

Hospital Financing in England

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Introduced in 1948 by the Labor Party, Britain's National Health Service (NHS) is based on the principle that everyone is entitled to any kind of medical treatment for any condition, free of charge. The NHS is not insurance-based but is funded almost exclusively from general tax revenues. The aggregate NHS budget is fixed every year, based on the previous year's budget and adjusted for inflation estimates and the population's estimated health care needs. The Department of Health allocates the aggregate NHS budget for hospital care to regional and district health authorities who, under the traditional system, were responsible for providing and paying for hospital services; Family Practitioner Committees are responsible for providing primary care for several district populations and receive funding directly from the Department of Health. The third component of the NHS is the personal social services category. Local governments receive payments from district health authorities to provide community-based services, including nursing home care, home care for the elderly, and other support services.

The United Kingdom's centralized, mostly public, comprehensive health care system was a pioneer of national health care. Currently, however, the NHS is undergoing an important program of reforms, principally announced in the government's 1989 White Paper entitled *Working for Patients* and enacted as legislation in the NHS and Community Care Act of 1990 (7). The United Kingdom's comprehensive health care reform program, based on concepts of "managed competition," will result in the most significant changes to the NHS since its creation more than 40 years ago (10). The main elements of the reforms are as follows:

- the introduction of contractual funding designed to separate the provider and purchasing roles for health services within



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NHS to encourage efficiency through “managed competition” among both public and private providers, and

- increased consumer choice of providers and services.

These changes, which became effective April 1, 1991, will substantially affect the way that hospitals conduct their business. Although the British government will continue to play a key role in health care planning, financing, management, and limiting of the aggregate amount of funds available for health services, the distribution of these funds among regions and among hospitals may change dramatically. The locus of hospital decisionmaking will also shift from local government entities to individual hospital managers.

The NHS is currently divided into three distinct components: one for hospital care (which includes inpatient and hospital outpatient care), one for primary care, and the third for community/social services and long-term care. In the hospital sector, there are 14 regional health authorities (RHAs) that are each responsible for four to five million people. Every RHA is divided into approximately 15 district health authorities (DHAs), which are each responsible for around 260,000 people and 4 to 5 hospitals. The aggregate hospital sector has a cash-limited budget that (even under the reforms) is allocated to the RHAs according to a formula that takes into account the age and mortality rates of the particular population it is to cover. In turn, RHA budgets are allocated to DHAs.

Previously, the responsibility for both the funding and provision of hospital services rested with the approximately 190 DHAs. The responsibility for strategic management and coordination of services resided with the higher administrative layer of the RHAs. However, under the reformed system, DHAs now have the central functions of assessing the health of their resident population,

determining the population’s health care needs, and purchasing services appropriate to those needs.¹ Thus, DHAs now mainly fund hospital services, while the provision of services is competitively determined. The nature of the reforms as they affect the hospital sector are described in more detail in the rest of this chapter.

STRUCTURE OF THE HOSPITAL SECTOR

The public (NHS) and independent (private voluntary and for-profit) hospital sectors coexist in England. In 1990, there were approximately 115,000 acute care beds available in NHS public hospitals, comprising almost nine-tenths of all available acute care beds. Prior to the reforms, public hospitals were both owned and operated by DHAs; however, the structure of the public hospital sector was changed substantially by the reforms. DHAs may continue to manage hospitals as directly managed units (DMUs), but NHS hospitals are encouraged to become self-managing NHS Trusts independent of the DHAs.

The first wave of NHS Trusts, involving 57 hospitals and units, became operational on April 1, 1991, and a further 99 hospitals and units became Trusts on April 1, 1992. Following the third wave, which became operational on April 1, 1993, approximately two-thirds of NHS hospital provider units in England are estimated to have Trust status.²

In the future, NHS Trusts will compete with private providers of hospital services by negotiating contracts or service agreements with DHAs. (Currently, such contracts include both hospital outpatient and inpatient services; however, in the future, separate contracts for inpatient and ambulatory care may be negotiated). DHAs will purchase care from NHS hospitals, private hospitals, or the self-governing Trusts. The Trusts will also

¹ A number of DHAs have entered into formal or informal agreements with other DHAs to jointly negotiate contracts and purchase services, which has resulted in approximately 80 to 90 purchasers within the NHS.

