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Public Expenditure Reform: The Health Care Sector in the United Kingdom

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PUBLIC EXPENDITURE REFORM: THE HEALTH CARE SECTOR IN THE UNITED KINGDOM

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by
Vincent Koen

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ABSTRACT/RÉSUMÉ

Health services are largely tax-financed in the United Kingdom and account for 14 per cent of general government spending. This paper analyses how the National Health Service (NHS) has been dealing with the associated expenditure pressures in the pre-1990 set-up and during the "quasi-market" years and how it is to cope with them under the "co-operative" arrangements put in place since 1997. While the budget constraint was traditionally tight in the NHS, leading to pervasive rationing and queuing as well as diversion towards the private sector, it has been relaxed somewhat with the budgetary boost announced by the Government in March 2000. The challenge is now to make the best use of the new-found financial room for improvement.

JEL Code: H40, H51, H61, I11, I18.
Keywords: United Kingdom, health, budget

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Les services de santé sont largement financés par l'impôt au Royaume-Uni et représentent 14 pour cent de la dépense des administrations publiques. Ce document analyse comment le Service National de Santé (NHS) a géré les pressions à la dépense associées dans le contexte du système existant avant 1990 et pendant la période du « quasi-marché », et comment il est appelé à y faire face dans le cadre « co-opératif » mis en place depuis 1997. La contrainte budgétaire était traditionnellement rigoureuse dans le NHS, d'où un rationnement et des files d'attente généralisés, de même qu'un effet d'éviction vers le privé, mais elle a été assouplie quelque peu avec l'annonce par le gouvernement, en mars 2000, d'une injection de ressources budgétaires supplémentaires. Le défi est maintenant de faire le meilleur usage de la marge de manœuvre financière nouvellement dégagée.

Classification JEL : H40, H51, H61, I11, I18.
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PUBLIC EXPENDITURE REFORM: THE HEALTH CARE SECTOR IN THE UNITED KINGDOM

Vincent Koen[1]

1. Public spending on health care accounts for a bit less than 6 per cent of GDP and 14 per cent of general government spending, and is on a rising trend. The NHS employs around 1 million persons, mostly in hospitals, and its wage bill absorbs one-quarter of the total public sector wage bill. Containing expenditure pressures has therefore traditionally been an important concern, leading to a number of reforms of potential relevance for the public sector at large. This paper first briefly describes the health system in place through 1990 and the one that replaced it. The latter's merits and drawbacks are then assessed. This sets the stage for a presentation of the overhaul of the NHS undertaken by the Government that came into power in 1997.[2] While it is too early to pass an overall judgement on a system that is still absorbing the changes, the paper ends with some preliminary lessons. All along, the focus is on public health expenditure management more than on health issues *per se*.[3] Moreover, alternatives to the existing set-up involving a significant increase in private funding are not discussed.

Pressures for change built up during the 1980s

2. The NHS was created in 1948 as a publicly financed and centralised system providing free universal access to health care. Those features were essentially preserved over the next four decades, despite some erosion of the principle of free access, notably in dental and optical care, and for pharmaceuticals. Regional budgets for hospitals and community care services were set up on a per capita basis adjusted for demographic and other factors, and passed on to hospitals and other facilities *via* district

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1. An earlier version of this paper served as background for the OECD *Economic Survey* of the United Kingdom published in June 2000 under the authority of the Economic and Development Review Committee of the OECD. Vincent Koen is Head of the European Union/United Kingdom Desk in the Economics Department. The author is grateful to OECD colleagues Jeremy Hurst, Val Koromzay, Andrew Dean, Jørgen Elmeskov, Peter Hoeller and Alain de Serres for valuable comments. Special thanks go to Desney Erb for technical support and to Valérie Luccioni-Lassaut and Celia Rutkoski for secretarial assistance. The paper has benefited from discussions with numerous experts in and outside the United Kingdom Department of Health and National Health Service, particularly with Clive Smee. The cutoff date for information is end-May 2000, meaning that the plan announced in late July 2000 is not taken into account here.

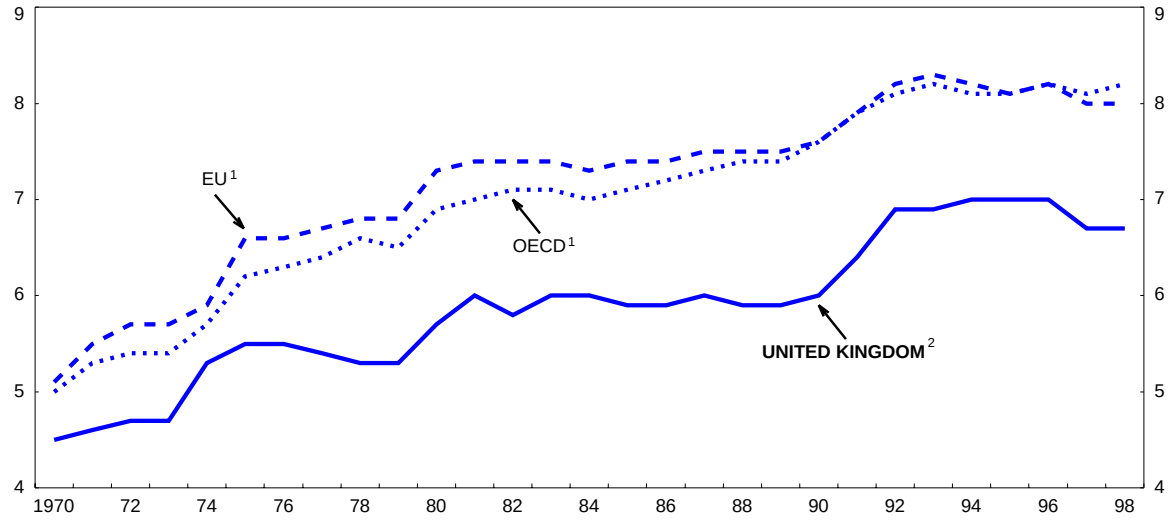
2. The details of the institutional set-up described in this paper pertain to England (which accounts for four fifths of total United Kingdom public expenditures on health and personal social services). Some arrangements are a bit different in Scotland, Wales and Northern Ireland.

3. Hence, the paper does not dwell on health outcomes in comparison with other countries (see OECD, 1995), nor on prevention *lato sensu*, which leads into education, lifestyles, food safety and balance, environmental pollution and other important issues, and is the focus of the 1999 governmental White Paper *Saving Lives* (DoH, 1999*a*).

health authorities (HAs). General practitioners (GPs) were self-employed and paid according to a central contract involving a mix of capitation, fee for service and other payments. They provided ambulatory services and acted as "gatekeepers" for non-emergency hospital care. Patients could be enrolled with only one GP at a time. In this context, there was scarcely any competition between hospitals.

3. Contrasting with experience in many other OECD countries, budget limits were generally strictly enforced, especially on hospitals. As a result, total health care spending was relatively low when viewed from an international perspective (Figures 1 and 2).[4] Hard budget constraints were associated, however, with rigidities in resource allocation, rationing and queuing, and a lack of sensitivity to patients' needs and tastes. Among other incentive problems, hospitals lacked the motivation to properly use available capacity or dispose of redundant assets. With spending slowing and demographic and technological developments stoking demand, dissatisfaction with the NHS grew. The system was subjected to an official review in 1988, which led to wholesale reforms.

