Quick Health Financing Stats for United Kingdom

Basic statistics (2013, WHO Global Health Observatory)	**United Kingdom**
Population	63 million
GDP per capita (USD)	$39,538
Total health expenditure per capita (USD)	$3,598
Total health expenditure as % of GDP	9.1%
Government health expenditure as % of total government expenditure	16.2%
Government health expenditure as % of total health expenditure	83.5%
OOP spending as % of total health expenditure	9.3%

DEMAND-SIDE PROGRAMS

In this framework we define demand-side UHC programs as programs that aim to reduce economic barriers and expand access to more and better services. Many major national, demand-side health system programs either target a specific population (*poor and vulnerable people*, the *non-poor informal sector*, or the *formal sector*) or have distinct design features depending on the beneficiary's economic and work status. Therefore, this matrix includes questions specific to the program's design features for each specific population.

		National Health Service (NHS)	**Private medical insurance**
Identify each major, nation-wide program / system that aims to reduce economic barriers and expand access to more and better health services for the population, and when the program started or was reformed. List one program per column.		•NHS legislation passed in 1946, implemented in 1948. •Numerous reforms over subsequent decades, continuing to the present day.	Various
Population Covered: • How are beneficiaries identified and targeted? • What are the eligibility rules?	Poor/vulnerable	•Coverage is **universal**. All persons "ordinarily resident" in the U.K. are entitled to NHS benefits, regardless of how much they have contributed financially.	NA
	Non-poor informal sector		Uncommon
	Formal sector employees		•Private insurance is voluntary and mainly provided by employers as part of their benefits package for employees. 12.3% of population had some private insurance in 2008. •Most subscribers are male, older, urban, and wealthy.
Services and Benefit entitlements • Summarize the services or benefit entitlements for each population group • Specify whether the services or benefits are defined in the form of a positive list, a negative list, or not explicitly defined. • How are benefit packages selected? • How are they updated over time? For example; health technology assessment	Poor/vulnerable Non-poor informal sector Formal sector employees	•Coverage is **"comprehensive" but not based on a defined list of benefits** (neither positive nor negative). In practice, comprehensive means that all health care services that might reasonably be included in the benefits package will be included – but it is not a promise that everything will be covered. •The **National Institute for Health and Care Excellence (NICE),** established in 1999, is responsible for assessing and issuing guidance on whether new and existing medicines, treatments and procedures will be covered by the NHS. NICE uses **Health Technology Assessments** to evaluate the safety, efficacy, cost and cost–effectiveness as well as social, organizational, legal and ethical implications of new technologies which might be covered by the NHS (medicines, treatments, procedures). •Local-level **"Primary Care Trusts"** (PCTs) receive budgets from the NHS, and are responsible for purchasing health services for populations in their catchment area. Following the guidelines set by NICE, they make choices about the type and quantity of services to be provided within the limits of the fixed budgets they receive. •Since 2002, PCTs have been ***required*** **to provide funding for medicines and treatments recommended by NICE**. If NICE recommends that a technology or drug is *not* adopted, PCTs must also follow the guidance. When NICE approves a new technology, resources to provide the technology must come from existing budgets. This may mean reallocating resources from already established types of services, and hence a service already covered may be rationed.	•Private insurance functions as a supplement, providing cover for enhanced services such as faster access and increased consumer choice. Typically cover inpatient and specialist acute care at private hospitals; less common for outpatient care.

