THE FINANCE AND DELIVERY OF HEALTH CARE IN GUERNSEY

AN OPTION APPRAISAL

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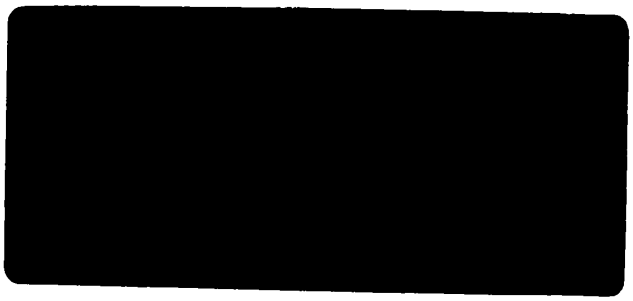

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April 1993

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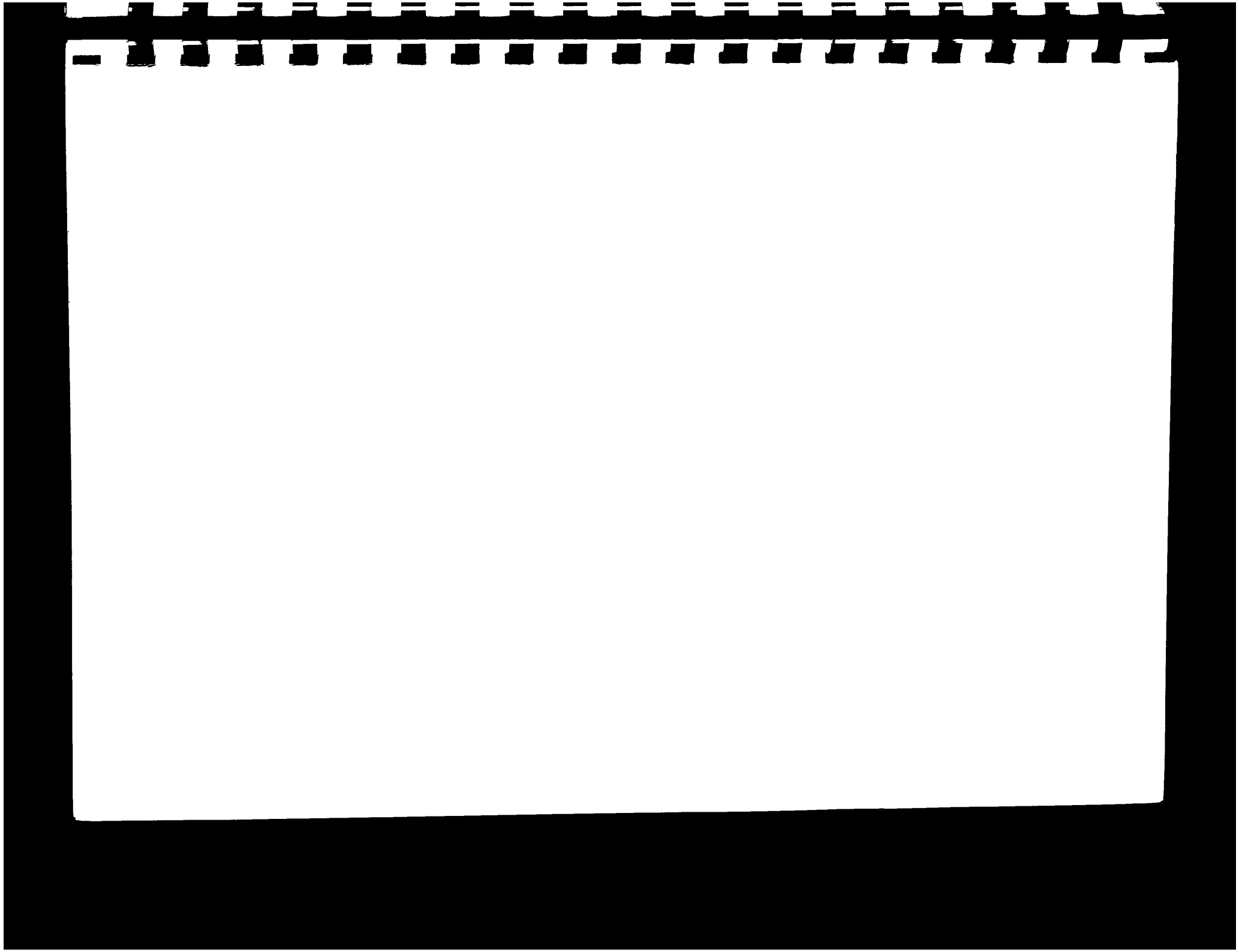

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

1. This report contains an abbreviated appraisal of the options for future health policy in Guernsey. It is divided into three main sections. The first section makes clear the main objectives that any policy must meet. The second section identifies the key components of alternative reform packages with an assessment of their strengths and weaknesses. The final section puts forward a short list of policy options from among which we believe a preferred option is likely to emerge.

Objectives

2. The major objectives set for health policy in Guernsey in the future are the containment of growth in public expenditure in a way that ensures fair access to health care and fairness in the way in which it is financed.

3. Our assessment of health expenditure during the 1980s does not suggest that it has grown at an excessive rate; however, pressures arising from demographic change, new medical technologies and increasing unit costs suggest that effective methods of cost containment will be required in the future.

4. Analysis of the current composition of activity and costs in the primary care sector indicates that the annual rate at which GPs are consulted is 3.7 consultations per person. This is below the UK average of 5 consultations per person. Expenditure on pharmaceuticals accounts for 54 per cent of SIA expenditure on health and is likely to be a major focus of cost containment policy in the future.

5. Analysis of the current composition of activity and costs in the hospital sector suggest that utilisation is low in comparison with UK figures and that the hospital has considerable excess capacity. Thus, hospitalisation rates for Guernsey residents of 112.5 acute cases per 1,000 population are 10 per cent below the average for England. The throughput rate at the PEH is 35 cases per bed compared with approximately 50 per bed in England when just in-patient cases are considered. The 19 maternity beds at the PEH cater for 750 deliveries per year; this represents a throughput of 39 cases per bed compared with 70 cases per bed in England. Since 1989, there have been decreases in both the length of in-patient stay (-28 per cent) and the number of in-patient days (-20 per cent).

6. Containing the growth in expenditure in the hospital sector will involve reducing excess capacity, containing hospital unit costs through efficient management of capacity and staff, and effective control of specialists' fees.

7. There appears to be a strong desire to maintain the high standard of health care that is currently available to all of the population of Guernsey and to ensure that gaps in access to care, or unfairness in the ways in which it is financed, do not arise.

8. We understand that gaps in insurance coverage (over 50 per cent of the population have no health insurance) have not meant that patients have been denied necessary treatment but they can mean that the uninsured face unacceptable financial burdens. Unless action is taken, this problem is likely to increase in the future - particularly for the large numbers of elderly people without insurance - as the costs of medical care rise.

Components of Policy Options

9. We have identified the key components of the policy options facing Guernsey as:

* Managed care and the management of clinical activity
* Organisation of insurance
* Methods of paying doctors
* Cost sharing arrangements
* Methods of raising insurance premiums

10. We believe that an effective system of managed care should form a key part of the Guernsey health system no matter what funding or organisational arrangements are adopted.

11. Much of the evidence about managed care arrangements comes from the United States where health insurance plans have developed a range of ways of operating this approach in recent years. Utilisation review (UR) forms a key part of this approach. UR is designed to control costs and ensure quality. However, care will need to be taken in selecting an approach that is appropriate for the Guernsey situation.

12. In the United States, managed care is often operated through some form of Health Maintenance Organisation (HMO). Once again, there are a variety of HMOs extending from the 'tight' staff models to the 'looser' network models or independent provider associations. If Guernsey decides to explore this option, it might be advisable to start with a loose model with a view to working towards a full staff model over time.

13. The experience of the NHS in introducing medical audit and the resource management initiative offers the prospect of some valuable lessons in ways of managing clinical activity.

14. A key issue that needs to be resolved is whether a social insurance arrangement would be best managed by a single insurer or through multiple insurers. The main advantage of a multiple insurer arrangement is that it would offer choice to Guernsey citizens and that competition between insurers might be expected to make them more sensitive to individuals' preferences. The main disadvantage is that this arrangement would impose substantial administrative costs. A risk-adjusted, capitation formula would need to be developed in order to allocate premiums to individual insurers on the basis of the number and characteristics of the population enrolled with them. Similarly, billing separate insurers would be more complicated than a single insurer system.

15. A single insurer system would be administratively far simpler and could prove an easier way of introducing managed care if a single company with proven expertise was selected. On the other hand, a single insurer arrangement would bestow limited monopoly power upon whichever company was selected. As such, careful consideration needs to be given to the tendering and re-tendering process. Full information on costs and activity will need to be made available to the SIA and it will require independent audit/actuarial advice. If a single insurer option is selected, the SIA should - over time - assume the role of the insurer, as its expertise develops.

16. An alternative to a single, external insurer carrying out the purchasing function - or the SIA taking over this task - would be for the Board of

Health to assume the role. We understand that a number of appointments are currently being made by the Board with this function in mind. However, for this arrangement to work satisfactorily, it would be necessary for there to be a clear separation between the Board, as a purchaser, and the PEH, as a provider. Such an arrangement would also throw doubt on the need for an external insurer, as the Board would carry out many of its key functions in relation to purchasing and managed care.

17. If there are strong concerns about the absence of choice in a single insurer model, a mixed model could be considered. This would involve single insurer, managed care arrangements for secondary care but a system of voluntary insurance offered by private commercial companies and friendly societies in the primary care sector.

18. Doctors' activities are at the centre of health care delivery. Large increases in fee payments were of particular concern to the SIA in 1992. In the longer term, the whole issue of payments systems and the incentives they offer needs to be reviewed. The existing fee for service system, through which both GPs and specialists are paid, is generally seen as a poor mechanism for controlling costs. Frequently, it tends to encourage over-provision. In fact, there is no evidence to suggest that the volume of service in Guernsey is excessive, rather it is the level of fees that has given rise to concern.

19. Prospectively determined capitation payments and salary arrangements are the main alternatives to a fee-for-service system. Both of these have advantages and disadvantages. Whether or not a movement away from total reliance upon fee-for-service, as part of a managed care system, is desirable is one of the options that needs to be considered in more depth.

20. The current SIA/BoH proposals for health finance reform involve the introduction of charges for in-patient, day-case and out-patient treatments. There would also be separate charges for the use of operating theatres, diagnostic tests, surgical implants and maternity care. The rationale for these charges is that they will introduce greater cost consciousness on the part of both consumers and providers.

21. We would caution against too ready acceptance of these arguments. Certainly, the introduction of charges may serve as a stimulus for the production of better cost data. However, with full insurance cover, consumers would still face a zero price at the time of use. What is important for cost containment purposes is cost sharing, ie requiring consumers to meet part of their bills directly. Even here, however, the evidence on the effectiveness of cost sharing as a means of cost containment is ambiguous. It appears to be quite effective in restricting demand for pharmaceuticals, and also in restricting GP consultations and out-patient visits, but far less effective in restricting the demand for in-patient care. There is also a concern that it may deter essential as well as inessential use of health care facilities, and impact more heavily upon low income groups and the chronically sick.

