

**Study of the Blair Government's Healthcare Financial Reform
from a perspective of soundness and fairness**

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Abstract

This paper focuses on the effects of the healthcare reform of the British Labour Party Administration under Prime Minister Blair on finances from the point of view of its soundness and fairness.

It is hard for Advanced countries to maintain public finances as the Welfare State and the healthcare policy is the most important issue. Accordingly, the Hashimoto and Koizumi Administration followed a policy of privatization similar to that of the Conservative Government under the Thatcher and Major eras. Therefore, I think that by studying the Blair Government we can predict the future of Japan.

Although the UK expanded healthcare expenditure in FY 2003, the NHS went into deficit from FY 2004 and recovered largely in FY 2006. The deficit was caused by the increase of labour costs and the change of budget allocation systems as well as the increase of medical staff which was one of Blair's commitments.

However, the expansion of healthcare expenditure raised the healthcare costs per capita. As a result, access to medical care for low-income group could increase and the system was made more equitable.

Also, the Conservative Party Administration focused on cash benefits but the Blair Government focused on the benefits in kind such as including healthcare.

Introduction

This paper focuses on the effects of the healthcare reform of the British Labour Party Administration under Blair on finances from the point of view of its soundness and fairness.

It's difficult for advanced countries to maintain the public finance as the Welfare States and the Healthcare policy is the most important issue. Healthcare reform was one of the pillars of The Blair Administration Reform. Although the UK expanded healthcare expenditure in FY 2003, the NHS went into deficit from FY 2004 and

recovered largely in FY 2006. To find out how the policies of the Blair Administration worked we need to look at the financial soundness and fairness as well as the achievement of the Blair's commitments. Accordingly, the Hashimoto and Koizumi Administration followed a policy of privatization similar to that of the Conservative Government under Thatcher and Major. Therefore, I think that by studying the Blair Government we can predict the future of Japan. I especially think the Healthcare reform is a good reference point for future Japanese Administrations.

There are previous studies of the Blair NHS, such as Street and Ward (2009) in which they conducted a cost-benefit analysis and Wanless, Appleby, Harrison and Patel(2007) and Appleby, Ham, Imison and Jennings (2010) predicting future NHS finances, compared with the Wanless report. The others are Trades Union Congress (2010), Glennerster (2006) performing analysis of fairness, it is an overview and is not focused exclusively on NHS. There are previous studies of NHS management accounting, such as Lapsley (1994, 2001a, 2001b), Ellwood (1996a, 1996b, 2008) , Llewellyn and Northcott (2005), to name a few. In Japan, there is an administrative accounting study by Arai (2004), as well as other studies, such as Ito (2006), Takeuchi and Takenoshita (2009), Kondo (2004), Mori (2009). None of these studies analyzes deeply the Blair NHS from a financial perspective. Thus, in a strict sense, there is no study about NHS from the perspective of soundness and fairness. Unless one analyzes NHS finance, however, it is not possible to properly examine the significance of the Blair government's healthcare reform. Therefore, I will endeavor to analyze the NHS finance.

Contents are follows. Section 1 describes the overview of healthcare reform and analysis of the factors of the deficit from point of view of soundness in Section 2. The achievement of the Blair Government Manifesto is checked with Section 3, and I express my opinion, compared with the opinions of the NHS and the House of Commons Health Committee on how the deficit occurred with Section 4. I examine the healthcare fairness in Section 5. Finally the conclusion details the suggestion for Japan.

1 . The overview of healthcare reform of the Blair Administration

The features of healthcare reform are the expansion of healthcare expenditure and the change of the budget allocation system¹. Specifically, 1) The rate of national

¹ The Blair Government advocated "The Third Way"; it is different from "Old" Labour. It was supposed to realize socialistic values, such as social equity, equality and solidarity such as Old Labour without taking a hostile view of the market economy, while cooperating with the market. It differed also from the Conservative Party which emphasizes "freedom", "rights" and "efficiency". It was especially aimed at improvement in fairness and modernization of services in a healthcare policy.

insurance was increased by 1% as a financial resource of healthcare expenditure expansion². 2) PCT (Primary Care Trust) became the authority of budget allocation from HA (Health Authorities) and GPFH (General Practice Fund Holder) of the Conservative Party era³. 3) Resource Accounting and Budgeting was introduced from FY 2001. AME (Annually Managed Expenditure) was provided and Accounting became transparent. 4) The reference cost accounting system was introduced for improvement in the quality of healthcare and accountability to citizens⁴. 5) The formula of the contracts based on budget allocation was changed.

Since it is a particular feature of the restructuring that the authorities of budget allotment have consolidated to PCTs, I will explain the framework of budget allocation in detail. The budget of the DH (Department of Health) is determined by Parliament and allocated 90% to NHS and 10% to personal social service etc. 75% of NHS budget is allocated to PCTs which provide primary medical care, and the rests is allocated to NHS headquarters, SHAs, Monitor, etc. The budget of the NHS trusts and FTs (Foundation Trust) which provide secondary medical care allocated by PCTs as well as GP (General Practitioner) and GP Practices. GP and GP Practices have adopted the new GMS (General Medical Service) contract⁵ or The PMS (Personal Medical Service) contract which was negotiated regionally in FY 2004. APMS (Alternative Provider Medical Services) and PCTMS (Primary Care Trust Medical Services) were introduced because of an access improvement of GP Practices since FY 2004. NHS trusts and FTs

² The healthcare resource consists of tax and national insurance fee.