MANAGING MONEY/ FINANCING UHC			
		National Health Service (NHS)	**Private medical insurance**
Financing sources	• Government source of revenue (e.g. taxes) for this program? Earmarked taxes, sin taxes, general taxes? • Mandatory contributions by formal sector workers (payroll taxes)? • Beneficiary premiums? • Beneficiary cost sharing at the point of service? • Provide specific information about any separate features of the beneficiary contribution model covering poor and vulnerable people, the non-poor informal sector, and the formal sector (if applicable). • Summarize how each source of financing is collected.	•**The NHS is financed mainly through general taxation (76%) and "national insurance contributions" (NICs, 18%).** •General taxes include income taxes, corporate taxes, VAT, and excise taxes on fuel, alcohol, and tobacco. Collected by the department of Revenue and Customs. •"NICs" are compulsory contributions paid by employers, employees and self-employed people on earned income. Both employee and employer make a contribution. In 2010–2011, for income over £110 per week, NICs were levied at a rate of 11% (employees) and 12.8% (employers) on gross earnings. •Taxes tend not to be earmarked for a particular purpose. •There are no beneficiary premiums. •There is no beneficiary cost sharing for primary, specialist, or inpatient care. •Beneficiaries pay a flat co-payment for prescription drugs. •Beneficiaries pay for some eye care, some dental care, and private treatment at NHS hospitals (mainly elective surgeries).	Premiums are paid voluntarily by individuals, employers and employees Premiums are set based on individuals' or groups' age and health risks as assessed by the insurer. Private insurance constituted less than 3% of total health expenditure in 2008.
Risk pooling	• Is there one national pool, separate national risk pools for distinct beneficiary groups, or subnational level pools? • Are the poor cross-subsidized by higher income people? Discuss for each program.	•**One national pool** •The poor are cross-subsidized by wealthy (because taxation is progressive). •To promote equitable resource allocation, about 80% of the total NHS budget is allocated to PCTs using a **weighted capitation formula**. This takes account of population size, age distribution and various indicators of health care need as well as unavoidable differences in costs between different geographic areas.	Numerous small risk pools No cross-subsidization across risk pools
Financial management	• What institution manages the program? • How does the program remain solvent? • Are there mechanisms in place, such as caps or utilization review, that maintain the financial viability of the system?	•The Department of Health manages the NHS. •**The Treasury (equivalent to a Ministry of Finance) sets the budget** for the Department of Health, with oversight from Parliament. •**80% of the NHS budget is allocated to the local Primary Care Trusts** (there were about 150 PCTs as of 2011). Allocation of resources to PCTs is prospective, based on expected expenditure, and involves fixed budgets. PCTs then have responsibility for purchasing services for their populations, within those budgets. •PCTs enter into binding contracts with GPs (for primary care) and NHS Trust hospitals (for secondary care), and may also contract with private providers.	Private for-profit and not-for-profit insurance companies manage the programs Contracts are reviewed semi-annually or annually and may be cancelled Premiums can be raised to reflect beneficiary risk
Financial protection	• Financial protection for households: Are there caps on cost sharing or other safeguards that protect households against impoverishment due to health costs?	•Financial protection is mainly achieved by **providing universal entitlement to free primary, specialist, and inpatient care**. •Co-payments are required for prescription drugs, but about 50% of the population is exempt from charges (children under 16 years, full-time students aged 16–19 years, people 60 and over, pregnant women and women who have given birth in the previous 12 months, people with specified medical conditions (such as cancer), and people on the NHS low-income scheme). •OOP spending accounts for less than 10% of total health expenditure.	NA

		National Health Service (NHS)	Private medical insurance
Provider payment	• Describe the payment mechanisms used to pay primary health care (including preventive and promotive care) • Describe the payment mechanisms used to pay for hospital level care. • Are payments tied to quality of care, and if so, how does this work? • Do the systems contract private providers or private health plans? If so, describe the payment mechanisms incorporated into contracts.	•There has been a “purchaser-provider split” in the UK since 1991. •**For primary care** including preventive and promotive care: PCTs contract with local (self-employed) GPs, and pay them via: 1) **Capitation**: known locally as “Global Sum” Payments for a core set of essential services. Per-patient allocations are based on a statistical model taking account of sex and age distribution of patient population, morbidity and mortality rates, and higher costs of delivering services in rural areas and London. 2) **Enhanced service payments**: Extra payments for enhanced services which GP practices can agree with the PCT to deliver. These may require specialist skills and typically respond to special national and local priorities. 3) **Out of hours care contracts**: GP practices can choose to have a separate additional contract for out of hours care. Most practices delegate this care to dedicated after-hours care practices. 4) **Performance-based payments**: Since 2010, extra payments are provided for GP services linked to achievement of quality standards. The **Quality Outcomes framework** (QOF) is a set of indicators that generate a score upon which is based the amount of extra funds paid to each practice. Practices are not required to take part, but most do. QOF scores are recorded by practices themselves electronically and submitted to their PCT; a sample of scores is audited by the PCT to prevent fraud. •**For hospital care**: PCTs contract with public hospitals (semi-autonomous “NHS Trust” hospitals) and sometimes with private hospitals. 5) **Salaries**: Health workers at NHS Trust hospitals are salaried employees of the NHS. 6) **DRGs**: Since 2003, hospitals have been paid using an English equivalent of DRGs, known as “healthcare resource groups” (HRGs). This funding arrangement is also referred to as Payment by Results (PbR) and is meant to better reflect the actual activities hospitals undertake. This system still being refined and expanded and has not worked perfectly.	Insurers enter into contracts with private hospitals. Payment mechanisms vary.

