

King Edward's Hospital Fund for London

King's Fund Centre

THE NATIONAL HEALTH SERVICEGENERAL

The National Health Service Act of 1946 aimed at promoting 'the establishment in England and Wales of a comprehensive health service, designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis and treatment of illness'. Through the Act the Minister of Health was made responsible to Parliament for seeing that health services of every kind, and of the highest possible quality, were available to everyone who needed them. The NHS (Scotland) Act 1947 laid similar responsibilities on the Secretary of State for Scotland. Both these Acts were passed by Parliament and came into force on 5 July 1948.

Under the National Health Service (NHS), the essential freedoms have been safeguarded, for the public is free to use the service or not. The patient is free to choose his family doctor and to change to another if he wishes to do so. The doctor is free from interference in his clinical judgment, and may accept private patients while taking part in the service. The service is available free to all residents in Britain according to their medical need, except that certain small charges are made for some items. Treatment can be given under the emergency provisions of the service to any visitor from abroad who has the misfortune to fall ill during his visit, but visitors who come to Britain specifically for treatment are expected to pay for it. About 97% of the population of Britain are using the service.

ORGANISATION IN ENGLAND

From 1948 to 1974, the NHS was administered in three parts - the hospital and specialist services, the general practitioner services and the local authority services. Under the NHS Reorganisation Act of 1973 these services were unified, with just over 100 regional and area health authorities taking control in place of over 600 boards, committees and councils that had previously been responsible for them.

The new arrangements came into force on 1 April 1974, and provide for three levels of planning: central strategic planning and monitoring by the Department of Health and Social Security; regional planning and general supervision of operation by regional health authorities (RHA's); and area planning and operational control by area health authorities (AHA's).

THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY (DHSS)

The DHSS came into being on 1 November 1968, as an amalgamation of the Ministry of Health (first established in 1919) and the Ministry of Social Security. The section dealing with health has a staff of about 5,000 people, and is mainly a central supervisory department for the general organisation, planning and financing of the health and welfare services. The Secretary of State for Social Services is the head of the DHSS: this is a political appointment, as are those of the Minister of State and the Parliamentary Under-Secretary of State (Health) and the Parliamentary Under-Secretary of State (Social Security). The two senior permanent officials of the DHSS are the Permanent Secretary and the Chief Medical Officers: these are both members of the Civil Service, as are the rest of the staff of the DHSS. But none of the staff employed by regional and area authorities in the NHS are civil servants.

The Secretary of State is responsible to Parliament for the NHS and the role of the DHSS is to assist him in the following ways:

- (a) Settling the kind, scale and balance of service to be provided in regions and areas.
- (b) Guiding, supporting and (to the extent that this is desirable) controlling RHA's. Here it is the Department's job to help the authorities to understand the guide-lines and the reasoning behind them. It also allocates to the RHA's the necessary resources.
- (c) Obtaining or developing resources which strongly influence the adequacy, efficiency and economy of the services. This requires specialist work on particular resources - personnel; finance; property and building; supply. The Department has a special responsibility in relation to staffing - for instance forecasting staff requirements, planning the number of training places, etc.
- (d) Carrying out other functions which are best organised centrally, such as some types of research, standardisation and preparation of national statistics.
- (e) Supporting the Secretary of State in his Parliamentary and public duties.

REGIONAL HEALTH AUTHORITIES

There are 14 Regional Health Authorities (RHA's) in England, each consisting of between 3 - 11 health areas. The RHA forms part of the chain of responsibility running from the Secretary of State to each AHA. The Chairman and members of the RHA are appointed by the Secretary of State after consultations with interested organisations, including the universities, the main local authorities, the main health professions and the TUC. Members are unpaid (but entitled to travelling and other allowances) but the Chairman may be paid on a part-time basis.

The role of the RHA is to develop strategic plans and priorities based on a review of the needs identified by the AHA's. It is responsible for allocating resources among AHA's, agreeing area plans with them and monitoring their performance. The most important of the RHA's executive functions is the design and construction of new hospitals and other health buildings. It is also responsible for identifying, in consultation with the AHA's, services which need a regional rather than an area approach and arrange for their provision.

