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Costing Practice Nurses

Implications for Primary Health Care

Karl Atkin
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DISCUSSION PAPER 117

Costing Practice Nurses:

IMPLICATIONS FOR PRIMARY HEALTH CARE

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March 1994

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Acknowledgements

This paper is based on research funded by the Department of Health. We want to thank Professors Ken Wright and Martin Roland for reading an earlier draft and offering critical comments. We also wish to thank Jenny Bowes for her secretarial support throughout the project. The views expressed are the authors and do not necessarily reflect those of any individual or government department.

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ABSTRACT

General medical practice has changed significantly in the past ten years reflecting a range of innovations giving greater priority to health prevention and promotion and to primary health care generally. One consequence has been a rapid increase in the number of practice nurses. Since 1988 the number of whole-time equivalents has trebled and most practices now employ at least one nurse.

Practice nurses make an increasingly important contribution to both the practice team and the delivery of primary health care. They undertake a wide range of activities, in the practice and the patient's home, including traditional nursing tasks, chronic disease management, health promotion, new patient registration health checks, counselling, advice, investigation, treatment, and health assessments of elderly people.

There is, however, widespread uncertainty about their role and how it might develop. Cost has been largely ignored because where the money comes from, that is who bears the cost of practice nurses, is to a great extent divorced from the responsibility for their employment. General medical practitioners who employ nurses are usually reimbursed by Family Health Services Authorities for most of the nurse's salary.

This paper provides unit cost estimates of practice nurses and discusses the implications for their future role and deployment. As well as direct costs, it considers the wider opportunity cost associated with the growth in practice nurse numbers.

INTRODUCTION

The 1990 contract for general medical practitioners (GPs) provided new payments to expand primary care services. These include health promotion and other clinics, minor surgery, and targets for child immunisation and cervical cytology screening (Department of Health and the Welsh Office, 1989). Much of the increased workload could be delegated to appropriately trained nurses and practice nursing expanded as a consequence.

Ten years ago nurses employed in general practice under the direction of GPs were comparatively rare. Since 1988 the number of whole-time equivalents has trebled and most practices now employ at least one practice nurse (one WTE equals 37.5 hours a week). By 1992 there were an estimated 15,000 practice nurse posts in England and Wales, representing around 9,400 whole-time equivalents (Atkin, *et al.*, 1993). Indeed the number of practice nurses is approaching that of health visitors (12,600 WTEs) and district nurses (19,800 WTEs) whose numbers have remained stable in recent years (Law, 1992).

Nurses, therefore, make an increasingly important contribution to both the practice team and the delivery of primary health care (Atkin *et al.*, 1993). They undertake a wide range of activities, in the practice and the patient's home, including traditional nursing tasks, chronic disease management, health promotion, new patient registration checks, counselling, advice, investigation, treatment, and health assessments of elderly people.

The growth in practice nurse numbers and the diversity of their work has fuelled a debate about precisely what their role might be within the practice team and in community nursing

generally. This debate touches on questions about their training, professional standards, employment and management (NHS Management Executive, 1993). A separate question, and the focus of this paper, is the cost of practice nursing. Empirically-based data on service costs have become essential since the National Health Service reforms of 1990, not only for policy-makers and service planners but also for purchasers of health care.

This paper provides for the first time estimates of the costs that can be attributed to a practice nurse adopting the approach to costing community health and social services developed by researchers at the *Personal Social Services Research Unit* (Netten and Beecham, 1993). This approach is based on the concept of opportunity cost, that is the value of resources allocated to the production of a service that are not available to provide alternative services. Information about practice nurses, their grades and hours of work is drawn from a national census of all practice nurses working in England and Wales conducted in September 1992 (Atkin *et al.*, 1993). In addition to salary-related costs, estimates of office and service-related expenses such as travel costs are included. The aim is to calculate the cost per hour and cost per patient of a practice nurse, including domiciliary visits, for comparison with the unit costs of other community nurses (Netten and Smart, 1993).