22. There is still some debate in Guernsey about whether health insurance contributions (premia) should be collected on an income basis or on an earnings basis. Many of the issues involved in choosing between these two options, and variants of them, relate to broad political considerations. Nonetheless, choice between them could have some implications for the achievement of cost containment and equity aims. As

far as cost containment is concerned, there is a case for making the maximum number of people aware of the link between health care costs and insurance contributions. This would favour an income based scheme. Similarly, the equity principle of relating contributions to ability to pay would also favour the more widely based income-related option. Set against these arguments, however, there is the greater administrative complexity and the possible political unpopularity that an income based scheme would involve.

Short List of Policy Options

23. From our examination of the strengths and weaknesses of the various policy components set out above, we have selected a short list of three policy packages which we believe should be considered by the States when deciding upon the future of health policy in Guernsey. These are:

* A continuation of existing policy
* A single insurer, managed care system
* A mixed model incorporating a single insurer managed care system in secondary care and multiple insurer arrangements in primary care

24. In the status quo option, there is neither a change in the method of delivery nor in the financing of health care. On this basis, we have sought to estimate the likely growth in health spending over the next ten years. To do this, we have used alternative projections of population growth, age-specific GP consultation rates, age-specific hospital utilisation rates and assumptions about increases in unit costs. On one set of assumptions, these factors suggest a rate of growth in spending of at least 6 per cent per year over the next ten years. Given that there

is a strong commitment on the part of the Advisory and Finance Committee that there should be a zero rate of real growth in public expenditure for the forseeable future, funding this option clearly becomes problematic.

25. We believe that the case for a single insurer, managed care system is a strong one. In fact, the single insurer would be acting primarily as a purchaser rather than an insurer. In the short run, there is a clear argument for assigning this purchaser function to an agency with expertise in this area. This may be a commercial insurer or it could be the Board of Health if staff with the necessary expertise are appointed. In the longer term, we recommend that the BoH or the SIA develops their own expertise as purchasing organisations and take over the responsibility for managing the health care budget.

26. The introduction of managed care is vital for the success of this option. Utilisation review in relation to the hospital sector is an important aspect of managed care. However, given the absence of evidence of serious hospital over-utilisation in Guernsey, it is not clear that some of the more vigorous and costly examples of US practice are appropriate to the Island. In the longer term, the establishment - and acceptance by the medical profession - of protocols on treatment based upon clinical and cost-effectiveness information will probably be more important. Peer review and medical audit have a clear role to play here.

27. The key factors that will need to be addressed through managed care are: the control of hospital utilisation, doctors' fees, excess capacity at the PEH and expenditure on pharmaceuticals.

28. The proposals for a mixed system adopts exactly the same arrangements for

the secondary care sector as those outlined in the single insurer, managed care model. However, in an effort to meet some of the Guernsey residents' demands for choice among insurers, we have suggested that multiple insurers could continue to offer insurance on a voluntary basis in the primary care sector.

29. We do not believe that the fundamental aims of social insurance and managed care in the secondary sector would be jeopardised by these arrangements. There is at present no evidence to suggest that GP referrals to the PEH are excessive. However, if cost shifting arose in a mixed system, clear protocols for GP referrals would need to be developed. Similarly, we do not see major problems of inequity arising through gaps in insurance cover, given the modest costs of primary care, at least in relation to secondary care.

INTRODUCTION

I INTRODUCTION

There have been a number of reviews of the health care system in Guernsey since the mid 1980s, starting with the Black Report which was published in 1985. These reports have identified various features of the existing system which require attention and have, in a number of cases, made specific proposals for reform. The most recent reform proposals are, of course, those produced by the States Board of Health (Health Care in Guernsey - Future Plans and Funding) and the States Insurance Authority (Comprehensive Health Insurance Scheme) as set out in Billet d'Etat, VI, 1992; 29 April.

The amount of work that has gone into the production of these proposals is impressive. However, we feel that, on some occasions, the case for particular reform proposals has been made incompletely. Moreover, given the length of time over which discussion has taken place, there is a danger that key issues have become submerged or obscured. Accordingly, this report seeks to do three things; namely, to:

* offer a clear statement of the aims of the health care reforms being put forward by the States Board of Health and the States Insurance Authority.

* identify the key components of alternative reform packages, with an assessment of their strengths and weaknesses.

* put forward a short list of reform packages from among which we believe a preferred option is likely to emerge.

As far as the first of these tasks is concerned, ie specifying the aims of health care reform in Guernsey, we believe that the desire to contain the rise in health care costs and to ensure that it is made available, and funded, on a

fair or equitable basis are the paramount objectives.

There are a variety of finance and delivery arrangements that can be used to address these objectives. Among the key components of these arrangements, we have examined different ways of:

* managing care and clinical activity
* organising insurance
* paying doctors
* cost sharing between patients and insurers
* raising health care finance.

Our analysis has sought to identify the strengths and weaknesses of alternative arrangements by drawing on both our understanding of the Guernsey situation and also the wider body of international evidence on alternative finance and delivery systems.

Following our examination of these factors, we have presented three main policy options which, we believe, need to be considered by the States. First, we have identified the implications of continuing with the existing health system; that is, a 'no change' or 'status quo' option. Second, we have specified a single-insurer, managed care system and identified the ways in which this can be expected to perform. Third, we have specified a 'mixed-model' in which a single insurer covers the secondary care sector while multiple insurers (including existing private insurers and friendly societies) are able to offer coverage for primary health care costs.

In presenting this report, however, it is important to emphasise that we have not set out to provide a fully-specified detailed option appraisal. Given the time available to the King's Fund Institute, over the period in which the States Insurance Authority required a report, it was agreed that the Institute

would produce an 'abbreviated' option appraisal. This has meant that we have sought to identify the key issues in order to inform policy discussion and debate. Further work will be necessary if it is decided to examine and develop any particular option in greater detail.

THE AIMS OF HEALTH CARE REFORM IN GUERNSEY

II THE AIMS OF HEALTH CARE REFORM IN GUERNSEY

On the basis of our reading of previous reports, and of discussions we held during a two-day visit to Guernsey, we believe that there are two major aims which have been set for the Guernsey health system in the future. These are:

* Total cost containment.
* Equity in access to, and finance of, health care.

II.1 Total Cost Containment

There is a general belief that the current rate of growth of expenditure on health care is not sustainable in the long term. In common with most other countries that are displaying a similar concern, it is the growth in public expenditure which it is felt needs to be controlled. Nonetheless, we believe that it is also important to take into account the growth in private expenditure as this may well have implications for access to health care.

Over the 1980s, the real rate of growth of public expenditure on health (cash expenditure adjusted by changes in the retail price index) was just over five per cent per year (cash figures shown in Table 1). To place this in some context, it is relevant to note that, over the same period, total public expenditure grew by approximately six per cent per year so that the proportion of expenditure going to health care actually fell. Thus, in 1980, expenditure on health was 20.3 per cent of total public expenditure, whereas by 1991, it had fallen to 19.4 per cent.

At the same time, the overall state of the public accounts seems to have been fairly healthy during the 1980s. Over the period, revenue has increased as rapidly as public expenditure with the result that Guernsey has been running a budget surplus.

Despite this generally healthy picture, however, there is nonetheless general agreement about the need to restrain the growth in health expenditure in the future. This would seem primarily to be motivated by two assumptions: that, as the population of Guernsey becomes older, and as medical technology develops, an ever increasing portion of public expenditure will be needed for health care; and, that public revenue is unlikely to increase at such a high rate in the future. On the latter point, we understand that there is a strong commitment on the part of the Advisory and Finance Committee (AFC) that there should be a zero rate of real growth in public expenditure in the foreseeable future. Hence the need to look at cost containment in the health sector.

In considering cost containment strategies, it is necessary to examine the make-up of total costs. Thus, Table 2 indicates the breakdown of health expenditures, by sector, for 1991.

As the table shows, acute and general services accounted for the largest proportion of Board of Health expenditure and are, therefore, an obvious focus for cost containment strategies. Within the SIA budget, spending on pharmaceuticals, at 54 per cent of the total, represents the lion's share and will similarly require attention as part of a cost containment strategy.

(Note: Our calculations suggest that public expenditure on health was approximately £37.05 million in 1991 rather than the figure of £33.85 million which is given in Guernsey Statistics for 1992 (see Table 1). Our figure takes into account both the £28.64 million which is administered by the Board of Health and the £8.41 million administered by the SIA. The Statistical Digest, on the other hand, includes the total spent by the Board of Health but only part of the SIA expenditure, ie spending on pharmaceuticals and the associated administration. It does not include payments for primary care consultations and various supplementary benefit medical payments.)

TABLE 1

GUERNSEY EXPENDITURE, 1980-91 (£ MILLION)

	Public Expenditure on Health	Total Public Expenditure	Total Public Revenue	Public Surplus
1980	9.69	47.61		
1981	11.10	58.33	63.57	5.23
1982	12.71	66.59		
1983	13.99	75.55		
1984	14.90	81.82		
1985	16.00	88.06		
1986	17.34	94.22	107.56	13.34
1987	19.58	108.62	123.64	15.01
1988	23.64	122.19	139.28	17.09
1989	28.71	143.99	158.15	14.16
1990	31.46	167.79	172.06	4.28
1991	33.83	183.41	186.01	2.60

Notes: Figures are rounded to two decimal places

Source: Guernsey Statistics, 1992

TABLE 2

BREAKDOWN OF PUBLIC HEALTH EXPENDITURE IN GUERNSEY, 1991

BOARD OF HEALTH

	£M	%
Acute & General	12.27	43
Elderly	4.74	17
Psychiatric	5.69	20
Community	2.18	8
Services Abroad	1.55	5
Various Grants	0.84	3
Central Administration	1.22	4
States Analyst	0.16	1
TOTAL	28.64	101

STATES INSURANCE AUTHORITY

	£M	%
Pharmaceutical	4.57	54
Primary Consultations	1.70	20
Administration	0.59	7
Supplemenary Benefit Medical Payments	1.55	18
TOTAL	8.41	99
TOTAL PUBLIC EXPENDITURE	37.05	

Notes: Totals may differ due to rounding error. This table is based on the States Accounts for 1991. The item of expenditure, Services Abroad, includes that on reciprocal health agreements and the maintenance of patients in UK hospitals. The item Various Grants includes grants to various local societies, of which nearly 90 per cent is to St John's Ambulance Brigade. The SIA pays various supplementary benefit medical payments including limited and industrial medical benefits, special grants and the medical expenses assistance scheme (MEAS). Travel allowances to the UK are not included.

Estimates of private expenditure on health care can only be approximate. The report of the Thomason review of doctors' remuneration (October 1990) suggests £4.74 million as the total of such costs. More recent estimates have been based on GP costs of £4.4 million, specialist consultation costs of £1.75 million and specialist procedure costs of £2.76 million, totalling some £8.9 million. However, a part of this is already covered by the SIA grant of £2.88 million. Subtracting this from the total of £8.9 million would suggest private expenditure of some £6 million, which is paid either from private insurance or out-of-pocket. (Note: this figure does not include private expenditure by Guernsey residents in the UK.)

By combining public expenditure of £37.1 million with an estimate of £6 million of private expenditure, we obtain an estimate of total expenditure on health in Guernsey of £43.1 million. This represents about 5 per cent of GNP which is low by international standards. (Note: It is usual to relate health expenditure to GDP. However, historical practice in Guernsey has related official figures on health expenditure to GNP, possibly because of a 'rentier' sector of around 20 per cent of GNP.)

