BILLET D'ÉTAT

II
2002

WEDNESDAY, 27th FEBRUARY, 2002

GUERNSEY SOCIAL SECURITY AUTHORITY

NEW CONTRACTS FOR SPECIALIST HEALTH INSURANCE SCHEME

APPENDIX

Guernsey Social Security Authority – Guernsey Health Service Fund Actuarial Review, p. 107.

Printed by Guernsey Herald Ltd., Victoria Road, Guernsey.

Price £1.50

B I L L E T D ' É T A T

TO THE MEMBERS OF THE STATES OF

THE ISLAND OF GUERNSEY

I have the honour to inform you that a Meeting of the States of Deliberation will be held at **THE ROYAL COURT HOUSE, on WEDNESDAY,** the **27th FEBRUARY, 2002,** at 10.00 a.m.

(**NB** – Without prejudice to the right of any member of the States to propose a change in the order of business, I propose to take this Billet d'État immediately after any draft legislation for approval and any Committee elections contained in the main February Billet d'État.)

GUERNSEY SOCIAL SECURITY AUTHORITY

NEW CONTRACTS FOR SPECIALIST HEALTH INSURANCE SCHEME

The President,
States of Guernsey,
Royal Court House,
St. Peter Port,
Guernsey.

18th January, 2002.

Dear Sir,

New contracts for specialist health insurance scheme

Executive Summary

1. The specialist health insurance scheme, which commenced on 1 January 1996, involves four commercial contracts between the States and providers of healthcare. The current contracts and the 2002 costs are below:

Contract with Medical Specialist Group	£6,065,130
Contract with Ophthalmic Group	£551,375
Contract with Guernsey Physiotherapy Group	£328,052
Contract with Alderney doctors	£22,604
	£6,967,161

2. All of the above contracts will end on 31 December 2002.

3. In addition to the above contracts, the Board of Health has contracted with the Medical Specialist Group for Community Paediatrics and has recently agreed a contract for Geriatrics. The annual cost of these, at 2002 rates, is £430,920.

4. The Guernsey Social Security Authority and the Board of Health, on behalf of the States, are joint signatories to the contracts and the two committees work closely to ensure the successful delivery and administration of the scheme's benefits. The committees believe that the specialist health insurance scheme has been a great success in ensuring access to specialist medical services without any barrier of cost. Year 2000 statistics for the scheme show that 27% of the population had at least one consultation with the specialists at their out-patient clinic and 15% of the population received treatment by the specialists in hospital.

5. Public criticism of the scheme, such as it has been, has tended to be in relation to waiting times, with patients reporting that they have been offered earlier appointments if they agree to pay privately outside the scheme. The statistics, however, show a low incidence of private practice, being 11% of all specialist out-patient consultations and 4% of inpatient treatment. The proposals in this report further strengthen the position of patients treated under the scheme by having substantially reduced contractual maximum waiting times.

6. In preparation for the ending of the contracts, the Authority and the Board have, over the last 18 months, been in detailed discussion and negotiations with the Medical Specialist Group and the Guernsey Physiotherapy Group over the scope of services to be covered from 1 January 2003 under new contracts and also the cost of those services.

7. All parties to the proposed new contracts have received the same, independent advice on clinical governance and recommended staffing levels from experts appointed, by joint agreement, for the service scoping stage of negotiations.

8. The Authority and the Board have judged the acceptability of the negotiated contract prices against detailed Value-for-Money models of the States providing similar services by direct employment.

9. The Authority and the Board have now concluded the main negotiations and are satisfied with the outcomes for recommendation to the States.

10. The recommendations are being presented in this policy letter by the Social Security Authority, but all recommendations also have the unanimous support of the Board of Health. Much of the content of this policy letter involves matters within the Board's responsibilities and, where that is so, the Board has supplied or approved the text.

11. The key points of the new contracts for the specialist health insurance scheme are as follows:

    a. The Ophthalmic Group will merge with the Medical Specialist Group (MSG) and move from the Eye Clinic in Hauteville to the MSG premises at Les Friteaux. A single contract will, therefore, replace the two separate contracts currently in place.

    b. All new contracts will be for fifteen year terms, giving a security and commitment from all parties. There will be major review points at five and ten years.

    c. The new contract with the MSG will be based on a per-doctor contracted price basis to cover the specialist's earnings, the administration, facilities and support staff costs, other overheads and business profit. This price will be £231,818 per doctor in 2002 prices, uprated in January each year by the annual movement in RPI to September of the previous year.

    d. The maximum number of specialists working for the MSG in the first five years of the contract will be 37. This gives a maximum contract price of £8,577,273 in year 2002 prices.

    e. The MSG and Ophthalmic Group currently employ 28.5 specialists, funded through the specialist health insurance scheme contracts. The maximum increase of 8.5 specialists include 2.5 transfers to the MSG from Board of Health employment (1.5 Paediatricians and 1 Geriatrician).

    f. The increased staffing levels at MSG will enable the contractual maximum waiting times to be substantially reduced within 12 months of the commencement of the new contract. From 1 January 2004, the maximum waiting time for a routine adult referral from GP to specialist will reduce from 20 weeks to 8 weeks. The maximum waiting time for routine admission to hospital after seeing the specialist will reduce from 26 weeks to 8 weeks. Orthopaedic admissions will also reduce from the current maximum of 39 weeks to a maximum of 8 weeks.

g. The MSG will be able to continue and expand its private practice outside the contract with the States. Private practice is understood to represent 11% of consultations at the MSG premises and 4% of procedures at the Princess Elizabeth Hospital. The Authority and the Board consider that the position of patients treated under the specialist health insurance scheme will be adequately protected, and improved, through the substantially reduced waiting times.

h. The MSG accepts the need for disclosure of financial information to the Authority. Subject to the States approving the recommendations in the report, and prior to signature of the proposed contract, the MSG has agreed to disclose mutually agreed sections of their audited accounts to the Authority's external auditors. The MSG will also comply with any reasonable audit requirements of the Authority, its auditors and the Audit Commission in respect of the operation of the contract.

i. There will be a considerable expansion of the separate contract with the Guernsey Physiotherapy Group (GPG). The current limitation to inpatient and post-discharge physiotherapy, which is believed to be compromising some health improvement outcomes, will be extended to all physiotherapy treatments recommended by a specialist.

j. It is intended that, incrementally, the Board of Health provided physiotherapy service will transfer to the GPG to ensure a fully integrated service monitored by a single head of service employed by the Board of Health. The Board will not exert any pressure on its employed physiotherapists to move to the GPG but will not replace posts as they become vacant, other than internal promotions.

k. The new contract with the GPG will be based on a per-physiotherapist and per-assistant price, with different rates applying to different grades of physiotherapist. The maximum contact price in the first five years of the contract, allowing for complete transfer of Board of Health physiotherapy services, will be £1,277,035 in year 2002 prices. A complete transfer of the services within the first five years may not be achieved.

l. The Authority and the Board have not, to date, negotiated a new contract with the Alderney doctors. In comparison with the MSG and GPG contracts, the Alderney contract is very small and does not have a material effect on the funding provisions and contribution rates. The Authority will, therefore, seek the approval of the States to negotiate and sign a new Alderney contract, in co-operation with the Board of Health, without further reference to the States.

12. The additional expenditure on the Guernsey Health Service Fund will require an immediate increase in contribution rates of 0.2 percentage points, taking the contribution rate for specialist health insurance from 1.0% of earnings or income to 1.2%. In 2002 terms, this will take the maximum contribution for the scheme from £5.64 per week to £6.77 per week. For employed persons, the extra 0.2% will be shared with the employer, each paying 0.1%. Self-employed and non-employed persons, including persons over 65, will pay an extra 0.2% for the specialist health insurance scheme.

13. Increased contribution income to pay for the scheme will give rise to additional payments from general revenue, by way of the States grant to the Health Service Fund, which is currently an amount equal to 36% of contribution income. The additional annual requirement from general revenue, by way of the States grant, will be approximately £0.5m in 2003, increasing as contribution income increases to an estimated £0.75m in 2012.

14. The proposals include transfers of specialist medical and physiotherapy staff from Board of Health establishment to the Medical Specialist Group and Guernsey Physiotherapy Group. The Authority proposes that the relevant parts of the Board of Health revenue budget, made available from these transfers, be allocated to the Health Service Fund by increasing the States grant from 36% to 40% of contribution income.

15. These proposals, in particular the increased number of specialists working for the Medical Specialist Group, the substantial reduction in waiting times and the increased focus on clinical governance, have an impact on the capital and revenue budgets and the establishment of the Board of Health. The impact includes the need to upgrade the Day Patient Unit to provide a third operating theatre, properly equipped and staffed and the need to establish a Medical Investigation Unit. The Board of Health has estimated that there will be a capital cost of £1.04m to achieve this. For the same reasons, the Board has also identified the need to increase its manpower requirements above current levels by 27 whole-time-equivalents. This will give rise to additional recurring revenue expenditure for the Board, estimated at £1.09m in 2002 terms.

16. This report is in 7 parts:

Part I **Introduction** Paras. 17 to 23

Part II **Specialist Medical Benefit and Ophthalmic Benefit**
Proposed merged contract with MSG and Ophthalmic Group, existing and proposed new services, reduced waiting times, private treatment, quality, contract price and review mechanisms
Paras. 24 to 187

Part III **Physiotherapy Benefit**
Proposed contract with Guernsey Physiotherapy Group, expansion of services, transfer of Board of Health services, private treatment, quality, contract price and review mechanisms
Paras. 188 to 228

Part IV **Alderney Hospital Benefit**
Authorisation sought for Authority and Board of Health to contract with Alderney GPs on similar lines to present contract.
Paras. 229 to 236

Part V **Impact of new contracts on Board of Health costs and staffing**
Board of Health's report on capital, revenue and manpower implications of proposed new contracts, need for an extra operating theatre, support staff and equipment.
Paras. 237 to 248

Part VI **Funding**
Proposed increase of 0.2 percentage points in health insurance contributions, implications on formula-led States grant from general revenue, ten-year projection of Health Service Fund income and expenditure until 2012.
Paras. 249 to 288

Part VII **Conclusions and recommendations** Paras. 289 to 296

Part I Introduction

17. The specialist health insurance scheme commenced on 1 January 1996. The scheme currently covers specialist treatment provided under contracts with the Medical Specialist Group (MSG) and the Ophthalmology Group as well as inpatient and post discharge physiotherapy through a contract with the Guernsey Physiotherapy Group (GPG). There is also a provision for some inpatient treatment in Alderney through a contract with the Alderney general practitioners.

18. All of the contracts providing the specialist health insurance scheme are due to come to an end on 31 December 2002. This policy letter outlines the provisions for the specialist health insurance scheme from 1 January 2003.

19. Discussions on service provision have taken place over the last eighteen months. Independent, external advice regarding the scope of services has been provided to the relevant parties by:

- Charles Collins, ChM, FRCS, Vice President, Royal College of Surgeons;
- Professor John Yates, Inter-Authority Comparisons and Consultancy, Health Services Management Centre, University of Birmingham;
- Mrs Natalie Beswetherick, Chair of Council, the Chartered Society of Physiotherapy.

In addition, Mr Collins arranged for advice to be provided in respect of each medical specialty by recognised experts.

20. It is proposed that the States enter into long term contracts of 15 years with the Medical Specialist Group, Guernsey Physiotherapy Group and the Alderney doctors with each contract being reviewed after 5 and 10 years of operation or at the retirement/resignation of key specialist or physiotherapy staff to determine service levels and contract value.

21. In order to facilitate this, the contract with both the Medical Specialist Group and the Guernsey Physiotherapy Group will not be a single, fixed price but will be based on a cost per doctor or physiotherapist employed to meet the agreed service levels. This cost per doctor or physiotherapist will not only include the direct cost of the doctor or physiotherapist but also the ancillary staffing costs and other overheads relating to the provision of the service.

22. Currently, there is a separate contract for ophthalmology with the Ophthalmic Group. The Medical Specialist Group and the Ophthalmic Group have agreed to merge with one contract for both specialist services proposed from 1 January 2003.

23. The Social Security Authority and the Board of Health work closely together on the delivery and administration of the specialist health insurance scheme. While the recommendations in this policy letter are being presented by the Authority, all recommendations have the support of the Board of Health. Much of the content of this policy letter involves matters within the Board's responsibilities and, where that is so, the Board has supplied or approved the text.

Part II Specialist Medical Benefit and Ophthalmic Benefit

Specialist Medical Benefit and Ophthalmic Benefit Background

24. In 1995 (Billet d'État XIII, 1995) the States approved the introduction of Specialist Medical Benefit which provided specialist healthcare free at the point of delivery to residents in Guernsey and Alderney through a seven year contract with the Medical Specialist Group. This benefit took effect from 1 January 1996.

25. At the same time, the States authorised the Guernsey Social Security Authority and the Board of Health to negotiate and conclude contracts with providers of ophthalmic services and physiotherapy associated with specialist medical care, for services to be included also in the specialist health insurance scheme.

26. The Authority and the Board were able to conclude a contract with the ophthalmologists and ophthalmic benefit was introduced on 1 January 1996 under a fixed price seven year contract with the Ophthalmic Group.

27. The specialist medical and ophthalmology services are therefore currently provided under two separate contracts performed by two separate groups.

28. The Authority and the Board believe that the specialist health insurance scheme, principally based on these two contracts, has been a great success in ensuring access to specialist medical services without any barrier of cost. Statistics for the year 2000 reveal that, based on a population of 60,000:

- the scheme covered 39,191 specialist out-patient consultations;
- this involved 16,369 individual patients (27% of population);
- the scheme covered 14,321 specialist hospital episodes;
- this involved 9,192 individual patients (15% of population).

29. Public criticism of the scheme, such as it has been, has tended to be in relation to waiting times, with patients reporting that they have been offered earlier appointments if they agree to pay privately outside the scheme. The statistics, however, show a low incidence of private practice, being 11% of all specialist out-patient consultations and 4% of inpatient treatment. The proposals in this report further strengthen the position of patients treated under the scheme by having substantially reduced contractual maximum waiting times.

30. Given the Committees' opinion on the success of the scheme and the wish to develop proposals for replacement contracts, the Authority and the Board, with the Medical Specialist Group, have considered the services that should be provided. This took place over 18 months with the help of the outside advisors, Professor John Yates, and Charles Collins, ChM, FRCS.

31. With their assistance, the specialist medical staff requirements over the first five years of the proposed new contract were considered. The external advisers obtained the available evidence published by each specialty association or Royal College and looked at the statistics for activity in different hospitals and specialties across the UK.

32. They found that much of the current advice was in relation to resources required, including staffing levels, but in some cases was also about appropriate workload levels. In carrying out

the review, the advisers also considered the principles of specialist responsibility over the five year period in terms of:

- maximising the medical services that can safely be provided on-Island;
- skills / training to meet the needs of each post;
- qualifications / continuing professional development;
- team work / off-Island professional contracts;
- workload sufficient to maintain skills.

33. In order to interpret the professional advice in the context of the special circumstances of Guernsey, the advisers undertook a series of discussions with other external professional medical staff, familiar with professional guidelines, and with the clinicians and managers on-Island. A key issue the advisers had to resolve was how to make adjustments for Guernsey having a consultant only provided service when comparing it with the UK National Health Service (NHS) which is a consultant-led service supported by junior medical staff.

34. After weighing up all evidence, the advisers came to the conclusion that the absence of junior staff support effectively necessitated Guernsey having an increase in the number of consultants in certain areas if it was to provide appropriate on-Island services, adequate hospital medical staffing levels and if it was to remain at the forefront of medical service provision.

35. This conclusion was reinforced by two factors:

- ensuring that the Islands had a level of service that was superior to that found on the mainland e.g. shorter waiting times; and
- in comparing staffing numbers to the UK NHS, the advisers felt that the British standard was substantially undermanned compared with its European neighbours.

Persons Covered

36. The current contract covers persons eligible under the Health Service (Benefit) (Guernsey) Law, 1990 or under the reciprocal health agreements with the UK and Jersey.

37. To be eligible for the Health Service benefits, which in addition to the specialist health insurance scheme also includes the pharmaceutical scheme and the £8 medical consultation grants, a person currently has to be resident and present in Guernsey or Alderney for 13 weeks. This gives rise to occasional, but significant, problems where newly arrived workers, who have not been in the islands for 13 weeks but are paying social insurance contributions, require specialist treatment. Depending on the medical condition, this can be very costly for the individual. The Authority takes the view that incoming workers should receive the protection of these health benefits. To remedy this situation, it is intended to bring entitlement to all benefits under the Health Service Law in line with entitlement to travelling allowance grant under the Social Insurance (Guernsey) Law, 1978, as amended. This will require the person to be an insured person under the 1978 Law, and resident in Guernsey, Alderney, Herm or Jethou.

