

Introduction

- 3.1 The Review will assess the resources that will be required in two decades' time to provide a comprehensive, high quality health service available on the basis of clinical need and not ability to pay.
- 3.2 What such a service might involve in 20 years' time needs definition in the light of the objectives of the NHS since its inception, over 50 years' experience of running it and, crucially, changes in society's values and expectations.

1944 White Paper

- 3.3 In the opening paragraph of the White Paper¹ establishing the NHS, the stated objective for the health service was:

“to ensure that in future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health; that what they get shall be the best medical and other facilities available; that their getting these shall not depend on whether they can pay for them, or any other factor irrelevant to the real need”.

- 3.4 The White Paper also sought to define what a comprehensive health service would mean:

“The proposed service must be comprehensive in two senses – first, that it is available to all people and second that it covers all necessary forms of health care”.

Much of the health policy debate since 1948 has been about what comprehensiveness can actually mean in practice.

1956 Enquiry

- 3.5 As early as 1953, five years after the NHS began, it became clear that the costs of running the health service were increasing rather than contracting as had originally been assumed. In response, the Government established the Guillebaud Committee² with a remit to cost ‘an adequate service’. In 1956 the Committee concluded that:

“There is no objective and attainable standard of ‘adequacy’ in the health field... There is no stability in the concept [of an adequate service] itself: what might have been held to be adequate twenty years ago would no longer be so regarded today, while today’s standards will in turn become out of date in the future. The advance of medical knowledge continually places new demands on the Service, and the standards expected by the public also continue to rise.”

¹ A National Health Service (1944).

² Report of the Committee of Enquiry into the Cost of the National Health Service (1956), Cmd 9663.

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3.6 This observation is as true today as it was in 1956. The public's future expectations of the service – examined in Chapter 7 – will be as material to its cost as the pressures of technological advance.

3.7 The Committee also found that:

“There is every reason to hope that the development of the National Health Service will increase the years of healthy life per head of the population, but there is no reason at present to suppose that the demand on the Service as a whole will be reduced thereby so as to stabilise (still less to reduce) its total cost in terms of finance and the absorption of real resources.”

3.8 The increase in healthy years of life has certainly taken place, as has the continued increase in demands. Chapter 9 of this report discusses the impact of further increases in life expectancy over the next two decades.

1979 Royal Commission

3.9 In July 1979, after 30 years' experience of the NHS, a Royal Commission on the National Health Service completed a major review³.

3.10 It made many specific recommendations for change. It observed that good health depends on much more than a good health service and that the measurement of 'health' and of the effectiveness of health care are, at best, uncertain sciences. It noted that the objectives of the NHS at the outset were not laid out in detail, nor were its principles. Although one of its most significant achievements had been to free people from the fear of being unable to afford treatment, the impossibility of meeting all demands for health services had not been anticipated.

3.11 The 1979 Commission wrote down what it believed the objectives of the NHS should be. These were to:

- encourage and assist individuals to remain healthy;
- provide equality of entitlement to health services;
- provide a broad range of services of a high standard;
- provide equality of access to these services;
- provide a service free at the time of use;
- satisfy the reasonable expectations of its users; and
- remain a national service responsive to local needs.

³ Report of the Royal Commission on the National Health Service (1979), Cmd 7615, The Stationery Office, London.

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- 3.12 It recognised that these objectives were imprecise – indeed potentially conflicting, controversial or unattainable. It also concluded that:

“it is misleading to pretend that the NHS can meet all expectations. Hard choices have to be made. It is a prime duty of those concerned in the provision of health care to make it clear to the rest of us what we can reasonably expect”.

Priorities set from time to time, it observed, were the result of subjective judgement.

- 3.13 The Royal Commission defined the need for comprehensiveness to include health promotion, disease prevention, cure, care and after care.

- 3.14 Not surprisingly it found “no objective or universally acceptable method of establishing what the right level of expenditure on the NHS should be”, “if indeed there is meaning in the concept of the right level”.

- 3.15 It issued two notes of caution. Firstly,

“Spending more on the NHS will not make us proportionately healthier or live proportionately longer, although it may improve the comfort and quality of life of patients or the pay and conditions of staff”.

Secondly,

“Whatever the expenditure on health care, demand is likely to rise to meet and exceed it. To believe that one can satisfy the demand for health care is illusory and that is something that all of us, patients and providers alike, must accept in our thinking about the NHS”.

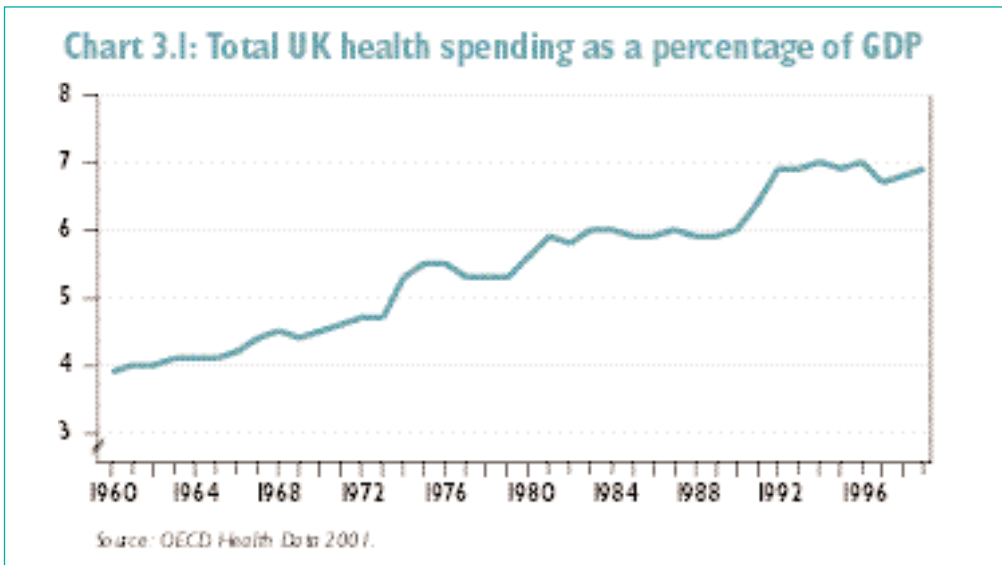
- 3.16 The first assertion may be disputable but the second is not. The need for priorities to be set is clear, and for areas of existing spending which may be relatively unproductive to be eliminated. Areas of potential new spending likely to be insufficiently productive should also be rejected. But the mechanisms for making such difficult decisions must command popular acceptance.

