Perspectives in NHS Management

Learning to live with cash limits—and other financial matters

GORDON GREENSHIELDS

Many of the most contentious issues in health care finance stem from cash limits—the maximum amount of cash that a health authority is allowed to spend in any financial year. This limit on the amount of money available to spend on health care in a district, region, or nationally is not new. Cash limits were introduced in 1976 but have been applied with increasing vigour in recent years. This restriction means that choices and decisions over competing needs and demands have to be made by clinicians, managers (a better word than administrators), and members of health authorities.

Whether cash limits should be applied to health care with their consequent rationing effect is and probably will remain a political decision. Nevertheless, so long as health care is a political football patients are potential losers in the game of cash limits. We must, however, live in the real world, where the costs of medical care dictate that there will be limitations on resources, limitations that will probably continue for the foreseeable future. Thus pragmatism dictates that we should spend more time and effort as managers trying to maximise the service to patients from present resources and less on complaining to all and sundry how difficult it all is. At the end of the day actions speak louder than words.

An important distinction in the allocation of NHS resources lies in the way that money is allocated by parliament between the hospital and community and the family practitioner services. Different rules pertain: for the former, strict cash limits are applied; but family practitioner services have an open ended budget—that is, there are no cash limits. This point came home rather forcibly last July when the hospital and community funds were reduced by 1% as part of the public expenditure cuts and originally we were led to believe that this was due to the likely level of overspending on the family practitioner services.¹ Paradoxically, however, despite cash limits the hospital service has maintained its proportion of the total NHS budget at around 62% of total expenditure. Nevertheless, these different funding rules cause problems and fuel accusations on lack of efficiency and effectiveness between the two factions, a position I believe could deteriorate if family practitioner committees become more independent. Indeed, this division may increase overall NHS expenditure if health authorities introduce policies to transfer responsibility for prescribing drugs, etc, from hospitals to family practitioners as part of their continual quest to reduce costs to enable them to live within their cash limits. It seems unproductive for this type of activity to continue as the patient does not necessarily benefit.

The Department of Health and Social Security has recently commissioned management consultants to investigate the possibility of applying cash limits to family practitioner services, and if press reports are to be believed the investigators doubt the practicability of their applying limits in this particular case. Looking into my crystal ball, however, I would be surprised if some form of spending restraint on family practitioner services is not introduced in the next five years or so; indeed, the Secretary of State has recently given advance warning of a government green paper on these services.

Value for money

Resource constraints have intensified the quest for more efficiency in both clinical and non-clinical areas: they will continue to do so as government pressure mounts for cost improvement programmes and reductions in staff numbers. The in phrase in the public sector is “value for money”—probably best defined as being the three Es—economy, efficiency, and effectiveness (see box).

- *Economy*—The practice by management of the virtues of thrift and good housekeeping; an economical entity acquires resources in appropriate quantity and quality at the lowest cost possible.
- *Efficiency*—Ensuring that the maximum useful output is achieved from the resources applied to each activity or, alternatively, that only the minimum level of energy and work is used to achieve a given level of output.
- *Effectiveness*—Ensuring that the output from any given activity is achieving the desired result.

Value for money is not necessarily about the cheapest in cost terms; it is about costs, but also very much about benefits and quality. It is vital, therefore, that there should be a practical dialogue with clinicians on value for money in investigation and treatment to ensure that available resources are being used to the maximum advantage of all patients. Financial pressures mean that great emphasis is now placed on performance and in the development of performance indicators. The DHSS has published volumes of these figures, but at local level it has been found relatively easy for clinicians to discredit many of them, often leading to genuine discrepancies in clinical practices being ignored due to the general criticism. These performance indicators must be seen for what they are—comparative, broad brush statistics that at best suggest areas where more intensive investigation is required to see whether a problem really exists.

North Western Regional Health Authority, Gateway House, Piccadilly South, Manchester M60 7LP

GORDON GREENSHIELDS, MLITT, IPFA, regional treasurer

They provide a trigger mechanism that requires the help of clinicians not only to improve their applicability and robustness, but also to look behind the figures at the problem areas highlighted.

My personal preference would be to develop information systems that compare actual resources committed against those expected to be deployed, based on the case mix of patients being treated. This should provide the basis for the most relevant information being available to all levels of management, starting at the potentially most important one—the clinicians.