SALARY COSTS

With their emphasis on a precise definition of role and responsibilities, the Whitley pay Scales seem of little relevance to the flexible and varied work of practice nurses. Nevertheless practice nurses usually have nationally applicable pay and conditions according to Whitley Scales. According to the national census, 96 per cent of practice nurses are allocated a clinical

grade ranging from 'B' to 'I', although the vast majority have an 'F' or 'G' grade (Atkin *et al.*, 1993). Each grade has five salary points, except 'C' and 'F' which have six.

Anecdotal evidence suggests that practice nurses are disproportionately located on the upper salary points of each grade because it is often difficult to transfer to a higher grade. However, lacking firm information about the distribution of nurses within grades we estimated salary costs for 1992/93 from the midpoint of each grade. These are related to the number of whole-time equivalent practice nurses in England and Wales in Table 1.

Table 1: Practice nurses and salary cost by clinical grade

Grade	Number of nurses	Whole-time equivalent	Salary (midpoint)
B	5	1.4	£8,840
C	17	8.8	£10,280
D	271	135.3	£11,580
E	815	456.1	£13,250
F	5,124	2,918.1	£15,270
G	8,150	5,360.3	£17,460
H	726	481.1	£19,400
I	15	11.9	£21,360
All	15,123	9,373.0	£16,580

In addition to direct salary costs, employer's national insurance and superannuation contributions need to be considered. These are six and four per cent respectively for grades 'B' to 'D', and 7.2 and 4 per cent respectively for grades 'E' to 'F' (Netten and Smart, 1993). According to the national census, only 52 per cent of practice nurses are covered by a

superannuation scheme so it was decided to distinguish those with and without employers' contributions when estimating costs.

OVERHEADS

Direct and indirect overheads and capital overheads are difficult to estimate because they are split between the employing GPs, Family Health Services Authorities (FHSAs), and Regional Health Authorities (RHAs). General practitioners provide the premises from which most practice nurses work. They also meet most of the direct overheads such as day-to-day expenses, supplies, heating, telephone, stationery and immediate line management. There is, too, the additional cost of practice staff, for example receptionists, who are required to deal with work arising from the presence of the nurse.

FHSAs provide support directly by employing nurse advisors and facilitators, and indirectly by providing administrative and financial staff to oversee GP reimbursement. RHAs also employ managers and advisors who have some responsibilities for practice nursing. (The proposed disbanding of RHAs is likely to mean that these costs are transferred to the NHS Management Executive.) Of course, many of these overheads would exist whether the practice nurse is there or not; nor are they consumed exclusively by practice nurses. They contribute nevertheless to the opportunity costs of practice nursing.

Other overheads include the cost of initial education and training. The costs of nurse training are substantial but they are normally excluded when estimating service costs because they are

borne by the exchequer rather than FHSAs or GPs (Hartley and Goodwin, 1985; Goodwin and Bosanquet, 1986; Bosanquet and Jeavons, 1989).

However, 70 per cent of the costs of continuing education and in-service training, such as attending approved courses and study days, is met by the FHSA while the GP would be expected to make a contribution. GPs also provide on-the-job training. Unfortunately there is no information on these costs. The question is further complicated by practice nurses themselves contributing to the costs of training. A survey of practice nurses in South West Thames RHA found that one in twenty practice nurses paid for additional training; while a study in Walsall found that most practice nurses attended study days in their own time (Evans, 1992; Ross and Bower, 1992).

Although practice nurse overheads are elusive, comparison with other community nurses suggests provisional cost estimates. The nearest equivalent seems to be a district nurse. For one WTE grade 'G' district nurse indirect and direct overheads are estimated at £3,205 for 1992/93 (Netten and Smart, 1993). The capital overheads of a district nurse, put at £679 for 1992/93, are however less appropriate to practice nursing because they reflect the proportion of district nurses who work from home. Practice nurses rarely work from home and consequently generate higher direct capital cost overheads. These are more likely to resemble those of a health visitor, estimated at £1,810 in 1992/93 *(ibid.)*. Clearly, in the absence of better information these figures provide no more than an approximate guide to the overheads incurred when employing a practice nurse full-time. We have further assumed that they apply to all practice nurses irrespective of grade.

