The Economist

National Health Service

Stressed out

The NHS's financial difficulties highlight why reforms are so urgent

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AT THE general election in May, Labour convinced voters that it should be given a third chance to sort out the National Health Service. Since then, however, there have been some worrying signs that things are not going to plan.

A recent survey of medical directors by the British Medical Association (BMA) painted a depressing picture. Three-quarters of those working in acute-care hospitals reported that their trusts were facing a funding shortfall. Some 40% said this would lead to a recruitment freeze and around 25% that their trust was considering redundancies.

The spectre of financial famine appears perplexing at a time of financial feast. Record sums of money are coursing into the NHS. Since 1998, cash spending has risen by nearly 10% a year, equivalent to real annual increases of over 7%. The Treasury is committed to keep boosting the health budget at around these rates until the financial year ending in spring 2008.

Against this background of tax-funded abundance, critics of the government, not least the BMA, are suggesting that reforms to inject more market forces into the NHS are to blame for its financial problems. The doctors' trade union is too modest. A big reason for the distress is the BMA's success in negotiating lucrative pay deals for its own members.

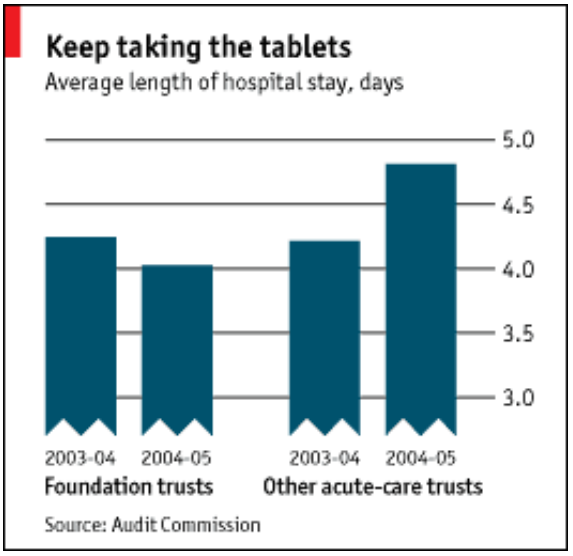
New contracts for hospital consultants and family doctors (GPs) are proving far more costly than the government expected. The consultants have got a large pay increase for very little so far in return, says John Appleby, an economist at the King's Fund, a health-policy think-tank. GPs are now earning £100,000 ($175,000) a year on average from the NHS according to AISMA, an association of medical accountants. Their income has been lifted by a big increase in performance-related pay, which Chris Ham, professor of health policy at Birmingham University, says is much more generous than in other countries. With nurses and other NHS workers also getting a boost in earnings, higher pay accounts for about half the increase in this year's budget, estimates Mr Appleby.

The NHS is in a financial fix not because of reform but because of a lack of it. Not before time, that is starting to change. One step is the introduction of a new payments system. Until

this year, most hospital trusts were paid through "block contracts" which mainly reflected previous budgets, adjusted for cost inflation, with no direct link to how much work they actually did. But since April, every patient admitted for elective (non-emergency) operations has had a price-tag attached to his treatment, so that hospitals are rewarded according to how busy they are.

The potential gains in efficiency are well worth having. "Payment by results" will generate strong pressures within the NHS to boost efficiency as relatively expensive hospitals strive to push down their costs and cheap ones try to get more business. According to a report this week from the Audit Commission, a public-spending watchdog, the introduction of a similar system in Australia resulted in a big productivity improvement.

The new payments system was used in 2004-05 for both elective and emergency admissions to foundation hospitals, a select group that have won more freedom to run their affairs. Already, there are signs that it is starting to work. Foundation trusts cut the length of hospital stays in 2004-05, whereas it rose among other hospitals (see chart).



Foundation trusts are also improving their performance because they now face more rigorous financial discipline than other hospitals. But the commission expects payment by results to encourage similar efficiency gains to those achieved in other countries. James Strachan, its chairman, said on October 10th that the new system is "fundamental to the modernisation of the NHS".

However, this positive endorsement drew less attention than worries in the report that payment by results may destabilise NHS finances at local level. There are two main risks. Primary-care trusts (PCTs), the 300 local organisations that purchase hospital treatments, could face a funding shortfall if hospitals do more work than budgeted for. Hospitals, for their part, will run into trouble if they fail to get enough work or to control their costs.

The government has already delayed the full implementation of payment by results in most acute-care hospitals, deferring its use for emergency care until next April. The commission suggests that it could be introduced then in a less stringent form, by including, for example, a standing charge for emergency capacity. A snag with this proposal is that hospitals may then try to shift some of their overhead costs on to the emergency-care budget.

The government is determined to press ahead with payment by results. Indeed, Patricia Hewitt, the health secretary, has said that any instability that it will create is an essential part of raising efficiency. Ministers are planning to try to restrain demand overruns in other ways.

By the end of next year, the number of PCTs, which have sometimes been ineffective, is to be cut by half. More important, GP practices will be playing a much bigger role in commissioning treatments, with budgetary incentives for them to lower costs.

Careful, this might hurt

In a report published on October 12th, the OECD said that the government should build on payment by results with further reforms to pep up efficiency. It advocates tying earnings for hospital doctors more closely to their productivity through fee-for-service payments and says that further expansion of private-sector provision of NHS health care may be necessary.

The OECD also calls upon the government to slow the growth in the country's health budget. In his review for the Treasury in 2002, Sir Derek Wanless envisaged that real spending would continue to rise at an annual rate of 4.4-5.6% in the five years after 2007-08. According to the OECD, this would mean average real growth of 6-6.5% in the 15 years to 2012-13, which among the advanced countries would be an unprecedentedly big increase over so long a period. It questions whether the NHS can absorb these extra resources without cost-inflation and waste, and says it would be better if growth were to slow to 2.5% a year after 2007-08.

The Treasury recently confirmed that it will revisit the Wanless review as part of its spending settlement in 2007. The NHS has to prepare for a stretch of modest years after so many abundant ones. Which is why it must become more efficient.

From the print edition: Britain