature and content of the clinical data base and discussing how it might be used to inform peer-review processes.

(4) Deciding how best, reliably and with a minimum of effort, to collect the new diagnostic and operation data and feed it into the data base (collection points, encoding techniques, staffing and validation arrangements, and so on).

2. The results of this work have been made available to all the other sites.

Case-mix classification systems

3. As mentioned in paragraph 7 of the main appendix, the major limitation of speciality costs is that they pay no regard to the impact of variations in case-mix on levels of resource utilisation. Under speciality costing each case would normally attract the same average cost calculated by reference to total resources utilised and number of patients handled.

4. Because case-mix analysis data lies at the heart of any effective patient treatment costing system, considerable emphasis is being put on how best to group the large number of medical conditions and treatments which characterise existing activity coding systems. The resource management programme is experimenting with a US based "grouping" system which consolidates the 20,000 plus medical classifications that represent the latest (ICD 9 CM) codes used in North America into 467 resource homogenous diagnostically related groups (DRGs). This grouping has won widespread acceptability amongst doctors in North America.

5. DRGs represent a classification of inpatients which reduces data volumes to manageable proportions. The classification is considered to be medically meaningful, comprehensive and unambiguous, obtainable from existing data and (in North America at least) consistently able to delineate groups of patients with similar patterns of resource use. This covers use of operating theatres, medical time, medical tests, drugs, length of inpatient stay (nursing and hotel services) and costs.

6. NHS hospitals use an earlier and less detailed version of the ICD code referred to above rather than the latest (ICD 9 CM) version on which DRGs are based. In consequence, the resource management programme is currently:

(1) Assessing whether existing UK ICD 9 based HAA data can be translated into ICD 9 CM equivalents without unacceptable compromises in reliability and accuracy. This involves using "mapping" programmes developed by Yale University which originated the DRG system.

(2) Determining whether the US developed DRGs adequately reflect UK hospital treatment practices. Part of this involves establishing whether the application of DRG groupings in England produce data clusters which have medical validity and cover cases which absorb broadly similar amounts of resource.

(3) Assuming affirmative answers to the above questions (and the early evidence is encouraging), testing the US DRG based cost model to establish whether it is suitable (with or without modification) for English hospital circumstances.

(4) Developing suitable software to run the cost model on micro as well as main-frame computers.

7. Good progress is being made in the mapping and validation activities described above using 1985 NHS HAA data covering hospitals in Mersey, Northern and Yorkshire regions. The early evidence suggests that UK data can be successfully grouped into DRGs and that the resultant groups will be medically valid and resource homogenous. A definitive report on all these issues will be available in late March/early April.

8. Work is also being undertaken to test the potential suitability of the US DRG cost model and to explore the practicability, or otherwise, of implementing a system of DRG costing throughout the NHS from 1 January 1989, in advance of other parts of the resource management project. A report on the results of these tests will also be available in late March/early April.

Nurse management

9. The third major component of the work at all 5 reference sites concerns nurse management. Currently no widely respected computer based nurse dependency or management systems are being used within NHS hospitals despite the fact that any improvements in this area will have an immediate impact on quality of care. Better information is needed urgently about the effectiveness with which nursing time is managed and the extent to which they may over recent years have become diverted into "non-nursing" duties unrelated to patient care.

10. A range of nurse management systems is being implemented at four of the sites. They are aimed at helping ward sisters and nursing officers to assess the individual nursing needs of patients so that nurses can be deployed accordingly. They are also aimed at helping nurse managers to monitor service quality, maximise the amount of time nurses spend providing direct patient care and measure the nursing resource used in looking after individual patients.

GM1864p

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for Social Services

Paul Gray Esq
Private Secretary
10 Downing
LONDON
SW1A 2AA

5 February 1988

Dear Paul

CONSULTANTS CONTRACTS

I understand that, in the context of the NHS review, you have asked to see the form of NHS consultant contracts.

I enclose a copy of the relevant material. The model contract is at Annex D, and a recommended form of job description at Annex F.

I am copying this letter and enclosure to Richard Wilson at the Cabinet Office.

Yours ever

Flora

FLORA GOLDHILL
Private Secretary

RA Health

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1 2NS

Telephone 01-210 5166/7/8

From Sir Roy Griffiths

5th February, 1988

P. Gray, Esq
10 Downing Street
LONDON
S.W.1.

Dear Paul,

I enclose 12 copies of a note on Costing Systems, as requested. It is extremely hurried and I hope it fits the bill.

Yours sincerely,

ROY GRIFFITHS

Enc.

Jan. 4, 1987.

GERMAN HEALTH SERVICE UNDER REVIEW

This background paper on the health service in the Federal Republic of Germany examines the likely effect of reforms envisaged in the Health Expenditure Law expected to reach the statute book in Bonn this summer:

The health service is not suffering from shortages but from oversupply, which means that it is running short of money. The Federal Republic of Germany already has 165,000 doctors, 35,000 dentists and 18,000 pharmacies with 47,000 pharmacists and totals keep rising. The hospitals have 50,000 beds too many.

The Federal Government has therefore decided that everyone must economise: the doctors and dentists, the pharmaceutical industry and the manufacturers of medical equipment.

Not all Germans are equally affected by this. Under regulations of 1911, the basic elements of which are still valid, the health insurance system is divided into two categories: employees with a monthly income of up to DM 4,275 (DM 4,500 in 1988) must be insured under one of the statutory health insurance schemes -- a variety of local, company and wage-earners' schemes.