Looking to the future, the Board of Health expenditure increased to £31.03 million in 1992, and is estimated at £34.02 million in 1993. This amounts to an increase of over 18 per cent over the two years. If this same rate of increase is applied to total health expenditure (ie public plus private), the result is a figure of £51.2 million in 1993, of which public revenues would account for over £44.1 million.

In analysing the sources of total cost escalation, it is useful to distinguish between cost increases resulting from growth in the <u>volume of care</u> and those resulting from increases in the <u>unit cost of care</u>. The volume of care measures the number of cases treated, whereas unit costs depend upon doctors' fees and hospital costs in relation to the number of cases treated. Below, we

consider the current situation in Guernsey in relation to these factors, looking first at the primary sector and then the cost of hospital care.

The Primary Sector

The primary sector includes consultations with GPs, other services offered within the GP environment, eg immunisation, consultations with practice nurses, and pharmaceuticals. GPs are self-employed and charge a fee for service, which currently is set at approximately £19 per consultation. Of this, £8 is reimbursed by the SIA. This is an approximate figure, as GPs are in fact free to charge whatever fee they wish although, of course, the usual market constraints would eventually operate. We estimate GP fees in total represent nearly 10 per cent of the total health spending in Guernsey, or £4.4 million. Thus, at the moment, they are not a substantial part of the overall health expenditure.

Ideally, we would like to analyse primary care data over a period of years in order to identify changes and trends in GP activity and costs. However, such data are not available; instead, in Table 3 we have presented figures on the current usage of GPs by the population of Guernsey and Alderney. Interestingly, these indicate that the annual consultation rate per person is just 3.7. This is considerably lower than the most recent General Household Survey estimate of 5 consultations per person for UK residents.

As would be expected, however, the consultation rate for the 65+ age group is a good deal higher. Thus, as the age structure of the population becomes older, so the number of consultations, and hence cost, will increase. Some calculations of projected future costs are presented later in this report.

UK data show that there are large variations in GP prescribing of pharmaceuticals between practices, and that this is one of the first

TABLE 3

GP CONSULTATIONS, BY AGE-GROUP, 1992

Age Group	Total	Consultation Rate
0-14	33,900	3.1
15-64	142,200	3.5
65+	52,600	5.4
Total	228,400	3.7

Notes: Figures are rounded to nearest hundred; the consultation rates are based on 1991 Census populations. This table is based on figures for Guernsey and Alderney supplied by the SIA.

priorities for containing the growth of costs in primary care. While no data on the prescribing behaviour of Guernsey GPs are presented, it has been confirmed that similar variations also exist.

Table 4, showing practice nurse consultations, is included as this may be a way of reducing the costs of consultations in the future. This depends on the extent to which these consultations can be viewed as true substitutes for some GP consultations, ie nurses acting as nurse practitioners, actively carrying out diagnosis and prescribing drugs. We understand that, at present, this is not the case. (Note: Currently there are no nurse consultations in Alderney.)

The Hospital Sector

Hospital care includes acute medical and surgical services; maternity services, allied services including radiology and pathology; elderly and psychiatric services. For the purposes of this report, we have concentrated on the acute and maternity services offered chiefly in the Princess Elizabeth Hospital (PEH).

The total costs of the hospital service depends upon (i) doctors' fee levels, (ii) hospital unit costs, and (iii) the number of patients treated.

With the exception of the nine specialists employed by the States, all specialists in Guernsey are self-employed and charge a fee for service to patients based upon:

i) consultations - generally outside the PEH; and

ii) attendance at hospital and performance of operations and other related clinical activity.

TABLE 4

NURSE CONSULTATIONS, BY AGE-GROUP, 1992

Age Group	Total	Consultation Rate
0-14	1,900	0.2
15-64	25,100	0.6
65+	10,100	1.1
Total	37,100	0.6

Notes: Figures are rounded to nearest hundred; the consultation rates are based on 1991 Census population. This table is based on figures supplied by the SIA.

The payments for these services are covered either by private insurance policies, personal payments, or through supplementary benefit medical cover. A schedule of fees has been agreed between the BMA and SIA with respect to those paid by the SIA, through supplementary benefits or industrial injuries. However, as with GPs, the specialist doctors are free to charge their private patients on the basis of whatever fee schedule they wish. In fact, insurance companies claim that their fee structure relates fairly closely to that paid by the SIA.

Events over the last financial year have given particular cause for concern about doctors' fees. Over this period, expenditure on doctors' fees rose by over 22 per cent, even though there was only an 8 per cent increase in the scale of fees. It seems that this large increase was due to a shift in charging procedures by specialists so that consultations which were previously charged for at the GP rate are now charged at the specialist rate. There would also appear to be some increase in the volume of medical activity. These figures are based on supplementary benefit medical payments, but the general trend is confirmed by the private insurance companies.

Hospital costs cover nursing services, support services such as radiology and pathology, and running costs such as laundry, catering and cleaning. There are also the overhead costs of plant maintenance, heating and lighting. The efficiency with which these inputs are combined will determine the costs per unit of care.

The Board of Health has, until very recently, lacked a financial information system which would permit the allocation of costs to cases treated and, therefore, it is impossible to examine efficiency at the disaggregate level. Nonetheless, there are some aggregate data which indicate the scale of the increase in costs in recent years.

Figures available from Billet D'Etat, XXIV 1989, Health Care in Guernsey - Future Plans and Funding, suggest the following comparison between 1982 and 1988. In 1982, the cost per in-patient day in the PEH was £87.4 and the cost per case was £893. By 1988, cost per day had almost doubled and cost per case had risen by 60 per cent.

However, these figures are based on the allocation of the total cost of the hospital to in-patient care, and hence are not strictly comparable with UK or US figures which give a more detailed breakdown between in-patient, day care, out-patient and A&E services. Moreover, unlike the UK, the cost of specialist medical staff is not included in the total cost of the hospital.

Data on the volume of care provided are also relevant to the question of efficiency. Table 5 shows that the use of in-patient services in Guernsey has been growing over the last five years. In 1991, 95 per cent of patients treated in the PEH were from the Bailiwick of Guernsey. The increase in Guernsey residents treated in the PEH, between 1987 and 1991, was over 15 per cent, slightly higher than the increase in total utilisation (ie Guernsey and non-Guernsey residents) of the hospital.

Recent figures on off-Island referrals for the period 1990-1992 reveal 828 cases in 1990, 742 in 1991 and 809 in 1992, substantially more than the flows of patients into Guernsey which are shown in Table 5. Assuming that these off-Island referrals are mainly acute, the overall hospitalisation rate for Guernsey residents in 1991 was 112.5 acute cases per 1,000 population. This is 10 per cent less than the English average and on a par with the leafy London suburbs of Bromley and Bexley.

In Table 6, we show activity data for the last 14 years. The volume of cases treated has increased by some 41 per cent over this period.

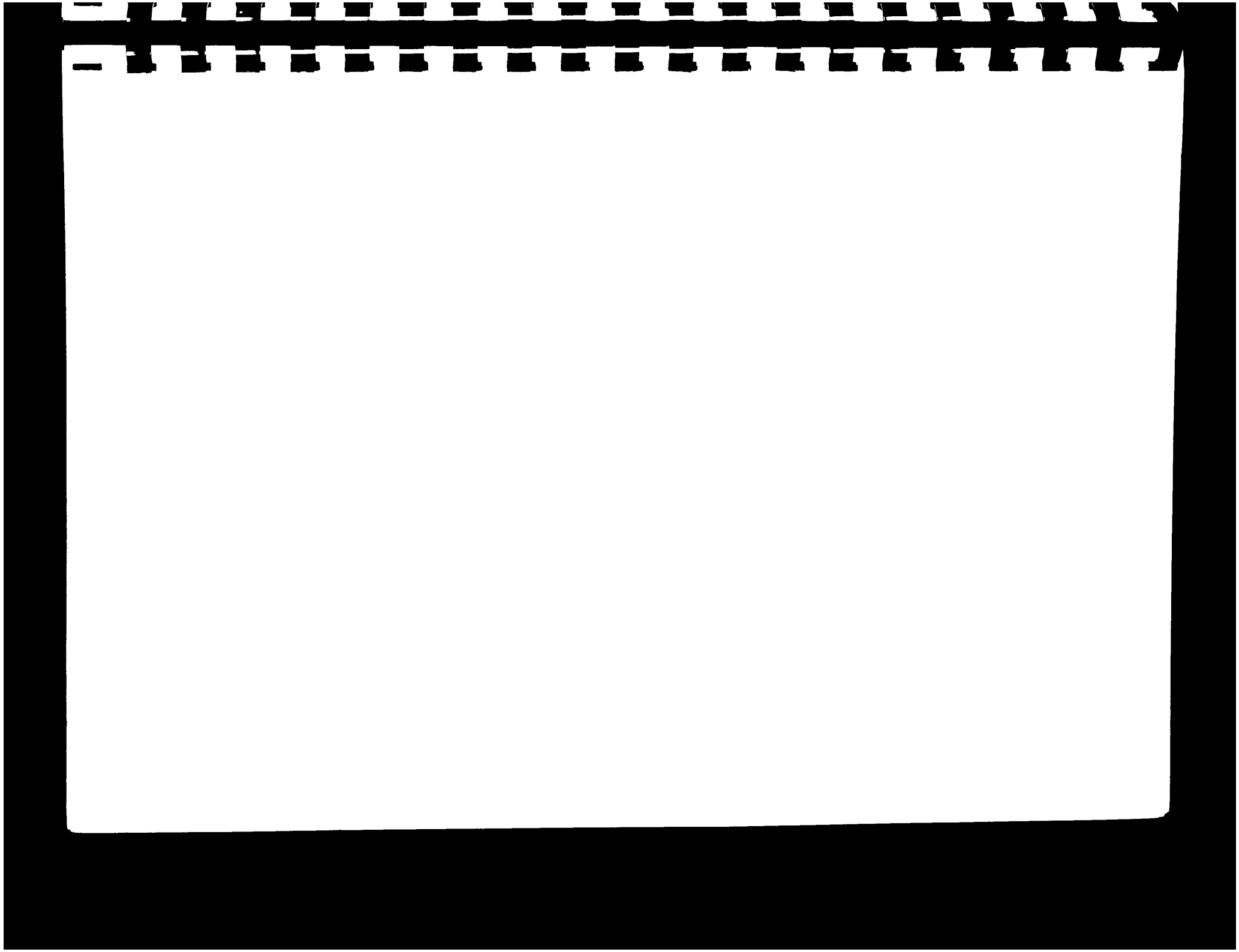

TABLE 5

THE USE OF IN-PATIENT SERVICES

	SOURCE OF PATIENTS				
	GUERNSEY & ALDERNEY	OTHER CIs	UK	OTHERS	TOTAL
1987	5,322	72	242	23	5,659
1988	5,688	70	196	20	5,964
1989	5,962	96	238	25	6,321
1990	6,333	94	224	15	6,666
1991	6,140	99	192	16	6,447

Source: Guernsey Statistics, 1992.

Note: The Board of Health supplied a correction to the published figures, for 1991.