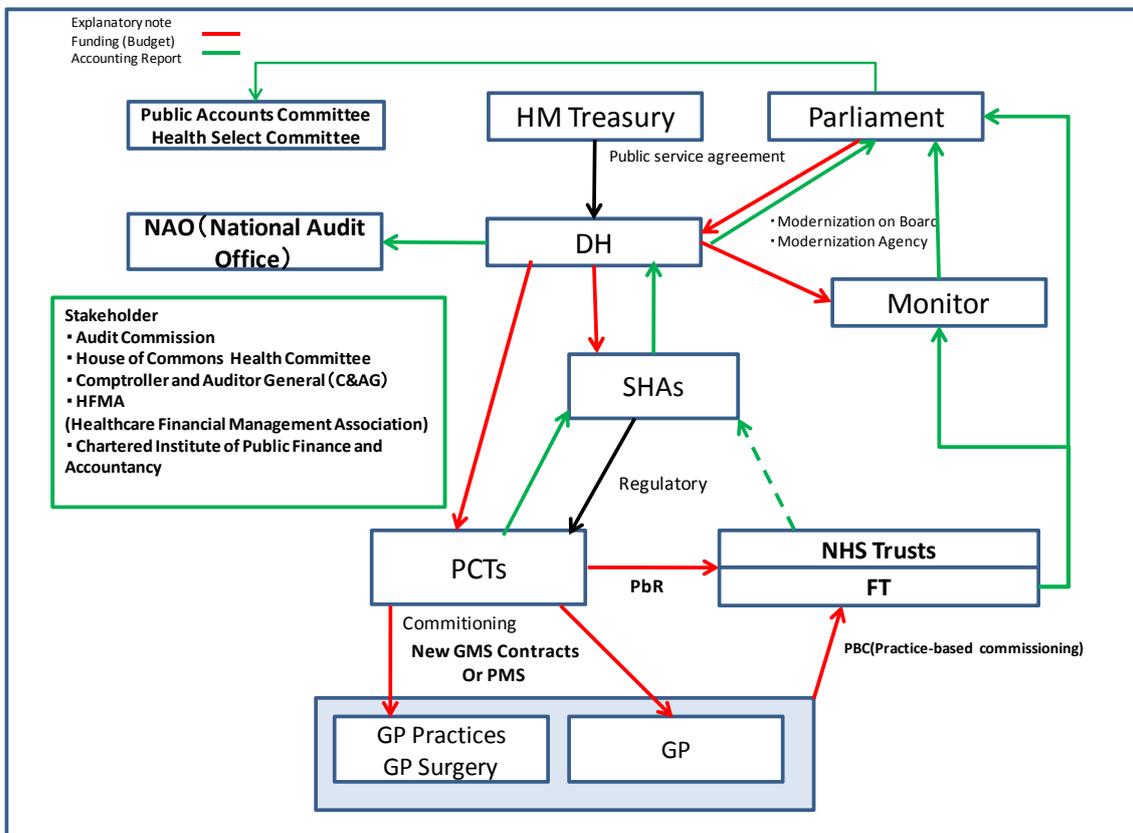
³ The causes of change are as follows. 1) Contracts between GPFH and NHS Trusts were difficult because a medical costing was technically difficult. Labour claimed that transaction costs skyrocketed and the budget of patient care costs decreased in the Internal Market at that time. 2) There were situations that patients of GPFH being given priority to undergo surgery because negotiating powers of GPFH were stronger than the common GPs. Refer to Gunji (2005). Moreover, PBC (Practice Based Commissioning) which GPs and GP Practices pay the charge to NHS trusts and FTs directly was introduced since FY2006. Many people said the PBC was the GPFH under a different name.

⁴ Every Trust was required to cost based on the Uniform Standards and they adopted the HRGs (Health Resource Groups). The Reference cost accounting system is a system to announce the cost price of the HRGs per hospital, the national average of the cost price of the HRGs and index showing the relation between the national average cost price and the cost price per hospital and it has been carried out since FY 1998.

⁵ Regarding GP practices costing, it is calculated in the combination of 1) capitation, 2) fee-for-service system and 3) QOF (Quality and Outcomes Framework). Regarding GP, it is calculated in the combination of 1) the capitation of budget, 2) the QOF of PbR and 3) operational expenses. The new contract changed the foundation of the contract of primary care service. Since the contract become a contract per GP practices unit fundamentally, the half of GPs have the salary from GP practices. Refer to the NAO (2008) etc.

have gradually introduced PbR (the Payment by Results)⁶ since FY 2004 instead of the budget allocation system called Block Payment.

It's also important to remember that there were repeated reorganizations. The primary care groups founded in FY 1999 became PCTs in FY 2001. 100 HAs became 28 SHAs (Strategic Health Authorities) in FY 2002, and 302 PCTs were reorganized to 152 PCTs and 28 SHAs were reorganized to ten SHAs in FY 2006. NHS trust founded by the Conservative Party era in FY 1991 decided to shift to FTs which are financially independent. So the first FT was born in FY 2004 and NHS trusts have been moving to FTs continuously⁷.