38. In order to clarify the proposal, some explanation of what constitutes ‘an insured person’ is necessary. Anyone coming to the Island to work as an employed person is required to pay social security contributions from the outset of employment. The worker will, therefore,

immediately be an insured person and, if the Authority's proposal is approved, will in future be entitled immediately to the cover of the specialist health insurance scheme and other health benefits. Newly arrived residents who are either self-employed or non-employed are allowed a period of up to 26 weeks before becoming insured persons. Consequently, they will have the choice of being assessed for contributions soon after arrival, and having the simultaneous cover of the health benefits, or not being assessed for contributions for up to 26 weeks and not having the cover of the scheme for that period. After being resident in the islands for 26 weeks, all adults must become insured persons and will all, therefore be covered for health benefits.

39. It is proposed that for health benefits, children also be treated in a similar way to that under the travelling allowance grant scheme whereby children of insured persons are covered for the benefits.

40. The existing provisions of the Health Service Law and subordinate legislation also give cover for all children in full time education in Guernsey or Alderney, with the exception of children ordinarily resident in Sark. This is intended to give health benefit cover to boarders in Guernsey schools, who would not otherwise be covered, by virtue of a local parent, until resident for 13 weeks. With the proposed change from a qualifying period of 13 weeks to a requirement of being an insured person or child of an insured person, there is a continuing need to make special provision to cover school boarders. The Authority, therefore, recommends that children who are ordinarily resident and in full time education in Guernsey should also be covered for all health benefits. For the avoidance of doubt, this would not include boarders from Sark who generally return to that Island at weekends.

41. The Authority is mindful that an amendment to the Health Service Law may be required for the proposed change in entitlement criteria and the necessary processes may not be concluded in time for the start of the new contracts on 1 January 2003. It should not cause any problem for this change to take effect at some point in the early term of the new contracts.

Existing Services covered by MSG and Ophthalmic contracts

The Medical Specialist Group

42. The contract with the Medical Specialist Group currently provides for all persons eligible for health benefits and visitors from reciprocating countries to receive acute specialist care, consultations, procedures and treatment in Guernsey and Alderney.

43. The contract also covers the services of practice nurses, theatre assistants and other staff employed by the Medical Specialist Group.

44. The main control over access to treatment under the contract is that a referral is required from a general practitioner and a patient cannot go directly to the specialist unless an appointment has been made by the general practitioner or the patient's treatment is ongoing.

45. The services currently provided are in the specialties of:

- Anaesthesia (including pain management but excluding dentistry, other than oral surgery),
- Medicine (including chemotherapy);
- Obstetrics and Gynaecology;
- Paediatrics;
- Surgery (including orthopaedics, urology and ENT).

46. It is proposed that all current specialties offered by the Medical Specialist Group be retained.

47. The Medical Specialist Group commenced the current contract with 19 specialists with a planned increase in the first year to 22. It currently employs 25.5.

48. The cost to the States of the current contract with the Medical Specialist Group is £6,065,130 in 2002, its final year.

Transfer of Services from the Ophthalmic Group

49. Currently, there is a separate contract for ophthalmology with the Ophthalmic Group. It is intended that the Ophthalmic Group will merge with the Medical Specialist Group to become one group.

50. It is therefore proposed that the States should contract with the new, combined Medical Specialist Group for ophthalmic services as well as the other specialties previously provided.

51. This will ease organisational problems relating to theatre use and anaesthetist cover. It is proposed that the out-patient clinics will be held at Alexandra House, which will be extended to accommodate the ophthalmologists. This will improve access for people with mobility problems.

52. The transfer of the ophthalmologists will increase the specialists employed by the Medical Specialist Group by 3 initially. Staffing numbers are dealt with in more detail in paragraphs 75 to 77 below, however it is likely that by the end of 2007 the numbers of ophthalmologists would have reduced to 2, which was the original level of staffing.

53. The cost to the States of the current contract with the Ophthalmic Group is £551,375 in 2002, its final year.

Transfer of Services from the Board of Health

Paediatrics

54. The Medical Specialist Group started the current contract in 1996 with 1 paediatrician, who had responsibilities for acute services.

55. In 1998, on the retirement of the Community Paediatrician, the Board of Health agreed to contract with the Medical Specialist Group for Community Paediatric Services. This contract was separate from the main Medical Specialist Group contract and was paid for by the Board of Health from its general revenue allocation.

56. This contract increased the numbers of paediatricians employed by the Medical Specialist Group by 1.5 to 2.5. The Group decided at the same time to increase its own complement so that a total of 3 paediatricians were employed.

57. Until the paediatric contract was made, the service comprised the acute paediatrician, employed by the Medical Specialist Group, a community paediatrician, employed by the Board of Health, and half a whole time equivalent associate who was a general practitioner with an interest in paediatrics who was sub-contracted by the Medical Specialist Group.

58. The fragmentation of the service had led to problems of organisation, of emergency cover and communication between acute and community services. It was also more difficult to provide strategic direction and planning for paediatrics. The Board of Health therefore took the opportunity of rationalising this service on the retirement of its community paediatrician and after consideration of the options available, agreed to transfer the community work to the Medical Specialist Group. Consideration was given to peer support available through other specialists employed by the Medical Specialist Group in reaching this decision.

59. The service continues to be provided by 3 paediatricians, all of whom are employed by the Medical Specialist Group.

Geriatrics

60. The Board of Health currently has establishment for one consultant geriatrician and one associate specialist. On the retirement of the Board's geriatrician, a long-term locum was appointed to allow an interim period in which the rationalisation of geriatric services could be considered and discussions held with the Medical Specialist Group.

61. The geriatric service currently covers long-term care, assessment and rehabilitation services. The UK Health Advisory Service (HAS) report on geriatric services recommended that geriatric services should provide assessment, rehabilitation services, community and long term care. The Board of Health decided that the service would be better integrated into the Medical Specialist Group to provide this enhanced integrated service, which has close links with acute medicine.

62. Staffing numbers are dealt with in more detail in paragraphs 75 to 77. However, in relation to geriatrics, it is proposed to increase the number of specialists from 1 to 2 initially with a review following the appointment and a period of assessment by the two new geriatricians as to whether a third geriatrician is required. This provides for a maximum of 3 geriatricians by the end of 2007.

63. The post of the associate specialist will be retained by the Board of Health as a transitional measure so as not to disadvantage the current post holder.

64. The appointments to the geriatrician posts will be made in accordance with the current contractual terms and standards as soon as possible by the Medical Specialist Group. These terms are described in paragraphs 156 to 161 below. However, like paediatrics, until incorporated in the health scheme from 1 January 2003 it will be a separate contract between the States and the Medical Specialist Group, funded by Board of Health revenue.

Other Specialties

65. The Board of Health currently has establishment for specialists in the following areas:

- radiology – 3 consultants
- pathology – 2 consultants
- adult psychiatry – 2 consultants
- psychogeriatrics – 1 consultant
- adolescent and child psychiatry – 2 consultants.

66. Consideration has been given to the transfer of all these services to the Medical Specialist Group. It was considered, however, that the independence provided by the Board of Health employing pathologists was important, particularly given the nature of their investigative work in carrying out post mortems. As both radiology and pathology provide investigative

and diagnostic support services and require a large team of support staff to be led by the specialists in each area it was agreed to retain these as States employed staff.

67. The Board of Health considered that adult psychiatry should be retained as a stand-alone service and that the other services provided by the Medical Specialist Group did not complement the development of this specialty. There are also substantial support staff associated with this specialty. Although there is a requirement for the geriatricians and the psychiatrists to both consider the treatment and care of psycho-geriatric patients, it was considered that it should not unduly affect the service if they were not employed by the same body. It was considered preferable, therefore, for the psycho-geriatrician post to remain States-employed.

68. Child and adolescent psychiatry has links to both the paediatric services and the adult psychiatry services. It is therefore one service that is equally suited to being retained with the other psychiatry services or being transferred to the Medical Specialist Group. On balance, it was considered that child and adolescent psychiatry being retained by the Board of Health would be appropriate, particularly again due to the large team of specialist support staff that are required.

Expansion of Services under MSG/Ophthalmic Group contract

Termination of Pregnancy

69. The June 1995 policy letter (Billet d'État XIII, 1995) did not mention termination of pregnancy as the States did not approve the proposals which led to enactment of the Abortion (Guernsey) Law, 1997 until June 1996 (Billet d'État VIII, 1996).

70. As termination of pregnancy is now a lawful specialist procedure, when considered necessary for particular medical reasons by two doctors, it is proposed that it should be included in the new contract with the Medical Specialist Group.

Dental Anaesthesia

71. It is proposed that anaesthesia for specialist dental surgery carried out by a specialist dental surgeon will be covered under the new contract. It is also proposed that all general anaesthesia required for any dental procedures provided to patients on the register of people with a learning disability will also be covered under the new contract.

Extensions under Current Contract

72. The current contract was very specific as regards the procedures and treatments covered under the scheme, with an appendix to the contract listing these in detail, based on what had historically been carried out prior to 1 January 1996.

73. During the life of the current contract, specialties have changed as different specialists have joined the Medical Specialist Group bringing different skills with them.

74. An example of one such area is within the specialty of ENT where there has been an increase in the range of operations performed over the life of the contract as well as their complexity. This was carried out by the Medical Specialist Group at its own expense and no contract variation was made.

Increases in Numbers of Specialists

75. It is proposed that the new contract will provide the following **maximum** additional staff over the first five years in comparison with those currently employed by the Medical Specialist Group and the Ophthalmic Group:

- 1 extra specialist in trauma and orthopaedics;
- 1 extra physician,
- 1 extra anaesthetist;
- 1 extra specialist in obstetrics and gynaecology;
- 1 extra paediatrician;
- 3 extra geriatricians.

76. The maximum number of doctors recommended over the next 5 years is 37, including three transfers from the Ophthalmic Group and two geriatricians and one and a half paediatricians from the Board of Health as outlined above.

77. The following table summarises the changes and the recommended increase in numbers proposed by the external advisers Charles Collins, ChM, FRCS, and Professor John Yates.

	Existing number of specialists	Advisers' proposed numbers	Increase or decrease	Notes
Medical Specialist Group Contract				
Ophthalmology	0.0	2.0	2.0	Currently three for control of workload, anticipated two long term.
General Surgery	4.0	4.0	0.0	To include breast, vascular, gastrointestinal and minimally invasive surgery.
Orthopaedics	2.0	3.0	1.0	Three required to provide reduced waiting times and improved emergency on-call for trauma and orthopaedic surgery.
Ear, Nose and Throat	2.0	2.0	0.0	To provide the present extended range of procedures with separate on-call rota.
Urology	1.0	1.0	0.0	Including paediatric urology and routine paediatric surgery.
Paediatric Medicine	1.5	4.0	2.5	Future fourth post to cover increasing community commitments in due course.
General Medicine	5.0	6.0	1.0	To include cardiology, gastro-enterology, oncology, nephrology, respiratory medicine, diabetes and endocrinology.
Anaesthetics	7.0	8.0	1.0	Additional post required to service the expanded surgical workload as well as increasing ITU work and specialised clinics such as the pain clinic.
Geriatrics	0.0	3.0	3.0	To fulfil the requirements of the HAS 2000 report and to provide a modern, integrated geriatric service able to respond to the needs of an increasing elderly population.
Obstetrics and Gynaecology	3.0	4.0	1.0	To fulfil the modern requirement for labour ward cover as well as providing shorter waiting times for gynaecology and maintaining on-call rota.
Board of Health Funded				
Paediatrics	1.5	0.0	-1.5	
Geriatrics	1.0	0.0	-1.0	
Ophthalmic Group				
Ophthalmology	3.0	0.0	-3.0	
Total	31.0	37.0	6.0	

Proposed exclusions from contract

78. It is proposed that the following specialist medical treatments be specifically excluded from the new contract with the Medical Specialist Group as from the existing contract:

- contraceptive procedures, including sterilisation operations, unless medically indicated;
- reversal of contraception procedures;
- screening programmes, for example cervical smears, but as in the current contract, breast assessment following mammography would be covered;
- cosmetic surgery and procedures, unless medically indicated;
- treatment for chemical, drug and alcohol dependency, but drug and alcohol related illnesses and disease, for example cirrhosis of the liver, would be included;
- in-vitro fertilisation (IVF);
- specialist treatment provided by the Board of Health;
- anaesthesia for operations performed by a general practitioner;
- anaesthesia for operations performed by a general dental practitioners, other than for patients on the register of people with a learning disability.

79. It is proposed that hearing and sight tests will be excluded except where carried out as part of a specialist medical procedure under the contract.

Adding, Suspending or Discontinuing Services

80. It is proposed that similar conditions will apply for adding, discontinuing or suspending services as are contained in the current contract. This would mean that no services could be introduced, suspended or discontinued without prior notification and agreement of all parties, namely the Social Security Authority, the Board of Health and the Medical Specialist Group.

81. Discussion between the parties will also be required for proposed changes in primary care, such as any changes to the medical benefit consultation grant or the introduction of population screening, so that the implications for all parties are investigated and reviewed.

Waiting times

82. It is intended to improve substantially the waiting times under the new contract with the Medical Specialist Group. In looking at waiting times, it was considered that the UK NHS waiting times should be taken as a minimum standard. Where the UK NHS sets these for individual specialties over the course of the contract, through National Service Frameworks (NSFs) or by other means, and these times are shorter than the contracted maximum waiting times, then the new NHS standard will be met locally.

83. The existing and proposed waiting times are summarised in the table below.

Patient Category	Existing	Proposed
Outpatients		
Emergency	24 hours	24 hours
Urgent	7 days	7 days
Routine Children	10 weeks	6 weeks
Suspected Cancer Referral as in NSF	20 weeks	2 weeks
Suspected Angina Referral as in NSF	20 weeks	2 weeks
All Other Adult	20 weeks	8 weeks
Inpatients and Day cases		
Emergency	24 hours	24 hours
Urgent	7 days	7 days
Cancer Admission as in NSF	26 weeks	2 weeks
Orthopaedics	39 weeks	8 weeks
All Other Routine	26 weeks	8 weeks

84. A proposed increase in the number of specialists in orthopaedics from 2 to 3 will mean that there will be no difference between the waiting times for this and other specialties in the proposed contract.

85. As in the current contract, all patients will be offered specific individual appointment times for outpatient appointments. These will be notified to patients within a maximum of 7 days of the Medical Specialist Group receiving the referral from the general practitioner.

86. Patients must inform the Medical Specialist Group if they are unable to attend an appointment and a suitable alternative will be agreed. If patients fail to attend an appointment without notifying the Medical Specialist Group and without having good reason for failing to notify the Group, they may be discharged back to their general practitioner who will have to refer the patient to the Group again if specialist treatment is still required.

87. For inpatient and day cases, once an admission date has been given it should not normally be changed or cancelled. Examples of when dates will be unavoidably changed are at the request of the patient or for clinical reasons.

88. After 1 January 2004, if any of the above waiting times are exceeded due to the fault of the Medical Specialist Group or the Board of Health, the patient will have the option of being treated locally by the Medical Specialist Group at a time convenient to the patient or will be offered prompt treatment in the UK. The cost of treatment in the UK will be met in the first instance by the Authority and will later be recovered from the Medical Specialist Group or the Board of Health, as appropriate.

89. As under the current contract, if the specialist believes the patient has been inappropriately referred by the general practitioner, the specialist may refer the patient back to the general practitioner.

90. It is intended that protocols will be drawn up by the specialists in consultation with the general practitioners to ensure that patients are referred at the optimum time for specialist treatment, having already had appropriate investigations undertaken. This is an important element in ensuring that the agreed waiting time standards can be met.

Private medicine

91. The agreement with the Medical Specialist Group on contract terms, including the price, is dependant on the Group's ability to continue and expand its private practice.

92. Currently, private practice is about 4% of inpatient and 11% of out-patient work.

93. The intention is that private practice will not be available in Guernsey to non-Bailiwick residents. Exceptions to this will be for emergency treatment for visitors or with the prior agreement of the Board of Health.

94. With the proposed term of the contract being extended to 15 years, it is impossible to predict, with any certainty, the level of private insurance cover that people will have, and choose to call on, over this time. The numbers of patients treated under the contract will be monitored and should there be a significant shift between the numbers of private patients and patients treated under the contract this will be fully examined with the Medical Specialist Group as part of the contract review process and, if appropriate, a variation in contract price agreed.

95. Concern has been expressed during the life of the current contract that patients who have been referred under the specialist health insurance scheme have been offered earlier appointments as private patients.

96. The Medical Specialist Group has advised that patients requesting private appointments in order to be seen earlier, often have no clinical reasons for an earlier appointment. However, there is no reason why these patients may not be seen early as long as they do not displace a patient treated under the contract.

97. To overcome some of the concerns, protocols have been agreed that will ensure no patient treated under the contract should be deferred or inconvenienced by an individual consultant's involvement in private practice.

98. Patients referred by their general practitioner under the contract should not be offered a private appointment unless they raise the subject themselves and they should not be given the impression that their condition will be better managed privately than under the contract.