AREA HEALTH AUTHORITIES

There are 90 Area Health Authorities (AHA's) in England whose boundaries generally match those of the new non-metropolitan counties and metropolitan districts of local government. In London the health authority boundaries correspond to those of an individual London Borough in four cases, and two, three or, in one case four London Boroughs grouped together in the remaining 12 cases.

The AHA is the operational NHS authority, responsible for assessing needs in its area and for planning, organising and administering area health services to meet them. It is the employer of the staff who work at area headquarters and in the districts. It is also responsible for services such as catering and domestic, as well as for other supportive services which back up the health professions and, in so doing, contribute to patient care.

The Chairman of the AHA is appointed by the Secretary of State after consultation with the Chairman of the RHA. There are about 15 members for each AHA, four of whom are appointed by the corresponding local authority, one by the university concerned (areas with substantial teaching facilities are administered by AHAs (Teaching)) and the remaining members appointed by the RHA after consultation with the main health professions, the trade unions and other organisations. An AHA always includes doctors and at least one nurse or midwife, but otherwise the proportion of professional members is not prescribed. Members are unpaid (but entitled to travelling and other allowances) but the Chairman may be paid on a part-time basis.

HEALTH DISTRICTS

The day-to-day running of the services for which each AHA is responsible is based on 205 health districts. These usually contain a district general hospital and usually have a population of between 150,000 and 300,000. The AHAs decide the number of districts in their areas and there are between one and six districts in each area. There is no statutory authority at district level, as there is at area or region, and responsibility for the day-to-day operation of the services at district level lies with the district management team of about six senior medical, nursing, administrative and finance officers.

At district level there are also health care planning teams whose function is to determine health care needs of groups of patients (e.g. elderly, mentally ill, mentally handicapped children, etc.) or to look at particular problems (e.g. review of primary care services, re-organisation of out-patient department, etc.).

SOCIAL SERVICES

Under the new arrangements, as under the old, health service costs are met mainly through central government funds from tax revenue. Social services, on the other hand, are planned and controlled by local government authorities (sharing the same boundaries as area health authorities, in most cases) and their costs are met mainly through local government funds. Although separately financed, it is very important that health and social services should be planned jointly, particularly for the old, the mentally ill and mentally handicapped. There is therefore under the 1973 Act a statutory responsibility for area health authorities to collaborate in planning with their corresponding local government authorities. Co-operation in this field is vital to the success of the reorganised NHS.

COMMUNITY HEALTH COUNCILS

A completely new feature of the reorganised NHS is the establishment of Community Health Councils (CHC's). These CHC's represent the views of the consumer. There is one for each of an area's health districts. Half the members of the Council are appointed by the local authorities of which the area, or part of it, is included in the CHC's district, at least one-third by voluntary bodies concerned locally with the NHS and the remainder by the RHA after consultation with other organisations. The number of members varies according to local circumstances, but there are usually between 20 and 30. Members are unpaid, but entitled to travelling and other expenses. Councils appoint their own Chairmen from among their members.

The Council's basic job is to represent to the AHA the interests of the public in the health service in its district. Councils have powers to secure information, to visit hospitals and other institutions, and have access to the AHA and in particular to its senior officers administering the district services. Councils may bring to the notice of the AHA potential causes of local complaint, but their function is distinct from that of the AHA's complaints machinery and of the Health Service Commissioner.

The AHA is required to consult the Council(s) on its plans for health service developments - e.g. closures of hospitals or departments of hospitals, or their change of use. The full AHA meets representatives of all its Councils at least once a year. The Council publishes an annual report (and may publish other reports) and the AHA is required to publish replies recording action taken on the issues raised.

HEALTH SERVICE COMMISSIONER

Another new feature of the NHS is the appointment of a Health Service Commissioner to investigate complaints against NHS authorities. This is an important extension of the ombudsman principle in the public service. The necessary legislation is part of the NHS Reorganisation Act, and from 1 April 1974 his jurisdiction covers the whole of the unified NHS. He does not, however, investigate complaints which, in his opinion, relate to the exercise of clinical judgement by doctors and other staff, nor does he deal with complaints for which statutory procedures already exist (e.g. those about general medical and dental practitioners, pharmacists and opticians, which continue to be dealt with under the service committee procedure) or which he thinks the complainant could reasonably pursue through the courts of law.