Spending trends

- 3.17 In 2000, the UK spent £66.7 billion on health care, just over 7 per cent of Gross Domestic Product (GDP) or £1,100 for every man, woman and child in the UK⁴. 86 per cent (£57.1 billion) of this came from public funds. Over the past 40 years, total spending on health has increased by an average of 3.9 per cent a year in real terms. As a result, health care spending as a share of GDP has increased by around 75 per cent over this period. This is illustrated in Chart 3.1.

⁴ Office of Health Economics (2001), *Compendium of Health Statistics 2001*, Table 2.1.

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3.18 As Table 3.1 shows, 30 per cent of public expenditure on health and social care in England goes to acute hospital services, 11 per cent to social care for the elderly and 10 per cent is spent on drugs prescribed by GPs.

Table 3.1: Gross expenditure on hospital and community health services, family health services and personal social services in England (1998-99)

	£ billion	Per cent
HCHS: Acute	13.6	30.0
HCHS: Mental health	3.1	6.6
HCHS: Elderly	2.4	5.3
HCHS: Other community care	1.7	3.7
HCHS: Learning disability	1.4	3.0
HCHS: Maternity	1.1	2.5
HCHS: Other	1.1	2.5
HCHS: HQ administration	0.8	1.7
FHS: Drugs	4.4	9.5
FHS: General medical services	3.1	6.8
FHS: Other	2.5	5.4
PSS: Elderly	5.2	11.0
PSS: Children	2.5	5.3
PSS: Learning disability	1.5	3.2
PSS: Adults	1.0	2.1
PSS: Mental Health	0.6	1.2
PSS: HQ costs	0.1	0.3
Total*	46.1	100

Source: Department of Health (2001), *Department Report*, Cm 5103, The Stationery Office, London.

* Excludes central health and miscellaneous services gross expenditure. Components may not sum to total due to rounding.

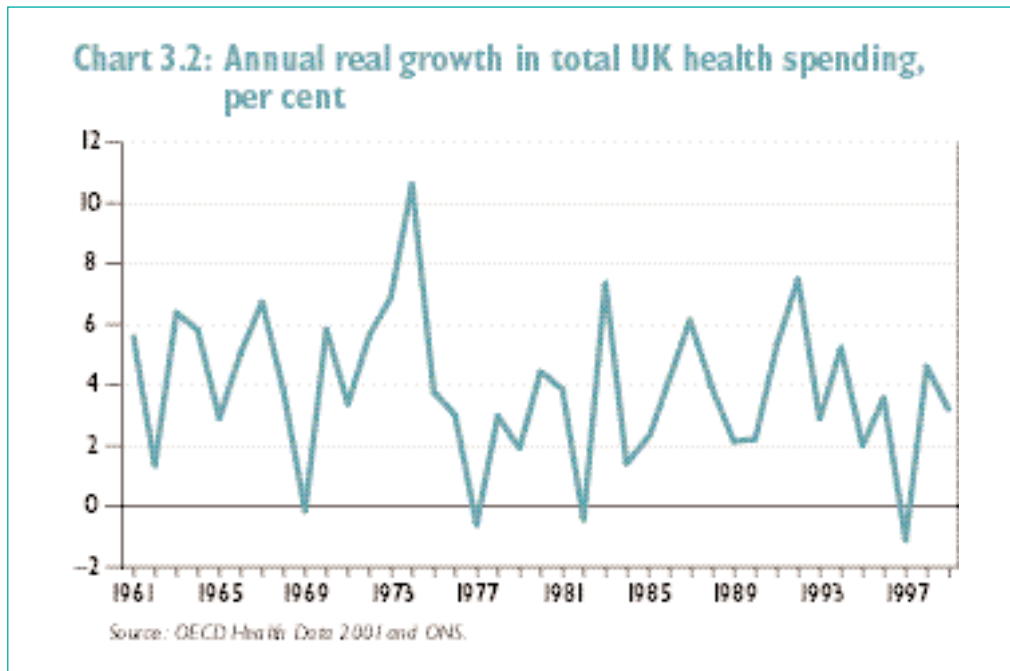
Definitions: Hospital and Community Health Services (HCHS) includes NHS services provided by NHS Trusts.

Family Health Services (FHS) includes the costs of GPs (General Medical Services), other practitioner services such as dentists, opticians and pharmacists, and drugs prescribed by GPs.

Personal Social Services (PSS) includes social services provided by Social Services Departments to clients.

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- 3.19 Chart 3.2 shows that spending increases have varied considerably from year to year, reflecting the progress of the economy overall and government attitudes to spending. Over the past two decades, spending has grown at an average real rate of 3.6 per cent a year.