99. Patients will be able to change between being treated privately and under the scheme for each episode of treatment. However, it must be made clear before treatment is provided whether the patient wishes to be treated privately or under the scheme. If the intention is not clear, and the patient fulfils the eligibility requirements for the scheme, they will be assumed to be patients treated under the specialist health insurance scheme.

Amenity Beds

100. An amenity bed is a hospital bed for which the patient chooses to pay the Board of Health a charge, while receiving the specialist medical treatment under the health scheme. This is to have more privacy than on the general wards. An amenity bed arrangement is not the same as a fully private arrangement where the patient pays the Medical Specialist Group for the

medical treatment and pays the Board of Health a charge for the bed which is substantially higher than the amenity bed charge. At present, most of the amenity bed provision is on Victoria Wing, subject to availability of beds not being used by fully private patients.

101. The Board of Health will continue to provide amenity beds. In future, as the Board's site development plan is commissioned, these will be provided as side rooms on general wards. This will mean a move from such beds being provided on Victoria Wing.

Quality and Clinical Governance

Underlying Principles of Clinical Governance

102. As healthcare becomes increasingly more complex, more sub-specialised, and more likely to be delivered by teams rather than by individuals, so new and different approaches need to be adopted to ensure high clinical standards and successful health outcomes.

103. To assure these requires a true partnership between the Board of Health and clinical staff to accept both individual and collective responsibility for the quality of health services delivered. Such an approach is described as clinical governance.

104. Clinical governance is an evolving concept, and there have therefore been a number of attempts to define what it comprises. One accepted definition states:

> *'Clinical governance is the patient-centred, systematic and accountable delivery of quality healthcare.'*

105. However, whatever the definition used, it is commonly accepted that clinical governance is an umbrella term which covers a variety of other activities. These have sometimes been defined as the seven pillars of clinical governance and include:

- Clinical information;
- Clinical risk management;
- Clinical audit;
- Research and effectiveness;
- Staffing,
- Training and education;
- Patient and user involvement.

106. Under the structures proposed for clinical governance in secondary care under the contract, it will be possible to demonstrate structure, activity and compliance in all these areas.

Clinical Information

107. High quality clinical information will be essential to demonstrate the quality, appropriateness and effectiveness of clinical services delivered under the Medical Specialist Group contract. A health information unit has already been established by the Board of Health and needs to be resourced adequately to collect, analyse and report on clinical activity delivered under the contract. Underpinning a robust health information function is the need for an integrated patient medical record between the Board of Health and the Medical Specialist Group.

108. It is likely that, as the electronic patient record is progressively introduced into the UK NHS, similar developments will need to occur in Guernsey.

109. It will be the responsibility of the Medical Specialist Group, with the assistance of Board of Health and Medical Specialist Group administration staff, to ensure that a full record of consultations and treatment is maintained for each patient.

110. Transfer of any patient information shall meet UK NHS standards to ensure patient confidentiality.

Clinical Risk Management

111. Clinical risk management may be defined as learning from that small percentage of cases when things go wrong in healthcare.

112. A number of multidisciplinary clinical risk management groups have been established for all main healthcare areas in Board of Health services.

113. A clinical risk manager responsible for developing and co-ordinating the various groups, and ensuring that action is taken on their recommendations, has been in place for some two years. It is intended that such activity will continue to develop under the new contract.

Audit

114. Clinical audit may be defined as the systematic comparison of local practice against accepted standards, such as those endorsed by the medical Royal Colleges, the UK's National Institute for Clinical Excellence (NICE) and the various UK National Service Frameworks (NSF's), etc.

115. It is intended that all specialists employed under the contract will be involved in at least one clinical audit activity at any one time.

116. A Clinical Audit Committee has been established by the Board of Health to decide on which audit activities are most relevant to the health needs of Guernsey and to co-ordinate and monitor the presentation of completed audits at academic half days.

117. The Medical Specialist Group will participate in external and internal audits and will continue to provide information for national audits where appropriate. These will include:

- mortality rates (including perinatal mortality);
- morbidity rates (including infection rates, re-admission rates, post-operative complications and medical complications);
- medication errors (including admission rate for adverse drug reaction);
- maternity (forceps delivery rate and caesarean section rate).

Research and Effectiveness

118. The Clinical Audit Committee will also be responsible for maintaining an overview of developments in evidence based practice, auditing existing standards against these and recommending the adoption of UK national guidelines where these may be shown to benefit clinical care in Guernsey.

119. The Medical Specialist Group will develop best practice protocols and will monitor patient outcomes against these protocols.

120. Specialists will conform to standards of generally accepted medical and surgical practices and standards prevailing in the United Kingdom in their appropriate specialties at all times.

Medical Staff

121. All new specialists will be on the appropriate Specialist Register, and will need to show evidence of meeting the Continuing Professional Development (CPD) requirements of their particular Royal College or Faculty while continuing to deliver services under the contract.

122. Each specialist will have to be appraised, at least once every two years, or more frequently as demanded by the particular Royal College or Faculty or the General Medical Council.

123. Likely topics to be covered at appraisal will include participation in clinical audit, clinical risk management, appropriate local research, links with off island centres, continuing professional development and local team working.

124. If a doctor who is practising within the Medical Specialist Group is deemed unsatisfactory then the procedures for dealing with allegations about a doctor's misconduct, incompetence or fitness to practise within premises administered by the States of Guernsey shall be followed. These are procedures that are currently agreed between the Board of Health and the medical profession and may change over the life of the proposed new contract.

Other Staff Development

125. As well as the specialists complying with staff development requirements, the Medical Specialist Group will be required to develop its other staff and will be responsible for their training and appraisals.

Patient and User Involvement

126. Patient and user involvement has not been well developed in Guernsey to date, but it is intended that it will be increasingly developed under the clinical governance umbrella throughout the lifetime of the contract.

127. It is essential that the services provided by both the Medical Specialist Group and the Board of Health are satisfactory to the patients. It is therefore agreed that the Medical Specialist Group will continue to undertake patient satisfaction surveys, the results of which will be shared with the Authority and the Board. Surveys will also be conducted by the Board of Health, the results of which will be shared with the Authority and the Medical Specialist Group.

Underpinning Structures for Clinical Governance

128. It has been agreed that clinical governance will only be effective if it represents a true partnership between the Board of Health and all those delivering services (whether Board of Health employees or otherwise).

129. Clinical governance is also unlikely to be effective without commitment and support from clinicians. To achieve this, effective representative structures have been developed.

130. However, committees are expensive in terms of both resources and opportunity costs, i.e. clinicians being taken away from clinical work. Committees are also unlikely to be supported unless they are seen to serve a true purpose and can be demonstrated to produce regular results.

131. Underpinning structures for clinical governance in secondary care in Guernsey must therefore be proportionate to the size of the acute, psychiatric, elderly care, community and diagnostic services for a population the size of Guernsey and Alderney. A minimum requirement comprises:

- a well resourced Health Information Unit;
- a Clinical Risk Manager with clerical support serving multidisciplinary clinical risk groups in the various main branches of medicine;
- a Clinical Audit Committee with responsibilities in evidence based practice, local clinical audit and the academic half day programme;
- a Staff Development Subcommittee to monitor and report on CPD activities undertaken by members of MSG, States employed Consultants and other clinical staff.

132. In addition, a Clinical Governance Committee would receive reports from the above, and make quarterly reports and an annual report through the Medical Advisory Committee to the Board of Health on progress and results of clinical governance in Guernsey.

Professional Links to UK Hospitals

133. All specialists employed by the Medical Specialist Group will have links to UK hospitals. This will have the following benefits:

- providing peer support to the specialists locally to prevent professional isolation;
- providing exposure to a greater range of conditions and up to date techniques and treatments;
- providing networking collaboratives for cardiac and cancer care;
- establishing and maintaining links with tertiary referral centres accepting Guernsey and Alderney patients;
- providing continuity of care from secondary treatment to tertiary treatment within the same care pathway for the patients;
- ensuring that the special requirements of patients from the Islands are taken into account as specialist teams in the UK include local specialists;
- enabling certain specialties to continue to be provided locally where the resident population would not otherwise be large enough to ensure that competencies are maintained;
- supporting audit and benchmarking through access to other regions' data and internal UK NHS clinical governance support.

134. The external advisers strongly supported the establishment and maintenance of links with UK hospitals. It is proposed that these links will be set up, in conjunction with the Board of Health, with UK NHS hospitals and trusts where Guernsey and Alderney residents are treated.

135. A number of links have already been established. In addition to these individual links, the UK has formed specialist networks such as the cancer network, which require the participation of multidisciplinary teams, including Medical Specialist Group staff, at meetings held in the UK.

136. The time spent away from the Island in pursuing these links was taken into account in determining the numbers of doctors that would be required under the contract. However, there are a number of different types of links that will be established. These can be categorised as:

- specialists employed under a contract with a UK NHS hospital or trust where the specialist is remunerated for the work carried out and may also have expenses paid;
- specialists whose expenses only are paid to attend meetings as an integral part of a service team;
- specialists who require to travel to the UK for audit purposes or where they are being trained in different techniques and where there is no advantage to the UK NHS and no expenses are paid.

137. It is intended that all links with UK hospitals should be cost neutral to the Medical Specialist Group, the Board of Health and the Authority. However, the Islands have seen a rapid increase in the cost of flights from Guernsey to the UK over recent years and it would not be possible to predict the effect this might have over the 15 year life of the contract.

138. This is a concern that the Board of Health has in relation to its own staff as well as that of the Medical Specialist Group. It is therefore proposed that the general revenue budget for clinical governance should be able to cover half the cost of any deficit the Medical Specialist Group suffers in relation to travelling and accommodation expenses incurred in order to maintain links with UK hospitals, after offsetting any earnings from those activities.

Clinical Review

139. It is intended that each service covered under the contract would be subject to review following the resignation or retirement of any specialist in that field or otherwise at 5 year intervals. This would ensure a degree of flexibility, linking the service provided with the changing health needs of Guernsey. (For further details see paras. 176 to 181).

Complaints

140. Complaints made by patients or their authorised representatives will be investigated under the appropriate complaints procedure.

Referrals and Communication

Doctor Communications

141. General practitioners will continue to be the main referrers and gatekeepers into the secondary care system. However, health visitors and school nurses will still be able to refer directly to the paediatricians and opticians will be able to refer directly to the ophthalmologists.

142. A letter stating the outcome of any out-patient consultation will be sent to the patient's general practitioner within a maximum of 7 days of the consultation.

143. A copy of any onward referral letter will also be dispatched to the general practitioner at the same time as the original letter is sent.

144. Where the patient has been an inpatient, a discharge note will be dispatched to the general practitioner within 24 hours. A full discharge summary will be dispatched within 2 weeks.

Patient Communications

145. The Medical Specialist Group will undertake to contact patients to arrange appointments within the specified waiting times.

146. Follow-up arrangements will be made at the conclusion of the initial consultation.

Referrals to UK Hospitals

147. It is proposed that the referral route for treatment under the reciprocal health agreement and contracts which the Board of Health has with UK hospitals will only be through the Medical Specialist Group or other Specialists employed or contracted by the Board of Health or that Group.

Second Opinions

148. Each patient shall be entitled to request a second opinion. Under normal circumstances, this shall be obtained from another local specialist under the contract. Where another specialist opinion is not available locally, the patient may be referred off-Island under the reciprocal health agreement or other Board of Health off-island contract, at no charge to the patient.

Co-operation and Management

149. It is the aim of the Authority and the Board of Health that there will be co-operation between all parties under the proposed contract in order to improve services and improve efficiency. Some specific areas are listed below.

Regular Monitoring and Review Meetings

150. Meetings will be held between all parties not less than twice a year to review the performance of the contract.

Prescribing Support Unit

151. The Medical Specialist Group will co-operate with the Authority's and the Board of Health's initiatives to promote cost effective prescribing under the umbrella of the Prescribing Support Unit.

Site Development Plan and Utilisation Review

152. The Medical Specialist Group will co-operate with the Board of Health in the site development of the Princess Elizabeth Hospital.

Health Promotion

153. The Medical Specialist Group will co-operate with the Board of Health on mutually agreed promotion of health education.

Statutory and Other Forms and Patient Reviews

154. The Medical Specialist Group will, under the proposed contract, complete all statutory and other forms and correspondence required by the States.

155. Where the Authority requires statutory or other patient examinations and reviews to be undertaken, these shall also be covered under the contract.

Medical Specialist Group Staffing

Recruitment of Specialists

156. Guernsey has provided a consultant only service since the introduction of the contract in 1996. Consultants who were not placed on the specialist register when it opened were provided with grandfather rights under the contract, as happened in the UK. However, any new post holders since the commencement of the contract have been required to be on the specialist register.

157. It is therefore proposed that the current system of specialist only service be continued during the life of the new contract.

158. The current contract's requirement is that the Medical Specialist Group shall only recruit doctors who hold higher qualifications and who would be suitably qualified and who meet the criteria to be appointed a consultant in the UK National Health Service (NHS).

159. All new appointments will be subject to the agreed appointments procedure. This requires a Royal College assessor to be part of the interview panel.

160. If the Medical Specialist Group is unable to recruit a consultant of the above standard following exhaustive advertising and recruitment procedures and the Board of Health is satisfied that this is the case, the Board of Health may agree that another doctor can be appointed of the appropriate grade who would have qualifications and experience as agreed between the Board of Health, the Medical Specialist Group and the appropriate Royal College.

161. Other matters concerning quality of staff and monitoring the quality of work undertaken under the contract are addressed under clinical governance in paragraphs 102 to 140.

Use of 24 Hour Doctor

162. Outside normal working hours, the duty 24 hour doctor, who is a general practitioner, on rota, provided under a contract between the Board of Health and the primary care practices, will admit patients to the Princess Elizabeth Hospital. The duty doctor will also be responsible for assessing patients and calling the on-call specialist as required.

Ancillary Staff

163. The Medical Specialist Group shall be responsible for employing suitably qualified and experienced ancillary staff to support the specialists. Examples of these are:

- Administrative staff;
- Secretaries and personal assistants,
- Records clerks;
- Audiologist;
- Out-patient sister and other out-patient nurses;
- Theatre assistants.

Medical Staff Cover

164. The Medical Specialist Group will provide a 24 hour on-call service for all patients in the Princess Elizabeth Hospital and for emergency referrals.

165. In the event of a major accident, the Group will deploy all available staff in accordance with the Board of Health's Major Incident Plan.

Facilities Provided by Medical Specialist Group

166. The Medical Specialist Group will provide and maintain facilities and equipment at Alexandra House where most out-patient clinics will be held.

167. It is the intention of the Group to extend its current premises to accommodate the ophthalmic out-patient clinic.

Dispute Resolution

168. Any contractual disputes will in the first instance be resolved by discussion with all parties. Should this fail, the matter will be referred to arbitration.

169. Matters relating to any individual's performance under the contract will be dealt with under the clinical governance structure.

Term

170. It is proposed that the contract will have a term of 15 years, commencing on 1 January 2003 and expiring on 31 December 2017.

Price

171. The price which has been agreed between the Authority's and Board's negotiation team and the Medical Specialist Group under the proposed new contract is £8,577,273 for 37 doctors at 2002 rates.

172. The contract will contain a cost per doctor of £231,818, which will be up-rated by the 2002 September Guernsey retail price index for the beginning of the contract on 1 January 2003.

173. Only those doctors working under the contract at any time will be paid for. This means that the cost to the Fund will be reduced when less than 37 specialists are provided by the Medical Specialist Group.

Reviews and Contract Variations

174. It is proposed that there will be annual reviews, reviews at five year intervals in 2007 and 2012, and service reviews on the retirement or resignation of any specialist.

Annual Reviews

175. It is proposed that there will be an annual adjustment of the cost per doctor which will be increased by the rate of Guernsey's retail price index published for the 12 month period ending in September each year.

Five Year Reviews

176. It is proposed that a review will take place in the fifth and tenth years of the contract at which time the scope of services and the numbers of doctors required will be reviewed.

177. All services will be reviewed to ensure that numbers of specialists will be sufficient to provide services for a further 5 year contract period.

178. Any review of the cost per doctor under the contract will also take account of the following:

- ancillary staffing costs;
- numbers of patients seen;
- changes to UK NHS consultant rates.

Any review of the number of doctors would also take account of the European directives on working hours.

Retirement or Resignation Reviews

179. As well as undertaking reviews of all services during the five year review, there will also be a review of any specialty on the retirement or resignation of a specialist. This is likely to be with the assistance of an external assessor who would review Royal College guidelines in that specialty and bench mark the local service against others provided in similar areas elsewhere.

180. Any such service review would look at the number of specialists required.

181. Only if the Medical Specialist Group experienced difficulty in recruiting any specialist would the cost per doctor be reviewed which would then be applicable to all specialists employed.