TABLE 6

THE PRINCESS ELIZABETH HOSPITAL, GUERNSEY

IN-PATIENT ACTIVITY 1979-1992

Year	In-patient Discharges	Length Of Stay	In-patient Days
1979	4,973	9.93	49,384
1980	5,051	9.87	49,847
1981	4,998	9.78	48,884
1982	5,043	10.22	51,552
1983	5,296	9.46	50,114
1984	5,706	8.28	47,236
1985	5,806	8.26	47,930
1986	5,793	8.37	48,498
1987	5,659	8.44	47,748
1988	5,964	8.12	48,418
1989	6,321	8.32	52,617
1990	6,666	7.30	48,632
1991	6,447	7.38	47,605
1992	7,034	5.99	42,144

Source: Personal communication from Board of Health, 1993

At the same time, length of stay has fallen considerably - since 1989 there has been a reduction of 28 per cent. There has also been a substantial fall in in-patient days - by almost 20 per cent since 1989. This suggests that there should have been a commensurate reduction in bed capacity. However, in fact there has been a recent increase in capacity.

Based on 200 beds, the throughput rate for PEH is just 35 cases per bed. This compares with an England average of approximately 50 when just in-patient cases are considered. When we consider occupancy rates, we find that the rate for PEH is less than 60 per cent. The turnover interval in England is approximately 1.4 days, whereas the PEH figure is closer to 4.4 days. We also know, for example, that there are 19 maternity beds and just 750 deliveries per annum. This gives a throughput of just 39 cases per bed compared to the England average of nearly 70 cases. These figures suggest there is substantial under-utilisation of the PEH facilities. Put another way, the PEH appears to have considerable excess capacity.

Thus, reducing costs is not simply a matter of improving throughput in the PEH. The issue of the optimal level of total capacity is also important. The Chief Executive of the Board has suggested potential cost savings of approximately £1 million under current bed management constraints. But any long-term improvement in efficiency will depend upon the co-operation of doctors and the Hospital Management Board.

II.2 Fairness or Equity in Access and Finance

In our discussions with individuals and groups on Guernsey, we have been struck by the desire to maintain the generally high standard of health care that is currently available to everyone and to ensure that gaps in access to health care, or unfairness in the ways in which it is financed, do not arise.

On the question of access to services, we have been told that some gaps have started to emerge. We understand that these have not yet resulted in patients being denied necessary treatment but they can mean that the uninsured face unacceptable financial burdens. And, as Table 7 indicates, the number of people without insurance is surprisingly high, ie over 50 per cent of the population.

We heard that, in a number of cases, doctors have borne the costs of individuals unable to meet the full costs of their care. Particular aspects of care that can be problematic in this respect are unexpected cases requiring intensive care - which can be very expensive; chronic illnesses needing frequent GP consultations and long-stay nursing home care.

Despite the fact that a large proportion of the population have no or only partial insurance, these problems do not appear to be widespread at the moment, but they can be expected to increase in the future as the costs of health care rise. This is likely to be particularly true of the elderly, 70 per cent of whom are presently uninsured and, therefore, at risk if medical costs continue to increase.

The other area in which questions of equity arise is in connection with the contributions or premia that would need to be made under a social insurance scheme. In particular, which groups should contribute towards the scheme and how should the scale of payments be set? Debate has already centred on whether contributions should be income- or earnings-based, whether married women not in employment and persons over the age of 65 should make contributions and what the maximum contribution rate should be. The ways in which these issues are resolved will obviously have implications for the distribution of the burden of costs among the population. There will also be 'gainers' and 'losers' in terms of the personal costs borne compared with the existing system.

TABLE 7

PRIVATE HEALTH INSURANCE IN GUERNSEY, 1991

Degree of Insurance	0 - 14		15 - 64		65+		Total	
	No.	% of Total Known	No.	% of Total Known	No.	% of Total Known	No.	% of Total Known
None	4,498	46	19,376	49	6,290	69	30,164	52
GP Only	604	6	3,155	8	1,079	12	4,838	8
Specialist Only	387	4	1,653	4	311	3	2,351	4
GP and Specialist	4,372	44	15,107	38	1,492	16	20,971	36
Total Known	9,861		39,291		9,172		58,324	
Unknown	138		297		108		543	
TOTAL	9,999		38,588		9,280		58,867	

Source: Guernsey Census, 1991

Finally, it seems to us important to recognise that the prevailing view in Guernsey appears to be against the development of a 'two-tier' system on the Island. Rather, there is a strong preference for uniformly high standards for all. If this view is correct, it clearly has implications for the scale of privately-insured top-up coverage that is desirable. While we understand the wish to continue to offer the 48 per cent of the population who currently have some form of private medical cover - either through private insurers or friendly societies - the choice to which they have become accustomed, if the desire for uniform access is genuine, top-ups will need to be restricted to marginal aspects of the service, eg certain features of the hotel services. If private treatment on Guernsey was appreciably different for the treatment under the social insurance scheme, this could pose problems. However, the absence of NHS-style waiting times means that a major factor differentiating the NHS from private care in the UK is not present in Guernsey. We assume, however, that those groups who have grown accustomed to travelling to the mainland for hospital treatment will continue to do so under private insurance arrangements.

COMPONENTS OF POLICY OPTIONS

III COMPONENTS OF POLICY OPTIONS

In this section, we present an analysis of the key components of the policy options facing Guernsey. These are:

* Managed care and the management of clinical activity
* Organisation of insurance
* Methods of paying doctors
* Cost sharing arrangments
* Methods of raising insurance premiums

Each of these components is directly related to the overall aims of achieving total cost containment and/or securing equity in access to health care and the ways in which it is financed.

III.1 Managed Care and the Management of Clinical Activity

The States Board of Health document, Health Care in Guernsey - Future Plans and Funding (29 April 1992) records that the Board of Health and representatives of the doctors in Guernsey agree that the introduction of managed care will contain costs and improve the level of service. We believe that this is a crucial point of agreement and, furthermore, we suggest that a system of managed care should form a key part of the Guernsey health system no matter what funding or organisational arrangements are adopted. Below, we outline some of the key features of a managed care system.

The term managed care is usually used to refer to those systems in which organisations that are responsible for the purchase of health care seek to 'manage' the care received by their clients from doctors, hospitals and other providers. This management will cover the nature of the health care provided (eg whether or not a hospital admission is appropriate, what clinical

procedures should be undertaken, how long lengths of hospital stay should be, whether day case treatment is suitable etc) as well as its costs. Often - but not invariably - managed care is provided through prospective payment arrangements in which insurers contract with providers for all necessary care on the basis of a pre-paid sum per patient.

A good deal of the evidence about managed care arrangements comes from the United States where health insurance plans based upon these principles have expanded their coverage rapidly in recent years. Within these plans, utilisation reviews (URs) play a major role in the management of clinical activity.

Utilisation Reviews

Today, there are approximately 300 UR organisations operating in the US. The structure of the industry is complex and changing rapidly. In essence, however, there are four main types of UR firms:

* Independent UR firms, also known as freestanding or fourth-party firms. These are used by employers, insurers and managed care plans to apply UR techniques on their behalf.

* Insurer-based firms, which are usually in-house divisions of insurance companies.

* Insurer-owned firms, which are subsidiaries of insurance companies. These apply UR techniques on behalf of the parent company but also for other companies.

* Provider-based firms, which apply in-patient UR techniques to their own patients.

These firms use a range of UR techniques, including:

* Pre-admission reviews, in which hospitals are required to notify the UR firm of a decision to admit a patient as a condition of payment. The review process typically determines whether a planned procedure should be performed on an in-patient basis and, if so, what length of stay is appropriate. The evidence suggests that the pre-admission reviews have resulted in reductions in hospital utilisation but that cost savings have probably been more than offset by increases in out-patient procedures and additional administrative costs.

* Second opinions through which UR firms require all patients requiring certain surgical procedures to be evaluated by a second doctor prior to surgery. Given that 95 per cent of second opinions confirm the original decision, this approach tends to be very costly and yield few cost savings.

* Admission reviews which are concerned with the medical necessity of particular procedures. These are based upon research evidence about the appropriateness and effectiveness of different interventions and seek to specify guidelines for the treatment of patients. Early results suggest that up to 15 per cent of specified procedures have been deemed unnecessary when subjected to this form of scrutiny.

* Concurrent reviews monitor the way care is administered once a patient has been admitted to hospital. It covers instances when a hospital might decide that a patient requires additional days in hospital beyond those approved at the time of the pre-admission review. It also covers discharge planning which is used to make sure that lengths of stay are not unnecessarily long.

* Guideline/quality review is in its infancy but it has the potential to make the greatest impact of all forms of UR. It involves review nurses maintaining regular contact with hospitals to ensure that they are complying with guidelines for cost control and quality assurance.

Thus, there are many different ways of carrying out UR as part of a managed care system. The States will need to consider the feasibility of the different approaches for the Guernsey situation and the expertise that insurance companies and others either have, or may be expected to develop, for the execution of the necessary functions.

Health Maintenance Organisations

As mentioned above, managed care in the US is usually organised through prospective payment health plans. Health maintenance organisations (HMOs) were the first of these plans to develop. In a typical HMO, patients enrol through the payment of a set, annual fee usually paid through their employer. In return, the HMO contracts to provide all the health care that is deemed necessary. This may be organised in a number of different ways. A 'staff model' HMO involves the full integration of the insurance and delivery functions. The organisation will have its own health centres and will either contract for hospital services or, in the case of larger HMOs, may actually own them itself. In a staff model, doctors are usually employed full-time on a salaried basis. This removes the incentive for them to over-utilise hospitals and other services.

Other forms of HMOs maintain a larger degree of separation between the role of insurer and that of service deliverer. Thus, an HMO - acting primarily as an insurer - may contract with a large group practice to provide care (a group model), or with a number of group practices (a network model) or with a number

of solo practitioners or small groups (an independent practice association - IPA). In contrast to the staff model - with its directly employed, salaried doctors - providers in this second category of HMOs have rather more autonomy. Primary care doctors may be paid a fixed fee per enrolee, but they may also be paid on a modified fee-for-service basis. And practically all hospital care will be provided on a fee-for-service basis. In these settings, the payments system cannot be relied upon to encourage cost saving to the same extent as in a staff model and so rather more emphasis is placed upon utilisation controls.

In the Guernsey setting, the first point to note is that there is presently little evidence of over-utilisation. As we pointed out in Section II, both the level of GP consultations and, more importantly, hospital utilisation rates are low by UK standards. It appears to be the cost of services rather than their volume which requires attention and much of this cost results from doctors' fees and excess capacity in the hospital sector. Of course, the absence of evidence on over-utilisation does not mean that systems designed to, for example, increase day case treatments and to reduce further lengths of in-patient stays would not improve the efficiency of the system. But it is important to recognise that Guernsey does not appear to be characterised by excessive supplier-induced demand.

We understand that there is some interest in exploring HMO arrangements as a means of improving efficiency through managed care systems in Guernsey. As we mentioned above, there are several forms of HMO. Probably the simplest arrangement in the short run would be for an insurer to act as an HMO and for it to contract with groups of GPs and the PEH on an IPA basis. Over time, however, there is a case for seeking to develop a staff model HMO. This could require the Board of Health to act as an HMO offering primary and secondary care in return for capitation payments reflecting the number and composition of insurees. If this payment was organised through a single insurer, it would, in effect, be a global sum agreed in negotiation between the insurer

and the Board of Health. An important feature of an HMO is, however, that the HMO should bear the risk associated with activity exceeding the level permitted by prospectively agreed budgets. This is the financial incentive for providing cost-effective care. Given that the Princess Elizabeth Hospital is publicly owned - and that the States presumably has the ultimate responsibility for meeting any deficit - it is not clear how this incentive should be built into the system.