² As of April 1995, all but a few percent of hospital provider units have Trust status.

be able to contract with general practitioners to provide hospital services to their patients, as well as with other self-governing hospitals and private insurers (10).

The entire population, both publicly and privately insured, is entitled to treatment in NHS hospitals. Inpatient access for nonemergency care is mainly through referral from a general practitioner. In principle, access is based on need and is rationed in part through waiting lists for consultations and treatment.

The independent sector plays a relatively small role in England's hospital sector, with 10,906 beds in acute care medical and surgical hospitals (8.7 percent of total acute care beds). In addition, approximately 3,000 beds within NHS hospitals are authorized as "pay beds" for the treatment of private patients. (These beds have only about a 30 percent average rate of occupancy by private patients.) Private ownership of hospital facilities, although small now, is increasingly playing a larger part in the British system. Between 1978 and 1988, the number of beds in private hospitals increased by 50 percent (10). Traditionally, most independent hospitals have been nonprofit. The recent expansion in private beds, however, has been almost entirely in for-profit hospitals, most of which are subsidiaries of U.S. companies. Private medical care plays an essentially complementary role to NHS services, offering a choice of physicians, avoidance of waiting periods for elective surgery, and higher standards of comfort and privacy than the NHS (16).

Access to private hospitals depends on the patient's ability to pay through private insurance or out-of-pocket. Most of the private sector's case-load is limited to elective surgery (e.g., hernia repair, varicose vein surgery). A 1986 survey indicated that private patients accounted for 16.7 percent of elective surgery in England and Wales, with the proportion varying considerably among regions.

The public and independent hospital sectors in England coexist and are also interrelated in several ways:

- Most private hospital services are delivered by NHS consultants, who are hospital-based senior specialists. All full-time NHS consultants are permitted to earn up to 10 percent of their gross income from private practice. Consultants can also enter into contracts with the NHS that enable them to devote a greater proportion of their time to private practice. Approximately 12,000 of the 15,170 consultant-grade staff in NHS hospitals undertake some private practice.
- As noted previously, some private treatment is carried out in NHS hospitals through NHS pay beds. In 1989, the NHS earned 99 million pounds from private treatment.³ This amount may increase in the future, since the requirement to obtain authorization from the Secretary of State for Health for pay beds was removed in the 1990 health reform legislation.
- The NHS and private sectors are allowed to enter into partnerships. For example, a private partner might be given a lease on an NHS site to undertake a capital investment or might be given a contract to manage an NHS facility. Only a few such arrangements exist at present.
- NHS patients may be treated in private hospitals if their purchasing authority agrees to pay for treatment, although the volume of such cases is currently low.

PHYSICIANS

In 1990 there were 15,170 senior hospital doctors (consultants) in England and 32,848 other hospital medical staff. Hospital consultants have the choice of taking a full-time or part-time position with the NHS. If they choose part-time, they are allowed to perform as many private sector services as they like. If they choose full-time, how-

³ The exchange rate in January 1994 was approximately \$U.S. 1.48 to 1.00 pound.

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ever, their private practice is limited to 10 percent of their NHS salary (10).

Hospital doctors are paid for the delivery of hospital services through nationally negotiated salary scales.⁴ Since 1960, salaries have been based on the annual report of the independent Review Body on Doctors' and Dentists' Remuneration, which takes evidence from medical and dental representatives, the Department of Health, and other interested parties. The Review Body's recommendations are subject to governmental approval; they have never been rejected, although they have been deferred or modified.

