Funding in the UK: The NHS Reforms

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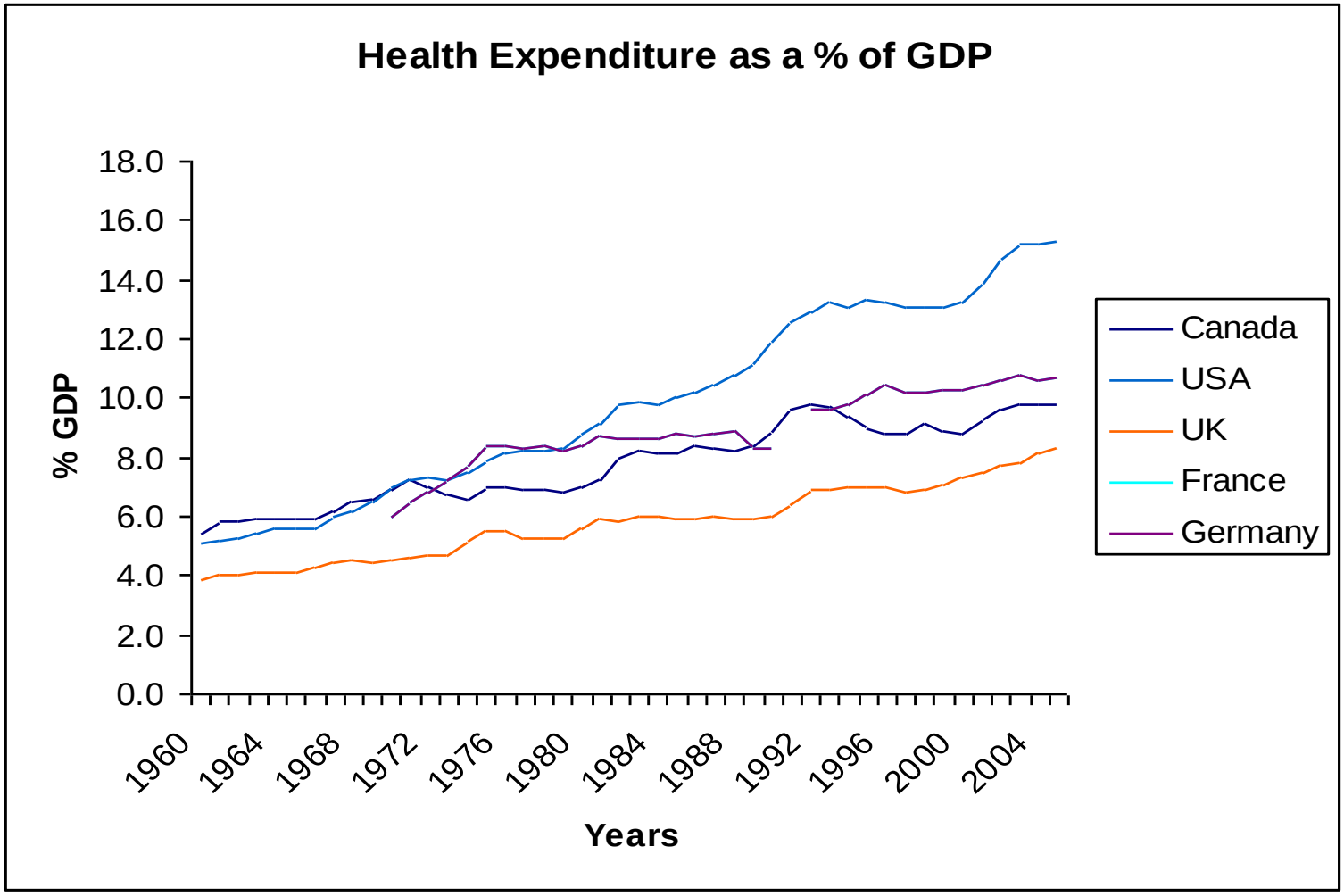
Drawing on work undertaken with Zack Cooper, Julian Le Grand and the European Observatory on Health Systems and Policies

