Health Care Expenditure and Financing in the United Kingdom

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C O N T E N T S

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EXECUTIVE SUMMARY

1. The UK government provides comprehensive health services to its people through the National Health Service (NHS). The NHS provides universal coverage, access and provisions for care at all levels. Most of these services are provided free at the point of delivery and according to people's clinical need.

2. The NHS is accountable to the Secretary of State for Health who is responsible to Parliament for the operation of the NHS as a whole. The NHS Executive sets objectives for the NHS and monitors Health Authorities (HAs). The HAs, together with primary care groups (which provide primary health care), NHS Trusts (which provide secondary, tertiary and community health care) and local authorities (which provide community health care jointly with the NHS trusts) identify the health needs of local people and allocate resources to meet the needs.

3. UK's total health care expenditure has been increasing over the past few decades. However, its proportion to GDP remained broadly constant in the same period. Growth rate of total health care expenditure was also in line with that of GDP. Total health care expenditure could be said to have been effectively controlled.

4. Since 1948 all UK governments have met their obligations and paid for the NHS and its related health services. In 1995, over 85% of health care expenditure was taken up by the public sector, with the remaining 15% from the private sector. Of the public sector (i.e. the NHS), 89% of its finance came from the government. Of the private sector, the main source of finance is private insurance. Since 1983, the proportions of these sources have not changed considerably.

5. NHS expenditure was the largest component in the total health care expenditure. Heavy emphasis was placed on curative care. Of the private health care expenditure, the largest expenditure item was long term health care. The second largest expenditure item was drug expenses.

6. There has been a general improvement in the health conditions of the UK population. Crude death rate, infant mortality rate and maternal mortality rate have been falling since 1980s. There was also progress made in life expectancy, teenage conception rate and adult smoking prevalence rate.

7. Waiting lists of in-patient and day cases of England tended to grow in the period 1991-1995 though the average waiting time for treatment had been improved. There was also a slight improvement of waiting time for out-patient cases.

8. It is reported that the availability of some treatments in the UK has been very limited. In a study by Aaron and Schwartz, it was found that both the number and types of treatments offered by the UK health service providers were fewer than that offered by their counterparts in the US.

9. Hong Kong has a lower per capita health care expenditure than that of the UK. The public and private sectors of Hong Kong share roughly the same proportion of financing of health care services (44% and 56% respectively) whereas in the UK, public sector takes up 85% of total health care financing and the private sector takes up the remaining 15%.

HEALTH CARE EXPENDITURE AND FINANCING IN THE UNITED KINGDOM

PART 1 - INTRODUCTION

1. Background

1.1 The Provisional Legislative Council (PLC) Panel on Health Services requested the Research and Library Services Division (RLS) to research on overseas health care financing system so as to facilitate their deliberation on a similar review which the Secretary for Health and Welfare would complete in 1998. This research report studies health care expenditure and financing in the United Kingdom.

2. Objective and Scope

2.1 The objective and scope of this research as agreed by the Panel are as follows:

(1) describe the health care system of the United Kingdom (UK);

(2) describe and analyse changes in the expenditure pattern of the health care system in the UK;

(3) describe and analyse health care financing arrangement in the UK.

3. Methodology

3.1 The study involves a combination of information collection, literature review and analysis.

3.2 In addition to materials available in the Provisional Legislative Council library, reference materials were borrowed from local academic libraries or acquired from UK publishers. Requests for information were sent to the Department of Health of the UK government, the National Health Service (NHS) and the Research Services of the House of Commons Library of the UK. In addition, reference has been made to the research findings of research institutions, past UK government reports and from the Internet. Where aggregate health care and its related data for the whole UK were not available, data on health expenditure, financing and health statistics of England were used as proxies. The data in England have been chosen as proxies because the population in England accounted for over 83%[1] of total population in the UK in 1993 and the NHS expenditure in England accounted for 80%[2] of total NHS expenditure in the UK in 1996-97.

1 Central Statistical Office, *Annual Abstract of Statistics*, 1995, p. 6-8.

2 Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999*; http://www.official-documents.co.uk/document/cm39/3912/

PART 2 - HEALTH CARE SYSTEM IN THE UNITED KINGDOM

4. Health Care System

Introduction

4.1 The government of the United Kingdom (UK) has taken up the responsibility for providing public health services to its citizens since 1948 through the establishment of the National Health Service (NHS). Before 1948, public health care services were provided only to people who could pass a means test. There was also a National Health Insurance Scheme but coverage was limited to a small group of labour force[3] and only limited medical services were provided. There were also some charitable hospitals offering fragmented medical care to the poor.[4]

4.2 After the establishment of the NHS in 1948, all hospitals were nationalized and virtually all doctors were employed by the NHS. Hence, after 1948, there has effectively been only one kind of health care system in the UK, the NHS. Yet, in recent years, private sector health care facilities flourished again. They provide service not only in areas such as elective surgery where public provision is also universal, but also in areas where NHS coverage is limited.[5] These services range from hospices, nursing and convalescent homes to chiropody, hernia or varicose veins and services not available at all district hospitals, such as ear, nose and throat services. It is reported[6] that nearly one tenth of the UK's health care was provided by the private sector in 1992 whereas in the past, its contribution was mainly in the provision of nursing homes for the elderly.

4.3 The NHS provides a comprehensive range of health care services to UK citizens (population: 59 million in 1996). They include primary health care (through family doctors (GPs), opticians, dentists and other health care professionals), secondary health care (through hospitals and ambulance services) and tertiary health care services (through specialist hospitals). Community health care services are provided jointly with local authorities.

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3 Only working people with a low income were covered by the Scheme. The unemployed, dependents of those in employment, the middle and the upper classes were not covered.

4 Appleby, *Financing Health Care in the 1990s*, Open University Press, 1992, p. 15.

5 *White Paper on Working for Patients*, presented to Parliament by the Secretaries of State for Health, Wales, Northern Ireland and Scotland, Jan. 1989. p. 67.

6 Newdick, *Who Should We Treat?* Clarendon Press, Oxford, 1995, p. 71.

4.4 Although there were a number of reforms introduced to the NHS since its establishment, the NHS has not altered its financial underpinnings. That is, the NHS remains a tax-based financed health care system. 89% of the NHS financing in England[7] comes from the government. Except for certain services such as sight test, dental care and home-help, most NHS services and facilities are provided freely and according to people's clinical need.

5. Policy Objective

5.1 The mandate of the NHS as set out in the NHS Act of 1946 is to *"... be a comprehensive health service designed to secure improvement in the physical and mental health of the people...and the prevention, diagnosis and treatment of illness... . The services so provided shall be free of charge, except where any provision of the Act expressly provides for the making and recovery of charges.*"[8]

5.2 The new Labour Government (elected in 1997) has not changed the above principle: *"...access to it [NHS] will be based on need and need alone - not on your ability to pay, or on who your GP happens to be or on where you live*." [9] Six key principles were introduced by the new Government [10]:

(1) to renew the NHS as a genuinely national service: patients will get fair access to the NHS across the country;

(2) to make the delivery of health care against the new national standards a matter of local responsibility;

(3) to get the NHS to work in partnership;

(4) to improve efficiency by cutting bureaucracy;

(5) to focus on quality of care;

(6) to rebuild public confidence in the NHS as a public service, accountable to patients, open to the public and shaped by their views.

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7 Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999*; http://www.official-documents.co.uk/document/cm39/3912/.

8 *National Health Service Act, 1946, and National Health Service (Scotland) Act*, 1947, Section 1.

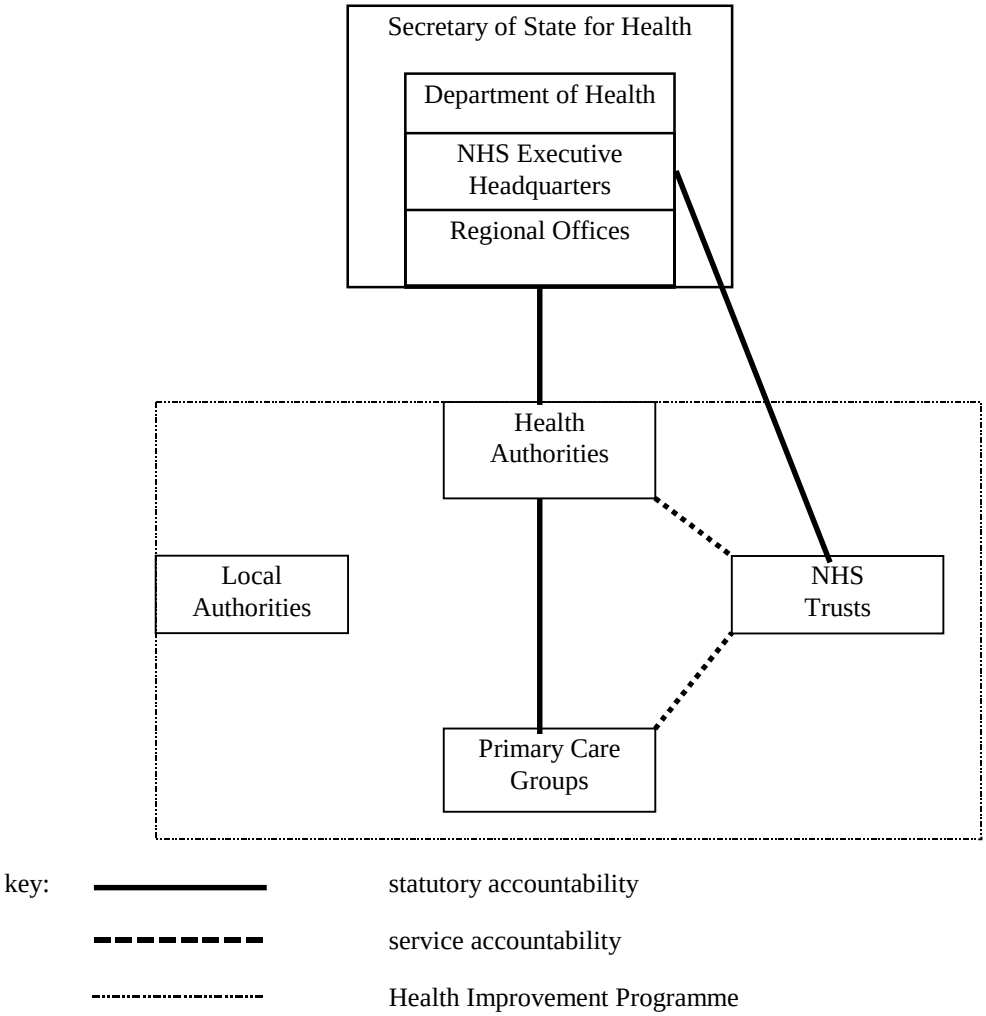
9 *White Paper on The New NHS*, presented to Parliament by the Secretary of State for Health, December 1997 p. 5.

10 Ibid., p. 11.

6. Structure of the NHS

6.1 The NHS has undergone a series of reforms since its establishment. These reforms were related to the organization and structure of the NHS and were usually accompanied by a change in government. Appendix I gives a summary of the development of NHS and its structural change. With a change of government in 1997, a new structure of the NHS was proposed. It is envisaged that these structural changes will take a period of ten years to be implemented and that the speed of change would be locally driven. (Appendix II gives the early milestones for NHS reforms in 1998-1999.) Figure 1 shows the new structure of the NHS.

Figure 1 - New Structure of the NHS, 1998



Source : *White Paper on The New NHS*, presented to Parliament by the Secretary of State for Health, December 1997, p. 21.

6.2 The NHS is accountable to the Secretary of State for Health, who is an elected politician appointed by the Prime Minister. The Secretary of State's tenure for office is at the discretion of the Prime Minister and/or depends on the results of election for government. He also sits in the Cabinet and is responsible to Parliament for the operation of the NHS as a whole. Staff of the Department of Health are civil servants who continue their work irrespective of change in government. The Department of Health is responsible for decision and action at a national level. It gives a national lead which other agencies such as Health Authorities (HAs), NHS trusts, etc. follow.

6.3 The NHS is headed by a Chief Executive who is appointed by the government. He also chairs the NHS Executive (NHSE) which sets objectives for the NHS and monitors the performance of HAs. The NHS Regional Offices are responsible for coordinating and integrating services of the HAs and the Primary Care Groups (PCGs) (to be created in 1998) at a regional level.

6.4 The new NHS structure proposes that the HAs oversee the effectiveness of the NHS locally. The chairman of each HA is appointed by the Secretary of State and is paid a part-time salary. Membership of HA includes local authority, university and professional nominees. Members are nominated not as representatives for any particular group, but as generalists so that they can make decisions on behalf of the community at large. Together with local authorities, NHS Trusts and PCGs, the HAs will take the lead in drawing up local Health Improvement Programmes (HIPs). These HIPs will identify the health needs of local people and allocate resources to meet these needs. HAs will also allocate funds to PCGs on an equitable basis and hold them to account.

6.5 PCGs will comprise all GPs in an area. They and community nurses will take the responsibility for commissioning health care services for the local community. These include providing traditional GP services, community services and purchasing secondary services. Each PCG is expected to serve around 100 000 patients. All PCGs will be accountable to HAs, but will have freedom to make decisions about resources allocation within the framework of the HIPs.

6.6 NHS Trusts provide health care services in hospitals and in the community. They will also participate in the HIPs in the new structure and form long term service agreements with PCGs. These agreements will be organized around a particular care group (such as children) or disease area (such as heart disease). NHS Trusts will have a statutory duty for quality.

6.7 It is noted that although the NHS has undergone a series of structural reforms, its funding method has not been altered, i.e., the NHS remains a tax-based financed system. The new Labour Government continues to maintain the financing of the NHS by government revenue but has introduced some changes in the distribution arrangement. More details are given in Part 4 of this research report.

7. Delivery System

Primary Health Care

General Practitioners (GPs)

7.1 Primary health care is the first point of contact for health services. Primary health care professionals include GPs, pharmacists, dentists and optometrists. They are independent and work under contract with the NHS and the terms of their contracts are subject to tight specification and regulation by the Department of Health.

7.2 GPs provide the overwhelming majority of their services free at the point of service for patients and they will be later reimbursed by the NHS. They also act as "gatekeepers" to secondary care so that a GP referral is usually required in order for a patient to see a hospital specialist, except in emergencies.

7.3 Compared with many other countries[11], the range of diagnostic procedures and treatments that GPs carry out in the UK is very limited. For example, few GPs have X-ray facilities or specimen testing equipment. Most of them confine themselves to treatment of minor illness through drug therapy and refer patients requiring specialised investigation or care to hospital specialists.

7.4 In 1994/95, there were over 26 570 GPs[12], mostly working in group practices and supported by a team of practice nurses and support staff. This represented about 4.5 GPs per 10 000 population. A typical GP has a list of 1 900 patients. As of 1996, any practice with over 7 000 patients may apply for fundholder status[13]. Services that fundholders can buy from other health care providers include diagnostic tests, out-patient services, some community health services and a defined group of in-patient and day cases, such as hip replacements and cataract removals. The more expensive and complicated types of hospital treatment are excluded. As of 1996, over 3 500 practices[14] became "fundholders". This covered over 24.5 million patients.

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11 Booer, "The Health Care System in the United Kingdom" in *Financing Health Care* edited by Hoffmeyer and McCarthy, Kluwer Academic Publishers, 1994, p. 1093.

12 Department of Health, *Departmental Report 1996*, p. 45.

13 Large GP practices (with over 7 000 patients) can apply to the local Health Authority to become a fundholder. A fundholder can hold and manage a budget which is designed to buy a limited range of health care services for the patients on their lists. This budget could not be used to increase GPs' own incomes nor to benefit the practice generally.

14 NHS, *A Guide to the National Health Service*, 1996. p. 6.

Pharmacies

7.5 Approximately 94% of prescriptions written by NHS GPs are dispensed through retail pharmacies. There were approximately 12 300 retail pharmacies in the UK in 1991[15]. Retail pharmacies must be run by a qualified pharmacist and are generally privately owned, although there is an increasing number of pharmacy chains. Pharmacies are registered with, and inspected and controlled by, the Royal Pharmaceutical Society of Great Britain. The siting of retail pharmacies is under HA control. Almost all retail pharmacies work under contracts to the NHS.

7.6 Some GPs have dispensing rights. Approximately 6% of NHS prescriptions come through dispensing doctors.

7.7 Most hospitals have a pharmacy. The NHS hospital pharmacy service dispenses nearly all prescriptions written by hospital specialists. However, dispensing of hospital prescriptions by retail pharmacies is becoming more common.

Other Primary Health Care Professionals

7.8 In 1994/95, there were 15 890 dentists[16] providing preventive and restorative treatment to patients in England. Eye services are provided by optometrists working in the private sector. In 1994/95, the number of optometrists and ophthalmic medical practitioners working in England was 6 620. Other primary care providers include health visitors who look after new-born babies and children under five years old, midwives, community nurses, physiotherapists, occupational and speech therapists.

