

# Health care reform: UK

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## Since 2001, the main policy pledges:

- Reduce waiting time, particularly for elective surgery
- Given patients a real chance to choose health care provider
- Obtain value for money
- We will look at the policy measures that were implemented

## Reduction in waiting time for elective surgery

- “Target and Terror Policy”:
  - National waiting time targets for public hospitals were announced
  - Targets: 18 months for inpatient treatment at the end of 2001 decreasing gradually to 6 months in March 2005
  - Managers of underperforming hospitals were dismissed, and managers of performing hospitals were granted more autonomy to run the hospital.
  - This policy decreased waiting time (see Propper *et al* 2008a)
- The NHS contracted to existing private hospitals a significant number of elective surgery to reduce waiting time (short term measure)
- Substantial investment in Treatment Centres

## Reduction in waiting time for elective surgery: What are Treatment Centres?

- Design to provide high volumes of faster, cheaper, specific, planned, non-emergency, very-short stay elective surgical procedures or diagnostic tests (i.e. ophthalmology and orthopaedics)
- They are build as modular units, flexible (easy to move or to change size) constructed for short-term use, with low overheads and maintenance

# Reduction in waiting time for elective surgery: What are Treatment Centres?

- Dual program of Treatment Centre provision:
  - NHS Treatment Centres
  - Built and run by private providers with guaranteed contracts awarded by the NHS
    - Staff could not have worked for the NHS in the 6 months prior to start to work in the *Treatment Centre* to ensure that Treatment Centres will not drain capacity from the NHS
    - Attracted providers from US, South Africa, Canada and Australia

## Reduction in waiting time for elective surgery: What is the future of Treatment Centres?

- They have been underutilized
- A significant proportion of treatment centres have been scrapped by the Department of Health, citing that additional capacity was not needed
- They argue that the need for additional capacity had been overestimated

## Promoting patient choice (The theory)

- Since 2006, NHS patients were given the right to choose from at least 4 providers (hospitals or treatment centres) selected by their local NHS agent
- Since 2008, NHS patients have had the right to choose from any provider of elective surgery (including private hospitals) that:
  - Meets the quality standards according to the regulator
  - Accepts to provide the service within the national maximum price (tariff) that the NHS will pay for the particular procedure

## Promoting patient choice (Implementation)

- The implementation has been slower than planned but it is already well under way
- In June 2009, there were 134 private hospitals listed on the “choose” system
- The number of procedures under the “choose” system have increased from 2.500 in September 2008 to 10.000 August 2009
- GPs have been reluctant to promote choice (or are still unaware of the system). The DoH is planning to introduce penalties for GPs if they do not promote choice (*unclear how it will be done!*)

## Changing how to pay providers

- The implementation of the choice system required that *money could follow the patient*
- A national tariff for each procedure has been established
- This tariff is used to pay both public hospitals and private hospitals that treat NHS patients
- The tariffs are based on average cost of public hospitals
- So far, private hospitals have undertaken procedures under this tariff (though private providers might have some costs that public do not have: pensions, corporation tax, and VAT)