Experience from the UK is also of relevance in considering different ways of managing clinical activity. In particular, experience with policies designed to improve professional standards through medical audit and efforts to involve doctors in management through the resource management initiative both merit attention.

Medical Audit

Medical audit is a process through which doctors themselves systematically review their work with a view to improving standards. It may take the form of an individual clinician reviewing his or her own work but more usually involves a group of doctors comparing and assessing one another's performance. Alternatively, an outside agency may be responsible for undertaking audit work.

While at one level audit involves simply describing and comparing clinical practices, at another it entails action to change these practices where shortcomings are identified. This can be achieved by isolating aspects of care which are deficient and encouraging the doctors concerned to change their methods of working. Quality can also be improved through the dissemination of good practice and by concentrating particular treatments in the hands of doctors who achieve better than average outcomes. A further aim of audit is to reduce unnecessary or inappropriate practices, thereby saving resources.

This may involve reductions in lengths of stay, changes in prescribing patterns, and limiting the use of diagnostic tests. Efficiency as well as quality is thus a key aim of audit.

While there have been many examples of individual medical audits carried out in the UK over the years, the NHS and Community Care Act, 1990 thrust audit to the front of the policy agenda by requiring all district health authorities to set up formal audit frameworks. These are required to embody the following features:

* Every consultant should participate in a form of medical audit agreed between management and the profession locally.

* The system should be medically led, with a local medical audit advisory committee chaired by a senior manager.

* Management should be responsible for ensuring that an effective system of medical audit is in place, and also that the work of each medical team is reviewed at whatever regular, frequent intervals are agreed locally.

* Peer review findings in individual cases should be confidential, but the general results of medical audit should be available to management locally and the lessons learned published more widely.

Despite these good intentions, recent research on audit arrangements within a sample of hospitals reveals uneven commitment and spasmodic progress. While there is general consent that medical audit is an essential pre-requisite for the achievement of appropriate and cost-effective care, a key issue remains how to translate good intentions into more widespread practical achievements. Much depends on the interest and enthusiasm of individual clinicians. Many doctors still appear to feel threatened by other colleagues examining their

work.

In Guernsey, with only about 30 specialists, including States-employed consultants, certain aspects of the logistics of organising an effective audit system may be more straightforward. Even within a small organisation, however, it is necessary to enlist the support and maintain commitment from doctors on a continuing basis. Moreover, the small number of consultants in each specialty also, of course, means that there are a limited number of peers available to carry out reviews. This would almost certainly lead to the need for assistance from doctors and other familiar with audit from outside the Island.

Resource Management Initiative

The Resource Management (RM) Initiative was launched at six experimental NHS acute hospital sites in 1986. A crucial feature of this approach is the involvement of doctors and nurses in the management of resources alongside general managers. This is usually achieved through the establishment of clinical directorates based upon the main specialties, each with a clinical, nursing and business manager. Improvement in information systems has also been an important element of the approach. Following the NHS and Community Care Act, 1990, RM became approved policy and is now being rolled-out across the entire NHS.

Independent evaluation of progress with RM at the six experimental sites suggest that it is too early to reach a definitive assessment of it as a working process for hospital management. But the same research has revealed that many managers already see the implementation of RM as an essential pre-requisite for a coherent management process. Central to this is the involvement of doctors - whose clinical decisions commit resources - in decisions about the planned use of resources. Once again, if Guernsey decides

to pursue a similar strategy, there is a case for drawing upon the expertise built up in the NHS over the last six years in connection with the implementation of RM.

Overseeing the Development of Managed Care

While there may be general agreement on the desirability of introducing better arrangements for managing care and clinical activity, there remains the important task of ensuring that these arrangements are actually put in place. Who should have responsibility for ensuring implementation? In Guernsey, four main models are possible:

* The Board of Health. The Chief Executive of the Board of Health has explained to us that he envisages the Board acting as the purchaser of health care and thereby assuming responsibility for ensuring improved quality and cost effective secondary care in the future. A number of key appointments, including a new head of finance and a commercial manager, are being made to further this aim. Moreover, the Medical Advisory structure has been reviewed, and the constitution of the Medical Advisory Committee to the BoH is currently being revised, with the aim of getting doctors more involved in management. As we have argued earlier, this is an important prerequisite for the effective management of clinical activity.

  In our view, the feasibility of the Board-led arrangement depends crucially on the extent to which the BoH is genuinely independent of the PEH management. Without a clear separation of the purchaser-provider functions, there is a danger that the purchaser may well identify itself too closely with the provider interests. This will weaken incentives for cost containment. The experience of those district health authorities in the UK, which have retained responsibility for managing their provider

units, in cases where NHS trusts have not yet been formed, highlights this danger. Moreover, the strictly limited scope for provider competition on Guernsey, eg referrals to Jersey or the mainland, makes independent purchasing activity even more important.

* A single external insurer. An external insurer would be organisationally separate from the PEH and, therefore, in a position to require services to be provided at specified prices. This would impose an external constraint on the hospital and could be used as a spur to greater efficiency through managed care. However, a single insurer would not face competition over its premium levels from rival insurers and would, therefore, itself face limited incentives to keep costs down. This would mean that the annual re-negotiation of premium levels with the SIA would be of crucial importance. To be able to negotiate effectively, we believe that the SIA will need reliable and comprehensive information on cost and activity levels for the previous year. We understand that there are plans for the SIA to call upon the services of an external auditor to assist it in assessing the acceptability of proposed changes in annual premium levels if a single insurer option is chosen. We confirm the need for this assistance.

Over a longer period of years, the main incentives for cost containment in a single insurer model can be expected to come through competition <u>for</u> markets rather than competition <u>in</u> markets. That is, when tenders are invited for a new franchise at the end of the four-year period, or whatever period is deemed suitable. Once again, however, for this process to work effectively, all bidders would need access to information on activity and costs so that the incumbent insurer was not placed in a privileged position.

* Multiple insurers. Despite the considerable disadvantage of greater

administrative complexity resulting from a system of multiple insurers, competition between them for insurees is a mechanism that is often relied upon as a means of keeping down costs. The current Dutch reforms emphasise this aspect of the market through competition between various non-profit sickness funds and private insurers, although it is significant that the Dutch system maintains a premium element that is paid directly by the insuree to the insurer, in addition to the social insurance payment which comes from the government to the insurer. It is this personal premium element over which there is expected to be price competition between insurers that will give them a vested interest in cost containment. When all payments to insurers come via capitation payments, competition often takes place in non-price terms over, for example, the quality of service. In such cases, cost containment must come from rigorous enforcement of cash limits by the government during annual negotiations with insurers. This will act as a spur to individual insurers to introduce managed care as they need to operate within these cash limits. Even where there is direct competition between insurers on the basis of individual premiums - as in the UK private health insurance market - the data showing rates of growth in premiums payable to private insurers over the period 1980-90 do not suggest that competition has been noticeably successful at cost containment (see Table 8).

* A health commissioner within the States Insurance Authority. In view of the potential shortcomings in all the above models, it may be that the SIA should consider the establishment of a small health commissioner office within its own organisation. The role of the office would be primarily regulatory. It would be able to audit the performance of the market on both the provision and finance side. This would involve working directly with insurers and providers to improve performance, and if necessary, making recommendation to the States for further action. This office would provide an external check whichever system is eventually adopted.

TABLE 8

PRIVATE INSURANCE IN THE UK, 1980-90

BUPA, PPP AND WPA Combined

	PREMIUMS PAID	BENEFITS PAID	BENEFITS AS % OF SUBSCRIPTIONS	PREMIUMS PER SUBSCRIBER
	£m	£m		£
1980	154	128	83	105
1981	205	195	95	116
1982	286	245	86	151
1983	355	291	82	183
1984	413	341	82	208
1985	470	415	88	228
1986	548	461	84	259
1987	628	510	81	289
1988	694	588	85	300
1989	803	692	86	326
1990	905	817 est	90 est	348

Source: Laing and Buisson, 1992

III.2 The Organisation of Insurance

Under the current proposals, funding for health care in Guernsey will be collected by the States Insurance Authority either directly through the existing social insurance system or indirectly through the income tax system. Once collected, the key question on the expenditure side is: how should the purchasing of health care be organised?

As the discussion of the arrangements for overseeing managed care discussed above indicates, one of the main issues to be resolved is whether insurance is best organised through a single insurer/purchaser or whether multiple insurers/purchasers would represent a better arrangement. There is also the question of the relationship between the insurer/s and the Board of Health if the Board assumes the role of the purchaser of secondary care. In this section, we consider these options in more detail.

Multiple Insurers

If a system of multiple insurers was maintained, following the introduction of a social insurance scheme, it would be necessary to ensure that the whole population was covered. This could pose some problems in the case of short stay and seasonal workers. In addition, premium payments to individual insurers would need to be made on the basis of the number and composition of the population enrolled with them. This would require the development of some risk-adjusted capitation formula. The main advantages of a multiple insurer system would be that it would offer choice to Guernsey citizens and that competition between insurers for insurees would encourage them to offer services that were sensitive to individuals' preferences.

The main disadvantage of this arrangement would be that it would impose substantial transactions costs. That is, the process of identifying who is

enrolled with which company - for both capitation payments and billing for doctors and hospital services - would impose substantial administrative costs. It is also not clear how, under a capitation payments system, competition between insurers for insurees would act as an incentive for them to contain costs in the way that it would do if they individually set premium levels.

Single Insurer

A single insurer model would be administratively far simpler and would, therefore, incur a lower level of transactions costs. Moreover, given the importance that we believe will be attached to the development of managed care arrangements, it may be easier to approach these through a single company with some proven expertise than to rely upon multiple purchasers. The latter arrangement would be more difficult to monitor and could make it more complex for the PEH as it seeks to introduce managed care systems.

On the other hand, a single insurer model would bestow limited monopoly status upon whichever company secured the contract. As such, careful consideration would need to be given to the length of the contract and the terms upon which the annual re-negotiation of premia take place. Arrangements for re-tendering at the end of the contract term should also be considered with care. Will the market remain contestable at the re-tender stage with other companies challenging the incumbent? What information should be made available to ensure that the incumbent does not enter negotations with an unfair advantage?

As we have pointed out already, full information on costs and activity, and independent audit/actuarial assistance, will be necessary to ensure that annual increases in premia are kept to an acceptable level. Arrangements for re-tendering at the end of the contract terms will also need to be considered with care. It is important that the market remains competitive at the re-tender stage and that the incumbent insurer does not enjoy an unfair

advantage during negotations. Of course, if - as has been suggested to us - the SIA develops the expertise to assume the insurance role itself, at the end of the first contract period, this would avoid many of these problems.

The other main disadvantage of the single insurer approach is that it would deny the people of Guernsey choice between insurers. We have heard it argued that this would prove unpopular, particularly among the 10,000 people who have insurance through friendly societies. We understand that the four main friendly societies all have more than 125 years experience on the Island and that there is a strong attachment to this arrangement. This has led us to consider a mixed system of insurance.