Clinical budgeting and costing

I support the growing demands for clinicians to be more concerned in the management of the NHS and the introduction of clinical budgeting. Increasingly, doctors want to know how much they spend, what resources they have committed, what cost improvements they could make, etc. Treasurers must ensure that these demands are acted on and that clinicians receive a proper financial management service. Finance staff must not be sycophants but respected financial advisers to clinicians, and I believe that most treasurers are willing and able to introduce this concept in a reasonable time scale—but some pressure from the “users” would do no harm.

There is little doubt in most people’s minds that the present method of costing in the NHS leaves much to be desired as it is based on costing categorised hospitals over various headings. While it may give some useful information on the non-clinical aspects of hospital costs, it does little to provide adequate clinical related information. The Körner committee, which has been examining the information needs of the NHS, has recommended that in relation to financial information in future the costs of specialties should be calculated as this will provide better management information on which to base decisions. Also, if clinical budgeting is to be introduced this is a useful base to develop from. If this approach is to be useful, however, there must be a proper breakdown of specialties with significant subspecialties to ensure that in any comparisons we are comparing like with like. I hope that the minimum data set of specialties recommended is not too small, although authorities can provide more detail locally if they consider it appropriate. Clinicians have a positive role to play in ensuring that the specialty breakdown provided within their district meets their needs as managers and budget holders.

While I accept that specialty costing is the best direction for the short term, I believe that there should be development of patient related financial systems integrated with the patient information systems. This would provide the greatest flexibility in applying the basic information—that is, an ideal data building brick from which you would be able to provide relevant information to all levels of management in the NHS structure. From this basic level specialty costs could be developed that allow for case mix, disease costing, case mix clinical budgets, better information for planning, patient costing, etc. I do not believe that the costs of development would be large as most of the information will, in all probability, be available as the by-product of other systems now being developed, and, looking at the potential benefits to managers, I believe this approach to be cost effective.

Redistribution of resources: geographical and care groups

The redistribution of resources has provoked arguments for several years and needs to be viewed from both a geographical and a care group aspect. Geographical redistribution between regions is really the battle of the Thames regions versus the rest, as London is comparatively overprovided in terms of health care. It would be easy to criticise the pace of change but I shall resist the temptation and look to the future. Current government

policy is that by the end of 1993 all regions should be on or about the Resource Allocation Working Party revenue targets—that is, all regions would be receiving their fair share of the revenue resources available, calculated on a population based formula.² This is, however, a comparative exercise that in no way assesses the funds needed to meet the health care needs of the population either locally or nationally.

Given the size of the regional allocations, we can accept a target being set without too much future debate on the detailed methodology of the present formula, though in parts it is applied with a broad brush. When this formula is applied subregionally, however, it may lead to all sorts of anomalies and problems due to the smaller amounts entailed and their consequent impact in terms of end result. Indeed, most regions have a continuing demand from districts to adopt, adapt, and improve various aspects of their regional Resource Allocation Working Party formula. Perhaps the main problem to be overcome if this is used as an allocation methodology is how to integrate it with the planning system. Many regions now seem to be developing revenue allocation approaches based on funding the agreed district plans rather than using a Resource Allocation Working Party basis in an attempt to overcome this problem. This has the benefit of putting agreed health care aims first and the fair allocation of the available funds to support them as a follow on, which seems to be the correct sequence. This approach also provides a fairer basis for distribution of resources by allowing for the levels of health care to be provided and the levels of efficiency to be achieved by districts in that provision.

Almost every region suffers from a geographical imbalance of resources between districts, a distortion often complicated by a further imbalance between care groups. This is especially true of inner city authorities, who may be above or on their revenue allocation target but deficient in mental illness and mental handicap services, etc. It is imperative, therefore, that we at least give careful attention to the means of achieving the desired end result of equal access to health care for all. It is vital that planning is on a realistic basis to ensure that health care plans are achievable. If they are not this not only discredits planning and management but leads to expectations from clinicians and patients that cannot be met. This would be in no one’s interests.