Value-for-Money of Proposed Contract with MSG

182. The Authority and the Board have taken the same approach as the committees took prior to approval of the current contract as regards making a judgement as to value for money. This has involved construction of a detailed Value-for-Money (VFM) comparison with the costs of a States-employed model involving the same number of specialists being employed and managed directly by the Board of Health. The current VFM model differs from that constructed in 1995 in that it does not include allowance for capital start-up costs of the States building its own out-patient clinic. The argument for excluding this cost in the current model is that the States have notionally met that cost through acceptance of the initial seven-year contract. The current VFM model, therefore, assumes that the premises exist and allows only for depreciation.

183. The current VFM model indicates that it would cost £222,978 per doctor, in 2002 terms, for the States to employ its own specialists, as compared with the figure of £231,818 in the proposed new contract with the Medical Specialist Group. The MSG price, therefore, is 3.96% higher than the States-employed option.

184. When the States approved the proposed contract with the Medical Specialist Group in 1995 (Billet d'État XIII, 1995) the VFM model, including initial capital costs, indicated that the MSG price was 3.68% higher than the States-employed model over the projected seven-year contract.

185. In view of the relatively narrow gap between the estimated cost of the States employing its own doctors and the proposal for a new contract with the Medical Specialist Group, the Authority and the Board recommend proceeding with the latter. The logistics of implementing a States-employed service should not be underestimated. It is worth noting, also, that the narrow margin between the VFM cost and the Medical Specialist Group price has been reached only after considerable dialogue and negotiation between the parties.

Disclosure of financial information

186. The Medical Specialist Group accepts the need for disclosure of financial information to the Authority. Subject to the States approving the recommendations in this report, and prior to signature of the contract, the Medical Specialist Group has agreed to disclose mutually agreed sections of their audited accounts to the Authority's external auditors.

187. As with all other recent contracts the Authority has made, it is intended that the contract will contain a clause that the Group is required to comply with any reasonable audit requirements of the Authority, its auditors and the Audit Commission in respect of the operation of the contract.

Part III Physiotherapy Benefit

Physiotherapy Benefit Background

188. Despite best endeavours, it was not possible to conclude a fixed price contract with the providers of physiotherapy before 1 January 1996, the starting date of the specialist health insurance scheme. As an interim measure, a fee for service arrangement was put in place from 1 January 1996, which provided acute inpatient physiotherapy free of direct charge to the patient.

189. In April 1997 (Billet d'État V, 1997) the Authority and the Board brought a policy letter before the States in which it was recommended that inpatient and post discharge physiotherapy be provided by the Board of Health by physiotherapists directly employed by, or contracted to the Board. Following a successful amendment the Authority and the Board were directed to re-open negotiations with the physiotherapists in private practice.

190. In November 1997 (Billet d'État XXII, 1997) the States approved a fixed price, five year contract, with the Guernsey Physiotherapy Group. This took effect from 1 January 1998.

191. Currently the contract with the Guernsey Physiotherapy Group provides for all inpatient treatment and post discharge treatment required following inpatient or day-case treatment. Treatment is only provided at the Princess Elizabeth Hospital, the Guernsey Physiotherapy Group's out-patient clinic or in Alderney.

192. The cost to the States of the current contract with the Guernsey Physiotherapy Group is £328,052 in 2002, its final year.

Persons Covered

193. As described in paragraphs 36 to 41 it is the Authority's intention to change the eligibility criteria for benefits provided under the Health Service (Benefit) (Guernsey) Law, 1990. Physiotherapy benefit will therefore be included in this change.

194. As under the current contract with the Guernsey Physiotherapy Group, persons treated under the UK NHS or under the contracts that the Board of Health has with UK hospitals and trusts are covered for post discharge physiotherapy on their return to the Islands.

Changes and Expansion in Physiotherapy Service Provision

195. The Authority and the Board have now, together with the Guernsey Physiotherapy Group, considered the service that should be provided. This took place over twelve months with the help of an outside adviser, Mrs Natalie Beswetherick, Chair of Council, the Chartered Society of Physiotherapy

196. With her assistance, the physiotherapy requirements over the first five years of the new contract were considered. Discussions were held with specialists from each care group to determine the resources required, including staffing levels.

197. One of the fundamental problems needing to be addressed was the lack of an integrated physiotherapy service. This was due to the current service being provided by the Guernsey Physiotherapy Group, for acute hospital services and post discharge physiotherapy, and by the Board of Health for paediatric and care of the elderly physiotherapy.

198. The recommendation of the external adviser was that the services should be amalgamated. This means that there will be a large number of services potentially provided under the contract with Guernsey Physiotherapy Group.

199. There is currently no out-patient physiotherapy provided under the scheme except if it is required as follow up treatment on discharge. This has meant some people have not had the optimum physiotherapy as an outpatient or prior to an operation unless they were prepared to pay privately.

200. In some cases, out-patient physiotherapy may prove sufficient and may prevent surgery. It was therefore considered appropriate to extend the provision of physiotherapy treatment to cover all physiotherapy recommended by a specialist employed under the Medical Specialist Group contract or by the Board of Health.

201. In discussions with the medical specialists, they highlighted that some areas of treatment were outside the terms of the current contract and patients were being denied care except on a private basis.

202. Physiotherapy services now to be included are:

- orthopaedic fracture clinic;
- pain clinic;
- rheumatology;
- women's health; and
- urodynamic studies.

Transfer of Physiotherapy Services from Board of Health

203. The Board of Health currently employs physiotherapists in care of the elderly services and in paediatrics.

204. The Guernsey Physiotherapy Group currently employs physiotherapists under the contract for acute inpatients and post discharge physiotherapy only. There is currently no physiotherapist who is in charge of all physiotherapy offered in the Board of Health premises and under the contract. The services provided by the Guernsey Physiotherapy Group and the Board of Health do not therefore operate under the same management and gaps in physiotherapy service are evident. These could be addressed under a jointly managed service.

205. In order to provide the integrated service recommended by the external assessor, the Board of Health is proposing to integrate these services on a professional basis.

206. It is proposed that the existing States-employed physiotherapists in paediatrics and care of the elderly will remain employed by the Board but become accountable to a professional head of service, employed by the Board. The operation of the contract with the Guernsey Physiotherapy Group will also be monitored by this head of service.

207. There is also a need to increase the numbers of physiotherapists and assistants to meet the proposed expansion of services. These new posts will be provided under the contract by the Guernsey Physiotherapy Group.

Exclusions

208. No treatment will be available as physiotherapy benefit for any patient receiving private specialist treatment.

209. Primary care physiotherapy will not be covered. This will mean that a referral will be required from a specialist prior to treatment.

210. Domiciliary physiotherapy will be excluded from the contract.

Adding, Suspending or Discontinuing Services

211. It is proposed that similar conditions will apply for adding, discontinuing or suspending services as are contained in the current contract. This would mean that no services could be introduced, suspended or discontinued without prior notification and agreement of all parties.

Waiting times

212. Physiotherapy will be provided as required, dependant on the patient's condition. Treatment protocols have already been developed in a number of areas and will continue to be developed over the life of the contract. Treatment plans and goals will be explained to each patient.

Clinical governance

213. All physiotherapists will be required to meet clinical standards set by the Chartered Society for Physiotherapy. Similar requirements will have to be met by the Guernsey Physiotherapy Group as by the specialist doctors in paragraphs 102 to 140 relating to clinical governance.

Staffing of Physiotherapy Services

214. Initially, staff will be employed by both the Board of Health and the Guernsey Physiotherapy Group, with one overall professional head of service as described in paragraph 206, above.

215. When any member of the Board's staff retires or resigns, the vacant post will not be refilled by the Board of Health and the Guernsey Physiotherapy Group will be able to appoint a member of staff. Protection will however be extended to any Board of Health member of staff who wishes to apply for a more senior post. Ultimately, it would be desirable for all physiotherapists to be employed under the contract with the Guernsey Physiotherapy Group. However, the Board of Health will not disadvantage any member of its staff who does not wish to leave the Board of Health's employment to join the Guernsey Physiotherapy Group.

216. Staffing will initially be increased in care of the elderly services and paediatrics as well as the out-patient clinic to cope with the anticipated increase in work. Other posts will be added to the contract as workload increases subject to the proposed contract maxima outlined below.

217. The number of staff over the life of the contract are shown in the following table:

	Current States Employed Physiotherapists	**Current Guernsey Physiotherapy Group**	**Combined Guernsey Physiotherapy Group and States Employed at 1 January 2003**	**Combined Guernsey Physiotherapy Group and States Maximum Until 2007**
Manager	0	0	1	1
Physiotherapy Lead	1	2	1	1
Physiotherapist Senior I	3.23	5.84	12.23	12.73
Physiotherapist Senior II	2	0	4	6
Assistant	4.08	2	10.75	11.25
Total	10.31	9.84	28.98	31.98

Private medicine

218. The Guernsey Physiotherapy Group will continue to be able to undertake private work at its clinic and within the Princess Elizabeth Hospital where patients have elected to be treated privately or who fall outside the proposed terms of the contract.

Price

219. The price of the physiotherapy contract will depend on the numbers and skill mix of the people employed at any time. There is therefore a cost per post, including all overheads contained within the contractual sum. The Guernsey Physiotherapy Group will be paid in relation to the number of staff it employs.

220. Over the first five years, from 2003 to 2007, inclusive, the maximum contract price in 2002 terms will be £1,277,035.

Term

221. It is proposed that the physiotherapy contract will be for the same term as the Medical Specialist Group contract, which is for 15 years commencing on 1 January 2003.

Reviews and Contract Variations

Annual Reviews

222. It is proposed that there will be an annual review of the cost per physiotherapist which will be increased by the rate of Guernsey's retail price index published for the 12 month period ending in September each year.

Five Year Reviews

223. It is proposed that a review will take place in the fifth and tenth years of the contract at which time the scope of physiotherapy services and the numbers and skill mix of physiotherapists required will be reviewed.

224. All services will be reviewed to ensure that numbers and skill mixes of physiotherapists will be sufficient to provide services for a further 5 year contract period.

225. In considering the cost per physiotherapist the review will take account of the following:

- ancillary staffing and overhead costs;
- numbers of patients seen;
- changes to UK NHS physiotherapy rates;
- European directives on working hours.

Retirement and Resignation Reviews

226. As well as undertaking reviews of all physiotherapy services at five-year intervals, there will also be a review on the retirement or resignation of a key medical specialist of any consequences for physiotherapy services in the relevant area of:

- elderly care;
- paediatrics;
- acute inpatients;
- out-patients.

Dispute Resolution

227. As with the contract with the Medical Specialist Group, any contractual disputes will in the first instance be resolved by discussions with all parties. Should this fail, the matter will be referred to arbitration.

228. Matters relating to any individual's performance under the contract will be dealt with under the clinical governance structure.

Part IV Alderney Hospital Benefit

Alderney Hospital Benefit Background

229. In January 1997 (Billet d'État I, 1997) the States agreed to introduce Alderney Hospital Benefit so that short-term inpatients at the Mignot Memorial Hospital treated by the Alderney general practitioners would receive that treatment free at the point of delivery. This was in response to representations from Alderney that residents of that Island were not getting the same access to free hospital care as Guernsey residents.

230. Alderney Hospital Benefit is provided by way of a contract between the States of Guernsey and the two Alderney general medical practices.

Existing Service

231. The current contract provides for all inpatient medical treatment by Alderney medical practitioners to persons formally admitted to the Mignot Memorial Hospital. The contract does not cover treatment in the casualty department of the hospital, nor medical treatment to patients who are classed as long-stay patients for the purpose of accommodation charges.

232. The cost to the States of the current contract with the Alderney doctors is £22,604 in 2002, its final year.

Extension to Service

233. It is proposed that the existing services provided by the Alderney general practitioners continue. In addition to these services, it is proposed that treatment provided at the Mignot Memorial Hospital for day patients is also covered.

234. In the past, patients have had to be monitored during or after certain treatments. These include some cancer treatments where the patient would otherwise have to travel to Guernsey to have the treatment administered at Bulstrode House. The Authority would cover the cost of travel from Alderney under the travelling expenses assistance scheme. This is not currently a frequent occurrence and it is likely that the contract will make provision for this on a fee per item of service basis.

Future Contract

235. The Authority and the Board have yet to have detailed negotiations with the two Alderney medical practices. It is intended that these will take place in 2002. The maximum contract term will be 15 years, to coincide with the other contracts.

236. The intention is to re-negotiate a similar fixed price contract to that in place, with the additional ad hoc work being covered on a fee for item basis. As this contract involves minor expenditure to the Guernsey Health Service Fund, the Authority seeks the approval of the States for a new contract, with a term not exceeding 15 years, to be negotiated and signed by the Authority and the Board of Health, on behalf of the States, without further referral to the States.

Part V Effect of Proposed new Contracts on Board of Health Costs

237. This part of the report has been provided by the Board of Health after careful examination of the effect of an increase inpatient demand on the Princess Elizabeth Hospital and other service costs. The Board has requested that the Authority includes in this report appropriate recommendations asking for the States to direct the Advisory and Finance Committee and the Civil Service Board to have regard to the Board's need for additional capital and revenue expenditure and additional staff.

Report from the Board of Health to the Social Security Authority

238. The key objectives of the new contract with the Medical Specialist Group are to reduce waiting times, improve quality, and to extend the range of services provided and maintain or improve the existing services.

239. To reduce waiting times, an increase in the number of specialists working under the contract is needed. This will require additional resources in respect of facilities, staffing, capital and revenue expenditure.

240. The number of specialists employed under the contract will increase from 31 doctors to a maximum of 37 in the first five years. The Board of Health has identified the following needs to provide the necessary support from its own services.

Initial capital expenditure

241. The increase of specialists in orthopaedics and obstetrics and gynaecology will increase the demands on the Princess Elizabeth Hospital operating theatres. The current three theatres are almost at maximum capacity and therefore the Board wishes to up-grade one of its major treatment rooms in the hospital's day patient unit to full theatre standard to cope with the additional requirements for surgery.

242. These additional theatre sessions will require extra theatre instrumentation and equipment.

243. The appointment of an additional physician and improvements in the geriatric service will require the development of a medical investigation department principally devoted to respiratory and cardiac investigations.

Capital Cost (at 2001 costs)	**£,000**
Day Patient Unit Up-grade	482
Theatre Instrumentation	310
Medical Investigation Unit	247
Total Capital Cost	1,039

Recurring Revenue and Establishment

244. The Board has looked at each department affected by the changes proposed under the new contract and has identified the following departments that will be most affected by a faster throughput of patients to meet the new waiting times and the increased demands through the appointment of additional specialists.

245. The departments include operating theatres, intensive care unit, surgical wards, day patient unit, sterile services, pharmacy, radiology, pathology, medical records, social work and clinical governance.

246. The Board would expect its manpower requirements to increase above their current levels by 27 whole time equivalents. There will be other staffing implications as a result of the aims of the new contracts, for example in many service departments such as house keeping and laundry but the Board will continue to try and absorb these through efficiency improvements.

247. There will however be associated costs concerned with the employment of these additional staff in respect of recruitment, accommodation and relocation expenses.

248. There will be additional recurring costs in respect of theatre, intensive care unit, wards and medical investigation unit, for drugs dressings and other disposable items.

Revenue Cost (at 2001 costs)	**£,000**
Staffing	736
Accommodation / Relocation Expenses	175
Clinical Governance	50
Operating Theatre Consumables	100
Total Revenue Cost	1,061

Part VI Funding the Specialist Health Insurance Scheme

Transferred Funding from Board of Health Services

249. The Board of Health intends to terminate the paediatric contract it currently has with the Medical Specialist Group and for the work to be carried out under the main new contract with the Group. The Board's current budget allocation for this contract for 2002 is £164,160. Additional provision has already been made by the Medical Specialist Group at no additional cost under the current contract to bring the complement of paediatricians up to 3. This may increase by a further paediatrician under the proposed contract.

250. The Board also intends relinquishing its current establishment in relation to geriatrics. It currently has £266,760 allocated for 2002 for two posts. It is proposed that these posts will be provided by the Medical Specialist Group under the new contract. An additional geriatrician may also be appointed under the contract.

251. The Guernsey Physiotherapy Group will take on the care of the elderly services and the paediatric physiotherapy services from the Board of Health under the proposed contract. There will be a gradual transfer from provision of Board of Health-employed physiotherapists to physiotherapists provided under the new contract with the Guernsey Physiotherapy Group. Funding of physiotherapy provided by the Board of Health is £339,000 per year in 2002 terms.

252. Physiotherapy services under the proposed contracts will also be extended in care of the elderly and paediatric services.

253. While the Board of Health's general revenue allocation would cover some of the costs of the services being provided under the proposed contracts, as there are expansions to these services also, the Board of Health's current allocation would not cover the full cost of the new proposed services. The total allocated costs of physiotherapy, geriatric services and paediatric services for 2002, for the Board of Health, is £769,920.

254. As under the current contract, the Board of Health will also pay a sum toward treatment of reciprocal health agreement patients under the scheme. The allocation for 2002 is £99,182.

