CENTRE *for* ECONOMIC PERFORMANCE

ELECTION ANALYSIS

Health Care:
Evidence on the Impact of Increased Spending and Patient Choice

- Public spending on health rose by 10% a year in nominal terms (7% in real terms) between 1999/2000 and 2004/05. It is planned to continue rising at this rate until 2007/08.

- There have been substantial increases in staff in the National Health Service. For example, employment of nurses has increased by 3.5% a year since 1998. Waiting times and waiting lists have also fallen.

- Although overall NHS activity has increased, measured productivity has fallen as a large proportion of the increased expenditure has gone towards higher wages.

- The large number of targets introduced since 1997 has been criticised for leading to wasteful bureaucracy and the distortion of clinical priorities.

- There has been increased involvement of the private sector and overseas providers in the delivery of NHS health care. The system of foundation hospitals gives trusts greater autonomy.

- Allowing money to follow patients – 'payment by results' – should increase incentives to treat more patients. Both main parties are campaigning on offering patients greater choice.

- Effectively, this means that more 'quasi-markets' are being offered in health care. There are concerns over whether this will really increase quality.

- The Conservative proposal to subsidise private sector treatments will lead to large taxpayer losses unless there is a significant shift out of the NHS into the private sector as a result of the subsidies.

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Introduction

The NHS usually ranks top of the list of voters' concerns. The health sector is intrinsically prone to 'market failure' – usually patients neither choose their treatment nor do they pay for the cost directly. Yet the two main parties are both promising more 'patient choice' in health care.

The Labour government has staked a great deal on improvements in the NHS and began a serious expansion of spending in 1999 when the Prime Minister pledged to increase spending 'to the European average'. In practice, this has meant a 7% a year increase in health expenditure in real terms (10% in nominal terms) in the six years to 2004/05. This rate of increase is planned to continue through until the spring of 2008, and the Conservatives have promised to match it.

'Investment': where has the money gone?

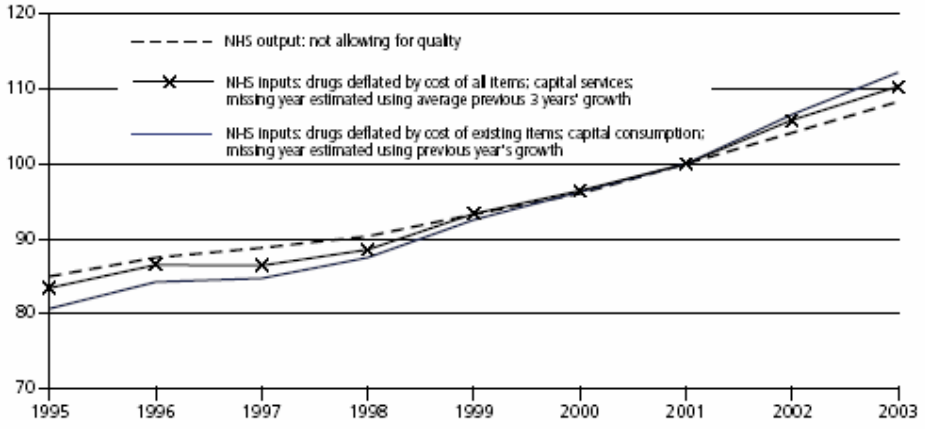
Some of the increased spending has led directly to increases in staff. Since 1998, there has been a 3.5% a year increase in the number of nurses and a 5.4% a year increase in hospital consultants. Numbers of general practitioners (GPs) have risen by 1.8% a year.

This has translated through into more NHS activity (such as operations) and therefore reduced waiting lists and waiting times. For example, 1.3 million people were on waiting lists in 1998 compared with 860,000 in 2004. Maximum in-patient waiting times have fallen from eighteen months in 2001 to nine months in March 2004 and will probably fall to six months by the end of this year. Measured NHS real output has risen by an average of 3.7% a year between 1998 and 2003, much faster than the growth rate of the economy.

The stark fact is, however, that NHS outputs have grown at a slower rate than NHS inputs, implying a sharp decline in NHS productivity (see Figure 1). This measure of productivity can be criticised, of course, as not fully taking account of any improvements in quality – for example, if a patient is given more time to talk to his or her GP, this will count as a fall in output, other things equal. But part of the reason for a fall in productivity is that a lot of the extra resources have been absorbed in the form of higher pay.

There has been a major overhaul in the consultants' contract, an ambitious new pay structure for most staff ('Agenda for Change') and implementation of the Working Time Directive has significantly reduced the hours that junior doctors have to work. Many of these changes were unavoidable consequences of complying with European employment legislation. Furthermore, changes to the pay structure may deliver dividends in the long run (such as greater cost of living allowances for London nurses and more committed NHS consultants). But in the short run, these changes are proving very costly and may have little direct impact on patient experience.