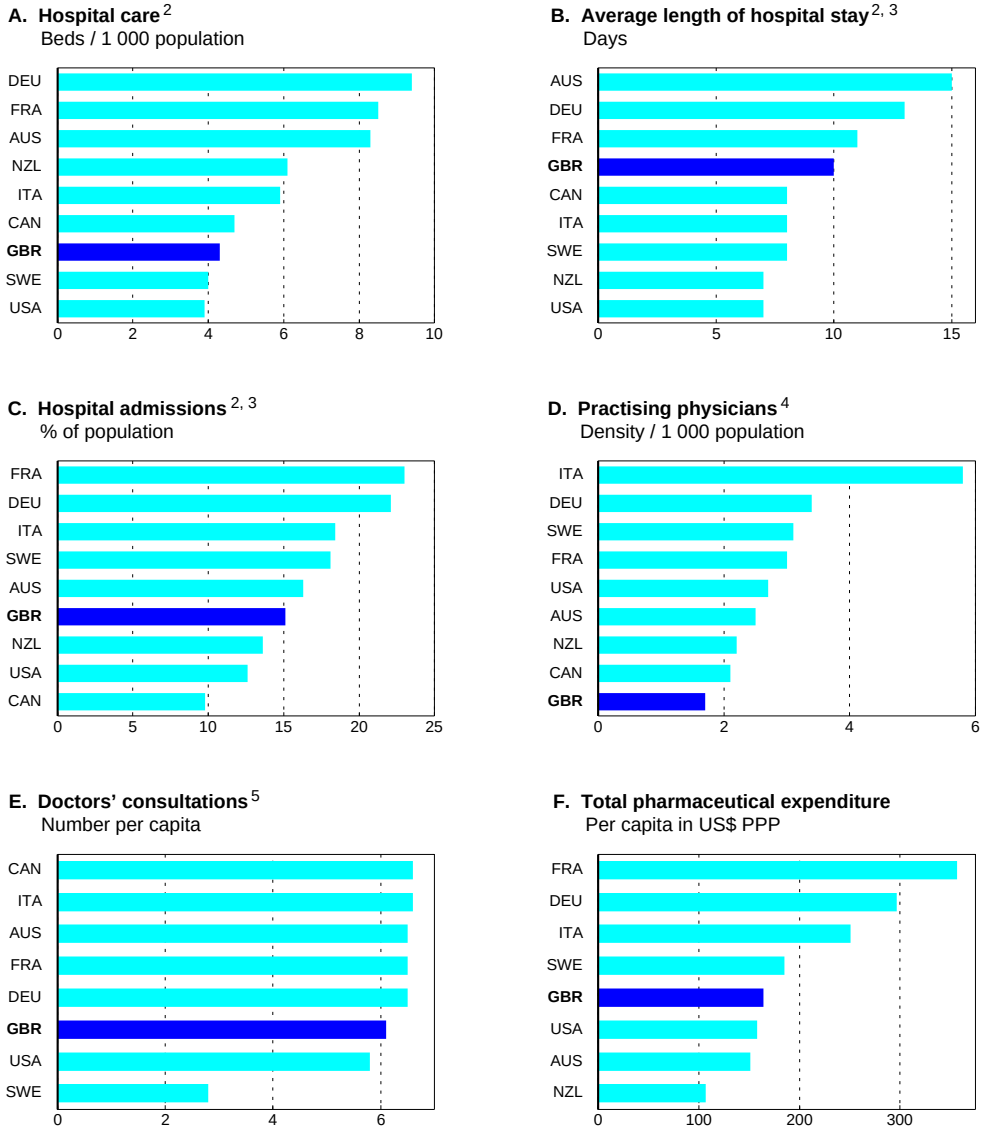
Figure 1. Health spending
Per cent of GDP



1. Unweighted averages. The OECD total excludes the Czech Republic, Hungary, Mexico and Poland.
2. Excludes private nursing home expenditure.
Source: OECD Health Data 2000.

4. This held — and still holds — when controlling for GDP per capita, although less strikingly so in volume than in value terms, given relatively low health services prices in the United Kingdom. However, private nursing home expenditure (which may amount to around 0.4 per cent of GDP) is not reflected in the health spending series for the United Kingdom, biasing it downwards compared with most other OECD countries.

Figure 2. Resource use in the health care sector
1997 [1]



1. Or latest year available.
2. Including other nursing and residential care facilities or establishments providing in-patient care.
3. Data for the United Kingdom only cover England.
4. For most countries, includes medical practitioners involved in non-clinical activities such as research, industry, teaching and administration. Data for France and Germany are in full-time equivalent terms. Data for several countries include those entitled to practise but not necessarily active.
5. Data for Sweden exclude consultations at mother and child clinics.

Introducing competition and contracts

4. The reforms were proposed in a 1989 White Paper, enshrined in 1990 legislation, and implemented as from 1991. The aim was to preserve largely free access to health care, essentially financed by taxation (for over three fourths) and national insurance contributions (for over one-eighth), but to have providers of specialist services compete in a "quasi" or "internal" market for secondary health care by separating them from, and having them contract with, purchasers. The latter were of two types (Figure 3):

- *First*, the HAs, whose role was recast from organisers and providers of care to evaluators of health care needs and contractors with service providers. In the process, their number was halved to 100 and they were merged with family health service authorities. They were allocated a budget to purchase secondary care based on the size and characteristics of their area's population.
- *Second*, the so-called GP fundholders, who were self-employed primary care doctors or groups of doctors with a large enough number of patients, volunteering to take part in this scheme. By 1997, they covered over half of the population. GP fundholders managed a budget which had to secure a defined set of hospital and primary care services and pharmaceuticals for their enlisted patients. This budget was deducted from the one received by the HA in the area in which the fundholder was situated. As the scheme evolved, different levels of fundholding were allowed: while small practices could purchase community services only, experimental "total purchasing pilots" (TPPs) were introduced allowing practices to purchase all forms of secondary care, including accident and emergency treatment.[5] Importantly, fundholders could keep any surplus they generated, as long as it was spent on services or facilities of benefit to patients (which by enhancing the value of the practice helped build up future if not current income).[6]

5. Non-fundholding GPs did not hold budgets for secondary care.[7] Their costs continued to be met by HAs. The latter also met those hospital care costs of GP fundholders that were typically not covered by the fund, namely emergency admissions and some elective care. As a stop-loss insurance, HAs furthermore paid any costs incurred by GP fundholders on a single patient in a given year in excess of £5 000.

6. On the supply side, hospitals and the providers of other services were corporatised as "trusts", semi-independent within the NHS. Trusts contracted on an annual basis with HAs and GP fundholders to provide services and in principle enjoyed some room for manoeuvre concerning pay, skill-mix, and service delivery. They were also allowed to borrow within certain limits. At the same time, trusts had to follow some central guidelines on pricing and investment. In particular, they were required to set prices so that the revenue earned on NHS contracts covered all costs including depreciation plus a given rate of return on net assets (Box 1). As regards investment decisions, since the 1980s a separate capital budget had been allocated by the centre to HAs for them to manage, except for large projects, for which approval had to be obtained from the Department of Health (DoH) following an investment appraisal. With the "quasi-market", this capital budget was split into a "block" and a "discretionary" component. The former was allocated by HAs on a depreciation-based formula and used to fund maintenance work, small building projects, and items of equipment. The "discretionary" component was also allocated by the HAs but served to finance major building schemes. When the size of the project exceeded a certain threshold, approval had to be sought by submitting a business case to the appropriate authority, which for very large schemes was the DoH and the Treasury.

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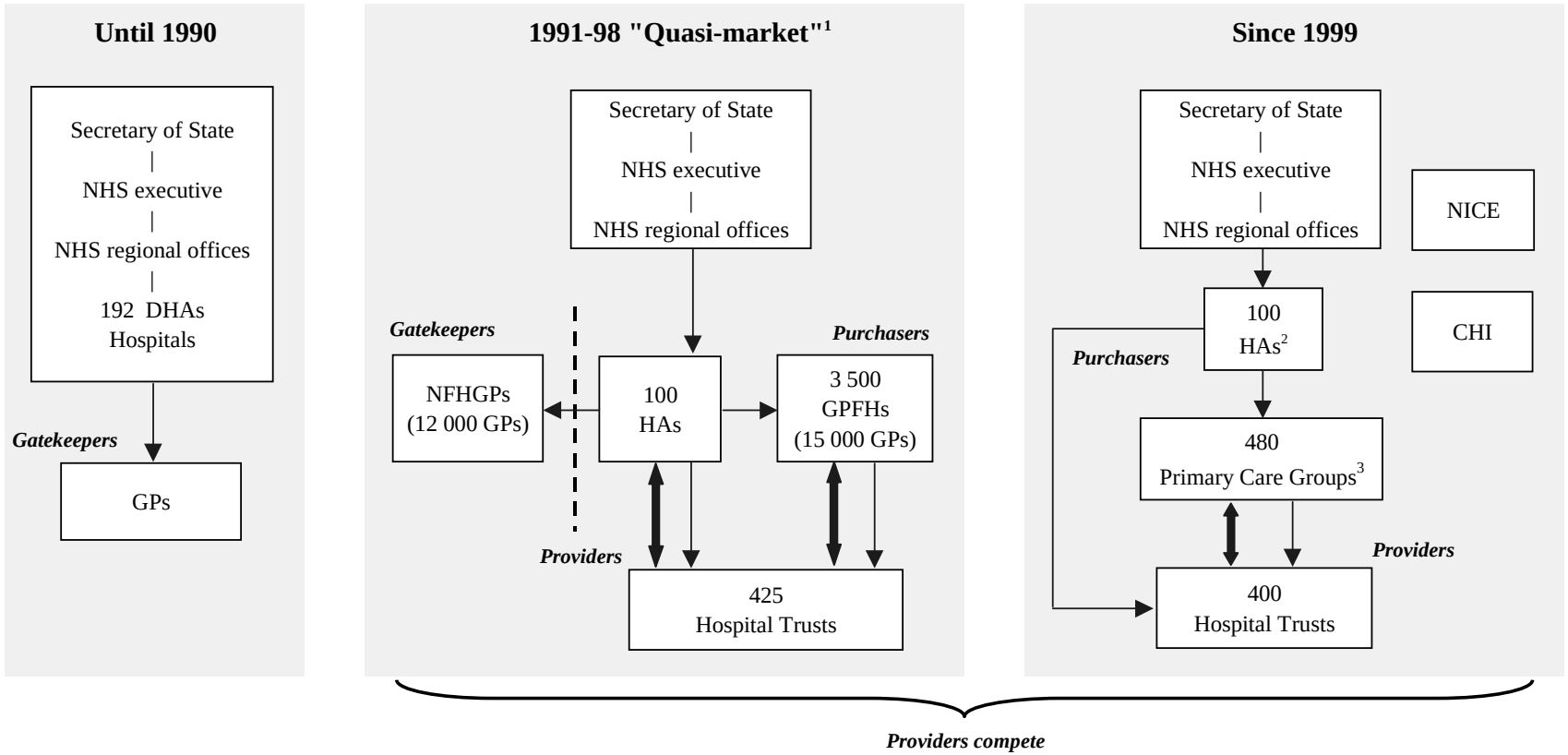
5. Some fundholders combined into multi-practice consortia called "multi-funds" with a view to economise on management costs.

