11
(A-MM)

CABINET OFFICE

70 Whitehall London SW1A 2AS Telephone 01-270

SECRET

P 03194

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON SW1.

22 July 1988

Dear Paul,

REVIEW OF THE NATIONAL HEALTH SERVICE

I enclose papers on the funding of hospitals and capital for hospitals, with a covering note by the Cabinet Office, for the next meeting of the Ministerial Group on Tuesday next, 26 July. I also enclose a new version of the note by the Cabinet Office which was considered at the Group's last meeting on 8 July, revised to take account of the discussion on that occasion.

I am copying this paper and the enclosures to the private secretaries to the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Scotland, the Secretary of State for Social Services, the Chief Secretary and the Minister for Health, and to Sir Roy Griffiths, Sir Robin Butler and John O'Sullivan.

I would be grateful if recipients would ensure that the papers are seen only by those who need to see them.

Yours,

Richard

R T J WILSON

B C

SECRET

HC35

REVIEW OF THE NATIONAL HEALTH SERVICE

FUNDING ARRANGEMENTS

Note by the Cabinet Office

At their meeting on 8 July the group asked the Cabinet Office to prepare a note on the funding arrangements which would accompany the changes in the NHS which Ministers had agreed. They also asked for further work to be done on the treatment of capital.

2. The attached paper on funding has been prepared by DHSS in consultation with the Treasury, and that on capital jointly with the Treasury. This note summarises their conclusions and suggests some points for consideration by Ministers.

Funding districts

3. RAWP, the present system for allocating funds to regions and districts, would be terminated. In its place there would be a much simpler capitation-based approach. Districts would receive funding related mainly to population, but with an allowance for extra costs, such as the number of elderly people. The complicated adjustment under the present system for funding cross-boundary flows would be phased out so that these flows would be funded directly and at the time.

4. This arrangement would introduce a much simpler system than exists at present. But it would also preserve financial control, since the funding received by the districts would be cash limited.

Funding hospitals

5. When this system was fully developed, districts would use their allocations to buy services from hospitals under contract. This arrangement would:

- encourage competition between hospitals. It would be the counterpart of the creation of self-governing hospitals;
- encourage competition also between the public and private sectors, since districts could buy from private sector hospitals if they wished;
- provide for hospitals to receive money in accordance with their success in attracting business, a principle to which Ministers have attached importance.

6. In general, hospital services to patients would be funded in three ways.

i. First, core funding. Under this, local services would be funded through performance-related budgets and, increasingly, through contracts between Districts and self-governing hospitals. This form of funding would apply to treatment that had to be provided locally such as accident and emergency treatment.

ii. Secondly, contract funding. Under this, and subject to pilot schemes, services such as elective surgery would be funded increasingly through:

- contracts with other Districts, with self-governing hospitals and with the private sector, and

- a "GP budget" for referrals by GPs not covered by contracts.

iii. Thirdly, tertiary funding. There would need to be separate arrangements for specialist units in hospitals which provide highly skilled services to a large number of other hospitals (eg a hospital unit doing heart transplants). One approach might be for referrals from one hospital to another to be funded - at least at marginal cost levels - by the referring hospital.

Detailed arrangements under these headings would be tested out in pilot experiments.

Transition to the new system

7. Overnight change could disrupt the continuity of services to patients and the effectiveness of expenditure control. So an essential element in the proposals is that:

i. the change must be carefully managed over time. For example, any large changes in the distribution of resources would need to be phased in over a transitional period. One possibility would be to use "top-slicing" to allocate specific sums to regions, districts or hospitals, in addition to a baseload allocation, in order to reward greater efficiency during the transition. This procedure could be phased out as the new arrangements came into effect;

ii. some of the proposals would be tested out through pilot schemes. The DHSS paper suggests experiments to test the new arrangements before they are introduced nationally: see Appendix B.

Questions for consideration

8. There are some questions which Ministers may wish to consider.

9. The first is the treatment of capital. The attached paper deals primarily with the scope for greater delegation to hospitals. The group may wish to agree that further work should be done as indicated. In addition, one main question when the new arrangements are fully in place will be who should decide on the building of new

hospitals. There are several possible condidates: the existing hospitals, the private sector, districts as buyers, regions and the DHSS.

10. The second is the role of the regions. The group has already agreed that there is a strong case for slimming them down, and perhaps eventually making them regional offices of the DHSS. As the funding responsibilities of the regions declined there could be a role for them in preparing hospitals to become self-governing and in supervising service standards.

11. The third is core-funding of a proportion of hospital services, mainly those that have to be provided locally. The case for such funding is clearly strong for such services as accident and emergency treatment. How far it would go beyond such treatment would be a matter for pilot experiment and decision in the light of local factors (there could be important differences, for instance, between urban and rural areas). The DHSS paper suggests that on average some two-thirds of treatment might be financed in this way.

12. The fourth is the arrangements for GP referral of patients under the new contract-funding. If GPs are to retain their freedom to refer, a way must be found of reconciling it with proper control of expenditure. At present GPs have this freedom (although "receiving" districts and their consultants are increasingly reluctant to accept "out of area" referrals) and expenditure control is maintained by waiting lists. Assuming that districts consult their GPs properly, it ought to be possible for them to place contracts which cover the great majority of the referrals which are likely to take place; and the effectiveness of these arrangements would be reviewed and refined through experience in the annual budget-setting. But there will always be some referrals which fall outside the normal pattern, for which provision has to be made. The DHSS paper suggests that it would be possible to achieve this by requiring districts to maintain an uncommitted budget which would be used by GPs to pay for referrals not covered by a contract. It would be important for such an arrangement to have the confidence of the medical profession. Pilot schemes would be especially important in this case, perhaps testing out arrangements which involved GPs' own peers, a group of whom would scrutinise any exceptional level of referrals outside the district's contracts. The mechanism for influencing the decisions of GPs if they were not acting cost-effectively would need to be worked out.

CABINET OFFICE
22 July 1988

NHS REVIEW: FUNDING HOSPITALS

1. This paper sets out how a new approach to funding hospitals might work in practice, and how the present funding system might be changed over time. It does not cover the funding of family practitioner services or capital.

Funding Districts

2. Once fully in place, the new arrangements envisaged by Ministers for self-governing hospitals and greater competition imply a new basis for funding Districts. Each District will need a budget with which it is expected to provide or secure a comprehensive range of services for the population it serves. That budget will come ultimately from Government, and there will need to be agreed mechanisms:

* for deciding within the PES how much in total needs to be spent from public funds.

* for distribution between Districts. To the extent that Districts are charged with securing services for all the patients they serve, funding should in the main be related to population (subject to any necessary allowance for extra costs, such as for the number of elderly people). Whilst they remain directly responsible for the delivery of services, the money they get should also reflect performance. The level of privately funded expenditure might also be a consideration. Most, if not all, cross-boundary flows will be paid for directly.

* for reflecting unavoidable variations in the cost of providing services, notably the excess costs in London and the South East (which may well grow if Regional pay variation increases.)

* for any remaining central initiatives to reward performance, reduce waiting times or encourage new developments.

3. The present financial allocation system (briefly described at Appendix A) would require substantial change. To move overnight would mean that the majority of Districts would get significantly more or significantly less than at present. Without the new system in place there would be chaos, leading almost certainly to the need for substantial extra expenditure. We shall therefore need to manage carefully the process of change, working primarily through a regional tier which will need to co-ordinate each year's "normal" allocations to Districts with

* new developments in the funding of services to patients, of the kind discussed later in this paper, and

* the development of self-governing hospitals.