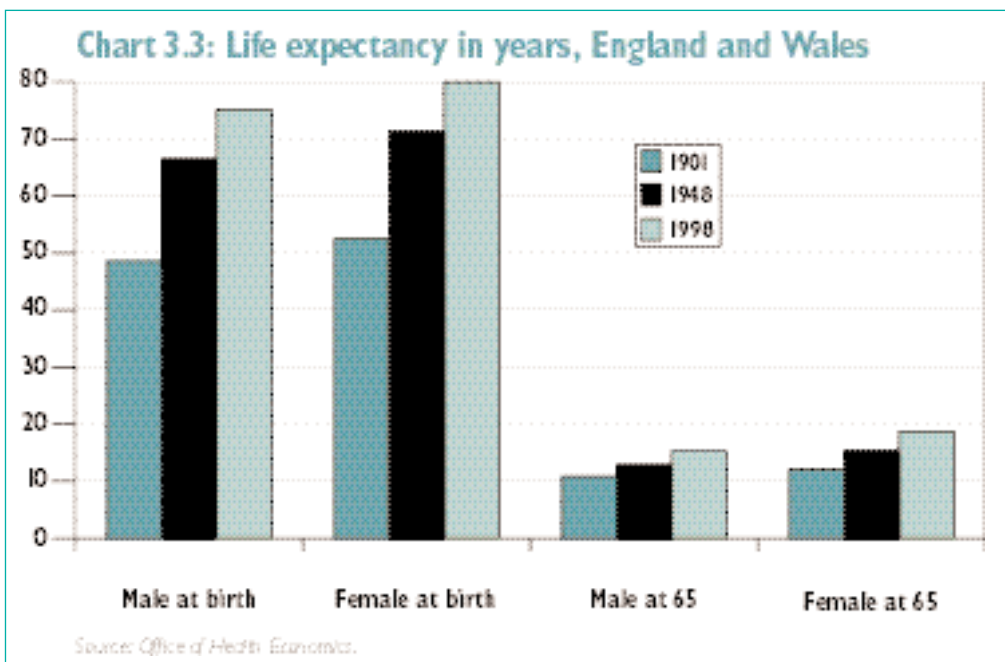


- 3.20 Despite these increases, a widening gap developed between UK spending and the higher EU average (as a percentage of GDP). The cumulative underspend (relative to the unweighted average of EU spending) between 1972 and 1998 has been calculated as £220 billion in 1998 prices. Relative to EU average spending on an income-weighted basis, the cumulative underspend is £267 billion. Not surprisingly, with such significantly lower spending, UK health service outcomes have lagged behind continental European performance, as Chapter 5 shows. The surprise may be that the gap in many measured outcomes is not bigger, given the size of the cumulative spending gap.
- 3.21 The mix of public and private spending on health care has also changed substantially. Private spending as a share of total health spending fell rapidly from over 17 per cent in 1964 to around 9 per cent in 1975. Between 1975 and 1990 the share increased again. In recent years, private spending has stabilised at around 16–17 per cent of total health expenditure in the UK. This is low in comparison with both the EU average, which was 25 per cent in 1998, and the OECD average of 26 per cent in the same year.

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Factors leading to the UK's rising spending

3.22 Through the 20th century, UK life expectancy increased by over 25 years. For example, male life expectancy at birth in England and Wales increased from 48.5 years in the first decade of the century to 75.1 years in 1998. Since the NHS was founded, one additional year has been added to life expectancy every six years on average. In 1948, a man aged 65 could expect to live a further 12.8 years. By 1998, this had risen to 15.3 years.



3.23 Mortality from infectious diseases has fallen but disability caused by chronic diseases has grown⁵. The extra years of life are not all extra years of healthy life. Men and women are living more years in poor health or with a limiting long-standing illness⁶. But older people are in significantly better health than before – between 1981 and 1997 the number of years a person could expect to live in good health rose by around two years from 64.4 to 66.9 years for men, and from 66.7 to 68.7 years for women⁷.

3.24 As people age, their health care needs increase. For adults, health care costs rise with age. Around a third of all spending on health care in the UK is on people over retirement age. The population aged 65 and over has increased from 7.4 million in 1971 to 9.2 million in 1998.

⁵ Dunnell K and Dix D (2000), Are we looking forward to a longer and healthier retirement? *Health Statistics Quarterly* 6:18-24.

⁶ Kelly S and Baker A (2000), Healthy life expectancy in Great Britain, 1980-96, and its use as an indicator in United Kingdom Government strategies, *Health Statistics Quarterly* 7:32-37. Note that limiting is defined as limiting "in any way".

⁷ Office for National Statistics (2001), *Social Trends* 2001.

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3.25 Despite this significant ageing of the population, demographic changes have so far accounted for a relatively small proportion of the increase in spending on health care in the UK. While overall spending (between 1965 and 1999) grew by 3.8 per cent a year in real terms, the demographic changes alone required annual real terms growth of just 0.5 per cent a year. Less than 15 per cent of the growth in health care spending over the past 35 years can therefore be attributed to the cost of meeting the needs of an ageing population⁸. This is in keeping with findings from other countries.

3.26 Other than population growth, the main pressures driving up health care costs in the UK have been:

- **rising patient expectations and demands for quality**

As individuals and societies become more affluent, they expect better standards of health care.

- **technological and medical advances**

This has been the factor most responsible for the rapid expansion of health care costs. For example, pharmaceutical spending as a share of total health spending has increased from 7.6 per cent in 1948 to 13.1 per cent in 1998-99. The technological intensity (in the broadest sense, encompassing medical advances) of health care has increased rapidly. New diagnostic and surgical procedures have increased substantially.

- **increasing relative health care costs**

Input costs have increased faster than general inflation. Health care is labour intensive and, although there have been year on year fluctuations, the health service pay bill has increased consistently faster than general inflation.

3.27 All these pressures are expected to intensify. This Review aims to quantify what the relative weight of these pressures is likely to be.

The economic environment

3.28 International evidence suggests that one of the most important drivers of health spending is the economic environment. Countries with high GDP can spend more in absolute terms and typically devote a greater share of their national income to health. The health of the economy over the next 20 years will be critical to the health service. The economic climate also impacts on many of the trends affecting the health service. For example, levels of poverty and inequality will influence the pattern of morbidity and the use of health services.

⁸ Brindle S (2001), *Our future health – assessing long-term health trends*, Imperial College of Science, Technology and Medicine, MBA Dissertation, London.

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3.29 The Government has set out its long-term objectives for the economy. This Review will not look at the implications of different macroeconomic environments for the resources required for the health service over the next 20 years. The Review assumes that the Government's economic objectives will be achieved and that economic growth will continue at around the currently predicted rate. The Government's central economic objective is to raise the economy's sustainable rate of growth and achieve rising prosperity. But the Review analysis will be based on the Government's neutral assumption for trend growth. Specifically, the Review assumes:

- low and stable inflation: the Government achieves its target of 2.5 per cent inflation;
- fiscal stability: the Government meets its two fiscal rules:
 - the golden rule – that over the economic cycle, the Government will borrow only to invest and not to fund current spending; and
 - the sustainable investment rule – public sector net debt as a proportion of GDP will be held at a prudent and stable level. Net debt will be maintained below 40 per cent of GDP over the economic cycle; and
- strong and stable growth: the economy grows by 2¹/₂ per cent a year on average over the cycle and productivity increases by 2 per cent a year.

2000 NHS Plan

3.30 In 2000, with increasing evidence that the UK continued to fall behind other developed countries and with serious inequalities in local health outcomes still remaining, a new NHS Plan was produced for England⁹. The Plan was followed by similar documents for Scotland and Wales. It is underpinned by ten core principles, which attracted widespread support. Some principles restate long-standing values, while others reflect issues which are felt to be more important now.