6. This arrangement shares some features with the health maintenance organisations (HMOs) in the United States, which use primary care practitioners to manage care and contract for secondary care with hospitals.

7. Quite a number of those GPs chose to form "commissioning groups" working with the local HA to set purchasing priorities.

Figure 3. **Secondary care access and financing: stylised features**

England



Symbols

A ⟶ B		Financial flow
C ⟷ D		C and D contract together

Glossary

NICE	National Institute for Clinical Excellence	(D)HA	(District) Health Authority
CHI	Commission for Health Improvement	GPFH	GP fundholder
NHS	National Health Service	NFHGP	Non-fundholder GP
GP	General practitioner		

1. Figures are for FY1997/98.
2. HAs remain purchasers for some specialised services.
3. Evolving into Primary Care Trusts.

Source: OECD.

Box 1. **Capital charging in the NHS**

Capital charging was introduced in 1991 in the NHS, at the same time as the quasi-market.[1] The idea was to induce NHS trusts to use assets more efficiently by requiring them to pay for the capital at their disposal. Capital charging was also meant to facilitate comparisons with private sector provision, including via Private Financial Initiative (PFI) options. Proper accounting for capital costs was of course a prerequisite for fair competition between providers.

The mechanics are as follows. Assets are classified by status (operational; surplus, *i.e.* available for disposal; under construction; administrative) and by type (land; buildings; equipment and vehicles). Operational specialised assets are valued at depreciated replacement cost (DRC), *i.e.* gross replacement cost (GRC) minus accumulated depreciation. For land and buildings, GRC and DRC are assessed every five years by district valuers, and their value is indexed in between assessments. Land is not depreciated, and the lives of buildings are assessed by the district valuer (*i.e.* a property surveyor employed by the central Government). Surplus land and buildings are valued at open market value for alternative use, while other surplus assets are valued at recoverable amount. Assets under construction are valued at GRC and administrative assets according to whether they are operational, surplus or under construction.

Capital charges on land consist only of interest, and capital charges on buildings and equipment of interest and depreciation. Interest is set at 6 per cent in real terms on the relevant net assets (to reflect the Treasury's opportunity cost of capital). Exemptions from liability to capital charges include donated assets, assets under construction and fully depreciated assets.

These principles and the way they have been implemented have in a number of cases tended to overstate asset values (Heald and Scott, 1996). One problem pertains to aggregation. District valuers add up the separate values of the parts of an estate even though its replacement cost is often smaller: for example, many hospitals have expanded by accretion and could have their capacity replaced with fewer buildings. Another problem is that owing to changes in technology and work practices, assets are usually not replaced like with like. Hence, valuation ought to reflect the often lower replacement cost of the assets' productive potential rather than the cost of its exact replication. Otherwise, assets that were expensive to construct but have become unsuitable by present standards, and thus already impose penalising operating costs, would be over-charged.[2] Over-valuation, coupled with a fairly high required rate of return, understates trusts' financial performance *vis-à-vis* private sector comparators.

When capital charges were first introduced, they were neutral, in the sense that each purchaser received an additional allocation equal to the actual charges incurred by the provider and passed it on to the latter. Over time, they were gradually made to bite more, as the allocation became more dependent on weighted capitation and less on the characteristics of individual providers, bringing more pressure to bear on high-cost providers.

Trusts are paying 5 to 15 per cent of their income on capital charges, with an average of the order of 9 per cent, much of the rest being spent on personnel. In a context where purchasers' budgets are limited, *i.e.* where the size of the overall market cannot substantially expand, capital charges provide a strong incentive to prefer refurbishment to new building or to dispose of underused assets.[3] They also encourage the search for donations (which as yet are very marginal, except in paediatrics). The experience has been deemed sufficiently successful to be extended to all central government assets as part of resource accounting and budgeting (see OECD, 2000, Chapter III).

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1. It had been advocated already in the late 1970s by a Royal Commission on the NHS.
2. Examples would include Victorian psychiatric hospitals or tower blocks built in the 1960s.
3. To the extent this is possible, as there are administrative and political restrictions to such divestiture and as there may be no market for some of these assets (Lapsley, 1997).

7. Providers thus competed with each other and in some cases with private hospitals for contracts with HAs, GP fundholders, and private insurers. On the purchasing side, GP fundholders competed with HAs and with private insurers, although for many hospital services, notably emergency care, the HAs were monopsonists.

Mixed results

8. Assessing the merits of the quasi-market is difficult, not least because it was phased in gradually, amended along the way, and declared *passé* in 1997.[8] Notwithstanding, its advent brought about a number of improvements. *First*, the separation of purchasers and providers and the associated contracting process forced greater clarity on standards and prices. *Second*, cost-consciousness was enhanced throughout the NHS, contributing to reduce costs, especially in the most competitive local markets (Propper and Söderlund, 1998). *Third*, the standing of GPs within what was a rather bureaucratised system improved. GP fundholders in particular were among the main agents and beneficiaries of change, all the more as monitoring of the use of the surpluses they generated was rather loose. *Fourth*, efficiency gains were achieved insofar as the average length of hospital stays declined (Figure 4), both for geriatric and for acute care: day case treatment as a percentage of total elective care rose sharply (Figure 5),[9] although it remained lower than in the United States for example, and trusts faced new incentives to contract with other providers, such as nursing homes, or to discharge patients to their own homes.

9. On some other dimensions, progress was less clear-cut. It has been argued that the quasi-market produced overall efficiency gains, as the ratio of a cost-weighted activity index over resources used grew by around 2 per cent yearly in the first half of the 1990s against 1½ per cent in the 1980s.[10] This is a crude measure, however, since it aggregates activities such as outpatient attendances and inpatient spells, ignoring case-mix changes and *a fortiori* effectiveness in terms of health outcomes. It has also been estimated that average waiting times have been shortened in some specialities.[11]

10. At the same time, the quasi-market and the way it was implemented led to a number of problems. The first set pertained to contracting. Since contracts involved negotiation and monitoring of compliance, as well as financial information of a new sort, administrative costs soared, as noted early on (OECD, 1994). Contracting costs were larger the more sophisticated the contracts, block contracts being less costly to administer than cost-and-volume contracts (Paton *et al.*, 1997),[12] although on the other hand block contracts tended to perpetuate the pre-1991 pattern of some hospitals stopping operations before the end of the financial year, once their specified level of activity had been achieved (Klein, 1998). In this context, administrative costs rose from (an admittedly low) 8 per cent of total costs in 1991/92 to 11 per cent in 1995/96, while the number of administrative, clerical and especially managerial staff increased sharply.

8. In addition, during the early years of the quasi-market, the Government did not encourage any thorough independent evaluations (partly for fear it would delay reforms). The void has since started to be filled, see Le Grand (1999) and the references therein.

9. It cannot be ruled out, however, that due to relative reimbursement rates, hospitals more and more treated some people as day case inpatients instead of as outpatients, for example for endoscopies, which would have led to overstate the surge in day cases.

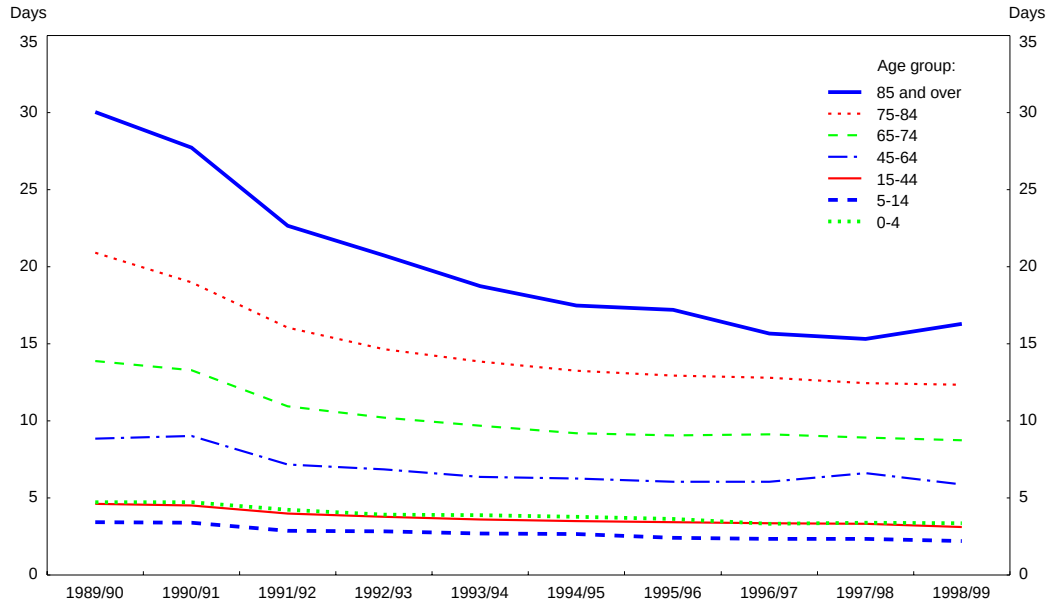
10. For details on the construction of this measure, see OECD (1994).