Guernsey Health Service Fund

255. The Guernsey Health Service Fund meets the costs of all benefits under the Health Service (Benefit) (Guernsey) Law, 1990. Expenditure for 2000, the last published accounts of the Fund, was as below:

Guernsey Health Service Fund Expenditure 2000	
Drugs and Medicines (Less Prescription Charges)	£10,290,216
Specialist Health Insurance	£6,417,513
Consultation Grants	£2,072,856
Administration	£741,406
Total Expenditure	**£19,521,991**

256. The Government Actuary has recently undertaken the statutory review of the performance of the Fund for the period 1997 to 2000, inclusive and has given a view on the adequacy of the Fund over the next five years. This projection takes into account the predicted increases in expenditure for drugs and medicines and consultation grants as well as the effects of the new contracts for the health scheme.

257. Work is being done by the Prescribing Support Unit to ensure that spending on drugs and medicines is cost effective and sustainable. During the proposed fifteen year contracts, there will have been a change in prescribing from a blacklist, where everything is able to be prescribed except what is on the blacklist, to a white list where only those items on the list may be prescribed at the expense of the Fund.

258. The effects of changes in pharmaceutical benefit over the life of the contracts are therefore difficult to predict. As this is the major area for expenditure on the Fund, it will have a significant effect on longer term predictions.

259. The Government Actuary was therefore requested, as a separate exercise to the main actuarial review, to comment on the likely position of the Fund at 2007 after five years under the new contracts and at 2012 after ten years.

260. The following table is based on the Government Actuary's figures with no increase in funding from higher contribution rates or general revenue, other than a transfer of funds from the Board of Health:

Financial projection of Health Insurance Fund - no contribution increase						
Figures in £000s	**2003**	**2004**	**2005**	**2006**	**2007**	**2012**
Increase in RPI (to mid year) %	3	3	3	3	3	3
Increase in earnings (to mid year) %	5	5	5	5	5	5
Fund at the beginning of the year	20,493	20,248	19,766	18,991	17,914	8,326
INCOME						
Contributions	17,280	18,013	18,772	19,620	20,497	25,519
States' grant	6,221	6,485	6,758	7,063	7,379	9,187
Board of Health Funding	793	817	841	867	893	1,035
Interest	1,183	1,195	1,165	1,099	1,023	284
Total income	25,477	26,510	27,527	28,649	29,792	36,025
EXPENDITURE						
Consultation grants	2,126	2,144	2,164	2,183	2,203	2,308
Total cost of drugs, medicines, appliances and oxygen service	13,798	14,750	15,774	16,868	18,038	25,217
Prescription charges	-1,091	-1,157	-1,224	-1,291	-1,360	-1,709
Specialist medical benefit	9,407	9,689	9,980	10,279	10,588	12,274
Additional Physiotherapy	645	664	684	705	726	841
Administration	858	901	946	994	1,043	1,331
Additional Computer Monitoring and Support	50	30				
Total expenditure	25,793	27,021	28,324	29,738	31,238	40,262
Operating surplus	-316	-511	-797	-1,089	-1,446	-4,238
Fund at the end of the year	20,177	19,666	18,869	17,780	16,334	2,616
Ratio of mean fund/total expenditure	0.79	0.74	0.68	0.62	0.55	0.12

261. From the above table it will be noted that the Fund will run into an immediate and increasingly serious operating deficit if no additional funding is provided. Any additional funding will have to be through increases in contributions and general revenue grant.

Contributions

262. The Authority proposes an increase of 0.2 percentage points in the rate of contributions to the Health Service Fund. For those people who pay contributions for the specialist health insurance scheme only, this would take the current contribution rate of 1.0% up to 1.2%. The increase would take the combined Class 1 contribution rate for employed persons and their employers from 9.9% to 10.1% and would take the total self-employed contribution rate from 8.9% to 9.1%.

263. The table below shows the proposed income and expenditure, taking account of the proposed increase in contribution rates of 0.2 percentage points:

Financial projection of Health Insurance Fund - with contribution increase						
Figures in £000s	**2003**	**2004**	**2005**	**2006**	**2007**	**2012**
Increase in RPI (to mid year) %	3	3	3	3	3	3
Increase in earnings (to mid year) %	5	5	5	5	5	5
Fund at the beginning of the year	20,513	22,199	23,731	25,055	26,173	31,382
INCOME						
Contributions	18,700	19,494	20,316	21,233	22,181	27,619
States' grant	6,732	7,018	7,314	7,644	7,985	9,943
Board of Health Funding	793	817	841	867	893	1,035
Interest	1,183	1,378	1,478	1,574	1,666	2,052
Total income	27,408	28,707	29,949	31,317	32,725	40,649
EXPENDITURE						
Consultation grants	2,126	2,144	2,164	2,183	2,203	2,308
Total cost of drugs, medicines, appliances and oxygen service	13,798	14,750	15,774	16,868	18,038	25,217
Prescription charges	-1,091	-1,157	-1,224	-1,291	-1,360	-1,709
Specialist medical benefit	9,407	9,689	9,980	10,279	10,588	12,274
Additional Physiotherapy	645	664	684	705	726	841
Administration	858	901	946	994	1,043	1,331
Additional Computer Monitoring	50	30				
Total expenditure	25,793	27,021	28,324	29,738	31,238	40,262
Operating surplus	1,615	1,686	1,625	1,580	1,487	386
Fund at the end of the year	22,128	23,814	25,439	27,018	28,505	34,392
Ratio of mean fund/total expenditure	0.83	0.85	0.87	0.88	0.89	0.85

264. The projections indicate that the proposed contribution increase will keep the Fund with an operating surplus, albeit reducing until 2012. It should be noted that, while the figure for 2012 is shown, the further into the future that is modelled the more uncertain, and therefore more unreliable the projections become. The very large expenditure on drugs, medicines appliances and the oxygen service has a major influence on whether a 0.2% increase will be sufficient over the whole 15 year term of the proposed contracts.

265. The Authority and the Board will continue to work jointly through the Prescribing Support Unit to look at prescribing. The Unit works with specialists, general practitioners, nurses, pharmacists and other healthcare professionals in providing pharmaceutical advice and support to ensure that maximum health gains are made by cost effective use of drugs, medicines and medical appliances.

266. It is hoped that the work carried out by the Prescribing Support Unit will help to ensure that expenditure on the pharmaceutical and appliance benefits is sustainable. However, research and development of drugs is always increasing demands for newer and more effective treatments and it would therefore be imprudent to suggest that the rate of growth in pharmaceutical expenditure will decline below the levels suggested by the Actuary.

267. As the 0.2% will be provided in different ways depending on the type of contributor, explanations are provided below for each group of insured persons.

268. Note: The figures below, for all social insurance classifications, do not include a contribution for long-term care insurance which, subject to legislation, will also apply from 1 January 2003. The contribution rate for long-term care insurance will be 1.4% of earnings, or income, paid by employed, self-employed and non-employed persons. No share of the long-term care contribution will be borne by employers.

Employed Persons

269. For employed persons, the increase in contributions would be shared between the employer and the employee, each paying 0.1 %.

270. All the rates of contributions required of employees and employers to fund both the increases in existing benefits and the new contracts are shown below:

Employed Persons	Employer	Employee	Total
Contributions for Existing Social Insurance Benefits	4.1 %	3.2%	7.3%
Existing Contributions for Health Benefits	1.3%	1.3%	2.6%
Increase in Contributions Proposed for Health Benefits	0.1%	0.1%	0.2%
Total Rate	5.5%	4.6%	10.1%
(Existing 2002 Rates)	(5.4%)	(4.5%)	(9 9%)

271. There is an upper earnings limit of £564 per week or £2,444 per month for 2002 which represents the highest level of earnings on which contributions are calculated. This means the maximum extra any employee will have to pay for the new health scheme contracts is 57 pence per week with the 2002 limit applied. This is likely to be increased by around the rate of inflation for 2003. The employer will have to pay an equal amount.

Employed Married Women and Widows paying reduced rate

272. At present, there is provision for married women, and widows in receipt of widows' benefit, who work for an employer, to pay contributions at a reduced rate. This reduced rate applies only to the share of contributions paid by the employee.

273. The reduction is in relation to benefits provided under the Social Insurance (Guernsey) Law, 1978 only. This means that the increases for the health scheme will be the same as for other employed persons under 65 as above. The total rates of contributions will be as follows:

Employed Married Women and Widows paying reduced rate	Employer	Employee	Total
Contributions for Existing Social Insurance Benefits	4.1%	0.5%	4.6%
Existing Contributions for Health Benefits	1.3%	1.3%	2.6%
Increase in Contributions Proposed for Health Benefits	0.1%	0.1%	0.2%
Total Rate	5.5%	1.9%	7.4%
(Existing 2002 Rates)	(5 4%)	(1.8%)	(7.2%)

274. As in paragraph 271 the upper earnings limit applies, meaning that the maximum increase for each employee for the new health scheme contracts will be 57 pence per week using the 2002 limits.

Self-employed persons

275. The rates of contributions required of self employed persons to fund both the existing benefits and proposed new contracts is shown below:

Self-employed persons	**Total**
Contributions for Existing Social Insurance Benefits	6.3%
Existing Contributions for Health Benefits	2.6%
Increase in Contributions Proposed for Health Benefits	0.2%
Total Rate	9.1 %
(Existing 2002 Rates)	(8.9%)

276. As the upper earnings limit applies also to self-employed persons, the maximum additional contribution for the new health contracts will be £1.14 per week in 2002 rates.

Non-employed persons under 65

277. Social Insurance contributions paid by non-employed persons, not to be confused with unemployed persons, are charged on income up to the upper income limit of £29,328, at 2002 basis.

278. The rates of contributions required of non-employed persons under 65 to fund both the existing benefits and proposed new contracts is shown below:

Non-employed persons under 65	**Total**
Contributions for Existing Social Insurance Benefits	5.7%
Existing Contributions for Health Benefits	2.6%
Increase in Contributions Proposed for Health Benefits	0.2%
Total Rate	8.5%
(Existing 2002 Rates)	(8.3%)

279. The maximum extra contribution that would be payable for the new health contracts by non-employed persons under 65 would therefore be £1.14 per week at 2002 rates.

Persons Over 65

280. All persons over 65 are classed as non-employed persons for their individual social insurance liability and required to pay income related specialist health insurance contributions at the current rate of 1% of income. Again, the upper income limit, which for 2002 is £29,328, applies. The proposed increase of contributions by 0.2% means that the maximum increase in contributions for the new health contracts will be £1.14 per week at 2002 rates.

General Revenue

281. The table in paragraph 263 represents not only an increase in contributions of 0.2% but, as the general revenue grant is formula-led and equal to 36% of contribution income, it also represents an increase in funding from general revenue.

282. If this table is compared with the previous table in paragraph 260 the increase in the cost to general revenue from the formula-led grant is as follows:

Figures in £000s	**2003**	**2004**	**2005**	**2006**	**2007**	**2012**
Increase in States Grant	511	533	556	581	606	756

283. The Authority is firmly of the opinion that the proportion of income from general revenue should be maintained relative to the income collected from individuals' contributions.

284. In addition to the requirements for an increase in the income from the 36% general revenue grant, there is a requirement for the transfers from the Board of Health to be incorporated in the Health Service Fund. The current general revenue allocation to the Board which the Board and the Authority wish to transfer is detailed in paragraphs 249 to 254.

285. It would reduce administration if, rather than undertake annual transfers of general revenue from the Board of Health to the Authority, the general revenue grant could be adjusted from 36% to 40% to account for the transfers in the most efficient way. For clarification, it should be noted that this increase would not include the sum paid to the Authority by the Board of Health in respect of patients treated under reciprocal health agreements in Guernsey and Alderney described in paragraph 254.

286. Using the figures for increased contributions in the table in paragraph 263 the extra 4% would provide the following income which is compared with the uprated Board of Health current general revenue allocation as shown in the same table.

Figures in £000s	**2003**	**2004**	**2005**	**2006**	**2007**	**2012**
4% Increase in States Grant	748	780	813	849	887	1,105
Board of Health Funding	793	817	841	867	893	1,035

287. The Authority, therefore, proposes that the general revenue grant to the Health Service Fund be increased with effect from 1 January 2003 to an amount equal to 40% of the contribution income allocation to the Fund.

288. As it is the intention to retain the physiotherapists employed by the Board of Health for as long as they wish, so as not to disadvantage current post holders, the Board of Health will continue to require an element of general revenue funding for this service. This will be required until all post holders have left the employment of the Board, through voluntary transfer to the Guernsey Physiotherapy Group, by retiring or by resigning from their current posts.

Part VII Conclusions and Recommendations

289. The Authority and the Board of Health consider that the specialist health insurance scheme has been highly successful in its first six years of operation. It has removed any financial barrier to accessing specialist medical care in Guernsey. Statistics show that more than one in four islanders has a least one specialist out-patient consultation per year and more than one in seven has a specialist treatment in hospital. The committees believe that the community has become very used to the scheme and that very few people would wish to return to the position prior to the scheme's introduction in 1996.

290. The Authority and the Board have concluded negotiations with the Medical Specialist Group and the Guernsey Physiotherapy Group and include in this report the heads of agreement that, subject to States approval, will allow new contracts to be signed on behalf of the States. The proposed Heads of Agreement include contract terms of fifteen years, with defined review points, which are intended to provide stability and continuity for all parties.

291. The Authority and the Board consider that the proposed contracts represent value for money, having compared the prices with the costs of a States-employed services, with the Board of Health directly employing the same range of medical specialists and physiotherapists as in the proposals.

292. The proposed new contracts have a different structure to those currently in place as they replace single, fixed price contracts with contracts which are priced in direct proportion to the number of medical specialists, or physiotherapists employed, subject to an overall limit.

293. The proposed new contracts offer a significant advantage to Guernsey and Alderney residents through greatly reduced, contractual, maximum waiting times and an increased range of specialties and facilities. There will also be a substantial increase in the provision of physiotherapy associated with specialist treatment.

294. The proposed new contracts, and their consequences for Board of Health support services, impose additional funding requirements on people who pay social security contributions and also on general revenue. The Authority and the Board have made every effort, through exhaustive dialogue and negotiations with the medical specialists and the physiotherapists, to keep the increases in cost to a minimum, while ensuring appropriate standards of health services and ease of access to those services.

Recommendations

295. The Authority, therefore, recommends:

(i) that the existing conditions for a person being entitled to benefit under the Health Service (Benefit) (Guernsey) Law, requiring 13 weeks' residence and presence, be replaced with conditions of the person being:

a. resident in Guernsey, Alderney, Herm or Jethou; and

b. an insured person under the Social Insurance (Guernsey) Law, 1978, as amended, or the child of an insured person or a child in full-time education and ordinarily resident in those islands;

(ii) that the States authorise the Social Security Authority and the Board of Health, on behalf of the States, to enter a contract with the Medical Specialist Group for 15 years, in accordance with the Heads of Agreement set out in paragraphs 42 to 187 of this report;

(iii) that the States authorise the Social Security Authority and the Board of Health, on behalf of the States, to enter a contract with the Guernsey Physiotherapy Group for 15 years in accordance with the Heads of Agreement set out in paragraphs 195 to 228 of this report;

(iv) that the States authorise the Social Security Authority and the Board of Health, on behalf of the States, to negotiate and enter a contract with the Alderney general practitioners on the lines set out in paragraphs 233 to 236 of this report;

(v) that the States direct the Advisory and Finance Committee to take due account of the estimated cost to the Board of Health resulting from the increase inpatient demand and other service costs arising from the new contracts, when calculating and recommending to the States, under the financial procedures:

a. any increase in the Board of Health's budget for 2003; and

b. the Board's annual additional capital allocations and revenue expenditure limits for 2003 and subsequent years;

(vi) that the States direct the Civil Service Board to have regard to the estimated establishment required by the Board of Health resulting from the increase inpatient demand and other service costs arising from the new contracts, when administering the staff number limitation policy for 2003 and subsequent years;

(vii) that, as regards contributions payable under the Social Insurance (Guernsey) Law, from 1 January 2003

a. the percentage rate of all primary and secondary Class 1 contributions shall be increased by 0.1 %;

b. the percentage rate of all Class 2 and Class 3 contributions payable by resident contributors shall be increased by 0.2%;

(viii) that, with effect from 1 January 2003, the percentage Health Service Annual Grant, specified under Section 2 of the Health Service (Benefit) (Guernsey) Law, 1990 shall be 40%;

(ix) that the Health Service Allocation for contributions paid in respect of employed persons and resident self-employed and non-employed persons from 1 January 2003 shall be adjusted to take account of the 0.2% increase in the appropriate contribution rate;

296. I should be grateful if you would lay this matter before the States with appropriate propositions including one directing the preparation of the necessary legislation.

Yours faithfully,

O.D. LE TISSIER,

President,
Guernsey Social Security Authority.

The President,
States of Guernsey,
Royal Court House,
St. Peter Port,
Guernsey.

18th January, 2002.

Dear Sir

I refer to the letter dated 18 January 2002 addressed to you by the President of the Guernsey Social Security Authority on the subject of the new contracts for Specialist Health Insurance Scheme.