2. The point of view of soundness: change of NHS finances and NHS deficit

2.1. NHS deficit between FY 2004 and FY 2005

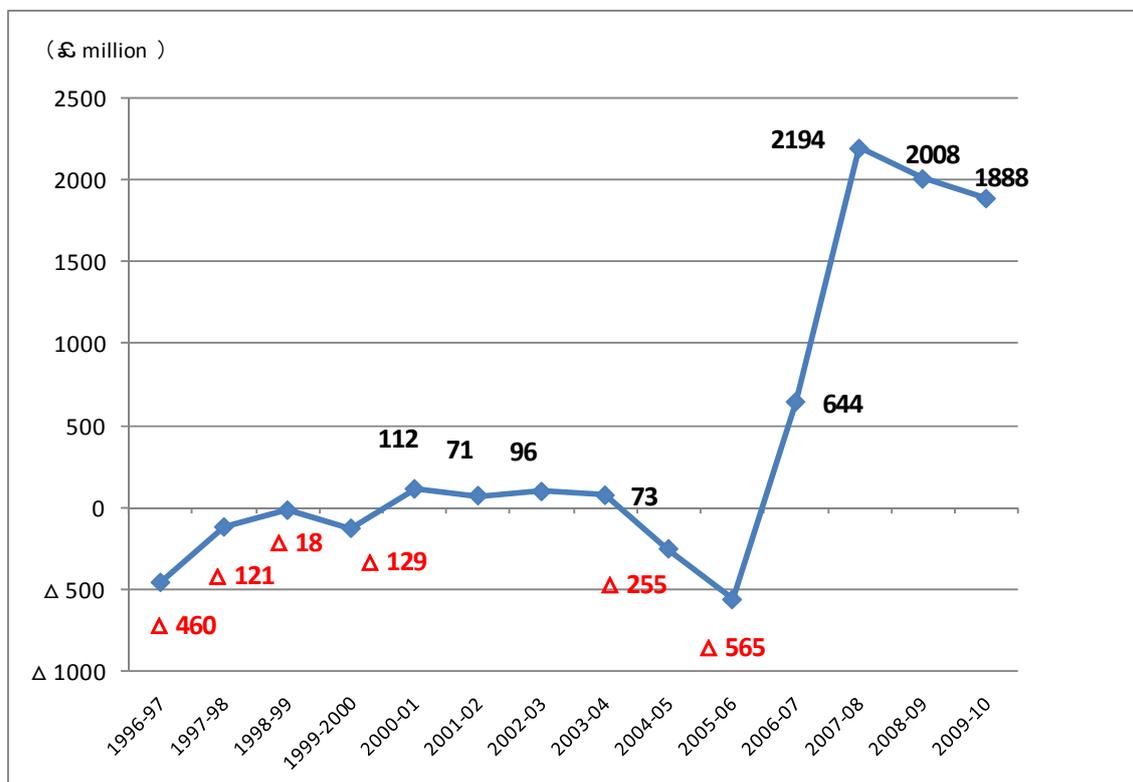
⁶ Tariff and HRGs are used. They evaluate activities by HRGs and calculate costs by Tariff which the government defined. Therefore, they don't negotiate about price but negotiate about quantity and quality. As a result of introducing PbR, the contract amounts increased 250 billion pounds in FY 2006. The allocation from PCTs increased 320 million pounds. Refer to AC (2004), the DH (2008), etc.

⁷ The policy dispute about FT is written in Ito (2006) 64 page in detail.

This section describes the deficit by change of restructuring from a point of view of soundness.

The Blair government decided to increase the healthcare expenditure to match the average level in other European countries, i.e. about 10% of GDP, and increased the rate of national insurance fee by 1% in FY 2003. This resulted in a healthcare budget of £ 86,147 million in FY 2003, £ 94,810 million in FY 2004, £ 100,806 million in FY 2005 and £ 109,016 million in FY 2006. However, while the NHS had a £ 73 million surplus in 2003-04, it had the deficit of £ 221 million in 2004-05, which grew to £ 547 million in 2005-06. In 2006-07, the NHS had £ 644 million surplus, a recovery of £ 1,294 million in one year (Figure 1).

Figure1 NHS financial position, 1996/97 – 2009/10



Source: House of Commons(2006)p.16 Table3; Monitor(2006)p.8; Monitor(2007)p.18; Monitor (2008)pp.30-31; Monitor (2009)p.13; Monitor (2010)p.22; DH(2011)p.3 Figure1, Figure2.

The deficit needs to be examined in detail now. All of SHA were black and the deficit was concentrated in PCTs and Acute Trusts. The numbers of PCTs in the deficit increased from 41 bodies in FY 2003 to 90 in FY 2004 and 125 in FY 2005. The size of the deficit increased. In FY 2003 the groups were as follows Table 1, “Deficit £8m-£12m”

was 1 organization, “Deficit £4m-£8m” were 7 and “Deficit up to £4m” were 33, in FY 2004 “Deficit over £16m” was 1, “Deficit £12m-£16m” were 3, “Deficit £4m-£8m” were 27 and “Deficit up to £4m” were 55. FY 2005 became worse moreover, “Deficit over £16m” was 5, “Deficit £12m-£16m” were 6, “Deficit £8m-£12m” were 15 and “Deficit up to £4m” were 62(Table 1).