TRAVEL COSTS

Over half of all practice nurses (59 per cent) visit patients in their own homes and the costs of travel are usually borne by the employing GP. Travel costs will vary considerably between urban and rural practices although practice nurses work largely in urban settings and one in ten describe the practice area as inner city (Atkin *et al.*, 1993). On average GPs spend 12 minutes travelling to a patient's home suggesting a typical journey of at least two miles (Doctors' and Dentists' Review Body, 1991). Assuming that practice nurses make similar journeys and that most GPs pay the mileage rate set by FHSAs, typically 22.3 pence per mile, gives an estimated travel cost of £0.45 per visit.

ESTIMATING UNIT COSTS

The information available to estimate unit costs is far from ideal and there is a further margin of error depending on the assumptions made. We have assumed that, irrespective of grade, a WTE nurse works 45 weeks a year and takes five weeks annual holiday pay plus 10 days statutory holiday. Practice nurses also take six study days a year on average, ranging from none to over 20, although we could not take this into account when estimating unit costs (Atkin *et al.*, 1993). Nor can we take account of the costs of sickness leave because the information is not available.

With these limitations in mind, the average unit cost of a practice nurse is estimated to be around £13 per hour, varying slightly according to whether superannuation is paid by the employing GP. Table 2 summarises the calculation and shows the cost of each element

weighted by the number of WTE nurses in each grade. To take account of time spent on travelling and non-nursing duties, we have further assumed a client to non-client contact ratio of 1:0.6, which is similar to that of auxiliary nurses (Dunnell and Dobbs, 1982). This provides the basis for estimating the cost of client contact at approximately £21 per hour.

Table 2: Average unit costs of a practice nurse

Costs	**Value**
A: Wages/salary	£16,580
B: Salary on-costs	i) £1,856.96 per year (with superannuation ii) £994.80 per year (without superannuation)
C: Overheads: direct	£3,205 per year
D: Overheads: indirect	
E: Capital overheads	£1,810 per year
F: Travel	£0.45 per visit
Unit estimation	
Working time	1,687.5 hours per year (45 week year, 37.5 hours per week)
Sickness leave	
Client/non-client contact	Ratio of client to non-client contact 1:0.6
Domiciliary v. office/clinic visit	
Regional variations	London 1.22 x (A to E)
Commodity/task	
Dependency/condition	
Outcomes	

Price base of costs	1992/93
Unit costs available	i) £13.90 per hour; £22.24 per hour with a client (includes A to E, with superannuation). ii) £13.39 per hour; £21.42 per hour with a client (includes A to E, without superannuation). Travel £0.45 per visit

The cost of visiting a patient's home can also be estimated. Although the work of practice nurses during a domiciliary visit will be different to that of a GP, we can assume that they take the same time as a GP visit, that is 25.5 minutes on average, including travelling time (Doctors' and Dentists' Review Body, 1991). If so, the average cost of a home visit by a practice nurse would be about £5.50 per visit plus £0.45 for travel. This is almost a quarter of the cost of a domiciliary visit by a GP (Netten and Smart, 1993).

An appendix provides estimates of the unit costs of a full-time practice nurse employed on each grade. These assume that nurses employed on grades 'H' and 'I' have greater administrative responsibilities than other grades, suggesting a client contact multiplier similar to that of district nurses at 1:1.1 (Dunnell and Dobbs, 1982). In addition, all costs are subject to a London weighting estimated to be a factor of 1.22 for each WTE (Akehurst *et al.*, 1991).