Hospital Services

7.9 NHS hospitals are owned by the public sector and are expected to provide care services within the agreed budgets. Each district has an acute general hospital, which aims to provide a comprehensive range of services. Some specialty services such as those with a low incidence or prevalence rate are provided on a regional instead of on a district basis. There are also some specialties such as heart transplantation which are organized on a national basis. Teaching is concentrated within a number of major hospitals in London and a number of provincial teaching hospitals associated with university departments.

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15 Booer, "The Health Care System in the United Kingdom" in *Financing Health Care* edited by Hoffmeyer and McCarthy, Kluwer Academic Publishers, 1994, p. 1102.

16 Department of Health, *Departmental Report 1996*, p. 45.

NHS Trusts

7.10 NHS trusts are hospitals and/or those offering ambulance services which are managed by their own boards of directors and are independent of HA control. The board of directors are appointed by the Secretary of State, with a mixture of executive and non-executive members, led by a part-time chairman. NHS trusts have a majority of doctors, nurses and other health service employees working as salaried employees for the NHS or having a close contractual relationship with the NHS.

7.11 Doctors working in NHS hospitals are employed on a salaried basis. However, it is common for senior medical staff (consultants) to hold contracts which allow them to engage in private practice and they are in such circumstances paid on a fee-for-service basis. Consultants holding full-time NHS contracts are permitted to earn up to 10% of their gross income from private practice. Consultants on part-time contracts are able to engage in private practice without restriction on their earnings.

7.12 According to a report on "Private Medical Services" for the Monopolies and Mergers Commission (1993), 17 000 out of some 20 000 NHS consultants (around 86%) carried out private practice. Their annual incomes from this source ranged from £1,000 to £400,000. The average consultant worked 35 hours a week for the NHS and another six hours in private practice.

7.13 There were about 280 major district general hospitals[17] in England in 1996. Traditionally, hospital capacity has been measured by the number of hospital beds. However, new treatment has led to a significant increase in day care and a fall in the number of long-term wards. For example, between 1984 and 1995, the number of available beds for all clinical specialist services fell from 335 000 to 212 000, while the number of in-patient cases treated rose by more than one-third. [18]

Private Hospitals

7.14 In 1991, there were 216 private hospitals with operating theatres in the UK. The total number of private beds in registered private hospitals or clinics was 133 500. The NHS also has 3 000 dedicated pay beds. These are beds in normal NHS wards that may be used for treating private patients.

7.15 These private hospitals are mainly staffed by NHS doctors undertaking private practice on a part-time basis. Nursing and other staff are usually employed exclusively within the private hospital.

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17 NHS, *A Guide to the National Health Service*, 1996. p. 8.

18 Ibid.

Community Health Services

7.16 Community health services are organized on a district basis and comprise a range of residential, day care and domiciliary services for elderly people and for people with mental illness and mental disabilities. Services such as health visiting, school nursing, chiropody and physiotherapy are also provided. They are usually health services other than primary care services and are provided by NHS trusts. In many instances, community health services overlap with social care services offered by local government social service departments.

To Whom are the Services Provided?

7.17 Health care services are provided universally. In 1996, there were 59 million people in the UK. (Please see Appendix III for population statistics.) These services are provided, for the most part, free at the point of delivery. In 1996, around 14% of the population had some form of additional private insurance cover for a specified range of services. These usually covered elective medical / surgical procedures for which there was often long NHS waiting time.

PART 3 - FINANCING ARRANGEMENTS

8. Development of Financing Policy

The 1950s - The 1970s

8.1 The NHS came into operation in 1948. Since then, it has been a national health service financed from taxation available to everyone. Resources allocated to the NHS were based on past expenditure patterns. Charges were introduced in 1951 on sight tests and dental examination and this markedly reduced the number of people presenting themselves for such services[19]. Prescription charges were introduced in 1952, abolished in 1965, but re-introduced in 1968 for control of demand[20].

8.2 In the early 1970s, when the growth of the economy slowed down, allocations were made cash limited[21] but with an allowance for inflation. If the inflation was higher than predicted, there were additions to allow for the provision of the planned volume of service. From 1976/77 onwards, no allowances were made for inflation and if it was higher than predicted, savings had to be found from the service.

8.3 The Resource Allocation Working Party (RAWP) was established in 1975 with the objective of allocating funds according to health need. The RAWP formula[22] began to influence allocations since 1977.

The 1980s - The Early 1990s

8.4 Following a review of RAWP and the implementation of the Working for Patients reforms, a revised weighted capitation formula[23] based on resident population was introduced in 1991. Patients were allowed to pay for private beds in NHS trust hospitals, and this money was counted as income for the trust. All hospitals were subject to fixed pricing set by the Department of Health. There were also some changes introduced in fees and charges. By 1994, 85% of all prescriptions charges were exempted[24].

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19 Levitt, Wall and Appleby, *The Reorganized National Health Service*, Chapman & Hall, 1996, p. 111.

20 Pregnant women, mothers, children, some elderly people and patients with some chronic conditions have been exempted from these prescription charges.

21 A cash limit is a set limit on the amount of money the Government proposes to spend or authorize on certain services during a financial year.

22 This RAWP formula suggested that each Region would have a target allocation based on the age structure of its population and factors affecting the need for health care.

23 Weighted capitation means that the distribution of funds is based on the number of residents served by each health care purchaser, and is weighted for age and morbidity of the residents served.

24 Levitt, Wall and Appleby, *The Reorganized National Health Service*, Chapman & Hall, 1996, p. 111.

1994 -1997

8.5 A thorough review of the funding formula was conducted and a modified formula began to influence allocations for 1995-96. It included estimates of each area authority's population, application of age weights, needs weights, market forces factor, i.e. cost of providing health services.

1997 Onwards

8.6 The new Labour Government now proposes that resources would be allocated to PCGs first and through the PCGs to provide for Hospital and Community Health Services (HCHS), prescription expenses and GPs.

8.7 A new "Advisory Committee on Resource Allocation" is to be established to refine the formula for allocating resources for both primary and secondary services.

9. Distribution of Government Funding

9.1 The cash allocation for the NHS is determined each year as part of the Department of Health's allocation through the government's annual public expenditure allocation process. This is a competitive bidding process in which individual spending departments submit proposals that are negotiated with the Treasury. Once an overall health expenditure level has been agreed, the Department of Health allocates the health care budget to the HAs.

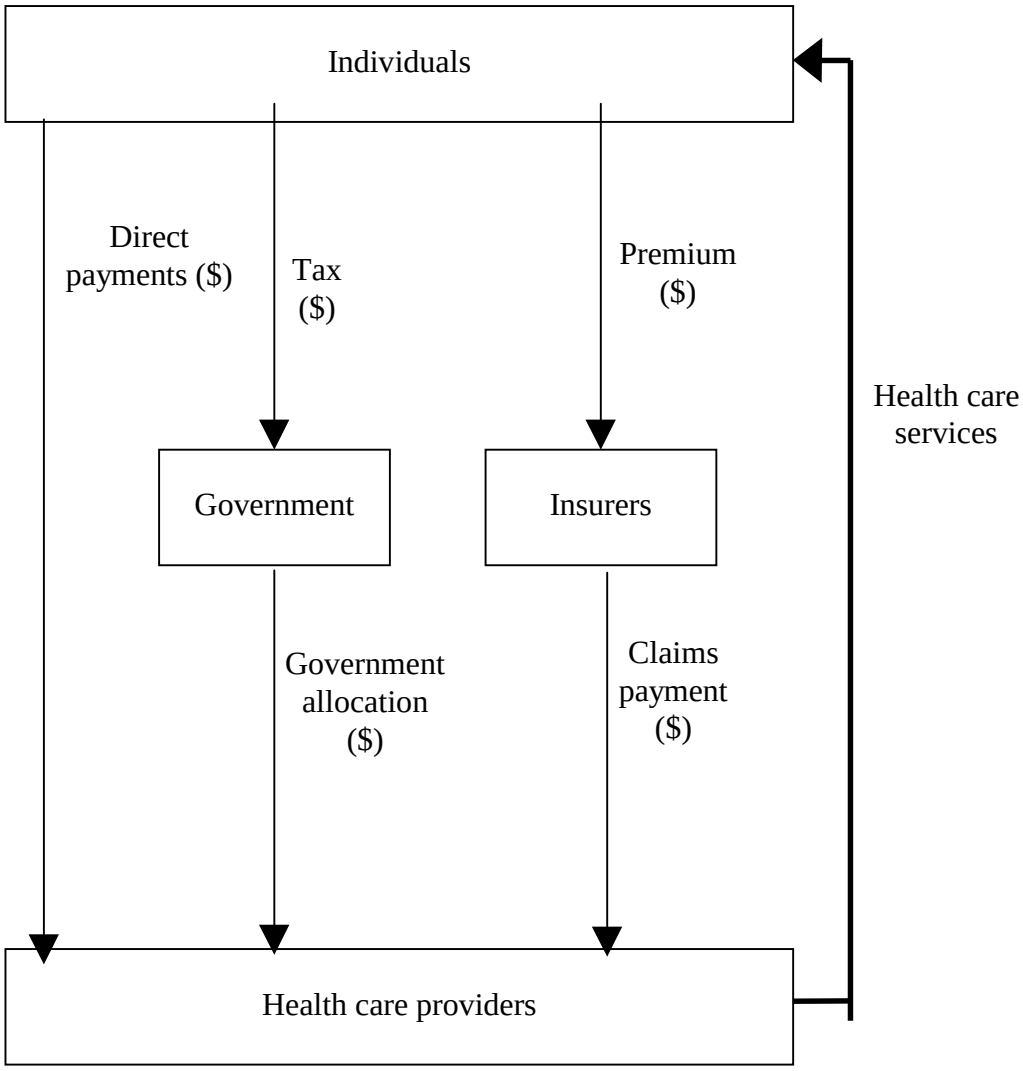
9.2 The new Labour Government in 1997 proposed to combine the HCHS budget, the cash limited GP budget and part of the non-cash limited GP budget into one single cash-limited allocation. There will be no fixed limit on individual parts of the budget but each budget as a whole will be cash limited. Hence, there will be flexibility of moving spending between GP services and secondary services but the overall spending will be controlled.

10. Features of UK Health Care Financing Arrangements

10.1 Financing in this paper refers to financing for health care services, and medical research and construction of health care facilities from the point of view of health care providers. There are three main sources of financing : directly from the government, directly from individuals and organizations in the private sector and indirectly through insurance companies.

10.2 Figure 2 describes the flow of funds from various financing sources to health care providers in return for services provided to individuals. Financing of health care by the government directly and indirectly through insurance schemes is classified as public financing on health care. Financing by individuals or organizations in the private sector directly and indirectly is regarded as private financing on health care.

Figure 2 - Health Care Financing



Public Sector

Taxation

10.3 The government is committed to finance the national health service from taxation. The effect of this financing arrangement is a re-distribution of resources to people who require more health care services. The tax rates are progressive in nature: lower tax rates are associated with lower income levels. For people aged 65 years and above, they also enjoy a higher level of personal allowance.

10.4 In 1994-95, the number of taxpayers was 25.7 million people (43.6% of total population). The average amount of tax payable was £2,680[25]. In 1971, income tax took up about 14% of household income. This proportion increased to 17% in 1976 and then fell to 12% in 1993[26].

National Insurance Contributions

10.5 National Insurance Contributions (NICs) are equivalent to a tax on earned income. They are paid by employers and employees within the Pay As You Earn (PAYE) system. The NICs are used to finance state pension (basic retirement pension and State Earnings-Related Pension Scheme), unemployment benefits, incapacity benefits and widow's benefits. Entitlement to all these benefits is based to some extent on the contributions made. In addition, some NICs (but with no fixed amount or proportion) are used to finance the NHS.

10.6 Contribution rates are set at the time of the annual Budget. There is a lower earnings limit (LEL) and an upper earnings limit (UEL). In 1996-97, the LEL and UEL were £61 and £455 a week[27]. No contributions are paid if earnings are below the LEL. For employees, their NICs rates for 1996-97 were 2% of the first £61 earned and 10% of earnings between £61 and £455. Employers' contributions are based on upon employees' incomes and for 1996-97, their rates varied between 3% to 10.2%, depending on the income level. [28]

25 Central Statistical Office, *Social Trends*, 1995 edition, p. 84.
26 Ibid.
27 http://www.open.gov.uk/
28 Ibid.

Private Sector

Direct Payment

10.7 Although most NHS services are free at the point of use, charges are imposed on some services. These have to be met by private individuals or their employers. There are guidelines imposed by the Department of Health regarding the level of fees and charges: *charges should be based upon average total costs, that there should be no planned cross-subsidization between services and that marginal cost pricing is only appropriate in cases where there is short-run, unused capacity. Moreover, each hospital is expected to earn a 6% return on the current value of its assets.*

10.8 Introduction of charges for sight tests and dental examination started in 1951. Prescription charges were first introduced in 1952, abolished in 1965 and then re-introduced in 1968, since when they have been increased virtually on an annual basis. Increasing amounts of money have been raised by charges, despite increases in the number of people exempted from paying. By 1994, about 85% of all NHS prescriptions were dispensed free of charge to groups exempt from payment[29]; they include people over the retirement age of 65 years, children under 16 years and those receiving various social security payments. The remainder have been subject to a flat rate charge. Alternatively, patients could purchase a "season ticket", covering an unlimited number of prescriptions during a period of four to twelve months. Annual season tickets are priced at about the cost of 13 individual prescriptions. [30]

10.9 Self medication for the relief of symptoms or health promotion is popular in the UK. It is estimated that one in three of the population is self medicating at any time.[31] Therefore, consumption of over-the-counter drugs, pharmaceuticals, health supplements and equipment are paid for out-of-pocket by private users. Moreover, expenses on alternative medicine such as homeopathy, osteopathy, spiritual healing, acupuncture, etc. are also met by out-of-pocket private patients.

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29 Levitt, Wall and Appleby, *The Reorganized National Health Service*, Chapman & Hall, 1996, p. 111.

30 Booer, "The Health Care System in the United Kingdom" in *Financing Health Care* edited by Hoffmeyer and McCarthy, Kluwer Academic Publishers, 1994, p. 1101.

31 Appleby, *Financing Health Care in the 1990s*, Open University Press, 1992, p. 61.

Private Insurance

10.10 According to Appleby (1992), private medical insurance is the major source of health care financing from the private sector. Of the purchasers of medical insurance - individuals, employees and companies -- the number of individual purchasers has fallen from 43% of total purchasers in 1972 to 27% in 1987. The number of employee purchasers has remained relatively static, while company purchasers have increased from 40% to 56%. According to Orton and Fry (1995), company-paid subscriptions accounted for 60% of all subscriptions in 1993, with the remaining 40% by individuals and employees.

10.11 The majority of subscriptions were taken out by employers for their employees as fringe benefits. In 1980, tax concession were introduced for employers who made contributions on behalf of their staff with incomes below £8,500. By the early 1980s, most large employers were offering health insurance to their senior managers. Since 1980s, white collar unions have also taken out subscriptions on behalf of their members[32]. Research studies [33] show that those who have private health insurance tend to have professional and managerial jobs. In 1987, 29% of those with degrees and 41% of those with incomes above £26,000 a year had taken out insurance. This compared to 7% of the least well-qualified and 4% of those in the lowest income group.

10.12 Private insurance is usually limited in coverage and is used to top up provision for elective procedures for which there are often long waiting times within the NHS. It does not usually cover primary health care.

10.13 Since 1990, the government has introduced tax relief on medical insurance premium payments for elderly people (people aged 60 years and over) with a taxable income or those who pay the premiums for elderly people.

Others

10.14 Sources[34] other than government and direct payments by private households of financing the NHS include charitable donations, income generation, land and estates sales. Income generation refers to income mainly generated from flower shops, cafeterias in hospitals and the like by the NHS. The NHS is also allowed to sell surplus land and buildings to generate income.

[32] Allsop, *Health Policy and the NHS: Towards 2000*, Longman, 1996, p. 162.
[33] Ibid., p. 164.
[34] Appleby, *Financing Health Care in the 1990s*, Open University Press, 1992, p. 10.

PART 4 - ANALYSIS OF HEALTH CARE EXPENDITURE AND FINANCING

11. Total Health Care Expenditure

11.1 Since the NHS has undergone a new structural change in 1997, budget for the new structure is not available. As a result, tables and charts in Part 4 give figures on the UK health expenditure and financing under the previous NHS structure. There are also instances where data for the entire UK are not available; hence, data for England are used as proxies.