Table1: Distribution of size of deficits across PCTs (accumulated balances)

	2003-04	2004-05	2005-06
Deficit over £16m	0	1	5
Deficit £12m-£16m	0	3	6
Deficit £8m-£12m	1	4	15
Deficit £4m-£8m	7	27	37
Deficit up to £4m	33	55	62
Breakeven	10	6	1
Surplus up to £4m	250	206	174
Surplus £4m-£8m	1	0	3
Surplus over £8m	1	1	0

Source: DH (2007) p.15 Table 3.7.

Regarding the numbers of PCTs in the deficit, 65 in 2003, 68 in 2004 and 77 in 2005 but the size of deficit increased each year. “Deficit up to £4m” were 44, “Deficit over £16m” was 1 and “Deficit £12m-£16m” was 1 in FY 2003. In FY 2005, although the numbers of “Deficit up to £4m” decreased which were 26, “Deficit over £16m” were 13 and “Deficit £12m-£16m” were 14 (Table2).

Table2: Distribution of size of deficits across Trusts (accumulated balances)

	2003-04	2004-05	2005-06
Deficit over £16m	1	4	13
Deficit £12m-£16m	1	1	14
Deficit £8m-£12m	1	14	10
Deficit £4m-£8m	13	14	14
Deficit up to £4m	44	31	26
Breakeven	23	18	10
Surplus up to £4m	151	151	144
Surplus £4m-£8m	1	0	4
Surplus over £8m	0	2	0

Source: DH (2007) p.16 Table 3.8.

The number of FTs in deficit was large in FY 2004 but the sizes of deficits were small. There was 1 organization in the “Deficit over £16m” category in FY 2005 but the impact of FTs was smaller than PCTs and Acute Trusts because the large numbers of

surplus bodies were as shown⁸.

2.2 Approach for returning to the surplus

(1) Approach of the Department of Health

The Department of Health (DH) covered the deficit and turned around management. DH covered the deficit in 2006-07 by two methods. One is 450 million pounds from Contingency which SHA squeezed out from the NHS Program Budget. The other was called Top-slice which cut the budgets to PCT 3% up from 0.5% beforehand, and the NHS collected 825 million pounds. These totaled 1,275 million pounds and accounted for 1,209 million pounds increase in NHS funds.

Regarding the turnaround in management, DH outsourced a research of the 98 deficit bodies (PCT and NHS trust) to KPMG in November 2005⁹. The research was divided into two parts, the first outsourcing cost was 1,493,500 pounds and the second was 1,092,400 pounds. As a result of the research, DH established the National Programme Office. The advisor of four large accounting firms such as KPMG, and directors of reconstruction in the DH started to support 25 bodies in May 2006 and the reconstruction directors staffed 31 bodies. The cost is announced officially as 177,000 pounds per body the total was 17,360,000 pounds in all. Ultimately the total cost of the turnaround management was 22 million pounds in addition to the outsourcing cost to KPMG.

(2) Approach of deficit bodies,

Meanwhile approaches of each deficit bodies were as follows; 1) cutting administration costs, 2) consolidations of hospitals and 3) financing from other bodies within SHA. Regarding saving, first of all, they reduced outsourcing costs, such as meal costs and cleaning expenses, then reduced maintenance costs and overtime payments and finally making redundancies. The number of compulsory redundancies in 2006-07 was 2,330 people; about 82% were non-clinical staff¹⁰.

The above approaches were emergency measures but led to a quick recovery within one year. However, for citizens, it meant that the medical service in 2006-07 was reduced after all, and I think that reduction of personnel and cutting of training budgets also affected the medical service in following year.

2.3 Analysis of cause of the deficit

⁸ Refer to DH (2006a) p.7 Table3; DH (2007a) p.13 Table3.4, p.15 Table.3.7, p.16 Table3.8; Monitor (2005)p.17; Monitor (2006)p.8,p.10

⁹ Refer to House of Commons(2006) p.49

¹⁰ Refer to DH(2007b)p.28

This section describes an analysis of finances of PCTs and NHS Trusts which caused the deficits. Since PCTs became the commissioning authorities shifted from SHA, their budget from DH increased sharply in 2002-03. The program costs also increased in connection with the increasing budget, and they went into the red (Table3). Since formulas of budget allocation were changed by introducing the new GMS contracts in 2004-05, GMS expense tripled and the payment for FT also started. Staff costs increased 883,790,000 pounds in 2004-05 and increased 619,100,000 pounds in 2005-06. The numbers of staff increased by 10,000 people each in 2004-05 and 2005-06. The Administration and estates staff and technical staff stood out¹¹.

In other hand, the balance of NHS trusts was in the red, but it had been black on cash flow (Table 4).