All consultants are also eligible to obtain distinction awards that supplement their basic salaries. The number and value of awards is fixed by the Review Body; recommendations concerning distinction awards come primarily from the medical profession. Approximately one-third of all hospital consultants hold a distinction award. As noted earlier, consultants may also obtain contracts that allow them to devote part of their time to private practice.

Consultants' contracts are held by regional health authorities, which also administer the payment of distinction awards. Other hospital medical staff are employed by district health authorities or DMUs, or, if they work in an NHS Trust, by the Trust.

Following the NHS reforms, hospitals can alter the pay and conditions of the staff they employ, including the medical staff. There is little evidence so far, however, that hospitals have deviated to any great extent from national salary scales, although many Trust hospitals are currently making plans to do so. Little change is expected before 1995.

Very few medical staff work on a full-time basis in private hospitals. Most physicians are NHS consultants who devote part of their time to private practice. Medical staff in the private sector are predominantly paid on a fee-for-service basis. There are no statutory controls on fee levels, al-

though the British Medical Association recommends fee scales, and some insurers will reimburse patients for fees only up to a certain amount. The basis for setting fees is the subject of a current investigation by the Monopolies and Mergers Commission, which is concerned that there is too little price competition for private medical services.

General practitioners (GPs) working in the community are self-employed. They contract with the NHS to provide services to NHS patients. Each British citizen enrolls with a GP, who is the patient's first point of contact with the health system. GPs determine when a patient will see a hospital-based consultant. They are paid under a mixed payment system with four elements:

- annual cavitation payments for each patient on the GP's list, weighted according to age;
- fees for some services (e.g., treating temporary residents or making night visits);
- a basic practice allowance to cover practice expenses; and
- payments for attaining certain targets, such as cervical screening or infant immunization rates.

The recent health reforms also introduced some major changes to GP practices. Because general practitioners are the main source of nonemergency referrals to NHS hospitals, reforms to the framework within which general practitioners work also affect hospitals. Under the reforms, larger GP practices have been given the option to become "fundholding" practices. These practices are allocated funds per enrolled citizen by their respective RHA to purchase nonemergency hospital services and community health services for their patients. They can purchase hospital services from public or private hospitals, which compete for the patients of these GPs. In theory, money follows patients to the most efficient providers of care.

In turn, because GPs receive more money for each additional patient they sign up, they will be

⁴ The pay of junior hospital doctors is determined primarily by national salary scales, supplemented in most posts by payments related to their hours of employment above a standard working week.

encouraged to compete for patients. GP fundholding aims to bring the purchasing of health services closer to the patient, with the GP negotiating contracts with providers based on the needs of patients. GP fundholding also aims to make GPs more conscious of the cost of services and to put pressure on providers to increase efficiency. It is also hoped that GPs will provide more services themselves, better coordinate services provided to patients, and reduce referrals of straightforward cases to hospitals.

The first wave of 306 GP fundholding practices, covering approximately 7.5 percent of the population, became operational on April 1, 1991. The number of GPs choosing to become fundholders has increased steadily, and perhaps 40 percent of England's population is now enrolled (11). Yet because only a limited range of treatments is financed through the fundholding scheme, most services are still purchased by DHAs, even for the patients of fundholding GPs.

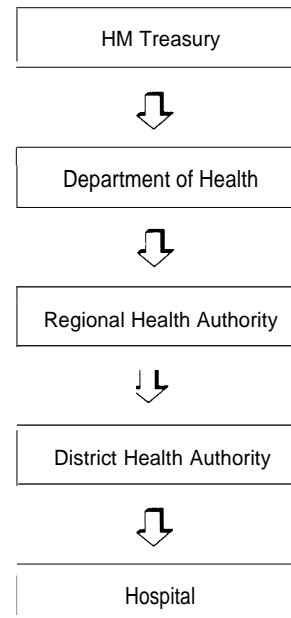
HOSPITAL OPERATING COSTS

■ Financing Model

The prevailing approach to financing hospital operating expenses in England has been via the National Health Service. The NHS is funded primarily through general tax revenues allocated to it as part of the central government's expenditure plans for its entire budget. NHS-owned (public) hospitals are funded mainly through NHS payments. The recent reforms make no changes to the basic flow of funds from the central government to hospitals, which follows the route shown in figure 3-1. However, the reforms affect the relationship between the NHS and hospitals. Following these reforms, funds move from a district health authority to a hospital on the basis of contracts for services rather than as direct funding. This process is described in further detail below.