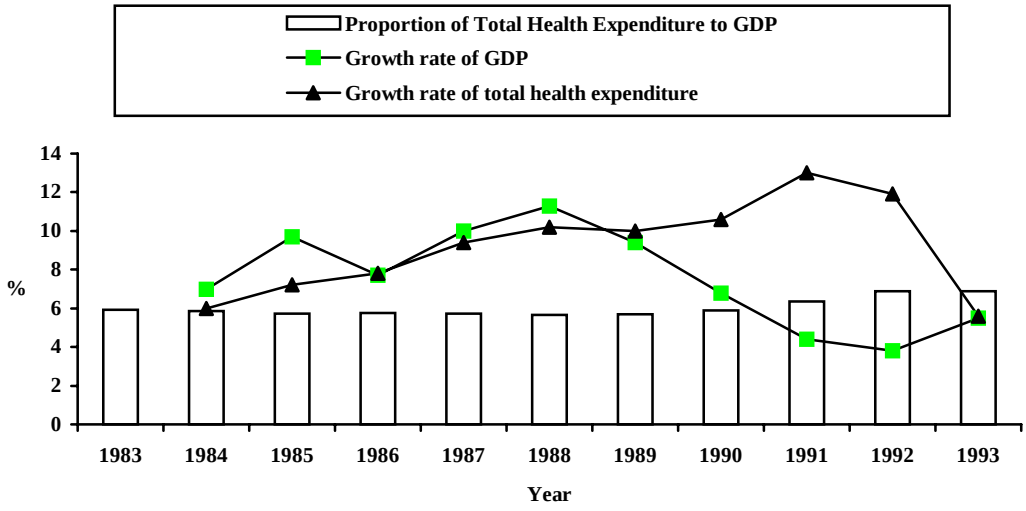
11.2 Total health care expenditure is the sum of what the government, individuals and organizations in the private sector spend directly or indirectly on health care services, administration of health insurance programmes, health education, medical research and construction of health care facilities. Table 1 and Figure 3 show the UK total health expenditure against Gross Domestic Products (GDP) in the period 1983-1993.

Table 1 - UK Health Expenditure, 1983-1993

Year	Total UK Health Expenditure (£m)	GDP (£m)	% of Total Health Expenditure of GDP
1983	18,046	304,456	5.93%
1984	19,120	325,852	5.87%
1985	20,506	357,344	5.74%
1986	22,111	384,843	5.75%
1987	24,198	423,381	5.72%
1988	26,671	471,430	5.66%
1989	29,333	515,957	5.69%
1990	32,443	551,118	5.89%
1991	36,657	575,321	6.37%
1992	41,004	597,121	6.87%
1993	43,313	630,023	6.87%

Remark: data are presented in calendar year.
Sources:
1. *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 166.
2. Central Statistical Office, *Annual Abstract of Statistics 1995*, p. 237.

Figure 3 - Total UK Health Expenditure Against GDP, 1983-1993

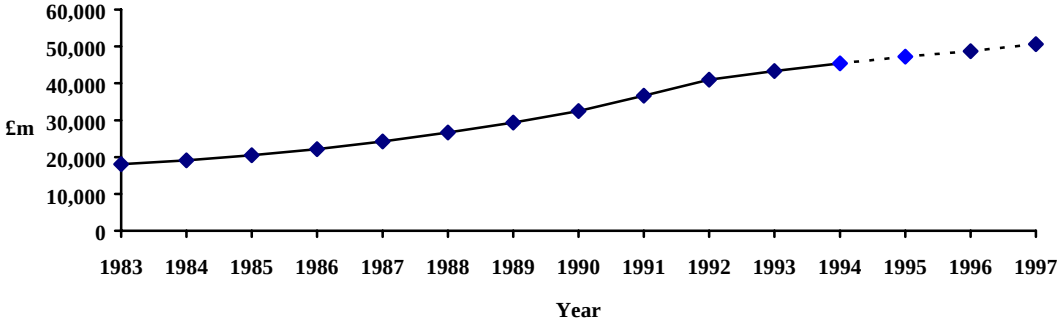


Sources:
1. *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 166.
2. Central Statistical Office, *Annual Abstract of Statistics* 1995, p. 237.

11.3 It is noted from Figure 3 that the proportion of total health expenditure to GDP remained broadly constant in the period. The annual growth rate of total health expenditure was also broadly in line with GDP annual growth except in 1990-92 where the growth of total health expenditure outpaced the growth of GDP. This was because in 1990-1992, a new reform was introduced and the government had increased the health budget as an upfront investment to improve and maintain the services of the NHS. In 1993, the annual growth rate of total health expenditure was equal to the growth rate of GDP again.

11.4 Figure 4 shows the change of total health care expenditure between 1983-1993 and the estimated change of total health expenditure between 1994-1997. It is noted that in the period 1983-1993, there was an increase of 140% in the total health expenditure. If we compare total health expenditure between 1983-1997, the increase amounted to around 181%.

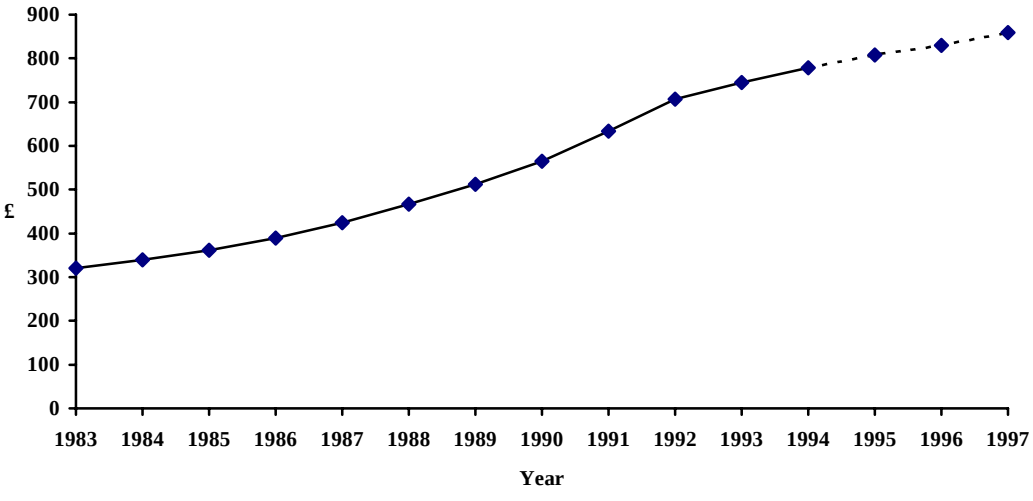
Figure 4 - UK Total Health Expenditure, 1983-1997



Remark: Data from 1994-1997 were projected figures.
Source: *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 166.

11.5 Health expenditure per person also increased 133% between 1983 and 1993. It was estimated that this expenditure would increase further by 10% from 1994 to 1997. Figure 5 shows the trend of health expenditure per person.

Figure 5 - Health Expenditure Per Person, 1983-1997



Remark: Data from 1994-1997 are projected figures.
Source: *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 166.

11.6 Table 2 compares the total UK health care expenditure with the mean of total health care expenditure of OECD[35] countries. It is found that both the UK and the OECD's total health expenditure as % of GDP and public expenditure on health care as % of GDP had been increasing since 1985. However, the UK figures were smaller than those of the OECD mean throughout the studied period. One reason for this "low" level of expenditure is that the UK government has introduced various measures to control health expenditure. More details are given in Part 5 of this research report.

Table 2 - UK Health Care Expenditure Versus OECD Mean

	Total Health Care Expenditure as % of GDP		**Public Expenditure on Health Care as % of GDP**	
	UK	OECD Mean	UK	OECD Mean
1985	6.0	8.8	5.1	5.0
1990	6.1	9.2	5.2	5.5
1991	6.6	9.6	5.6	5.8
1992	7.1	9.9	6.0	6.1
1994	6.9	10.2	5.8	6.2
1995	6.8	10.4	5.8	6.4

Source:
1. *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 167.

Discussion

11.7 Total health care expenditure has been increasing over the past ten years and it is expected that this increasing trend will continue. This might be owing to the growth of general population and the population is also aging. Between 1981 and 1996, general population increased by 4% whereas the increase of elderly population (people aged 65 years and above) in the same period was 10%. Trends within this age group are also important as the proportion of very old people (people aged 80 years and over) is also rising. In 1971, people aged 80 years and above accounted for 2% of the total population. In 1993, this proportion had risen to 4%[36]. (Appendix IV gives the breakdown of UK population by age.)

35 OECD stands for Organisation for Economic Co-operation and Development.
36 Central Statistical Office, *Social Trends*, 1995 edition, p. 17.

11.8 As far as health care spending is concerned, elderly people are heavy users of health services. They increase demand in a number of ways: in the number of GP consultations; the number of prescriptions; the number of admissions to hospital and the length of stay in hospital. As a result, per capita health care spending rises rapidly with age. More details are given in section 13.

11.9 Nonetheless, it is also noted that the growth rate of total health care expenditure increased broadly in line with that of GDP. This is possibly because expenditure was made cash limited in the studied period.

12. Total Health Care Financing

12.1 Table 3 and Figure 6 show the sources of finance of UK health care expenditure. It can be seen that around 85% of health care expenditure was financed by the public sector. Public sector financing refers to the NHS financing which has already included funding by the government. The remaining 15% of health care expenditure was met by the private sector. Private sector includes private households, business sector and insurance companies.

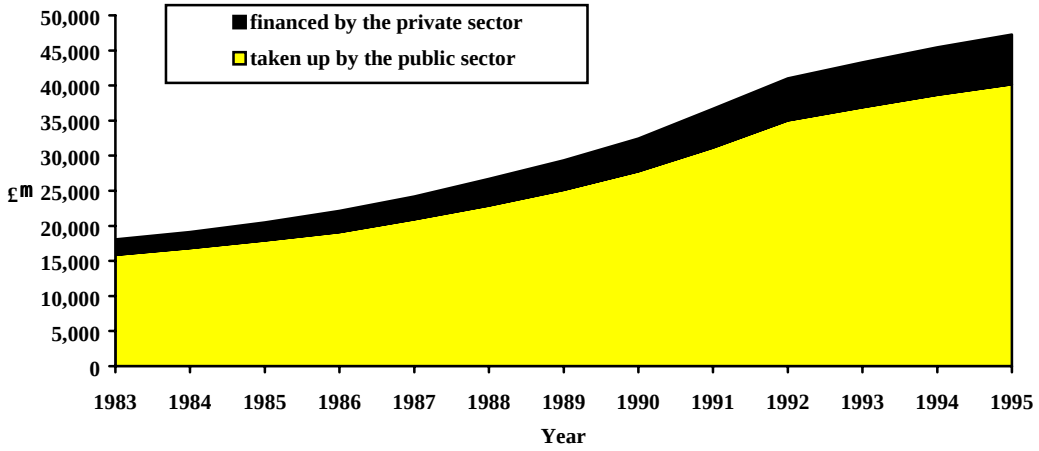
Table 3 - Sources of Finance of Health Care

Year	Total Health Care Expenditure (sum of (a) and (b))	Taken up by the Public Sector (a)		Financed by the Private Sector (b)	
	£m	£m	% of total	£m	% of total
1983	18,046	15,890	88.05	2,156	11.95
1984	19,120	16,817	87.95	2,303	12.05
1985	20,506	17,915	87.36	2,591	12.64
1986	22,111	19,109	86.42	3,002	13.58
1987	24,198	20,939	86.53	3,259	13.47
1988	26,671	22,912	85.91	3,759	14.09
1989	29,333	25,158	85.77	4,175	14.23
1990	32,443	27,798	85.68	4,645	14.32
1991	36,657	31,148	84.97	5,509	15.03
1992	41,004	35,023	85.41	5,981	14.59
1993	43,313	36,911	85.22	6,402	14.78
1994 [e]	45,447	38,680	85.11	6,767	14.89
1995 [e]	47,266	40,211	85.07	7,055	14.93

Remarks:
1. All figures relate to calendar year.
2. [e] = estimates

Source: *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 166-168.

Figure 6 - Sources of Finance of UK Health Care Expenditure



Source: *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 166.

12.2 It is noted that contribution to total health care expenditure made by the private sector has been increasing since 1983. It increased from 12% in 1983 to 15% in 1997. Contribution made by the public sector has been decreasing from 88% in 1983 to 85% in 1997. This change might be due to the increase in the types and volume of services provided by the private sector (please refer to paragraph 4.2 for details.) Nonetheless, the difference was small since the change in the proportion of health care financing was 3% in 12 years.

13. Public Expenditure and Financing for Health Care

Public Expenditure on Health Care

13.1 In this research report, public expenditure on health care is defined as the total gross NHS expenditure. Table 4 gives the public expenditure on health care against total public expenditure.

Table 4 - Public Expenditure on Health Care Against Total Public Expenditure

Year	Public Expenditure on Health Care = NHS gross expenditure (£m)	Total Public Expenditure[1] (£m)	% of Public Expenditure on Health Care Against Total Public Expenditure
1983	15,890	122,232	13.0
1984	16,817	129,361	13.0
1985	17,915	137,806	13.0
1986	19,109	142,605	13.4
1987	20,939	148,501	14.1
1988	22,912	156,930	14.6
1989	25,158	174,711	14.4
1990	27,798	193,041	14.4
1991 [e]	31,148	207,652	15.0
1992 [e]	35,023	233,489	15.0
1993 [e]	36,911	251,095	14.7
1994 [e]	38,680	257,867	15.0
1995 [e]	40,211	269,873	14.9

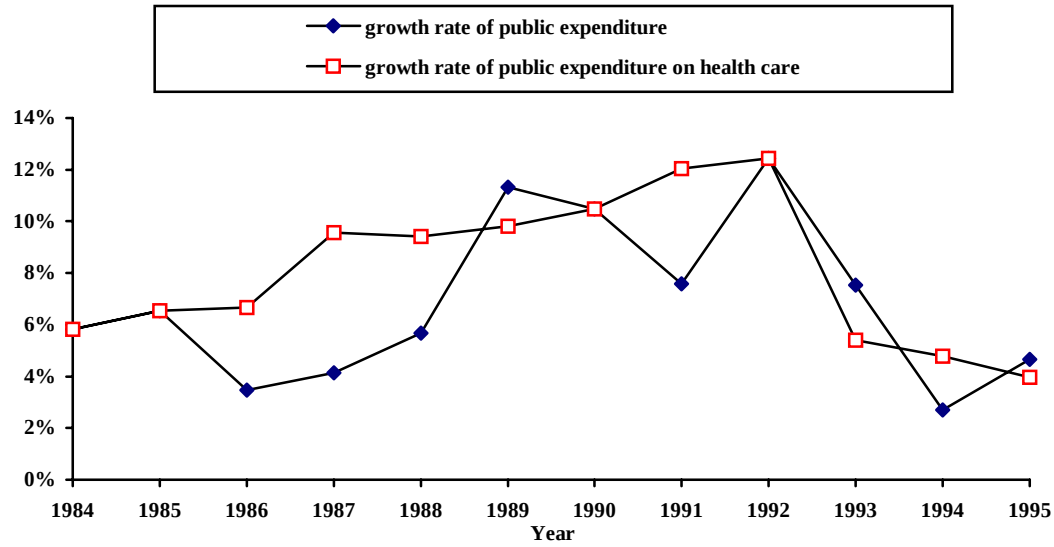
Remarks:
1. [1] = Figures relate to central government and local authority expenditure, less debt interest.
2. [e] = estimated figures
3. All figures relate to calendar year.

Source:
1. *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 166-168.

13.2 It can be seen from Table 4 that total public expenditure on health care accounted for 13% of total public expenditure in 1983 to 15% in 1995. Changes of public expenditure and public expenditure on health care in the studied period were 121% and 153% respectively. The growth rate of public expenditure on health care outpaced that of public expenditure, reflecting a higher than average demand for public health care. Nonetheless, they changed in the same direction in the studied period, i.e. they increased and decreased roughly at the same time.[37] Figure 7 shows the details.

[37] Except in 1990-1992 when a new reform was introduced and the government had increased the health budget as an upfront investment to improve and maintain the services of the NHS.

Figure 7 - A Comparison of Growth Rates of Public Expenditure on Health Care and Public Expenditure



Source:

1. *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 166-168.

13.3 If we compare the NHS expenditure (i.e. public expenditure on health care) with the other components of the total public expenditure, it is found that since 1987, the NHS has ranked second as the largest public sector expenditure. The proportion of the NHS expenditure to total public expenditure has also been increasing since 1982. Please see Table 5 and Figure 8 for details.