11. For example, for hip fractures — which are common, easy to diagnose, and do not suffer from any self-selection bias on the part of patients (Hamilton and Bramley-Harker, 1999).

12. With a simple block contract, purchasers pay the provider a fixed sum for access to a range of services. Cost-and-volume contracts instead specify outputs rather than inputs, and purchasers pay a lump sum for services up to a certain volume and a price per case above it.

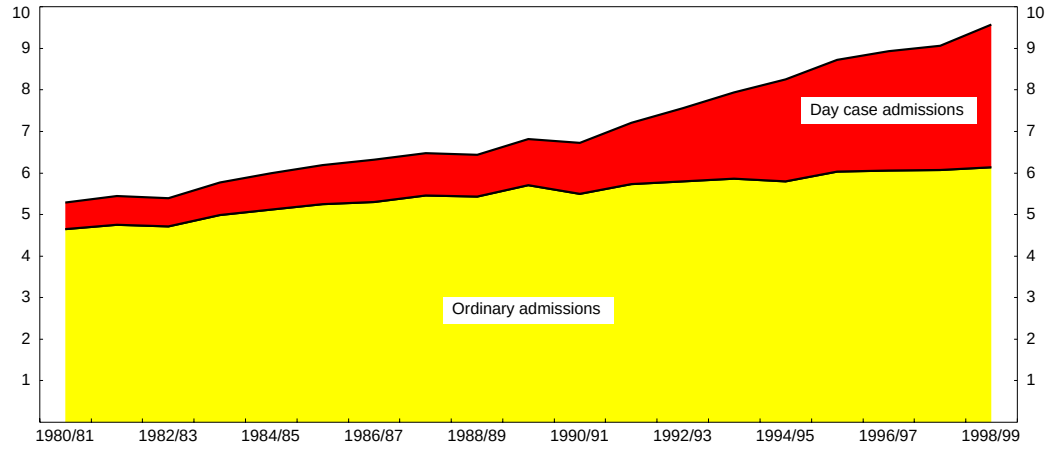
Moreover, HAs turned out to be in a weak position to contract, often lacking the medical expertise to bargain on equal terms with hospital specialists.

Figure 4. Length of hospital stays
General and acute sectors, average for each age group



Source: NHS.

Figure 5. Hospital admissions
General and acute sectors, million



Source: NHS.

11. Secondly, competition remained restricted in several ways. Patients could not choose their HA and were apparently not given much extra choice as to procedures or providers of specialist care (Le Grand *et al.*, 1998). In many areas, HAs were facing a single or dominant hospital and, in contrast with GP fundholders, were reluctant not to contract on a large scale with that provider.[13] Thus, close to two-thirds of trusts continued to receive over two-thirds of their annual income from the local HA.[14] HAs could not retain or invest the surpluses they generated, thus being constrained when trying to time spending over periods exceeding the financial year, a problem acknowledged by the DoH and which led it in 1997/98 to somewhat relax the requirement to break even each and every year (DoH, 1999*b*). Wage flexibility at individual trust level was limited, not least owing to strong union resistance to the decentralisation of wage setting (Thornley, 1998). As noted, investment and pricing were also regulated from the centre, although zero mark-up on average cost rules were not systematically followed, with some price variability across providers not solely explained by variation in average costs, and some price discrimination in favour of GP fundholder purchasers (Propper *et al.*, 1998). A significant proportion of trusts failed to meet their financial targets,[15] despite the build-up of a considerable maintenance backlog,[16] widespread late payments of bills,[17] and a sharp drop in gross and net capital investment. Even so, few trusts were closed or merged, even among the smaller ones suffering more than proportionately from the higher management and transaction costs.

12. Thirdly, the quasi-market has been criticised on equity grounds for leading to a two-tier service favouring GP fundholder patients at the expense of the patients of the non-fundholders. While it appears that indeed fundholders sometimes obtained quicker admissions and generally better response from providers, some dualism also existed under the old regime, in which GP competences and activism varied a lot as well. Moreover, to the extent hospitals innovated and improved care in response to fundholder pressure, there may have been positive spillover effects for other patients. However, there was indeed a shift in budgetary resources away from non-fundholding to fundholding practices within the total allocation given to HAs, as GPs opting for the new status significantly increased referrals during the year preceding the switch in order to be granted a larger budget.[18] Still as concerns equity, and contrasting with many analysts' worries at the onset of the quasi-market, there has been little evidence of cream-skimming effects, *i.e.* of discrimination against expensive service users by hospitals and fundholding practices, not least thanks to the aforementioned stop-loss insurance mechanism (Le Grand, 1999).

13. The introduction of the quasi-market failed to solve some long-standing problems, as reflected in opinion polls. A Eurobarometer survey conducted in 1996 showed 41 per cent of respondents in the United Kingdom to be dissatisfied with the way health care was run, against an EU average of 28 per cent; 56 per

13. In part, this was because since trusts had to price to break even, the local HA would bear the financial consequence of fixed costs being recovered across a smaller activity baseline at the local trust.

14. Some measure of "localism" is natural, however, and does not preclude competition at the margin or at least contestability.

15. At the end of FY1997/98, HAs in England reported an accumulated deficit of £717 million, most of which represented a call on future NHS cash resources, and the NHS Executive considered that 29 HAs and 78 trusts were in serious financial difficulty. In addition, the NAO estimated that unrecorded liabilities for clinical negligence could amount to £1 billion (NAO, 1999*a*).

16. Which rose to £3.1 billion by FY1997/98.

17. Compliance with legal or contractual payment terms has improved significantly since it started to be monitored a few years ago, but in FY1997/98, still 20 per cent of bills were being paid late.

18. See Croxson *et al.* (1999). Fundholders were given a budget based on their activity in the statutory period before they became fundholders, and therefore had an unintended incentive to step up referrals during that period and to decrease them thereafter (or substitute emergency for non-emergency referrals).

cent to consider that fundamental changes were in order, against an EU average of 41 per cent; and 81.5 per cent of respondents to say that government should spend more on health care, against an EU average of 48 per cent, with a stronger readiness in the United Kingdom to finance the increase by raising taxes or health insurance contributions, at 29 against 11 per cent (Mossialos, 1997). First and foremost underlying patient frustration were waits for non-emergency care that remained far longer than in most other OECD countries.[19] In part, the length of the waits results from the perverse incentives facing specialists, who are paid several times more when treating a patient privately than within the NHS. This means that the speed of health care delivery is in some cases a function of patients' ability and willingness to pay, in contradiction with the professed ambition that care is to be free for all at the point of delivery and that the quality of care should not be influenced by recipients' income or wealth. Other unresolved problems included an inadequate geographical allocation and sometimes inefficient management of hospital beds: despite a 20 per cent decline in the total number of beds (Figure 6),[20] excess capacity persisted in a number of areas, as a result of political resistance to closures, arguably coexisting with under-provision in other areas, as suggested by widely publicised pressures on emergency care in recent winters;[21] in addition, the existing stock of beds is not used optimally, in part owing to information system deficiencies depriving bed managers of up-to-date knowledge of bed occupancy and availability, and hampering proper planning (NAO, 2000), but more importantly due to "avoidable" bed use, particularly by older people (DoH, 2000).[22] Notwithstanding some divestiture and efforts at better planning and managing, the configuration of the vast NHS estate had not been adapting swiftly enough to the changing needs for patient accommodation stemming from the aforementioned increasing recourse to day case surgery and shift toward care provision in community settings. Also problematic were severe health inequalities, some of which continued to worsen during the 1990s (Acheson, 1998), although their root causes mostly lay outside the NHS itself. Against this background, private provision of health care continued to gradually expand (Box 2).