A Mixed System

There are a number of countries which operate compulsory social insurance schemes for those sections of the population below a specified income level and then permit higher income groups to make their own arrangements under private insurance. We do not, however, believe that this is likely to be a particularly suitable model for Guernsey, with its population of only 60,000 people. A major disadvantage would be that the public system would be likely to be left with high risk groups and, because of its coverage of the lower income groups, would have difficulty in funding the system from social insurance payments. Recourse to general taxation would be extremely probable.

The Guernsey proposals for social insurance are based upon universal coverage which offers access to a high standard of care for everyone. Within such a system, there are limited incentives for top-up private insurance. There is an absence of long waiting lists for hospital treatment, which might be expected to encourage people to opt for traditional private insurance in order to reduce waiting times, as happens in the UK. Moreover, the standard of hotel accommodation at PEH is high and unlikely to prompt many people to opt

for extra private facilities.

At the same time, however, there is a tradition among certain of the Island's residents for maintaining private insurance plans to enable them to receive treatment - particularly for more complicated procedures - on the mainland, if it proves necessary. We have heard of no suggestion that these arrangements would be affected by the social insurance arrangements except insofar as some people may incur higher personal costs and view themselves as paying for health care 'twice', ie through both social and private insurance.

Despite the fact that the major benefits from private insurance seem to be restricted to the rather small section of the population referred to above, there is nonetheless a far more general attachment to the concept of choice through pluralism in insurance. As such, one contender for a mixed system would involve the separation of the insurance arrangements covering primary care from those covering secondary care. Given that friendly society insurance is overwhelmingly concentrated on primary care services, there is a case for retaining the existing system of multiple, private insurers in this sector and restricting the social insurance, single insurer arrangement to the secondary care sector. This would offer a way of retaining choice and, given that the cost of primary care is low in relation to secondary care, it would not impose unacceptable personal costs and barriers to access. The SIA grant and/or income related exemption from charges could be used to overcome any residual barriers to access. If this option is pursued, however, it would be necessary to specify with some precision those services which fall within and without the social insurance scheme. This is particularly important because the boundaries between primary and secondary care are constantly shifting as new technologies enable erstwhile hospital procedures to be carried out at home or in GPs' surgeries.

The Board of Health

Towards the end of our study, it was suggested to us by the Chief Executive of the Board of Health that it was his intention that the Board should carry out the purchaser function in relation to secondary care and that the SIA and/or its agents should perform a similar function in relation to primary care. We have already discussed some of the aspects of this proposal in relation to the introduction of managed care. In terms of the insurance arrangements, this proposal would obviously reduce dramatically the range of activities that an insurer would be required to carry out. Indeed, in our opinion, it throws into doubt the need for an external insurer. Presumably the SIA or the tax authority could be responsible for raising revenue and negotiate an annual block allocation with the BoH. The administration of charges would require a claims system that might be beyond the present resources of the BoH. However, to assign this function to an external insurer without the associated responsibility for implementing managed care would be an unnecessary complicated arrangement. If this option is adopted, it may be that the decision to introduce charges should be re-considered. We understand that the Chief Executive of the Board of Health is not convinced that they are strictly necessary in order to achieve cost containment. However, he and we recognise that the introduction of a system of charges is likely to stimulate the generation of necessary cost information.

III.3 Methods for Paying Doctors

Doctors' activities are at the centre of health care delivery. It is through their decisions about whom to treat, how, where and when that resources are committed. Strong professional standards mean that these decisions are determined overwhelmingly by clinical considerations. As in most other areas, however, financial incentives, both corporate and personal, can be expected to exert some influence on doctors' behaviour. Often, this occurs indirectly through financial incentives exerting an influence upon what is regarded as

best medical practice, rather than through individual clinicians responding to a particular payments system. Nonetheless, the existence of both direct and indirect financial incentives means that alternative ways of paying doctors should be investigated. Three main options are available, although many systems include combinations of them. These are:

* fee per item of service,
* capitation payments,
* salary.

Fee Per Item of Service (FFS)

FFS is the system of payment currently employed in Guernsey for both GPs and specialists. It is a system that is found in many countries, including France, Germany and the United States, and is regarded as an effective means of encouraging doctors to cater for patients' needs as payment is directly related to the volume of care provided. Its main disadvantage is that it is often claimed to encourage over-provision; that is, because of financial incentives, doctors provide more services than are strictly necessary. However, as the figures cited earlier on GP consultations and hospital utilisation rates indicate, there is no evidence to suggest that the quantity of care currently provided in Guernsey is excessive. In fact, it is the level of fees - especially in relation to specialist consultations - rather than the volume of care that is presently giving rise to concern.

Some indication of the acceptability of fee levels is provided by the level of income they produce. In this connection, comparisons with the NHS are instructive. In 1992, approximately 12,000 of the 19,000 consultants employed by the NHS undertook some private practice. In a study undertaken for Norwich Union by William Laing, it was estimated that the average earnings for these consultants from both NHS employment and private work amounted to about

£95,000 per year. We do not have specific figures on the earnings of Guernsey specialists, but there is some evidence which suggests that their estimated earnings are considerably in excess of the UK levels.

The financial incentives facing GPs also need to be considered. A study carried out for the OECD and published in 1990 addressed this issue. The study covered six countries using different payment systems, ie the Netherlands, UK, Germany, USA, France and Canada (Quebec). It examined the average number of patient visits per year made to GPs, the average consultation time and the average number of hours worked by GPs per week. The main conclusion was that the influence of different payment systems was out-weighed by other factors, such as government regulation and/or bargaining power of insurers who often, for example, set target income levels for GPs in FFS systems. As a result, different payments systems did not appear to exert a systematic influence on GPs' behaviour. It should, however, be borne in mind that these countervailing regulatory and managed care arrangements are not at present very strong in Guernsey and, therefore, financial incentives may be more influential.

Capitation Payments

Systems based upon capitation payments (ie a fixed sum payable to the doctor per patient enrolled) are usually viewed as a way of encouraging cost-effective treatment. Moreover, because the doctor receives a fixed pre-payment, there is an incentive to keep patients healthy in order to reduce the volume of services provided. Certainly, HMOs in the United States which operate on this basis have been viewed as a means of reducing unnecessary referrals to hospitals and of encouraging the provision of preventative services.

In recent years, however, some concerns have been expressed about alleged

under-provision resulting from capitation payments. There are accounts of US patients who have complained about difficulties in getting appointments with HMO physicians, who often employ nurse practitioners to screen patients, and of excessive waiting times. In general, however, a system of capitation payments combined with modified FFS appears to be a model that is gaining increasing support as a method of paying GPs in a number of countries, eg the Netherlands, Denmark, Spain, Italy, Ireland and the UK.

Salaries

The direct employment of hospital doctors on a salaried basis is, of course, the method of payment used in the NHS. In international terms, it has proved to be a very effective way of controlling doctors' earnings, although as pointed out above, more than 60 per cent of NHS consultants supplement their salaries with private earnings.

The main concern expressed about systems based upon salary payments is the perceived lack of incentives faced by doctors. In fact, there is little hard evidence to suggest that the absence of personal financial incentives in the NHS does manifest itself in under-performance. Moreover, new management systems, such as the Resource Management Initiative, seek to offer a range of non-financial, corporate incentives. These provide an example of the countervailing factors identified in the OECD report referred to earlier. Nonetheless, if Guernsey was to contemplate a move towards a salaried system, the major change in the incentive structure faced by their existing doctors would obviously require careful attention.

III.4 Cost-Sharing between Patients and Insurers

Under the 1992 Board of Health proposals, a range of charges would be introduced for in-patient, day case and out-patient treatments. There would

also be separate charges for use of operating theatres, diagnostic tests, surgical implants and maternity care. These would supplement charges already levied for specialist consultations and treatment.

In support of these proposals, it is argued that it has been 'well demonstrated in all countries' that the absence of charges leads to increased demand and inessential use. In contrast, it is argued that, in those communities using charges, there is greater cost consciousness on the part of both consumers and providers and that people act responsibly and only utilise services when necessary.

However, we would caution against too ready acceptance of these arguments. Certainly, the need to implement a charging system may act as a spur to the production of accurate cost information. However, whether or not charges act to ration utilisation depends ultimately upon the insurance arrangements in force. International evidence suggests that when insurers offer full retrospective reimbursement there is little incentive for patients or providers to act in a cost conscious manner. Certainly, in the United States, this practice has led to serious cost escalation. Indeed, it was in response to this phenomenom that the United States introduced a series of cost sharing arrangements.

Co-payments are one form of cost sharing. Under this arrangement, the patient bears some of the health costs incurred at the time of use directly in addition to that part which is covered by third party (insurer) payments. In considering the most suitable form of co-payment arrangements, the States will need to examine them from both an efficiency and an equity perspective. Specifically, how effective are they in restricting unnecessary demand and containing costs? What impact do they have upon access to health care for different sections of the population?

To address these issues in any detail in the Guernsey context would require more time and data than we have available at the moment. Nonetheless, some general issues can be identified which will be of relevance in considering policy options.

* Not surprisingly, research evidence suggests that co-payments are more effective in restricting demand in the case of primary care than in the case of secondary care. The impact of co-payments is also more consistent with clinical priorities when applied to primary care as it would be inappropriate to restrict hospital demand once a GP referral has been made. Even in the case of primary care, however, there is some evidence that co-payments deter patients seeking essential, as well as less essential, treatments.

* Co-payments schemes add to administrative costs and the sums that are collected are generally small in relation to the total cost of health care. It is the United States that has emphasised co-payments as a means of cost control far more than most other countries and it is significant that the US has been less successful at cost containment than countries that have relied upon other mechanisms, most notably, global budgets.

* A number of European countries have adopted quite aggressive co-payment schemes in relation to pharmaceuticals and these seem to have had some impact. Often, co-payment arrangements are combined with systems for prescribing generic products so that the consumer is required to bear a higher proportion of the cost if he opts for a branded product rather than a generic substitute.

* Co-payments can be regressive in that, although charges are often modest, they represent a higher proportion of the incomes of lower income groups than of higher income groups.

III.5 Raising Health Care Finance

During the States' debate of Billet d'Etat VI, 1992 a variety of issues were raised concerning the proposed health insurance scheme. Subsequently, the States Insurance Authority, as part of its re-examination of the proposals, sought the guidance of the States Advisory and Finance Committee on a number of key issues. Some of the main ones, together with the Committee's guidance, are summarised below:

* A social insurance model is still appropriate, either earnings or income based, but this should be based upon an existing States of Guernsey system and should not involve the creation of a new administrative department to handle the scheme. Careful attention needs to be given to the rules for assessing contributions to avoid inequities.

* An income-based system is more closely related to ability to pay but it is important that this should not be perceived as an increase in income tax.

* The Committee is opposed to the introduction of a special health tax.

* The Committee does not believe that employers should be liable for any contributions to future health insurance services.

* In response to concerns about the impact of alternative financing arrangements on wage-bargaining claims, and hence the Island's economy, the Committee expressed the view that whichever scheme was introduced, it was likely to have an impact on the wage bargaining process.

* Contributions from general revenue will be necessary to cover the costs of those people not making contributions at the full support rate. However,

the Committee expressed the view that the introduction of any health insurance scheme should not impose any additional costs upon the general revenue account.

* Suggestions that the scheme should be funded wholly from general revenue were opposed by the Committee.