Outline

- General background
- UK background
- Recent reforms
- Assessment

Levels

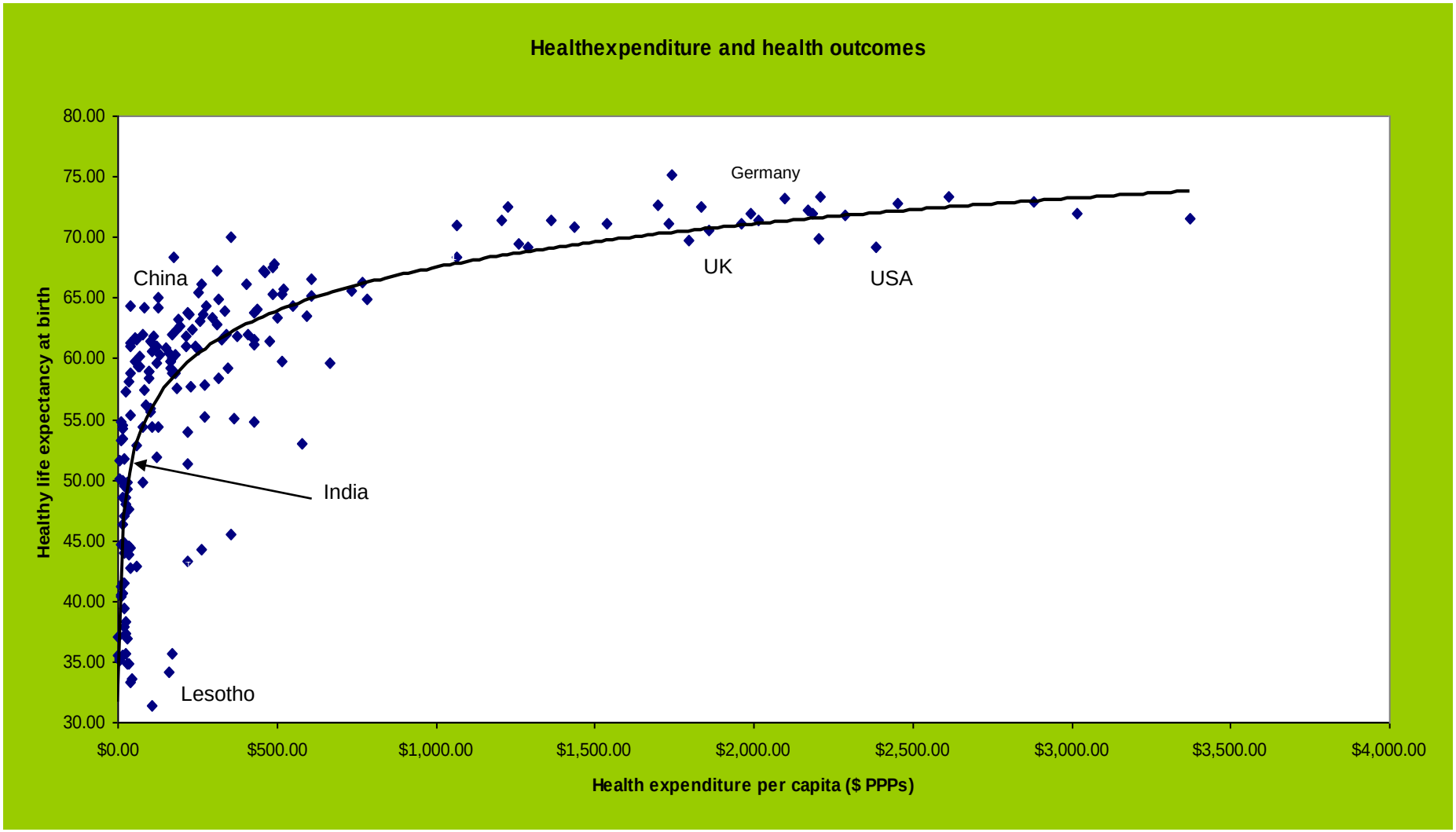

Health Expenditure as a % of GDP
% GDP
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
1960
1964
1968
1972
1976
1980
1984
1988
1992
1996
2000
2004
Years
Canada
USA
UK
France
Germany

Health expenditure growth versus GDP Growth

Total health expenditure per capita(US$ PPP)Compound annual rate of growth							
	1970-1975	1975-1980	1980-1985	1985-1990	1990-1995	1995-2000	2000-2005
France	13.5	12.4	9.3	7.2	6.6	3.8	6.3
Germany	16.2	11.2	7.7	4.7	5.2	3.4	4.5
UK	12.9	9.8	8.1	6.8	6.9	6.1	7.9
USA	11	12.6	10.6	9.2	5.9	4.6	7
Canada	9.8	10.2	10.1	6.6	3.4	4.1	6.6
GDP per capita (US$ PPP) Compound annual rate of growth							
	1970-1975	1975-1980	1980-1985	1985-1990	1990-1995	1995-2000	2000-2005
France	9.7	10.2	6.5	6.3	3.2	4.3	3.2
Germany	8.8	11	6.9	5.9	1.1	3	3.8
UK	8.6	9.1	7.2	6.3	3.9	5.2	5.2
USA	8.5	10.1	7.6	5.6	3.6	4.6	3.9
Canada	9.5	10.0	7.0	4.7	3.0	4.5	4.3

Health care expenditure growth > GDP growth in *ALL* OECD; except Finland

Diminishing returns to expenditure?



Large increase in health expenditure growth

- Health expenditure in the UK risen significantly in recent years
- Spending on health increased from 5.6% of GDP in 1980 to 8.4% in 2005
- Most rapid increase in spending during 1997 to 2005
  - spending rose from 6.6% to 8.4% of GDP
  - almost a doubling of spending in real terms
  - from £53.14 billion to £101.51 billion
  - 2002-2003 17.3% of Government spending was on the NHS

United Kingdom

Thatcher put the Great back into Britain, but took the United out of Kingdom

- England (55m), Scotland (5m), Wales (3m), Northern Ireland (1.6m)

- Scotland
  - Still centralised control
  - Higher per capita expenditure
- Wales
  - General failings
  - Lower per capita expenditure
- N. Ireland
  - Some times central government/sometimes not
  - Varying per capita expenditure