DISCUSSION

Grade for grade, practice nurse costs are similar to those of other community nurses. This is because their salaries, which are based on a common scale, form the major element of the unit cost calculation. In addition it was necessary in the absence of better information to use the same overhead figures for practice nurses as those estimated for community nurses. However four out of five practice nurses are employed on grades 'F' and 'G' with hardly any below grade 'D'. As a consequence the average salary of a practice nurse (£16,580) is roughly equivalent to the second point on grade 'G', just beyond the median point on the Whitley Scales (£15,920). The comparatively high grades to which practice nurses are appointed probably reflect the recent recruitment of many experienced nurses, mostly from hospital

settings, including up to a third who returned to work after a break from nursing (Atkin *et al.*, 1993).

The implied level of professional functioning behind their grades has important implications for role development. According to the national census most practice nurses carry out traditional nursing tasks. In addition, most practice nurses assist the GP, with minor surgery for example, or have taken over some of the work previously done by GPs implying that they can save the GPs' time. The wider involvement of practice nurses in health promotion, chronic disease management and the health assessment of new and elderly patients reflect recent initiatives in the delivery of primary health care. However many practice nurses also engage in general nursing duties (for example, first aid, disinfection of treatment rooms, travel immunisations) and non-nursing duties such as general reception - activities that could in principle be undertaken by nurse assistants.

There is also considerable overlap between the work of many practice nurses and that of district nurses, health visitors, continence advisors and other primary health care nurses. Aspects of the practice nurse's work also overlap with that of social workers and welfare rights workers. In addition wide area variations in the activity rates of practice nurses point to considerable uncertainty about how practices manage demand and precisely what skills the practice nurse should bring to the primary health care team (Hirst, Atkin and Lunt, 1994). It is not clear, therefore, whether, or to what extent, practice nurses' activities represent value for money. Nor is it clear that the potential for duplication of roles represents a waste of NHS resources.

Widespread variations in the practice nurses' role raise further questions about the appropriateness and potential benefits of practice-based nursing. Health promotion is a case in point. The 1990 GP contract encouraged the setting up of Health Promotion Clinics and responsibility for running them was frequently delegated to practice nurses (Robinson *et al.*, 1993). A moratorium has recently been announced to allow a more flexible approach to health promotion. The effectiveness of nurse led health checks has not been demonstrated or, where notionally effective, clinics are often used by patients who are least likely to benefit and are therefore inappropriate (Muir *et al.*, 1994; Wood *et al.*, 1994). The new arrangements, from April 1993, provide special payments for taking responsibility for patients with asthma and diabetes suggesting that practice nurses will further expand their role in chronic disease management. In addition there are specific payments relating to targets for cardiovascular disease which may or may not be a clinic. Practice nurses may rely on opportunistic screening or focus on patients at known high risk of disease. GPs will need to decide for themselves what form of health promotion package to provide in relation to other priorities in primary care. The implications for practice nurses are clear. As primary health care technologies are assessed for effectiveness and policy and purchasing decisions begin to influence the quality of health care, the practice nurses' role and responsibilities will continue to evolve.

There is no doubt that practice nurses want to develop their role. Opportunities for continuing education are being expanded and many want advanced and specialist training, including the relevant post-basic qualifications. Many also want increased responsibility and the opportunity to investigate, diagnose, prescribe and treat certain conditions - activities often associated with a nurse practitioner role. Most GPs also want to see further expansion of the practice nurse's

role although their views differ widely on what this might entail and fewer than one in three favour the nurse practitioner model (Robinson, *et al.*, 1993).

How far the practice nurse's role will be shaped by considerations of cost is not clear. Although most practice nurses (98 per cent) are employed by a GP, 70 per cent of their salary is reimbursed by FHSAs. This 70 per cent becomes a direct cost on the cash limited staff budget of FHSAs and therefore an opportunity cost in relation to other appointments. Since April 1990, FHSAs can decide the level of reimbursement of salaries paid to practice staff appointed after that date although most of the money is committed to staff already in post.

The other 30 per cent of the practice nurse's salary is effectively taken out of the profits of the practice and has a more direct impact on their patterns of work. The appointment of a practice nurse will result in a reduction in the take-home pay of the GP or the loss of another staff member unless that nurse can generate income. From the GP's point of view, the income generation potential of nurses is most important. Few practices would have achieved higher target payments for cervical cytology and immunisation levels without substantial input from practice nurses.