In reality the process of achieving equality is difficult and fraught with problems. In some instances where health care imbalances have to be corrected it is often necessary in the interests of achieving an overall benefit for above or on target districts to lose money and overprovided health care facilities to fund new developments in other districts in the short term, with their own imbalances being corrected in the medium or long term. This seemingly illogical—to the losing districts—approach is necessary to correct the worst imbalances in health care provision within regions as quickly as possible. This often leads to arguments about present locations of capital stock and whether districts should be self sufficient. In the present financial climate we must be sure that all resources are being used to achieve the greatest value for money. Part of that exercise must be to maximise the return from present investment in building stock, a policy that may lead to some district services being provided on behalf of other districts in many instances. This may be unfortunate but is a short to medium term necessity. When present capital stock requires replacing, however, it is imperative to replace it in the appropriate location for the population to be served.

It is the government’s policy to redistribute resources from acute services to mentally ill, mentally handicapped, and geriatric services, etc, as well as to run down the long stay institutions. This shift is beginning to happen, but perhaps the greatest problems lie in the fundamental change from long stay institutional care to community based care. There are some basic financial problems associated with this approach, in particular, the need to move funds to local authorities to enable them to undertake their responsibilities, especially for the mentally handicapped. Some may argue that funds should not be transferred, but if they are not most local authorities would not participate in this

change in the method of providing care. At the end of the day what matters most is what is best for the patient.

Another problem is the high level of bridging finance required to fund new community services in districts while authorities continue to fund the long stay institutions until they are able to rationalise their facilities and so reduce expenditure on a sensible and planned basis. Regions have a positive function here and must be prepared to commit funds accordingly if the end result is to be achieved on a planned basis and in a reasonable time scale. The final financial point is that it is probably more expensive in the short term to look after these patients in the community, but it is likely that as experience is gained on the alternative methods of care available future costs will fall to some extent.

There are some major problems that are not purely financial in relation to the movement of patients out of the institutions. The fundamental one is whether the local communities are prepared to support this change of policy. I believe that people in general are against the concept, but mainly owing to total ignorance of the problem and a complete misunderstanding of what is wrong with the patients. Time and effort has to be spent in educating the population about this new policy and its consequences for the community. If this is not done it will be difficult to run down the long stay institutions even in the long term.

High technology medicine

There is, and always has been, tremendous competition for available resources not only between districts and institutions but also between specialties. This problem is aggravated in times of financial constraint when a squeeze is exerted on available resources. This is further complicated by the growing interest in, and awareness of, health matters by the general public, who are rightly demanding the best possible local health care being made available to them.

The identification of national priorities that have to be followed may increase the problems locally relating to consideration of the alternative developments that may have to be foregone to meet the various demands. High technology medicine is and will continue to be a competing demand. There is little doubt that with advances in drugs, diagnostic and treatment techniques, surgical skills, etc, more and more patients can be cured or death appreciably delayed. The cost of these advances, however, tends to be high, and careful consideration needs to be given to the options available, especially the opportunities that would be foregone by expending resources on one patient, as against many patients in another specialty. There is no magic formula that can be used to ease this problem, but decisions, though difficult, have to be made. These decisions must be made specifically rather than passively to allow proper debate and consultation on the issues.

This whole problem is admirably expressed by Robert Maxwell in *Health Care—The Growing Dilemma* (see box).

This sums up the problem, but how do we decide how much should be spent on renal or bone marrow transplantation, cardiothoracic surgery, oncology, etc. The choices are easily defined; the decisions are harder to come by.

Asset consumption

Capital is a "free good" to the NHS. Each year an amount of money labelled capital—£755m in 1984-5—is allocated to regions, etc, and this is spent mainly on buildings and equipment. Unlike in the private sector, once this money is spent no further notice is taken of it when producing costs, etc. This hidden cost nullifies most cost comparisons that are now undertaken. Treasurers are aware of this problem, and the Association of Health Service Treasurers will shortly be producing a report suggesting major changes on this matter. It is vital that proper

recognition of the consumption of capital and assets is given in plans, budgets, and costs to ensure that a complete data set of financial information is available to achieve the best value for money in health care provision to maximise the return on the investment of capital in the NHS.