- NO SIGNIFICANT PATIENT MOVEMENTS

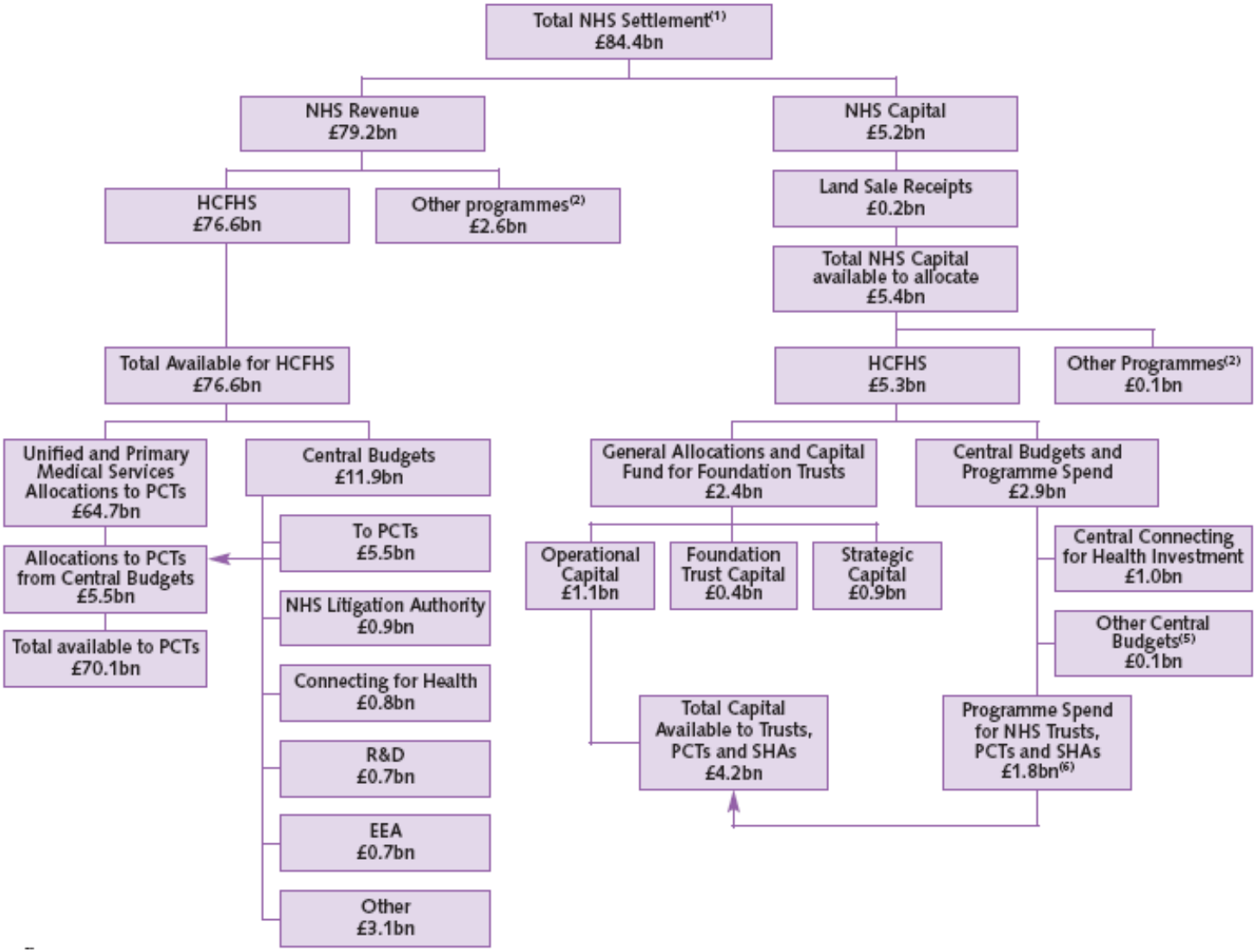
Recent NHS Reforms: England

Important policy documents published by the Department of Health in England

Title	Date of publication
The NHS Plan, A plan for investment, A plan for reform	July 2000
For the benefit of patients a concordat with the private and voluntary health care provider sector	October 2000
Shifting the Balance of Power within the NHS - Securing Delivery	July 2001
Modernising Regulation in the Health Professions	August 2001
Involving Patients and the Public in Healthcare	September 2001
Delivering the NHS Plan: Next steps on investment, next steps on reform	April 2002
Tackling health inequalities: a programme for action	July 2003
The NHS Improvement Plan : Putting people at the heart of public services	June 2004
Choosing Health: making healthier choices easier	November 2004
Agenda for Change Final Agreement	December 2004
Creating a patient-led NHS	March 2005
Commissioning a patient-led NHS	July 2005
Our health, our care, our say: a new direction for community services	January 2006

c2000 concern that UK health care was slipping far behind mainland Europe;
High mortality rates in some parts of the country and in some disease areas;
Geographical/social inequity

NHS: England


Total NHS Settlement(1) £84.4bn
NHS Revenue £79.2bn
NHS Capital £5.2bn
HCFHS £76.6bn
Other programmes(2) £2.6bn
Land Sale Receipts £0.2bn
Total NHS Capital available to allocate £5.4bn
Total Available for HCFHS £76.6bn
HCFHS £5.3bn
Other Programmes(2) £0.1bn
Unified and Primary Medical Services Allocations to PCTs £64.7bn
Central Budgets £11.9bn
General Allocations and Capital Fund for Foundation Trusts £2.4bn
Central Budgets and Programme Spend £2.9bn
To PCTs £5.5bn
Allocations to PCTs from Central Budgets £5.5bn
Total available to PCTs £70.1bn
NHS Litigation Authority £0.9bn
Connecting for Health £0.8bn
R&D £0.7bn
EEA £0.7bn
Other £3.1bn
Operational Capital £1.1bn
Foundation Trust Capital £0.4bn
Strategic Capital £0.9bn
Central Connecting for Health Investment £1.0bn
Other Central Budgets(5) £0.1bn
Total Capital Available to Trusts, PCTs and SHAs £4.2bn
Programme Spend for NHS Trusts, PCTs and SHAs £1.8bn(6)

General drives: Centralised funding, decentralised provision

- The NHS remains highly centralized in terms of funding; increasingly decentralised in terms of service contract provision (initially with centralised targets)
  - Tax-financed allocations from the UK Treasury
  - Department of Health negotiates and draws up public service agreements
  - Direct allocation of resources by the Department of Health to Primary Care Trusts (PCTs) and PCT commissioning (and now practice-based commissioning by GPs)
  - Continuing process of devolution that began with the previous (Conservative) government's creation of an 'internal market' (a purchaser-provider split)
    - PCTs introduced to replace GP fundholding
    - System set up to replace GP fundholding has effectively expanded it
    - In 1997 GP fundholders controlled 15% of NHS expenditure
    - PCTs now commission most secondary care, controlling 85% of the NHS budget
    - PCTs receive funds directly from the Department of Health
    - Cover a population on average of 330 000 people
  - Resource allocation is more decentralized and the purchasing function is more devolved than ever before
  - Plans to devolve purchasing further include
    - development of practice-based commissioning by GPs, leaving PCTs with a more strategic role