The costs of practice nursing can be substantial. In a typical FHSA with almost 100 (WTE) practice nurses the total service cost is estimated to be around £2 million a year. Yet FHSAs have little leverage to influence practice nursing and promote new developments. Expenditure on practice staff and premises represents only about one tenth of FHSAs' budgets for general medical services. Around 90 per cent of these funds goes to GPs for capitation payments and

various fees and allowances. This expenditure is not cash limited and is reimbursed automatically according to nationally agreed payments.

With limited funds at their discretion FHSAs can help shape practice staffing arrangements through providing advice on management and organisation, coordinating training and support, and promoting team working (Audit Commission, 1993). Some FHSAs are beginning to rationalise staff reimbursement and to look for a more equitable distribution of financial support for practice nurses across the FHSA (Practice Nurse, 1993). Additionally, some FHSAs are collaborating with health authorities employing health visitors, district nurses, and other specialist nurses, to integrate community services and involve practice nurses as part of a primary health care nursing team sharing common aims (NHS Management Executive, 1993).

Many GPs would welcome FHSAs extending their developmental function to promote good practice. As small employers, GPs often do not have the resources to develop the practice nurse's role by offering appropriate training and support. Nonetheless they may be reluctant to relinquish control over their practice nurses to the FHSA and community nursing managers. One possibility is for GPs to become more involved in purchasing primary care nursing services, whether as fundholders or in association with commissioning authorities, with FHSAs employing nurse supervisors and holding the practice nurses' contracts.

The spread of fundholding practices, which now serve more than one in four of the population, is expected to encourage participating GPs to be more cost conscious and shape the practice nurse's role. Funds cover, among other things, a proportion of practice staff costs

including training, with a separate allowance for management. Value for money issues that arise from employing a practice nurse with community nursing skills as opposed to purchasing nursing and specialist services from NHS community units and trusts are clearly important. Possibilities include fundholders, who share the same locality, jointly employing several nurses that serve all their practices and combine treatment room tasks with district nursing and health visiting skills. Involving non-fundholding GPs in the purchasing process of health authorities will also encourage active responsibility for the pattern of community nursing services and the considerable resource implications. Clearly, as the purchaser-provider system develops the role and deployment of practice nurses will change accordingly.

CONCLUSION

The recent rapid growth in the number of practice nurses now means that they comprise a significant component of the services delivering primary and community health care. Yet there is widespread uncertainty about their role and, to date, considerations of cost have been largely ignored in the debate about how practice nursing might develop. The divorce between financial accountability and the day-to-day direction of practice nurses has hindered a proper concern for cost constraint and the desire to improve cost effectiveness in the delivery of primary health care. As the NHS purchaser-provider system develops and GP fundholding expands, however, value for money and the appropriate use of practice nurses will become increasingly important criteria for policy and practice.

Cost is not the only relevant criterion however. It is important that potential changes to practice nursing are discussed with an awareness of evidence on the quality and effectiveness

of current provision. The social skills of the practice nurse, as well as clinical skills, multidisciplinary teamwork, leadership responsibilities, and the ability to work in isolation from other professional colleagues, are important for ensuring good quality patient care. The next stage of this research will address these wider, qualitative, aspects of the practice nurses' role.

REFERENCES

Akehurst, R., Hutton, J. and Dixon, R. (1991) *Review of Higher Costs of Health Care Provision in Inner London and a Consideration of Implications for Competitiveness: Final Report* (York Health Economics Consortium, University of York, York).

Atkin, K., Lunt, N., Parker, G. and Hirst, M.A. (1993) *Nurses Count: A National Census of Practice Nurses* (Social Policy Research Unit, University of York, York).

Audit Commission (1992) *Community Care: Managing the Cascade of Change* (National Health Service Report, No. 6, HMSO, London).