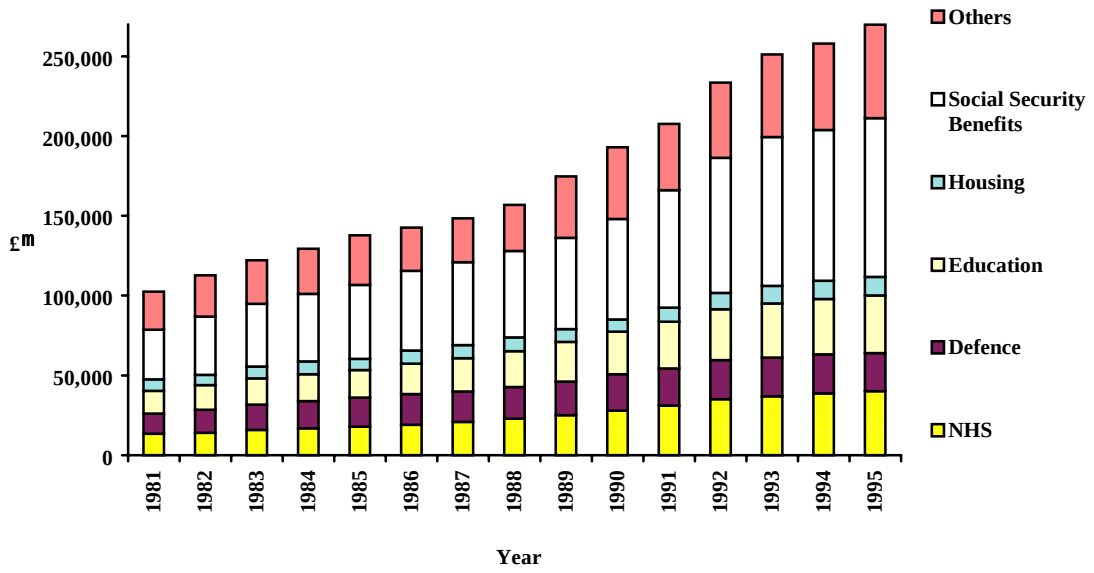
Table 5 - NHS Expenditure as a Proportion of Total Public Expenditure

Year	Public Expenditure[1] £m	% Share of NHS	% Share of Defence[2]	% Share of Education	% Share of Housing[3]	% Share of Social Security Benefits	% share of Others[4]
1981	102,434	13.1	12.3	14.0	7.0	30.3	23.3
1982	112,786	12.5	12.8	13.6	5.8	32.3	23.0
1983	122,232	13.0	13.0	13.4	6.1	32.1	22.4
1984	129,361	13.0	13.2	13.1	6.2	32.6	21.9
1985	137,806	13.0	13.2	12.5	5.1	33.6	22.6
1986	142,605	13.4	13.4	13.5	5.7	35.0	19.0
1987	148,501	14.1	12.8	14.0	5.5	35.1	18.5
1988	156,930	14.6	12.6	14.4	5.4	34.6	18.4
1989	174,711	14.4	12.0	14.2	4.6	32.8	22.0
1990	193,041	14.4	11.9	13.8	4.0	32.6	23.3
1991 e	207,652	15.0	11.2	14.1	4.2	35.5	20.0
1992 e	233,489	15.0	10.5	13.7	4.4	36.2	20.3
1993 e	251,095	14.7	9.7	13.5	4.4	37.1	20.6
1994 e	257,867	15.0	9.5	13.5	4.4	36.6	21.0
1995 e	269,873	14.9	8.8	13.4	4.3	36.9	21.7

Remarks:
1. [1] = Before debt interest.
2. [2] = Military and civil defence.
3. [3] = Including community amenities, e.g. water, sewerage and others.
4. [4] = Including personal social services, transport, etc.
5. e = estimated figures
6. All figures relate to calendar year.

Source:
1. *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 168.

Figure 8 - Breakdown of Total Public Expenditure By Major Policy Area, 1981-1995



Source:

1. *Introductory Guide to NHS Finance in the UK*, The Health Care Financial Management Association, 1995, p. 168.

13.4 Table 6 shows the recent expenditure trends and future spending plans for the NHS. It is noted that the largest part of NHS spending was on hospital, community health and family services (cash limited), which accounted for an average of around 75% of the total NHS expenditure in the period 1992/93 - 1998/99. The second largest component was NHS family health services (non-cash limited), which took up an average of 22.5% of the total NHS expenditure. It is also noted that the proportion devoted to community care and family health services had slightly increased by 1% since the government pledged to give a greater priority to these services. The proportion of the other expenditure components remained quite stable in the period. Figure 9 and Figure 10 show the details.

Table 6 - Components of NHS Expenditure, UK

(£m)	1992/93 outturn	1993/94 outturn	1994/95 outturn	1995/96 outturn	1996/97 outturn	1997/98 estimated outturn	1998/99 plans
NHS hospital, community health, family health (cash limited) and related services and NHS trusts	26,972	27,997	29,432	30,779	31,810	33,342	35,108
% to total NHS	74%	75%	75%	75%	75%	75%	75%
NHS family health services (non-cash limited)	8,003	8,388	8,825	9,244	9,709	10,219	10,591
% to total NHS	22%	22%	22%	22%	23%	23%	23%
Departmental administration [a]	407	358	350	341	328	317	310
% to total NHS	1%	1%	1%	1%	1%	1%	1%
MCA Trading Fund	n.a.	5	0	0	0	0	1
% to total NHS	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Central health and miscellaneous services	852	732	749	795	839	841	835
% to total NHS	2%	2%	2%	2%	2%	2%	2%
Total NHS	36,233	37,481	39,357	41,159	42,686	44,719	46,844

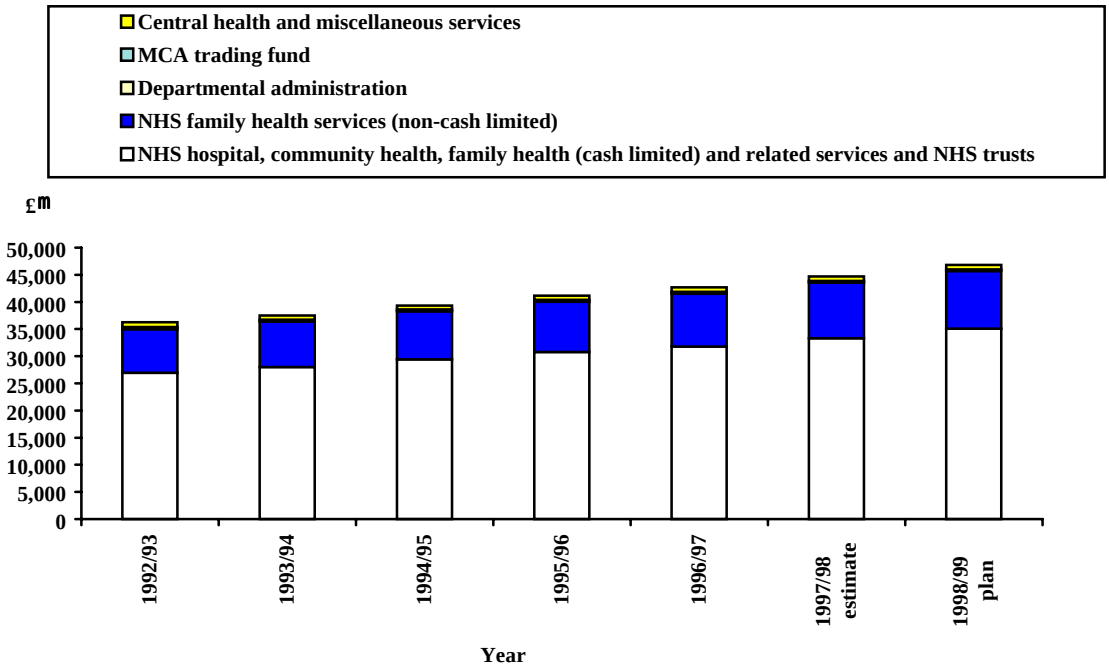
Remarks:

1. MCA Trading fund stands for Medicines Control Agency Trading Fund which is the UK regulatory authority charged with protecting public health through the control of human medicines. It carries out this task through a system of licensing, inspection, monitoring and enforcement. Prior to 1993/94, MCA figures are included in departmental administration.
2. n.a. stands for not applicable
3. [a] Excludes departmental administration of health programme in Scotland and Wales.
4. Cash amounts below £0.5m are not shown.
5. Figures may not sum due to rounding.
6. All figures relate to financial year.

Source:

1. Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999,* http://www/official-documents co.uk/document/cm39.

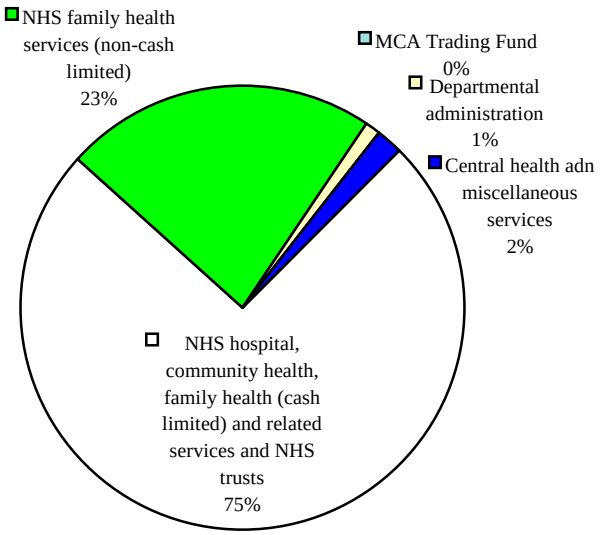
Figure 9 - Proportion of Components of NHS Gross Expenditure



Source:

1. Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999,* http://www/official-documents co.uk/document/cm39.

Figure 10 - Components of UK NHS Planned Expenditure 1998/99



Source:

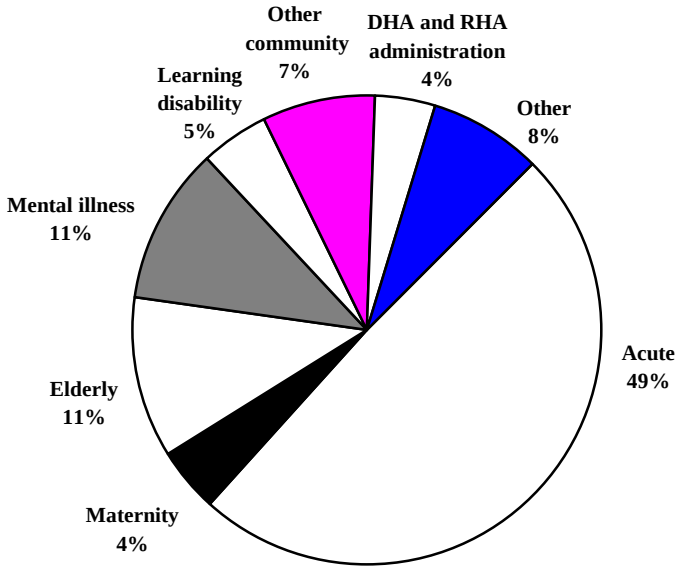
1. Department of Health, *Departmental Report: The Government's Expendiure Plans - 1998-1999,* http://www/official-documents co.uk/document/cm39.

NHS Expenditure by Service Sector (For England Only)

Hospital and Community Health Services, HCHS

13.5 Figure 11 shows the breakdown of HCHS gross expenditure by service sector in 1995-96. It is noted that acute hospital services accounted for 49% of the total. Mental illness and learning disability services accounted for about 16%. Services specifically for elderly people aged 65 years and over i.e., geriatric in-patient and out-patient services, day care, etc., accounted for 11% of the total. However, Appendix IV and Figure 12 show that while people aged 65 years and over accounted for about 16% of the population in 1996, they accounted for 41% of total HCHS spending. This is because around 40% of acute expenditure and services for mentally ill people and community services are for those aged 65 years and over.[38]

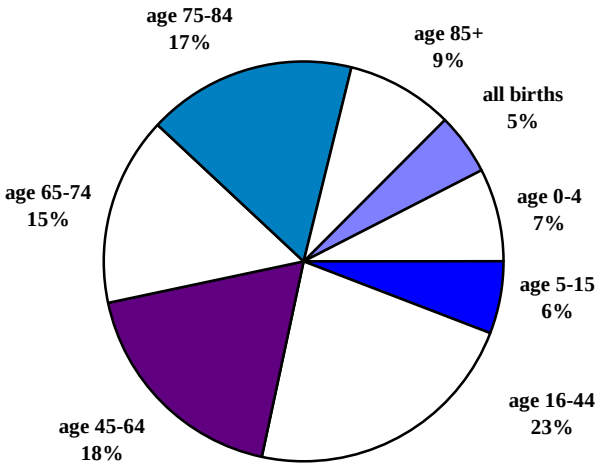
Figure 11 - HCHS Gross Expenditure by Service Sector, 1995/96



Source: Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999,* http://www/official-documents co.uk/document/cm39.

[38] Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999,* http://www/official-documents co.uk/document/cm39.

Figure 12 - HCHS Gross Expenditure by Age 1995/96 (estimate)



Source: Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999*, http://www/official-documents co.uk/document/cm39.

NHS Trusts

13.6 NHS trusts earn all their income through contracts to provide health care for HAs, GP fundholders and the private sector. They have to cover their recurrent costs and recover in prices a 6% return on their average net relevant assets and depreciation.[39] Since breakdown on aggregate expenditure of all NHS trusts is not available, Table 7 gives an example of expenditure of a typical NHS trust[40].

[39] Department of Health, *Departmental Report 1996*, p. 32.

[40] Hammersmith Hospitals NHS Trust is chosen as an example because it met over 80% of the national target of performance in waiting times announced in Patient's Charter in 1994/95.

Table 7 - Expenditure of Hammersmith Hospital NHS Trust, 1994/95

Expenditure Item	£ '000	% of total
Staff costs (total)	**98,964**	**51.5**
Board members and senior managers	3,656	1.9
Estates and ancillary staff	4,033	2.1
Admin. & clerical & management	13,898	7.2
Professional clinical support staff	16,421	8.6
Nursing & midwifery	37,617	19.6
Medical staff	23,339	12.2
Non-Staff (total)	**93,070**	**48.5**
Supplies & services - clinical	33,680	17.5
Supplies & services - general	3,672	1.9
Premises and fixed plant	20,300	10.6
Depreciation on buildings & equipment	9,717	5.1
Established expenses	4,155	2.2
Other	21,546	11.2
Total	**192,034**	**100**

Remark:
1. Supplies & services - clinical : mainly drugs and medical supplies and equipment.
2. Supplies & services - general : mainly catering, cleaning and laundry.
3. Premises : mainly fuel, computing, rates and estate maintenance.
4. Establishment expenses : mainly stationery and telephones.
5. Other : mainly contracted out services and miscellaneous.

Source: Hammersmith Hospital NHS Trust, *Annual Report 1994/95*, p.22.

13.7 It is noted from Table 7 that slightly above half of the expenditure went to staff expenses. (Please see Table 8 for number of staff employed by the Hammersmith Hospital NHS Trust.) The second largest component of the aggregate expenditure of the NHS trust was clinical supplies and services which accounted for 17.5% of total expenditure.

Table 8 - Staff Employed by the Hammersmith Hospital NHS Trust, 1995

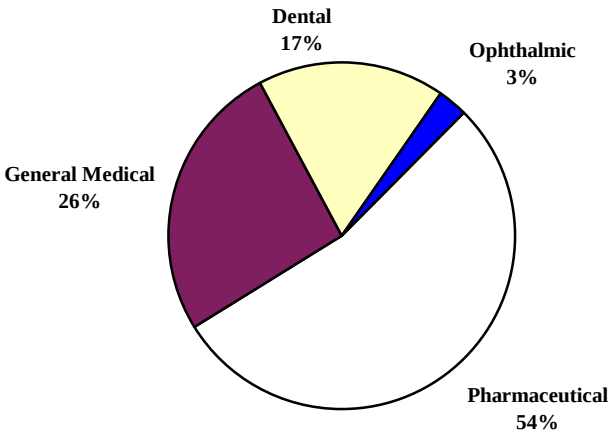
Staff	Number	% of total
Nursing and midwifery	1 800	44.4
Admin. And clerical	897	22.1
Other professional and technical	484	11.9
Medical and dental	443	10.9
Professions allied to medicine	236	5.8
Ancillaries and estates	197	4.9
Total	4 057	100

Source: Hammersmith Hospital NHS Trust, *Annual Report 1994/95*, p. 22.

Family Health Services, FHS

13.8 Figure 13 shows the non-cash limited gross expenditure of FHS 1994/95. The largest expenditure component of the FHS expenditure was pharmaceutical services, i.e., drug and prescriptions expenses, which accounted for 54% of the total. The second largest component was general medical services (26%) which mainly covered expenditure paid to GP. Dental and ophthalmic services took up the remaining 20% of the total.

Figure 13 - Non-Cash Limited FHS Gross Expenditure 1994/95

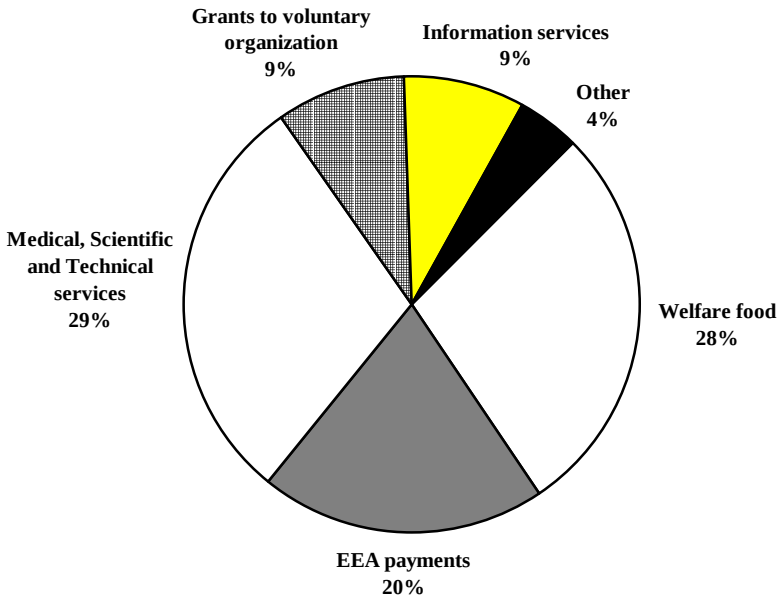


Source: Department of Health, *Departmental Report 1996*, p. 43.