Figure 1: NHS productivity, 1995-2003



Source: ONS

‘Reforms’: are they working?

A number of key reforms have been put in place by the government and more are promised if Labour is re-elected. These relate to the private sector, competition and targets.

Private sector involvement

The government has made an important ideological shift by being prepared to involve the private sector much more deeply than previous Labour administrations. On the investment side, there has been the continuing emphasis on the Private Finance Initiative. On the delivery side, under the ‘concordat’, the government buys spare capacity from the private sector (which has very low utilisation rates). Private providers currently carry out 4% of publicly financed elective treatment and the government wants this to rise to 15% by 2008.

Another radical policy has been the establishment of ‘diagnostic and treatment centres’ in 2001. These offer dedicated facilities for some forms of elective surgery, such as cataracts and hernias. The contracts to run these centres were open to bids from the private sector and overseas providers instead of just existing NHS suppliers. In the event, many overseas suppliers won these contracts and this has opened up more of the UK health sector. The UK private sector has been cutting prices rapidly in response to falling waiting lists and greater competition from foreign entrants.

Competition and choice

In 1997, the government formally abolished the previous administration’s ‘internal market’, although many elements such as the purchaser/provider split were kept (commissioning was to be by groups of GPs in ‘primary care trusts’ rather than individual GP fundholders). Since 2001, there has been a re-introduction of ‘quasi-market’ mechanisms.

If a hospital trust demonstrates sustained good performance, it can attain ‘foundation status’. One element of this earned autonomy is that it is allowed to retain surpluses, which can be used to improve services. By the end of March 2005, 25 of the 173 acute care trusts in England had gained foundation status.

Parallel to this greater autonomy is the system of ‘payment by results’, which essentially means that money follows the patient. The more activity that a trust performs, the more resources it will receive as set by centrally determined prices (‘the national tariff’). This should increase the incentives for hospitals to offer more and speedier treatments. The Labour Party has pledged to allow anyone requiring an elective operation the right to choose between four or five hospitals by the end of the year (and any English hospital by 2008[1]).

Will greater choice in health care improve efficiency?[2] This is a controversial question and is ambiguous from the perspective of economic theory. Empirical research in the United States seems to show that competition in health quasi-markets accompanied by strong regulation and good information generates lower costs and higher quality.[3] Less optimistically, evidence from the 1991-97 English internal market experiment shows some falls in quality.[4] A serious problem in any ‘NHS health market’ is allowing unsuccessful parts of the NHS to contract and, in extreme cases, to close. Such changes are very politically sensitive.

Targets and information

Controversially, the government has set stretching targets for health sector performance and published an unprecedented amount of information on health performance. Obviously, to exercise any choice there must be information and these benchmarks, by themselves, may encourage greater effort by hospital managers. There are at least two problems.

[1] The Conservatives have promised to allow this immediately.
[2] See Burgess et al (2005) for an in-depth survey of these issues.
[3] Kessler and McLennan (2000)
[4] Propper et al (2004)

First, the data may be corruptible because managers learn how to play games with the system. For example, official figures show that by mid-2004, 96% of all patients were seen within four hours in an Accident and Emergency department. But survey evidence from the Healthcare Commission suggests that many more than 4% of patients claim to have been waiting for over four hours and 6% said they had to wait more than eight hours.

Second, health managers may focus on meeting the targets and neglect other hard-to-measure or non-targeted parts of patient care.

Differences between the parties

The Conservative Party are also offering greater choice, including a 'patient passport', which will offer a subsidy to patients who switch from the NHS to the private sector. The subsidy is set at half the cost of the NHS equivalent treatment. One problem with this proposal is that there will be a large deadweight cost as current private patients will enjoy an immediate subsidy of about £1.2 billion. This cost could be offset if a large fraction of current NHS patients switched to using private health care. Although there is not a huge amount of evidence, research tends to find that the sensitivity of customers to changes in private health prices is not high, so large numbers of switches are unlikely to occur.[5]

The parties agree on the desirability of information but disagree on the need for targets. Labour wants to streamline and reduce the number, but the Conservatives and Liberal Democrats are pledged to scrap them altogether.

Conclusions

A defining feature of the Labour government has been the largest sustained increase in health expenditure for a generation – 7% a year in real terms between 1999 and 2008. This was funded by a substantial hike in taxation through increases in National Insurance. Although there have been undoubted improvements in the health service with falling waiting times, critics argue that a large proportion of the resources has been soaked up in the form of higher wages and bureaucracy.

There is currently an ambitious programme of reform that essentially allows more market-based choice in health. It remains to be seen exactly how this will work and whether it will improve productivity.

For further information

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[5] See Cutler and Zeckhauser (2000) for the United States or McGuire and Hughes (1995) for the UK.