Intraspecialty specialisation

Finally, I come to a financial problem that has worried me for some time—the consequences of the specialisation of clinicians within their own specialty. This trend is most apparent in teaching districts, where it is complicated by clinicians appointed by the university, over whose appointment the district has little or

"Today, there is a new challenge: how to use wisely the armoury of treatment skills available. Thanks to advances in knowledge and techniques, the skills at our disposal are greater than ever before. To use them indiscriminately is, however, to use them irresponsibly. We have advanced far beyond the point where the main health problems are uncomplicated, the steps to be taken obvious, and the results guaranteed. Rather we must recognise that benefit from intervention may be small, despite a large effort and high cost. Since resources are inevitably limited we should constantly ask whether we are using them to best effect. If resources are used on any case without considering the priorities, others will suffer." (Robert Maxwell in *Health Care—the Growing Dilemma*.³)

no control. Districts may appoint a clinician to a particular specialty only to discover afterwards that he is, or wants to be, an expert in a particular aspect of that specialty. His special skill means that he attracts patients from outside his normal catchment area for both first and second referrals. From the district point of view this may have various consequences ranging from a pattern of service being provided which is not that intended by the health authority, to a rise in resources committed if the treatment requires the use of expensive drugs, tests, etc—expenditure that again may not be in the health authority's priorities. As a potential patient I want to be treated by the best doctor available, no matter where he works, but we need more local dialogue about intraspecialty specialisation before commitments are entered into to ensure that the most equitable use is being made of the scarce resources available to health authorities. If the numbers of consultants increase as intended such specialisation may increase and the problems it presents may become more severe in future.

Treasurers used to be considered the great "no men" of the NHS, but this image is changing. They would like to be "yes men" in the best possible way—but this may only be done with clinicians' help. Together they can ensure that the most effective health care is being obtained from the resources committed. But, remember, it is the clinician who commits those resources.

References

- ¹ Anonymous. Spending on health. *Br Med J* 1983;287:235.
- ² Department of Health and Social Security. *Sharing resources for health in England: report of the resource allocation working party*. London: HMSO, 1976.
- ³ Maxwell R. *Health care—the growing dilemma*. New York: McKinsey & Co, 1974.

This is the second in a series of articles on NHS administration and management, which started on 28 April.

Annual representative meeting, 1984

Edinburgh Dinner

The Edinburgh Dinner will be held in the Midland Hotel, Manchester, on Monday 2 July at 8 00 for 8 30 pm, tickets £11.50 each. Further details from Dr T D Culbert, 42 South Drive, Manchester M21 2BA.

St Andrews and Dundee Dinner

The St Andrews and Dundee Dinner will be held at Stanneylands Hotel, Wilmslow, on Monday 2 July at 8 00 for 8 30 pm, tickets £12.50 each. Further details are available from Dr Jennifer R Anderson, Bramhall Cottage, 57 Bramhall Lane South, Bramhall, Cheshire. Sir Douglas Black, president elect of the BMA, together with Sir Christopher Booth and Professor H T Howat will be guests of honour.

Northern Universities Dinner

The Northern Universities Dinner will be held at Cheadle Royal Hospital on Monday 2 July at 8 00 for 8 30 pm. This will consist of a sherry reception followed by a buffet dinner. After the meal there will be light entertainment by the EL HAL Singers (of the Manchester Halle Choir). Tickets £10 each. Further details are available from Dr Charles Shiers, 37 St Ann's Road North, Heald Green, Cheadle, Cheshire.

Cambridge Dinner

The Cambridge Graduates Dinner will be held on Monday 2 July at 8 00 for 8 30 pm at Mottram Hall near Prestbury. Tickets £15 each (including wine). Further information may be obtained from Dr Lionel Kopelowitz, 18 Elmfield Road, Gosforth, Newcastle upon Tyne NE3 4BP.

St Mary's Hospital, Paddington

Arrangements will be made for an informal dinner in Manchester on Monday 2 July for graduates of St Mary's Hospital, Paddington. Anyone interested should write to Dr D L Leaming, Corby Lodge, 70 Junction Road, Norton, Stockton-on-Tees, Cleveland TS20 1PP.

Welsh Dinner

The Welsh Dinner will be held at the Belfry Hotel, Handforth, Wilmslow, Cheshire, on Monday 2 July at 8 00 for 8 30 pm. Tickets £15 each. Further details from Dr Bryan Davies, Welsh Secretary, Welsh Office, 195 Newport Road, Cardiff CF2 1UE.