Central Health and Miscellaneous Services, CHMS

13.9 Expenditure on CHMS goes to: (1) the welfare food programme which provides free liquid and dried milk for families with children under five and expectant mothers in receipt of Income Support; (2) European Economic Area medical costs which cover the costs of treatment given to UK nationals by other member States; (3) expenditure on medical, scientific and technical services; (4) grants to voluntary organizations; and (5) the Health Education Authority which provides information and advice about health directly to the public. Figure 14 gives the estimated gross expenditure of CHMS in 1995/96.

Figure 14 - CHMS Estimated Gross Expenditure 1995/96



Source: Department of Health, *Departmental Report 1996*, p. 16.

Discussion

13.10 It is observed that 85% of total health care expenditure was taken up by the NHS, of which, 75% covered hospital and community services, 23% covered family health services and the remaining for other services. Since hospital services have taken up a large proportion of NHS expenditure, the NHS remains predominantly a service for curative care. Of the hospital and community services, nearly half of the expenditure went to acute hospital services. Most of these services are consumed by elderly people. It is expected that with an aging population, there will be greater demand on health care services, especially long-term care and community care services. Of the family health services, over half of the expenditure was on drugs and prescription expenses. This implies that an increase in prices of drugs and related expenses would have great impact on the expenditure of family health services. According to Allsop (1996),[41] prescription charges had risen sharply: between 1979 and 1994, there had been an increase from under £1 per item prescribed to almost £5.

Public Financing for Health Care

13.11 NHS is heavily financed by the government. In 1997/98, 94% of NHS funding came from public revenue whereas only 6% came from other sources such as fees and charges, income generation, and land sales. However, the proportion of public revenue in financing the NHS is decreasing. This is because more money has been received from NHS trusts on repayments of NHS trust interest-bearing debt. (Please see Table 12 for details.) Table 9 and Figure 15 depict the proportion.

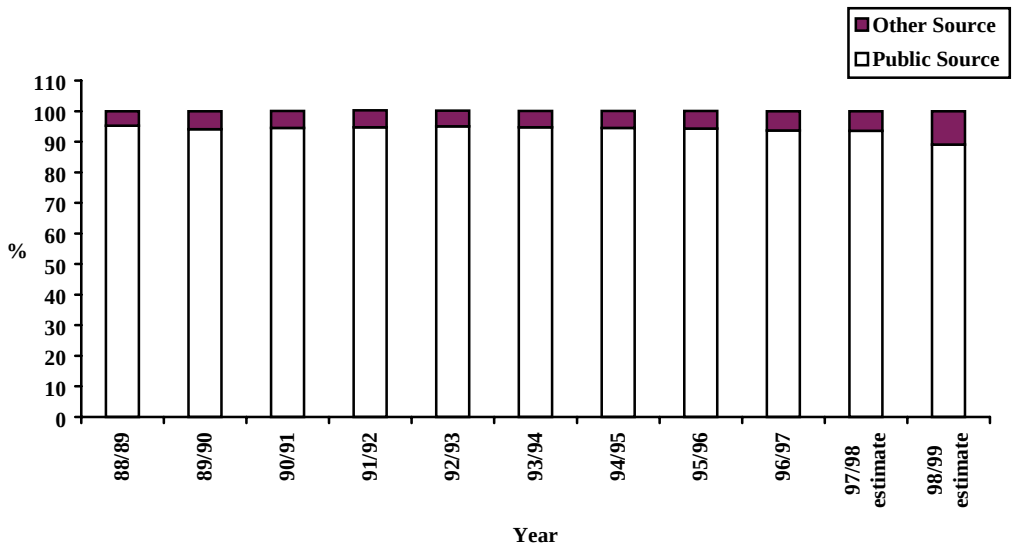
[41] Allsop, *Health Policy and the NHS: Towards 2000*, Longman, 1996, p. 164.

Table 9 - Proportion of NHS Sources of Finance

All figures are shown in percentages			
Financial Year	**Public Revenue**	**Other Sources**	**Total**
1988-89	95.2	4.8	100
1989-90	94.1	5.9	100
1990-91	94.5	5.5	100
1991-92	94.7	5.3	100
1992-93	95.0	5.0	100
1993-94	94.7	5.3	100
1994-95	94.5	5.5	100
1995-96	94.3	5.7	100
1996-97	93.7	6.3	100
1997-98 estimate	93.6	6.4	100
1998-99 estimate	89.1	10.9	100

Source: Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999*, http://www/official-documents co.uk/document/cm39.

Figure 15 - Proportion of NHS Sources of Finance



Source: Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999*, http://www/official-documents co.uk/document/cm39.

13.12 In 1995/96, 82% of public finance to NHS came from taxes, the remainder 12% from national insurance contributions (NICs). Table 10 shows how sources of finance have changed over time.

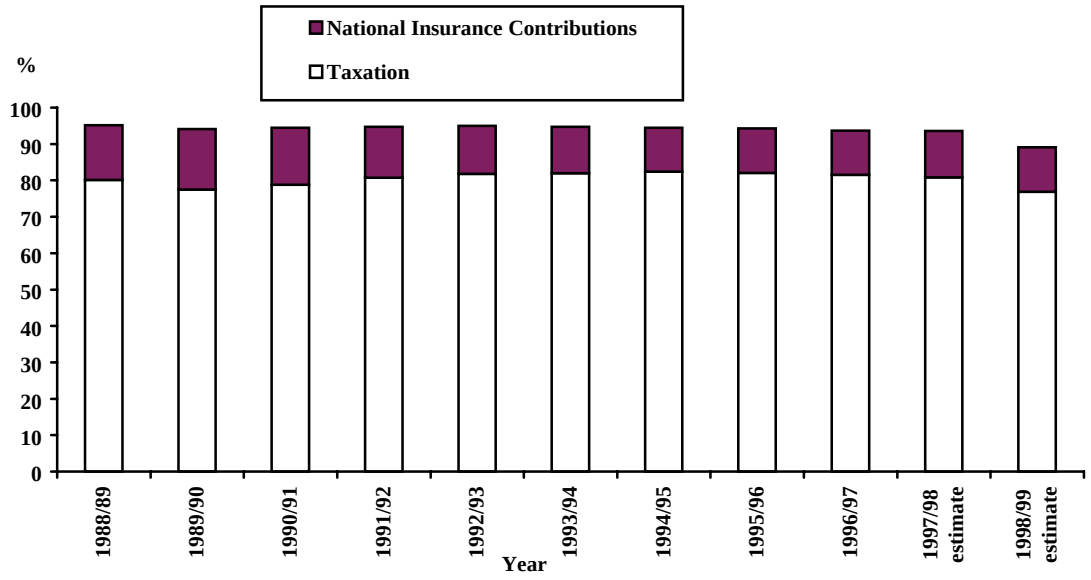
Table 10 - Breakdown of NHS Source of Finance - Public Revenue

All figures are shown in percentages			
Financial Year	**Taxation (a)**	**National Insurance Contributions (b)**	**Total Public Revenue (a) + (b)**
1988-89	80.1	15.1	95.2
1989-90	77.5	16.6	94.1
1990-91	78.8	15.7	94.5
1991-92	80.7	14.0	94.7
1992-93	81.8	13.2	95.0
1993-94	82.0	12.7	94.7
1994-95	82.4	12.1	94.5
1995-96 estimate	82.1	12.2	94.3
1996-97 estimate	81.5	12.2	93.7
1997-98 estimate	80.8	12.8	93.6
1998-99 estimate	76.9	12.2	89.1

Remarks:
1. n.a. detailed breakdown not available.

Source: Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999*, http://www/official-documents co.uk/document/cm39.

Figure 16 - Breakdown of NHS Source of Finance - Public Revenue



Source: Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999*, http://www/official-documents co.uk/document/cm39.

13.13 It is noted from Table 10 and Figure 14 that public contribution to NHS financing remained static (94-95%) in the period 1988/89 - 1997/98 except for 1998/99 when the Government expected to receive a large sum of repayment of principal on NHS trusts interest-bearing debt from NHS trusts, which would be ploughed back to finance the NHS as a whole. There was only a small change in the proportion of contribution made by taxation and NICs in the studied period. Therefore, they together did not provide more or fewer resources for the NHS in total (the difference in total was about 1%): they merely changed the balance of finances between the taxpayer (i.e. taxation) and the contributor (i.e. the NICs).

13.14 Table 11 shows the breakdown of NHS other source of finance. A 2% of these incomes came from charges to patients and 8% from other sources, mainly capital refunds from NHS trusts. The increase in the proportion contributed by charges from 1989-90 was mainly attributable to the increased income from private patient charges. This in turn was the result of provisions in the Health and Medicines Act 1988 which allowed HAs to set their own charges for private patients at commercial rates. These charges mainly applied to prescriptions for medicines, dental and ophthalmic services.

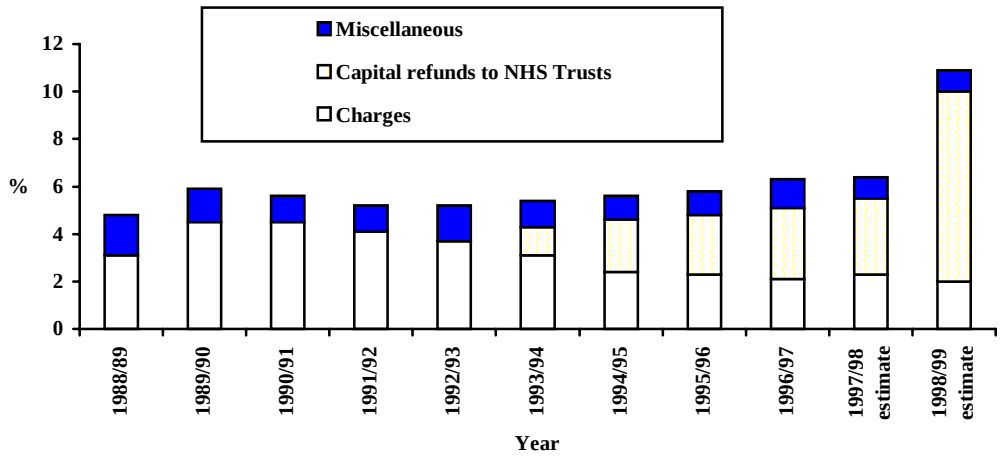
Table 11 - Breakdown of NHS Source of Finance - Other Source

All figures are shown in percentages				
Financial Year	**Charges[1] (a)**	**Capital refunds to NHS Trusts [2] (b)**	**Miscellaneous[3] (c)**	**Total (a) + (b) + (c)**
1988-89	3.1	n.a.	1.7	4.8
1989-90	4.5	n.a.	1.4	5.9
1990-91	4.5	n.a.	1.1	5.6
1991-92	4.1	n.a.	1.1	5.6
1992-93	3.7	n.a.	1.5	5.2
1993-94	3.1	1.2	1.1	5.4
1994-95	2.4	2.2	1.0	5.6
1995-96	2.3	2.5	1.0	5.8
1996-97	2.1	3.0	1.2	6.3
1997-98	2.3	3.2	0.9	6.4
1998-99 estimate	2.0	8.0	0.9	10.9

Remarks:
(1) Charges mainly refer to Family Health Services receipts in respect of prescription and dental charges. Pay bed and similar revenue income collected centrally by health authorities is also included. Pay bed and similar income collected locally by NHS trusts is not included.
(2) Capital refunds to NHS trusts were not identified separately prior to 1993-94.
(3) Mainly HA capital receipts.
(4) n.a. stands for detailed breakdown not available.

Source: Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999*, http://www/official-documents co.uk/document/cm39.

Figure 17 - Breakdown of NHS Source of Finance - Other Source



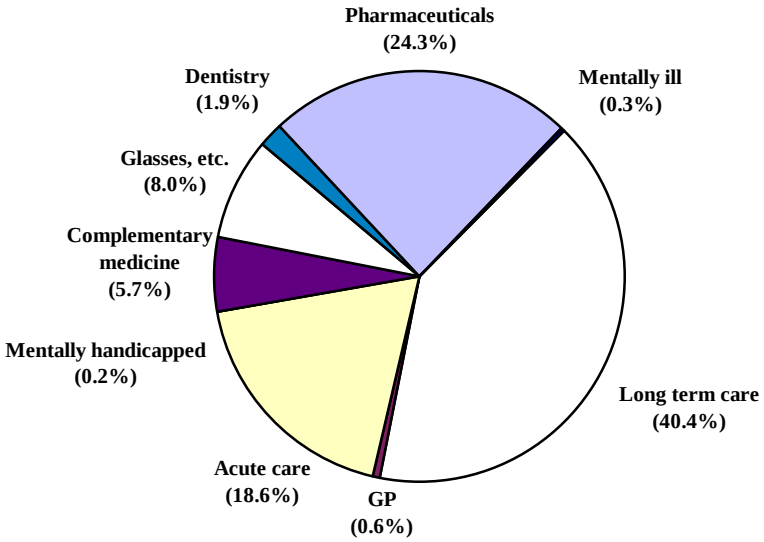
Source: Department of Health, *Departmental Report: The Government's Expenditure Plans - 1998-1999*, http://www/official-documents co.uk/document/cm39.

14. Private Health Care Expenditure and Financing

Private Health Care Expenditure

14.1 Since the NHS provides a comprehensive range of health care services to people of the UK free at the point of delivery, private health care spending has accounted for about 15% of the total health care expenditure. Figure 18 shows private health care spending by sector in 1989. It is noted that long term care accounted for 40% of total private health care spending. This is evidenced in the growth of long-term care sector since the mid-1980s: the number of private and voluntary nursing home places increased by more than three times between 1984 and 1989 and the number of private residential home places also trebled in the same period.

Figure 18 - Private Health care Spending by Sector, 1989



Source: Appleby, *Financing Health Care in the 1990s*, Open University Press, 1992, p. 53.

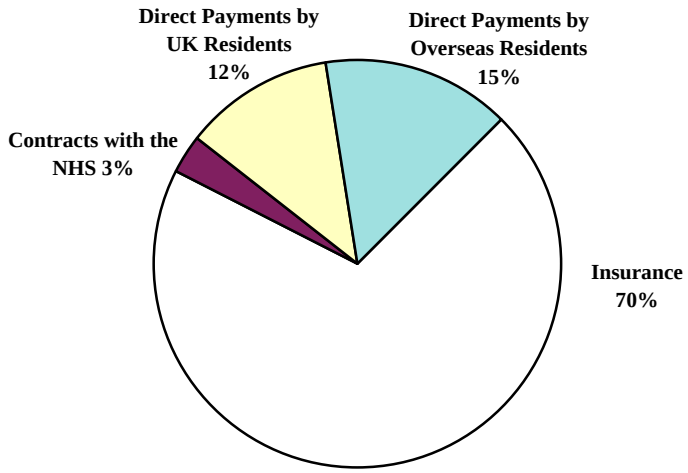
14.2 The second largest component was drugs expenses. Self care or self medication is popular in the UK. It is estimated[42] that one in three of the population is self medicating at any time. The most frequent symptoms for which self-medication is undertaken are coughs and colds, various aches and pains and overweight.

[42] Orton and Fry, *UK Health Care: The Facts*, Kluwer Academic Publishers, 1995, p. 61.

Private Health Care Financing

14.3 Figure 19 shows the sources of finance in the private health care sector. It is observed that 70% of private health care expenditure was paid through insurance. The majority of this financing went to the acute sector (providing specialized and mostly surgical care). [43]

Figure 19 - Sources of Financing in the Private Health Care Sector, 1989



Source: Appleby, *Financing Health Care in the 1990s*, Open University Press, 1992, p. 54.

Private Insurance

14.4 The proportion of the population covered by some form of private medical insurance has steadily increased over the last ten years. In 1985, around 9% of the UK population was covered by private medical insurance. By 1996, it was estimated that this proportion of the people covered had increased to 14%.[44] For the most part, private insurance and facilities are limited in coverage and are used to top up provision for elective procedures such as hernia and varicose veins for which there are often long waiting times within the NHS. They do not usually cover primary health care.

43 Appleby, *Financing Health Care in the 1990s*, Open University Press, 1992, p. 54.
44 Orton and Fry, *UK Health Care: The Facts*, Kluwer Academic Publishers, 1995, p. 59.

14.5 As above mentioned, long-term care was the largest component in private health care spending. Yet, the source of finance to private long-term care was not insurance, the largest source of private health care finance. Instead, it was direct payment and government subsidy. According to Appleby (1992), insurance has traditionally been a negligible or non-existent source of finance to long-term care. In 1988, about 60% of long-term care finance came from direct payments by users of private long-term care services while about 40% was funded by taxation via the Department of Social Security in the form of income support.

14.6 In view of this, since 1990, the government has introduced tax relief on medical insurance premium payments for elderly people (people aged 60 years and over) with a taxable income or for those who pay their premiums. This is to encourage people to buy private insurance and it is hoped that this might alter the proportion of long-term care financing from direct payment and government subsidy towards insurance.