The view of the States when approving the establishment of the original Health Insurance Scheme (Billet d'État XIII, June 1995) was that it offered the best opportunity to protect members of the public against medical bills which they could not afford. The States also agreed that the most efficient way of securing the delivery of specialist health services whilst at the same time allowing closer control of healthcare spending was to enter into a contract with a single entity, the Medical Specialist Group. That contract is now due for renewal.

The provision of healthcare, which has consistently been established as a high priority, is expensive, especially on an Island without the benefit of economies of scale. Furthermore, advances in medical science and improvements in medical practice together with increased patient expectations mean that in the foreseeable future these costs will continue to rise.

The Advisory and Finance Committee notes that the Authority's proposals are fully supported by the Board of Health. The Committee also notes the extensive expert medical advice that has been sought by the parties concerned in determining the levels of specialist healthcare required and the associated waiting times.

The Authority's proposals for increases in the overall number of medical specialists to offer a broader range of services and considerably reduced waiting times mean that the cost of meeting the contract requirements have increased. The transfer of some specialist services from the Board of Health to the Medical Specialist Group also increases the cost of meeting the contract requirements, although offset by savings in the Board's budget. Increased expenditure on drugs, medicines, appliances and the oxygen service will also need to be funded.

The Committee commends the Authority, the Board of Health and the Medical Specialist Group for the considerable time and effort they had put into developing and producing an agreed proposal. The Committee is pleased to note that under the new proposals there will be an increase in the amount of financial information provided by the Medical Specialist Group to the Authority to enable the detailed financial aspects of the contract to be monitored more closely. This exchange of financial information complements the clinical audit arrangements. Nonetheless the Committee will continue to liaise with the Authority and the Board to monitor the performance of the contract and the Medical Specialist Group to ensure that it continues to provide an appropriate quantity and quality of healthcare service at an affordable and sustainable level.

To meet the increased costs the Authority proposes that of all of the possible alternative methods, the fairest and most pragmatic way is by increasing contributions from employees and employers by 20% from 1% to 1.2%. In addition the States General Revenue grant will be increased from

36% of contribution income to 40% to reflect the transfer of some medical services from being funded from the Board of Health's budget to being provided under the new contract. Since this calculation is based upon a number of estimates and actuarial assumptions, the Committee will work with the Authority to ensure that this method of funding continues to remain appropriate in the medium and long term.

A minority of members of the Advisory and Finance Committee have consistently had concerns about the principle of having a Health Insurance Scheme through a contract with the Medical Specialist Group. However, the majority of the Committee believe that the provision of specialist healthcare services through a contract with the Medical Specialist Group has been proven and remains the best approach for the Island. **Therefore, by a majority, the Committee supports the Authority's proposals.**

The Committee welcomes the early publication of the Authority's policy letter. However, due to the resultant tight timetable the Committee has as yet been unable to fully explore its concerns relating to one particular issue, that of the arrangements for seeking second opinions. By the time of the States Debate, the Committee would hope to have received the necessary clarification.

The Authority's report includes an indication of the additional revenue (£1.1 million) and capital (£1.0 million) costs and extra staffing requirements (27 whole time equivalents) that the Board of Health may require to support the additional specialists and to deliver the substantially reduced waiting times.

The Committee will consider the financial implications of the Authority's proposals on the Board of Health when bringing forward its proposals as part of the 2002 Policy and Resource Planning process. No firm commitment to specific funding levels can be given at this time.

Yours faithfully,

L. C. MORGAN,

President,
States Advisory and Finance Committee.

The States are asked to decide:–

Whether, after consideration of the Report dated the 18th January, 2002, of the Guernsey Social Security Authority, they are of opinion:–

1. That the existing conditions for a person being entitled to benefit under the Health Service (Benefit) (Guernsey) Law, 1990, requiring 13 weeks' residence and presence, shall be replaced with conditions of the person being:

   (a) resident in Guernsey, Alderney, Herm or Jethou; and

   (b) an insured person under the Social Insurance (Guernsey) Law, 1978, as amended, or the child of an insured person or a child in full-time education and ordinarily resident in those Islands.

2. To authorise the Guernsey Social Security Authority and the States Board of Health, on behalf of the States, to enter a contract with the Medical Specialist Group for 15 years, in accordance with the Heads of Agreement set out in paragraphs 42 to 187 of that Report.

3. To authorise the Guernsey Social Security Authority and the States Board of Health, on behalf of the States, to enter a contract with the Guernsey Physiotherapy Group for 15 years in accordance with the Heads of Agreement set out in paragraphs 195 to 228 of that Report.

4. To authorise the Guernsey Social Security Authority and the States Board of Health, on behalf of the States, to negotiate and enter a contract with the Alderney general practitioners on the lines set out in paragraphs 233 to 236 of that Report.

5. To direct the States Advisory and Finance Committee to take due account of the estimated cost to the States Board of Health resulting from the increase in patient demand and other service costs arising from the new contracts, when calculating and recommending to the States, under the financial procedures:

   (a) any increase in the States Board of Health's budget for 2003; and

   (b) that Board's annual additional capital allocations and revenue expenditure limits for 2003 and subsequent years.

6. To direct the States Civil Service Board to have regard to the estimated establishment required by the States Board of Health resulting from the increase in patient demand and other service costs arising from the new contracts, when administering the staff number limitation policy for 2003 and subsequent years.

7. That, as regards contributions payable under the Social Insurance (Guernsey) Law, 1978, from the 1st January, 2003

   (a) the percentage rate of all primary and secondary Class 1 contributions shall be increased by 0.1 %;

   (b) the percentage rate of all Class 2 and Class 3 contributions payable by resident contributors shall be increased by 0.2%.

8. That, with effect from the 1st January, 2003, the percentage Health Service Annual Grant, specified under section 2 of the Health Service (Benefit) (Guernsey) Law, 1990, shall be 40%.

9. That the Health Service Allocation for contributions paid in respect of employed persons and resident self-employed and non-employed persons from the 1st January, 2003 shall be adjusted to take account of the 0.2% increase in the appropriate contribution rate.

10. To direct the preparation of such legislation as may be necessary to give effect to their above decisions.

DE V. G. CAREY
Bailiff and President of the States

The Royal Court House,
Guernsey.
The 1st February, 2002.

APPENDIX

GUERNSEY SOCIAL SECURITY AUTHORITY

GUERNSEY HEALTH SERVICE FUND ACTUARIAL REVIEW

The President,
States of Guernsey,
Royal Court House,
St. Peter Port,
Guernsey.

16th January, 2002.

Dear Sir,

Guernsey Health Service Fund Actuarial Review

Under Section 20(2) of the Health Service (Benefit) (Guernsey) Law, 1990, the Authority is required to lay before the States every report made of the Government Actuary of Great Britain on the operation of the Law.

I enclose a copy of a report by the Government Actuary covering the period 1 January 1997 to 31 December 2000. I should be grateful if you could arrange for this to appear in an appendix to a forthcoming Billet d'État.

Yours faithfully,

O.D. LE TISSIER,

President,
Guernsey Social Security Authority.

REPORT BY THE GOVERNMENT ACTUARY ON THE OPERATION OF THE HEALTH SERVICE (BENEFIT) (GUERNSEY) LAW IN THE PERIOD 1 JANUARY 1997 TO 31 DECEMBER 2000

To the President and Members of the Guernsey Social Security Authority:

In accordance with Section 20 (1) of the Health Service (Benefit) (Guernsey) Law 1990, I have reviewed the operation of the Law in the period of four years to 31 December 2000 and submit the following report on the adequacy of the present contribution rates. All references to Guernsey are to be taken to include the Islands of Herm, Jethou and Alderney.

Chris Daykin, CB FIA
Government Actuary

January 2002

REPORT BY THE GOVERNMENT ACTUARY ON THE OPERATION OF THE HEALTH SERVICE (BENEFIT) (GUERNSEY) LAW IN THE PERIOD 1 JANUARY 1997 TO 31 DECEMBER 2000

CONTENTS **Page**

Introduction 110
Income and Expenditure in the Years 1997 to 2000 110
Assumptions Underlying the Estimates for the Years to 2005 111
Numbers of Consultations 111
Consultation Grants 112
Numbers of Prescription Items 112
Cost of Drugs and Medicines 113
Prescription Charges 115
Appliances 115
Oxygen Service 116
Specialist Medical Benefits 116
Administration 116
Investment Income 117
Number of Contributors 117
Estimated Future Income and Expenditure 118
Effect of Varying the Assumptions 118
Conclusion and Recommendation 121
Appendix 1 122
Appendix 2 123
Appendix 3 124
Appendix 4 124
Appendix 5 125

REPORT BY THE GOVERNMENT ACTUARY ON THE OPERATION OF THE HEALTH SERVICE (BENEFIT) (GUERNSEY) LAW IN THE PERIOD 1 JANUARY 1997 TO 31 DECEMBER 2000

Introduction

1. Section 20(1) of the Health Service (Benefit) (Guernsey) Law 1990 requires regular actuarial reviews to be carried out of the operation of the law, in particular with regard to the adequacy of the contribution rates to meet benefit expenditure in future years. At the request of the Guernsey Social Security Authority I have carried out such a review under the terms of Section 20(1) as at 31 December 2000. The review covers the period from 1997 to 2000.

2. This report is addressed to the President and Members of the Social Security Authority, who are free to make it available to any interested parties. However, sections of the report should not be quoted out of context or without acknowledging authorship.

3. The previous review was carried out as at 31 December 1996, covering the period from 1993 to 1996, and the results of that review were set out in my report dated June 1998. The results showed that, on the main set of assumptions made, Fund income was projected to exceed expenditure over the whole future period considered by the review (the five years to 2001). In addition, the mean size of the Fund was projected to increase slightly as a proportion of annual expenditure.

4. Significant changes were made to the operation of the Fund by new legislation that came into effect on 1 January 1996. In particular, the legislation introduced a new range of benefits relating to certain specialist medical treatments. In order to pay for these new benefits the contribution rates were altered and new classes of contributors were introduced. The review as at 31 December 1996 allowed for the impact of these changes. A brief summary of the benefits provided and contributions payable is given in Appendix 1.

5. The calculations for this review were based on health benefit statistics and contribution statistics provided by the Guernsey Social Security Authority. Reference was also made to the Financial Statements of the Guernsey Health Service Fund, audited by Deloitte & Touche. There were some small discrepancies between these two sources, possibly owing to the different dates at which the statistics were finalised. Where there was any conflict, the figures in the Financial Statements were taken as definitive.

Income and expenditure in the years 1997 to 2000

6. The income and expenditure of the Health Service Fund in each of the years from 1 January 1997 to 31 December 2000 are summarized in Appendix 2. This also shows a comparison with the projections made at the time of the previous review.

7. It can be seen from Appendix 2 that the Fund's income was generally somewhat higher than projected at the previous review. A large part of this difference can be explained by the fact that Guernsey has experienced much lower levels of unemployment than anticipated at the previous review and therefore contribution income has been higher than expected.

8. Benefit expenditure has been very close to that projected at the previous review, except in 1999 when a sharp rise in the cost of generic drugs meant that expenditure was £400,000 more than expected.

9. Overall, taking income and expenditure together, operating surpluses have generally been greater than expected and the result has been that the Fund represents a higher proportion of annual expenditure than anticipated. In 2000, the mean Fund (excluding reserves for realised and unrealised gains) was equivalent to 74% of expenditure in that year. The corresponding figure including reserves for realised and unrealised gains was 80%.

Assumptions underlying the estimates for the years to 2005

10. In this section of the report an examination is made of the changes in recent years in the factors which affect the income and expenditure of the Fund, with a view to establishing suitable bases for estimating the income and expenditure in future years. However, it is not possible to forecast with certainty the future course of some important factors, such as the relationship between the average net ingredient cost per item for medicines and the general levels of prices and earnings, so an indication of the sensitivity of the estimates to changes in some of these factors is given in paragraphs 52 to 57.

11. Throughout this report Guernsey and the other islands comprising the Bailiwick (excluding Sark) have been considered together.

Numbers of consultations

12. The numbers of primary care consultations in the period since 1996 are shown in Table 1. The numbers do not include specialist consultations since these are provided under the various specialist contracts. Consultation grants are only payable for primary care consultations.

TABLE 1

Numbers of primary care consultations with doctors and nurses,1996 to 2000

Years	Doctor	Nurse
1996	221,859	47,283
1997	225,096	48,601
1998	224,077	52,007
1999	227,398	55,334
2000	229,328	57,648
Average annual increase over 4 years	0.8%	5.1%

13. The numbers of doctor consultations have increased slightly over the period. However, if we consider the monthly figures, which are set out graphically in Appendix 3, it is clearer that the increase in consultations has levelled off. In contrast, the numbers of nurse consultations show a more substantial increase. Appendix 3 also gives a graph of the monthly nurse consultation numbers and this shows the upward trend (with a seasonal pattern). I understand that part of the explanation for the increasing number of nurse consultations is that nurses are carrying out a wider range of procedures (eg taking blood) and this trend may continue in future.

14. The average numbers of doctor and nurse consultations (primary care and specialist) per head of population have been calculated separately by sex and five-year age-group, for the period from 1997 to 2000. These have then been applied to the future population as estimated for the Social Insurance review as at 31 December 1998, allowing for net migration of 200 a year. This gave a projection of the total numbers of (specialist and primary care) consultations for future years. The estimated numbers of consultations for 2000 were then compared with the actual numbers of primary care consultations for doctors and nurses respectively, and all future projected consultations were adjusted by these ratios. Finally the numbers of nurse consultations were increased by an extra 3 per cent a year in order to reflect the continuation of the upward trend in their numbers over recent years, although at a lower level than has recently been experienced.

15. The numbers of primary care consultations projected for the years from 2001 to 2005 are shown in Table 2.

TABLE 2

Projected numbers of primary care consultations with doctors or nurses to 2005

Year	Doctor	Nurse
2000	229,328	57,648
2001	230,469	59,741
2002	231,603	61,985
2003	232,667	64,289
2004	233,713	66,694
2005	234,862	69,198

Consultation grants

16. The amounts paid for each consultation have remained unchanged in Guernsey since the introduction of this benefit. Lower amounts were paid in Alderney from the beginning of the scheme, but in April 1996, they were raised to the same levels in Guernsey. They currently stand at £8 for doctor consultations and £4 for nurse consultations. No increases have been announced for the future. The Authority has indicated that it will keep the position under review, but at present it does not believe that the level of the grant is increasing barriers to access to primary care. It has been assumed, for the purposes of this review, that the grant will not be increased in the period under consideration.

Numbers of prescription items

17. The total numbers of prescription items, and the average number of items per doctor consultation are shown in Table 3 for each of the years from 1996 to 2000.

TABLE 3

Average numbers of prescription items per primary care doctor consultation, 1996 to 2000

Year	Doctor Consultations	Prescription Items	Average Number of Items per Consultation
1996	221,859	816,307	3.68
1997	225,096	851,977	3.78
1998	224,077	856,283	3.82
1999	227,398	893,491	3.93
2000	229,328	925,352	4.04
Average annual increase over 4 years	0.8%	3.2%	2.4%

18. It should be noted that the above table shows the number of items per primary care consultation. In practice, some of the prescription items will relate to specialist consultations where treatment was on an out-patient basis. However, where the specialist consultation took place on an inpatient basis, any drugs are supplied directly by the hospital drawing on its general revenue account.

19. The number of items prescribed in the scheme as a whole has grown quite strongly since 1996, which represents a continuation of the trend identified at the previous review.

20. The number of prescription items per consultation increased by 2.4 per cent a year between 1996 and 2000, but the increases over the second half of the period were higher averaging 2.8 per cent a year. The graph of the monthly figures in Appendix 4 indicates a seasonal pattern but with an underlying upward trend. Furthermore, the authority has provided additional information that the number of prescriptions in the year to September 2001 was 4% higher than that over the preceding year. We understand that the main reason for this increase is an increase in the uptake of particular drugs, rather than increased numbers of consultations.

21. It is not clear how long this upward trend will continue. For the projections, we have assumed that the average annual number of prescription items per doctor consultation will increase by 3.5 per cent from 2000 to 2001. After 2001, we have assumed increases of 2.5 per cent a year. The resulting projected numbers of prescription items are shown in Table 4.

TABLE 4

Projected number of prescription items to 2005

Year	
2000	925,352
2001	962,506
2002	991,420
2003	1,020,875
2004	1,051,101
2005	1,082,677

Cost of drugs and medicines

22. Although the number of prescription items has been increasing steadily from year to year, one of the most significant items contributing to the increased cost of the scheme has been the rising cost of drugs and medicines. The cost to the Fund in respect of drugs and medicines is made up of two main components: the net ingredient cost and the remuneration payable to dispensers. The former is calculated according to the provisions of the British Drug Tariff, the pricing of the prescription items being carried out on behalf of the Guernsey Social Security Authority by the Prescription Pricing Authority of Great Britain. The level of payment to approved dispensers is negotiated each year.