B:DC1823

F

4. These charges will need to be managed carefully and, at least in part, experimentally. A number of possible experiments are summarised in Appendix B, all of which - including those concerned with the phasing in of self-governing hospitals (experiments (4) and (5)) - would both inform and progress the changes needed. Legislation will be necessary to enable much of that experimental work to take place as well as to make some of the changes to the funding system which will be required. The outcome will be a system based essentially on

* primarily capitation-based allocations from the Department to Regions (or regional arms of the Department) and from Regions to Districts.

* performance-related contracts or management budgets between Districts on the one hand and their management units or self-governing hospitals on the other.

5. Ministers may wish to consider making two immediate changes during the interim period:

i. identifying specific sums (which to be effective would have to be seen as additional) to be allocated by Regions on the basis of a proven track record of efficiency or, as with the existing waiting list initiative, in order to encourage targeted improvements in efficiency or output. This approach would not necessarily form part of the longer-term system, and could be phased out as the new arrangements began to bite on efficiency and waiting times. If interim, specific funding is to be introduced as early as 1989-90 the recipients would have to be Districts, but the aim could be to move to including hospitals among the recipients as they become self-governing. In addition all health authorities would need sufficient additional resources to meet the costs of inflation and of general service pressures, notably from the elderly.

ii. dealing more expeditiously with cross-boundary flows. The evolution of the new funding arrangements proposed in this paper will itself steadily increase the proportion of cross-boundary flows which are paid for directly. For example, one of the experiments outlined in Appendix B would provide for every Region to move in this direction, specialty by specialty, in the field of elective surgery - where progress on cross-boundary flows is particularly important. In the meantime, it may be possible for neighbouring Regions to reach agreement to move immediately to direct payment for patient flows. As a first step the DHSS are examining now how quickly they can move to using patient flow data one rather than two years late.

Funding services to patients

6. Where the new funding arrangements will really "bite" is below District level, at the point of funding services to patients. For convenience, future funding arrangements at this level can be divided into three categories:

G

i. "core" funding for services which must be available locally because, for example, immediate accessibility is essential for emergency treatment.

ii. "contract" funding for services which could be subject to competition: these services could be provided locally but could instead be bought in partly or wholly from elsewhere (including the private sector).

iii. "tertiary" funding for services which are too specialised to be affordable in more than a few locations.

The services covered by these categories are described more fully in Appendix C.

Core" funding

7. The funding of "core" services will need to be arranged in a way which

* guarantees immediate availability, so that treatment is provided when it is needed without any question as to where the money is coming from.

* secures acceptable standards of performance in terms of quality and efficiency.

For the most part "core" services are not subject to waiting lists. There is therefore no need for their funding to provide incentives to greater activity.

8. The best approach at the start might therefore be

* budgets allocated by DHAs to each management unit, backed in each case by

* agreed performance targets which recognise past performance or aim to achieve significant future improvements.

The practical application of this approach would need to be tested by experiment.

9. For hospitals which became self-governing, these performance-related budgets would be turned into formal contracts. Some self-governing hospitals would need to hold such contracts with more than one District "buyer", replacing the present retrospective arrangements for funding cross-boundary flows.

10. The services which need to be provided locally and therefore funded in this way can be divided into five broad categories:

i. accident and emergency (A and E) departments.

ii. services for patients who need immediate admission to hospital from an A and E department, for example a significant proportion of general surgery and injury services.

B:DC1823

H

iii. services for other patients who need immediate admission, such as most general medicine and a substantial proportion of hospital geriatric and psychiatric services.

iv. out-patient and other support services which are needed in support of (i)-(iii), either on site or immediately available.

v. public health, community-based and other hospital services which need to be provided on a local basis as a matter of either policy (e.g. services for elderly and mentally ill people) or practicality (e.g. district nursing and health visiting).

"Contract" funding

11. "Contract" funding will apply to services which could be subject to competition and provided either locally or elsewhere. The funding of these services will need to be arranged in a way which

* offers patients and their GPs the maximum possible choice, including where relevant the possibility of trading off ease of access against length of waiting times.

* enables DHAs to look for the best "deals", for example in terms of cost and waiting times.

* frees hospitals to do more work as they become more efficient, but without risk to expenditure control.

* gives local GPs a significant voice in decisions by Districts as to where, and on what basis, Districts will fund treatment; and at the same time helps Districts to influence GP referral patterns where these are not necessarily making for the best use of hospital resources.

* preserves GPs' freedom of referral to their chosen specialist.

12. These objectives will not be easy to achieve, or to reconcile, in practice. It is not advisable to draw up a detailed national blueprint without experiment, and we cannot confidently predict how any particular solution will work in practice until we have tried it out.

13. Some of the experiments in Appendix B would be designed to assist this process, and these - or some equivalents - would be essential first steps. It would also be important to leave Districts with enough flexibility to adapt the outcome to their own circumstances. Subject to the outcome of pilot schemes, the main elements in "contract" funding will be:

* Districts would be free to enter into contracts with other Districts, with the private sector and, in due course, with self-governing hospitals for the provision of contract-funded services. These contracts would supplant current arrangements for funding cross-boundary flows in respect of those services.

I

* Each District would agree with its management units a performance-related budget for each of the relevant services. These budgets would secure the capacity needed

  a. for the District's own residents, to the extent that their treatment was not provided for in contracts with other Districts or the private sector; and

  b. to discharge the terms of any contracts to provide services to other Districts' residents.

  Self-governing hospitals would determine these budgets themselves. The aim of the budgets would be to anticipate future demand, including cross boundary flows, on the basis of past experience.

* Contracts and budgets would be reviewed annually. As "buyers", Districts would need to ensure that the hospitals concerned had fulfilled the performance targets in their contracts, were still offering better value for money than any alternative hospital, and were still providing the services required by their GPs (see below). In respect of non self governing hospitals, Districts would hold their hospitals to account for their performance and determine the following year's budgets in the light of their success. Budgets for each of a self-governing hospital's contract-funded services would be determined by their success in competition with other hospitals.

* Each "buying" District's contract or contracts for each service would be based on the referral patterns of each District's GPs and after consultation with them. The desirability of changing those patterns, on cost or quality grounds, would be subject to regular discussion with GPs. GPs - on behalf of their patients - would be able in this way to influence which consultants received bigger, or smaller, budgets. Districts would be able to ensure that GPs were fully informed about the relative cost-effectiveness, including waiting time, of alternative services; and would be free to try to persuade GPs to change their referral patterns in the interests of greater cost-effectiveness.

* Each District - again as "buyer" - would have a budget for in-year referrals which were not covered either by the budgets for its own hospitals or by a contract with other Districts and hospitals. This "GP budget", too, would be reviewed annually in the light of GPs' preferences, and could be either increased or decreased in the light of the performance of the hospitals with whom there were established contracts. The demands made by GPs on this budget would be subject to peer review, on an exception basis, to ensure that the money was not spent unnecessarily.

B:DC1823

14. Taken as a whole, the approach in paragraph 13 would enable budgets to be set in a way that reflects the past pattern of referrals whilst maintaining future GP freedom of referral. The system of annual budget review in particular would enable budgets to reflect what has happened to patients in the previous year and so take account of patient choice. Equally, it would mean that budgets were increasingly set on the basis of performance and practice, and not simply allocated from above.