General drives: Decentralised provision, centralised regulation

- *Decision making*
  - Service delivery been devolved through introduction of so-called ‘earned autonomy’
  - Rewards performing organizations to national standards with a lower level of central regulation
  - One example Foundation Trust status for qualifying hospitals
- *Management*
  - DoH does not directly manage PCTs
  - Responsibility for day-to-day management devolved to Strategic Health Authorities
- *Regulation*
  - Major growth in the number of organizations carrying out regulatory functions as government withdraws from the direct provision and management of health services
  - Decentralization and devolution of key health service tasks to SHAs and PCTs and increasing autonomy for Foundation Trusts has led to a need for national standard setting and performance monitoring to ensure quality, safety and cost-effectiveness
    - Healthcare Commission
    - National Institute for Health and Clinical Excellence (NICE)
    - Health Protection Agency
    - National Patient Safety Agency
    - NHS Institute for Innovation and Improvement
    - Care Quality Commission

General drives: decentralised provision to meet increased patient choice

- Expanding patient choice of hospital key part of strategy for the NHS
  - Giving patients more choice of hospital (and more control over the timing of hospital appointments and elective admissions), the government aims to increase NHS responsiveness to patient needs in the expectation that this will result in lower waiting times, improved quality of care and efficiency gains from greater provider competition
  - By 2003, nine pilot programmes in England were offering selected patients who had waited more than six months for elective surgery the choice of moving to another hospital for faster treatment
  - Under the national coronary heart disease pilot, almost half of patients offered choice to move to another hospital for faster heart surgery did so

Policy objectives: Waiting times a major issue

Aims:

- to achieve maximum wait of nine months for all inpatient waiters and reduce the number of six-month inpatient waiters by 80%
- to achieve a maximum wait of four months (17 weeks) for an outpatient appointment and progress towards achieving a maximum wait of three months for an outpatient appointment
- to achieve a three-month maximum wait for revascularisation
- to reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge
- to maintain a two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals
- to achieve a maximum wait of 26 weeks for MRI and CT scans
- a maximum wait of 13 weeks for any diagnostic test/procedure
- a maximum wait of six weeks for any diagnostic test/procedure

Future developments

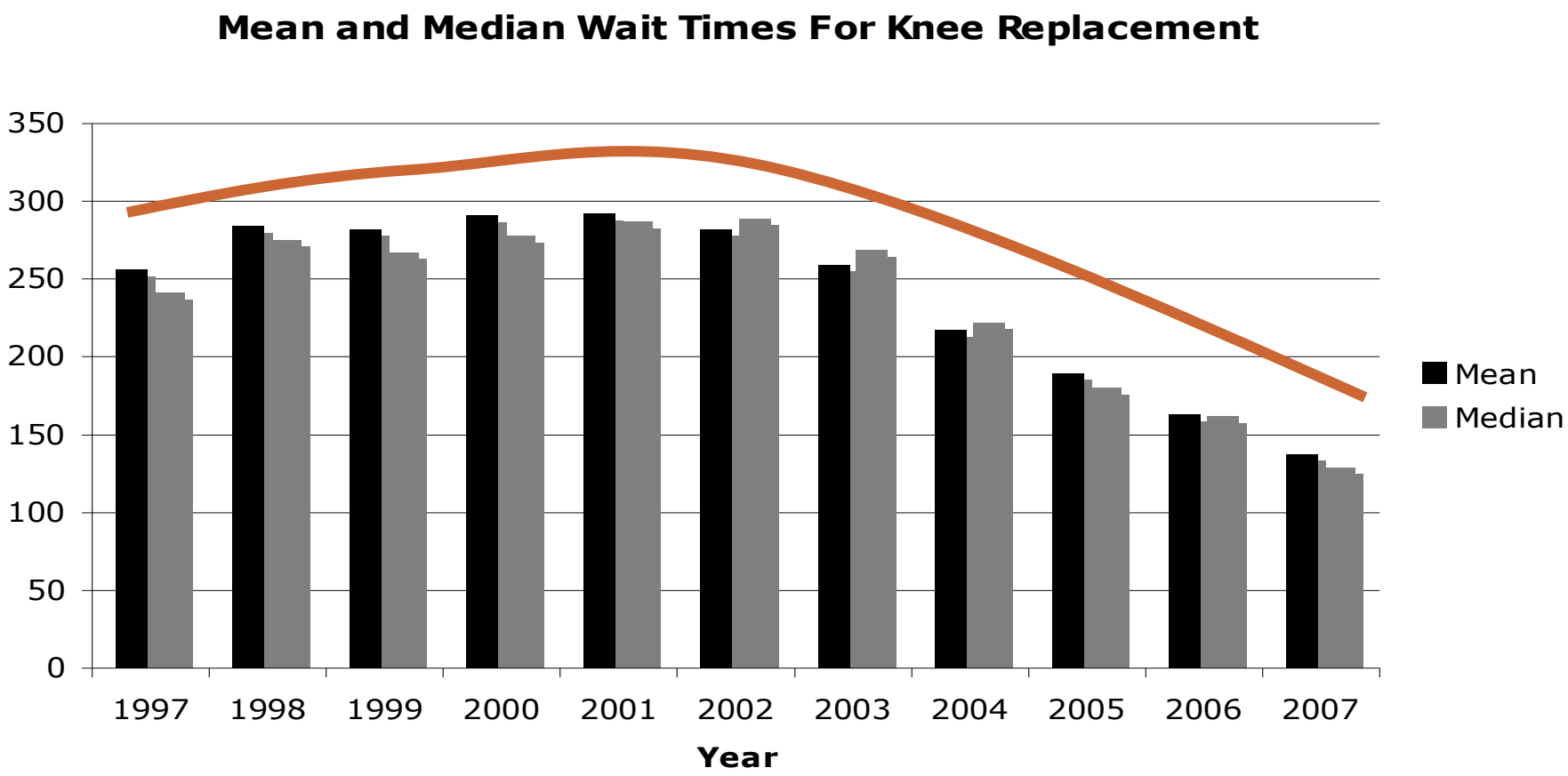
- *The NHS Improvement Plan* for the period 2005/6-2008/9
  - Emphasis on:
    - Making care more personalised (through enhanced choice, better and tailored information, involvement in decision making and support for self care);
    - Shift towards promoting health and well-being (more support for people living with chronic diseases, more proactive preventive strategies and support for healthier lifestyles);
    - Further devolution ([re-]introduction of practice based commissioning, greater diversity of provision, fewer national targets, more local autonomy)
    - Possible patient top-ups for expensive therapies (cancer drugs)