Discussion

14.7 Although the NHS covers the whole population, there are other private forms of health care to supplement the services of the NHS. Most of the private health care expenditure goes to residential and nursing homes, purchases of drugs and private medical insurance which covers some acute and specialist services.

14.8 A key factor in the development of the private sector has been the spread of private medical insurance. There has been a significant increase in the provision of medical insurance cover by companies for their employees[45] (please also refer to paragraph 10.11). However, this may pose a problem because this medical insurance cover may stop when an individual retires or leaves his job for other reasons. This would place a greater financial burden on elderly people or their families paying for long-term care on their behalf.

14.9 The above is evident that about 40% of long term care was financed out-of-pocket by the private sector. With an aging population, a greater financial burden would be placed on the private households or if they do not have the sufficient resources, this burden would be shifted to the government. It is quoted from an academician[46] that '*it is apparent that there has been a disengagement of the NHS from responsibilities in this area [long term care]*.' In a reply to the Ombudsman by the HA concerning a complaint on refusal of hospital admission by the NHS, the HA replied that *its policy was for shorter in-patient stay with continuing care to be provided in the community. ... if it were obliged to provide such care, it could be financially overstretched.* This raises the issue of insufficient government funding and hence, NHS health care services might not be able to satisfy all its needs. Part 5 of this research report looks at the costs and benefits of the financing arrangement adopted by the UK government.

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45 *White Paper on Working for Patients*, presented to Parliament by the Secretaries of State for Health, Wales, Northern Ireland and Scotland, Jan. 1989. p. 69.

46 Newdick, *Who Should We Treat?* Clarendon Press, Oxford, 1995, p. 9.

PART 5 - ANALYSIS OF HEALTH CARE FINANCING ARRANGEMENTS

15. Financing Arrangements

Public Revenue

15.1 Financing by national taxation allows the government to determine and control overall spending to meet health needs. Cover is universal, and access is based on need rather than contribution as in social or private insurance systems. Moreover, it can be said this financing method is equitable as general taxation is usually mildly progressive.

15.2 The disadvantage of tax-based systems is that health care spending must compete with other areas of public expenditure. People who use health care do not know the cost of services they are receiving because there is no need for pricing and costing. Therefore, demand may be high but access to health care may be provider-determined or through some form of rationing. If rationing is adopted, there might give rise to long waiting list and a reduction in the quality of service.

15.3 The 1992 OECD report comments:

> *At best, they [tax-based systems] seem to be capable of supplying good quality health care according to clinical need, financed at a reasonable cost. However, they are frequently attended by waiting lists and seem to encourage a brisk and impersonal style of service. At worst, the result is overloaded and low-quality services which are supplied by ill-motivated staff in shabby premises.* [47]

15.4 In sum, on the one hand, this tight control of the NHS budget offers an extremely effective way of containing NHS expenditure. On the other hand, this might lead to insufficient financing of the health care system as government funding is cash limited. If there is shortage of funds, rationing of health service might take place, which might create an arbitrary or biased allocation of resources.

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[47] OECD, *The Reform of Health Care: A Corporative Analysis of 7 OECD Countries*, OECD, Paris, 1992, p. 16.

Private Insurance

15.5 Private insurance gives patients more choice in terms of the timing of hospital admissions, choice of doctors, better nursing care, higher quality services once they are accepted as subscribers. They can have speedy treatment as well since waiting times within the NHS are usually long.

15.6 However, the take-up of insurance depends on people's willingness and ability to pay. The risk of ill-health is unpredictable and may be underestimated or ignored. Those with the least ability to pay premiums are often at the highest risk (e.g. elderly people). Moreover, from the insurers' point of view, there are incentives to 'cream skimming'. That is, the insurers may exclude those who are most vulnerable.

15.7 There are two other problems associated with insurance. One is moral hazard and the other is adverse selection. For moral hazard, since individuals, once insured, become less risk-averse, that is, they may engage in activities which are harmful to their health and they may care less for the consequences as the costs of medical treatment will be met by the insurers, there will be an upward pressure on treatment and consequently, on insurance premiums.

15.8 For adverse selection, it means that people will compare their costs of premium against the future health care costs. If they feel that the future health care costs will outweigh their premium costs, they will insure. The outcome is a potential increase of number of 'high risk' (poorer health) people buying insurance. In response, the insurers will raise the premium so as to cover costs. In sum, both of these two problems will raise the premium and eventually may destroy the insurance market.

Patient Charges

15.9 Charging patients for certain services was introduced in 1951 when access to free false teeth and glasses could not be sustained. Charging is often put forward as a further way of raising funds, but this might discourage the use of health services by poorer patients. Moreover, charging would only raise funds if sufficiently large amounts were paid by patients who received the majority of services. Since elderly people are mostly heavy consumers of health services and very likely belong to the low income group, it is unlikely that charges could be raised on those services for fear of leading these elderly patients to put off vital treatment. Therefore, only non-medical amenity services such as off-office-hours access to GP surgeries were charged. This explains why fees and charges only amount to 2% of health care financing.

16. Control of Expenditure

16.1 Spending on the NHS is determined as part of the public expenditure planning process. Control of aggregate expenditure is tight since spending is cash limited. Cash limiting enables the Government to maintain firm control over public sector (the NHS) cash expenditure. It is reported[48] that if the responsible staff fail to keep the health expenditure within the budget, they might be dismissed or otherwise sanctioned.

16.2 Apart from limiting cash spending, another cost saving feature is the control of doctors' salaries as nearly all doctors are employed by the NHS. According to Orton and Fry (1995), doctors' salaries in the UK are low in comparison with their counterparts in other countries. Table 12 shows the comparison.

Table 12 - Doctors' Earnings as a Multiple of Average Private Sector Wages

Countries	Multiple
USA	7.3
Germany	4.6
Canada	4.1
Australia	4.1
France	2.7
UK (consultants)	**3.4**
UK (GPs)	**2.7**

Source: Orton and Fry, *UK Health Care: The Facts*, Kluwer Academic Publishers, 1995, p. 54.

16.3 It is noted from Table 12 that doctors in USA earned 7.3 times that of average private sector wages whereas their counterparts in the UK earned 2.7 to 3.4 times that of average private sector wages. If compared with other professions within the UK, doctors' salaries are also lower. Table 13 gives the details.

[48] OECD, *Internal Markets in the Marketing: Health Systems in Canada, Iceland, and the United Kingdom*, 1995, p. 12.

Table 13 - Median Earnings (Index) for Professions in the UK

Professions	Index
Doctors	100
Accountants	140
Solicitors	142
Actuaries	175

Source: Orton and Fry, *UK Health Care: The Facts*, Kluwer Academic Publishers, 1995, p. 55.

16.4 A further cost saving feature is contracting out certain services which was originally provided by NHS staff. For example, HAs were required to put their catering, domestic and laundry contracts out to tender in 1981 so that these public services could be tested against market prices. It is believed that competitive tendering could bring about cost-effectiveness. By 1986, 55% of catering contracts and about 75% of the domestic and laundry services had been put out to tender. In 1987, the National Audit Office of the UK estimated that competitive tendering brought cost savings of around 20%. [49]

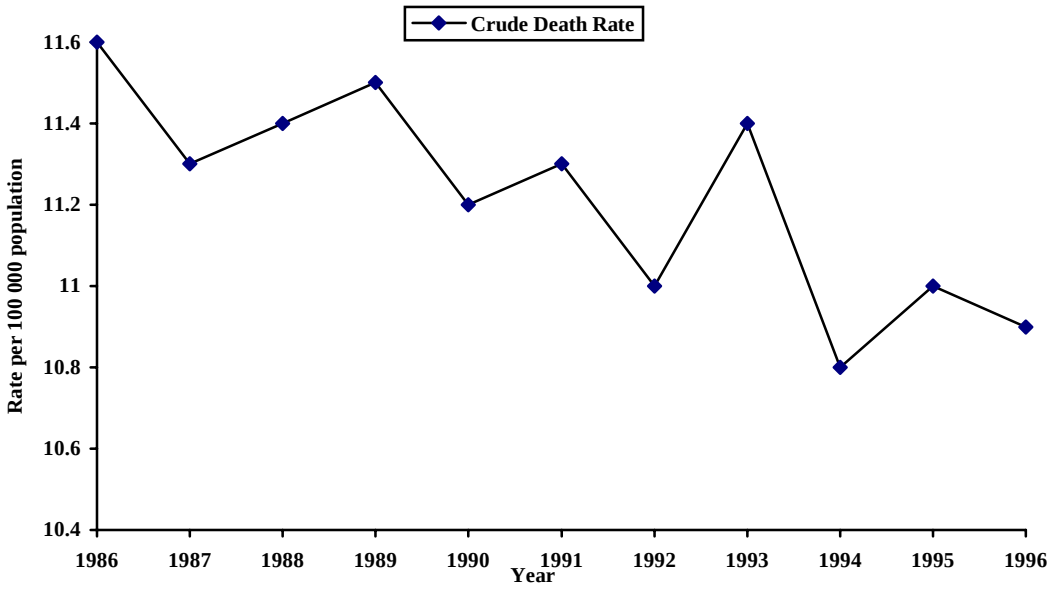
17. Performance of Health Care System

Health Outcomes

17.1 There has been a general improvement in the health conditions of the people in the UK. The general trend of crude death rate has been decreasing since 1986 although in the early 1990s, there had been a reverse pattern. For the infant mortality rate, the decreasing trend is more clear. (Please see Figures 20 and 21 for details.) Life expectancy rates of both male and female have been increasing since 1986. (Please see Table 14 for details.)

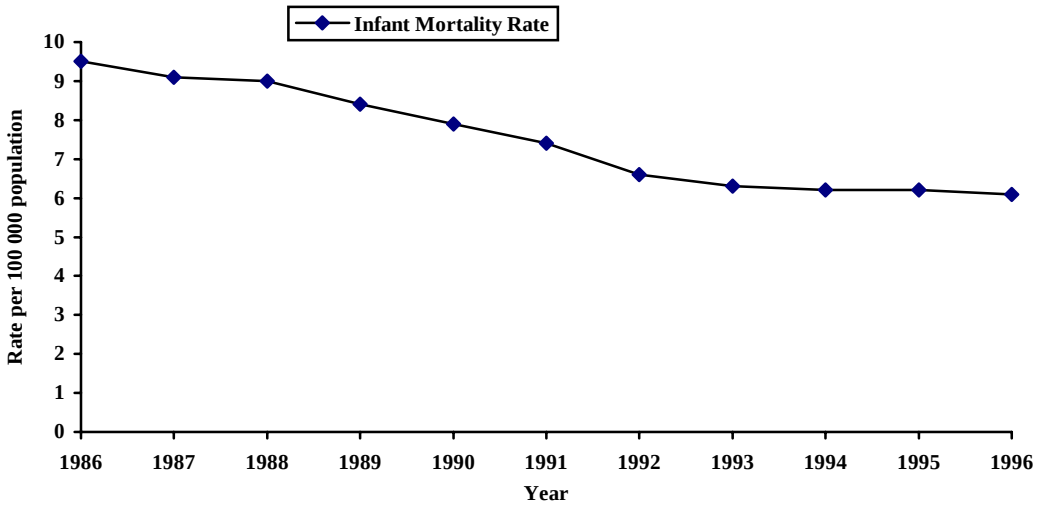
[49] Allsop, *Health Policy and the NHS: Towards 2000*, Longman, 1996, p. 165.

Figure 20 - Crude Death Rate in the UK, 1986-1996



Source: Office for National Statistics

Figure 21 - Infant Mortality Rate in the UK, 1986-1996



Source: Office for National Statistics

Table 14 - Life Expectancy in the UK, 1986-1996

Year	Life Expectancy: male	Life Expectancy: female
1986	71.9	77.7
1987	72.3	78.0
1988	72.4	78.1
1989	72.7	78.2
1990	72.9	78.6
1991	73.2	78.7
1992	73.6	79.0
1993	73.6	78.9
1994	74.2	79.5
1995	74.1	79.3
1996	74.3	79.4

Source: Office for National Statistics.

17.2 Maternal mortality rate has been decreasing since 1970. It is noted that this rate has been reduced by some two-thirds. Table 15 gives the details.

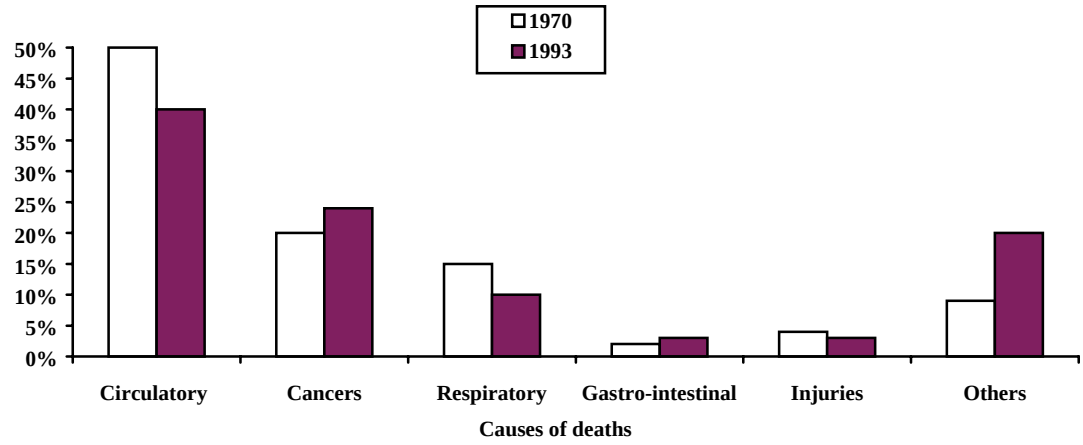
Table 15 - Maternal Mortality Rates

Year	Maternal Mortality Rates per 100 000 births
1970-1972	20.0
1980	11.0
1982-1984	9.3
1985-1987	7.6
1992-1993 (estimate)	7.0

Source: Orton and Fry, *UK Health Care: The Facts*, Kluwer Academic Publishers, 1995, p. 123.

17.3 The most prevalent causes of death in the UK are from circulatory diseases and cancers. Figure 22 shows the proportions of the main causes of death in 1970 and 1993.

Figure 22 - Proportions of Main Causes of Death in 1970 and 1993



Source: Orton and Fry, *UK Health Care: The Facts*, Kluwer Academic Publishers, 1995, p. 36.

17.4 It is noted that death rates had been falling in respect of some diseases but rising in some others between 1970 and 1993. Table 16 gives the details.

Table 16 - UK Causes of Death (1970-1993)

Trend	Causes of Death (unit: death rates per 100 000 people)
upward	most cancer; endocrine (diabetes); gastro-intestinal; mental; central nervous system; musculo-skeletal; liver;
no change	asthma; peptic ulcer; suicide; genito-urinary;
downward	circulatory; strokes; cancer stomach; respiratory - pneumonia, chronic bronchitis, emphysema; perinatal; congenital; accident - violence; cancer uterus;

Source: Orton and Fry, *UK Health Care: The Facts*, Kluwer Academic Publishers, 1995, p. 36.

17.5 There was also progress made in other areas of personal health. For example, according to the *UK Health Departmental Report 1996*, teenage conception rates amongst girls under the age of 16 have fallen for the past three years. This has reversed the upward trend of the 1980s. Smoking prevalence among adults has also continued to fall. Table 17 gives the details.

Table 17 - Smoking Prevalence Rates Among People Aged 16 and Above

Year	Males	Females
1972	52%	41%
1982	38%	33%
1992	29%	28%

Source: Central Statistical Office, *Social Trends*, 1995 edition, p. 127.

17.6 However, it is not clear whether these improved health outcomes are related more to the health system or more to socio-economic factors such as higher educational level, changed lifestyles or a general increase in income.

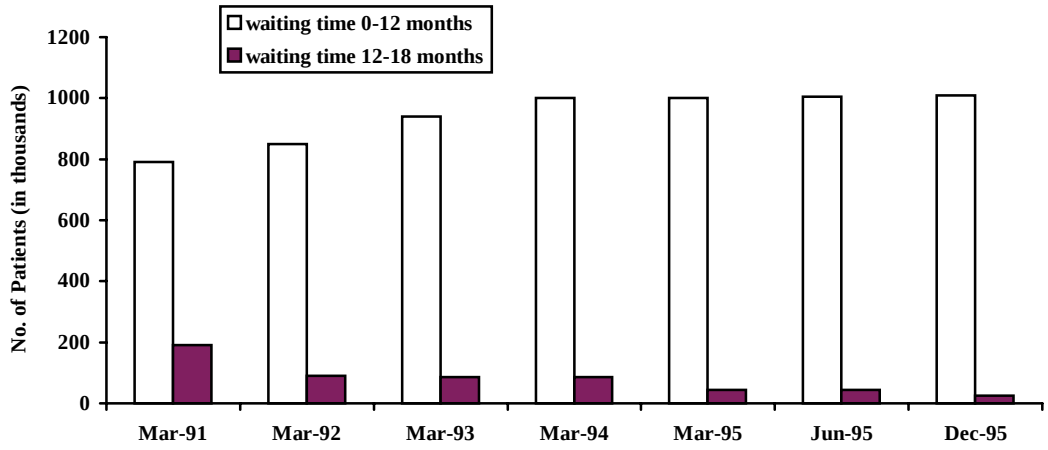
Waiting Time

17.7 Since consumers face zero money prices for most NHS services, there is always a high demand for health services. Examples are the hospitals elective procedures and services. They are always accompanied by a long waiting list. Excess demand could possibly be removed by greater expenditure, but this would involve higher taxes and resistance to tax increase is high.