3.31 The NHS Plan core principles are:

1. The NHS will provide a universal service for all based on clinical need, not ability to pay.
2. The NHS will provide a comprehensive range of services.
3. The NHS will shape its services around the needs and preferences of individual patients, their families and their carers.
4. The NHS will respond to different needs of different populations.

⁹ Department of Health (2000), *The NHS Plan – A plan for investment, a plan for reform*, Cmd 4818-1, The Stationery Office, London.

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5. The NHS will work continuously to improve quality services and to minimise errors.
6. The NHS will support and value its staff.
7. Public funds for health care will be devoted solely to NHS patients.
8. The NHS will work together with others to ensure a seamless service for patients.
9. The NHS will help keep people healthy and work to reduce health inequalities.
10. The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

3.32 These principles help to define what a high quality health service might look like. Providing health care that improves people's health and ensures that the system treats people as individuals and with dignity, are at the heart of any understanding of quality. This is also a relative issue, as people's knowledge and information sources grow and the performance of other countries is better publicised. The Review is based on the assumption that these principles will remain valid over the next 20 years.

3.33 The NHS Plan sets out what is needed in England to 'catch up' in outcomes – which need not, of course, mean catching up in spending. But 'keeping up' with other countries will demand continuous progress as those countries improve their outcomes further. Eliminating inequalities will extend beyond health service issues and will need careful definitions and good research into the relevance of other social issues to health outcomes.

Defining quality

3.34 Academics, policy makers and politicians around the world continue to wrestle long and hard to understand what quality, comprehensiveness and clinical need might mean for their health care systems, particularly when a population's health is related to so many factors outside health care. For example, the Department of Health estimates that smoking, lack of exercise, obesity and alcohol together account for 50 per cent of preventable life years lost.

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3.35 The World Health Organisation defines ‘health’ to be “a state of complete physical, psychological and social well-being, and not merely the absence of disease or infirmity”. This utopian and holistic view of health might help guide national systems towards a long-term goal, but, even in a 20-year forward look in an advanced country, objectives need to be more focused.

3.36 In the US, the Institute of Medicine has recently undertaken a major review of quality in health care¹⁰ and has identified six dimensions to quality:

- **safe:** avoiding injuries to patients from the care that is intended to help them;
- **effective:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding under use and over use);
- **patient-centred:** providing care that is respectful and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions;
- **timely:** reducing waits and sometimes harmful delays for both those who receive and those who give care;
- **efficient:** avoiding waste, in particular of equipment, supplies, ideas and energy; and
- **equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographical location and socio-economic status.

Clinical need

3.37 This Review has borne these dimensions in mind when considering what the service of the future should be. Clinical need is captured in the dimensions of safety, effectiveness, patient-centredness and timeliness. The need to tackle waste through safety, effectiveness and efficiency is also noteworthy in the US, where total health care spending is around 13 per cent of GDP. Clinical need is difficult to define and is a concept which changes with time. There is, however, widespread acceptance that clinical need should be based on the patient’s ability to benefit from treatment. Indeed the General Medical Council’s code of practice¹¹ tells doctors that the investigations or treatments they provide “*must be based on your clinical judgement of patients’ needs and the likely effectiveness of the treatment. You must not allow your views about patients’ lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age, or*

¹⁰ Committee on Quality of Health Care in America, Institute of Medicine (2001), *Crossing the quality chasm: a new health system for the 21st century*, National Academy Press, Washington DC.

¹¹ *Good Medical Practice* (2001), General Medical Council.

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social or economic status, to prejudice the treatment you provide or arrange. You must not refuse or delay treatment because you believe that patients' actions have contributed to their condition." Increasingly, there is also a consensus that account should be taken of the overall costs to society of meeting patients' needs. There is also a balance to be struck between the costs and benefits of treatment.

- 3.38 There have been important developments in quality recently in the UK, notably with the establishment in England of the National Institute for Clinical Excellence (NICE) and the development of National Service Frameworks (NSFs). Similar, though not identical approaches, exist in the devolved administrations.

Setting priorities

- 3.39 NICE has been set up to give advice on best clinical practice to NHS clinicians, to those commissioning NHS services (Health Authorities and Primary Care) and to patients and their carers. By establishing NICE, the Government aims to clarify which treatments are clinically and cost effective, both for patients and professionals.
- 3.40 The topics on which NICE issues guidance closely mirror national clinical priorities and will complement the NSFs as these are developed. NICE issues a variety of guidance, including:
- clinical guidelines;
 - appraisals of health technologies (drugs and devices); and
 - referral protocols.
- 3.41 The Commission for Health Improvement (CHI) will review progress locally on the implementation of NSFs and NICE guidance. NICE will receive feedback from CHI on the application of its guidance, which it monitors through clinical audit and performance assessment. NICE will also provide guidance (in the form of clinical audit methodologies) to enable hospitals and other health professionals to assess the quality of the care they give against established clinical standards.
- 3.42 Benefits and costs of treatments are, of course, difficult to assess, but the aim is to make these complex and inevitably subjective decisions more transparent and to ensure that all those involved in the provision of health services satisfy their "prime duty" (as the 1979 Royal Commission put it) "to make it clear to the rest of us what we can reasonably expect".

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- 3.43 The development of NSFs in key areas of the health service is a further attempt to set out what it is thought can be achieved in each separate area. Frameworks for cancer, coronary heart disease, mental health and older people have been produced so far, and work is underway on frameworks for renal and children's services.
- 3.44 When published, the frameworks are not yet accompanied by quantified long-term resource requirements, nor by longer-term views of the likely developments in each area and their uncertainties. They could, and should, be further enhanced to produce more comprehensive coverage and a fuller set of objectives properly costed for planning resource allocations. The final report will make recommendations about how this might be achieved.

Introduction

- 4.1 This Review has been set up to estimate the resources required to run the health service in 20 years' time. It is not set up to examine the way in which those resources are financed. The Terms of Reference specify that the Review should examine the resources required for a publicly funded, comprehensive and high quality health care service and so the Review needs to identify the key factors determining the resources required. It is therefore necessary to examine whether the method of funding the health service is itself a factor determining the resources which will be needed over the next 20 years.
- 4.2 The way in which the UK health service is financed has changed relatively little over the past 50 years. This chapter considers whether the current financing arrangement – with health care spending predominantly publicly financed through general taxation – can reasonably be assumed to be the most appropriate way of funding the service as it develops over the next two decades.
- 4.3 At the outset, it should be noted that in all other countries examined in this Review there are relatively high levels of dissatisfaction with health services, whatever the total amount spent on them and however they are financed. In almost all countries governments have their health systems under regular review and are seeking and introducing health reforms.