14. Furthermore, the bill for pharmaceuticals had been rising rapidly during the 1990s, notwithstanding increased recourse to generics. Outlays have increased by about 5 per cent a year in real terms, to some £6 billion (implying a sharp increase as a percentage of the total NHS budget, to 13.7 per cent in FY1997/98). Population ageing accounted for about a third of the growth in the drugs bill, and increases in average cost per item for most of the remainder. The latter primarily reflected "product mix effects", *i.e.* the displacement of older by more modern medicines, since the Pharmaceutical Price Regulation Scheme (PPRS) limited price increases for established branded medicines to negligible amounts.[23] The PPRS was renegotiated in 1999, and a 4.5 per cent price cut was agreed on branded medicines, coming into effect in October. Meanwhile, progress continued to be made in increasing the number of prescriptions written generically, the share of which expanded from 43 per cent in 1992 to

19. See Donelan *et al.* (1999), who document that this is the case compared with the United States, Canada, New Zealand and Australia.

20. The same trend fall in the number of beds has been observed in other OECD countries over the last two decades.

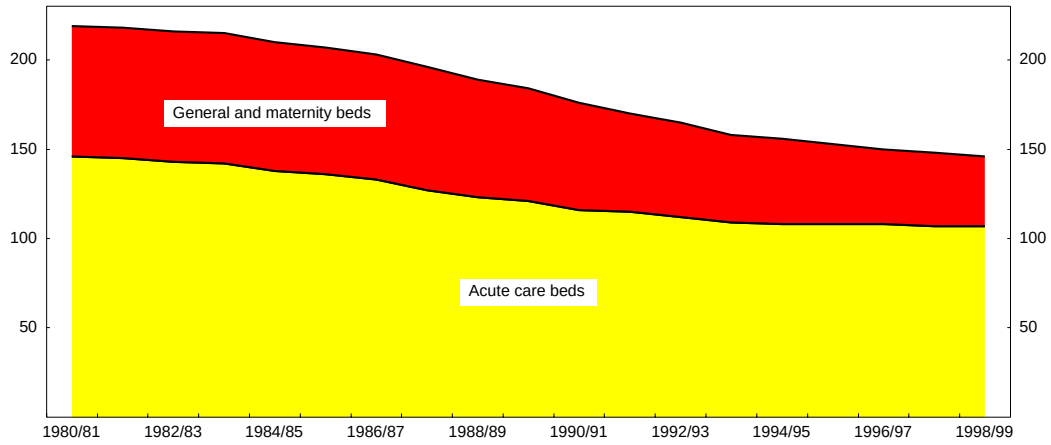
21. There is evidence that average bed occupancy rates exceeding 85 per cent are associated with bottlenecks in handling emergency admissions (DoH, 2000). There is also evidence that critical care beds are in short supply (Lyons *et al.*, 2000).

22. The NAO inspection showed that in over 90 per cent of trusts, bed managers obtain information on bed availability only through physical inspection and telephoning wards several times a day.

23. Unlike in most other countries, companies do not negotiate launch prices of new medicines with the Government, although they must keep within their profit band.

63 per cent in 1998.[24] GP fundholding offered participating GPs an incentive to make savings on their drugs budgets, in contrast with other GPs, who were set "indicative" prescribing budgets only.

Figure 6. Staffed hospital beds
Thousand



Source: NHS.

Box 2. **Private health care**

The share of the population using private alternatives to the NHS has been growing over the past two decades. Private insurance covers close to 7 million people, against 3 million in 1979, with the extent of coverage strongly correlated with income (40 per cent of those in the top decile are privately insured).[1] At the same time, the share in total health outlays of spending by individuals on private medical services rose.[2] The demand for private insurance increased rapidly in the 1980s, although it subsequently flattened out. While individuals with private insurance typically continue to rely on the NHS for primary and emergency care, private providers are making inroads, on a small scale, into the primary care market: 3 per cent of GP consultations are now privately paid for (against 13 per cent for elective surgery). Recourse to private health care can in the short term ease the pressures on the NHS but it can also reduce the supply of staff to the NHS. Furthermore, if increased NHS funding leads to better performance, demand for NHS services stemming from the privately insured may rise.

1. The number of people with private medical insurance totalled 6.8 million at the end of 1998 (4.5 million on account of company-paid schemes and the rest on a personal basis). An additional half million people enjoyed private medical treatment benefits through non-insured schemes offered by employers.
2. It should be noted that private policies are often restricted packages paying out only if an NHS admission is not offered in a certain time or only for a set list of providers. Some of them pay only small cash sums per day of hospitalisation.

24. Greater use of "true" generics is made in the United Kingdom than in most other countries.

Reorganising the NHS - again

15. In mid-1997, the new Government announced the termination of the quasi-market. The architecture of the new NHS was outlined in a December 1997 White Paper (DoH, 1997) and enshrined in the 1999 Health Act. A number of key new institutions started to operate in April 1999, but the Government has stressed that the reforms would take as much as a decade to produce their full effects. The new system was presented as a third way between "stifling top-down command and control" and a "random and wasteful grass roots free-for-all" (DoH, 1997). Based on the assessment that administered competition wasted resources and did not address some of the deep-seated health care problems, the new approach relies more squarely on co-operation and partnerships. Even so, the purchaser/provider split that was introduced with the quasi-market remains central, and purchasers retain the ability to change providers, albeit as a measure of last resort. In effect, efficiency is expected to be fostered by contestability, coupled with enhanced performance monitoring, in lieu of competition.

16. More specifically, fundholder practices have been abolished and all GPs have had to join geographically based primary care groups (PCGs) (Figure 3).[25] The independent contractor status of most GPs remains unchanged. They continue to receive directly the various fees and allowances for providing general medical services that account for the bulk of their earnings.[26] The size of the population covered by a PCG varies from around 30 000 to 250 000, but typically hovers around 100 000. The average PCG includes some 50 GPs. One reason for this relatively large size is the desire to spread fixed administrative costs sufficiently widely. PCGs are expected to evolve over time, from advisory to their local HA purchaser to autonomous primary care trusts (PCTs) holding the primary and hospital care budgets, with the pace of change subject to local discretion. They commission — or will do so in due course — hospital services for their patients on the basis of rolling multi-year contracts, which are service agreements between HAs, PCGs and hospitals reflecting national standards and targets, spelled out in local three-year health improvement programmes. Annual accountability agreements are drawn up between PCGs and HAs. PCGs are allowed to retain budget surpluses, which can be spent on services or facilities of benefit to patients. The hospital trusts have remained and are also entitled to retain surpluses, but they have been given a new statutory duty pertaining to the quality of care. Over time, HAs will relinquish direct commissioning functions, except for certain very specialised services. The main financial flows in the new set-up are depicted in Figure 7.

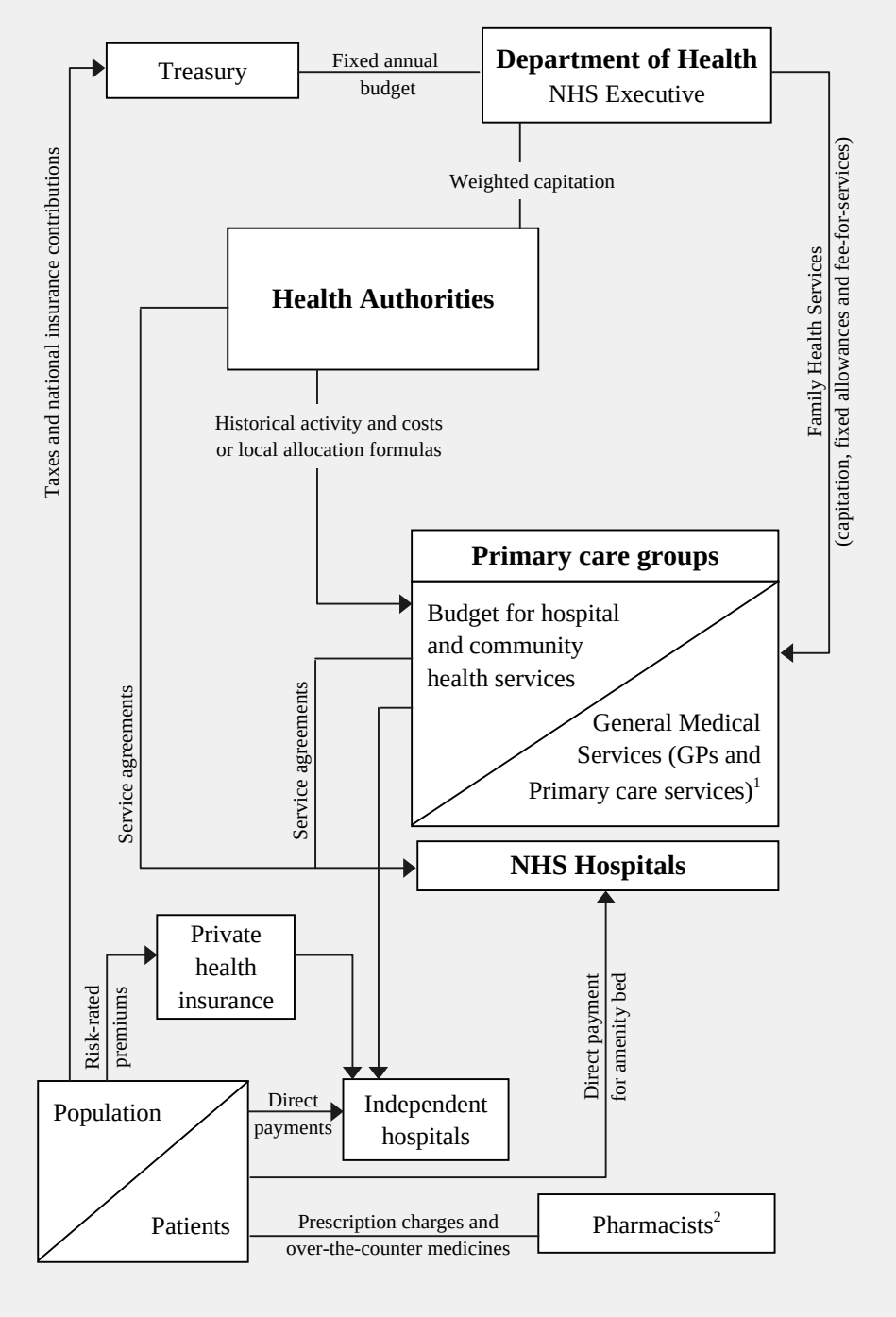
17. Quality management is given added emphasis, under the heading of "clinical governance", which encompasses policies for managing risk and tackling poor performance, clear lines of accountability for the quality of care and extended lifelong learning (NHS Executive, 1998).[27] A new performance framework, with new indicators emphasising effectiveness and outcomes, is being put in place. It covers six dimensions: health improvement, fair access, effective delivery of care, efficiency, patient/carer experience and health outcomes. A first batch of results for 47 indicators was made public in mid-1999, pertaining to FY1997/98 and disaggregated to HA and, for some indicators, hospital level (DoH, 1999*c*). Although performance is quantified and even ranked for several indicators, the intention is to move away from crude