Audit Commission (1993) *Practices Make Perfect: the Role of the Family Health Services Authority* (HMSO, London).

Bosanquet, N. and Jeavons, R. (1989) *The Future Structure of Nurse Education: An Appraisal of Policy Options at the Local Level* (Discussion Paper No. 54, Centre for Health Economics, University of York, York).

Department of Health and the Welsh Office (1989) *General Practice in the NHS: A New Contract* (HMSO, London).

Doctors' and Dentists' Review Body (1991) *General Medical Practitioners' Workload Survey 1989/90. Volume 1: Main findings* (Department of Health, London).

Dunnell, K. and Dobbs, J. (1982) *Nurses Working in the Community* (HMSO, London).

Evans, J. (1992) 'PNs: a picture', *Practice Nursing*, 9-12 September.

Goodwin, L. and Bosanquet, N. (1986) *Nurses and Higher Education: The Costs of Change* (Discussion Paper No. 13, Centre for Health Economics, University of York, York).

Hartley, K. and Goodwin, L. (1985) *The Exchequer Costs of Nurse Training* (Discussion Paper No. 6, Centre for Health Economics, University of York, York).

Hirst, M.A., Atkin, K. and Lunt, N. (1994) *Variations in practice nursing: implications for Family Health Services Authorities* (Social Policy Research Unit, University of York, York).

Law, S. (1992) *Community Nursing Workforce Study* (HMSO, London).

Muir, J., Mant, D., Jones, L. and Yudkin, P. (1994) 'Effectiveness of health checks conducted by nurses in primary care: results of the OXCHECK study after one year', *British Medical Journal*, 308, pp. 308-312.

Netten, A. and Beecham, J. (1993) *Costing Community Care: Theory and Practice* (Ashgate, Aldershot).

Netten, A. and Smart, D (1993) *Unit Costs of Community Care 1992/93* (Personal Social Services Research Unit, University of Kent, Canterbury).

NHS Management Executive (1993) *Nursing in Primary Health Care: New World, New Opportunities* (HMSO, London).

Practice Nursing (1993) 'FHSAs to rationalise staff reimbursement', *Practice Nursing*, 2-15 February, p. 1.

Robinson, G., Beaton, S. and White, P. (1993) 'Attitudes towards practice nurses: survey of a sample of general practitioners in England and Wales', *British Journal of General Practice*, 43, pp. 25-29.

Ross, F. and Bower, P. (1992) *A Study of Practice Nurses Working in South West Thames Regional Health Authority* (South West Thames Regional Health Authority, London).

Wood, D.A., Kinmonth, A-L, Pyke, S.D.M. and Thompson, S.G. (1994) 'Randomised controlled trial evaluating cardiovascular screening and intervention in general practice: principal results of the British family heart study', *British Medical Journal*, 308, pp. 313-320.

APPENDIX

COSTS	Grade B	Grade C	Grade D	Grade E
A: Wages/salary	£8,840 per year	£10,280 per year	£11,580 per year	£13,250 per year
B: Salary on-costs	i) £884 per year (with superannuation) ii) £530 per year (without superannuation	i) £1,028 per year (with superannuation) ii) £617 per year (without superannuation	i) £1,580 per year (with superannuation) ii) £695 per year (without superannuation	i) £1,484 per year (with superannuation) ii) £954 per year (without superannuation
C: Overheads: direct	£3,205 per year	£3,205 per year	£3,205 per year	£3,205 per year
D: Overheads: indirect				
E: Capital overheads	£1,810 per year	£1,810 per year	£1,810 per year	£1,810 per year
F: Travel	£0.45 per visit	£0.45 per visit	£0.45 per visit	£0.45 per visit
UNIT ESTIMATION				
Working time	1,687.5 hours per year (45 week year, 37.5 hours per week)	1,687.5 hours per year (45 week year, 37.5 hours per week)	1,687.5 hours per year (45 week year, 37.5 hours per week)	1,687.5 hours per year (45 week year, 37.5 hours per week)
Sickness leave				
Client/non-client contact	Ratio of client to non-client contact 1:0.6	Ratio of client to non-client contact 1:0.6	Ratio of client to non-client contact 1:0.6	Ratio of client to non-client contact 1:0.6
Domiciliary v. office/clinic visit				
Regional variations	London 1.22 x (A to E)	London 1.22 x (A to E)	London 1.22 x (A to E)	London 1.22 x (A to E)
Commodity/task				
Dependency/condition				
Outcomes				