15. The services which would need to be funded in this way can be divided into three broad categories:

i. those procedures or treatments which are currently provided in every District as part of the "core" services but which do not necessarily have to be carried out locally. These are in the main acute surgical operations such as varicose veins, hernias and hip operations which make up the bulk of waiting lists.

ii. services which are currently provided on a supra district basis, such as ear, nose and throat (ENT), ophthalmology and oral surgery, which some Districts will need to buy in.

iii. other services for which patients may wish to be able to exercise choice as to location and/or timing, for example some long-stay care for elderly people. (These services however raise some additional issues which are not addressed in this paper.)

16. The DHSS estimate that at any one time up to a third of all patients awaiting or receiving treatment could in principle be treated in another District. Many of these would be people needing elective surgery. These are typically routine - and relatively inexpensive - operations and would therefore represent a rather smaller proportion of an acute hospital's budget.

"Tertiary" funding

17. "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. Admission may or may not be required immediately. "Tertiary" services account for a small proportion of the average district's revenue budget, but are distributed very unevenly and are resource-intensive.

18. The funding of "tertiary" services will need to be arranged in a way which

* secures the availability of treatment for those who need it.

* maintains excellence and rewards efficiency.

* gives the referring consultant some choice where choice is practicable.

* avoids unnecessary duplication of these services.

B:DC1823

19. The ideal solution, and the one most consistent with Ministers' overall approach to funding, might be to have protected funding for the fixed costs of these specialist services, with marginal costs being met by the Districts or hospitals from which the referrals were made. In theory at least this would give specialist hospitals or units reasonable security of funding whilst injecting a degree of pricing into their use. But it would be important to be sure that the viability of such units was not undermined, and it may be that some at least would in practice need to be 100% funded by Regions or the Department. These are important and sensitive services, and it will be particularly important to test and explore the funding options fully.

Training and research

20. Funding arrangements along the lines suggested above will not of themselves meet the needs of

i. medical teaching (undergraduate and post-graduate), which involves both direct costs and significant indirect costs and might be squeezed out if not protected;

ii. nurse training and training for the paramedical professions - although the latter is split with further education sector and might be moved further in that direction;

iii. future development and research; or

iv. overseas visitors.

Separate arrangements will be needed to meet the service costs of these activities.

Promoting efficiency

21. The new funding arrangements outlined in paragraphs 7-19 above will have built-in incentives to greater efficiency. Both before and after they become self-governing, hospitals which are efficient and successful will be able to attract more income from their contract-based services - attracting money as they attract additional patients - and to expand. The less successful will lose business accordingly. Districts and self-governing hospitals will also be competing with each other and with the private sector for business from the private insurance market. Self-government for hospitals will maximise both the competitive pressures themselves and each hospital's ability to respond in an imaginative way.

22. In the short term Districts will need to give their management units increasingly performance-related budgets and, through the resource management initiative and other developments, to build up the capacity of each unit to run its business effectively. Specific, performance-related funding of the kind discussed in paragraph 5(i) would act as a further stimulus to improved efficiency during this period.

APPENDIX A

PRESENT ARRANGEMENTS FOR FUNDING

1. Under the present system:

   1. agreement is reached in the Survey on the total cash that is to be made available to health authorities, as well as on target levels for cost improvement programmes, income generation or income from private patient charges.

   2. the Department distribute the whole sum to Regions, who in turn make allocations to Districts.

   3. Districts give budgets to hospitals and units.

2. Allocations from the Department to Regions make use of the RAWP formula. The formula identifies target shares for each Region, taking account of population structure and morbidity, and allowing for cross-boundary flows. Because historically most Regions were significantly above or below their targets, a decision is needed annually on how far it is possible to distribute the available additional resources in favour of below target Regions. That decision is taken by Ministers, and turns crucially on the total amount of growth money available, and a view as to the minimum required by above target Regions. In 1988-89 that minimum was set at 0.7% compared to a growth figure of 1.2%. In cash terms the difference between Regions' shares is much less because provision for inflation and Review Body additions are distributed pro rata to baseline allocations. Specific sums are earmarked.

3. Regions' arrangements for distribution to Districts vary. Reliance on sub-Regional RAWP formulae has diminished in recent years, giving ground to the practice of allocating specific sums to enable planned service developments to go ahead. Again, the cash differences between District shares are much less.

4. Cross-boundary flows between Regions are taken into account in the RAWP formula, but the information is at least a year out of date. Regions may by agreement replace cross-country flows by a specific funded service contract. Arrangements within Regions for dealing with inter District flows are more varied, but in general are more likely to involve specific funding in order to provide for planned flows.

M

APPENDIX B

THE FUNDING AND ORGANISATION OF HOSPITAL SERVICES: EVOLUTION AND EXPERIMENT

Introduction

1. There is much to be done to assess as we go along what works and what does not, to identify the information and other requirements needed to make the funding system work, and to create a band of enthusiasts to encourage the wider process of change. At least three Regions have expressed interest in conducting pilots.

2. This note sketches out five possible experiments which might contribute to an evolutionary path from devolved management within the present organisational structure to a position in which hospitals are (a) self-governing and (b) operating within increasingly contractual and competitive disciplines. A specification for each experiment would need to be worked up in more detail before we could be sure of its viability.

3. The purpose of the experiments would be to test out, either separately or in combination:

(i) the operation of new funding arrangements;

(ii) the nature of self-government, and its impact on the hospital itself; and

(iii) the working of a competitive environment (in effect, (i) and (ii) in combination).

The experiments are themselves set out in a broadly evolutionary sequence, although they would not necessarily have to be mounted sequentially.

Possible experiments

Experiment (1): elective surgery, specialty by specialty
: all Regions, each at its own pace.

4. This experiment would develop and test trading in elective surgery, both between Districts and with the private sector. There need be no changes in the present organisational framework, and no self-governing hospitals. But close collaboration with FPCs and GPs would be essential, legislation would be needed to facilitate direct contractual relationships across District boundaries, and some adjustments to sub-Regional and perhaps Regional funding would be needed as cross-boundary flows were financed increasingly directly and at the

N

time. Each Region would select its own sequence of specialties. The aim would be to develop contractual relationships, exchange experience, and build District and unit expertise in the management of contracts.

Experiment (2): tertiary services
: all Regions, each at its own pace
: all postgraduate SHAs.

5. This experiment would develop and test alternative ways of funding specialist units, including postgraduate SHAs and tertiary referrals. It might explore the impact on specialist units of a shift in the balance between direct and contract-based funding. The conditions for this experiment would be similar to those for experiment (1). The aims would also be similar, but in more specialised areas and with an opportunity to explore the impact of a contract-based approach on already "self-governing" SHAs.

Experiment (3): a Region-wide "mixed economy"
: one Region (or possibly two contrasting Regions)

6. This experiment would also retain the present organisational framework, but would develop and test

* performance-based management budgets set by each DHA for its management units to cover "core" services.

* contracts between Districts and with the private sector for "contract-funded" services.

* GP budgets for "out of contract" referrals.