Three phases of the Labour health reforms

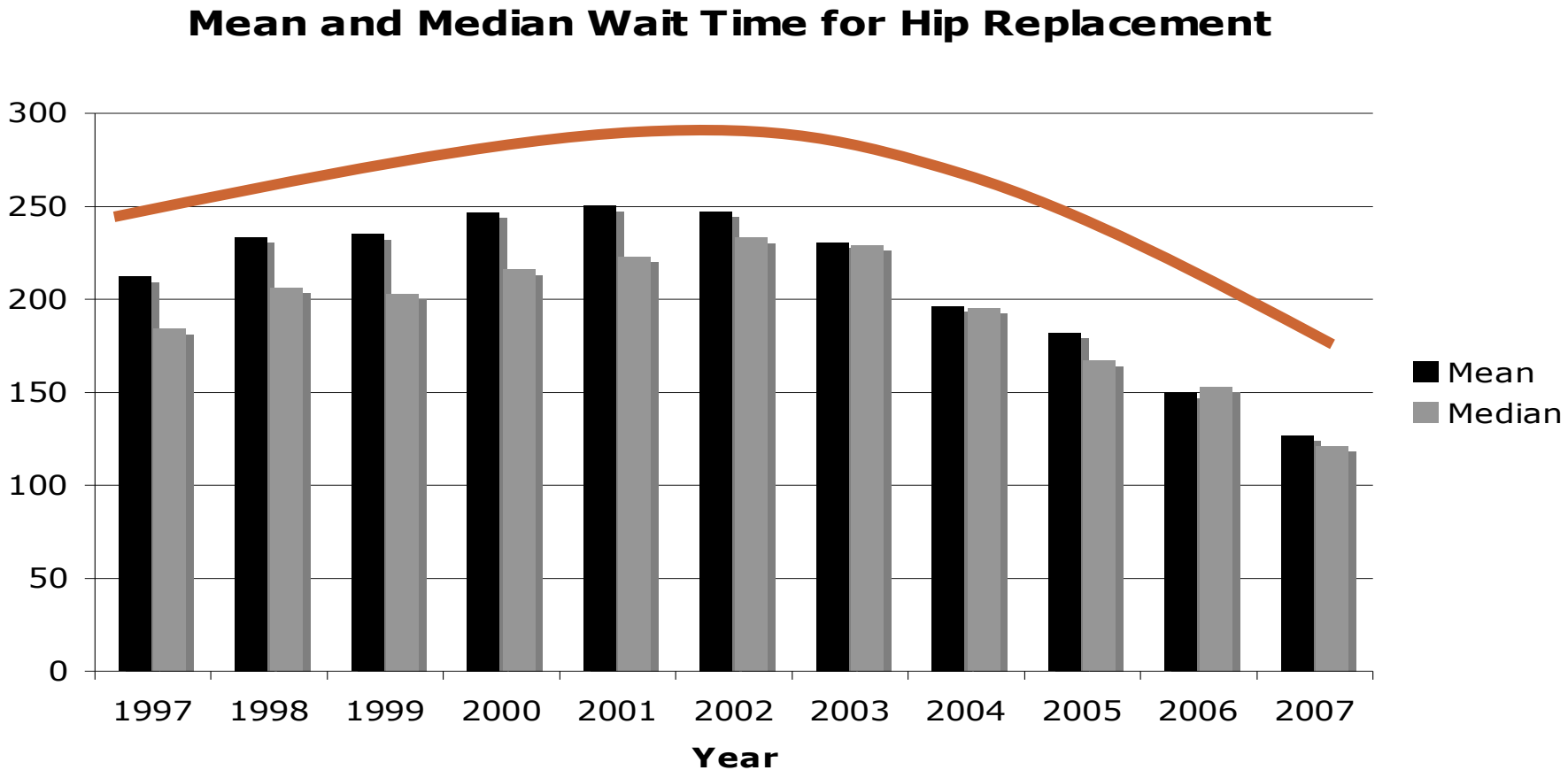
Policies specific to reducing waiting time:

1997 - 2000	2001 - 2004	2005 - Present
Trust & Cooperation	**Targets and Centralization**	**Choice & Competition**
– Focus on Reducing Overall # of Patients Waiting - NOT Waiting Time –Modest Funding Increases – Operational and Technical Support From the Center –Shift from competition to cooperation	– Focus on Waiting Time – Dramatic Increase in Funding – Set Stage For Choice and Competition – Central control --- 'Targets and Terror' – Aim to Increase Day Case Rate	– Patient Choice of Provider – Reimbursement Scheme With $$$ Following Patients which produced competition – Expand Supply including via private sector