Funding mechanisms

- 4.4 In most countries health care is financed through some combination of the following four mechanisms, the first two constituting public funding and the second two private funding:
- **general taxation:** general taxation revenues, incorporating both direct and indirect tax receipts, collected by government;
 - **social insurance:** earnings-related employee contributions and/or employer payroll taxes;
 - **out-of-pocket payments:** payments made directly by patients for the use of particular health services, in either the public or private sector; and
 - **private insurance:** private medical insurance taken out by individuals or, for example, by employers on their behalf.

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4.5 Table 4.1 provides a broad summary of the funding arrangements in place in the UK and the group of seven comparator countries which form the basis of the international comparisons in the next chapter. However, differences in accounting rules and conventions between countries may mean that some of the figures are not directly comparable. The table relates to the position in 1998 – the latest year for which comparable Organisation for Economic Co-operation and Development (OECD) data are available. The balance of funding between these methods has changed in some countries over the past three years, for example in France which has been moving towards what is essentially a more tax-financed system, with around a third of public financing for health now accounted for by taxation.

4.6 The table illustrates two key points:

- public funding (whether mainly through general taxation or social insurance) dominates in all the countries, accounting for between 69 and 84 per cent of total health spending; and
- while the relativities vary, most countries rely on a combination of the four mechanisms to finance health care.

Table 4.1: Sources of health care financing – percentage of total expenditure on health (1998)

	General taxation	Social insurance	Total public	Private insurance	Out-of-pocket payments	Other private ¹	Total private
Australia	70	–	70	8	16	6	30
Canada	69	1	70	11	17	2	30
France	3	74	76	13	10	1	24
Germany	6	69	76	7	13	4	24
Netherlands	4	65	69	18	8	6	31
New Zealand	77	–	77	6	16	–	23
Sweden	n/a	n/a	84	n/a	n/a	n/a	16
United Kingdom	74	10	83	4	11	2	17

Source: OECD Health Data 2001. Totals may not sum due to rounding. Breakdown of public and private funding not available for Sweden.

¹ Health expenditure incurred by corporations and private employers providing occupational health services and other unfunded medical benefits to employees plus expenditure by non-profit institutions serving households (excluding social insurance) such as red cross, philanthropic and charitable institutions, religious orders, lay organisations; benefits provided for free by medical care providers plus health expenditure incurred by the rest of the world.

4.7 In the case of the UK, around 74 per cent of health spending in 1998 was financed from general taxation and around 10 per cent from social insurance in the form of an NHS element within earnings-related employer and employee National Insurance Contributions (NICs). Outside of public funding, private insurance accounted for just 4 per cent of total funding, lower than in any comparator country. Out-of-pocket payments (which include expenditure on

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both prescription and non-prescription drugs and medicines) accounted for around 11 per cent of total spending.

- 4.8 Along with Sweden, the UK has the highest publicly-financed share of total health spending of the group of comparator countries and therefore the smallest privately-financed share. As the next chapter sets out, both total health spending and publicly-financed health spending also account for a smaller share of Gross Domestic Product (GDP) in the UK than any of the comparator countries.
- 4.9 Other countries relying mainly on general taxation funding are Australia, Canada, New Zealand and Sweden, while France, Germany and the Netherlands finance the majority of health spending through social insurance contributions (although, as noted above, the balance has been changing recently in France). Out-of-pocket payments are the main source of private financing in most countries, although in France and the Netherlands private medical insurance accounts for the largest share of private financing.
- 4.10 As discussed later, the nature of private insurance varies across countries. In the US it is the only means of cover for much of the population, while in Germany and the Netherlands it is held mainly by high income groups who opt out of social insurance coverage. In Canada private insurers are generally prevented from offering coverage that duplicates that provided by the government, while in the UK private insurance is held in addition to cover provided by the government. Private insurance is used widely in France to cover out-of-pocket payments.

Principles of health care funding

- 4.11 This chapter assesses health care financing systems against three objectives:
- **efficiency:** the extent to which a given level of health care is delivered at the lowest possible cost and creates minimum distortions and disincentives in the rest of the economy;
 - **equity:** the extent to which access is based on clinical need and contributions relate to ability to pay; and
 - **choice:** the ability to meet public expectations of choice and responsiveness in the health service.
- 4.12 Each of the various methods of financing health care are assessed against these criteria. However, some general points are worth considering first.

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- 4.13 As set out in Chapter 3 of this report, the NHS was founded on the principle of providing universal access to the best medical care irrespective of ability to pay. This objective is shared by the majority of health systems in developed countries around the world and has resulted in the dominance of public funding as the means of financing health care. It is interesting to note that OECD work¹ considered in the next chapter of this report suggests that a greater share of public financing of health care is associated with better health outcomes.
- 4.14 In the UK there are currently charges for a limited number of NHS clinical services – mainly prescriptions, dental treatments, sight tests and glasses and contact lenses. The principle that access to health care should be based on clinical need and not ability to pay does not, however, mean that there is no role for such out-of-pocket payments in a financing system. But these payments should be borne only by those who can afford to pay them, with a safety net built into the system to ensure that those who cannot afford to pay are not required to and so are not discouraged from seeking necessary advice and treatment.
- 4.15 A wide range of exemptions apply in the UK, including in most cases the young, the elderly and those who are unemployed or on low incomes. It is estimated that around 50 per cent of the population of England do not have to pay prescription charges. In 2000, 85 per cent of prescription items dispensed by community pharmacists and appliance contractors in England were free to patients. In addition, there are currently limited charges for non-clinical services such as single maternity rooms and car parking.
- 4.16 However, the situation in some other countries is quite different. In France many patients are required to make an out-of-pocket payment to see a doctor, while in Sweden health services which involve out-of-pocket payments include doctor consultations, outpatient services and visits to hospital emergency departments. As discussed later in this chapter, levying significant charges for services for which there is a clinical need raises clear equity questions.
- 4.17 In the United States (US) around 55 per cent of health spending is privately financed through private insurance and out-of-pocket payments, paid either by individuals or their employers. The Medicare and Medicaid programmes are publicly funded and provide support for the elderly, people with disabilities and those on low incomes. But a significant number of people – estimated at around one in six of the population² – has no insurance and is not covered by the federal safety net provisions. This was a concern expressed by many

¹ Or Z (2001), Exploring the effects of health care on mortality across OECD countries, *OECD Labour Market and Social Policy*, Occasional Paper No. 46, Paris.