23. The average net ingredient cost, and the average total cost of drugs and medicines, per prescription item are shown in Table 5 below for each year from 1996 to 2000. These costs are before the deduction of any offsetting prescription charge.

TABLE 5

Cost of pharmaceutical benefit 1996-2000

Year	Average net ingredient cost per item (£)	Cost per item of payments to dispensers (£)	Average total cost per item (£)
1996	8.38	1.13	9.51
1997	8.87	1.11	9.98
1998	9.47	1.16	10.62
1999	10.18	1.22	11.40
2000	10.30	1.29	11.59
Average annual increases over 4 years	5.3%	3.4%	5.1%

24. Overall, the average net ingredient cost per item rose by about 1.5 per cent per annum more than the increase in prices in Guernsey from 1996 to 2000. However, this conceals quite marked variations from year to year; for example there was a sharp increase in the cost from 1998 to 1999, which I understand reflected an increase in the cost of generic drugs. However, these price rises were partially reversed in 2000 leading to a much smaller increase in the net ingredient costs from 1999 to 2000.

25. The Social Security Authority has recently formed a Prescribing Support Unit that advises doctors on prescribing policies on the Island. In addition, the Authority intends moving from a position of "open prescribing" with a black-list of drugs which may not be prescribed, to a white-list approach where only drugs on this list can be prescribed. It is hoped that these measures will help contain future drug costs.

26. For the main projections I have assumed that average net ingredient cost per item will rise at 1 per cent a year in excess of RPI in future. The rate of increase in prices is assumed to be 3 per cent a year from mid-2000 onwards, which is broadly consistent with latest measured rates of price inflation in Guernsey. Thus average net ingredient cost per item is assumed to increase at 4 per cent a year to 2005.

27. The rate of increase of average net ingredient cost per item is influenced by many factors, some unconnected with the Guernsey Health Service, so that past experience may not be a reliable guide to the future. The future financial condition of the scheme is quite sensitive to the relationship between the rate of increase of average net ingredient cost per item, as the main determinant of the benefit cost, and the annual increase in the general level of earnings, on which the Fund's contribution income is based. Paragraph 53 considers the impact on the results of assuming that the average net ingredient cost per item will increase at the same rate as the rate of increase in earnings. The estimates assume that earnings increases will average 5 per cent a year to 2005.

28. In addition to the cost of the ingredients, the total cost of pharmaceutical benefits per item includes the remuneration of approved dispensers. Over the period since 1996 this element has increased broadly in line with prices. However, there are sharp variations from year to year, for example from 1996 to 1997 the dispenser cost per item actually fell (following a very large increase in 1996). A factor that will have tended to increase the dispensing costs is the move from dispensing within the medical practice to the use of independent dispensing pharmacies. This results in higher dispensing costs in the short term, although the long term effect of separating prescribing and dispensing is expected to be beneficial. Most of these changes took place in 1999 and the last remaining dispensing practice in Guernsey changed in June 2001, leaving one such practice on Alderney. It has been assumed that dispensing costs per item will increase in line with price inflation, namely at 3 per cent a year. The resulting projected costs of pharmaceutical benefit, on a per item basis, are shown in Table 6.

TABLE 6

Projected cost of pharmaceutical benefit to 2005

Year	Average net ingredient cost per item (£)	Total cost per item (£)
2000	10.30	11.59
2001	10.71	12.04
2002	11.14	12.51
2003	11.58	12.99
2004	12.05	13.50
2005	12.53	14.03

Prescription charges

29. The remaining element in determining the net cost to the Fund of pharmaceutical benefit is the prescription charge made in respect of each item. The prescription charge has been increased regularly since the last review, roughly to keep pace with the increases in net ingredient costs. Until April 1996 Alderney residents had to pay higher prescription charges than Guernsey residents but these were equalised at the Guernsey level of £1.50 in April 1996. In 2000 the prescription charge stood at £1.90. Over recent years, prescription charges have increased each year by 10 pence and it has been assumed that this practice will continue until 2005. This represents an annual percentage increase of about 5 per cent, compared with our assumption of 3 per cent a year for the rate of price inflation.

30. Some people receiving prescriptions are exempt from paying prescription charges. The proportion of exempt items rose from 46.3 per cent in 1996 to 48.4 per cent in 2000. The percentage increase in the proportion of exempt prescription items over the period since 1996 was a little over 1 per cent per annum, although in the later years the increase has been higher. I have therefore assumed that the proportion that are exempt will increase by 1.5 per cent in future.

31. Total prescription charges have been projected using the projections of non-exempt prescription items. However, for all years in the review period the average prescription charge per non-exempt prescription item is lower than the quoted prescription charge. This arises for two reasons. First, where the patient receives two packets of the same drug but at different strengths, the packets count as two items in the health benefit statistics but are only liable for one prescription charge. Second, some prescriptions are delayed beyond the year end and as a result are included in the later year's benefit statistics but with the previous year's charge. To allow for these features, the average prescription charge per non-exempt prescription item of £1.86 in 2000 has been used as a base and it has been assumed that the same ratio of average to quoted prescription charges will apply in future.

Appliances

32. A limited range of appliances has been provided under the Health Service scheme since November 1977. The number of appliances prescribed and the average cost per appliance in the period 1996 to 2000 are shown in Table 7.

TABLE 7

Numbers of Appliances Prescribed and Average Costs 1996-2000

Year	Number of Items	Average Cost Per Item (£)
1996	1,916	86.38
1997	1,947	83.60
1998	2,056	82.63
1999	2,137	83.16
2000	2,458	79.69
Average annual increase over 4 years	6.4%	-2.0%

33. The number of appliances prescribed, as a percentage of the total population, has increased gradually over the period 1996 to 1999. However, in 2000 there was a much sharper increase and I understand that the reason for this was that an additional type of appliance was made available under the scheme during 1999. Further types of appliance have been added in 2001 and it is likely that further additions will be made in 2002. We have assumed that the number of appliances provided will increase by 4 per cent a year until 2005.

34. The cost per appliance has shown a somewhat erratic pattern, although the trend since 1996 is down, probably reflecting the changing nature of the appliances being prescribed. However, in the preceding period from 1991 to 1996 there had been a rise in the cost per appliance broadly in line with price inflation. It is not clear that the recent downward trend will continue and therefore it has been assumed that the cost per appliance will increase from its 2000 level in line with the rate of increase in RPI.

35. As in the case of prescriptions, a charge is usually made for appliances (at the same rate as for prescriptions), but some people are exempt from appliance charges. I have assumed that appliance charges will increase in line with prescription charges. Analysis of the proportions exempt shows that the proportion of exempt appliances has been rising over the period since 1996, although prior to this the proportion had been falling. It is difficult to tell how the proportion will change in future and therefore we have assumed it will remain constant at its 2000 level of 0.823.

Oxygen service

36. The scheme also finances the provision of a free oxygen service in the home for those patients who need it. The cost of the service has reduced from £274,552 in 1996 to £256,776 in 2000 and I understand that part of this reduction relates to a change in supplier during 2000. It is not clear to what extent costs can be expected to fall further and therefore for prudence it has been assumed that the cost will in future rise in line with prices, ie 3 per cent a year.

Specialist medical benefits

37. The Authority has set up four fixed fee contracts to provide certain specialist medical benefits. The contracts are with the Medical Specialist Group, the Eye Clinic, the Guernsey Physiotherapy Group and two medical practices in Alderney. The annual fee is increased to allow for the rise in the RPI and for certain other contingencies. Each of the contracts is due to expire at the end of 2002 and negotiations are currently underway on the terms that will apply from 1 January 2003. The terms that are agreed will have an important impact on the financial development of the Fund.

38. For the Specialist Medical Group and the Eye Clinic, it has been assumed that in 2001 and 2002 the annual fees will be increased from their 2000 level in line with the RPI. The Authority has indicated that an initial estimate of the price of these two contracts from 2003 is £8,557,273 plus the increase in the RPI to September 2002. This is based on 37 doctors working under the contract. It has been assumed that after 2003 the contract price would increase in line with the rise in the RPI. The estimate we have been given by the Authority for the price of the Physiotherapy contract from 2003 is £651,430 plus the RPI increase to September 2002. No estimate is available for the cost of the new contract with the Alderney medical practices and we have therefore simply assumed that this would increase from its 2000 level in line with RPI.

39. A deduction is made from the cost of the contracts which amounted to £92,506 in 2000. This sum relates to sums that can be recovered from other countries, such as the United Kingdom, in respect of treatments provided to visitors from those countries. It has been assumed that this deduction will also increase in line with RPI.

Administration

40. The cost of administering the scheme falls on the Health Service Fund. The administration cost in 2000 (£741,406) was considerably higher than that in 1999 (£593,051) and this difference primarily relates to an increase in the Fund's computer costs as a result of a special project to update the systems. I understand that computer costs at these levels are likely to be incurred over the next few years. It has therefore been assumed that the costs of administration will rise in line with the level of earnings, using the 2000 accounts figure as a base.

Investment income

41. There has been a change in the Fund's investment policy over the period of the review. Previously the Fund invested in short-term fixed interest stocks and cash. There is now a much greater emphasis on equity investments and at the end of 2000 about one third of the Fund's investments were held in equities. It is generally expected that equities will earn a higher rate of investment return than fixed interest investments, although the returns could be quite volatile from year to year. At the previous review we assumed that the Fund earned a return of 2.5 per cent per annum above price inflation. On this occasion, bearing in mind the increased exposure to equities, we have increased the investment return to 3 per cent per annum above price inflation.

42. It should be noted that the value of equities is more volatile than that short-term stocks and cash. This is likely to mean that there will in future be more volatility in the level of the fund relative to expenditure. This is considered briefly in paragraph 55 below.

Number of contributors

43. There are three main types of contributor to the scheme:

- those making earnings-related contributions (including both employees and the self-employed);
- those under age 65 making income-related contributions;
- those over age 65 making income-related contributions.

44. The variation in the numbers of contributors under age 65 owing to demographic effects can be taken to be the same as for contributors to the Social Insurance Scheme. In addition numbers under 65 making earnings-related contributions will vary with the level of unemployment. For contributors over 65 the demographic effects can be judged directly from the population projection.

45. In the report to the Social Security Authority on the operation of the Social Insurance (Guernsey) Law in the period 1994 to 1997, projections were made of the total population of Guernsey and of the numbers of contributors to the Insurance Fund in future years. These projections were made on the basis of a long-term average level of unemployment over an economic cycle of 300. Two bases for future migration patterns were considered: net migration of zero and net immigration of 200 a year.

46. No information was available on recent levels of migration to and from the Island. For the purpose of the main projection basis, it has been assumed that there would be immigration of 200 a year.

47. The number of unemployed is currently under 100 and is therefore very much lower than the long-term level of 300 assumed in the Social Insurance review. This, in turn, means that the number of earnings-related contributors is higher. For the health service review, it has been assumed that unemployment will rise steadily from its 2000 level to reach 200 by 2005. The combined effect of demographics (including migration) and the change in unemployment will result in numbers of earnings-related contributors remaining broadly constant between 2000 and 2005.

48. The income-related contributions from persons under 65 for 2000 were projected forward allowing for demographic effects, which amounted to an increase of about 0.5 per cent a year. The income-related contributions from persons over 65 for 2000 were projected similarly, based on changes in the population over 65 from the population projection, which resulted in a projected growth rate which averages 1.0 per cent a year. An adjustment was

made to allow for the change in the income limits (which are assumed to rise in line with prices) relative to income levels. Over the long-term, the income of these contributors might be expected to grow broadly in line with earnings. However, over the shorter-term they will be affected by many factors, including interest rates and dividend declarations. The recent downward trend in interest rates might hold back increases in income levels and we have therefore assumed that it will only rise in line with prices (ie 3 per cent a year).

49. The development of the Fund is very dependent on the level of contribution income, which could vary significantly according to the level of unemployment and migration. Projections have been made on the alternative assumptions of unemployment rising to 100 by 2005, and of a steeper rise in unemployment to 300 by 2005. We have also considered the position if net migration is zero over the period to 2005. These alternatives are discussed further in paragraphs 54 and 55.

Estimated future income and expenditure

50. The estimated income and expenditure of the Health Service Fund on the main basis (assuming that the net ingredient costs of drugs increase at 1 per cent a year more than RPI, long-term unemployment of 200 and net immigration of 200 a year) are shown in Appendix 5 for each year up to 2005. Please note that, in contrast to Appendix 2, the fund values given in Appendix 5 include realised and unrealised gains; such gains are likely to be more significant in future given the increased investment in equities. It can be seen from Appendix 5 that there is a sharp change in the scheme's finances in 2003 as a result of the cost of the new specialist contracts. From 2003, the excess of income over expenditure is dramatically reduced and expenditure is actually projected to exceed income.

51. The mean balance in the Fund as a proportion of annual expenditure is summarised in the following table:

TABLE 8

Mean Fund as a Proportion of Total Expenditure for the Year
Main projection basis

Year	2000	2001	2002	2003	2004	2005
Main projection basis	0.80	0.85	0.90	0.81	0.75	0.68

Effect of varying the assumptions

52. As already mentioned, a key determinant of the Fund's future finances will be the prices of the new specialist contracts to apply from 2003. For the purpose of the main projections given in Appendix 5, it was assumed that the total cost of the contracts in 2003 would be £9.407 million and that this would rise in future years in line with the change in the RPI (ie 3 per cent a year). To show the impact on the Fund of a higher or lower price being negotiated we have considered the position if the total cost was 10 per cent higher or lower than in the main projection (ie total costs of £10.348 million or £8.466 million respectively). The effect of this on the Fund balance as a proportion of annual expenditure is shown in Table 9. It can be seen that there is quite a dramatic effect on the Fund, with the balance as a proportion of expenditure falling to 0.57 (about 7 months' expenditure) or increasing to 0.81 (about $9^1/_2$ months' expenditure), compared with 0.68 under the main projection.

TABLE 9
Change in Mean Fund as a Proportion of Total Expenditure for the Year
Special Medical Contracts Variants

Year	2000	2001	2002	2003	2004	2005
Main projection basis Total cost of contracts in 2003 of £9,407,000	0.80	0.85	0.90	0.81	0.75	0.68
Variant basis 1 Total cost of contracts in 2003 of £10,348,000	0.80	0.85	0.90	0.76	0.67	0.57
Difference				-0.05	-0.08	-0.11
Variant basis 2 Total cost of contracts in 2003 of £8,466,000	0.80	0.85	0.90	0.86	0.84	0.81
Difference				+0.05	+0.09	+0.13

53. Table 10 shows the effect on the mean Fund balance as a proportion of annual expenditure if the average net ingredient cost per item increases in line with the rate of increase in earnings from 2000 onwards. All other assumptions are as in the main projection. This reduces the ratio of the mean Fund to total annual expenditure by 0.07 to 0.61 by 2005 (nearly $7^1/_2$ months' expenditure).

TABLE 10

Change in Mean Fund as a Proportion of Total Expenditure for the Year
Pharmaceutical Benefit Variant

Year	2000	2001	2002	2003	2004	2005
Main projection basis Increasing net ingredient cost at 1% p.a. more than prices	0.80	0.85	0.90	0.81	0.75	0.68
Variant basis Increasing net ingredient cost in line with earnings (ie 2% pa more than prices)	0.80	0.84	0.88	0.78	0.70	0.61
Difference		-0.01	-0.02	-0.03	-0.05	-0.07

54. Table 11 shows the effect on the mean Fund balance as a proportion of annual expenditure if the level of unemployment is higher or lower than under the main projection, leaving all other assumptions unchanged. If unemployment were to rise to just 100 by 2005, then the Fund would build up somewhat more rapidly to reach 0.73 (nearly 9 months') of annual expenditure by 2005. Alternatively, if unemployment were to rise more steeply to reach 300 by 2005, the Fund as a proportion of annual expenditure would fall to 0.65 (nearly 8 months' expenditure) by 2005. Thus a change of 200 in the level of unemployment by 2005 can be seen to alter the balance of the Fund as a proportion of annual expenditure by nearly 0.1 over the five year period.

TABLE 11

Change in Mean Fund as a Proportion of Total Expenditure for the Year
Unemployment Variants

Year	2000	2001	2002	2003	2004	2005
Main projection basis – Unemployment rising to 200 by 2005	0.80	0.85	0.90	0.81	0.75	0.68
Variant basis 1 Unemployment rising to 100 by 2005	0.80	0.85	0.91	0.82	0.78	0.73
Difference			+0.01	+0.01	+0.03	+0.05
Variant basis 2 Unemployment rising to 300 by 2005	0.80	0.84	0.89	0.79	0.73	0.65
Difference		-0.01	-0.01	-0.02	-0.02	-0.03

55. We have also considered the impact of different levels of migration. The main projection allows for net immigration of 200 a year. Table 12 shows the effect on the mean Fund balance as a proportion of expenditure if there is nil net migration in future. On this basis the Fund balance in 2005 reduces from 0.68 of expenditure under the main projection to 0.64 (just over $7^1/_2$ months' expenditure).