Golf

The following golf competitions will be held at the Chorlton cum Hardy Golf Course, Chorlton cum Hardy, Manchester, on Thurs-

day 5 July at 2 pm (as soon after 3 30 pm as possible for representatives).

Nathaniel Bishop Harman Golf Cup—divisional winners or nominees only.

Leinster Cup—members with handicaps of 12 and under.

Childe Cup—members with handicaps of 13 and over.

All competitions will be based on Stableford Rules. The cost is £12 inclusive of green fees, gratuities, prizes, and buffet.

The ladies' golf competition will be held at the Chorlton cum Hardy Golf Course, Chorlton cum Hardy, Manchester, on Thursday 5 July at 12 00 noon. It is open to women members of the BMA and wives and daughters of members and is played according to the ladies golf union handicap rules (medal round 18 holes). The cost is £12 inclusive of green fees, gratuities, and buffet.

Application should be made to Dr T D Culbert, 42 South Drive, Manchester M21 2EA. For the ladies' golf competition application should be made to Mrs Valdez, 8 Hillside View, Meadow Lane, Haighton Green, Denton, Manchester M31 1PZ.

Accommodation

There is still single accommodation available at Hartley Hall and the Manchester Business School.

Overseas visitors: DHSS advises GPs on private treatment

The Department of Health and Social Security has issued a Health Notice (HN(FP)(84)7) advising family practitioners about the treatment of overseas visitors.

From October 1982 overseas visitors have had to pay special statutory charges for most National Health Service hospital treatment, but there have been no charges for domiciliary nursing, ambulance transport, or family planning services provided by community clinics. Health authorities have recently been advised, however, that a person intending to stay in the United Kingdom for less than six months should not normally be eligible for free treatment.

So far as the family practitioner services are concerned it is a matter for the discretion of the individual doctor whether he accepts a particular person as a NHS patient. But under the doctor's terms and conditions of service a general medical practitioner is obliged to provide for anyone treatment "which is immediately required owing to an accident or emergency at any place in his practice area and, in the case of a person who lives in his practice area and who he has refused to accept for inclusion on his list, to provide immediately necessary treatment for a period of up to 14 days."

The circular advises doctors that they should ensure that people from European Community member states or from countries with which the United Kingdom has reciprocal arrangements know their entitlements. Subject to these and to the proviso for providing "immediately necessary treatment," there is no objection to

NHS general practitioners offering private treatment. In fact, ministers think it particularly appropriate to offer private treatment if it seems that the patient has come to the United Kingdom specifically to obtain treatment. Doctors who refer overseas visitors to hospital for NHS treatment should warn them that they are liable to be charged unless they are covered by one of the statutory exemptions.

Hospital waiting lists in Wales

In a recent parliamentary answer, dated 10 April, the Secretary of State for Wales gave information on the length of time that individual patients had to wait in 1983 for admission to hospital from the waiting list.

District Health Authority	Average number of days waiting for inpatient admission
Clwyd	113
East Dyfed	74
Pembrokeshire	130
Gwent	130
Gwynedd	65
Mid Glamorgan	137
Powys	50
South Glamorgan	91
West Glamorgan	105

The minister stated that the figures did not reflect accurately the waiting time for all inpatient admissions. There was a wide variation depending on the clinical judgment of the consultant in each case.

Women doctors in NHS

The following table, which was produced in *Hansard* on 22 March, shows the number of women doctors working in the National Health Service.

Women doctors in the NHS

	1963	1974	1983
Hospital service*	2474	4407	7790
Community health service and community medicine	NA	2228	3511
General medical services	1746	2975	4876†
Total		9610	16 181†

NA = Not available.

*Excluding hospital practitioners and paragraph 94 appointments, the majority of whom also work in the general medical services.

†Provisional and excluding restricted principals, of whom there are likely to have been about 80.

Nuffield Library's periodicals

The BMA's Nuffield Library currently takes 1100 periodicals. All these, together with some of the library's 5000 sets of periodicals, are listed in a pamphlet, which is available free to BMA members. Members may obtain a copy by sending a stamped addressed A4 envelope (23p) to the librarian, Nuffield Library, BMA House, Tavistock Square, London WC1H 9JP.