The conditions of the experiment would be similar to those for experiment (1), but with sub-Regional funding taking no account of cross-boundary flows except, perhaps, for "tertiary" services. Although there would be no "self-governing" hospitals, it would be important for the "provider" end of contracts to be managed as far as possible at unit level. The aim would be to establish a comprehensive "mixed economy" of devolved management and inter-District trading within one Region. The change in funding arrangements would force management to question whether services should be provided direct or bought in, and the impact of this would be assessed.

Experiment (4): self-governing hospitals.
: one Region or part-Region.

7. This experiment would establish "self-government" for a geographically-related group of hospitals. Legislation would be needed to set up boards of management which were able to employ staff, enter into contracts, and so on. The hospitals covered by the experiment would be accorded the full range of responsibilities envisaged for

self-governing hospitals, but would remain accountable to their "home" DHA on a limited, strategic basis and might have only limited freedom to sell their services to other Districts. The aim would be to test the internal consequences for the hospitals themselves, for example the management and other resources needed to make self-government "work"; the scope for self-government between and within current management units; and perhaps some of the implications for the functions of Districts and Regions.

Experiment (5): competitive self-governing hospitals.
: one Region (or possibly a large conurbation, eg London).

8. This experiment would establish a competitive market for self-governing hospitals, making the full range of funding and organisational changes over a sufficiently large geographical area for competition to work and be tested realistically. If the private sector were prepared to co-operate, the impact of competition with and among private hospitals might also be evaluated. Districts would continue either to provide direct or to buy in from elsewhere those services not provided by self-governing hospitals, and would hold substantial "core" contracts with self-governing DGHs. The aim would be to test the operation of all three of the elements in paragraph 3 above when working in combination.

Some general points

9. Important general points include:

(i) all five experiments assume that significant devolution from Districts to units - if not necessarily, say, the full implementation of the resource management initiative - will already have taken place.

(ii) all five experiments require at least some legislative cover (because legislation is needed for all three purposes summarised in paragraph 3).

(iii) there is nonetheless a quantum leap between experiments (1)-(3) on the one hand and (4)-(5) on the other, partly because more legislative cover is needed but mainly because experiments (4) and (5) might be effectively irreversible (for example because of the major changes required in conditions of employment). The Government would therefore need to be ready to commit itself to the main features of self-governing hospitals and the new funding arrangements before embarking on experiments (4) or (5).

(iv) experiments (1)-(3) would offer practical experience of the effects of trading on cross-boundary flow adjustments to

revenue allocations; but would not test the comprehensive changes implicit in a competitive "market".

(v) experiments (1)-(3) would nonetheless have a cost. All would need a reserve of money to ensure that they did not run out of steam or have unintended short term effects such as unwanted closures.

(vi) all five experiments would need very careful management by Regions, for example to ensure that experimental changes and sub-regional funding remained in step and that the experiments were adequately structured, managed, monitored and evaluated.

(vii) the choice of experiments assumes that it is not sensible to proceed on the basis that hospitals can simply "opt" into the new approach. (The funding arrangements imply a geographical market. Self-government implies privileges which could unnecessarily damage non-self governing, and therefore less advantaged, neighbours).

(viii) an experiment confined to teaching hospitals is not suggested, partly because of the reasons given at (vii) and partly because it would be resented by non-teaching hospitals who regard teaching hospitals as sufficiently privileged already.

APPENDIX C

"CORE" AND "CONTRACT-FUNDED" SERVICES

1. Under any revised funding arrangements district health authorities will need to ensure that their resident population continues to have access to a comprehensive range of "core" services. These are briefly summarised in paragraph 10 of the main paper. Within these core services there will however be some scope for health authorities to buy in certain procedures or treatments from another district if this offers a more effective or efficient use of resources. In addition, there are other acute services which are provided at present on a supra-district basis. Together these make up the services described in the main paper as "contract-funded".

2. This appendix concentrates on the "core" acute specialties; assesses the potential for buying in from outside the district some treatments covered by these specialties; and gives an indication of what proportion of an acute hospital's workload this might represent. By definition, there are no core acute services which can be wholly bought in from outside because all general acute hospitals will need the range of core services to support their central emergency functions. The scope for buying in specific treatments will vary from hospital to hospital and specialty to specialty. The greatest potential lies in the area of surgical specialties where the longest waiting times exist at present.

CORE DISTRICT SERVICES

Accident and emergency (A and E) services

3. By their very nature, A and E these services provide the "core" of a general acute hospital. They most commonly consist of an accident and emergency department supported by a range of general medical, surgical and diagnostic facilities. In any revised funding arrangement, an accident and emergency service will need to form an integral part of a package of local acute services. Depending on the nature and proximity of alternative facilities, there may however be scope for contracting out part of the service to a neighbouring hospital, particularly where a health authority finds it difficult to staff its "local" accident and emergency department round the clock. In practice this already happens in large conurbations where groups of hospitals in neighbouring districts pool their resources to provide a comprehensive emergency bed service.

Medical services

4. Medical services most commonly deal with conditions such as strokes, heart attacks, heart failure and pneumonia, often occurring in the elderly. The great bulk of treatment provided under this specialty is of an urgent nature requiring immediate attention as well as local

R

follow-up, including referral back to the patient's general practitioner. The scope for buying in part of the service from outside the district is therefore limited. In 1985, general medicine accounted for 17% of all acute admissions of which over 80% were admitted as emergency cases.

Surgical services

5. Surgical services cover a wide range of acute specialties and operative procedures, some of which do not require immediate treatment and could in principle be undertaken at a distance from home. Six surgical specialties (in order of magnitude: general surgery, orthopaedic, ear, nose and throat (ENT), gynaecology, ophthalmology and oral surgery) account for some 85% of all waiting lists. Of these, ENT, ophthalmology and oral surgery are not in fact core services and are already provided on a supra-district basis. A study of long waiting lists in West Midlands and Wales suggests that 46% of total waiting lists is accounted for by seven operations (varicose veins, hernia, hip replacements, arthroscopies, (operating on a joint), tonsils and adenoids, sterilisations and cataracts), none of which need necessarily be done in the "home" district. In practice, however, all surgical units would need to balance their emergency and elective services so as to maximise cost-effectiveness to meet teaching requirements, and to attract good quality staff. In 1985, surgical acute specialties as a whole accounted for 57% of all acute admissions.

Paediatrics

6. Like general medicine, the vast majority of paediatric admissions require urgent attention. In 1985, nearly 90% of all paediatric cases were admitted to hospital immediately. Paediatrics account for nearly 7% of acute hospital admissions. It needs to be provided locally not only because it is effectively an emergency service but also because of the need for parental access and support.

Maternity services

7. Maternity services need to be provided in association with acute medical, surgical and paediatric facilities to cover circumstances in which complications arise. Admission is normally immediate, but treatment is usually planned which makes maternity services more susceptible to contract-funding than other emergency services. Maternity services account for 6% of all health authority expenditure.

Priority care groups

8. Nearly a third of all health authority expenditure is accounted for by the priority care groups (the elderly, mentally ill, mentally handicapped and the physically disabled). This excludes the proportion of acute expenditure that is accounted for by elderly people. Current

S

policy is that districts should become self-sufficient in the provision of long-stay and acute support services for these groups. The creation of larger district health authorities should however encourage more competition in the provision of services, particularly for the long-stay population. There may also be greater scope for more private sector provision.