25. These PCGs have a number of similarities to New Zealand's independent practitioner associations, with the important difference that membership in the latter is not compulsory (Majeed and Malcolm, 1999). Likewise, they bear some resemblance with some physician-led HMOs in California.

26. However, a number of alternative remuneration schemes are being tried out, including salary payments.

27. For details from various perspectives on the somewhat slippery clinical governance concept, see the contributions edited by Lugon and Secker-Walker (1999).

Figure 7. **Financial flows**



1. In most NHS hospitals, patients paying a supplementary charge can benefit from superior facilities known as "amenity beds".
2. Pharmacists are reimbursed by the Prescription Pricing Authority, a special Health Authority of the Department of Health.

Source: European Observatory on Health Care Systems (1999*b).*

league tables towards benchmarking and good practice emulation.[28] The indicators also help to plan services and to substantiate accountability arrangements. Furthermore, a new annual national survey of patient and user experience is being introduced. Also, a new Health Development Agency is being established, replacing the Health Education Authority. This advisory body is to maintain a map of the evidence on public health, commission research and evaluation and formulate recommendations, with an emphasis on the worst off and on narrowing health inequalities. A public health observatory will be created in each NHS region, closely linked with universities, to identify and monitor local health needs and trends and to set up disease registers, as well as to promote research. More recently, the Government has proposed that doctors be subjected to annual performance appraisals: poor results would cause them to be referred to independent assessment centres entitled to recommend retraining or sanctions.

18. National standard setting is introduced for the first time. National service frameworks (NSFs) are being established, setting standards with a view to improving quality and reducing unacceptable variations in service. NSFs for coronary heart disease and mental health have been published, to be followed by an NSF for older people this year and an NSF for diabetes in 2001. In addition, a new National Institute for Clinical Excellence (NICE) was created in 1999, to produce and disseminate clinical guidelines and referral protocols, and to drive good practice based upon evidence of clinical and cost-effectiveness. It is to appraise new treatments and technology and to advise the NHS on their clinical and cost-effectiveness and their place in relation to existing treatments. By centralising guidelines, it is hoped that NICE will remedy the equity problems arising from the fact that thus far each HA decided separately on the choice of drugs and other forms of treatment ("postcode prescribing"). In this sense, NICE is presented by the Government as "the biggest assault on the lottery of care in the history of the NHS" (Milburn, 1999). NICE itself is a light structure, and much of the technical work is subcontracted to academia and hospital professionals.

19. A new Commission for Health Improvement (CHI) has been set up to monitor the implementation of the standards set by the NSFs and NICE guidance. Local NHS health care organisations are to be reviewed every three or four years by this independent body. CHI may be sent in by the Secretary of State to identify rapid action to address serious or persistent clinical problems. It may also be invited in by others to investigate local concerns about services.

20. Two new services have been inaugurated. One is NHS Direct, a 24-hour telephone helpline operated by nurses to offer on-the-spot advice on self-care or refer callers to the appropriate service, akin to what exists in the United States but offering an integrated, national service available to all. By end-1999, over half of the country was covered, and the service should be available throughout the whole of England by October 2000.[29] Early independent evaluation results indicate that this new service is proving very popular (Munro *et al.*, 2000). By providing upstream triage, it helps match services to needs. The same evaluation suggests that this is achieved without compromising patient safety or generating additional demands on the NHS — indeed, there is evidence that it has helped stem rising demand for out-of-hours services. Questions have been raised, however, as to the cost of NHS Direct, prompting an ongoing value-for-money review by the National Audit Office (NAO). The net cost will depend *inter alia* on the proportion of patients dealt with by NHS Direct turning to a less expensive form of treatment than they would otherwise have had.

21. The other new service consists of walk-in centres, piloted in 1999 in a variety of places, including airports and supermarkets. Staffed by nurses, they are open from early morning to late evening, seven days

28. Several potential biases may plague such indicators. For example, data reporting may be positively correlated with performance. Also, deaths occurring shortly after discharge are not counted in, which tends to overstate relative death rates in hospitals allowing longer stays.

29. In December 1999, an internet version of NHS Direct was put on-line (www.nhsdirect.nhs.uk).

a week, and offer advice and treatment of minor ailments without an appointment. They are meant to supplement rather than to replace GPs. Walk-in centres can be particularly useful for patients unable to schedule appointments at regular hours or to make any appointment at all (homeless and refugees, for example). Yet another innovation, focused on the worst off, are health actions zones (Box 3).

Box 3. **Health Action Zones**

Since 1998, 26 health action zones (HAZs) have been created — for a period of seven years — covering a population of 13 million, in an attempt to target deprived areas with a particularly high incidence of ill health, including inner cities and coalfield communities. HAZs form part of the Government's agenda for tackling social exclusion, alongside other initiatives such as Healthy Living Centres and Education Action Zones. The idea is to break down the bureaucratic impediments to modernising local health services by bringing together the local institutions whose activities have a bearing on health — including private sector and community groups — and having them agree on a detailed joint strategy to improve the health of the poorest citizens.* It is hoped that in this way the typical fragmentation of services and associated dilution of resources can be overcome. Experience across HAZs is shared *inter alia* via a dedicated website (www.haznet.org.uk).

Specifically, in the Tyne and Wear HAZ for instance, a new approach to the health of the elderly has been adopted, involving a new risk assessment system, improved access to public transport, better special housing, and a home insulation programme. In the Luton HAZ, a joint bid is being undertaken with the Employment Service — in the context of the New Deal initiative, to improve the health of the worst off by focusing on employment.

* Back in the 1980s, a number of initiatives were launched in the same spirit — including Healthy Cities, the Urban Programme, City Challenge, and regeneration bids — but with more limited health objectives.

More budgetary resources

22. Following an initial surge accompanying the introduction of the quasi-market, real NHS spending slowed. In the three years to FY1997/98, its annual growth rate averaged 1.5 per cent (in cash and gross terms, *i.e.* before subtracting user charges, receipts from sales of surplus land and the like) — significantly below the expansion of GDP. It increased to 2.2 per cent in FY1998/99, and under the Comprehensive Spending Review (CSR) completed in July 1998 was projected to average 4.7 per cent over the next three years.[30] In the context of the March 2000 Budget, however, and ahead of the conclusion of the second Spending Review, the NHS was given a major multi-year boost, with funding to rise in real terms by 7.4 per cent in 2000/01 and by 5.6 per cent in each of the following three financial years (Table 1).

23. The extra resources under the CSR are to finance a catch-up in some categories of NHS wages, additional staff recruitment and the rehabilitation of the capital stock, but they will also have to cover reorganisation costs. They are further meant to allow the shortening of waits, which remain inordinately protracted and on some measures have worsened since 1997 (Table 2).[31] For example, as regards cancer, the DoH has promised to speed up procedures: from this year, everyone with suspected cancer should be able to see a specialist within two weeks of their GP deciding they need to be seen urgently and requesting an appointment. The extra resources are also intended to reduce health inequalities, in particular

30. All figures based on nominal amounts adjusted by the GDP deflator (DoH, 1999*b*). To the extent that prices in health care tend to rise somewhat faster, service volumes are in fact rising less.