Price base of costs	1992/93	1992/93	1992/93	1992/93
Unit costs available	i) £8.73 per hour; £13.97 per hour with a client (includes A to E, with superannuation). ii) £8.52 per hour; £13.63 per hour with a client (includes A to E, without superannuation). Travel £0.45 per visit	i) £9.67 per hour; £15.47 per hour with a client (includes A to E, with superannuation). ii) £9.43 per hour; £15.08 per hour with a client (includes A to E, without superannuation). Travel £0.45 per visit	i) £10.77 per hour; £17.23 per hour with a client (includes A to E, with superannuation). ii) £10.25 per hour; £16.40 per hour with a client (includes A to E, without superannuation). Travel £0.45 per visit	i) £11.70 per hour; £18.72 per hour with a client (includes A to E, with superannuation). ii) £11.39 per hour; £18.22 per hour with a client (includes A to E, without superannuation). Travel £0.45 per visit

Appendix (continued)

COSTS	Grade F	Grade G	Grade H	Grade I
A: Wages/salary	£15,270 per year	£17,460 per year	£19,400 per year	£21,360 per year
B: Salary on-costs	i) £1,710 per year (with superannuation) ii) £1,099 per year (without superannuation	i) £1,956 per year (with superannuation) ii) £1,257 per year (without superannuation	i) £2,173 per year (with superannuation) ii) £1,397 per year (without superannuation	i) £2,392 per year (with superannuation) ii) £1,538 per year (without superannuation
C: Overheads: direct	£3,205 per year	£3,205 per year	£3,205 per year	£3,205 per year
D: Overheads: indirect				
E: Capital overheads	£1,810 per year	£1,810 per year	£1,810 per year	£1,810 per year
F: Travel	£0.45 per visit	£0.45 per visit	£0.45 per visit	£0.45 per visit
UNIT ESTIMATION				
Working time	1,687.5 hours per year (45 week year, 37.5 hours per week)	1,687.5 hours per year (45 week year, 37.5 hours per week)	1,687.5 hours per year (45 week year, 37.5 hours per week)	1,687.5 hours per year (45 week year, 37.5 hours per week)
Sickness leave				
Client/non-client contact	Ratio of client to non-client contact 1:0.6	Ratio of client to non-client contact 1:0.6	Ratio of client to non-client contact 1:1.1	Ratio of client to non-client contact 1:1.1
Domiciliary v. office/clinic visit				
Regional variations	London 1.22 x (A to E)	London 1.22 x (A to E)	London 1.22 x (A to E)	London 1.22 x (A to E)
Commodity/task				
Dependency/condition				
Outcomes				

Price base of costs	1992/93	1992/93	1992/93	1992/93

Unit costs available	i) £13.03 per hour; £20.85 per hour with a client (includes A to E, with superannuation). ii) £12.67 per hour; £20.27 per hour with a client (includes A to E, without superannuation). Travel £0.45 per visit	i) £14.48 per hour; £23.17 per hour with a client (includes A to E, with superannuation). ii) £14.06 per hour; £20.50 per hour with a client (includes A to E, without superannuation). Travel £0.45 per visit	i) £15.75 per hour; £33.08 per hour with a client (includes A to E, with superannuation). ii) £15.30 per hour; £32.13 per hour with a client (includes A to E, without superannuation). Travel £0.45 per visit	i) £17.05 per hour; £35.75 per hour with a client (includes A to E, with superannuation). ii) £16.54 per hour; £34.74 per hour with a client (includes A to E, without superannuation). Travel £0.45 per visit