OTHER CONTRACT-FUNDED SERVICES

9. As indicated above, within the core district services there will be some scope for buying in certain treatments or procedures from other districts. In addition, there is a range of acute services which are currently provided on a supra-district basis and which, by definition, would be "contract-funded" under the proposed funding arrangements. These include cancer services, ENT, ophthalmology and oral surgery.

CONCLUSION

10. Any assessment of how much of an average district health authority's budget could be "contract-funded" is necessarily imprecise. Based on 1985 acute hospital admission figures, a quarter of all patients needing treatment had not been given a date for admission. In addition, 17% of the patients were on the "booked and planned" list, i.e. had been given a firm date but had not yet been admitted, and some of these patients will have been "non-urgent" in terms of representing an immediate call on local core services. On this basis, at any one time up to a third of all acute patients could in principle - if resources and alternative facilities were available - be treated elsewhere. These patients would be likely to represent rather less than a third of a district's acute service budget (some 46% of all HCHS spending) because the treatments they require are, in the main, relatively cheap.

NHS REVIEW

CAPITAL FOR HOSPITALS

1. The paper considers the capital arrangements for hospitals that would be needed to reflect and complement the new system for funding and managing hospitals.

2. The present capital allocation system is set out in the annex. It will need substantial change if it is to fit in with a system where hospitals are increasingly responsible and answerable for the services they provide under contract to one or more DHAs.

3. There are three areas of possible change:

first, greater delegation than now, within present structures.

second, taking proper control of the cost of capital.

third, clarifying the role of private finance.

Greater delegation

4. The aim would be to minimise the need for detailed resource management decisions to be taken at higher than operational levels. At the same time, it would be important to maintain the effective overall expenditure control and cost effective planned use of resources which has enabled the United Kingdom to avoid the oversupply or poorly distributed supply of services found in a number of other countries.

5. The first step would be more delegation from Regions to Districts, broadly within existing structures.

u

6. The second step would be delegation of more decisions to hospitals, when individual hospitals become able to cope with it. This delegation would be one of the stages towards self governing hospitals.

7. A number of measures would push decisions down to the operational level. They would however need to be subject to the competence of district/hospital managers in handling the correspondingly greater responsibilities, in particular in investment appraisal and professional expertise. The measures are:

* Higher delegated limits on allocation to districts for capital projects, either equipment or buildings. Because of the unevenness of capital expenditure, some pooling would remain necessary, unless the more radical changes outlined in para 11 below are implemented.

* Districts, and in turn, hospitals, given complete responsibility for the management of capital projects, once the decision to invest (whether delegated or not) had been taken. They could be encouraged to contract out project management to the private sector.

* Greater freedom to retain land and property sales receipts. At present these are pooled, so that the Region can use a part for developments elsewhere. Safeguards would be needed to ensure cost effective use of capital receipts

8. As the annex indicates, there are several flexibilities in the existing system which are intended to ease the management of the Programme: the ability of health authorities to retain the proceeds of land sales; a substantial virement facility between current and capital; the option of "brokerage" between regions and between districts; and the usual flexibility to carry forward up to 5% of capital underspending into the next year (which is currently under review). Nevertheless, as

V

a more entrepreneurial approach to management has taken root in the NHS over the last few years, some managers have argued that they need more flexibility. A particular point that has been raised is the scope to anticipate future land and property sales receipts. A number of examples have arisen where DHAs could rationalise services, with revenue savings, if they could anticipate the land sales income that would result, but cannot otherwise secure the capital to invest. The DHSS has proposed in the 1988 Public Expenditure Survey the creation of a special fund, for short-term borrowing, repayable in say 3 years, to enable authorities to overcome timing difficulties of this sort. DHSS and Treasury officials are examining how far the concerns of NHS managers can be met within existing arrangements, or whether changes to those arrangements are needed.

9. Given the present system for allocating funds to the hospital service, these measures are aimed primarily at districts. As indicated, however, and in keeping with the general thrust of delegation, some of them could be correspondingly applied to individual hospitals. In the longer term, as hospitals become self governing, this delegation and lifting of restrictions will be essential to secure the genuine autonomy which hospitals will need in order to compete and develop in new ways. Local control of capital would be a strong incentive for clinicians to become more effectively involved in management.

Taking proper account of the cost of capital

10. The major failing in the current arrangements is that capital can be regarded as a free good, because it does not have to be paid for out of revenue, notwithstanding the requirements for health authorities to undertake full investment appraisal of new projects. This biasses health authorities' decisions in two ways:

* in favour of "capital intensive" rather than "revenue intensive" projects despite cost appraisals;

W

* against projects involving the private sector, where capital costs have, of course, to be taken into account.

11. In principle the solution is to require Districts and in time self-governing hospitals to take both investment and service decisions on a basis which properly reflects the cost of capital. DHSs has already started a Capital and Asset Accounting initiative to evaluate the capital employed in the NHS. Given such information, one possibility is the creation of Management Accounts, which would put a notional book value on capital employed.

12. However DHSS is concerned that this would not be effective in reaching effective and transparent decisions, particularly where use of the private sector is concerned. DHSS and Treasury officials are therefore currently working to see whether a scheme can be devised for charging health authorities (and later self governing hospitals) for the use of the capital assets they employ on a basis which would provide the necessary incentive structure. This would need to be subject to overall expenditure limits as at present.

13. A paper setting out recommendations will be put to Ministers in September.

Private sector finance

14. As in other sectors there are increasing opportunities for the use of private finance in health care. Interest in this area is likely to increase under a more delegated system, and as cooperation opportunities between the public and private sectors are extended.

15. Some of the measures identified in paras 7 and 8, by increasing the opportunities for Districts to obtain publicly-funded capital, would probably take the edge off their appetite for private finance, but would

not be likely to remove it. Many new Chairmen and general managers argue that they should be free to borrow, but there are major problems with this, notably the scope it would provide for creative accounting and the probability that health authority paper would command significantly less favourable terms in the market than conventional central government borrowing. They are also keen to enter into partnership schemes involving the use of private capital, or to lease; these approaches do not raise difficulties of principle.

16. Such schemes are likely to involve unconventional finance. As such they are acceptable so long as they offer the best value for money to the tax payer and are not used simply as a means of getting around public expenditure controls. the discussions noted in paragraph 12 will address the precise application of these principles to health authorities.

Conclusions

17. Ministers are invited to:-

* Agree that further work be done on the greater delegation and flexibility set out in paras 7 and 8;

* note that a further paper on charging for capital and access to private sector finance will be put to them in September.

D4.5/7

4

ANNEX

The present capital allocation system

1. Capital is distributed to Regions on the basis of population projections 5 years ahead. No account is taken of cross boundary flows and an adjustment to reflect disparities between the value of Regions' inherited capital stock is being phased out. The allocations do not take account of the extent to which Regions are able to supplement their funds through land sales (see para 3). Regions have flexibility to vire up to 1 per cent of revenue to capital or 10 per cent of capital to revenue in any one year.

2. Regions formulate capital expenditure plans and allocate resources to Districts. Arrangements vary, but Regions generally allocate a proportion of their capital to Disticts for "small schemes", and manage the remainder regionally for major schemes. Capital programmes are submitted to the Department for approval as part of Regional Strategic Plans and Short Term Programmes, are subject to formal option appraisal requirements and are monitored through the planning and accountability review system. A very few schemes are funded by topslicing from the Department.