² Anderson GF and Hussey PS (2000), *Multinational Comparisons of Health Systems Data 2000*, The Commonwealth Fund.

in the US to whom the Review team spoke as part of its international consultation.

- 4.18 As discussed in Chapter 7 of this report, meeting rising patient expectations of a high quality health service will be a difficult challenge for all countries over the next 20 years. Patients can be expected to become increasingly demanding, for example in terms of the quality of treatment they receive, the time they are willing to wait to receive it and the comfort and convenience of the environment within which they receive it. Demands for greater choice and responsiveness are likely to grow. A predominantly publicly-financed health service has to decide what it is and is not able and willing to provide on a universal basis, free at the point of delivery.
- 4.19 When the NHS was established, its objectives were not just about the benefits to individuals but also about the wider benefits to the economy and society of curing sickness and preventing disease, thereby creating a healthier nation and a fitter workforce. Individuals, employers and the Government stood to benefit from the economic and social gains of improved levels of national health and were therefore all deemed to have a stake in delivering them. This continues to be the case today. For example, it has been estimated that workplace absence cost British business over £10 billion in 1999³, illustrating the potential benefit to employers and the economy of a healthier workforce.
- 4.20 However, there is increasingly demand for additional health services which are more difficult to justify on the basis of clinical need and where the gains to an individual in terms of their quality of life and comfort may be significant but the wider health benefits to society are at best limited. The gains to individuals may also vary significantly between individuals, and be valued very differently by them.
- 4.21 In cases where there is clinical need for a particular additional treatment or service it seems reasonable on equity grounds that it should either be available to all on the basis of clinical need and not ability to pay, or it should not be available at all through the public health service. However, deciding what constitutes clinical need is not straightforward. The processes to make such decisions need to be acceptable to the public and patients. The National Institute for Clinical Excellence (NICE) and National Service Frameworks (NSFs) provide the main building blocks for such a process.
- 4.22 In the case of demands for better non-clinical services (for example, significantly enhanced hospital accommodation facilities) charging patients for provision through the public health service already happens. If, in future, it

³ Confederation of British Industry (2000), *Focus on Absence survey*, CBI, June 2000.

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is considered inappropriate for taxpayers to fund the availability of a wider range of non-clinical choice there may be a case for building on such charging. It provides a mechanism to allow patients to express the extent of their preferences for greater choice in non-clinical services while at the same time enabling the health service to preserve its resources for areas which without doubt fall within the definition of clinical need.

Assessing the alternatives

- 4.23 The main advantages and disadvantages of each of the particular methods of financing health expenditure are outlined below, concentrating on the objectives of efficiency, equity and choice. Detailed assessments of the advantages and disadvantages of alternative funding mechanisms can be found in the academic literature^{e.g. 4,5,6} and Chapter 3 of the NHS Plan⁷ discusses the efficiency and equity of funding systems. As already noted, no country relies solely on one of these means of financing expenditure and instead health spending is financed by a balance of them, with this balance varying between countries.

General taxation

- 4.24 The financing of health care through general taxation is widely regarded as being highly efficient from a macroeconomic perspective, delivering strong cost containment and forcing prioritisation through what are typically overall cash-limited health care budgets set by government. Under tax financing, the government has both a strong incentive and the capacity to control costs. Many would argue that the UK system has gone too far in controlling expenditure, leading to under-investment in the UK health service in comparison with other countries over many years.
- 4.25 General taxation is also an efficient way of funding health care from a microeconomic perspective. It typically involves low administrative costs. Because it draws revenue from a wide base it helps to minimise distortions in particular sectors of the economy, although to the extent that the tax system in a country results in economic distortions or disincentives, financing health care through the general tax system will contribute to these.

⁴ Evans RG (2000), Financing health care: taxation and the alternatives, Centre for Health Services and Policy Research, Health Policy Research Unit Discussion Paper Series HPRU 2000:15D.

⁵ Kanavos P (1999), Economy and Finance: A prospective view of the financing of health care, *Policy Futures for UK Health*, Technical Series No. 5, The Nuffield Trust, London.

⁶ Mossialos E et al (eds) (2001), *Funding health care: options for Europe*, Open University Press, Buckingham.

⁷ Department of Health (2000), *The NHS plan: A plan for investment, a plan for reform*, Cmd 4818-1, The Stationery Office, London.

- 4.26 It is sometimes suggested that a reliance on general tax financing can leave a health system vulnerable in times of economic and fiscal difficulties. For example, a sharp slowdown in the economy can result in lower tax revenues and pressure to reduce public spending, including on health care. However, this is not a feature which is specific to tax financing and tax financing can help individuals in difficult times when they are less able to afford out-of-pocket payments or private insurance. Adverse economic developments are likely to put pressure on resources available for health care spending (and indeed other goods and services) whether health care is financed by general taxation or social insurance, or indeed through private insurance or out-of-pocket payments.
- 4.27 Funding health care through general taxation ensures universal access to services irrespective of ability to pay, with maximum separation between an individual's financial contributions and their utilisation of health care services. This is the key requirement of an equitable financing system – access based on clinical need and not ability to pay. The financial contributions made are related to ability to pay as defined by the country's tax system. In general, studies find that financing through general taxation is a progressive means of raising revenue, with the amount that individuals pay as a proportion of their total income rising as income rises, although the degree of progressivity depends on both the nature of a country's direct and indirect tax systems and the balance of revenue raised through direct and indirect taxes. A 1999 study⁸ found funding of health care through general taxation in the UK to be progressive overall. Within this, the UK had the most progressive direct tax system of the 13 major countries studied although one of the most regressive indirect tax systems.
- 4.28 The degree of individual choice available to patients tends, however, to be relatively limited under tax financing. The overall level of resources available for health care is constrained by what the government judges the economy can afford and choices between what services are and are not provided are made centrally. Such an arrangement seems entirely appropriate in the case of clinical services where there is judged to be clinical need. But in a world where patient expectations are rising rapidly and people are increasingly looking for health services which offer greater personal choice in non-clinical services, it may not be acceptable or equitable to meet all of these additional demands through public financing.