Nationally, the Department of Health represents the NHS in an annual process by which the central government makes its expenditure plans for the following three years. All major spending departments and the Treasury are involved.

FIGURE 3-1: Flow of General Revenue Funds from the Central Government to Hospitals



SOURCE: A. Gray and C. Normand, 1994

Spending plans are published each January in a government White Paper on public expenditures entitled *The Government's Expenditure Plans*. The plans set forth total cash limits for each main spending program. For the NHS, the main programs are hospital and community health services (HCHS) and Family Health Services, which include primary care provided by general practitioners, dentists, opticians, and pharmacists. (Hospital and community health services include home nursing and ambulance services [16]). Separate cash limits are established for operating expenditures and capital expenditures.

The Department of Health divides its cash allocation among the 14 RHAs on the basis of an allocation formula. The formula is based on each RHA's population, weighted for age and morbidity, measured in terms of standardized mortality ratios. An RHA's block allocation covers most areas of service provision, but some specific services (e.g., research, teaching, the prevention and

treatment of HIV and AIDS) are funded separately by means of other allocation formulas. RHAs then distribute most of their allocations to the 190 DHAs, retaining a small proportion for spending at the regional level. Prior to the reforms, DHAs were allocated resources primarily on the basis of the hospital services they provided, with some adjustments to allow for flows of patients across DHA boundaries. Following the reforms, DHAs have been funded on the basis of their population, similar to the RHA formula, weighted for age distributions and morbidity patterns.

Although the initial allocation to the Department of Health limits the aggregate amount of money available to fund hospital and community health services, there is no formal guidance as to the exact proportion that each RHA should devote to hospital services from its cash allocation. Similarly, DHAs have freedom in dividing their block allocation among different types of health services. This process determines an aggregate amount available for hospital services, and purchasers (e.g., DHAs) are constrained to stay within their total allocation. The cash-limited system at the national level ensures that it is not possible to exceed aggregate expenditure limits.

Prior to the United Kingdom's recent health reforms, hospitals received global budgets based mainly on historical costs (16). Following the reforms, however, the operating costs of an individual NHS hospital—be it a Trust or a directly managed unit—have been determined by the contracts it negotiates with purchasers for specific services. In other words, there are no longer prospectively fixed budgets for individual hospitals. Under the reformed system, it is anticipated that hospitals that are successful in making contracts with purchasers will expand and that hospitals that fail to

make or maintain contracts with purchasers will reduce their capacity or close.

Private hospitals, consisting of independent hospitals and hospitals owned by private health insurers, are currently funded primarily through private health insurance payments. The NHS reforms envisage that the NHS and private sectors will become more interrelated, with private hospitals competing with NHS Trusts and directly managed NHS hospitals for contracts from purchasers.

■ Sources of Funding

NHS hospital services are financed mainly through general tax revenues and through a portion of national insurance contributions. In the 1990-91 fiscal year, 94.1 percent of total revenues came from those sources, with general taxation (from the Consolidated Fund) contributing 79.2 percent and the NHS element of national insurance contributions accounting for 14.9 percent. The remaining 5.9 percent of NHS hospital revenues came from charges to patients for specific courses of treatment, appliances, amenity beds, and other private charges (4.2 percent), along with miscellaneous income (1.7 percent) mainly from the sale of capital assets (e.g., land).