3. Regions supplement their Exchequer allocations with proceeds from the sale of surplus land and property. Retention of these proceeds for reinvestment in services provides an important incentive to the estate rationalisation process. Wide variations in land values across the country result in substantial disparities in Regions' ability to supplement their allocations by this means. On the other hand higher land sales receipts broadly correspond to areas of high land and construction costs.

4. Health authorities have no powers to borrow to finance capital development. Their use of capital from external sources must also conform to the general Government groundrules concerning the use of unconventional finance.

2 D

HC 36

CONSULTANTS

Note by the Secretary of State for Social Services

1. Annexed to this note is a paper which sets out in detail my proposals for change in three key areas:

* the employment and management of consultants
* distinction awards
* additional consultant posts.

Main package

2. The main package of changes concern employment and management and distinction awards. Here I propose that:

* every consultant - including, crucially, maximum part-time consultants - should have a clear and precise job description. This would cover management as well as clinical commitments, would be reviewed annually, would be managed by the District, and would be the basis on which the consultant's performance is monitored.

* we should introduce a range of measures which make it easier, if necessary, to dismiss consultants or to move them from one job to another.

* we should reform the distinction awards system, whilst leaving unaffected the current entitlements of existing award-holders.

3. I do not now think we should introduce a new, short-term contract for new consultants. In practice it would not add substantially to management's ability to manage a consultant's work. It would take a long time to take full effect. It would be fiercely resisted by the profession, out of proportion to the likely gain. And it would be difficult to justify publicly (and certainly impossible to negotiate) without a cumulatively expensive increase in pay to compensate for any reduction in job security.

4. The package outlined in paragraph 2 would itself be resisted by the profession, parts of it strongly so. But I believe it would constitute a publicly defensible - even welcome - removal of unjustified privileges. That makes it the more important not to risk jeopardising public support by including changes which would be less easy to defend. This part of the White Paper will need to be drafted with particular care: we shall need to stimulate public support but also to leave ourselves room to negotiate.

AA

Additional consultant posts

5. I do not believe that we should commit ourselves to any specific increase in consultant numbers, not least because the cost-effectiveness of every additional post must be subjected to careful scrutiny. But there is undoubtedly scope for such expansion, and I propose that we consider introducing a new, centrally funded scheme closely dovetailed with any scheme directed at reducing waiting times. This should be welcome to the profession and would help us to portray the outcome of the review as a balanced package, with "carrots" as well as "sticks".

July 1988

BB

CONSULTANTS

1. This paper seeks to take forward the Group's discussion of three related issues: the employment and management of consultants; distinction awards; and the need for additional consultant posts.

A. EMPLOYMENT AND MANAGEMENT

Managed contracts

2. The main weaknesses of present arrangements are that consultants' duties are often not clearly defined, so that there are no clear criteria against which to monitor what they do; and that managers find it difficult to make desirable change in the pattern and location of services. Our minimum objective for the management of existing, as well as new, consultants should be to tackle these weaknesses.

Defined duties

3. The present contractual basis for the employment and management of consultants is summarised in Appendix A. The exact terms of each individual contract vary, but the model contract which has been negotiated nationally already includes two provisions which can help deal with the weaknesses described in paragraph 2:

i. It provides for the insertion into each consultant's contract of a job description, or provision for some modest local mobility, or anything else which the health authority and the consultant agree should be included.

ii. It specifies, in effect, that the job is reviewable by agreement between the authority and the consultant. (Any consultant who refused to accept changes could be dismissed, and the dismissal would be likely to be upheld as "fair" if the authority was held to be acting reasonably and the consultant unreasonably.)

4. The problem lies in the way in which the model contract has been applied in practice. In particular:

* precise, detailed job descriptions are exceptional.

* whether precise or not, job descriptions are only rarely incorporated expressly into the contract.

* there is no general expectation that the content of a consultant's job should be kept under review.

* cumbersome disciplinary procedures surround dismissal for unreasonable refusal to accept a changed job.

5. With the partial exception of disciplinary procedures, these problems could be tackled within the terms of the present model contract by ensuring that each consultant's contract expressly included:

cc

i. a detailed job description, with a weekly timetable, to be reviewed annually and changed by agreement.

ii. a "protocol", or series of "protocols", also reviewable annually and covering at least

- a requirement to participate in medical audit; and
- managerial commitments, such as involvement in setting budgets and determining priorities, and accountability for the use of resources.

6. Local management would need to discuss and agree with each consultant the substance of his or her job description and related documents. At least some local resistance would be likely, and success would be more assured if we were able to agree with the profession nationally both the principles to be applied and a suitable national framework for job descriptions and "protocols". I suggest that this is what we aim to do, taking care to ensure that such discussions do not become stalled.

Discipline and mobility

7. In addition to securing better defined duties, we need also to ease the problems involved in moving consultants from one job to another and, partly to that end, to streamline the present, cumbersome disciplinary procedures.

8. Current disciplinary procedures are laid down partly in consultants' national terms and conditions of service and partly by long-established custom and practice. As such they effectively constitute part of each consultant's contract. Discussions already under way with the profession should result in agreement to introduce for the first time an acceptable procedure for handling misconduct short of that leading to dismissal, together with some improvements to existing procedures for dealing with dismissals. But the profession have strongly opposed the suggestion that we should remove the right of a dismissed consultant to appeal to the Secretary of State against his dismissal.

9. This right is a major disincentive to dismissing a consultant. It applies to redundancy as well as misconduct; it is peculiar to consultants; it does not replace any other rights under NHS conditions of service or employment protection legislation; and it can be a very protracted process. On the other hand the profession can argue, with some justification, that it is exceptionally difficult for a consultant dismissed from his NHS post to find alternative employment as a doctor elsewhere.

10. In my view our minimum objective should be to secure a time limit for these appeals. The current discussions with the profession offer a good prospect of agreeing to an upper limit of nine months in which to complete an appeal following dismissal. After this period, if the dismissal was

DD

confirmed, the consultant would lose his right to be paid. I believe this would suffice as a way of making managers less disinclined to dismiss a consultant, or to make him redundant, where necessary. But we might also seek to secure the profession's agreement to excluding redundancy from the current right of appeal provision; this would no doubt be difficult to negotiate - because of the scope for managers to "create" a redundancy - and I do not regard it as critically necessary.

11. In addition, as further support to greater flexibility and mobility, I propose to

* negotiate changes to the Appointment of Consultants Regulations to aid relocation (as well as to provide for general managers to be members of appointments committees).

* enable health authorities to offer locally negotiated financial incentives to move posts.

A package of changes

12. Taken as a whole, the package of changes outlined so far in this paper would enable management properly to manage consultants and their contracts for the first time. As such it is historically radical, and would be regarded as such by the profession. It should be negotiable, although not easily so. I do not think we can or should attempt to put a specific "price" on it, but in industrial relations terms we must recognise that it would have a cost. I believe we should be ready to indicate to the pay Review Body that agreement by the profession to the package would provide an opportunity to be more generous in the relevant review.

13. The implications of the package also enable us to think differently about three other aspects of the employment and management of consultants which we have previously discussed: short-term contracts; the location of contracts; and maximum part-time contracts.

Short-term contracts

14. Colleagues wished to consider further the introduction of a new, short-term rolling contract for new consultants. The main practical advantage would be to maximise consultants' mobility. In particular, their right of appeal to the Secretary of State would effectively lapse. But there are also disadvantages:

* the profession would argue fiercely that the relative insecurity of such contracts is inconsistent with the NHS being virtually a monopoly employer.