31. The Government has spelled out an objective of cutting inpatient waiting lists by 100 000 over this Parliament; to ensure that this is meaningful and not counterproductive (the reduction in numbers could be achieved through lengthening durations, or clinical priorities could be distorted, with inpatients displacing outpatients or easily treatable conditions crowding out urgent cases), it is complemented by measures of waiting times. For waiting time statistics, see http://www.doh.gov.uk/waitingtimes.

concerning premature deaths from heart disease and stroke, cancer and mental illness. Part of the new money is ring-fenced in a special £5 billion "Modernisation Fund", *i.e.* it is earmarked for improvements. One of the envisaged measures to reduce inequalities involves changes to the budget allocation formula so as to gradually shift resources towards relatively deprived areas. The Government is committed to economising resources by cutting red-tape, notably through a reduction in contracting costs (the target being to save £1 billion over this Parliament). A national plan, to be announced in the summer, will set out how the resources from FY2001/02 will be spent.

Table 1. **NHS funding**
Total for the United Kingdom[1], £ billion, in cash terms

	1998/99	**1999/00**	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**Average**
Previous plans	45.1	49.3	52.2	55.5			
New allocations	45.1	49.3	54.2	58.6	63.5	68.7	
Annual real growth[2] (%)			7.4	5.6	5.6	5.6	6.1

1. Include additions to devolved administrations and Northern Ireland departments.
2. Deflated by the projected GDP deflator (which is posited to rise by 2¼ per cent in FY2000/01 and by 2½ per cent per annum thereafter).

Source: Budget 2000.

Table 2. **Waiting lists and times**
NHS Trusts in England, end-year

	1997		1998		1999	
	Number of patients	% of total	Number of patients	% of total	Number of patients	% of total
First outpatient appointment						
Number of GP written referral requests seen	1 888 560	100	1 894 358	100	1 935 766	100
of which: number who waited						
Less than 4 weeks	747 252	40	696 199	37	686 568	35
Between 4 and 12 weeks	789 824	42	780 267	41	762 903	39
Between 13 and 25 weeks	284 127	15	329 383	17	360 029	19
26 weeks or more	67 357	4	88 509	5	126 266	7
Hospital inpatient waiting list (all specialties)						
Ordinary admissions: patients waiting	593 115	100	541 310	100	514 224	100
Less than 3 months	246 379	42	231 271	43	222 702	43
Between 3 and 5 months	143 959	24	132 174	24	125 373	24
Between 6 and 11 months	160 855	27	142 504	26	130 887	25
12 months or more	41 922	7	35 361	7	35 262	7
Day case admissions: patients waiting	668 800	100	632 288	100	593 782	100
Less than 3 months	348 977	52	353 033	56	342 105	58
Between 3 and 5 months	155 042	23	141 396	22	132 386	22
Between 6 and 11 months	138 371	21	117 126	19	102 406	17
12 months or more	26 410	4	20 733	3	16 885	3

Source: NHS Executive.

24. In recent years, earnings for some categories of NHS employees had been lagging relative to others and to economy-wide earnings, contributing to low morale and difficulties in recruiting and retaining staff. Therefore, the Government in early 1999 granted significant pay rises. The increase was not staged and was more generous than in the rest of the public sector. Nurses, midwives and health visitors were awarded a 4.7 per cent, across-the-board increase, against 3.5 per cent for hospital doctors and GPs. Newly qualified nurses saw their starting salaries raised by 12 per cent, which brought them almost into line with entry salaries in teaching. At the same time, the DoH put forward proposals to streamline the complex system of pay scales and to tighten the link between performance on the job and pay awards. In the autumn of 1999, an agreement was reached to cap average working hours for junior doctors at 56 per week and to pay overtime hours at the full rate, as well as to free them from certain administrative tasks.[32] Moreover, pay incentives were improved for doctors in the most hard-pressed posts (such as surgery). In January 2000, the Government announced further large wage increases for NHS staff, ranging from 3.25 to 8.4 per cent, implying significant hikes in real terms. The awards are to be implemented without staging, but the Government warned they should not be seen as a norm for other groups, such as teachers.

25. The United Kingdom has a low number of physicians per capita, at 1.6 per thousand (which is more than one standard deviation below the OECD mean of 2.7). One-quarter of these are graduates from foreign medical schools, mostly from developing countries, as the number of graduates from medical schools in the United Kingdom has not kept pace with the rising demand for doctors (Table 3). Acute shortages of doctors, as observed in some specialities, are detrimental to health outcomes.[33] These staffing problems have been recognised and efforts have been deployed to step up the hiring of doctors, which have recently been intensified. The present Government has also agreed to a 20 per cent hike in places at medical schools, to be phased in over the next five years. Improved staffing levels would allow for more sustainable workloads and thereby facilitate the wholehearted implementation of the new clinical governance principles.[34]

26. As noted above, capital investment in the NHS has declined until 1998/99, even as health service infrastructure retains many pre-NHS features: half of the beds in NHS hospitals are located in accommodation built before the First World War, and three quarters of ward blocks are hand-me-downs from the days of charity, voluntary and municipal and emergency wartime hospitals. Therefore, the CSR proposed a sharp increase in investment. Much of the planned increase stems from an acceleration in the construction of hospitals under the PFI scheme (described in Annex III of OECD, 2000). In many cases, this involves major restructuring of the physical asset base, with premises being centralised on a single, usually cheaper, site.

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32. At the time, according to the British Medical Association, one in four junior doctors was working more than 56 hours per week.

33. Based on a comprehensive data set spanning the first half of the 1990s, Jarman *et al.* (1999) argue that hospital death ratios adjusted for age, sex and diagnosis are negatively correlated with the density of GPs in the surrounding area and with hospital staffing (but their methodology has been contested).

34. The Government is in the process of modernising pay, employment and working practices of NHS staff, with a view to increasing workforce flexibility and ensuring that skills and services fit the needs of patients. Work is under way to extend the responsibility of nurses (including via an expansion of the nurse prescribing programme), a Royal College of Physicians proposal to introduce a new category of health care workers between doctors and nurses is under consideration, a review of hospital career structures has been undertaken, and, locally, many NHS organisations have introduced or are developing new roles and responsibilities for key workers.

Table 3. **Doctors**

Number of NHS doctors in England by country of qualification[1]

	1991	1998
All United Kingdom qualified doctors	**56 800**	**64 160**
Hospital medical consultants	13 120	16 650
Unrestricted principals	20 470	22 170
Junior doctors	17 080	19 980
Others	6 120	5 350
Doctors qualified overseas	**17 880**	**24 070**
Hospital medical consultants	2 710	4 390
Unrestricted principals	5 210	5 220
Junior doctors	7 170	9 800
Others	2 790	4 660
Total	**74 680**	**88 230**
Hospital medical consultants	15 840	21 040
Unrestricted principals	25 690	27 390
Junior doctors	24 250	29 790
Others	8 900	10 000

1. Figures are rounded, hence elements may not sum to totals.

Source: Department of Health.

27. A major change in the way budgetary resources are allocated in the new system pertains to the annual budgets handed down to PCGs by HAs. In the quasi-market, GP fundholder budgets were partitioned, with limited scope to move funds between the envelopes for emergency care, waiting list surgery and drug treatments. Henceforth, and irrespective of the PCG's level of responsibility, its budget is unified, so that resources can be matched locally against patient needs. This budget covers a much broader range of services than the typical GP fundholder budget used to. In that sense, it resembles the more comprehensive TPP budgets. The issue arises of how budgetary control will be maintained within a PCG, which typically includes some 50 GPs. Clinical guidelines can help reduce variations in referral practice but do not suffice for budgetary control purposes (Box 4). The Government therefore expects that over time each PCG will extend indicative budgets to individual practices for the full range of services, with some supporting incentives. This will require more co-ordination between practices than occurs at present. As the experience with TPPs has illustrated — even though they typically included only a handful of practices — it is difficult to ensure that practices stay within budgets and adhere to referral and prescribing protocols.

Assessment

28. The experience with the quasi-market provides some interesting lessons, even if a comprehensive assessment is difficult. One of the main conclusions is that the separation of purchaser and provider of health care has merits, notwithstanding the implied contracting costs. The full extent of the efficiency gains it allows cannot be ascertained, however, not only because competition remained administered with a rather heavy hand, but also because such gains take more time to materialise than the period allowed for the quasi-market to work itself out. While GP fundholders contributed to a better allocation of budgetary resources, the latter was far from optimal for many trusts.

Box 4. **Budgetary envelopes and risk diversification**

A "fair" budgetary formula for individual practices should produce an unbiased estimate of the expected spending level in each practice if it responds in a standard fashion to its patients' needs. For a number of reasons, actual spending patterns are likely to deviate significantly from what such a formula would predict (Smith, 1999). *First*, some relevant patients' characteristics may not be taken into account in the formula, which can only embody a limited number of variables. *Second*, variations in clinical practice — which are likely to explain a considerable portion of spending variations — can only partly be controlled by GPs, as they are also influenced by specialists. *Third*, random variations in sickness levels are very large for individual patients. *Fourth*, variations in the price of treatments may also be substantial, as was the case in the quasi-market. Based on the variations arising from patient characteristics, clinical practice and levels of sickness, Martin *et al.* (1997) estimated that for a population of 10 000 there is a probability of one-third that spending would deviate by more than 10 per cent from a "fair" annual budget, but that for a population of 100 000, this probability drops to only a quarter of 1 per cent. Such estimates highlight the crucial importance of population size for risk diversification and suggest that setting health care budgets for small populations, such as those corresponding to individual practices, will be challenging.

