

## The UK Health Care System

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### Who is covered?

Coverage is universal. All those ‘ordinarily resident’ in the United Kingdom are entitled to health care that is largely free at the point of use.

### What is covered?

*Services:* Publicly-funded coverage: the National Health Service (NHS) covers preventative services; inpatient and outpatient (ambulatory) hospital (specialist) care; physician (general practitioner) services; inpatient and outpatient drugs; dental care; mental health care; learning disabilities; and rehabilitation.

*Cost-sharing:* There are relatively few cost-sharing arrangements for publicly-covered services. Drugs prescribed by general practitioners are subject to a co-payment (£6.85 per prescription; \$13.79), but about 88% of prescriptions are exempt from charges (Department of Health 2007). Dentistry services are subject to co-payments of up to about £200 per year (about \$400), although there is difficulty in obtaining NHS dental services in some areas. Out-of-pocket payments accounted for 11.9% of total expenditure on health in 2005 (World Health Organization 2007).

*Safety nets:* Most costs are met from the public purse. There are measures in place to alleviate costs where these may have an undue impact on certain patient groups. The following are exempt from prescription drug co-payments: children under the age of 16 years and those in full-time education aged 16, 17 or 18; people aged 60 years or over; people with low income; pregnant women and those having had a baby in the last 12 months; and people with certain medical conditions and disabilities. There are discounts through pre-payment certificates for people who use a large amount of prescription drugs. Transport costs to and from provider sites are also covered for people with low income.

### How is the health system financed?

*National Health Service (NHS):* The NHS accounts for 86% of total health expenditure. It is mainly funded by general taxation (76%), but also by national insurance contributions (19%) and user charges (5%) (Department of Health 2006). Apart from the income the NHS receives for the provision of prescription drugs and dentistry services to the general population, there is some income from other fees and charges, particularly to private patients who use NHS services.

*Private health insurance:* A mix of for-profit and not-for-profit insurers provide supplementary private health insurance. Private insurance offers choice of specialists, avoidance of queues for elective surgery and higher standards of comfort and privacy than the NHS. It covers 12% of the population and accounted for 1% of total health expenditure in 2004.

*Other:* People also pay directly out-of-pocket for some services – for example, care in the private sector. Direct out-of-pocket payments account for over 90% of total private expenditure on health.

### How is the delivery system organized?

*Physicians:* General practitioners (GPs) are usually the first point of contact for patients and act as gatekeepers for access to secondary care services. Most GPs are paid directly by primary care trusts (PCTs) through a combination of methods: salary, capitation and fee-for-service. The 2004 GP contract introduced a range of different local contracting possibilities as well as providing substantial financial incentives tied to achievement of clinical and other performance targets. Private providers of GP services set their own fee-for-service rates but are not generally reimbursed by the public system.

*Hospitals:* These are organized as NHS trusts directly responsible to the Department of Health. More recently, foundation trusts have been established as semi-autonomous, self-governing public trusts. Both contract with PCTs for the provision of services to local populations. Public funds have always been used to purchase some care from the private sector, but since 2003 some routine elective surgery has been procured for NHS patients from purpose-built treatment centers owned and staffed by private sector providers. Consultants (specialists) work mainly in NHS hospitals but may supplement their salary by treating private patients.

*Government:* Responsibility for health legislation and general policy matters rests with Parliament at Westminster. The NHS is administered by the NHS Executive and the Department of Health, and locally is provided through a series of contracts between commissioners of health care services (PCTs) and providers (hospital trusts, GPs, independent providers). PCTs control around 85% of the NHS budget (allocated to them based on a risk-adjusted capitation formula) and are responsible for ensuring the provision of primary and community services for their local populations. Recent policy developments include the introduction of patient choice of hospital and a move to the reimbursement of hospitals using a DRG-like activity-based funding system known as Payment by Results (PbR). PbR relates payment to the quantity and case mix of activity undertaken.

*Private insurance funds:* Private insurers provide their subscribers with health care at a range of private and NHS hospitals. Patients generally can choose from a number of health care providers.

### **What is being done to ensure quality of care?**

Quality of care is a key focus of the NHS. A Department of Health objective in 2007 was to enhance the quality and safety of health and social care services. Quality issues are addressed in a range of ways including:

*Regulatory bodies:* A number of bodies monitor and assess the quality of health services provided by public and private providers. This involves regular assessment of all providers, investigation of individual providers where an issue has been drawn to the attention of the regulatory body, and consideration of key areas of provision in order to recommend best practice. The three bodies primarily responsible for regulation in England (the

Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission) are due merge in 2008.

*Targets:* Targets have been set by the government for a range of variables that reflect the quality of care delivered. Some of these targets are monitored by the regulatory bodies mentioned above; others are monitored on a regular basis either by the Department of Health or its regional organizations (ten strategic health authorities).

*National Service Frameworks (NSFs):* Since 1998 the Department of Health has developed a set of NSFs intended to improve particular areas of care (for example, coronary, cancer, mental health, diabetes). These set national standards and identify key interventions for defined services or care groups. They are one of a range of measures used to raise quality and decrease variations in service.

*Quality and Outcome Framework:* This is a new framework for measuring the quality of care delivered by GPs. It was introduced as part of the new GP contract in 2004, which provided incentives for improving quality, and has been operating since 2005. GP practices are awarded points related to payments for how well the practice is organized, how patients view their experience at the surgery, whether extra services are offered, such as child health and maternity, and how well common chronic diseases such as asthma and diabetes are managed.

### **What is being done to improve efficiency?**

Efficiency has always been a key focus of the NHS. The NHS seeks to improve efficiency in a range of ways including:

*High-level efficiency targets:* The government is committed to a program to achieve efficiency gains of £6.5 billion (\$13 billion) by March 2008 through a range of policies known as the Gershon Efficiency Programme. These include increasing front-line productivity, centralizing procurement to obtain more cost-effective deals, reductions in the costs of both NHS provider and central administration and increasing the efficiency of social care provision. Local NHS organizations are also set targets for efficiency savings.

*Benchmarking:* NHS organizations are benchmarked against the performance of their peers on a number of activity measures, including day case rates and lengths of stay for common operative procedures, readmission rates and NHS reference costs (costs of standard procedures known as Healthcare Resource Groups). The Healthcare Commission reviews the performance of NHS trusts against these measures in providing an overall assessment of NHS performance through the Annual NHS Health Check.

*Institute for Innovation and Improvement:* The Department of Health supports the development of better and more efficient ways of providing health care through the use of semi-autonomous bodies such as the Institute for Innovation and Improvement. The Institute helps the NHS to develop new ways of dealing with the introduction of new technology and changes to working practices, and helps to spread these throughout the NHS.

#### **How are costs controlled?**

The government sets the budget for the NHS on a three-year cycle. To control utilization and costs, the government sets a capped overall budget for PCTs. NHS trusts and PCTs are expected to achieve financial balance each year. The centralized administrative system tends to result in lower overhead costs. Other mechanisms that contribute to improved value for money include arrangements for the systematic appraisal of new technologies through the National Institute for Health and Clinical Excellence (NICE).

#### **References**

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