* as the new arrangements would apply only to new consultants, it would be many years before the change fed through the system completely. Yet confining short-term contracts to new consultants would not avert a major confrontation with the profession.

* whether the new arrangements were negotiated or imposed, it would be difficult to justify introducing short-term contracts without a significant increase in pay. On the assumptions given

EE

in my earlier paper (HC29) - and assuming the present number of consultants - the cost would be about £7 million in year 1, with similar cumulative increases in subsequent years rising to about £100 million after 15 years and £135 million when fully implemented. (The cost could rise more quickly to the extent that the new contract proved attractive to, and was taken up by, existing consultants.)

15. A further consideration is that, unless they had waived their rights to do so, consultants whose contracts were not renewed would still be able to claim the protection of employment protection legislation as if they had been dismissed. But if they did waive them their case for substantial compensation for loss of security would be that much stronger.

16. Two other, more general issues bear on the question whether we should introduce a new contract for future consultants:

* as Sir Roy Griffiths has argued, we must be careful not to weaken our ability to enforce the existing contract by implying that it is inadequate.

* it could set a difficult precedent for our current post-White Paper negotiations with GPs, who might see it as a way of enabling existing contractors to avoid changes they dislike.

17. I conclude that, since the package of changes I have already proposed gives managers the tools to manage, we should not pursue short-term contracts for new consultants. The inevitably fierce resistance of the profession could easily jeopardise the progress we need to make elsewhere, and the gains would be limited, long-term and expensive.

Location of contracts

18. Tighter management of contracts can be achieved sensibly only at local level. As we have discussed before this would seem to argue for moving contracts to Districts, which would indeed be seen as a signal of the Government's determination that local management should be free to manage.

19. Nonetheless, assuming for the moment that we decide to retain Regional Health Authorities for other purposes, I believe we should keep contracts formally at Regional level. Moving contracts to Districts would if anything make it more difficult to move consultants from one post to another. It could be imposed without negotiation, but would require secondary legislation preceded by consultation with relevant bodies; and the profession would contest the change strongly. In my judgement this would be a quite unnecessary row if we specify clearly Districts' responsibility and authority to manage contracts on the basis set out in this paper. I suggest that this is the approach we adopt.

Maximum part-time contracts

20. At our last meeting we discussed the need to secure a closer match between the salaries of "maximum part-time" consultants and the proportion of their time devoted to NHS work.

21. The current position is as follows:

RF

* whole-time consultants (48% of the total) are free to undertake private practice, but the income from this must not exceed 10% of salary.

* maximum part-time consultants (32% of the total) are paid 10/11ths of a whole-time salary and are free to undertake unlimited private practice. Under their terms of service they are expected, like whole-time consultants, to devote "substantially the whole" of their professional time to their duties in the NHS - in effect to provide 24-hour cover.

22. There is concern that some maximum part-timers are not devoting sufficient time to their NHS duties, and that 10/11ths of the whole-time salary is an unjustifiably high proportion. We could respond to this concern either by paying them less or by ensuring that they all put in the work they are paid for.

23. I do not recommend reducing the 10/11th proportion of salary to a lower figure, for the following reasons:

* it would be difficult or impossible to negotiate for existing consultants.

* those consultants who are honouring fully their 24-hour commitment - or would in the future have done so - would feel justified in doing less.

* it would tend to act against our wish to encourage more doctors to go into hospital medicine (whether in public or private practice).

* it might tend to encourage the kind of segregation between the public and private sectors which are trying to break down.

24. I suggest instead that we build on our proposals for managing the contract and thereby ensuring that every consultant's duties are clear and commensurate with their salary. For maximum part-timers we could do this in one of two ways:

i. by retaining the 10/11ths contract but ensuring that each consultant's job description provided for the required work commitment (including a 24-hour commitment to his or her patients).

ii. by merging the whole-time and maximum part-time contract offering all maximum part-timers whole-time contracts, with suitable job descriptions; and removing the 10% limit on the amount of private practice which whole-time consultants can undertake. This would recognise the fact that there is no substantial difference between what is expected of whole-time and maximum part-time consultants, and it could prove a useful bargaining counter in negotiations with the profession. But it would cost money - about £17-18 million if all maximum part-timers took the whole-time option.

25. Option (ii) is attractively logical, and may be worth considering in the longer term. But it would be an expensive and potentially disruptive change. Option (i) is achievable and meets our objectives. I recommend that we adopt it.

B. DISTINCTION AWARDS

26. We agreed at our last meeting that action was needed to reform the distinction awards system, but that we should consider further whether such reforms should apply only to new consultants and/or new award-holders.

27. I see the main objectives of any reforms as being

* to ensure that distinction awards are an effective incentive to future performance as well as a reward for past performance.

* to widen the criteria for awards to include the consultant's contribution to the management and development of the service.

* to include a stronger management voice in the awards process.

* to ensure that new awards are not given just before retirement.

28. A background note on distinction awards is at Appendix B. The right to receive an award once recommended by the Advisory Committee on Distinction Awards is laid down in consultants' terms and conditions of service and, as such, constitutes part of each consultant's contract. Changes to the system of distinction awards would require negotiations with the profession. The difficulty of these negotiations would depend on the precise detail of the proposals, but in general the profession regard this as a highly sensitive issue.

29. In view of these difficulties, I suggest that we should be prepared to limit to new award holders (including those moving from one level of award to the next) one of the changes proposed in my last paper, namely

* making awards reviewable after, say, 5 years.

This will not avoid the need for negotiation, but it should make the change easier to negotiate. The two other changes I proposed apply only to the holders of new or increased awards anyway, namely

* widening the criteria for awards beyond just clinical excellence, and
* changing the awards process, including the composition of the committees which make the recommendations, to inject a stronger management voice.

And to these reforms I suggest we add another in the light of our last discussion:

* giving new or increased awards only where the recipient completes at least three years' further service.

HH

30. This package would leave unaffected the current entitlements of existing award-holders. But I believe it should be applied to new or increased awards to existing as well as new consultants, and that we should impose the changes concerned if negotiations fail. Even then, as I explained in my last paper, it will take about 6-7 years for 50% of consultants with awards to be on the new system, with full implementation taking perhaps 15 years.

C. ADDITIONAL CONSULTANT POSTS

31. The Group wished to consider further feasibility, and likely cost, of setting up an additional 200-400 consultant posts in the acute specialties.

Feasibility

32. Over the last 10 years the annual growth rate in consultant posts has been about 2%, or 300 posts a year. In the very short term some additional consultant posts could be filled by "time-expired" senior registrars (SRs) - doctors who have already completed training and are waiting for a consultant post. Among the major acute specialties this would apply to any significant extent only in general medicine and general surgery. A further expansion in the supply would be possible if employers (and their professional advisers) were prepared to accept candidates with only three years' training at SR level instead of the usual four. Beyond this, expansion in the supply would require an increase in the number of SR posts; this would take 3-4 years at the earliest to have any impact.