Prior to the reforms, hospitals funded their operating costs through prospectively determined budgets established by their respective DHA. Under the reformed health system, the operating costs of NHS Trusts and DMUs are financed via contracts with public and private purchasers. Trust hospitals have a statutory duty to operate within the income they obtain from these contracts; DHAs have the same duty with respect to other NHS hospitals.⁵ Contracts may be of three different types: block, cost and volume, and cost per case, as described below:

⁵ A system of financial audit ensures that expenditures accord with contracts and rules. Trusts are obliged to submit audited accounts annually at a public meeting. External audit of NHS expenditures is the responsibility of the Audit Commission, an independent body funded by audit fees, which appoints auditors to examine the accounts and financial systems of purchaser and provider units in the NHS. In extreme circumstances the Secretary of State for Health has the authority to appoint commissioners to take over the running of any unit within the NHS that is in breach of cash limits or contracts, but there are no recorded instances of this.

- With block contracts, the purchasing health authority pays an annual amount in installments to the providing hospital unit for access to a specified set and volume of services, especially for urgent and emergency cases requiring immediate treatment.
- With cost and volume contracts, purchasers pay a providing hospital a fixed sum for a baseline number of treatment episodes or cases, thus giving the purchaser some security; any additional cases treated are paid for on a cost-per-case basis.
- With cost-per-case contracts, purchasers pay a specified price for a particular case. These contracts occur most frequently when a purchaser does not have routine contact with a particular hospital; such cases are called extra contractual referrals (ECRs).

Approximately 80 percent of private revenues for acute care hospital services comes from private insurance, mainly through fee-for-service payments. Private insurers covered about 12.5 percent of the United Kingdom's population in 1991; the remaining 20 percent of revenues comes from direct patient payments. (Private hospital revenues from contracts to treat NHS patients are at present very small.)

■ Bulk Purchases of Pharmaceuticals and Supplies

Before the NHS reforms, most regional health authorities had established regional distribution centers that purchased pharmaceuticals and supplies on behalf of district health authorities. In October 1991, a new NHS Supplies Agency was established that assumed national responsibility for NHS supplies. All regional supplies staff have been transferred to this agency, which is structured around six geographical divisions. Purchasing is intended to occur through the best priced local source except where bulk purchasing has the potential to realize major savings. (The previous more centralized system was criticized because routine items were often available locally at lower prices, but hospitals could not take advantage of

the lower prices because they were required to buy from the regionally centralized system.)

A national purchasing unit within the NHS Supplies Agency is responsible for developing and maintaining a limited list of products that should be purchased only via national NHS contracts. Typical products covered by national contracts include surgical gloves, batteries, and medical gases. The NHS Supplies Agency often negotiates a national unit price for such products, and the provider units draw off supplies under this central contract rather than receiving them via the Agency; therefore, it is not possible to estimate accurately the volume of pharmaceuticals and other supplies covered by bulk contracts.

■ Operating Expenditures

The 1989-90 fiscal year is the most recent year for which accurate data on NHS acute care hospital operating expenditures are available. Operating expenditures for NHS acute hospital services totaled \$6,112 million in that year(8). This is equivalent to 42.8 percent of the NHS's operating expenditures for all hospital care, 28.9 percent of total NHS expenditures (which equaled 21,102 million pounds in the 1989-90 year), and 1.2 percent of GDP (which equaled 511,413 million pounds in current market prices in calendar year 1989) (1). Hospital expenditures rose by about 19 percent between the 1989-90 and 1991-92 periods in nominal terms (i.e., not adjusted for general inflation), and by 2.5 percent in real terms (i.e., after adjustment for inflation) (15).

Expenditures for private sector, acute care hospital services in the United Kingdom were estimated at 1,217 million pounds in 1989 (12). This figure includes expenditures for independent, psychiatric, and substance dependency hospitals. Excluding the latter group, this is equivalent to approximately 90 percent of all private sector hospital expenditures, 45.6 percent of all private sector hospital and residential home expenditures, and 18.6 percent of total private sector health expenditures using abroad definition that includes private hospital and residential care, clinics, alternative

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medicine, and nonprescription medicines. Private sector, acute care hospital expenditures in 1989 were equivalent to 0.2 percent of GDP.