Anyone whose earnings are above this ceiling can opt for exemption from the insurance liability and join one of the 49 private schemes, where premiums are generally higher but the policies are geared to individual requirements and kept within limits by the insured paying part of the medical expenses involved. At present 5,200,000 people are privately insured.

In recent years, the spending of the statutory health insurance schemes for 37 million members and their families has risen sharply due to better medical care and longer life expectancy. In 1960 this spending amounted to only DM 9.5 bn., but it has now reached DM 108 bn. -- DM 8 bn. more than revenue from contributions.

This expenditure requires contributions averaging 12.6 per cent of the gross earnings of the insured. Schemes with many "bad risks" must levy up to 14 per cent. Employees and employers each have to pay a half; the workers notice the impact on their purchasing power, and the firms on labour costs, with the result that the investment capacity of companies is reduced and they become less willing to take on more staff.

REPORT FROM THE FEDERAL REPUBLIC OF GERMANY
EMBASSY: 23 BELGRAVE SQUARE LONDON SW1X 8PZ TELEPHONE 01-235 5033

Structural reform

The proposed new structure guarantees health care for the population, but the insurance schemes must pay only for what is medically necessary. More extensive benefits, such as expensive dental work, medicines and sanatorium and hospital treatment not considered absolutely essential, must be paid for by the patient.

The health insurance schemes are also to be relieved of costs not really regarded as being part of their field of responsibility. For instance, death benefits amounting to as much as DM 6,000 at present will no longer be granted. For a transitional period, patients will also have to bear a sizeable share of the cost of medicines (up to 20 per cent or DM 10), medical aids (up to 40 per cent), and hearing aids, for which only a basic sum of DM 800 will be refunded. Those requiring spectacles will in future get only the cost of lenses reimbursed.

All these limitations are to exist only for a transitional period until the expenditure and revenue of the statutory health insurance schemes are once again in balance.

Prevention features prominently in the new Health Expenditure Law to be adopted in mid-1988. This begins with regular health education at school. Anyone going for a medical check-up will be allowed to pay a smaller share of the medical expenses. This is likely to be of particular advantage in the case of dental treatment. The cost of plasters, skin ointments and headache remedies must in future be met by the patient.

DM 14 bn. savings

Under the new legislation the Federal Government hopes to reduce the bill of health insurance schemes by DM 14 bn. Half of this will go straight back to the insured through a one per cent cut in contributions. The Federal Government will devote the other DM 7 bn. saved to remedy a long-criticised shortcoming in health policy: the money will go to the relatives who look after 630,000 severely handicapped people at home. In future, these relatives will -- at the expense of the statutory health insurance schemes -- be able to take an extra four weeks' holiday a year on top of their normal entitlement and have a nurse replace them for one hour a day.

With this reform plan, Chancellor Kohl's administration has tackled one of the two major problems in the social sector at present. The other is the old-age pension insurance scheme, but this still has sufficient resources for the next few years until the 1990's.

Nat Health

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

SIR ROBIN IBBS

The Prime Minister was most grateful for your minute of 29 January and for your comments on the possibility of a scrutiny.

The Prime Minister has noted the possibilities and will want to consider this further when the work programme for the overall NHS review is a bit clearer.

I am copying this minute to Sir Robin Butler.

PAUL GRAY

4 February 1988

js/1818p

CBG

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for Social Services

PO1/1694/500

Mark Addison Esq
Private Secretary
10 Downing Street
LONDON
SW1A 2AA

4 February 1988

Dear Mark

Thank you for your letter of 26 January about perinatal mortality. ~~January~~ Jan + Feb

I attach a revised table for perinatal mortality rates which has been compiled by OPCS mostly using the WHO and UN Demographic Yearbook. This is the latest data available from the WHO and the table updates the previous WHO information we have given you. The most notable difference is the rate for the Federal Republic of Germany. This is because the figure previously quoted was in fact the figure for the East Germany. The figures for <u>both</u> countries are now shown.

For the longer term, I have asked OPCS to let us know the reasons for the disparities between the WHO statistics and those used by the CSO.

I hope this all puts us on a somewhat firmer footing.

Yours ever

Flora

FLORA GOLDHILL
Private Secretary

PERINATAL MORTALITY INTERNATIONAL COMPARISONS WHO STATISTICS

COUNTRY	YEAR	RATE
England and Wales	1984	10.1
Austria	1984	10.2
Belgium	1984	11.3
France	1984	11.2
Germany Federal	1984	8.6
East Germany	1984	10.6
Greece	1984	16.5
Republic of Ireland	1983	13.7
Italy	1981	16.7
Netherlands	1984	10.0
Luxembourg	1984	8.8
Spain	1980	14.4*
Switzerland	1982	9.0
Denmark	1984	8.4
Finland	1984	7.6
Norway	1984	8.9
Sweden	1984	7.3
Japan	1984	8.7
Canada	1983	9.5
USA	1981	15.6

The year is the latest given by the majority of countries to WHO. Perinatal mortality includes live and still births but countries do not have a common baseline for registration of births which in the UK is 28 weeks gestation or any child which has shown any sign of life.

The statistics for 1984 indicate that fewer babies died here than in France, Belgium, Austria, Greece, Italy, Republic of Ireland, Spain and USA.

* EEC Eurostat Annual Returns and used by WHO.

4 February 1988