Financing the Health System: Public Expectations and Who Pays for Them?

Public Expectations:

With rising health costs and growing expectations about what health care services can and should be doing, there is increasing pressure to meet public expectations in an affordable way. Anna Dixon, of the LSE and European Observatory for Healthcare Systems, presented results from several European patient satisfaction surveys, including the Eurobarometer and Commonwealth Fund polls. In general, many patients across Europe are reasonably satisfied with their health systems. In France, Germany, Spain, Netherlands, Sweden and the United Kingdom, 40% or more believed the health system works well or needs only minor changes according to Eurobarometer 1996 (although UK satisfaction levels were lower in the Commonwealth Fund survey, at around 25% in 1998). The level of satisfaction is not strongly correlated with expenditures, with America and Canada particularly low at less than 20%. In the Eurobarometer data, satisfaction is highest soon after a medical encounter for many survey respondents and, within the UK, overall satisfaction with the NHS seems to have increased slightly over the past decade. This is somewhat surprising given negative media coverage and perceived quality concerns. One possible explanation, however, is that patient expectations are particularly low in the UK. If those expectations rise with more talk of consumer-oriented health care, the NHS will face increasing pressure to provide better quality services in a more user-friendly, consumer-driven manner than ever before. Recognizing the financial constraints, 29% of survey respondents in the UK said they would support higher taxes to increase health service funding. And 92% of those supporting taxes would be willing to pay more taxes themselves (though there is little support for increased user charges).

Financial Requirements:

Will there be enough money to fund the health service? And how should the financing be structured? Mark Bassett of BUPA working with a team of researchers from National Economic Research Associates have constructed a model of health funding requirements for the future. Working with a range of assumptions, they found that the expected budget increases should be able to maintain current waiting times, but are not likely to reduce them significantly. Without growth in the number of beds (such as intermediate care beds, for example) or staffing levels (especially nursing staff), the current waiting times are likely to continue and possibly worsen. The Wanless Report’s assumptions about future budgetary requirements are highly sensitive to wage increases and the work by BUPA suggests the Wanless Report may have been overly optimistic in its assumptions.
Two possible means of addressing future waiting times were raised: increasing the number of intermediate care beds and ensuring adequate staffing. According to the work done by BUPA, 13,000 intermediate care beds would be enough to eliminate waiting lists by 2009, assuming the additional nursing staff for the intermediate care facilities came from outside the NHS. (If the staffing came from the existing NHS nursing stock, the waiting list problem would persist.) However, tackling the issue of the nursing shortage is no simple matter. Nurses’ decisions to leave the profession and the difficulty in attracting new workers to the profession are affected not just by wages, but by the net benefit of the job. Pay, job characteristics and the work environment (training opportunities, flexible hours, adequate staffing levels and reasonable workload, standard of facilities, level of pressure, etc) all factor into the decisions to enter or remain in the nursing market. And with the size of the European workforce expected to fall by 2011, attracting qualified nurses with the right skill mix to the health service is of utmost importance.

**Private Sector Solutions:**

A possible solution for improving health care services is to introduce ‘mixed’ systems of both public and private financing and/or provision. Ray Robinson of the LSE discussed several existing models of public-private relationships found in different countries. Private financing through the Private Finance Initiative (PFI) was introduced in the UK in the 1980s and the current government is pursuing the PFI with renewed intensity. Australia recently developed a system of financial incentives to increase take-up of private medical insurance. The Netherlands are encouraging competition between non-profit sickness funds and private insurers. Germany is attempting to shift from passive retrospective reimbursement to a more pro-active, prospective, competitive payment system. There are also efforts to encourage private delivery of publicly funded care. Private provision is common in Germany and the Netherlands; is being encouraged in the UK under the PFI and PPP (Public Private Partnerships); and exists in Australia where a ‘co-location policy’ of building private hospitals on public sector hospital campuses is a growing trend.

Why is there a trend towards increased private activity in predominantly public health systems? Much of this is being driven by ideology. But there are also pragmatic reasons. In the UK, for example, increased NHS use of the private sector seems to be driven by the need to:

- increase capacity quickly;
- to challenge the public sector monopoly
- to offer greater diversity and choice.
One area where the UK Department of Health expects the private sector to make a major contribution to provision of care in the NHS is in relation to intermediate care facilities. These are seen as a means of reducing demand for scarce acute hospital beds. The Department has earmarked specific funds for the expansion of these facilities.

**PFI (Private Finance Initiative):**

Nicholas Jennett of the European Investment Bank presented some of the arguments in support of the PFI for major capital schemes. The key elements of the contracts include:

- Private sector partner (Special Purpose Company, or consortium);
- DFBOT (Design, Finance, Build and Operate the hospital, and, after the contract expires, Transfer the asset back to the NHS), subject to minimum quality standards;
- Project agreement and payment mechanism (setting minimum standards without which the private sector partner would not be paid);
- Private financing which transfers the risk to the financier and private partners.

Among the many arguments against PFIs, some of the most worrisome include:

- High transaction costs of bidding for and managing these contracts;
- Off-balance sheet motivation: The PFI allows an infusion of capital in the NHS which does not appear on NHS balance sheets today, but the revenue budgets of tomorrow and while purchasers and commissioners have made additional revenue available for many schemes, there remain affordability issues;
- Affordability gap: most trusts embarking on PFI schemes have outdated capital assets. They are replacing these with new assets and making a commitment to maintain their over their lifetime. This is bound to cost more than the status quo.

Ultimately, the success of the PFI or any other initiative needs to be evaluated in the future. And while there may be some examples today (such as private involvement in the delivery of mental health services), there has been little evaluation or evidence to inform the debate on appropriate financing mechanisms. There is even less evidence on the success of private provision of publicly funded services. How successful, for example, are policies to encourage competition through commissioning? Should this be done at the PCT level or higher? What improvements are we likely to see from the increased budget? And what form will rationing of the future take, if not waiting times?
Key Findings:

The key findings of this meeting are that:

- There is apparently relatively high public satisfaction with the NHS.
  - But this may be related to low expectations. As these grow, so too will financial pressures.
- Development of intermediate care facilities or increased hospital capacity can help address the long waiting lists and public satisfaction.
  - An infusion of capital will not address the significant (& growing) nurse staffing shortage. Not only wages, but hospital administration, the nature of professional interactions, job characteristics and skill mix matter.
- Shifting the balance between the public and private sector may help address future demands on the health sector.
  - There is little evidence about private financing; private provision; NHS commissioning activities. An unintended consequence of current policy may be increased provider dominance to fill the void left by poor planning and underinvestment.

Future Research:

Our discussions raised questions surrounding the benefits and costs of the different financing initiatives proposed by the NHS.

- Research on the effects of various private initiatives or commissioning activities is needed.
- More systematic evaluation of performance (efficiency, equity, accountability and responsiveness) is needed.
- The nurse staffing shortage and future workforce issues need to be addressed.