Hospital-based doctors' remuneration is included in estimates of U.K. hospital expenditures. In the 1989-90 fiscal year, the salaries and wages of all medical staff employed by regional and district health authorities (in NHS hospitals of all types) was 1,437 million pounds. (No breakdown of expenditures for medical staff is available by type of hospital.) This equaled 11.3 percent of hospital expenditures, 6.8 percent of total health expenditures, and 0.28 percent of GDP.

HOSPITAL CAPITAL COSTS

■ Relationship of Operating and Capital costs

Prior to the recent NHS reforms, depreciation and the opportunity costs of using capital assets were not explicitly accounted for in NHS accounts. Most of the facilities used to provide hospital services were owned and operated by the NHS. No rent for the use of facilities or capital was paid, and the opportunity costs of using the capital were not calculated. Capital was considered an expense only in terms of the costs initially incurred to buy the capital; the NHS's cost of using its money to purchase hospital capital instead of paying for other services or supplies was not considered. In planning health services, there was no incentive either to use existing capital resources efficiently or to dispose of the surplus. The goal of reforming capital financing was to introduce such incentives.

Beginning on April 1, 1991, schemes for charging for hospitals' use of capital assets are being introduced gradually.⁶ In the early stages the introduction of capital charges has been simply a bookkeeping exercise. Contracts with purchasers of hospital services include a charge for the use of capital, which is taken from the hospital. Real incentives to use capital efficiently are likely to be

introduced shortly; hospitals using buildings and equipment more efficiently will be able to charge lower prices to purchasers of hospital services and obtain more contracts.

Directly managed units must reflect the cost of using assets in capital charges, which consist of depreciation and an interest charge representing a rate of return on the current value of assets. Depreciation is not provided for land assets. The rate of return on the value of assets is set by the Treasury, currently at 6 percent. Interest charges are applied to land and other assets used to provide health care services.

NHS Trusts do not pay capital charges as such; however, they are required to provide for depreciation on the same basis as DMUs. They must also satisfy an annual target rate of return on the current value of their assets, which is set at 6 percent so that contract prices for the purchase of hospital services are not distorted between Trusts and DMUs.

The cash flows generated by capital charges and Trust capital provisions typically do not leave the NHS. The goal is to levy from hospitals depreciation costs and the opportunity cost of funds tied up in hospital capital stock so that more accurate price signals are conveyed to purchasers and providers. The rather complicated accounting mechanism also aims to create a level playing field for providers within the public sector and between the public and private sectors, giving equal opportunities for all types of hospitals to win contracts.

■ Financing Model and Source of Funding

NHS hospital capital expenditures are currently funded in the same way as NHS operating expenditures: from general tax revenues, the NHS component of national insurance contributions, and income from NHS service charges and other miscellaneous sources. Aggregate capital and operating budgets are subject to separate negotiations in

⁶Capital assets are defined as buildings, land, or equipment valued in excess of 1,000 pounds. Beginning on April 1, 1993, this threshold was raised to 5,000 pounds.

the annual public expenditure system. The Department of Health and the Treasury are the main parties to the negotiations.

Once an aggregate capital expenditure limit has been agreed upon, the Department of Health allocates it to the RHAs according to a formula similar to that governing allocations of operating funds, based on the size, age, and health distributions of the resident population. RHAs then allocate capital resources to the DHAs. DHAs directly control capital expenditures associated with minor building projects, but RHAs control major capital schemes, such as the construction of new hospitals.

As the NHS reforms are implemented, however, hospitals will increasingly be allowed to generate their own capital funds, which will then account for a larger proportion of total capital spending. Hospitals will also have more control over their capital investment plans. Purchasers will not influence the pattern of capital investment directly but rather indirectly through the services for which they contract.