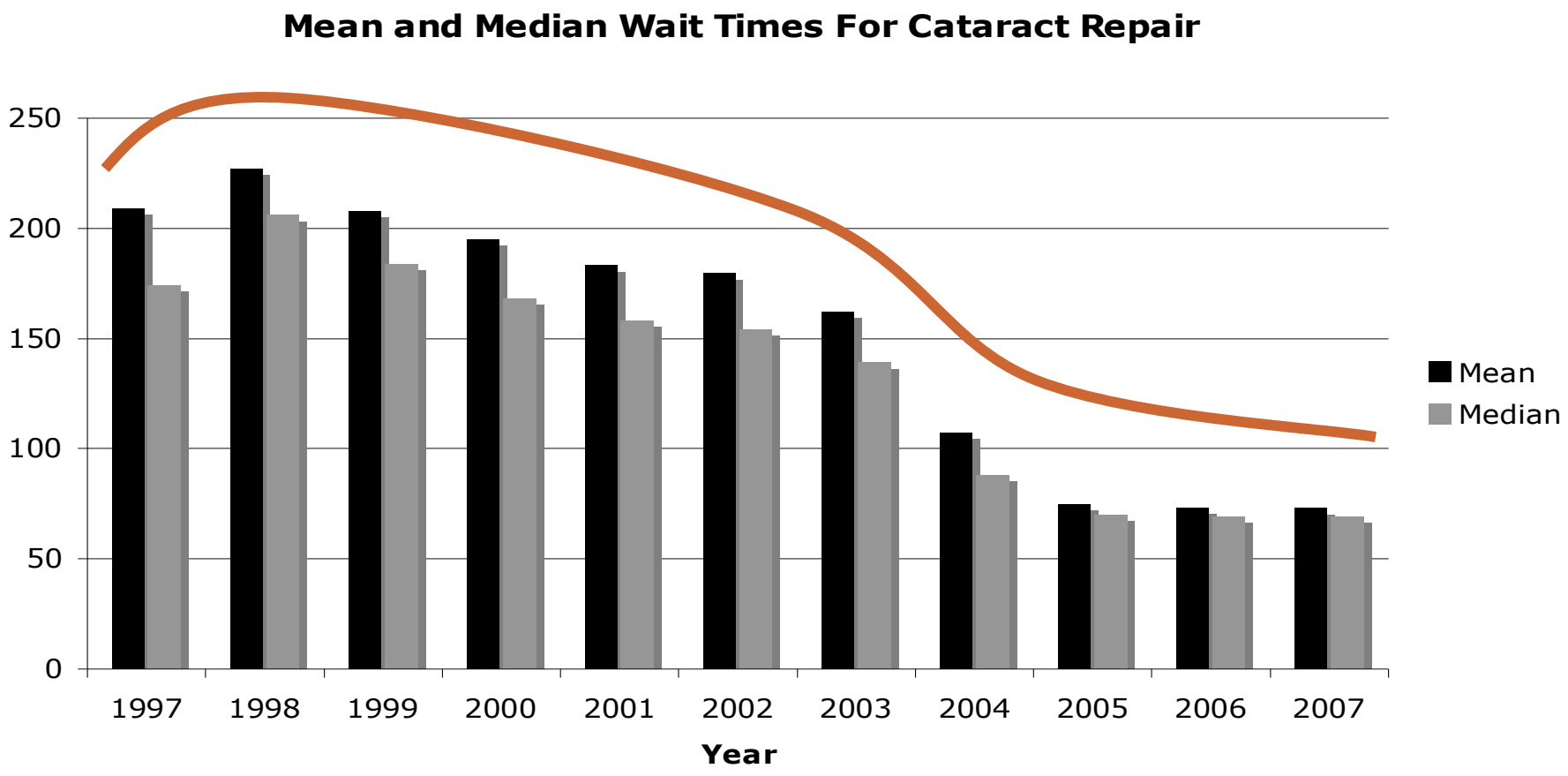
Assessment: Mean and median waiting times for knee replacement rose initially, and then fell over time



Mean and median waiting times for hip replacement rose initially, and then fell over time



Mean and median waiting times for cataract repair rose initially, and then fell over time