TABLE 12

Change in Mean Fund as a Proportion of Total Expenditure for the Year
Migration Variant

Year	2000	2001	2002	2003	2004	2005
Main projection basis Net immigration of 200 a year	0.80	0.85	0.90	0.81	0.75	0.68
Variant basis Nil net migration	0.80	0.85	0.89	0.79	0.72	0.64
Difference			-0.01	-0.02	-0.03	-0.04

56. The Fund now invests a significant proportion of its assets in equities. Although, equities might be expected to provide, in the longer-term, higher returns than fixed interest stocks and cash, they are also likely to lead to increased volatility in the value of the Fund. As an illustration of this, let us assume that one third of the Fund is invested in equities and that the value of these equities falls by 25% at the end of 2004. In this case, the mean fund in 2005 as a proportion of annual expenditure would fall from 0.68 under the main projection basis to 0.62. The projections also show that by 2003 it will be necessary to sell assets in order to meet benefit payments. It would be desirable to avoid a situation in which it was necessary to sell equities for this purpose, at potentially unfavourable prices.

57. For clarity, the above tables show the impact of each variant in isolation. In practice, one or more of the variants could occur at the same time. We have not considered the effect of combining the variants, but, as a first approximation, the change in the fund caused by each variant can be added together.

Conclusion and recommendation

58. Over the period from 1997 to 2000, the Fund has remained in a satisfactory financial position and operating surpluses have been slightly higher than projected at the previous review.

59. In 2000, the ratio of the average Fund balance (including reserves for realised and unrealised investment gains and losses) to expenditure was 0.8. The present review projects an increase in this ratio to 0.9 in 2002, before declining to 0.68 in 2005. The main reason for the decline from 2003 is the cost of the new specialist contracts that come into force in that year.

60. It is not necessary to build up a large balance in the Fund. The main requirement is for a working balance to cover prepayments, sums due from debtors and adverse fluctuations from year to year. This review shows that the Fund balance remains satisfactory over the period of the review, but it is expected to be declining quite quickly by 2005. As a result, it is likely that corrective action will be required in order to restore stability to the Fund's finances. Such action might include either increases in contributions or reductions in benefits (or a combination of the two).

61. It is not possible to determine definitively what minimum level of fund should be maintained. Nevertheless, the main projections we have carried out indicate that by 2007 the Fund will have reduced to about 50% of expenditure and that this ratio will be falling by about 10% each year. It may therefore be considered appropriate to implement any corrective action by 2007. However, the Fund's finances could deteriorate more quickly if experience is less favourable than we have assumed, for example if drug costs were to rise more quickly than anticipated or the cost of the new specialist contracts is higher than expected. In such circumstances, earlier action could be needed to stabilise the financial position of the Fund and for this reason the position should be monitored regularly so that any necessary action can be taken in good time.

62. The next formal actuarial review is due as at 31 December 2005. However, it may be appropriate to consider carrying out the review earlier if the Fund declines more quickly than anticipated.

APPENDIX 1

Summary of benefits from and contributions to the Guernsey Health Service Fund

Benefits

Consultation grants	The Fund makes a grant towards the costs of consultations with doctors and nurses. In 2001, the grant stands at £8 for doctors and £4 for nurses. This grant is only payable for primary care consultations.
Drugs	The Fund finances the cost of certain drugs prescribed on an out-patient basis. However, unless the patient is exempt, he or she must pay a prescription charge to the Fund for the drugs; this charge stands at £2 per item in 2001.
Appliances	The Fund also finances the provision of a limited number of medical appliances, subject to payment of the prescription charge (except where the patient is exempted from paying this charge).
Oxygen	The Fund finances a scheme which provides home oxygen therapy and electric compressors for use by the patients at home for nebulising medicines.
Specialist health insurance scheme	Subject to certain conditions, the Fund provides cover for specialist medical services including ophthalmology, inpatient and post-discharge physiotherapy and some treatment in Alderney.

Contributions

Lower Earnings Limit (LEL) for 2001	£76 per week
Upper Earnings Limit (UEL) for 2001	£531 per week
Class 1	These are paid by employees and their employer and amount to 2.6% of all earnings up to the UEL. Individuals are exempted from payment if their earnings are less than the LEL (although prior to 2001 a lower threshold applied).
Class 2	These are paid by the self-employed and amount to 2.6% of all earnings up to the UEL.
Class 3	These are income-related contributions paid by individuals who do not pay either Class 1 or Class 2 contributions. Those under age 65 pay 2.6% of all income up to the UEL and those age 65 or more pay 1% of income up to the UEL. Individuals are exempted from payment if their income does not exceed twice the LEL.

APPENDIX 2

Guernsey Health Service Fund – Income and expenditure and balance in the Fund 1997-2000

Figures in £000s	**1997**		**1998**		**1999**		**2000**	
Fund at the beginning of the year	9,594	*(9,594)*	10,894	*(10,940)*	12,361	*(11,971)*	13,605	*(12,819)*
INCOME								
Contributions	12,643	*(12,643)*	13,323	*(13,142)*	14,295	*(13,666)*	15,090	*(14,207)*
States' grant	4,551	*(4,551)*	4,796	*(4,731)*	5,146	*(4,920)*	5,432	*(5,114)*
Interest	644	*(658)*	808	*(580)*	612	*(657)*	592	*(727)*
Total income	17,837	*(17,852)*	18,927	*(18,454)*	20,052	*(19,242)*	21,114	*(20,048)*
EXPENDITURE								
Consultation grant	1,977	*(1,943)*	2,019	*(1,958)*	2,045	*(1,971)*	2,073	*(1,984)*
Total cost of drugs, medicines, appliances and oxygen service	8,960	*(8,833)*	9,551	*(9,492)*	10,648	*(10,195)*	11,183	*(10,953)*
Prescription charges	-728	*(-707)*	-765	*(-735)*	-784	*(-762)*	-893	*(-790)*
Specialist medical benefit	5,724	*(5,772)*	6,067	*(6,003)*	6,306	*(6,243)*	6,418	*(6,493)*
Administration	604	*(665)*	588	*(705)*	593	*(747)*	741	*(792)*
Total expenditure	16,537	*(16,506)*	17,461	*(17,423)*	18,808	*(18,394)*	19,522	*(19,432)*
Operating surplus	1,300	*(1,346)*	1,467	*(1,031)*	1,244	*(849)*	1,592	*(617)*
Fund at the end of the year	10,894	*(10,940)*	12,361	*(11,971)*	13,605	*(12,819)*	15,197	*(13,436)*
Mean fund/Total expenditure	0.62	*(0.62)*	0.67	*(0.66)*	0.69	*(0.67)*	0.74	*(0.68)*

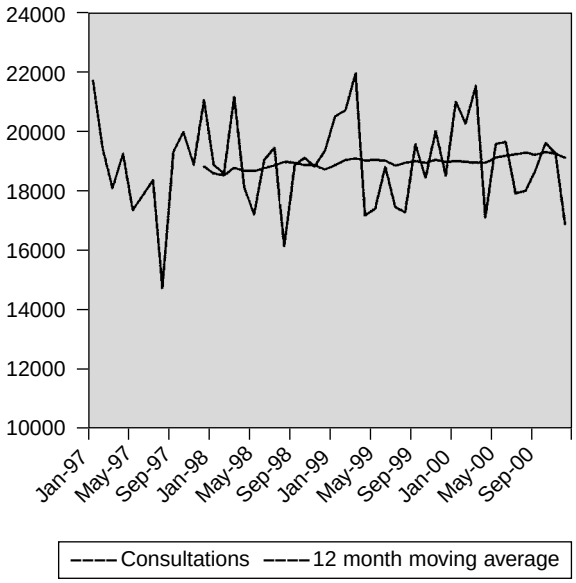
(1) Figures may not sum to totals due to rounding
(2) Figures in brackets are estimates made at the previous review as at 31 December 1996.
(3) The fund values exclude the reserves in respect of realised and unrealised gains and losses on investments. If we did allow for these gains and losses, the fund values would be restated as follows:

Figures in £000s	**1997**	**1998**	**1999**	**2000**
Fund at beginning of the year	10,397	11,693	13,173	14,670
Operating surplus from above table	1,300	1,467	1,244	1,592
Realised and unrealised gains arising in the year	(4)	14	253	136
Fund at the end of the year	11,693	13,173	14,670	16,399

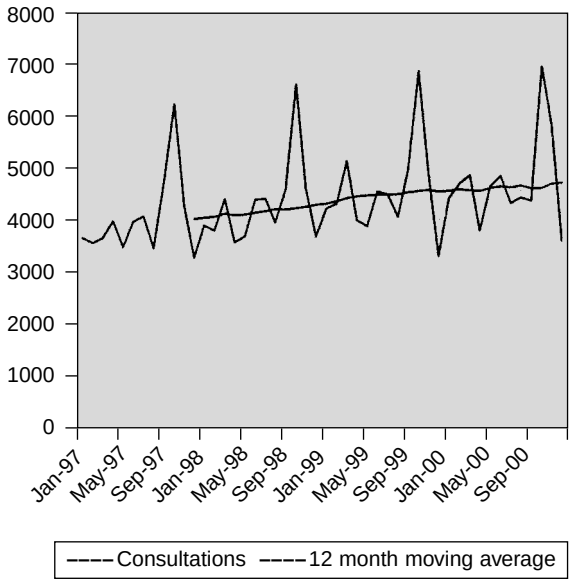
APPENDIX 3

Graphs of Primary Care Consultations

Monthly Doctor Consultations

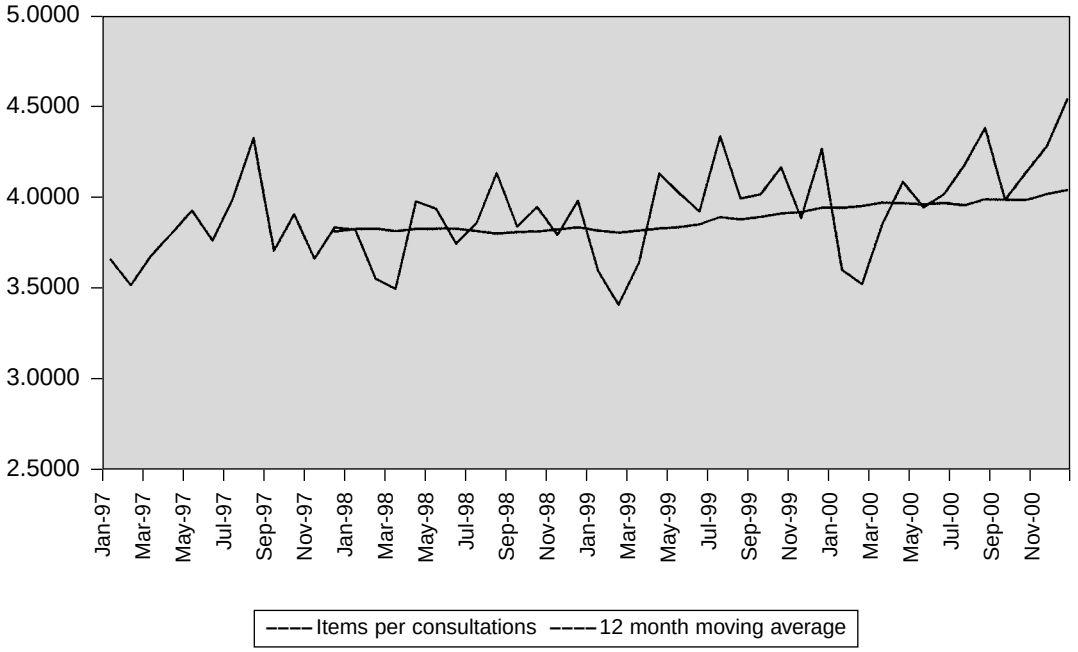


Monthly Nurse Consultations



APPENDIX 4

Graphs of Prescriptions Items per (Primary Care) Doctor Consultation



APPENDIX 5

Estimated future income and expenditure and balances of the Guernsey Health Service Fund 2000-2005

Figures in £000s	2000	2001	2002	2003	2004	2005
Increase in RPI (to mid year) %		3.0	3.0	3.0	3.0	3.0
Increase in earnings (to mid year) %		5.0	5.0	5.0	5.0	5.0
Fund at the beginning of the year	14,670	16,399	18,448	20,510	20,095	19,415
INCOME						
Contributions	15,090	15,897	16,575	17,280	18,013	18,772
States' grant	5,432	5,723	5,967	6,221	6,485	6,758
Interest	729	1,015	1,135	1,183	1,151	1,102
Total income	21,251	22,634	23,676	24,683	25,648	26,631
EXPENDITURE						
Consultation grant	2,073	2,090	2,109	2,126	2,144	2,164
Total cost of drugs, medicines, appliances and oxygen service	11,183	12,070	12,907	13,798	14,750	15,774
Prescription charges	-893	-964	-1,027	-1,091	-1,157	-1,224
Specialist medical benefit	6,418	6,610	6,808	9,407	9,689	9,980
Administration	741	778	817	858	901	946
Total expenditure	19,522	20,586	21,614	25,098	26,327	27,640
Operating surplus	1,729	2,049	2,062	-415	-680	-1,008
Fund at the end of the year	16,399	18,448	20,510	20,095	19,415	18,407
Mean fund/Total expenditure	0.80	0.85	0.90	0.81	0.75	0.68

(1) In contrast to the main table in Appendix 1, the fund values shown above include the reserves in respect of realised and unrealised gains and losses on investments. These gains and losses are included in the interest item.

(2) Figures may not sum to totals due to rounding.

IN THE STATES OF THE ISLAND OF GUERNSEY

ON THE 28TH DAY OF FEBRUARY, 2002

The States resolved as follows concerning Billet d'Etat No. II
dated 1st February, 2002

(Meeting adjourned from 27th February, 2002)

GUERNSEY SOCIAL SECURITY AUTHORITY

NEW CONTRACTS FOR SPECIALIST HEALTH INSURANCE SCHEME

After consideration of the Report dated 18th January, 2002 of the Guernsey Social Security Authority:-

1. That the existing conditions for a person being entitled to benefit under the Health Service (Benefit) (Guernsey) Law, 1990, requiring 13 weeks' residence and presence, shall be replaced with conditions of the person being:

   (a) resident in Guernsey, Alderney, Herm or Jethou; and

   (b) an insured person under the Social Insurance (Guernsey) Law, 1978, as amended, or the child of an insured person or a child in full-time education and ordinarily resident in those Islands.

2. To authorise the Guernsey Social Security Authority and the States Board of Health, on behalf of the States, to enter a contract with the Medical Specialist Group for 15 years, in accordance with the Heads of Agreement set out in paragraphs 42 to 187 of that Report.

3. To authorise the Guernsey Social Security Authority and the States Board of Health, on behalf of the States, to enter a contract with the Guernsey Physiotherapy Group for 15 years in accordance with the Heads of Agreement set out in paragraph 195 to 228 of that Report, subject to the Authority, the Board and the Guernsey Physiotherapy Group exploring fully, through discussion with other community-based physiotherapy undertakings, sub-contractual or other arrangements enabling the supply of agreed physiotherapy services by and at the premises of those undertakings, where clinically appropriate and where the patient so wishes.

4. To authorise the Guernsey Social Security Authority and the States Board of Health, on behalf of the States, to negotiate and enter a contract with the Alderney general practitioners on the lines set out in paragraphs 233 to 236 of that Report.

5. To direct the States Advisory and Finance Committee to take due account of the estimated cost to the States Board of Health resulting from the increase in patient demand and other service costs arising from the new contracts, when calculating and recommending to the States, under the financial procedures:

   (a) any increase in the States Board of Health's budget for 2003; and

   (b) that Board's annual additional capital allocations and revenue expenditure limits for 2003 and subsequent years.

6. To direct the States Civil Service Board to have regard to the estimated establishment required by the States Board of Health resulting from the increase in patient demand and other service costs arising from the new contracts, when administering the staff number limitation policy for 2003 and subsequent years.

7. That, as regards contributions payable under the Social Insurance (Guernsey) Law, 1978, from the 1st January, 2003.

   (a) the percentage rate of all primary and secondary Class 1 contributions shall be increased by 0.1%;

   (b) the percentage rate of all Class 2 and Class 3 contributions payable by resident contributors shall be increased by 0.2%.

8. That, with effect from 1st January, 2003, the percentage Health Service Annual Grant, specified under section 2 of the Health Service (Benefit) (Guernsey) Law, 1990, shall be 40%.

9. That the Health Service Allocation for contributions paid in respect of employed persons and resident self-employed and non-employed persons from the 1st January, 2003 shall be adjusted to take account of the 0.2% increase in the appropriate contribution rate.

10. To direct the preparation of such legislation as may be necessary to give effect to their above decisions.

D.R. DOREY
HER MAJESTY'S DEPUTY GREFFIER