⁸ Wagstaff A et al (1999), Equity in the finance of health care: some further international comparisons, *Journal of Health Economics*, 18:264–90.

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Social insurance

- 4.29 In social insurance systems, employer and/or employee earnings-related contributions are usually paid to and managed by social insurance or 'sickness' funds. A criticism of traditional social insurance systems is that these sickness funds face little incentive to seek to contain the payments they make to health care providers because of their ability to raise contribution rates. As a result, many argue that cost control under traditional social insurance models has been weak and resulted in inefficient use of resources. The existence in some countries of multiple sickness funds and the greater fragmentation in health care purchasing involved in these systems can also result in relatively high administration and transaction costs.
- 4.30 Sharply rising costs and emerging deficits in social insurance funds in recent years have led several countries to introduce reforms to their social insurance systems. These have involved moving towards financing arrangements where they can exert greater control on the overall level of health spending. For example, in 1997 Germany attempted to limit increases in social insurance premiums by imposing greater competitive pressures on the sickness funds and extra co-payments on the members of sickness funds which decided to increase premiums. And in France, there has been a shift in the balance of funding from social insurance towards taxation, with the French parliament being given the power to set a global budget for health care. To reduce inefficient use of resources, France and Germany have also been looking to learn from features of the UK health system such as the role of GPs in acting as gatekeepers.
- 4.31 Social insurance contributions are raised from a narrower base than general taxation, with the costs falling mainly on employers and employees rather than the wider group of taxpayers. Estimates published in the NHS Plan relating to 1997 suggest that a move to financing the NHS predominantly from NICs would cost an additional £1,000 a year per employee using the French system and an additional £700 a year per employee using the German system.
- 4.32 As with general taxation, social insurance contributions may lead to economic distortions and disincentives. Such effects might be more pronounced in systems dominated by social insurance because the revenue base is more concentrated, i.e. on employment. One of the main reasons for the shift in the balance of funding from social insurance towards taxation in France since 1997 has been the potential negative impact on industry of the country's previously very high reliance on social insurance financing. Like tax-financed systems, social insurance systems can be vulnerable to periods of economic downturn which can result in reduced revenues into the sickness funds.

- 4.33 The equity of social insurance systems depends on the nature of the particular system. As with tax-financed systems, access to health services is typically universal or near universal and not based on ability to pay. The extent to which contributions reflect ability to pay does, however, differ significantly between countries. Social insurance can be progressive or regressive depending on the nature of the scheme.
- 4.34 The social insurance element of UK health financing in the form of NICs paid by employees and employers, although relatively small, has been found to be highly progressive (more so than general taxation overall) contributing significantly to the overall progressivity of publicly-financed health care in the UK. It is worth stressing that this system is very different from traditional social insurance systems found in many countries of continental Europe. There is only one fund and one set of contribution rates, with the health element of contributions paid by employers and employees going to fund the NHS.
- 4.35 There is little scope for expression of individual choice under social insurance models. Some countries allow higher income earners to opt out of social insurance schemes (itself raising equity issues) and some allow scope to choose between individual sickness funds, but there is little choice between contribution rates and benefits available within schemes. Together with an increasing tendency for governments to cap expenditure levels of social insurance funds, there appears to be little difference in terms of individual choice between tax and social insurance financing.

Out-of-pocket payments

- 4.36 Patients may be required to pay for all or part of the cost of a particular publicly-provided service through user charges. In addition, individuals are increasingly choosing to pay privately for specific interventions as and when they need them, although this could reduce in future if waiting time and responsiveness objectives in the NHS are met. An efficiency argument in favour of such charges is that they can help to encourage the responsible use of resources by limiting wasteful and unnecessary activity and contain the total amount of health expenditure which the government has to finance publicly.
- 4.37 However, savings in some areas can be more than offset by higher expenditure in other areas and/or in the longer term. As set out in the NHS Plan, a randomised trial in the US in the 1970s found that charges led to less use of preventative care. There is also evidence that charges can discourage people from seeking treatment at all, or can direct them to other areas of a health system where charges are not levied. In such circumstances, activity may be diverted to more costly parts of the system or delayed to a point at which treatment is more expensive. Out-of-pocket payments also inevitably involve administration and collection costs. And in some countries, for example

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France, patients have responded to out-of-pocket payments by taking out private insurance to pay for them, thereby negating any potential efficiency gains.

- 4.38 Flat rate out-of-pocket payments are unrelated to income and therefore regressive. They relate access much more directly to ability to pay than either general taxation or social insurance. The equity of out-of-pocket payments should not, however, be considered in isolation from the type of service for which the charge is being made.
- 4.39 Where out-of-pocket payments are levied on what are clearly regarded as clinically necessary services, such charges are inequitable unless accompanied by adequate exemptions to ensure that those with a clinical need are not discouraged or prevented from receiving treatment. In addition, in cases where out-of-pocket payments are designed to increase efficiency by discouraging wasteful use of resources, e.g. unnecessary visits to a GP, such charges are most likely to achieve the aim by discouraging use among the less well off in society – the charge is much less likely to change the behaviour of those who can easily afford the payment.
- 4.40 There is evidence that out-of-pocket payments increase inequalities in access to health care. Research⁹ in Sweden found that after controlling for health status there was no socio-economic difference in the proportion of the population who visited a doctor in the 1970s and 1980s, whereas studies from the 1960s showed greater use of health services among high income groups. However, there was evidence of some re-emergence of inequalities in access in the 1990s. While these changes may have reflected a number of factors, it is notable that the greater equality of utilisation during the 1970s and 1980s followed a reduction of user fees, while the widening in inequality in the 1990s followed large increases in user charges. Evidence from France and Denmark also points to user charges for clinical services restricting health care access for some socio-economic groups¹⁰. For example, one in four people in France declared they had been put off seeking care for financial reasons, with women, older people and the unemployed forming a large proportion of those not seeking care. This is clearly inequitable.

⁹ Whitehead M et al (1997), As the health divide widens in Sweden and Britain, what's happening to access to care?, *British Medical Journal* 315:1006-09.

¹⁰ Dixon A and Mossialos E (2001), Funding health care in Europe: recent experiences, *Health Care UK Spring 2001*, King's Fund.