Following this consultation, the States Insurance Authority has identified two key issues to be resolved; namely, (i) the choice between an earnings- and an income-based scheme, and (ii) the criteria for eligibility for contributions. Its summary of the earnings-based and income-based options, together with preferred contributory principles, is listed below:

Earnings-Based System

1. Health insurance contributions would be paid to the States Insurance Authority as an extension to the social insurance and health service contribution systems.

2. Contributions would be paid on an earnings-related scale for employed persons and subject to a maximum (support rate) contribution.

3. The contribution for an employed person would be shared equally with the employer or in such other proportion as the States may decide.

4. Contributions would be paid on an earnings-related scale for self-employed persons, based on earnings from trade or profession and subject to a maximum contribution.

5. Contributions by non-employed persons under 65 would be paid on an income-related scale, based on total income and subject to a maximum

contribution. This would replace the current flat rate contribution.

6. Non-employed married women with income would not automatically be exempt from contributions and would be assessed in the same way as other non-employed persons under 65.

7. No contributions would be required from non-employed persons aged 65 and over, but they would receive all benefits.

8. No contribution would be required in respect of children, but they would receive all benefits.

9. A States grant from General Revenue would be required to fund the contributions of persons not liable for a contribution and to top-up the contributions of persons who paid at less than the support rate.

Income-Based System

1. The health insurance contributions would be collected by the States Income Tax Authority, charged separately to the existing income tax assessment.

2. The health insurance contributions would be collected from all individuals with a taxable income above a prescribed threshold. This would include contributions from persons aged 65 and over.

3. Corporate bodies would have no liability for health insurance contributions.

4. Employers would have no liability for the health insurance contributions of their employees.

5. Contributions paid by an individual would be paid on an income-related scale up to a maximum (support rate) contribution.

6. For persons in employment, health insurance contributions would be collected weekly or monthly as an extension to the ETI tax deductions. As with the tax collection, an end of year account from the Income Tax Authority would show whether the individual was owing health insurance contributions or was in credit.

7. The health insurance contributions collected by the States Income Tax Authority would be paid to the Guernsey Health Service Fund, administered by the Insurance Authority, at regular intervals.

8. A States grant from General Revenue would be required to fund the contributions of persons not liable for a contribution and to top-up the contributions of persons who paid at less than the support rate.

Many of the issues involved in choosing between these two options, and variants of them, relate to broad political considerations on the Island. As health policy analysts, we do not feel qualified to comment upon these. Nonetheless, there are some considerations which relate to clarification, and to consistency in pursuing declared objectives, that we feel it is worth commenting upon.

First, by way of clarification, it is worth bearing in mind that there are three main ways of paying for health care: through general taxation, through social insurance and through private insurance. (Personal out-of-pocket payments are also important in some sectors, especially in the case of over the counter sales of pharmaceuticals.) At the moment, Guernsey relies upon general taxation and private insurance. The proposed scheme would involve replacing these arrangements with a system of social insurance. Unlike

private insurance, contributions to social insurance schemes are not based upon individual actuarially determined, risk-based premia. Rather, an average level of premia is calculated and contributions are based upon some assessment of individuals' ability to pay. In reality, therefore, it is a form of health tax. This point should be realised, although we appreciate that for political reasons it may not be described as such. Another point of clarification to bear in mind is that, while the introduction of social insurance may re-distribute the costs of health care, in comparison with their existing distribution, there is no reason why total costs should change.

The declared objectives of health care reform are cost containment and equity. At first sight, the choice between the earnings-based and income-based options does not seem to have any particular relevance for the issue of cost control. However, there is the question of transparency. If the aim is to make people more aware of the link between health care costs and contributions, there is an argument for spreading contributions as widely as possible. This would tend to favour an income-based option.

On the question of equity, this has been considered primarily in terms of access to services. However, there is also the issue of equity in contributions. Once again, the principle of relating contributions to 'ability to pay' would favour a wider income-based scheme over a more narrowly defined earnings-based scheme.

Both of the above arguments tend to favour an income-based system of contributions. However, these arguments need to be offset against considerations of administrative complexity and political acceptability, both of which favour the earnings-based option. Ultimately, the question of who should contribute and on what basis must be a matter for local political decision. However, we would urge that certain efficiency considerations - such as the cost implications of an ageing population - should be borne in

mind when making these decisions. As the Channel Islands Actuarial Society has pointed out in its evidence to the States Insurance Authority, changes in the demographic profile of the population are likely to have the twin effects of increasing the total costs of health care while reducing the income raised through an earnings-based social insurance scheme, thereby increasing recourse to general revenue in the future. An income based scheme, on the other hand, would have a wider revenue base and be less susceptible to this problem.

SHORT LIST OF POLICY OPTIONS

IV. A SHORT LIST OF POLICY OPTIONS

From our examination of the various policy components in Section III, we have selected three packages or policy options which we believe should be considered by the States when deciding upon the future of health policy in Guernsey. These three options are:

* A continuation of existing policy, ie the status quo option.

* A single-insurer/purchaser, managed care system.

* A mixed model, incorporating a single insurer, managed care system in secondary care and voluntary multiple insurer arrangements in primary care.

In the case of each of the options, we have specified the key elements of the scheme and, where possible, made projections about future costs.

IV.1 The Status Quo

Key Elements

In this option, there is neither a change in the method of delivery nor in the financing of health care. Thus, the primary and hospital sectors remain as currently organised. GPs are self-employed offering primary care on a fee-for-service (FFS) basis. The specialist medical profession also offers care on a FFS basis, with the hospital system administered by the Board of Health. The hospital is financed by General Revenue and doctors' fees, both GP and specialist, are paid for either from private insurance or personal payments.

Current Cost of the System

Costs and activity are summarised previously in this report. Thus, approximately £43 million is spent on health care. Of this, 85 per cent is funded publicly, the remainder coming from private insurance or personal payments. Public expenditure comprises £28.64 million, which is Board of Health expenditure, paid from General Revenue, and £8.41 million which is SIA expenditure, paid from General Revenue and insurance contributions. Approximately 80 per cent of public expenditure takes place in the hospital sector, while less than 20 per cent is spent on GP consultations and pharmaceuticals in the primary care sector.

Future Projections

Unfortunately, there is a lack of detailed data in both the hospital and primary care sectors on the basis of which future projections can be made. Nevertheless, by making a number of general assumptions, it is possible to build up a broad picture of the likely increases in health expenditure if there is no change in policy.

Estimates of future population growth provide the basis for these projections. It was suggested to us that two alternative estimates of future population growth should be used. Consequently, tables 9A and 9B gives population estimates over the next 35 years, based on (i) annual inward migration of 400 persons per annum and (ii) zero migration. By applying current GP consultation rates and hospital utilisation rates, by age group, to these population figures, it is possible to obtain baseline figures for growth in primary and secondary care levels of activity.

Figures for Guernsey GP consultation rates, by age group, for 1992 are available. Table 10A shows that, when these are applied to future population

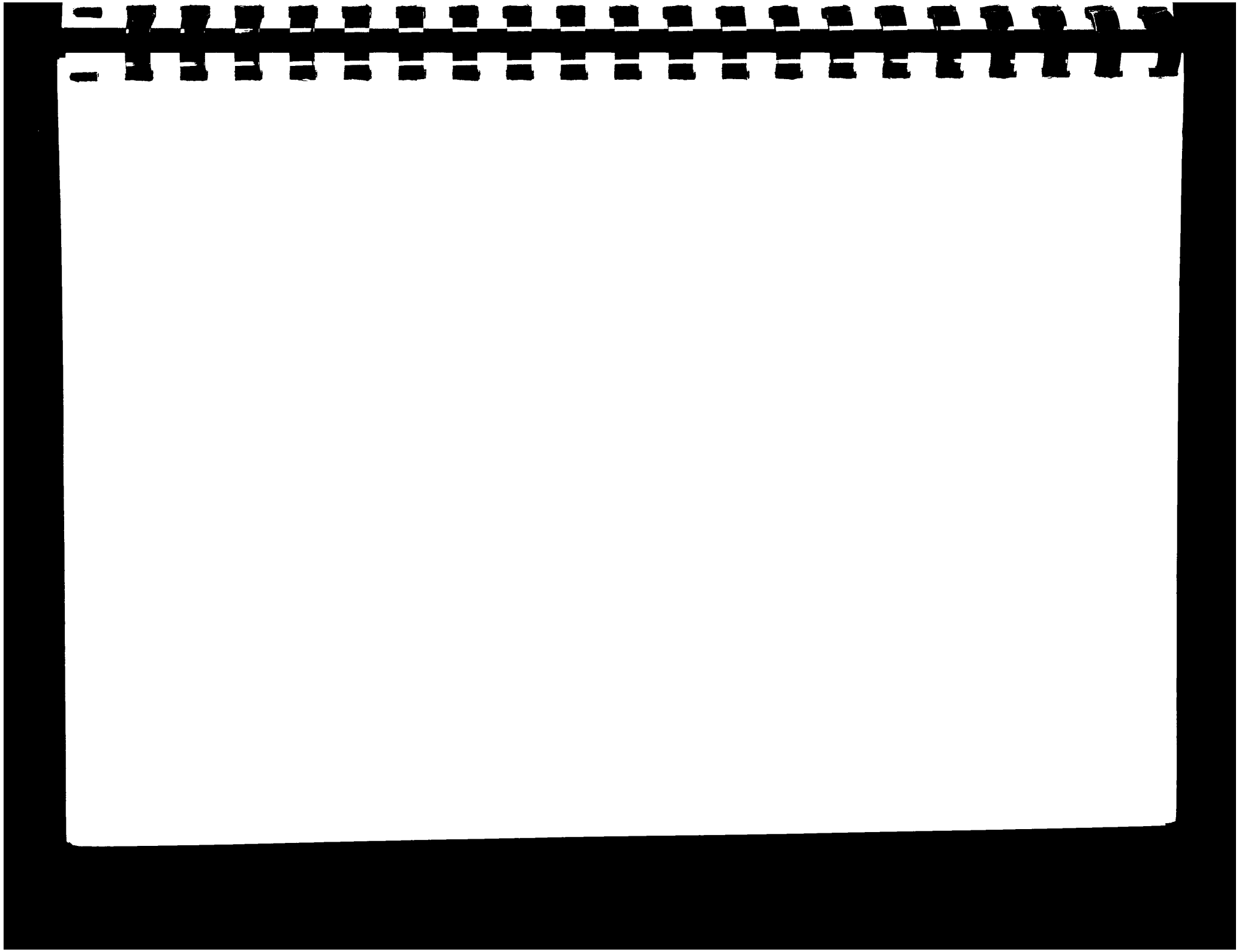

TABLE 9A

ESTIMATED FUTURE POPULATION OF THE BAILIWICK OF GUERNSEY

	1991	1998	2003	2018	2028
0-15	10,950	12,118	12,656	12,118	12,740
16-64	40,400	42,412	43,920	47,655	47,502
65+	9,815	10,379	10,744	13,527	15,679
TOTAL	61,165	64,909	67,320	73,300	75,921

Notes: Based on actuary's estimates, projecting from 1986 Census figures, with growth rate of 0.85% per annum (1990-98), 0.73% p.a. (1998-2003), 0.57% p.a. (2003-2018), and 0.35% p.a. (2018-2028), for total population. But 1991 Census figures used as the base year. Figures embody assumption of net inward migration of 400 per annum.