Table3:Balance sheet and Profit and Loss of PCT (FY2001-2006) £ 000

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07
Net Parliamentary funding	18,383,036	47,937,967	52,870,862	59,112,898	64,509,682	66,995,083
Capital grants received	825	3,944	4,702	9,118	16,484	6,274
Operation income	1,417,032	2,278,094	2,487,238	2,886,285	2,818,349	2,871,565
Income amounts	19,800,893	50,220,005	55,362,802	62,008,301	67,344,515	69,872,922
Programme costs	19,629,361	50,005,274	55,584,181	62,769,808	67,782,030	67,782,031
Balance	171,532	214,731	(221,379)	(761,507)	(437,515)	2,090,891
Cash flow balance	(23,291)	(7,722)	(12,137)	(20,887)	10,341	(1,783)
Programme costs						
Good and services from NHS bodies	11,167,618	28,932,160	30,740,506	30,535,930	30,651,980	28,626,899
Good and services from NHS Foundation Trusts				3,454,588	5,479,561	4,956,497
Staff costs	1,389,386	4,089,431	4,687,513	5,571,300	6,190,404	6,394,574
Board members	54,853	138,429	164,818	182,615	193,904	171,190
Supplies and services-clinical	147,624	349,106	358,765	404,766	448,888	475,581
Supplies and services-general	50,292	166,545	150,300	144,327	150,141	152,845
Prescribing costs	2,647,409	6,344,901	6,963,029	7,375,763	7,463,658	7,590,004
GMSinfrastructure costs	432,475	912,276	852,815			
GMS,PMS,APMS and PCTMS	0	952,481	1,903,113	6,003,060	6,772,754	6,937,544
PMS and PDS pilot	315,707	912,384	1,380,481	225,285	788,896	2,131,360
Non-GMS services from GPs	32,223	66,913	77,196	38,121	34,415	25,773
Pharmaceutical services	776,442	865,077	961,635	989,215	1,161,048	1,141,135
General dental services	1,622,398	1,696,551	1,766,809	1,671,374	1,446,890	26,328
General ophthalmic services	0	150,480	321,611	340,756	360,120	360,120
Expenditure on drugs action teams	0	131,472	181,882	194,726	236,349	236,349
Social care from independent providers	0	304,037	271,265	288,301	302,586	302,586
Purchase of healthcare from non-NHS bodies	409,936	1,199,941	2,847,987	3,353,031	4,091,792	4,091,792
Other	500,440	2,583,267	1,705,137	1,748,515	1,750,866	3,846,121
Amounts	19,629,361	50,005,274	55,584,181	62,769,808	67,782,030	67,782,030

Source: NAO(2004) p. B10,B12, pp.B19-B21 ; NAO(2005) p.B13,B15,B22; NAO(2007a)p.B8, B10, B17

¹¹ Refer to NAO(2004) pp. B19-20; NAO(2005) pp.B23-24; NAO(2007b)p.A18

Table4: Balance sheet and Profit and Loss of NHS Trsuts (FY2001-2006) £ 000

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07
Income from activities	28,711,092	29,071,459	31,163,798	31,423,977	31,856,942	31,518,298
Other operating income	4,219,145	4,356,340	4,673,678	4,140,501	4,110,533	3,659,198
Income amounts	32,930,237	33,427,799	35,837,476	35,564,478	35,967,475	35,177,496
Operating expense	31,784,702	32,279,362	35,187,310	35,124,554	35,683,250	34,502,759
Public dividend capital dividends payable	1,241,776	1,276,977	830,783	817,584	907,107	860,486
Interest receivable etc	56,012	35,011	43,000	55,834	41,443	108,338
Balance	(40,229)	(93,529)	(137,617)	(321,826)	(581,439)	(77,411)
Cash flow balance	38,748	8,252	6,275	4,839	10,329	36,142

Source: NAO(2004) p.C9; NAO(2005) p.C15; NAO(2007a)p.C8; NAO(2007b) p.C8.

As mentioned above, I think that the cause of the deficit was the centralization of allocation to PCTs and increasing of Commission costs to GPs, NHS trusts and FTs as well as large staff costs which employed large numbers of staff. In terms of NHS trusts, they had to pay large dividends because they had continued to get into debt.

3. Achievements of the Blair's Commitments

This section describes the achievements of the Blair Government's commitments. Table5 shows achievements of Commitments based on "NHS plan" and "new NHS plan". In terms of increasing the numbers of nurses, GPs, consultants and other clinical staff, the target was surpassed by a large margin.

Table5: Achievements of Commitments

	Commitment	In 2004-05	Difference
Additional nurses	55,000	73,780	18,780
Additional GPs	2,000	4,271	2,271
Additional Consultants	7,500	8,672	1,172
Additional other clinical staff	6,500	13,162	6,662
Additional beds (General and Acute Trusts)	2,000	2,197	197
Additional bed (Intermediate care)	5,000	4,686	△374

Source: DH(2007a)p.43 Table 4.1; DH(2000)p.43; DH(2005) p.47Table N.

Regarding increasing beds¹², the numbers of general and acute beds were 135,080 in 1999-2000 and went up to 137,277 in 2004-05, the goal of increasing beds was attained. However the numbers of intermediate care beds were 4,242 in 1999-2000 going up to 8,928 in 2004-05, This goal was not achieved.

In terms of decreasing waiting lists¹³, the government set a target of patients with

¹² Refer to DH(2000)p.43, DH(2005)p.47 Table N.

¹³ Refer to DH(2000)p.12, p.101, DH(2005)p.20, p.21 Table B, p.22 Table C, p.23Table D, p.24 Table E

“access to a GP within 48 hours” by 2004-05 in "NHS plan". Percentage of patients with “access to a GP within 48 hours” would become 74.64% in 2002-03 and 99.98% in 2005-06. This target was, for the most part, achieved. Regarding emergency care, a target was established of spending four hours or less in A&E. The percentage of patients spending four hours or less in A&E went up 98.1% in 2005-06 from 80% in 2003-04. Regarding patients waiting over 13 weeks for an outpatient appointment, the numbers of outpatients were 393,027 in 2000-01 to 30,468 in 2005-06. About patients waiting over six months for inpatient admission also, the numbers of inpatients were 264,370 in 2000-01 to 40,806 in 2005-06 but this target was not met.