■ Determining Capital Requirements

The process of capital investment is detailed in the codes of practice prepared by the Department of Health. These codes specify procedures for planning, option appraisal, tendering, project management, and financial control. They also specify procedures for the sale and resale of plant, equipment, and other capital assets. Policies for projects carried out over several years are no different in principle from those governing single-year projects. Once an investment appraisal has been undertaken and a capital expenditure plan is produced by the hospital, and once any necessary authorization from the RHA, NHS management executive, and/or Treasury has been obtained, the capital requirements of the project are incorporated into the hospital's current and future plans. In the case of multiyear projects, it is likely that capital requirements will have first claim on the capital budget once the project is under way.

DMUs are not allowed to raise private funds for the purchase of building capital or equipment, al-

though they may accept donations of equipment (e.g., equipment purchased by a charity). Charitably donated assets need not be included in the capital charging procedure.

NHS Trusts are allowed to finance their capital requirements from internally generated income, including contract income and income from the sales of assets, and from external borrowing. External borrowing is subject to external financing limits (EFLs), which are cash limits set by the Department of Health following negotiations with the Treasury. An EFL is set globally and for each Trust and may be positive (i.e., the allowable capital spending limit is in excess of the Trust's internally generated capital funds), neutral, or negative (i.e., the allowable agreed capital spending limit is less than internally generated capital funds). Trust hospitals are required to provide evidence that they are likely to win enough purchasing contracts to cover the costs of major capital schemes.

All capital investment projects by NHS Trusts or DMUs will continue to require external authorization under the reformed health system if they exceed certain limits. At present, a Trust must obtain approval from a regional office of the NHS management executive for any capital project in excess of 1 million pounds, approval from the national office of the NHS management executive for any capital project in excess of 10 million pounds, and approval from the Treasury for any project in excess of 15 million pounds. In addition, RHAs have their own limits above which national authorization is required, varying from approximately pounds 1 to 5 million.

Private sector hospital investment in land, buildings, or equipment is not subject to government control. No mechanism exists to prevent replications of the provision of services or equipment by the public and private sectors. Contracting between these sectors for services is encouraged by the purchaser/provider split introduced in the NHS reforms. In addition, public and private sectors may enter into formal partnerships involving capital schemes, leases, or shared access to capital.

■ Capital Expenditures

In the 1989-90 fiscal year, total capital expenditures for all hospital and community health services equaled 1,299 million pounds.⁷ The Department of Health suggests that it would not be unreasonable to assume that this was apportioned roughly in line with the breakdown of operating expenditures. This would suggest that acute care hospital capital expenditures totaled 556 million pounds, equivalent to 4.28 percent of total hospital expenditures, 2.6 percent of national health expenditures, and 0.11 percent of GDP.

Of the aggregate capital expenditures for hospital and community health services in 1989-90, 58 percent was for buildings and engineering works, 2.5 percent for vehicles, 12.1 percent for equipment and furniture, and 27.4 percent for other items.

Aggregate capital spending is controlled by the nationally cash-limited system and by internal and external auditing, similar to operating expenditures. Historically, capital funds have been particularly subject to modification in light of prevailing macroeconomic and political factors. For instance, capital funds ran at very low levels in the 1950s and fell substantially during the later 1970s, causing the House of Commons Public Expenditure Committee to express concern at the overall balance between capital and operating funds.

HOSPITAL INDICATORS AND TRENDS

In fiscal year 1990-91 there were approximately 115,000 acute care beds available in the NHS providing 5.8 million inpatient episodes. The average length of stay was 6.3 days, lower than in the United States, and the average occupancy rate of hospitals was quite high (at least as compared with the United States) at 87 percent. NHS acute care hospitals dealt with 1.2 million day cases, 7.5 million new outpatient visits, and 11.2 million accident and emergency visits.

In the private sector, there was a total of 10,906 beds in acute care medical and surgical hospitals in 1990. The average occupancy rate was lower

than in NHS hospitals and more closely matched the average occupancy rate of U.S. hospitals at approximately 60 percent. The average rate of occupancy of the 3,000 pay beds within NHS hospitals by private patients is about 30 percent.

