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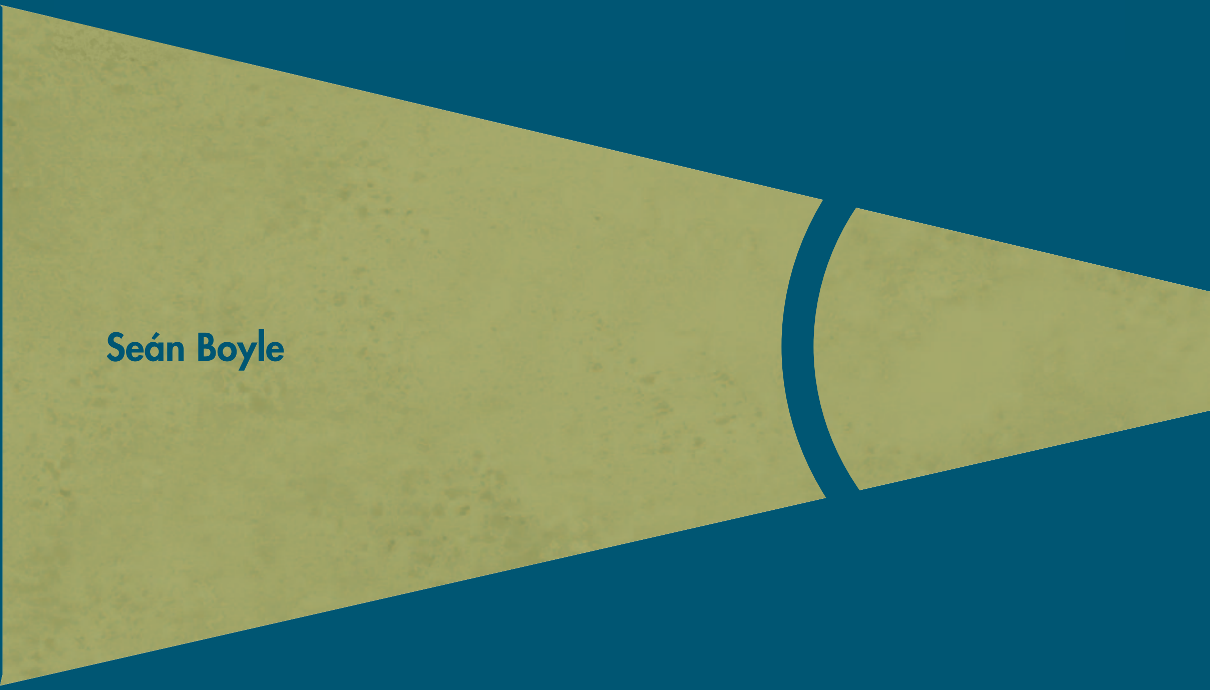

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Health Systems in Transition

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United Kingdom (England):

Health System Review

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Preface

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

HiT profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries;
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the

World Health Organization (WHO) Regional Office for Europe Health for All database, national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, the International Monetary Fund (IMF), the World Bank and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differs across countries. However, it also offers advantages, because it raises similar issues and questions. The HiT profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

HiT profiles and HiT summaries are available on the Observatory's web site at www.euro.who.int/observatory.

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The production and copy-editing process was coordinated by Jonathan North with the support of Steve Still (design and layout), Jane Ward (copy-editing) and Alison Chapman (proofreading). Administrative and production support for preparing the HiT was provided by Caroline White.