TABLE 9B

ESTIMATED FUTURE POPULATION OF THE BAILIWICK OF GUERNSEY

	1991	1998	2003	2018	2028
0-15	10,950	11,536	11,625	9,682	9,732
16-64	40,400	39,960	39,690	38,111	35,415
65+	9,815	10,239	10,465	12,440	13,540
TOTAL	61,165	61,735	61,780	60,233	58,689

Notes: Based on actuary's estimates, projecting from 1986 Census figures, with growth rate of 0.13% per annum (1990-98), 0% p.a. (1998-2003), -0.17% p.a. (2003-2018), and -0.26% p.a. (2018-2028), for total population. But 1991 Census figures used as the base year. Figures embody assumption of zero future migration.

figures, they indicate an annual increase of 0.8 per cent in activity over the next ten years, and 0.7 per cent over the next 25 years, when there is in-migration of 400 people per annum. However, a zero migration assumption leads to a projection of no increase in activity - the fall in the size of the population being offset by an increase in the proportion of elderly people.

Guernsey data on current in-patient usage by age group are not available. In their absence, we have used English age-specific utilisation rates, after taking account of the overall difference in utilisation between Guernsey and England. In fact, the age distributions in England and Guernsey are broadly similar, though there are slightly fewer younger people in Guernsey, as a percentage of the total population. Combining population growth figures with these age-specific utilisation rates suggests that there will be an annual increase of 0.9 per cent in activity in the acute hospitals sector over the next 10 years and 0.7 per cent over the next 25 years, when there is future inward migration of 400 people per annum. Once again, zero migration leads to a forecast of zero growth in activity.

It should be borne in mind, however, that these are likely to be minimum estimates. No allowance has been made for growth in either GP or in-patient activity, other than that arising from changes in the population structure. In fact, the experience of the last ten years in the UK shows an increasing trend in both factors. Similarly, activity in the PEH has increased substantially over the last ten years, although some of this may also be due to demographic factors. Also, in terms of hospital activity, no account has been taken of the increase in the proportion of patients in the 65+ age group. This would usually be at a higher cost per case as factors such as length of stay and nursing time increase with the age of the patient.

To examine the likely impact that increases in unit costs would have upon total expenditure, given the growth in activity resulting from population

TABLE 10A

PROJECTED GROWTH IN ACTIVITY

	1992	1998	2003	2018
GP Consultations	230,000	240,000 (0.9)	250,000 (0.8)	280,000 (0.7)
In-patient Cases	7,030	7,470 (1.0)	7,750 (0.9)	8,530 (0.7)

Notes: Growth in in-patient cases is based on English age-specific hospitalisation rates as no age-banded figures are available for Guernsey. These are adjusted to take account of current differences in utilisation rates between England and Guernsey. 1991 Census population figures are used for the calculations. Annual percentage rates of increase are given in parentheses. Figures embody assumption of net inward migration of 400 per annum.

TABLE 10B

PROJECTED GROWTH IN ACTIVITY

	1992	1998	2003	2018
GP Consultations	230,000	230,000	230,000	230,000
In-patient Cases	7,030	7,140	7,170	7,120

Notes: Growth in in-patient cases is based on English age-specific hospitalisation rates as no age-banded figures are available for Guernsey. These are adjusted to take account of current differences in utilisation rates between England and Guernsey. 1991 Census population figures are used for the calculations. Figures embody assumption of zero migration. There is virtually no growth in activity under these assumptions.

changes, we have forecast expenditure on the basis of annual increases of 0, 5 and 10 per cent in unit costs, assuming migration of 400 per annum (see Table 11). Taking the 5 per cent assumption, for example, this indicates a projected annual increase in costs of 5.8 per cent in the GP sector and 5.9 per cent in the hospital sector, in the next 10 years, falling to 5.7 per cent in both sectors over 25 years.

Clearly, these figures may not apply precisely to every other part of the health care sector. In the case of specialist medical staff, 5 per cent may be an underestimate of likely growth in unit costs, given recent experience. Nevertheless, we believe that these figures give some feel for the likely escalation in expenditure if no measures are taken. In particular, a figure of at least 6 per cent annual growth in costs over ten years seems likely under the net inward migration assumption.

IV.2 Single-Insurer, Managed Care System

Key Elements

We believe that the case for replacing the existing mixture of public and private finance with a single, social insurance scheme is a strong one. Given that revenue is raised in this way, there is also a strong case for expenditure to be managed by a single insurer. In fact, this is primarily a 'purchaser' rather than an 'insurer' function, as it is the efficient management of a pre-determined health budget that is the key objective.

In the short run, there is a clear argument for assigning this purchaser function to an agency with expertise in this area. There are a range of private insurance firms that have been carrying out these functions for a number of years, but many of them have only limited and recent experience in the important task of managed care (see below). We have been informed that

TABLE 11

PROJECTED GROWTH IN TOTAL HEALTH COSTS (£ MILLIONS)

	COST ASSUMPTION	1992	1998	2003	2018
GP Costs	0%	4.4	4.6 (0.9)	4.8 (0.8)	5.3 (0.7)
	5%	4.4	6.2 (5.9)	8.2 (5.8)	18.8 (5.7)
	10%	4.4	8.2 (11.0)	13.7 (10.9)	62.9 (10.8)
Hospital Costs	0%	13.3	14.0 (1.0)	14.7 (0.9)	15.9 (0.7)
	5%	13.3	18.9 (6.1)	25.1 (5.9)	56.7 (5.7)
	10%	13.3	25.0 (11.1)	41.9 (11.0)	190.0 (10.8)

This is based on zero, five and ten per cent increases in unit cost. Annual percentage rates of increase are given in parentheses. In this case, hospital costs here are that part of Board of Health expenditure allocated to the Acute and General category in 1991, adjusted by 8% for growth in 1992. The figures embody an assumption of net inward migration of 400 per annum.

the Board of Health is currently building up its expertise in order to be able to carry out the purchaser function and this proposal clearly deserves serious consideration, either as a short run alternative to an external insurer arrangement or as a longer term option. There is also a case for the SIA - with its greater independence from the provider side - seeking to develop its own expertise as a purchaser organisation and taking over responsibility for managing the health care budget, either independently or in collaboration with the Board of Health.

Whatever the precise purchaser arrangement that is chosen, the introduction of managed care is vital for the success of future policy. This should have a number of elements. Utilisation review in relation to the hospital sector is important but, given the absence of evidence of serious hospital over-utilisation in Guernsey at the moment, we would caution against the introduction of the more vigorous and costly US examples of this practice. In the longer term, the establishment - and acceptance by the medical profession - of protocols on treatment based upon clinical and cost effectiveness information will probably be more important. Peer review and medical audit have a clear role to play here.

At the same time, however, managed care arrangements will need to address the question of unit costs. In this connection, both payments to doctors and the level of capacity at the PEH will need to be reviewed. In the case of the former - payments to doctors - we believe that some form of capitation payments system for primary care and a movement away from total reliance on a fee for service system in the hospital sector are both desirable. Specifying the details of these possibilities would clearly require more work. As far as capacity at the PEH is concerned, we believe that it is probably excessive in terms of the levels of activity for which it is likely to be expected to cater. This view seems to be shared by the present hospital management and so their co-operation in reducing the scale of the hospital can be expected.

Finally, the main aspect of managing care in the primary sector that we would recommend is the scrutiny of GP prescribing behaviour with a view to reducing unnecessary and expensive prescribing.

Future Projections

It is clearly impossible to make predictions about the growth in overall health care expenditure under Option 2, without far more detailed specifications of its components. Nonetheless, we would reiterate that the key variables in this respect are:

* methods for controlling growth in hospital utilisation
* control over doctors' fees
* reductions in excess capacity at the PEH
* control over pharmaceutical prescriptions

IV.3 A Mixed Model

Key Elements

The proposal for a mixed system adopts exactly the same arrangements for the secondary care sector as those outlined in the single-insurer, managed care option. The arrangements for primary care, however, are different. In an effort to meet some of the Guernsey residents' demands for greater choice among insurers, we have suggested that multiple insurers could continue to offer insurance in the primary care sector. This function could be carried out by private commercial insurers and the friendly societies.

We do not believe that the fundamental aims of social insurance and managed care in the secondary sector would be jeopardised by these arrangements.

There is, at present, little evidence to suggest that GP referrals to the PEH are excessive and, therefore, an apparent lack of control over referral rates - in comparison with Option 2 - should not pose a major problem. However, if a problem of cost shifting from primary to secondary care did emerge, it would be necessary for the PEH to establish clear referral protocols with GPs.

By leaving responsibility for insurance arrangements to individuals, it may be feared that some groups would fail to take out cover and experience financial difficulties in gaining access to primary care. After all we understand that over half of the population are without health insurance of any kind at the moment. However, the costs of GP services are not large - at least in comparison with secondary care - and so we do not envisage GPs' fees representing a major barrier to access. If this did become a problem, some system of States subsidy to low income groups, and/or those people with chronic sickness or disability, might become necessary.

Payment to GPs under this arrangement could continue to be on a fee-for-service basis, although the fact that GPs would be outside the direct managed care system suggests that some movement towards a capitation system would be desirable.

Future Projections

As in the case of the single-insurer, managed care model, it is not possible to make projections about future costs without far more detailed specification and analysis of this option. For present purposes, we have confined ourselves to issues of principle. More detailed costings could be undertaken subsequently if required.

APPENDIX

APPENDIX

Interviews were held with the following individuals and organisations:

Conseiller L C Morgan, President, SIA
Mr M H De La Mare, Administrator, SIA
Mr M Nutley, Assistant Administrator, SIA

Deputy Mrs S Plant, Vice-President, Board of Health
Mr A Hodgkinson, Chief Executive, Board of Health

Mr M Dallamore, Guernsey Insurance Association
Mr M Savage, Guernsey Insurance Association
Mr I McCathie, Guernsey Insurance Association

Dr N C King, President, BMA, Guernsey and Alderney Division
Mrs C Walter, Secretary, BMA, Guernsey and Alderney Division
Mr R Allsopp, Member, BMA, Guernsey and Alderney Division
Dr A O'Donnell, Member, BMA, Guernsey and Alderney Division
Dr T Lee, Member, BMA, Guernsey and Alderney Division
Dr J Longan, Member, BMA, Guernsey and Alderney Division
Dr N Boyle, Member, BMA, Guernsey and Alderney Division
Mr R Reynolds, Member, BMA, Guernsey and Alderney Division
Dr S Brennand-Roper, Member, BMA, Guernsey and Alderney Division

Mr M J Brown, States Supervisor
Mr D Trestain, States Treasurer

Miss P Merriman, Chairman, Guernsey Friendly Societies Council

Mrs W Wolstenholme, Chairman, Health Welfare and Education Committee, Alderney

Deputy O D Le Tissier, Vice President, SIA
Deputy D Evans, SIA
Deputy Mrs C Fletcher, SIA
Douzaine Representative, H J Dorey, SIA
Mr J S Guilbert, SIA
Mr R J Le Prevost, SIA

Dr Armstrong, CIGNA Services UK Ltd
Mr R Dockett, CIGNA Services UK Ltd

Mr S Randall, International Sales Manager, PPP

Mr D Cavers, Managing Director, Norwich Union Health Care

Ms P Howard, BUPA International
Mr D Holden, BUPA International

Mr J Wort, WPA
Mr D Mutteen, WPA

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