The complainant has direct access to the Commissioner who, however, does not investigate a complaint until he is satisfied that the health authority concerned has had a reasonable opportunity to investigate it and reply to the complainant who, despite this, is still dissatisfied. Complaints to the Commissioner do not have to be made by the patient himself: there are some cases where the patient is unable to act for himself, and in such cases the complaint may be made on his behalf.

VOLUNTARY SERVICES

Under the new arrangements, voluntary bodies, which have always played an important part in the development of the health and welfare services, are being encouraged, in close co-operation with the area health and local authorities, to increase and extend their activities. Through their membership of the Community Health Councils they are able to influence the way in which the health services are developed. The recent growth in the number of organisers co-ordinating voluntary help in hospitals will continue and this method of co-ordination is being extended to the wider field of voluntary work in the community.

The RHA's and AHA's will be able to make grants in support of voluntary bodies which provide and promote services within the general scope of the authorities' responsibilities. Financial help for national activities continues to come from the central Department. As all this voluntary activity develops, it is important to emphasise that the role of volunteers is no longer seen as being to plug gaps in the welfare state, but rather to complement and enrich the quality of life for people in need, whether they are living in their own homes or in hospital or in any form of residential care, and also to pioneer new ideas and to develop in the hospital and its neighbourhood a real sense of community involvement in the services which as taxpayers or rate-payers they largely finance.

King Edward's Hospital Fund for London

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The following figures are taken from Health and Personal Social Services Statistics for England, 1974.

Hospital patients	1972 Thousands	1973 Thousands
Available staffed beds (daily average)	413*	404*
Occupied beds " "	342	328
Discharges and deaths	5,223	5,132
Waiting lists	479	509
Out-patient and casualty attendances	46,290	46,674

* Of the total of 404,000 beds approximately 41% are for psychiatric patients.

Hospital staff	1972	1973
Doctors and Dentists (equivalent of whole-time)	24,413	25,573
Professional and Technical (equivalent of whole-time)	36,444	38,255
Nursing and Midwifery (whole-time)	193,564	194,929
Nursing and Midwifery (part-time)	108,847	113,617
Works, maintenance and domestic (equivalent of whole-time)	196,173	191,290
Administrative and clerical	55,190	59,142

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22 January 1975

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NATIONAL HEALTH SERVICE FINANCE - HOSPITALS

Expenditure of hospital authorities in England in year ending 31 March 1973
(taken from Health and Personal Social Services Statistics for England, 1974)

<u>CAPITAL EXPENDITURE</u>		<u>£ thousands</u>	
Gross Expenditure	183,065	
<u>REVENUE EXPENDITURE</u>		<u>£ thousands</u>	<u>% of total hospital maintenance</u>
Salaries and wages:			
(i) Medical and dental	136,895	11.08)
(ii) Nursing	368,836	29.84) 72.63
(iii) Others	391,873	31.71)
Provisions	54,303	4.39
Staff uniforms and patients' clothing	9,252	0.75
Drugs	34,720	2.81
Dressings	8,115	0.65
Medical and surgical appliances and equipment	61,916	5.01
General services (includes power, light, heating, water, cleaning and laundry)	51,886	4.20
Maintenance of buildings, plant and grounds	38,185	3.09
Domestic repairs, renewals and replacements	19,260	1.56
Other expenditure	60,695	4.91
Total hospital maintenance	1,235,936	100.00
Blood transfusion, mass radiography, etc	19,763	
Central administration	43,076	
Total hospital revenue expenditure	1,298,775	
Less : Direct credits	36,096*	
Total net revenue expenditure	1,262,679	
Income:		16,000*	

* Note: Revenue income is derived mainly from patients in private or amenity beds, from charges for the supply and repair of certain appliances, and from payments under the Road Traffic Acts. Direct credits represent payments by staff for board, lodging, supplies and services. These direct credits are netted against expenditure in the hospital accounts.