4.41 There will, however, be cases where the use of charges does not result in such significant equity concerns. As discussed earlier in this chapter, this might be the case with charges for services which are unrelated to clinical need – for example, levying a charge for those patients who wish to have access to computer facilities in their hospital room. Such out-of-pocket payments have the potential to offer patients greater opportunity to experience choice and responsiveness in a health system. As patients become increasingly demanding, it may become more difficult to justify the public financing of all the non-clinical services to which they seek access and it may be considered inappropriate for taxpayers to fund a greater range of non-clinical choice. Introducing charges for certain additional non-clinical services would be one way of providing access to such services and enabling patients to reveal the extent of their preferences for them.

Private insurance

4.42 The extent to which private health insurance finances health spending varies considerably across countries, as shown in Table 4.1, with a considerably smaller share of spending being financed by private insurance in the UK than in other countries.

4.43 The nature and coverage of private insurance also differs significantly across countries, and partly explains the differences in the aggregate figures. In some countries (for example the US) private insurance is relied on by a majority of the population as their sole means of cover. In other countries, private insurance is largely taken out by higher income groups, either in place of social insurance (for example, Germany) or in addition to cover provided by the government (for example, the UK). Finally, in some countries (for example, France) private insurance is taken out widely by the population for the specific purpose of covering their liabilities for user charges within the health system.

4.44 Systems which rely on private medical insurance tend to exhibit poor cost control, with spending largely demand led, an absence of global budgets and the fragmented commissioning of health care services. As the NHS Plan notes, the fact that pharmaceutical prices are on average 75 per cent higher in the US than in the UK is at least partly due to fragmentation of health care purchasing. Management and administration costs are also high under private insurance, including the costs which are required in assessing risk, setting premiums and assessing claims. The NHS Plan quotes figures showing that administrative costs in the US are up to 15 per cent higher than in Canada, largely because of the cost of insurance processing.

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- 4.45 In countries where private insurance is relied on by much of the population as the sole means of cover, the level of access to health services is determined by the level of insurance cover which an individual can afford to purchase, and contributions are based not on ability to pay but on an individual's health risk rating as assessed by the insurer. It will usually be the poorer, older and less healthy in society who are considered by private insurers to have the greatest health risk and therefore face the highest insurance premiums. Access depends on ability to pay and the lowest income earners tend to pay more. Such private insurance financing is highly regressive and inequitable: *"The most obvious consequence of shifting from public financing to private spending is to shift the burden from the relatively rich to the relatively poor"*.¹¹
- 4.46 This can result in a situation, as in the US, whereby a significant proportion of the population has no access to health services other than the last resort of the emergency room, either because they cannot afford the insurance premiums or because private insurers refuse to insure them because they are deemed too risky.
- 4.47 In other countries where private insurance is largely held by those in high income groups in place of public cover, financing through private insurance is generally found to be progressive – although the financing system overall tends to be regressive. Private insurance against out-of-pocket payments varies between being progressive and regressive depending on how wide a group of the population holds such insurance.
- 4.48 For those who can afford to take out private medical insurance, choice is likely to be greater than under public financing, with choice of both insurer and the type of care package and range of benefits which it offers. The issue for this Review is to ensure that it is costing an NHS where the standards of care for all meet the agreed future criteria as they are laid down. There will still, as at present, be the opportunity where people want it to pay for private insurance in addition to paying taxes and NICs and receive, in return, a greater element of choice.

¹¹ Normand C (1998), Ten popular health economic fallacies, *Journal of Public Health Medicine*, 20:129-132.

Organisation and delivery

- 4.49 It is important to note that the system of financing health care is only one of the differences between countries. Countries also differ in the organisation and delivery of their health care and within this in the role of the private sector in providing, rather than funding, health care.
- 4.50 Differences in the organisation and delivery of health care (for example, whether doctors are paid on a capitation or fee-for-service basis, whether GPs play a gatekeeper role in the system and whether organisation and delivery is integrated or fragmented) may well be more important to overall resource requirements than the system of financing. They will have a strong influence on the incentives in the health care system and through this will impact on the system's efficiency and productivity.

Conclusions

- 4.51 In most countries health care is financed through some combination of the funding mechanisms discussed in this chapter. However, most health systems – certainly all those of the group of comparator countries considered in this Review – rely mainly on public financing with universal access.
- 4.52 The above analysis suggests that the current UK system for financing health care shapes up well against the alternatives:
- financing through general taxation is generally regarded as being more efficient than other means of financing, ensuring strong cost control and prioritisation and minimising economic distortions and disincentives;
 - a reliance on financing through general taxation and some forms of social insurance such as in the UK involves the maximum separation between an individual's financial contributions and their utilisation of health services. This meets the key objective of providing universal access to medical care irrespective of ability to pay. Of 13 major countries studied, the UK has been found to have the most progressive financing system overall;
 - there is evidence that a greater share of public financing of health care is associated with better health outcomes; and
 - the general absence of out-of-pocket payments for clinically necessary services and treatments and widespread exemptions in the limited cases where such charges are levied ensures that the financing system is equitable and does not discourage people from seeking treatment.

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- 4.53 There is therefore no evidence that any alternative financing method to that currently in place in the UK would deliver a given level and quality of health care at lower cost to the economy as a whole. Indeed other systems seem likely to prove more costly. Nor do alternative balances of funding appear to offer a greater degree of equity in the way services are provided.
- 4.54 Over the next 20 years, and particularly as patients' expectations of the health service continue to rise, there will be difficult decisions to be made about what constitutes clinical need, what level of patient choice to accommodate and what can be afforded or is considered appropriate through public funding. These are matters for the government of the day. Out-of-pocket payments for higher levels of non-clinical services may provide one means of meeting demands for greater choice and responsiveness. But such questions would be for after this Review, or subsequent reviews, have reported on the likely total resources required in the long term. They would be addressed in the context of the macroeconomic background against which the Chancellor of the Exchequer, from time to time, considers the implications of the estimates of future resource requirements for the Government's wider economic and fiscal strategy.
- 4.55 The key conclusion for this Review, however, is that the current method by which health care is financed through general taxation is both a fair and efficient one from a macroeconomic point of view. A continuation of a system of funding broadly similar to that at present is not, in itself, anticipated to be a factor leading to additional resource pressures over the next 20 years. It is therefore appropriate to conduct the Review on the basis of a continuation of the current system for funding UK health care.