SUPPLY-SIDE PROGRAMS

In this framework we define supply-side UHC programs as nation-wide programs that aim to reform and upgrade the production of health services.

		National Health Service (NHS)	
Identify each major, nation-wide program / system that aims to reform and upgrade the production of health services. List one program per column.			
Human Resources	• Summarize design features of programs aiming to improve distribution of health workers, retention of health workers, or outreach by health workers.	•The government’s ***NHS Plan*** in 2000 identified shortages of skilled staff as one of the main challenges facing the NHS. NHS expanded its workforce substantially over the next decade and by 2009 its targets were met (2.7 doctors per 1,000 population – still lower than most European countries). Some areas, especially in the north of England, have long been undersupplied with doctors. They receive extra NHS resources to hire health workers from the private and non-profit sectors. •There has recently been a strike by NHS health workers over pay and working hours.	
Managerial Flexibility	• Do managers of facilities or at subnational level have the flexibility to hire and fire, to manage money, to procure commodities? Summarize design features of programs aiming to improve managerial flexibility in public facilities.	•Overall system stewardship (resource allocation, target setting, quality standards) is centrally driven. Local PCTs have authority over the purchasing function (budget management) in their areas, but hiring and firing are handled by the provider facilities themselves.	

		National Health Service (NHS)	
Private Providers	• Summarize design features of programs aiming to increase participation of or oversee quality of private providers.	•In 2000, the NHS committed to allowing greater use of private-sector providers to alleviate waiting lists and increase NHS capacity in the hospital sector. Legislation in 2004 opened the way for the NHS to contract with private companies to provide general medical services.	
Health Care Provision / Accreditation and Other Regulation of Quality	• Summarize design features of programs aiming to accredit health facilities or regulate quality of service provision in another way.	•See description of pay-for-performance **Quality Outcomes Framework** above. •The **Care Quality Commission (CQC)** is responsible for regulation and inspection of all health care providers – including NHS, private sector and voluntary sector. All facilities must register with the CQC and demonstrate that they meet some common quality standards. The CQC also inspects and monitors registered providers to ensure ongoing compliance with regulations, and it has enforcement powers (e.g. fines, public warnings, suspension or cancellation of registration, prosecutions), which it may invoke if the legal requirements of registration, including quality standards, are not met. •The CQC was given a new power in 2009, to license all providers, both public and private, including primary care providers as well as hospitals.	
Health Care Provision / Integrating the Health System	• How is beneficiary care coordinated across levels of care? Is there a system of referrals and counter-referrals and the information system to manage this? Please describe.	•Responsibility for the coordination of primary care services rests with PCTs, which must ensure that the appropriate range of services is available to their populations. GPs are the focal point for all primary care services in England and also act as gatekeepers to secondary care. To access NHS specialist care, patients require a referral from a GP. Patients can go directly to the emergency room if they believe their condition is very urgent.	
Accountability	To what extent is health sector governance characterized by decentralization and regulation, or what *Going Universal* refers to as “arm’s length” relationships (i.e. an actor who delegates the task (e.g. MoH; purchaser of health services) and a separate actor who is responsible for carrying it out (E.g. local government; service providers))? Summarize the governance structure of the health sector and features of the purchaser-provider split, where one exists.	•There has been a “purchaser-provider split” in the UK since 1991; see descriptions above.	

Primary source: Boyle, Sean. (2011). United Kingdom (England): Health System Review. *Health Systems in Transition* 13(1):1–486.