HEALTH SERVICE COSTS AND SOURCES OF FINANCEIN THE YEAR ENDING 31 MARCH 1973ENGLAND

<u>COST OF SERVICE</u>			<u>SOURCE OF FINANCE</u>		
	£	%		£	%
	million			million	
Central administration	17	0.6	Exchequer	1,826	70.0
Hospitals current	1,303	49.9	N.H.S contributions	197	7.5
Hospitals capital	184	7.0	Payments by persons using the services	129	4.9
Executive councils service					
Administration	15	0.6	Rates and exchequer		
General medical	175	6.7	grants to local authorities	452	17.3
Pharmaceutical	226	8.7	Other	8	0.3
General dental	112	4.3			
General ophthalmic	27	1.0			
Welfare foods	10	0.4			
Local health authority	147	5.6			
Personal social services	355	13.6			
Others	41	1.6			
	£2,612	100.0%		£2,612	100.0%
	million			million	

National average cost of maintaining in-patients 1972/73

£

(a) Non-teaching hospitals - weekly in-patient cost

Acute	89.06
Maternity	95.26
Mental illness	30.34
Mental handicap	28.02

(b) Teaching hospitals - weekly in-patient cost

Acute (London)	129.14
Acute (Provinces)	115.66

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28 January 1975

King Edward's Hospital Fund for London

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Details of Medical and Dental Staff employed in hospitals in England as at 30 September 1973 (extracted from Health and Personal Social Services Statistics for England, 1974).

Grade	Staff Employed (including part-time staff expressed as whole-time equivalent)
Consultant	9,285
Senior Hospital Medical/Dental Officer	225
Medical Assistant	812
Senior Registrar	1,890
Registrar	4,514
Junior Hospital Medical Officer	2
Senior House Officer	6,377
House Officer - (Post-Registration and Pre-Registration)	2,456
Other Ungraded Staff	12
Total	25,573

General medical practitioners in the N.H.S.

Numbers at
30 September 1973

Principals	20,341
Assistants	570
Trainees	447
	<hr/>
	21,358
	<hr/>

GRADES OF HOSPITAL MEDICAL STAFF

Based on extracts from Hospital Administration

by
Geoffrey A. Robinson, F.H.A., F.C.A.
(1962; rev. ed. 1966)

The following are the principal grades of medical staff employed in hospitals:

CONSULTANT - A senior practitioner who has been appointed by a statutory hospital authority, who performs clinical duties and has ultimate personal responsibility for the treatment of the patients under his care.

SENIOR REGISTRAR - Posts obtained by practitioners, normally not less than three years after full registration and held normally for three or four years.

REGISTRAR - Posts obtained by practitioners, normally not less than one year after full registration and held normally for two or three years.

SENIOR HOUSE OFFICER - A post obtained after at least twelve months post-graduate experience in hospitals. The post is held normally for one year.

HOUSE OFFICER - Normally the first post held after qualification.

MEDICAL ASSISTANT - An intermediate grade of medical practitioner capable of assuming responsibility delegated by senior staff, capable of carrying out complex diagnostic and therapeutic procedures, and giving support and supervision to the house office grades. These posts are open to practitioners who have served in the hospital service for at least three years since full registration, including at least two years in the grade of registrar or with equivalent experience. Appointments are for two years in the first instance and renewable, subject to confirmation, for an indefinite period.

New appointments to the following posts ceased in 1964, when the post of Medical Assistant was introduced:

SENIOR HOSPITAL MEDICAL OFFICER - A senior practitioner performing clinical duties who is not of consultant status but is not in the registrar grades.

JUNIOR HOSPITAL MEDICAL OFFICER - An officer who has held house appointments but is not a registrar, who has less responsibility than other hospital officers of non-consultant status, and who has been appointed for a limited or indefinite period.

DOCTORS' PAY

Doctors working in hospitals are paid on a salaried basis, either full-time or part-time. General practitioners are paid on a more complicated basis, calculated largely according to the number of patients on each doctor's list, with a variety of special allowances and supplements. The extract below is reproduced by kind permission of the Editor, from the January 1974 issue of *WHICH?*, the journal of the Consumers' Association.

HOW YOUR FAMILY DOCTOR GETS PAID

GPs are paid for each patient on their list, and also allowances for being a practitioner, for practising in certain areas and types of practice, as well as fees for some treatments or visits.

Doctors' fees and allowances are based on recommendations by the Review Body on Doctors' and

Dentists' Remuneration. Their intention is that the various payments and allowances should give GPs an average income (net of medical expenses) of £5,750.

To give an idea of how the NHS pay scheme works in practice, and how actual incomes can vary between different GPs, we set out below how the incomes of two imaginary GPs add up (for 1973-74).