List of abbreviations

Abbreviations	
A&E	Accident & emergency
AIDS	Acquired immunodeficiency syndrome
AOT	Assertive outreach team
BDA	British Dental Association
BMA	British Medical Association
BMI	Body mass index
CAM	Complementary and alternative medicine
CAMHS	Child and Adolescent Mental Health Services
CASSR	Council with adult social services responsibility
CHI	Commission for Health Improvement
CHRE	Council for Healthcare Regulatory Excellence
CPA	Care Programme Approach
CPD	Continuing professional development
CPI	Consumer price index
CQC	Care Quality Commission
CRT	Crisis resolution team
CT	Computed tomography
DALY	Disability-adjusted life-year
ECJ	European Court of Justice
EEA	European Economic Area
EIT	Early intervention team
EMEA	European Medicines Agency
ENT	Ear, nose and throat
EPS	Electronic Prescription Service
EU	European Union
EU15	The 15 countries that joined the EU before May 2004
FBC	Full business case
FT	Foundation Trust
GATT	General Agreement on Tariffs and Trade

Abbreviations	
GDC	General Dental Council
GDP	Gross domestic product
GHE	Government health care expenditure
GMC	General Medical Council
GP	General practitioner
HCHS	Hospital and community health services
Hib	Haemophilus influenzae type b
HIV	Human immunodeficiency virus
HPA	Health Protection Agency
HRG	Healthcare resource group (English equivalent of diagnosis-related group)
HTA	Health technology assessment
ICAS	Independent Complaints Advocacy Service
ISTC	Independent-sector treatment centre
IT	Information technology
LIFT	Local Improvement Finance Trust
MCADD	Medium-chain acyl-coenzyme A dehydrogenase deficiency
MenC	Meningococcal Serogroup C
MFF	Market forces factor
MHRA	Medicines and Healthcare products Regulatory Agency
MMR	Measles, mumps and rubella vaccine
MP	Member of parliament
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant *Staphylococcus aureus*
NAO	National Audit Office
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NHS	National Health Service
NHS CRS	NHS Care Records Service
NHS PASA	NHS Purchasing and Supply Agency
NHSLA	NHS Litigation Authority
NIC	National insurance contribution
NICE	National Institute for Health and Clinical Excellence (was National Institute for Clinical Excellence)
NIHR	National Institute for Health Research
NPfIT	National Programme for Information Technology
NPSA	National Patient Safety Agency
NSC	National Screening Committee
NSF	National Service Framework
OBC	Outline business case
OECD	Organisation for Economic Co-operation and Development
Ofsted	Office for Standards in Education, Children's Services and Skills
ONS	Office for National Statistics

Abbreviations	
OTC	Over the counter
PACS	Picture archiving and communication system
PBC	Practice-based commissioning
PbR	Payment by results
PCT	Primary care trust
PFI	Private finance initiative
PMI	Private medical insurance
PMS	Primary medical services
POM	Prescription-only medicine
POPPs	Partnerships for older people pilots
PPP	Purchasing power parity
PPRS	Pharmaceutical Price Regulation Scheme
PROM	Patient-reported outcome measure
PSA	Public Service Agreement
PSS	Personal Social Services
QOF	Quality and Outcomes Framework
RCN	Royal College of Nursing
R&D	Research and development
ROC	Return on capital
SCR	Summary Care Record
SHA	Strategic health authority
S.I.	Statutory Instrument
SOC	Strategic outline case
TGE	Total government expenditure
TRIPS	Trade-related Aspects of Intellectual Property Rights
UDA	Units of dental activity
VAT	Value-added tax
WHO	World Health Organization
WTE	Whole-time equivalent
WTO	World Trade Organization

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Abstract

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. HiTs examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

Various indicators show that the health of the population has improved over the last few decades. However, inequalities in health across socioeconomic groups have been increasing since the 1970s. The main diseases affecting the population are circulatory diseases, cancer, diseases of the respiratory system and diseases of the digestive system. Risk factors such as the steadily rising levels of alcohol consumption, the sharp increases in adult and child obesity and prevailing smoking levels are among the most pressing public health concerns, particularly as they reflect the growing health inequalities among different socioeconomic groups.