33. The table below summarises the additional supply which would be possible on this basis in the short and medium term in the five main "waiting list" specialties:

Potential additions to supply

	within 1 year	within 4 years
General surgery	75	125
Trauma and orthopaedic surgery	30	65
Ear, nose and throat (ENT) surgery	5	20
Ophthalmology	10	30
Obstetrics & gynaecology	10	50
	130	290

34. Whatever the number of training posts, supply could falter if the current fall in popularity of hospital medicine relative to general practice were to continue. But this is likely to be a significant factor only for ENT surgery and possibly also obstetrics, and the trend could easily be

II

reversed if career prospects in surgical specialties were seen to be improving so dramatically. There would be a reasonable prospect of making good any shortfalls by increasing the inflow of doctors from the EC (where there is a surplus).

35. The required boost to consultant expansion could be achieved by a new central funding initiative. Health authorities could be invited to submit bids for new consultant posts, supported by estimates of the additional output expected. In a recent pump-priming scheme a modest contribution from central funds (£15,000 a year plus salary) was sufficient to enable 100 new posts to be set up over two years in three acute specialties, but there have been many complaints that the £15,000 was inadequate and that the extra on-costs falling on authorities - equipment, theatre time, nursing and other support - delayed other worthwhile service developments. Key features of a new scheme, learning from the experience of the previous one, might be:

* the range of specialties allowed could be extended to include all acute medical and surgical specialties and support specialties such as anaesthetics, pathology and radiology.

* the sum available for each post (in addition to salary costs) would not be fixed in advance. Instead, authorities' bids would detail the on-costs for which they were seeking central support. The most cost-effective proposals would be selected.

* the total sum available (rather than the number of posts "on offer") would be fixed.

Costs

36. The average levels of current expenditure per consultant within the NHS is considerably in excess of £500,000. This average figure gives a misleading indication of the likely costs incurred from modest expansions of consultant numbers, given the existence of some fixed costs and areas of spare capacity. Costs will also depend on whether an additional consultant is appointed to begin a new service or to expand an existing one. The actual on-costs of an additional consultant appointment probably lie in the range £100,000 to £350,000, depending on specialty.

37. There are also staffing implications. In very broad terms each additional consultant post in acute specialties might be expected to generate up to 20-25 additional posts, the majority of which would be nursing staff. Given the current supply situation and the additional demands associated with Project 2000, it must be extremely doubtful whether the recruitment of nurses on the scale required for, say, 400 new consultant posts would be feasible.

38. On the basis described here the on-costs of appointing every 100 additional consultants could range from £10 million to £35 million, in addition to salary costs of around £3 million. To the extent that these costs were not met from additional funds any expansion above current plans would have to be financed at the expense of other priorities. Leaving aside the availability of nurse manpower, the question remains whether additional consultant appointments would represent the most effective use of these sums. The answer will vary between Districts and specialties: in some, the availability of consultant sessions may well be the constraint which is

JJ

limiting output; elsewhere the money might be better used to fund the full costs of existing consultant posts or to finance deals with the private sector.

Conclusion

39. I propose that

* we do not commit ourselves to any specific increase in consultant numbers.

* in the light of other work on central funding, and in particular on a possible successor to the current waiting lists initiative, we consider introducing a new central funding scheme - closely dovetailed with any scheme directed at waiting times - along the lines set out in paragraph 35 above,

* we determine in the usual way the funds to be put into such a scheme.

KK

APPENDIX A

MODEL CONTRACT

1. The present model contract for consultants was negotiated nationally in 1979 and came into effect on 1 January 1980. Health authorities are not legally obliged to use the model contract but in practice are expected to do so.

2. The model contract includes a number of items which are standard to most contracts of employment, such as arrangements for pay, superannuation and notice; and some which are specific to doctors, such as a requirement to be fully registered with the General Medical Council and to be a member of a professional defence organisation. It states that the appointment is subject to the national Terms and Conditions of Services for Hospital Medical and Dental Staff, and refers briefly to the relevant disciplinary and appeals procedures.

3. The contract contains details of the duties assigned, including:

- diagnosis and treatment of patients at specified hospitals, health centres and clinics.

- continuing clinical responsibility for patients in the consultant's charge (subject to proper delegation).

There is space for the health authority to include other duties which are not specified in the model, and the paragraph concludes by stating that the duties and the places where they are to be carried out may be varied by agreement between the Authority and the consultant.

4. There is also a nationally recommended form of job description, but this is for advertising purposes only and does not form part of the contract itself. But there is nothing to prevent a health authority, with the agreement of the consultant concerned, from including a reference to a job description in the contract itself. In practice this is unlikely to happen at present because of opposition from the profession.

LL

APPENDIX B

DISTINCTION AWARDS

1. Distinction awards were introduced at the start of the NHS in 1948, as a result of the recommendations of the Spens Committee. The Spens Committee concluded :

- that the wide diversity of ability and effort amongst specialists made it impossible to recommend single simple scales of pay that could be applied to all;

- that if the recruitment to, and status of specialist practice was to be maintained specialists must be able to feel that more than ordinary ability and effort received adequate reward;

- that a "significant minority" of specialists should have the opportunity of earning a salary comparable with the highest which can be earned in other professions.

The Spens Committee recommended that a predominantly professional committee should select "individual specialists whose outstanding distinction merits additional reward".

2. The Royal Commission on Doctors' and Dentists' Remuneration in 1960 and the Royal Commission on the NHS in 1979 both examined the distinction award system and judged that it performed a useful purpose commenting, for example, that "some considerable differentiation of income amongst consultants is necessary in order that good work may be encouraged and rewarded and that there may be a spread of income amongst consultants comparable to that in other professions". Although there have been some changes over the years (such as the extension of awards to community physicians), the system is substantially the same as that recommended in 1948.

3. A distinction award takes the form of a superannuable increase in salary at one of four levels which, once awarded, remains payable until retirement. An independent Advisory Committee on Distinction Awards makes annual recommendations about new recipients: apart from the Vice Chairman, this is a professional body which takes advice from many professional sources and Regional Health Authority Chairman.

4. The are some 3900 C awards (£6,260), 1700 B awards (£14,200), 700 A awards (£24,850) and less than 200 A+ awards (£33,720). The normal pattern is for progression through the levels of award, but few can expect to get beyond the lower levels. Consultants are normally appointed in their mid-30s, and as a result very few awards are made before the age of 40. Hence:

MM

* the average age for a C award is 49 years, with the majority of awards being made between 41 and 55, and very few going to those over 60.

* the average age for receipt of a B award is 52, with a majority of awards going to those between the ages of 47 and 59.

* with A awards there is a fairly even distribution between the age of 50 and the early 60s, with the average age of 56 years.

* with A+ awards, the average age of receipt is 59 years, with most of them being given to consultants in their mid-50s to early 60s.

In 1987, in England and Wales, 88 new and increased awards were made to consultants in the 60-65 age group, some 10% of the total number of awards made in that year.

5. 35.6% of consultants have distinction awards, but the percentage of award holders varies between specialties. The specialties with the lowest and highest proportions of award holders tend to be those with the smallest number of doctors in them. Of the specialties with a large number of doctors in them, the proportion of award holders varies from 49.8% in general surgery and 48% in general medicine to 22.1% in geriatrics, 29.1% in anaesthetics and 32.2% in mental illness. These last three are all "growth specialties" where the number of consultants has grown at a much higher rate over the last few years than in other specialties and consultants tend to have had less service in the grade. It is therefore not surprising that they should have a lower proportion of awards, and we would expect that proportion to increase substantially in future years.