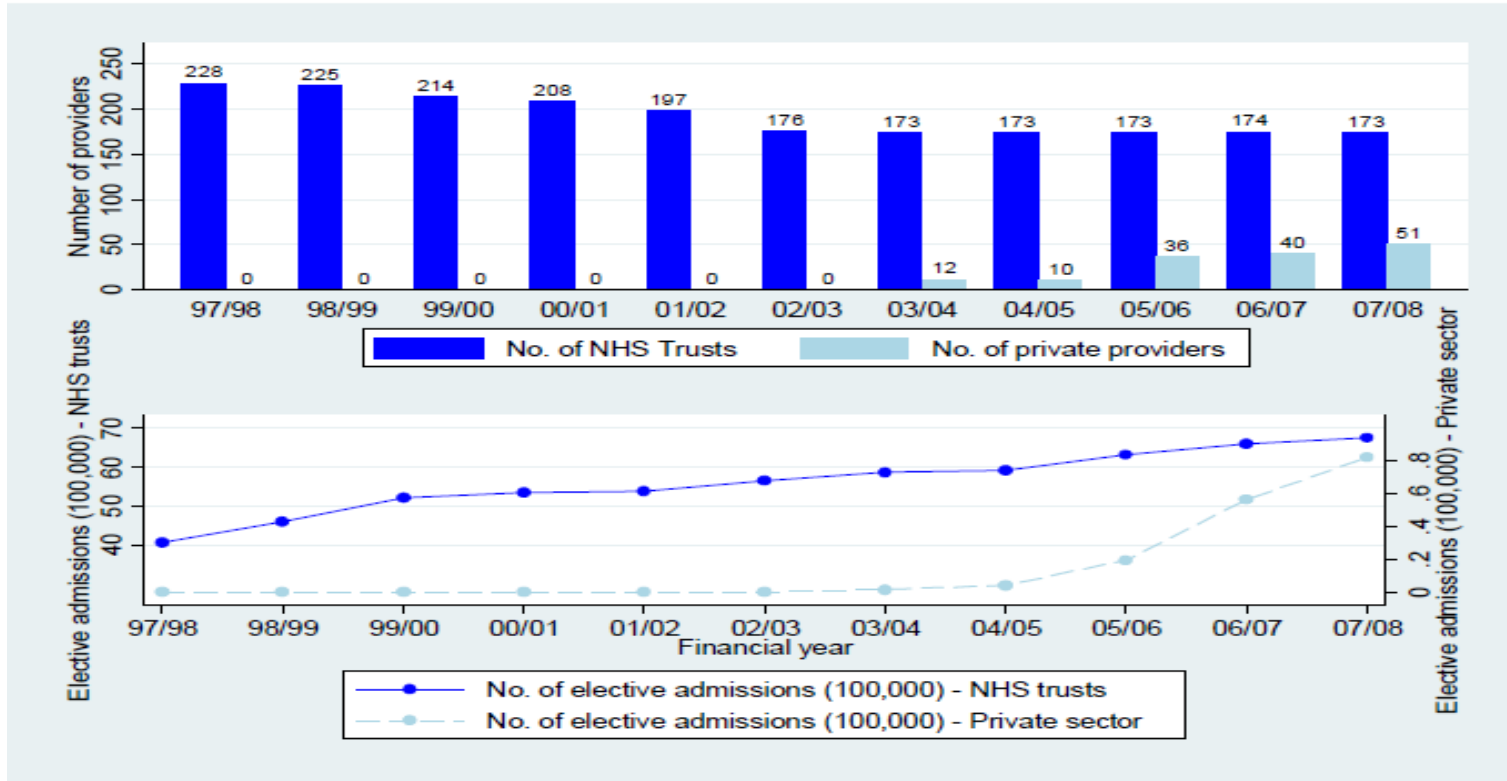
# Competition

- Patient choice implies that public hospitals will compete among themselves and with private hospitals
- Competition will also need good systems to collect, publish, and disseminate information on hospital quality
- The experience of competition between 92-96 resulted in increased levels of quality for published measures of quality, but decreased levels for unpublished measures (Propper *et al* 2008b)
  - During 1992-1996, patients did not have such choice but it was GPs and Local NHS agencies that would negotiate and contract with public hospitals

# Competition

- Competition might imply that some public hospitals might not be able to attract enough patients and might have to close down... which is politically controversial!

