

Ms Westbrook P/S CE/NHSMB

From: M A Harris

Date: 20 May 1988

cc. Dr Pickles
Dr Moore

BTS

We are meeting Mr Peach at 3.30 pm on Monday 23 May. To help focus discussion I attach a short paper. Mr Peach may want to know that we expect another leader in the BMJ on the BTS shortly, possibly next week.

GRO-C

M A HARRIS

A406/AFH

Ext GRO-C

no doc Jeshy

ORGANISATION OF NBTS

Way Forward

1. Recap of Problem

- 1.1 BTS is still basically OK as RHA run service; BUT
- 1.2 Regional self sufficiency in blood and derivatives no longer reasonable goal for some RHAs especially Thames.
- 1.3 Regional activity level also has to be geared to meeting plasma needs for national self sufficiency.
- 1.4 CBLA plasma needs driven by increasing demand for blood products. National self sufficiency a moving target.
- 1.5 As CBLA approaches full production present bartering of plasma for products will break down.

2. Solutions

- 2.1 Cross charging is seen as a necessary but not sufficient step.
- 2.2 Bilateral cross charging for blood already a fact, eg Oxford/NWT, to meet 1.2.
- 2.3 Cross charging between RHAs and CBLA a pressing requirement to meet 1.5. CBLA to 'buy' plasma from RHAs and 'sell' them blood products - see paper attached. (A)
- 2.4 Cross charging (or transfer pricing) needs regulating.
- 2.5 Can't have CBLA being inefficient monopoly or dictating price of plasma to RHAs.
- 2.6 Cross charging will remove disincentives. It may not be sufficient to provide incentives for RHAs to expand blood collection beyond break even on plasma/product exchange.
- 2.7 Because all RHAs will gain from CBLA lower prices there will be no losers (see paper). (B)

3. Further requirements

- 3.1 A supra-regional 'National manager' is needed, to -
- 3.2 ensure blood is available when and wherever needed by facilitating bilateral arrangements between over/under providers.
- 3.3 agree and promote a plasma supply strategy.
- 3.4 review the management arrangements of Regional Transfusion Centres.

- 3.5 get best practices adopted and set targets.
- 3.6 oversee an MIS implementation.
- 3.7 hold the ring in cross-charging arrangements.

4. Power Base for National Manager

- 4.1 HS proposals were for RHA's to relinquish power to a joint body of their representatives who would delegate it to an NBTS National Manager.
- 4.2 NHSMB seemed to favour the Board taking supra-regional powers with the National Manager reporting directly to an NHSMB member.

5. Discussion

- 5.1 The success or failure of 4.2 depends on whether the NHSMB can (and will on occasions) direct RHAs to act against their own interests eg expand blood and plasma collection requirements beyond Regional break even point.
- 5.2 Constitutionally BTS is a Regional function delegated from S of S.
- 5.3 Conflict could be minimised if the NHSMB member regularly called together representatives of the RHAs and CBLA to reach a consensus view whenever possible.
- 5.4 The BTS is perceived to be a clinical service albeit with a large logistical element. It would be best to avoid identifying it too closely with any particular non-medical interest at NHSMB level.

6. Proposal

- 6.1 National Manager of BTS to be accountable to an NHSMB member.
- 6.2 RHAs would be invited/told to accept a degree of direction from NHSMB but would be given a seat on a National Management Committee deciding broad policy thrusts. The Management Committee could be chaired by an NHSMB member.
- 6.3 Day to day management would be in the hands of the National Manager.
- 6.4 National Manager to be seconded from NHS to DHSS to be supported by small team. Alternatively National Manager and team could rely on NHS for pay and rations and Regions would each contribute a proportion.
- 6.5 The National Manager should initially be drawn from the NBTS ie; an existing RTC Manager not a lay manager.

BP DIST. 1/88

DISTRIBUTION OF BPL PRODUCTS AND SUPPLY OF PLASMA
TO BPL: A NEW APPROACH

1. Background

- 1.1 The new BPL is working up towards full capacity and the goal of self sufficiency for E & W in blood products.
- 1.2 The existing distribution method provides for RTCs to receive free from BPL a volume of products pro rata to the volume of plasma supplied.
- 1.3 This method will not be viable under self sufficiency conditions. Demand for blood products is not correlated to the ability to supply plasma.
- 1.4 Demand for products especially coagulation factors is still growing. To satisfy this demand requires more plasma.
- 1.5 Finance will be an obstacle to expanded collection where RTCs do not need back products of commensurate value.
- 1.6 To satisfy growing demand will require BPL to incur additional running costs. It will become increasingly difficult to meet this by topslicing resources for HAs.

2. Objectives for a New Approach

- 2.1 To provide a financial incentive to RTCs to meet plasma targets, or at least remove disincentives.
- 2.2 To provide a rational means of distributing blood products.
- 2.3 To provide a means of financing BPL without top slicing the HCHS Vote.
- 2.4 To provide BPL with an incentive to efficiency.

3. Outline of a New Approach

- 3.1 The only obvious way of meeting the objectives above is to implement cross charging.
- 3.2 BPL will pay RTCs a national price for supplying plasma.
- 3.3 RTCs will pay BPL for blood products supplied.