Dr Newcome did three years vocational training on top of his medical training, to become a GP at the age of 28. He took over a practice of 1,500 people in Lancs. Of these, 450 are 65 or over. He employs a receptionist/secretary at £1,000 a year. Last year he did 50 night visits (between 11pm and 7am) and attended to three temporary residents. He has started a cervical smear programme - he's examined 40 women. He dispenses medicines from his surgery. This year he did a postgraduate training course on the *Early Diagnosis of Cancer*. He works from his home, rented for £500 a year.

His income works out at:	£
Basic practice allowance	1,815
Vocational training	400
1,050 patients under 65 @ £1.50	1,575
450 aged 65 or over @ £2.10	945
Payment for out-of-hours responsibilities	350
500 patients over 1,000 @ 28p	140
Payments for dispensing	800
Postgraduate training allowance (lump sum)	140
50 night visits @ £3	150
40 cervical smears @ £1.50	60
4 temporary residents @ £1.50	6
Payment for rent	150
Payment for receptionist's income	700
	£7,231

Medical Expenses (which can be set off against tax)

	£
Receptionists' income	1,000
Practice expenses - including rent, heating, cleaning and so on	350
Car	650
Medical supplies	400
Other expenses	400
Locum while on holiday	200
	£3,000

Dr Newcombe's net income is £4,231

Dr Longstay has been practising for 35 years. He works as a partner in a group of five doctors in London, and has 2,800 patients on his own list, of whom 600 are over 65. He is on duty one night in the week - 50 night visits a year. He vaccinates the schoolchildren in his practice - and provides maternity medical services. He treated 30 temporary residents. The group has a trainee practitioner learning the ropes - they get a grant for this. The five doctors employ four receptionists/secretaries (£1,400 each). Each partner pays £300 a year towards the maintenance of the practice building, bought some years ago (but which they get a payment for).

His income works out at:	£
Basic practice allowance	1,815
Group practice payment	270
Seniority payment	910
2,200 patients under 65 @ £1.50	3,300
600 aged 65 or over @ £2.10	1,260
Out-of-hours responsibilities	350
1,800 patients over 1,000 @ 28p	504
50 night visits @ £3	150
100 vaccinations @ 50p	50
28 births @ £21.75	609
30 temporary residents @ £1.50	45
Share of trainer's grant (£850)	170
Notional rent payment	150
Share of payment towards receptionists' income	784

£10,367

Medical expenses (which can be set off against tax)

	£
Practice expenses - including rent, heating, cleaning and so on	300
Share of receptionists' salary	1,120
Car	500
Medical supplies; other expenses	350

£2,270

Dr Longstay's net income is £8,097

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NATIONAL HEALTH SERVICE - DISTRICTS & AREAS

<u>England</u> (14 regions)	<u>No. of Areas</u>	<u>No. of Districts</u>	<u>No. of areas with</u>						districts
			<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	
Northern	9	16	6		2	1			
Yorkshire	7	17	1	4		2			
Trent	8	18	3	1	3	1			
East Anglia	3	8		1	2				
N W Thames	7	18	1	3	1	2			
N E Thames	6	17		3	2		1		
S E Thames	5	16	1	1	1	1			1
S W Thames	5	14	2		2				1
Wessex	4	10	1	1	1	1			
Oxford	4	7	1	3					
S Western	5	13	1	2		2			
W Midlands	11	22	7		2	1	1		
Mersey	5	12	1	3			1		
N Western	11	17	9	1					1
Total	90	205	34	23	16	11	3	3	
<u>Wales</u>	8	17	3	3		4			
	98	222	37	26	16	13	3	3	
<u>Scotland</u>									
(Health Boards)	15	34	5	4	4	1	1		
	113	256	42	30	20	14	4	3	

(Source : Hospitals Year Book 1974)

King Edward's Hospital Fund for London
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 NATIONAL HEALTH SERVICE - DISTRICTS & AREAS