17.8 Figure 23 shows the waiting list of in-patient and day cases of England. Waiting lists tended to grow in the period 1991-95. Although the number of patients waiting for more than one year has fallen, those waiting for less than one year has increased. According to Allsop (1996), queues tend to be longer in areas such as elective surgery and fertility treatment. [50]

[50] Ibid., p. 79.

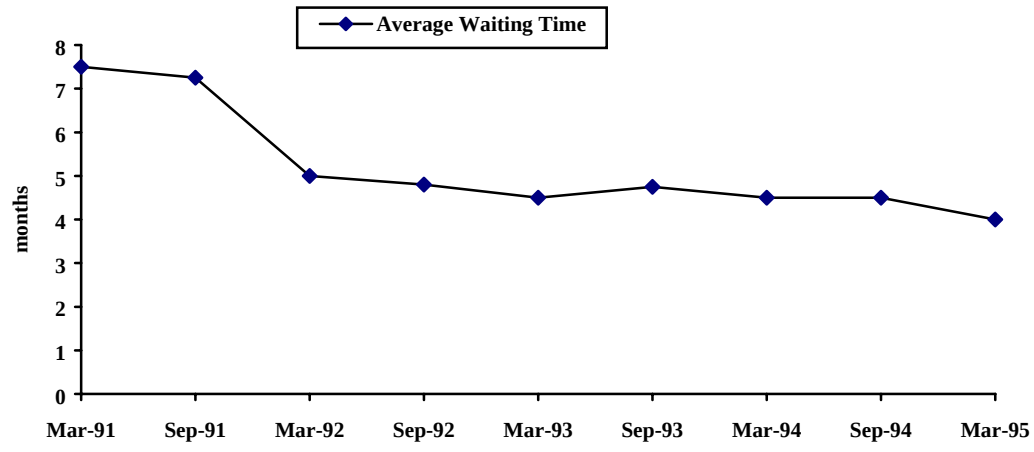
Figure 23 - Waiting List of In-patient and Day Cases of England



Source: Department of Health, *Departmental Report 1996*, p. 54.

17.9 Figure 24 shows the average waiting time of in-patient and day cases. It is noted that in March 1991, patients on the waiting list had waited an average of seven and a half months for treatment; by March 1995 the average waiting time had been reduced to four months.

Figure 24 - Average Waiting Time of In-patient and Day Cases, 1991-1995



Source: Department of Health, *Departmental Report 1996*, p. 54.

17.10 For out-patient cases, 95% of first appointments were seen within 26 weeks of referral and 82% seen within 13 weeks in March 1995. By September 1995, performance had slightly improved: 97% were seen within 26 weeks (2% improvement) and 83% seen within 13 weeks (1% improvement).

Availability of Service

17.11 Another way of rationing is not to provide a service or to provide the service to a limited extent. In the UK, the availability of some treatments such as fertility treatment and intensive care cots for very premature babies has been very limited. As mentioned in paragraph 7.3, the range of treatments provided by GPs in the UK is very limited. Aaron and Schwartz (1984)[51] compare provision between the US and the UK in relation to ten types of hospital treatment. In six of these, provision in the US was much higher. There were also major differences in the numbers of diagnostic tests, rate of operations for a wide number of common conditions such as tonsillectomies, hysterectomies and hernias offered by the UK health service providers.

17.12 Table 18 shows the community health and paramedical services activity statistics. It is noted that nearly all activities have remained broadly constant throughout the period. Yet, elderly population (people aged 65 years and over) grew by 8% [52] which should have generated a corresponding demand for community health service. This stagnant growth of health care services might be owed to the tight control of resources (resources were made cash-limited) and the consequence might be longer waiting time for treatment and services.

Table 18 - Community Health and Paramedical Services Activity Statistics

						'000 of episodes
	1988/89	**1989/90**	**1990/91**	**1991/92**	**1992/93**	**1993/94**
Health visiting	4 100	3 900	3 600	3 700	3 700	3 700
Community nursing services	2 800	2 800	2 600	2 700	2 800	2 800
Chiropody services	880	920	910	940	970	1 010
Clinical psychology	150	150	140	150	160	170
Dietetics	650	630	620	640	640	670
Occupational therapy	770	750	740	840	880	940
Physiotherapy	3 100	3 200	3 200	3 300	3 400	3 500
Speech therapy	240	230	240	250	270	290
community dental services	n.a.	n.a.	1 160	1 190	1 210	1 160

Remark: n.a. stands for not available.
Source: Department of Health, *Departmental Report 1996*, p. 47.

[51] Aaron and Schwartz, *The Painful Prescription*, Brookings Institute, 1984.
[52] Central Statistical Office, *Annual Abstract of Statistics*, 1995, p. 6.

18. Health Care Expenditure and Financing and Health Outcome in the UK and Hong Kong

18.1 Table 19 gives a comparison of the health care expenditure and financing and health outcomes between HK and the UK. Per capita health care expenditure in Hong Kong (HK) in 1996 was HK$9,455 whereas in the UK, it was HK$10,375: around 10% higher than that of HK. Public health care expenditure as % of GDP was also higher (66%) in the UK than that of HK. This is because about 85% of the UK health care expenditure was taken up by the public sector whereas in HK, the private sector took up a relatively larger share (56%) in paying for health care services.

18.2 HK has achieved better results in the health outcomes. In terms of health indicators, namely, life expectancy, infant mortality rate and crude death rate, HK has achieved a better score than that of the UK. However, it should be noted that these health outcomes might be affected by the differences in the two territories' demographic characteristics, geographical size, level of medical technology and other socio-economic factors such as lifestyles, education level, income level. In short, the differences in the performance of health indicators might not be due to the difference in the health care financing arrangements.

Table 19 - Health Care Expenditure and Financing and Health Outcomes in Hong Kong and the UK

	Hong Kong	UK
Health Care Expenditure		
Total health care expenditure (HK$ million) in 1995/6	54,895	590,825 [a]
Per capita health care expenditure (HK$) in 1996	9,455	10,375
Total health care expenditure/GDP (%) in 1993/94	4.1	6.9 [b]
Public health care expenditure/GDP (%)	*2.0*	*5.9* [b]
Private health care expenditure/GDP (%)	*2.1*	*1.0* [b]
Health Care Financing		
Total health care financing (HK$ million) in 1995/96	54,895	590,825 [a]
Public health care financing/total health care financing (%)	*44*	*85.0* [a]
Private health care financing/total health care financing (%)	*56*	*15.0* [a]
Health Outcomes		
Life expectancy at birth in 1996 : Male Female	76.3 years 81.8 years	74.3 years 79.4 years
Infant mortality rate (per 1 000 live births) in 1992 [c]	4.8	6.6
Crude death rate (per 1 000 population) in 1992 [c]	5.3	11.0
Leading causes of death (as at 1993)	1. Malignant neoplasm 2. Heart diseases 3. Cerebrovascular diseases 4. Pneumonia 5. Injury and poisoning	1. Circulatory diseases 2. Cancers 3. Respiratory diseases 4. Gastro-intestinal diseases 5. Injuries

Remarks :

1. Please refer to RP01/PLC, RP02/PLC and RP06/PLC for detailed analysis on Hong Kong's health care delivery system and health care expenditure and financing.
2. The exchange rate of UK£ : HK$ is 12.5:1.
3. [a] Figure presented is at calendar year 1995.
4. [b] The latest figure available for the UK is at 1993.
5. [c] The latest figure available for the UK is at 1992.

Sources:

1. RLS, *Long Term Health Care Policy*, Provisional Legislative Council Secretariat, 1998.
2. RLS, *Health Care for Elderly People*, Provisional Legislative Council Secretariat, 1998.
3. RLS, *Health Care Expenditure and Financing in Hong Kong*, Provisional Legislative Council Secretariat, 1998.
4. Central Statistical Office, *Annual Abstract of Statistics*, 1995.
5. UK Department of Health, *Departmental Report 1996*.
6. HK Department of Health, *Annual Report 1992/93*.

19. Concluding Remark

19.1 Although it is difficult to find any conclusive evidence on the effectiveness of the health care financing arrangement in the UK, several factors might help to indicate its effectiveness. First, the UK has shown continuing improvement in its health outcomes. Secondly, the UK has effectively controlled health care expenditure as its growth rate is broadly in line with that of the GDP. Thirdly, health services coverage is universal and access is based on need and not on paying ability. Equity could be said to have been achieved. Fourthly, waiting time has improved and patient charges are limited to value-added services (such as private wards, non-medical amenity services) for fear of discouraging people from seeking treatment. Last but not least, there is a small but expanding private health market to offer supplementary NHS services. The problem that warrants attention is the financing of long term care where 40% of this financing came from private households.

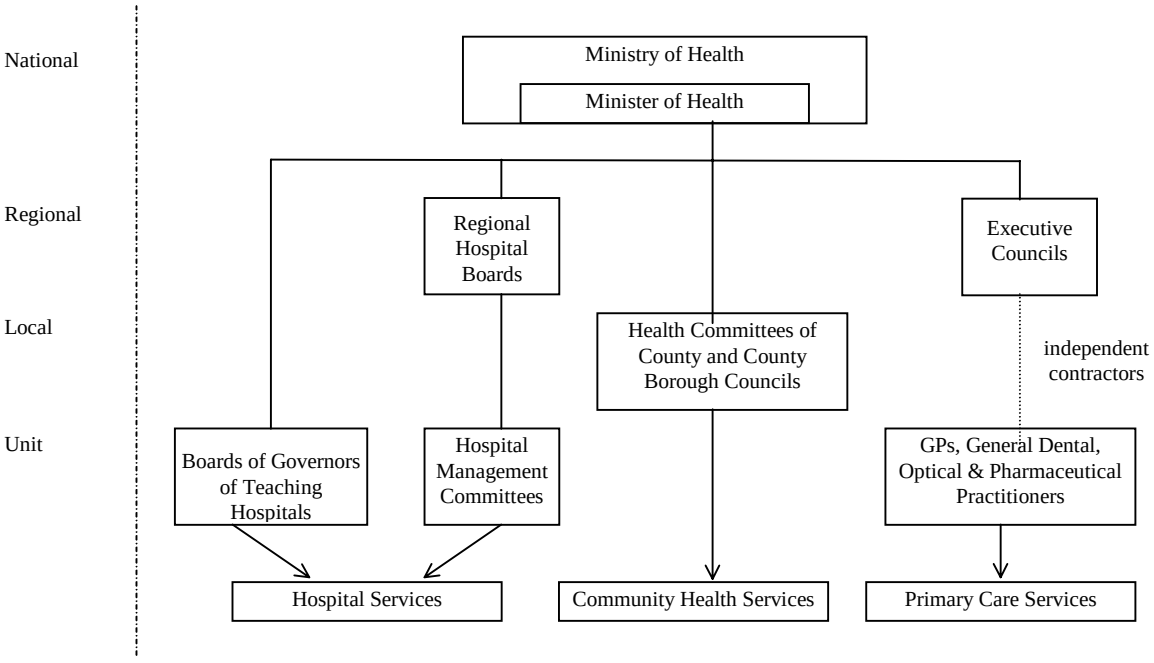
Appendix I

A. Development of NHS 1946 -1960

A.1 The three main types of services provided by the NHS were (1) primary care services; (2) community health services; and (3) hospital and specialist services. In the case of primary care, General Practitioners (GPs), General Dental Practitioners, Pharmacists, and Opticians were self-employed practitioners. Community health services were provided by local government, i.e., County Councils and County Borough Councils. They were responsible for preventive services, maternal and child welfare, home nursing, etc. These local authorities would appoint a health committee of councillors to monitor the services provided.

A.2 The UK was divided into a number of Regions, each containing a medical school and each controlled by a Regional Hospital Board (RHB). The RHB was responsible to the Minister of Health. Groups of hospitals within each Region were presided over by Hospital Management Committees (HMCs) or Boards of Governors (as in Scotland). Medical Teaching Hospitals were run by Boards of Governors and were directly responsible to the Minister of Health. Figure A depicts the structure.

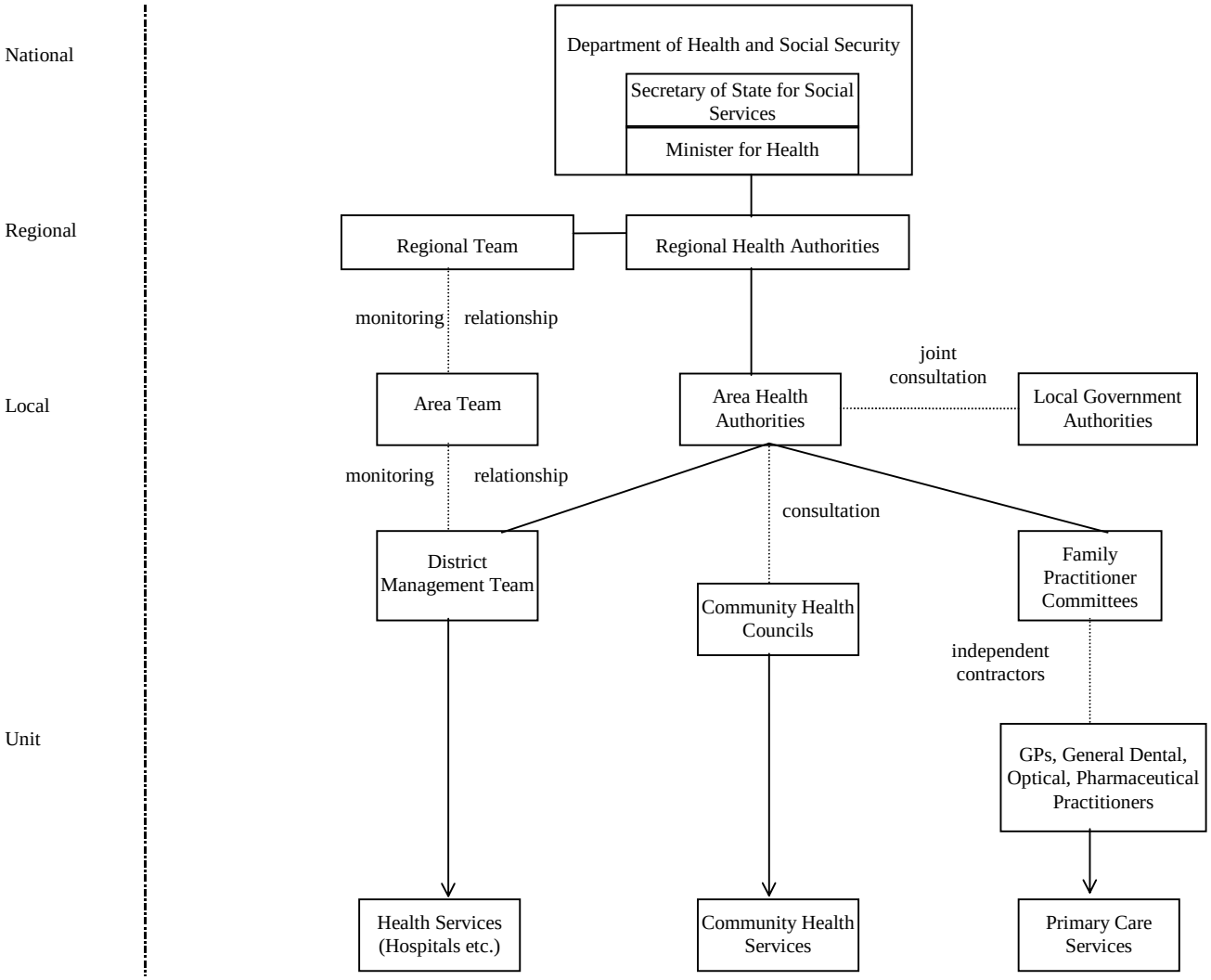
Figure A - Structure of NHS - 1948



B. Development of the NHS in the 1970s

B.1 In 1974, a re-organization of the NHS was implemented. Regional Health Authorities and Area Health Authorities were established. Each area authority was divided into two or more Districts. Each District was nominally based on the catchment area for a District General Hospital. There were multi-disciplinary management teams (i.e. members of teams consisted of administrators, nurses, treasurers, medical officers etc.) to conduct management at Region, Area, and District levels. Each area authority would establish Family Practitioner Committees (FPCs) to hold contracts of GPs and other independent practitioners. Community Health Councils (CHCs) were created to represent the consumer interest. Half of the members of CHCs were nominated by the local authorities, one third by voluntary organizations and the remaining by the RHAs. Figure B outlines the new structure.