Policy Questions

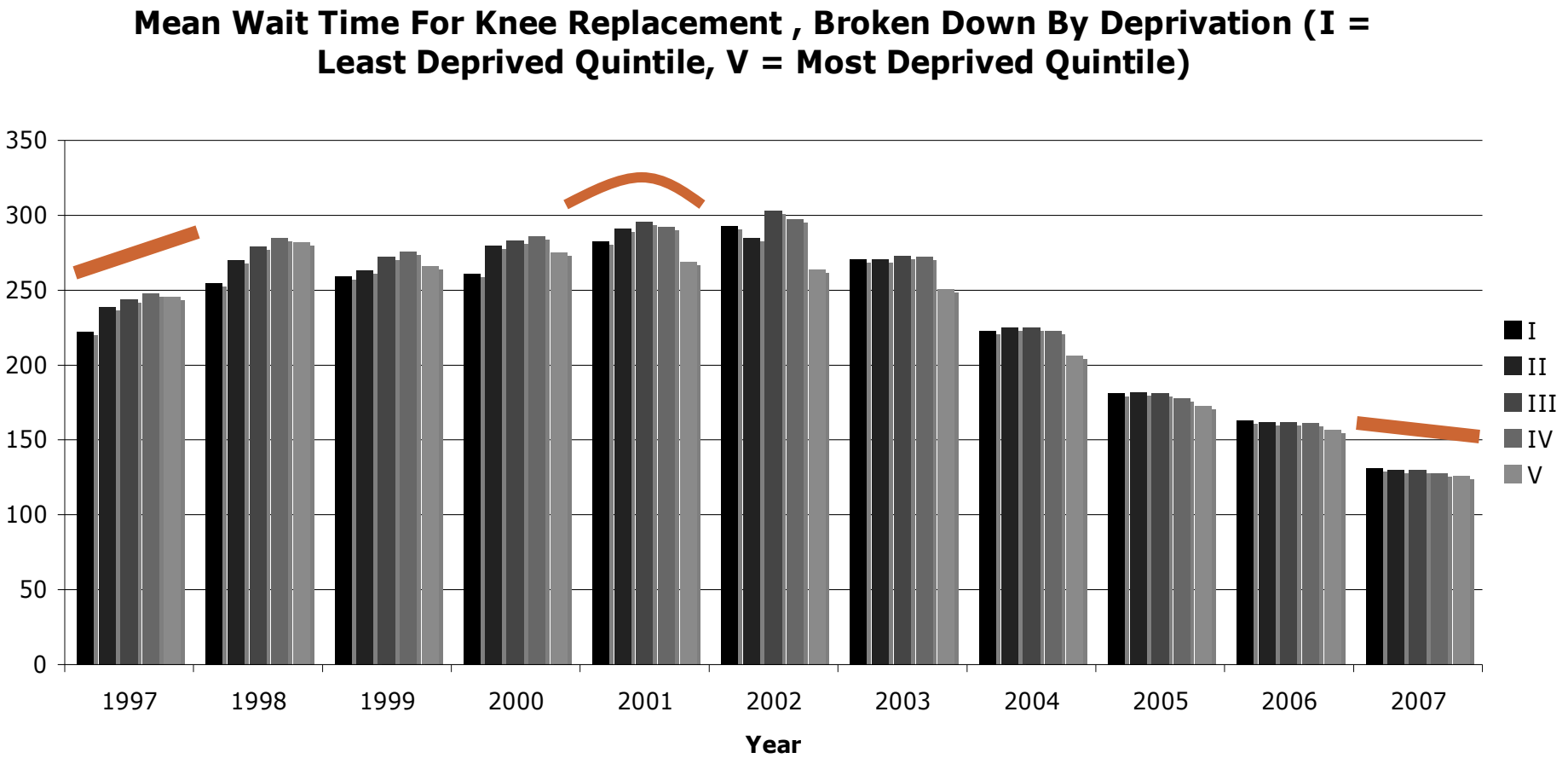
Q 1

Were the changes in waiting times observed from 1997 through 2007 equitable?

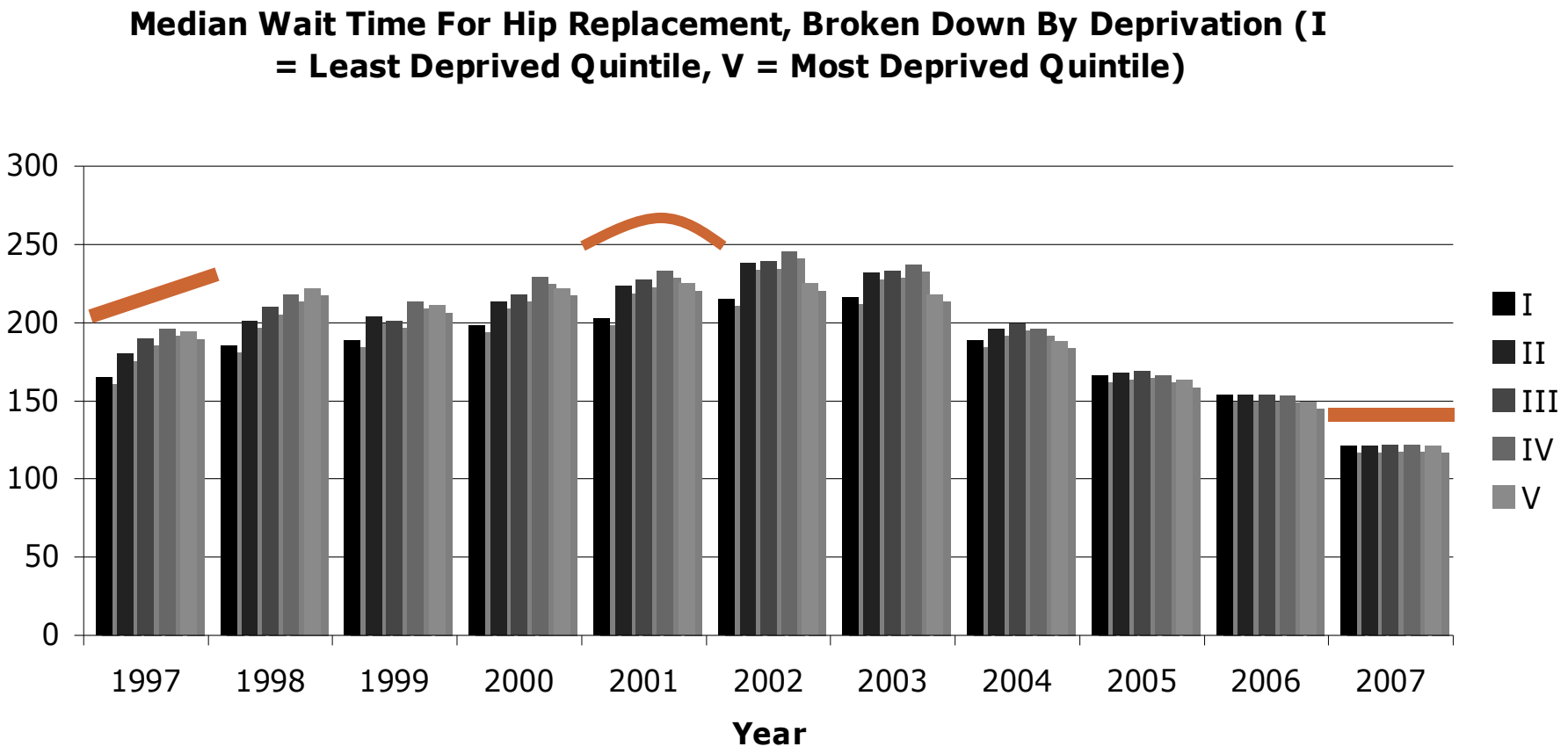
Q 2

Did the period of choice and competition create winners and losers or did everyone benefit?