No. of Districts	No. of Areas	No. of Patients	No. of cases with					No. of cases with disability
			1	2	3	4	5	
1	2	3	4	5	6	7	8	9
10	11	12	13	14	15	16	17	18
19	20	21	22	23	24	25	26	27
28	29	30	31	32	33	34	35	36
37	38	39	40	41	42	43	44	45
46	47	48	49	50	51	52	53	54
55	56	57	58	59	60	61	62	63
64	65	66	67	68	69	70	71	72
73	74	75	76	77	78	79	80	81
82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99
100	101	102	103	104	105	106	107	108
109	110	111	112	113	114	115	116	117
118	119	120	121	122	123	124	125	126
127	128	129	130	131	132	133	134	135
136	137	138	139	140	141	142	143	144
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154	155	156	157	158	159	160	161	162
163	164	165	166	167	168	169	170	171
172	173	174	175	176	177	178	179	180
181	182	183	184	185	186	187	188	189
190	191	192	193	194	195	196	197	198
199	200	201	202	203	204	205	206	207
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217	218	219	220	221	222	223	224	225
226	227	228	229	230	231	232	233	234
235	236	237	238	239	240	241	242	243
244	245	246	247	248	249	250	251	252
253	254	255	256	257	258	259	260	261
262	263	264	265	266	267	268	269	270
271	272	273	274	275	276	277	278	279
280	281	282	283	284	285	286	287	288
289	290	291	292	293	294	295	296	297
298	299	300	301	302	303	304	305	306
307	308	309	310	311	312	313	314	315
316	317	318	319	320	321	322	323	324
325	326	327	328	329	330	331	332	333
334	335	336	337	338	339	340	341	342
343	344	345	346	347	348	349	350	351
352	353	354	355	356	357	358	359	360
361	362	363	364	365	366	367	368	369
370	371	372	373	374	375	376	377	378
379	380	381	382	383	384	385	386	387
388	389	390	391	392	393	394	395	396
397	398	399	400	401	402	403	404	405
406	407	408	409	410	411	412	413	414
415	416	417	418	419	420	421	422	423
424	425	426	427	428	429	430	431	432
433	434	435	436	437	438	439	440	441
442	443	444	445	446	447	448	449	450
451	452	453	454	455	456	457	458	459
460	461	462	463	464	465	466	467	468
469	470	471	472	473	474	475	476	477
478	479	480	481	482	483	484	485	486
487	488	489	490	491	492	493	494	495
496	497	498	499	500	501	502	503	504
505	506	507	508	509	510	511	512	513
514	515	516	517	518	519	520	521	522
523	524	525	526	527	528	529	530	531
532	533	534	535	536	537	538	539	540
541	542	543	544	545	546	547	548	549
550	551	552	553	554	555	556	557	558
559	560	561	562	563	564	565	566	567
568	569	570	571	572	573	574	575	576
577	578	579	580	581	582	583	584	585
586	587	588	589	590	591	592	593	594
595	596	597	598	599	600	601	602	603
604	605	606	607	608	609	610	611	612
613	614	615	616	617	618	619	620	621
622	623	624	625	626	627	628	629	630
631	632	633	634	635	636	637	638	639
640	641	642	643	644	645	646	647	648
649	650	651	652	653	654	655	656	657
658	659	660	661	662	663	664	665	666
667	668	669	670	671	672	673	674	675
676	677	678	679	680	681	682	683	684
685	686	687	688	689	690	691	692	693
694	695	696	697	698	699	700	701	702
703	704	705	706	707	708	709	710	711
712	713	714	715	716	717	718	719	720
721	722	723	724	725	726	727	728	729
730	731	732	733	734	735	736	737	738
739	740	741	742	743	744	745	746	747
748	749	750	751	752	753	754	755	756
757	758	759	760	761	762	763	764	765
766	767	768	769	770	771	772	773	774
775	776	777	778	779	780	781	782	783
784	785	786	787	788	789	790	791	792
793	794	795	796	797	798	799	800	801
802	803	804	805	806	807	808	809	810
811	812	813	814	815	816	817	818	819
820	821	822	823	824	825	826	827	828
829	830	831	832	833	834	835	836	837
838	839	840	841	842	843	844	845	846
847	848	849	850	851	852	853	854	855
856	857	858	859	860	861	862	863	864
865	866	867	868	869	870	871	872	873
874	875	876	877	878	879	880	881	882
883	884	885	886	887	888	889	890	891
892	893	894	895	896	897	898	899	900
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1018	1019	1020	1021	1022	1023	1024	1025	1026
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