4. Constraints

- 4.1 Cross charging has to operate within the framework of public expenditure conventions and the health service funding system.
- 4.2 The Vote Accounting System, annuality, and HA cash limit controls, will prevail.
- 4.3 CBLA like other HAs cannot build up capital reserves or invest surplus funds.
- 4.4 Only revenue resources will be transferred to RHAs from CBLA (see below)
- 4.5 Cross charging will thus aim to recover Revenue Costs only, not capital costs, and will not include any profit element or return on capital. (ROC)
- 4.6 Charges on customers outside the NHS will however reflect capital costs and a ROC.

5. Plasma Prices

- 5.1 There will be a national average price for plasma with perhaps different prices for different qualities when costs can be identified.
- 5.2 RTCs will agree to supply BPL with specified quantities over an agreed period.
- 5.3 Prices will be fixed annually by national agreement between representatives of RHAs and CBLA in the light of current costs adjusted for forecast inflation, agreed productivity goals, and data on commercial comparators.

6. CBLA Prices

- 6.1 CBLA will recover from RHAs the total running costs of CBLA including their R & D budget, CBLA administration and BGRL. (This will include recovery of 'BPL diagnostics' costs via separate charges).
- 6.2 BPL prices for blood products will include the cost to them of RHA plasma.
- 6.3 Prices will be fixed at a level which will encourage BPL to be more efficient and in the light of data on commercial comparators.

7. Cash Flow

- 7.1 CBLA costs total around £14m. Plasma production costs are estimated to be around £20 m ie a total cash flow of £34m.

7.2 Use of the banking system for settlement incurs a cost but is administratively simpler.

7.3 Settlement made by non-cash settlements avoids banking costs but is less easy to manage.

7.4 Either way CBLA will invoice RHAs for products. RHAs will invoice CBLA for plasma.

7.5 The net charge to the CBLA revenue cash limit will thus just reflect any increase in working capital ie an increase in stock, WIP, and debtors less any increase in creditors.

8. Resource Transfer

8.1 The total net cash revenue limit of CBLA will be transferred to RHAs.

8.2 CBLA will require a proportion of their current expenditure annual as working capital.

8.3 CBLA's initial working capital and any increase in subsequent years in line with expanded activity should be a central charge.

8.4 The resources transferred will be distributed on a simple pro rata basis to total revenue allocations. This is because overall the pattern of supply is believed to be similar. However a sensitivity analysis will be done before a final decision is taken.

9. CBLA Income from outside NHS

9.1 CBLA external income will be used either to reduce the cost of products to customer RTCs or to provide additional incentives for plasma producing RTCs.

9.2 If used to provide incentives to RTCs these 'premium' payments will not be reflected in prices for NHS customers.

10. Plasma Stockpile

10.1 CBLA hold a stock pile donated by RHAs on which RHAs have incurred expenditure.

10.2 Products will be made in part from this stockpile.

10.3 RHAs should not have to pay twice for this plasma.

10.4 Those RHAs who have donated most should benefit most.

10.5 The stock pile will be valued and a national unit price agreed.

10.6 RHAs will be given credits equivalent to their contribution to the stock pile.

11. Capital Expenditure

11.1 Capital expenditure will continue to be centrally funded by DHSS.

MAY 1988

Benefit of Transfer Pricing to Regions

Prices of Blood Products

1. Table 1 based on current costings shows that the likely prices recharged to Regions for blood products would be about 60% of their commercial equivalent. This assumes that BPL pay Regions for their plasma at £30/litre which is an estimated marginal cost. If BPL pay Regions at £40/litre, which is close to the full cost, then blood products would be priced about 75% of their commercial equivalent.

Benefit to Regions

2. Region with plasma supply matching its needs for blood products

Such a Region will get back most of the money it spends on plasma harvesting from BPL. It will also get around £1m as its share of BPL revenue costs. This Region should therefore break even and incur no extra costs from cross charging. It will save money by the extent to which BPL products replace commercial products.

3. Region with plasma supply exceeding its needs for blood products

This Region will recoup its plasma harvesting costs from BPL and have its £1m share of BPL revenue costs. Since it does not need its full 'quota' of BPL product it will actually have cash in hand over present no-charge arrangements which may encourage even more plasma production.

4. Region with plasma supply well-below its needs for blood products

This Region will recoup its plasma harvesting costs from BPL and have its £1m share of BPL revenue. This money will not be sufficient to provide for its blood product needs and money from other sources within Region will need to be found. However this Region will be no worse off than at present. It will benefit by being able to buy BPL blood products at 60% of commercial price (effectively 'surplus' to Regions such as 3 above).

TABLE 1

Estimated Unit Costs 89/90

Product	Estimated Cost	Present Commercial costs
Albumin	£1.11 /g	£2 /g
Factor 8	15.1p/i.u.	25 p/i.u.
Factor 9	13.2p/i.u.	20 p/i.u.
Specific Immunoglobulin	3.9 p/unit	-
Normal "	6.6 £/g	10 £/g

Assumptions (based on CBLA Accountability Review Figures)

- 1) 600 tonnes plasma makes £32m of product
- 2) CBLA Revenue costs £14m
- 3) Plasma value £18m (£30/litre)
- 4) Yield of F8 = 166 i.u./kg of plasma.