As mentioned above, I think that in achieving their targets of increasing clinical staff deficits also resulted.

4. Why the deficit occurred: The view of Author, NHS and the House of Commons Healthcare Committee

4.1 Analysis of deficit by NHS

The NHS analyzed the causes of deficits as follows¹⁴. 1) NHS increased staff and raised wage levels by the Health dividend. Accordingly, Staffing costs rose. The number of full-time staff increased to 178,973 between 2000 and 2004, and put pressure on the finance as the size of labour costs were the same between 1996 and 2000. 2) There were many deficit bodies which went to excess for achieving the Performance Targets which did not fit the actual situations. 3) The removal of local virement flexibility by changing accounting practices caused the 2004-05 deficit. Management invulnerability and a bias of resource allocation became entwined with the above factors and the NHS could not identify a unique factor and enumerated four lessons as follows¹⁵.

(1) Targets

The NHS was concerned about the geographic unevenness of starting positions. Moreover, they expressed the need to conduct detailed analysis of the marginal costs and benefits of varying the timing and application of targets and to avoid using input targets.

(2) Time horizons

The NHS suggested a strict strategy of preparation to facilitate the accumulation of balances to provide buffers to absorb shocks. Also, allowing spending to be postponed when high value-added spending is unavailable.

(3) Resource Allocation

¹⁴ Refer to DH(2007a)

¹⁵ Refer to DH(2007a)

The NHS reported that the estimation of local needs based on observed utilization should investigate controlling for geographical variation in the supply and quality of all types of service, not just for admitted patients. They added that the relationship between the revenue costs of younger capital and deficits needed to be investigated further. The impact of weaknesses in the resource allocation process may in the past have been softened by flexible accounting practices such as brokerage and capital to revenue transfers. They said that such weaknesses may in future be exposed under a stricter and more transparent financial regime, raising the significance of the resource allocation process. They expressed the need for further analysis of how the SHA may offset a weakness in the allocation process, without undermining incentives for subsidiary organizations to make efficient decisions”.

(4) Employment

The NHS thought that at a time of financial consolidation, innovative employment arrangements may be required to ensure that graduating clinical staff are offered employment in the NHS. Relying upon decentralised behaviour by individual organisations may fail to capture wider ‘external’ benefits from offering NHS employment to those completing training, with too few staff retained for the long run strength of the NHS.

4.2 The analysis and view by House of Commons Health Committee

The House of Commons Health Committee emphasized that the organizations were unable to discover the issue at an early stage due to the way they were structured. The SHAs failed to monitor the trusts activities adequately and the DH neglected to check the SHAs work¹⁶. The other analyses were as follows¹⁷.

(1) The Resource Accounting and Budgeting (RAB)

Accounting procedures associated with the introduction of the Resource Accounting and Budgeting regime were switched. As a result, it was no longer possible to underspend on capital expenditure and use the money to subsidise current spending. House of Commons Health Committee agreed that the presently operating RAB was not a suitable accounting regime to use within NHS.

(2) Funding Formula

The funding formula allocated considerably more money per head to some PCTs than others. This may be related to the scale of health inequalities but it can make financial balance harder to achieve.

¹⁶ Refer to House of Commons (2006) p.81 No.26

¹⁷ Refer to House of Commons (2006) pp.77-81

(3) Poor central management

House of Commons said that poor central management had contributed to the deficits. The Government's estimates of the cost of Agenda for Change and the new GP and consultant contracts proved to be hopelessly unrealistic. Government targets, such as the 4-hour A&E target, had been expensive to meet and had unintended consequences which imposed additional costs.

(4) Poor local management

They had a good deal of evidence of poor financial management, for example: a hospital trust which hired staff without knowing whether it could afford to pay their salaries; and PCTs which failed to recruit vital members of the financial management team. Nevertheless, poor financial management is not just caused by local managers and boards.

"Top-slicing" and "Contingency" were especially important concerns of House of Commons. It recommended Top-slicing was temporary but must not become a permanent part of NHS funding. It was feared that routine emergency funds dampen morale and motivation of staff, and it did not go in the right direction.

Moreover, The Department planned to be in overall surplus by the end of March 2007. However, not all of the trusts would be in surplus by then and it was unlikely that trusts with the biggest deficits will be able to repay their accumulated deficits in five years. Such trusts should be responsible for drawing up a recovery plan which is agreed by the SHA. They said it was important that as a first step they achieve 'in-year' balance. Where there was no realistic chance of recovering the deficit over the 3- to 5-year period without severely affecting local services, consideration should be given to allowing a longer period to pay off historic deficits. In addition, the heavy cuts in the training budget were unacceptable because they were having adverse effects on staff morale and development.

Furthermore, it recommend that an alternative to, or refinement of, Resource Accounting and Budgeting be introduced. While Trusts pay back a deficit, they operate on reduced income which is inappropriate for a healthcare service. They stressed that it was fundamental that the regime chosen did not reduce trusts' income at the same time as requiring them to pay back any deficit owed.