Figure B - Re-organization of the NHS - 1974

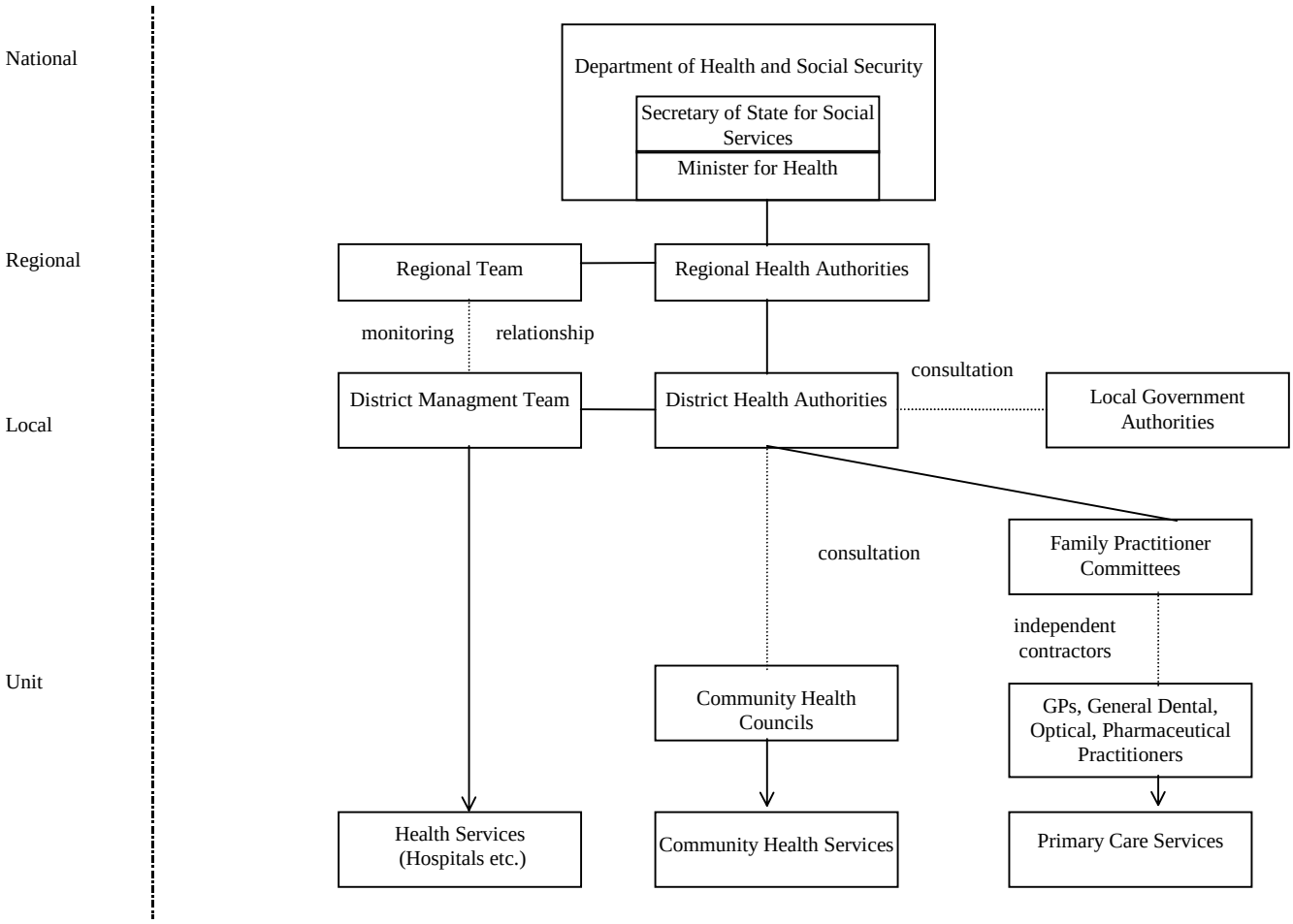


Source: Harrison, *National Health Service Management in the 1980s*, Avebury, 1994. p. 19.

C. Development of the NHS in the 1980s

C.1 In 1979, the UK government published a consultative document which proposed the abolition of the Area tier and replaced it by statutory District Health Authorities (DHAs). The retention of FPCs and the experimentation with "management advisory services" within Regions were also announced. Most of the proposed changes were subsequently brought into operation. Figure C summarizes the changes.

Figure C - Organization Structure of NHS - 1982



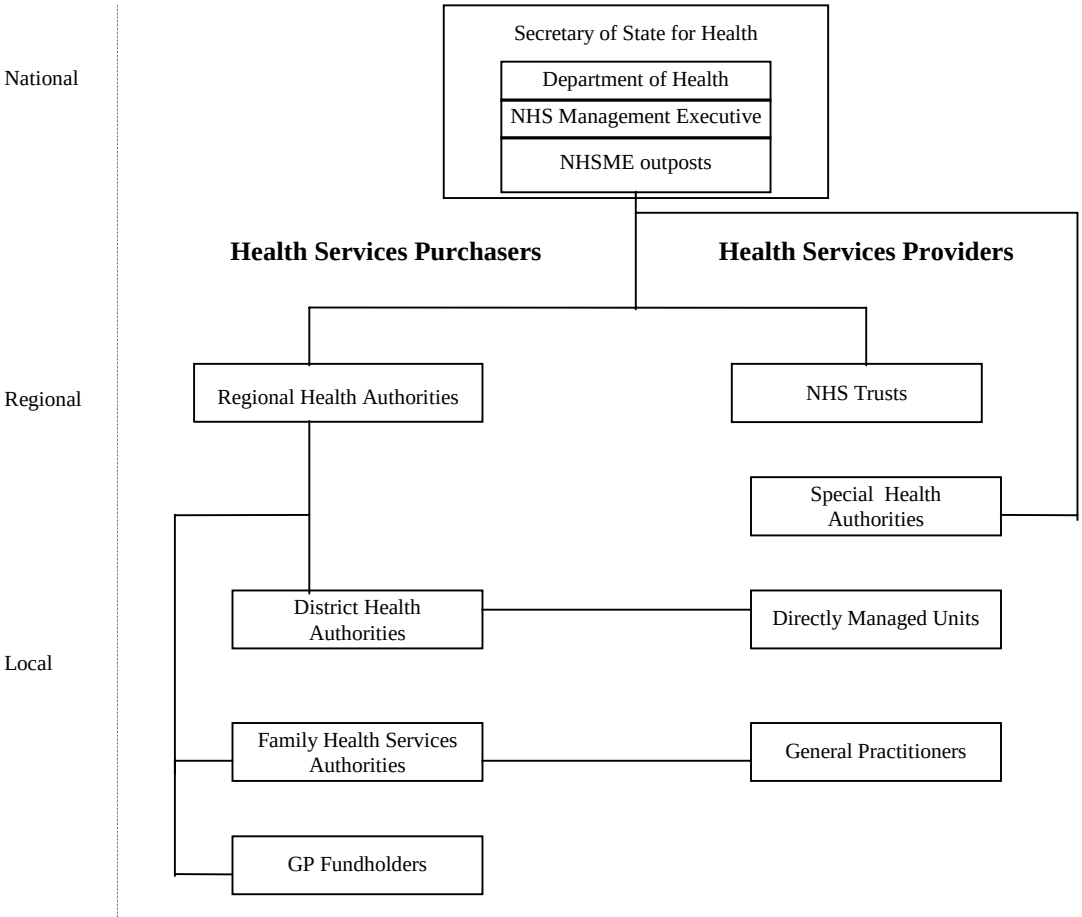
Source: Harrison, *National Health Service Management in the 1980s,* Avebury, 1994. p. 22.

D. Development of the NHS in the 1990s

D.1 In 1989 the government published proposals for a further reform of the management of the NHS. The reform was designed to introduce the concepts of market into the operation of health care financing, with a view to encouraging efficiency, good management and allowing a greater degree of choice to patients.

D.2 The main idea of the changes is to sub-divide the NHS into two main groups: providers and purchasers of health services. Health authorities are the major purchasers; the hospitals and other units are the main providers. Purchasers and providers must now enter into contracts which lay down what is to be provided, provided by whom, to whom and on what terms. The contract includes not only an agreement on price but also includes indicators of the level of service expected, performance targets, and so on, with the contractual price able to reflect directly performance relative to these targets. Figure D outlines the structure.

Figure D - Structure of the NHS - 1991

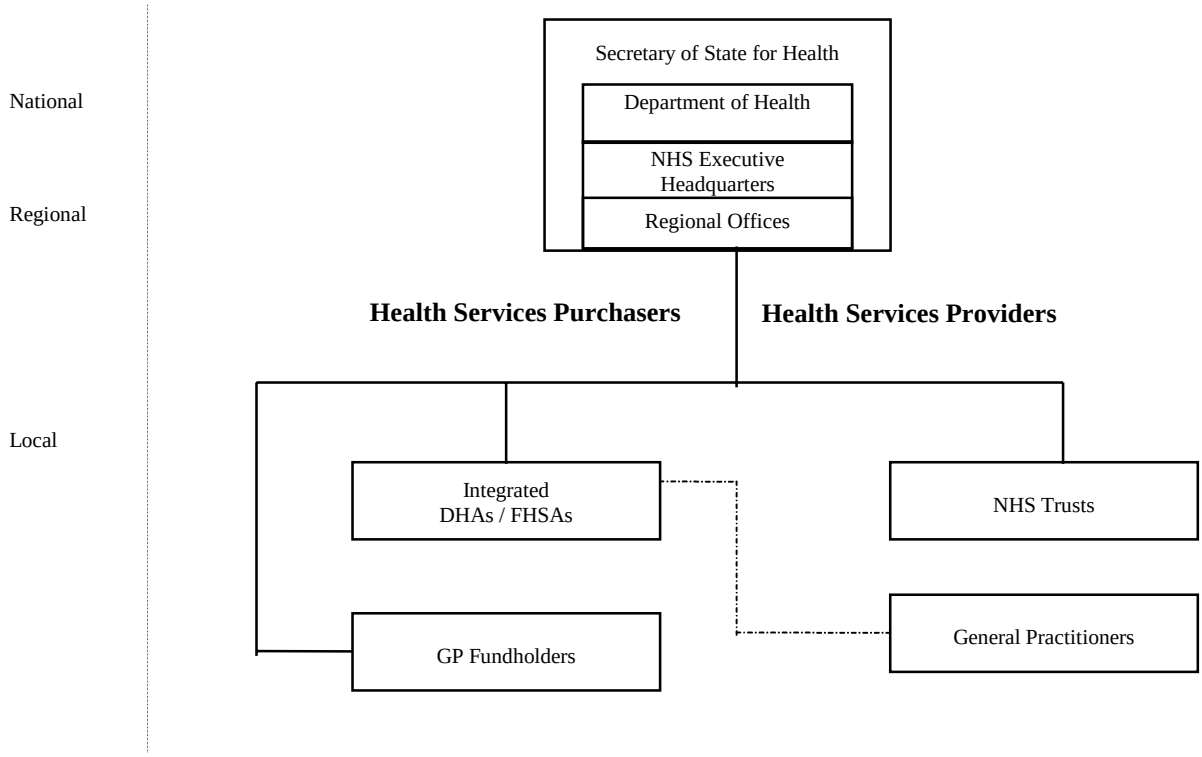


Source: Allsop, *Health Policy and the NHS: Towards 2000*, Longman, 1995, p. 175.

E. Development of the NHS: 1994 -1997

E.1 Further changes were made in April 1996 when the Regional Health Authorities were abolished and the District Health Authorities and Family Health Authorities combined. This was to continue the rationalization of the NHS. Figure E gives the structure of the NHS in the period 1994-1997.

Figure E - Structure of the NHS in 1994-1997



Source: Allsop, *Health Policy and the NHS: Towards 2000*, Longman, 1995, p. 181.

Appendix II

Milestones of NHS Reforms made by the new Labour Government in 1998-1999

Year		Action
1998	-	prepare the way for development of Primary Care Groups (PCGs)
	-	first national survey of patient and user experience
	-	establishment of Health Action Zones
	-	prepare Health Improvement Programmes (HIPs)
	-	GP Commissioning Group pilots begin
	-	new partnership arrangements will develop, and NHS Trusts will participate in preparation of the first HIPs
	-	a strategic plan for improving human resources management in the NHS will be published
	-	new Information Management and Technology Strategy for the NHS published
	-	consultation document on quality issues includes proposals for new National Institute for Clinical Excellence, and Commission for Health Improvement
	-	first tranche of long-term agreements
	-	publication of NHS Trusts costs and the schedule of 'reference costs'
1999	-	subject to legislation, Health Authorities' (HAs) new statutory duties to be introduced
	-	support PCGs in their first year
	-	the first HIPs begin
	-	GP fundholders, Total Purchasing Projects, multifunds, and locality commissioning GP will move on to PCGs and subject to legislation, the fundholding scheme to be wound up
	-	subject to legislation, Institute and Commission to be established
	-	new arrangements for commissioning specialist services
	-	the NHS will begin to report performance nationally and locally
	-	introduction of new combined HCHS, GP prescribing and cash limited GMS budgets from April 1999

Source: *White Paper on the New NHS*, presented to Parliament by the Secretary of State for Health, December 1997.

Appendix III

Population Statistics of the UK, 1980 - 1996

Year	Males ('000)	Females ('000)	Total ('000)
1980	27 411	28 919	56 330
1981	27 409	28 943	56 352
1982	27 391	28 927	56 318
1983	27 429	28 948	56 377
1984	27 511	28 995	56 506
1985	27 611	29 074	56 685
1986	27 698	29 153	56 852
1987	27 789	29 220	57 009
1988	27 876	29 282	57 158
1989	27 989	29 368	57 358
1990	28 118	29 443	57 561
1991	28 246	29 562	57 808
1992	28 362	29 645	58 006
1993	28 474	29 718	58 191
1996 *	28 855	29 930	58 784
2001 *	29 475	30 325	59 800
2006 *	29 980	30 630	60 610
2011 *	30 380	30 878	61 257
2021 *	30 883	31 263	62 146
2031 *	30 900	31 341	62 241

Remarks:
1. all figures are mid-year estimates of resident population.
2. * 1996 - 2031 figures are mid-year projections.

Source: Central Statistical Office, *Annual Abstract of Statistics*, 1995, p. 4.

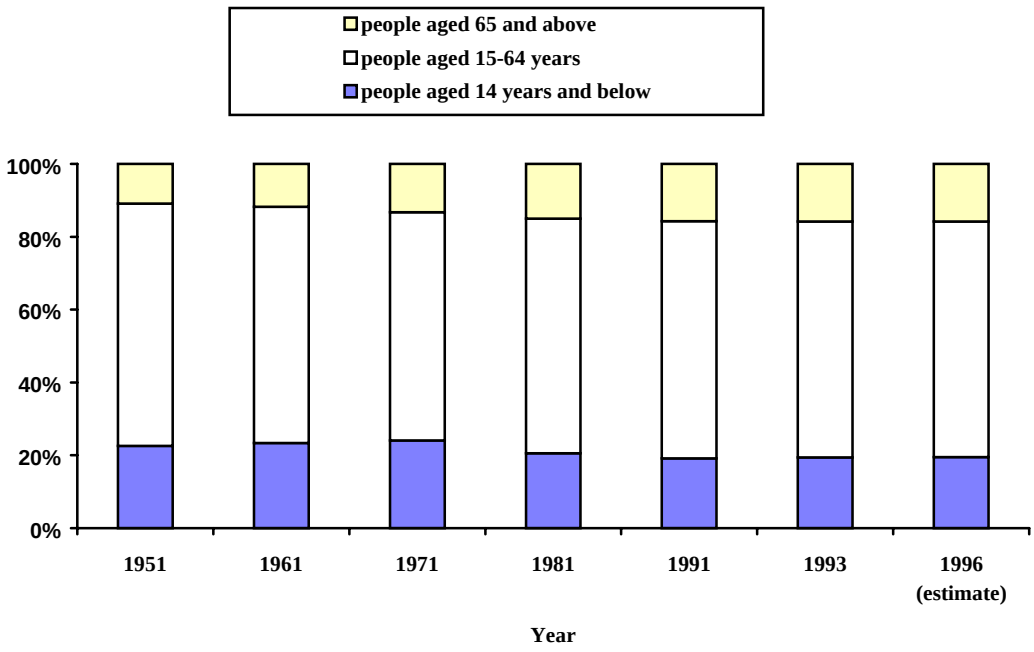
Appendix IV

Breakdown of UK Population by Age, 1951-1996

Year	% of people aged 14 and below	% of people aged 15 - 64	% of people aged 65 and above
1951	22.6%	66.6%	10.9%
1961	23.4%	64.8%	11.8%
1971	24.1%	62.7%	13.3%
1981	20.6%	64.4%	15.0%
1991	19.1%	65.1%	15.7%
1993	19.4%	64.8%	15.8%
1996 (estimate)	19.5%	64.7%	15.8%

Source: Central Statistical Office, *Annual Abstract of Statistics*, 1995, p.6.

Breakdown of UK Population by Age, 1951-1996



Source: Central Statistical Office, *Annual Abstract of Statistics*, 1995, p. 6.

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