Two issues dominate health system reform throughout the world: How much should be devoted to health care? And how can resources be managed to achieve maximum health gains – taking due account of the need for improved equity?

The last two years have seen the introduction of perhaps the most far-reaching reform of the National Health Service (NHS) in the United Kingdom since it was first established in 1948. Although the notion of an “internal market” has been proposed, or put into effect in other countries (Netherlands, New Zealand, Sweden), the changes in the UK have been the most radical both in the speed of change – a little over two years after publication of the government’s document heralding the move – and in the extent of the shift away from an integrated model in which the government plays roles of both the funding agency and the service provider. Despite these changes, the source of funding – general taxation – remains the same, even though questions may be raised in the future about the suitability and level of funding.

Prior to 1991, resources for hospital and community health care were allocated to district health authorities (DHAs) on the basis of population size, taking into account health needs and some other local factors. The district authority had responsibility for managing and paying the providers of care on the basis of bed capacity, and of past and projected utilization levels. Since 1991 the relationship between DHAs and providers has changed, and today hospitals and other providers – such as ambulance services – are permitted to become self-governing trusts. Although still owned by the NHS, they are no longer managed by the DHA and have substantial autonomy over decisions on personnel employed, salary structure, use of facilities and specialities offered. The payment or purchasing, and service-providing roles of the DHA have been substantially separated.

Better health status

The purchasing side of the DHA is charged with using its budget to maximize the health status of the population. In order to achieve this, it may contract with any provider on the basis of the cost and quality of services offered. Providers need not be local district NHS facilities; they might be private hospitals or NHS facilities in other districts. Contracts are agreed with providers before the beginning of the financial year, and may simply specify the service to be provided for a target population, or they may go into detail about the cost and volume of the service.
A new method of managing capital spending has also accompanied the reforms. Health service providers must now pay a capital charge based on the value of their physical assets.

A major effect of the internal market on health service purchasing patterns is that city centres, particularly London, will tend to lose out because of their higher capital and operating costs. Health authorities will prefer to contract with provincial hospitals which can offer an equivalent service at much lower cost. Now that purchasers are free to choose among providers, the higher capital charges in city centres are particularly London, will tend to lose patterns is that city centres, hospitals which can offer an equivalent service at much lower cost. Although unpopular to many people, the reforms may succeed in bringing about some long-needed rationalization of London’s hospital service. But concern has been expressed that, if a reduction in accident and emergency facilities is not accompanied by an improvement in primary health care, the population will suffer.

Ensuring quality of care

In order to ensure that the internal market improves the efficiency of health care provision, two issues are important: the availability of information on the costs, consequences and quality of treatments; and the adequacy of competition between providers.

Internal markets depend on information. Information is required not just on treatment costs but also on the quality of service if provision is not to be judged on price alone. Although considerable investment in information technology has already been made, the contracting process is still at a relatively rudimentary stage. The cost of introducing the new procedures has been substantial and there are claims that wastage has occurred.

Although the operation of a contracts system is new for secondary health care, i.e., referral centres and larger hospitals, this has always been the case in the primary care sector, with independent doctors in general practice contracted by the Family Practitioner Committee (now the Family Health Services Authority, on the basis of capitation (annual fee per patient) and an experience-related practice allowance. Since 1990 the proportion of general practitioners’ income received through capitation has increased. The main check on the quality of service is the patient’s freedom of choice of general practitioner. But this is only effective where there is a wide choice of practitioners so that the patient can identify those who provide the best service. A lack of competition in some areas, or a tendency for patients to judge doctors on non-medical attributes (such as quality of the waiting room), may mean that the clinical elements of quality of care are neglected.

In the case of secondary health care, the problems of competition are heightened because of the relatively small number of service providers. The purchasing authority (DHA) may have no real choice among providers. This problem, together with the large amount of costly information required, could render the “contract” model unable to ensure satisfactory provision in some areas.

Internal markets may make budget constraints more explicit. At present the main rationing device in Britain is the hospital waiting list. There are long waiting lists for some procedures, and these encourage patients who can afford it to seek treatment in the private sector. Some districts are beginning to experiment with methods of prioritizing treatment procedures such as differences in the cost per QALY (Quality-Adjusted Life Year). These allow a rough comparison of the health status gain per unit of expenditure. One scenario is that treatment provided by districts is restricted to a specific package of services that exclude procedures that are too expensive or of dubious effectiveness.

Such pressures as these are heightened by continued suggestions that the increase in funding is not sufficient to cover the needs of a growing elderly population and the increasing cost of medical technology. Although real funding has steadily increased in recent years, current pressures to restrain growth in public expenditure make further substantial increases in funding from central taxation unlikely. Future options for increasing the level of supplementary funding may include higher patient charges for non-medical services and voluntary insurance for non-core NHS services and referrals of private patients. While a more fundamental review of the way in which the National Health Service is funded at present appears improbable, debate on alternative funding mechanisms could be revived if strong budgetary pressures continue.

Dr. Tim Ensor is research fellow at the Centre for Health Economics, University of York, York YO1 5DD, England.