In 1997, there was a positive relationship between waiting time and deprivation; by 2007, there was a negative relationship



In 1997, there was a positive relationship; by 2007, there was a uniform distribution of waiting times across deprivation quintiles



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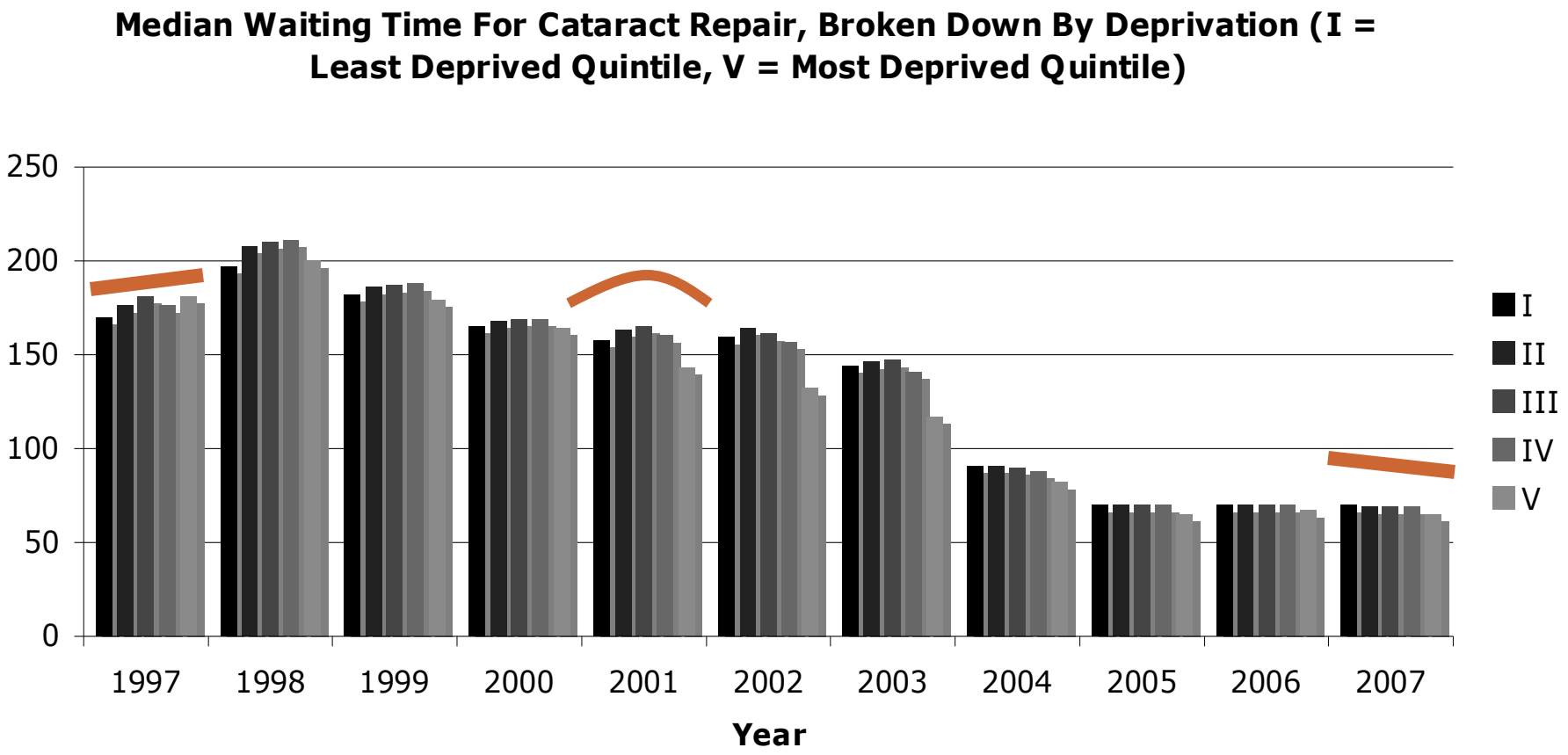

Conclusions

C 1

From 1997 through 2007, waiting times fell and the variation in waiting times across socio-economic groups was reduced

C 2

Cannot prove with certainty that choice and competition improved equity - we can safely say that choice and competition did not harm equity

C 3

Results consistent with the argument that extending patient choice does improve the relative position of the less well off

Implications

-Market-based reforms have the potential to shorten waits and improve equity

-Choice and competition could be a policy vehicle for traditional left-of-centre values

-Not always an equity/efficiency tradeoff

What can be learnt? Will systems converge? Path dependency

- If patients not fully transferable are health care systems?
- Reminds me of the joke of an French tourist on holiday in the Scottish highlands who asks a local Scotsman “Do you know how I can get to Auchtermuchty?”
- After considerable silence, presumed to be masking thought, the Scotsman says
- “Aye”
- The infuriated Frenchman says “Well how?”
- To which the reply is
- “Well I wouldn’t start from here…”
- However a number of systems are moving towards improving choices