FUTURE DIRECTIONS

The greatest achievement of the NHS has probably been to provide universal access to medical care, mainly based on need, at a low cost as compared with other OECD countries. This has been achieved at a price, however, in terms of some poor facilities, delay in obtaining access to nonemergency care, and some political unpopularity.

Control over health service expenditures comes from the nearly complete cash limitations of the system and various controls on access (in particular, gatekeeping practices by general practitioners). The NHS experience **suggests that** avoidance of rapid growth in health care costs requires overall control of budgets. It also may help to have a large share of services provided by professionals paid salaries or via capitation. It is interesting that the NHS reforms did not change these features, which are often associated with effective cost containment. Competition between providers may lead to greater efficiency and lower costs, but there is no evidence yet that this has occurred.

The extensive review of Britain's National Health Service and the resulting reforms followed a heated public debate about the level of funding for health care. No significant change was made, however, to the main source of funds, and no additional spending was introduced as a direct result of the reforms. Instead, the reforms primarily restructured the internal configuration of the British health system by introducing "internal markets" for health care services.

The main elements of these reforms affecting hospitals include the following:

- the introduction of contractual funding that separated the provider and purchasing roles for

⁷ No information on capital expenditures is available by type of hospital.

health services within the NHS, designed to encourage efficiency through “managed competition” among providers;

- the introduction of GP fundholding practices designed to increase the efficiency and quality of care;
- the ability of purchasers, especially DHAs, to choose from a wide range of providers, thereby enhancing competition and consumer choice; and
- a broader accounting of capital costs to encourage hospitals to use capital more efficiently.

It is difficult at this early stage to evaluate the changes in detail, as many are in the early stages of implementation and data are scarce. In addition, the government has done little to encourage systematic evaluation of the reforms. There are reasons to expect some important benefits from the changes, however. Introducing an awareness of capital costs is likely to improve the efficiency with which assets are used. Separating purchasers from providers potentially allows health authorities to concentrate on the health care needs of their populations instead of simply on running facilities. However, the small amount of available evidence shows little progress in purchasing for health gain (i.e., purchasing packages of health services that have been or can be shown to maximize effects on the population’s health), and patterns of service delivery still largely reflect historical patterns.

The early experience with Trust hospitals has been mixed. Financial controls have sometimes been inadequate, and it is not yet clear what will happen if Trusts fail to generate sufficient income to stay in business. There is some evidence of improved efficiency in the provision of services by Trust hospitals, but also some evidence that measured improvements largely reflect changes in the recording of work rather than in the actual volumes of services delivered. The need for a good system of workload classification of has become apparent.

The health reforms appear to have led to an increase in the costs of managing the NHS, although no accurate data on this phenomenon exist. It can be argued that the pre-reform NHS devoted inadequate resources to management and that possible increases can be justified on the grounds of more efficient services. It is not yet clear, however, whether the additional costs of administration can be justified.

The reforms have re-ignited the debate on equity and access to care. Patients whose GP is a fundholder have apparently been able to obtain more rapid access to services at the expense of other patients. There is little doubt that some unequal access has resulted. Yet the move to funding populations according to their size, age, sex distributions, and morbidity patterns is moving resources away from historically overfunded regions and districts and toward those that have been underfunded.

The process of setting priorities for access to health care is increasingly visible following the reforms. Purchasers have a duty to buy services to meet the needs of their communities to the greatest extent possible. This has helped reveal the paucity of evidence available on health care needs, and some of the more visible signs of rationing have been controversial. Any system of health care that gives access to all, free or nearly free at the point of use, and that aims to control overall expenditures, needs explicit rationing for some services.

Overall, the NHS reforms attempt to increase accountability, introduce certain market incentives, and increase efficiency and patient choice. It is perhaps more interesting to note the features of the former system that have not been changed than those that have been reformed. General revenue financing of health care, free and universal access to services, and a range of cost-controlling features have been maintained in the United Kingdom’s current health care system.

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