Regarding local management, it recommended to the central government issue a statement of the duty about basic accounting procedures to the government. Next, there was a need to strengthen the role and position of Finance Directors.

As for the central government, the House of Commons suggested the new emphasis on finance must not lead to a reduction in the quality and scope of evidence-based

clinical care but measures to reduce NHS spending wasted on inappropriate or unproven therapies were to be welcomed and encouraged. They welcomed the Department's commitment to improve forecasting and undertake more local testing of new policies. The NHS must make its calculations explicit and make them widely available well in advance of implementation. If the timescale had to be extended as a result, so be it. New policies must be widely piloted.

4.3 Author's view of deficit

I think that increasing the transparency which Resource Accounting and Budgeting, Tariff and Reference Cost System were introduced and establishing FTs on independent accounting system made it easy to reach into a deficit on behalf of traditional sweet hearting. I think that the amount of charge to PCTs increased from GPs, NHS Trusts and FTs because medical treatments increased by increasing clinical staff and formulas of commissioning were changed. Moreover, I think that inefficiency of operations caused to go to red since the authorities of budget allocation changed to PCTs from SHAs.

Furthermore, as I mentioned in the previous section, I think that a factor was increasing labour costs which NHS increased staff over the commitments and raised level of wage. I think that it is difficult to grasp total picture and control by the central government since shifting to PCTs from SHAs became complicating communications

Since the budget was increasing, the deficit was not external economic factors, such as a financial recession of City. It was caused from the inside of NHS absolutely. I think that NHS ought not to have gone to the red if NHS kept a watchful eye on finances more.

5. The point of view of fairness: Impact of healthcare delivery

I will look at how the changes in the structure of the budget affected by healthcare reform affected the overall budget from a fairness perspective. In order to focus on the effects on income redistribution, I compared healthcare expenditure data and income decile data under the Conservative from 1987 to 1996 and the Blair governments from 1997 to 2007.

Regarding a history of healthcare expenditure, per capita healthcare expenditure in 2006 was £ 2,001, which was more than twice that in 1997, when Blair came into office, and over ten times that in 1987, when Thatcher was in office, and three times that in 1991 when the Internal Market was introduced.

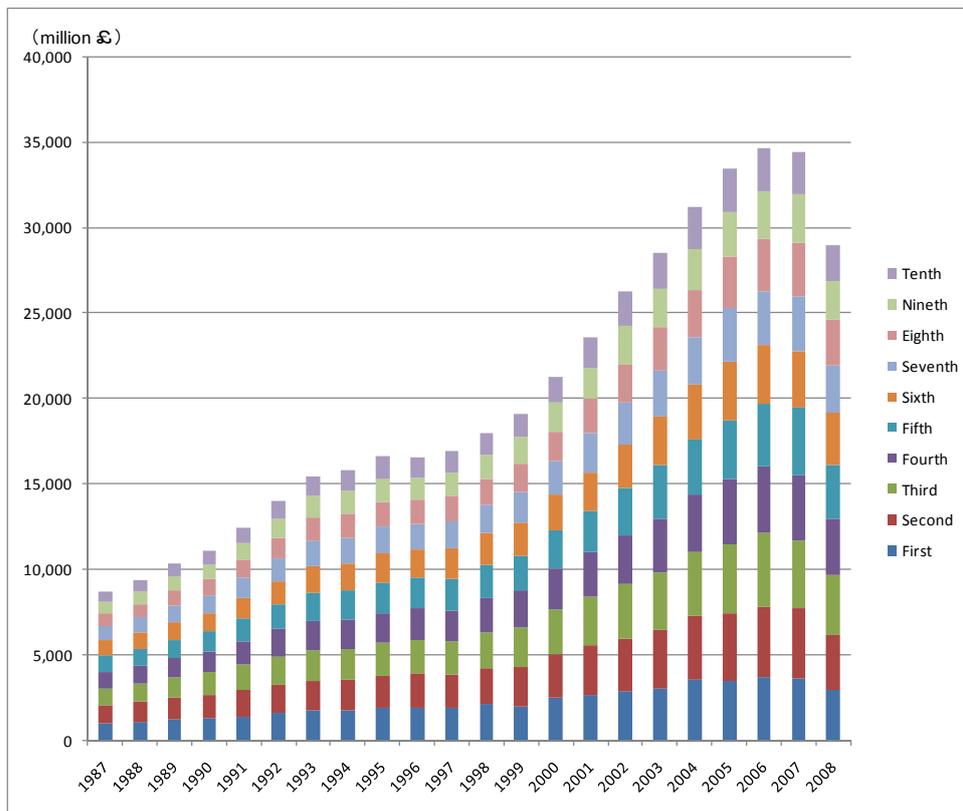
When you look at medical expenditures by income level, every level is about the

same from the Conservative government and allocate healthcare equally regardless of income level (Figure2).

I examine the Gini coefficient through Original Income, Post-tax Income and Final Income data. The difference between Post-tax Income and Final Income data is only in-kind benefit amount and I think it is showed the effect of in-kind benefit included healthcare cost.

Calculation results are shown in Table 6. Every Original Income are over 0.4, that is, the gap between rich and poor is wide but every Final Income are under 0.3, that is, it is quite equal. Since figures were especially reduced from 2002 to 2008, they clearly shows rising of effect of income redistribution.