# Evolution of referral patterns by GPs



Taken from Dusheiko *et al* (2009)

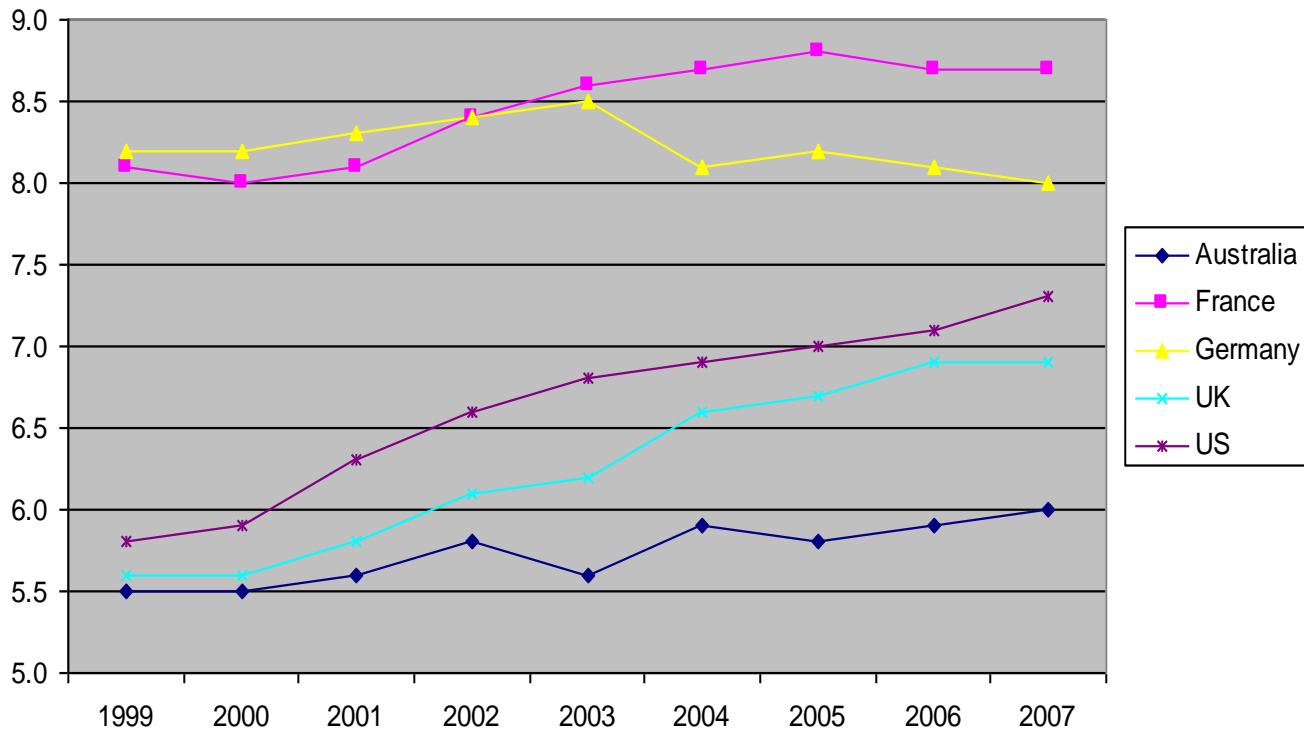
## Payment for performance for GP services

- Since 2003, 25% of GP's income is determined by their quality of the care that they provide
- Based on 65 clinical quality indicators
- The incentive scheme is such that if the doctors achieve quality indicators above a certain threshold, they do not earn more by improving quality further
- Doctors behaviour has been compatible with quasi-altruism: overall doctors could have reduced the quality indicators by 11.8% without reducing their threshold because most of them ended up with better quality levels than the threshold (Gravelle *et al* 2008)
- There is some evidence of gaming the system by missreporting

## Public Spending in Health

- Partly to back up these policy pledges, The Labour government commits to an important increase in public spending
- In 2000, public spending in health as % of GDP was much lower than in other European countries
- Around 8% for Germany and France versus 5.5% for the UK

### Public Expenditure on Health as % of GDP



source: OECD Health Data 2009

# Financing

- Financing of public spending remains tax based
- No significant changes in consumer cost-sharing
- Subsidies to private health insurance were eliminated in 1997
- The fraction of the population with private health insurance remains around 12% during the decade, but the % of employer provided has increased very importantly (representing 66% private health insurance contracts)

## References

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