Ways to cope with uncertainty would include: the pooling of practices, in the form of joint budgets for voluntary associations of practices within a PCG (although this may add another layer of management costs); pooling risk over time, by extending the budgetary horizon beyond one year; transferring budgetary responsibility for predictably expensive patients or treatments to the PCG; building up contingency funds at PCG level; identification of the source of departures from budgeted expenses, which may reflect systematic risk factors, such as capitation formula weaknesses (a managerial issue), deviations in clinical practice (which call for clinical guidance) or in contract prices (necessitating consultation with providers or referral guidance).

29. Implementation of capital charging was slow, owing to the sheer scale of the task in an environment where asset registers were often absent or inaccurate, but also because of the NHS's notorious weaknesses in IT,[35] and staffing problems in the central NHS administration. In a number of instances, capital charging came to be perceived more as a financial accounting ritual than as a management tool. Even so, capital charging would appear to have contributed to rationalising capital stock utilisation, for instance via greater recourse to flexible bed management techniques (bed pools, multi-use beds). Given the poor condition of whole portions of the NHS estate, and the fact that many buildings are more valuable as historical monuments than as functional facilities, this is important.

30. A number of deep-seated problems persisted throughout the quasi-market era, partly related to the basic fact that the United Kingdom has continued to strictly cap the resources devoted to health care.[36] A particular feature of this cap is that the number of physicians has been restricted even more tightly than health expenditure itself, leaving the United Kingdom with the lowest ratio of physicians per unit of health expenditure (adjusting for purchasing power parity) among OECD countries paying physicians mainly by capitation and salary. Since there is some evidence that paying physicians in this way can depress their productivity compared with fee for service pay, physician output in the United Kingdom may have been doubly constrained. Possibly as a result, health outcomes in the United Kingdom are mediocre in some respects, *e.g.* certain cancer survival rates appear to be closer to Eastern than to Western European averages (Coebergh *et al.*, 1998) and the incidence of heart attacks is higher and has improved less than

35. On the shortcomings of the NHS's 1992 (and 1998) information management and technology strategies, see NAO (1999*b*).

36. This contrasts with the United States for instance and has been interpreted by some as a social choice based on a perception that the marginal improvements in health outcomes extra money would buy are not sufficient to justify a major budgetary boost (Jacobzone, 1999).

elsewhere (Robinson *et al.*, forthcoming).[37] Even in the areas where outcomes compare more favourably, protracted waiting, brief consultations and frequently poor infrastructures mean that the quality of health care delivery is not up to par. Somewhat in contrast to these points, cost containment has not been quite as rigorous as may seem from the NHS budget allocation, as there has been a trend over the past two decades to shift some costs, notably for long term care, out of the NHS, to other public budgets or to users, which has raised equity problems.[38]

31. The latest wave of wholesale reforms, outlined in 1997 and gradually phased in since, involves less of a reversal of the previous one than sometimes suggested. The key purchaser/provider split remains. Competition is still to play a role, albeit more in the form of contestability. Even though membership is no longer optional, PCGs could be viewed as a logical development of TPPs, which were the ultimate extension of fundholding (but in contrast to TPPs, coverage of a defined geographical area avoids cherry-picking of low-cost patients). Some budgetary wherewithal is retained by trusts and PCGs, with the possibility to allocate budgets over periods exceeding one year and, for PCGs, with unified instead of partitioned budgets. The most advanced PCGs — primary care trusts, or PCTs (of which there are now 17) — can also own and operate community health services. The emphasis on properly measuring outputs and developing better indicators to do so should constitute another welcome element of continuity.

32. Even though they try to preserve what worked and to remedy what did not in the quasi-market, the new arrangements are not risk-free (Table 4). *First*, it is far from clear that the short-term reduction in administrative costs will be maintained while institutions continue to be reorganised. Improving management systems and information support will absorb considerable resources and take several years. *Second*, the traditional centralisation that endured in the 1990s is reinforced in some important ways. Harmonising standards and monitoring compliance with the latter may not do enough to level up the quality of service across the country. The attempt to do so might uncover a need to adjust resource allocation, for example in terms of sectors, input ratios or geography. The introduction of unified budgets for HAs and PCGs/PCTs, however, should make it easier to rebalance spending between sectors or inputs if needed, and the geographical allocation of resources is currently under review, with the objective to reduce avoidable health inequalities. *Third*, if contestability is to be effective and to have the hoped-for impact, HAs should indeed let PCGs switch providers. *Fourth*, it remains to be seen how fair budgetary discipline can be achieved within PCGs at reasonable managerial cost, given the heterogeneity of their membership and the novelty of peer pressure for those GPs who had not opted for fundholder status under the quasi-market. *Fifth*, specialist doctors continue to face a strong financial incentive to treat patients after NHS-hours for a much higher remuneration. *Sixth*, and more generally, it will be essential for the NHS to make the best possible use of the new-found and unexpected financial room for manoeuvre, which calls for a revision of existing spending plans. In any event, new schemes will have to be carefully assessed as they unfold, with more external evaluation than in the early years of the quasi-market.

33. In addition to these potential hazards, some managers and practitioners who are being asked to work out on the ground the numerous and sometimes quite ambitious initiatives initiated by the centre, may suffer from reform fatigue. In a system with tight overall budget constraints, NSFs should therefore be used as tools to openly clarify priorities. The discussions on partnerships and better service as well as the publicity given to increased funding have presumably raised expectations quite considerably, making it all

37. Or (2000) provides econometric evidence that health outcomes, measured as potential years of life lost ("premature mortality"), are indeed worse if health spending is low, especially for women. On the other hand, spending more does not automatically produce better health outcomes: for example, while Germany spends much more on dental services than the United Kingdom (Mossalios and Le Grand, 1999), it has one of the highest rates of dental decay in Europe (European Observatory on Health Care Systems, 1999*a*).

38. See Harrington and Pollock (1998) and Royal Commission on Long Term Care (1999). Nursing is free for individuals receiving care in hospitals but not when it is provided in nursing and residential care homes.

the more challenging to meet them. Disappointment might lead to more prominence being given to the simmering debates on restricting the NHS to a core set of services, imposing charges or extending the role of private insurance.

Table 4. **Key OECD conclusions and recommendations**

- The initial proliferation of reform initiatives, overhauling existing arrangements and cutting across institutional boundaries, should now be followed by more focussing and prioritising, lest overstating the ability of the parties involved to enact change results in dilution.
- The reforms should be thoroughly scrutinised by independent auditors as they unfold, and the framework adjusted as appears needed in the light of experience.
- Further support should be given to the effective development of the split between commissioners and providers of secondary health care within the NHS.
- Effective contestability is important and HAs should not be allowed to prevent PCGs from switching providers.
- More attention needs to be paid to the internal management and support of PCGs, to the distribution of influence and resources across practices, and to the incentives facing practices, in order to ensure that PCGs improve primary care and contribute to stimulating improvements in secondary care.
- Given the low numbers of specialists per capita and the apparent weakness of the financial incentives for these physicians, consideration should be given either to accelerating their recruitment, at least in shortage areas, or to improving the financial incentives for the current specialists, within suitably controlled increases in hospital budgets.
- The restructuring and modernisation of the NHS physical infrastructure should continue, albeit with a view to avoid (re-)creating local oversupply.
- The financial commitment horizons for modernisation monies *lato sensu* should be extended as much as possible.
- Performance indicators need to be developed and refined further, and published with the proper caveats.
- The financial control of trusts should continue to be improved, which should be facilitated by the greater flexibility they now enjoy with respect to organising their spending over periods exceeding the fiscal year.
- Asset registers should be used more actively for management decisions.
- The emerging international evidence on relatively poor health outcomes for some conditions and the exceptionally long waiting time many patients experience for specialist care in the United Kingdom warrant cross-country research on the causes and potential remedies.

Glossary of acronyms

CHI	Commission for Health Improvement
CSR	Comprehensive Spending Review
DoH	Department of Health
DRC	Depreciated Replacement Cost
FY	Financial Year
GDP	Gross Domestic Product
GP	General Practitioner
GRC	Gross Replacement Cost
HA	Health Authority
HAZ	Health Action Zone
HMO	Health Maintenance Organisation
NAO	National Audit Office
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
PBR	Pre-Budget Report
PCG	Primary Care Group
PCT	Primary Care Trust
PFI	Private Finance Initiative
PPP	Purchasing Power Parity
PPRS	Pharmaceutical Price Regulation Scheme
TPP	Total Purchasing Pilot

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