Figure 2 History of medical expenditures by income level (1987-2008)



Note : Accumulated amounts are not amount of healthcare costs.

Source : ONS Data(1987-2008) *Effects of Taxes and Benefits on Household Income*

<http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15369>.

Table6 Gini coefficient (1987-2008)

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Original Income	0.453	0.457	0.449	0.458	0.460	0.459	0.472	0.466	0.456	0.464	0.464
Post-tax Income	0.344	0.371	0.361	0.378	0.373	0.359	0.359	0.355	0.351	0.362	0.364
Final Income	0.266	0.292	0.282	0.301	0.295	0.275	0.271	0.269	0.262	0.277	0.282
Difference between Post-tax and Final Income	0.078	0.079	0.079	0.077	0.078	0.084	0.087	0.086	0.089	0.085	0.082
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Original Income	0.465	0.469	0.455	0.466	0.450	0.453	0.447	0.456	0.452	0.446	0.452
Post-tax Income	0.370	0.383	0.370	0.383	0.355	0.358	0.351	0.357	0.364	0.356	0.356
Final Income	0.285	0.296	0.282	0.293	0.266	0.268	0.259	0.264	0.264	0.259	0.270
Difference between Post-tax and Final	0.085	0.087	0.088	0.090	0.089	0.090	0.091	0.093	0.099	0.097	0.086

Source: ONS Data (1987-2008) Effects of Taxes and Benefits on Household Income.
<http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15369>.

Furthermore, it is found that Blair government focused on in-kind benefit well than the Conservative, because the difference between Post-tax Income and Final Income data expanded since 2001.

As mentioned above, the expansion of healthcare expenditure raised double healthcare costs per capita in Blair's era. As a result, access to medical care for low-income group could increase and the system was made more equitable.

6. Conclusion and lessons to Japan

The aim of the healthcare reform of the Blair Government was to maintain healthcare in 2050. Therefore NHS set out more equity, efficient and independent organizations and improved the quality of services from now. The Blair Government evaluated internal market by the Conservative Party Administration was inefficient because it bore a heavy burden to GPFHs but has been maintained the efficient policy while it shifted to the present framework to the internal market. I think shifting a role of allocation to PCTs from SHAs broke traditional organizations and protocols. Changing of budget allocation system and introduction of Resource Accounting and Budgeting improved transparency. Establishment of FTs promoted to become independent by giving the responsibility for management, too. The UK has carried through equity and introduction of the Reference Cost was for accountability. Regarding the allocation of Contingency, NHS did not pay the Contingency intensively to the East SHA which had a large deficit badly¹⁸. However, it should be remembered that reasons which the Blair Government achieved results had a good economy and a good conditions that fiscal deficit already reduced by the Conservative Party era, either.

¹⁸ Refer to DH(2006b)p.1; DH (2007b) p.3.

Lessons to Japan are four. 1) We should to secure a sufficient budget and preparation period when we reorganize and reform. It is because it is impossible to estimate a sufficient budget in advance and not to avoid inefficiency after reform. 2) We should to improve transparency and strengthen check functions. Introduction of Reference Cost System and Resource Accounting and Budgeting raised public trust, strengthened check functions by themselves and provided medical information to citizens. We cannot improve healthcare without information for making a decision. It is necessary to strengthen accountability when we consider future healthcare. House of Commons recommended a flexible accounting system because the Resource Accounting and Budgeting is not suitable to NHS but I think that NHS could recover rapidly because of limit of budget such as AME (Annually Managed Expenditure) . 3) We should keep constantly a watchful eye on finances and govern organizations. It is important to achieve commitments but Blair Government went to red. This case taught it is important not only to go on goal but also to pay attention to finance, otherwise if we increase the burden of healthcare cost, we may not to provide sufficient healthcare. 4) We must not to overdo many reforms at once. I think the reforms were over the top. It is important to promote them steadily.

At the end, I think that the Blair's healthcare reforms were remarkable that It reformed for continuation of a welfare state and as a result, the equity of healthcare was improved in the UK.

Closing remarks

This paper focuses on the effects of the healthcare reform of the British Labour Party Administration under the Blair on finances from the point of view of its soundness and fairness.

What we showed are three. 1) Causes of deficit and approaches for returning to black from a perspective of soundness: key causes were expanded labour costs by increasing staff and raised expenditure by changing formulas of budget allocation, 2) I examine the Gini coefficient compared between the Blair and the Conservative. The expansion of healthcare expenditure raised the healthcare costs per capita. As a result, access to medical care for low-income group could increase and the system was made more equitable. Also, the Conservative Party Administration focused on cash benefits such as but the Blair Government focused on the benefits in kind such as including the healthcare. 3) I studied about achievements of the Blair Government's commitments. I think that achieved exceeding the commitments of clinical staff caused to go to deficit.

Most important lessons to Japan is not only to go on goal but also to pay attention

to finance, otherwise if we increase the burden of healthcare cost, we may not to provide sufficient healthcare. We come as a fresh reminder that it is important to implement policies with keeping a watchful eye on finances.

After that this experience, NHS has maintained black. In 2005 it introduced FT Diagnostics in FTs as a whole which is a method of management assessment and is going to improving its operations. Evaluation of FT Diagnostics remains as a matter to be discussed further.

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