Health services in England are largely free at the point of use. The NHS provides preventive medicine, primary care and hospital services to all those “ordinarily resident”. Over 12% of the population is covered by voluntary health insurance schemes, known in the United Kingdom as private medical insurance (PMI), which mainly provides access to acute elective care in the private sector. Responsibility for publicly funded health care rests with the Secretary of State for Health, supported by the Department of Health. The Department operates at a regional level through 10 strategic health authorities (SHAs), which are responsible for ensuring the quality and performance of local health services within their geographic area. Responsibility for commissioning health services at the local level lies with 151 primary care organizations, mainly primary care trusts (PCTs), each covering a geographically defined population. Health

services are mainly financed from public sources – primarily general taxation and national insurance contributions (NICs). Some care is funded privately through PMI, some user charges, cost sharing and direct payments for health care delivered by NHS and private providers.

While the reform programme that developed since 1997 proved to be massive in its scope, some basic features of the English NHS, such as its taxation-funding base, the predominantly public provision of services and division between purchasing (commissioning) and care delivery functions, remain unchanged. Nevertheless, in addition to the unprecedented level of financial resources allocated to the NHS since 2000, the most important reform measures included the introduction of the "payment by results" (PbR) hospital payment system; the expanded use of private sector provision; the introduction of more autonomous management of NHS hospitals through foundation trusts (FTs); the introduction of patient choice of hospital for elective care; new general practitioner (GP), consultant and dental services contracts; the establishment of the National Institute for Health and Clinical Excellence (NICE); and the establishment of the Care Quality Commission (CQC) to regulate providers and monitor quality of services. The English NHS faces future challenges as 2010 draws to a close, with significant restrictions on expenditure and a newly elected government that has announced its intention to introduce further widespread reform.

Executive summary

Introduction

England is one of four countries, along with Scotland, Wales and Northern Ireland, that make up the United Kingdom of Great Britain and Northern Ireland. In 2009, the English population was estimated at 51 809 700, constituting 83.8% of the total population of the United Kingdom. The United Kingdom is a constitutional monarchy governed by a parliament formed of two houses. Democratically elected members of parliament (MPs) representing 650 local constituencies sit in the House of Commons. An upper house of mainly appointed members, the House of Lords, comprises 744 members. Elections to the House of Commons take place at least once every five years under a first-past-the-post electoral system. The head of state is a hereditary monarch, Queen Elizabeth II (since 1952). The head of government, the prime minister, is the leader of the party that can command a majority in the House of Commons. The United Kingdom is one of the 27 members of the European Union (EU). England is divided further into 354 smaller administrative regions run by local government (known as local authorities or councils).

Various indicators show that the health of the population has improved over the last few decades. Life expectancy at birth increased between 1981 and 2008 by 5.1 years for women and 6.9 years for men, reaching 82.1 years and 78.0 years, respectively. In addition, mortality rates have declined for most major disease categories, with large falls in the three major categories: respiratory (by 56% for men and almost 30% for women), cancers (by 22% for men and 10% for women) and circulatory disease (by approximately 64% for both men and women). Moreover, infant and perinatal mortality rates in England have decreased dramatically since 1976. Infant mortality fell from 14.2 per 1000 live births in 1976 to 4.7 in 2008, while the perinatal mortality rate fell from 17.6 deaths per 1000 live births to 7.6 over the same period. However, inequalities in health across socioeconomic groups have been increasing since the 1970s; for example, in England and Wales for people born between 2002 and 2005, there was a difference between the unskilled class and the professional class of 7.3 years in male life expectancy at birth and 7.0 years in women.

The main diseases affecting the population are circulatory diseases (accounting for 33% of deaths in England and Wales in 2009), malignant neoplasms (i.e. cancer, 28%), diseases of the respiratory system (14%), diseases of the digestive system (5.1%) and infectious diseases (1.2%). The steadily rising levels of alcohol consumption and alcohol-related deaths and the sharp increases in adult and child obesity are among the most pressing public health concerns, along with the (albeit steadily decreasing) rate of smoking prevalence, with 24% of men and 20% of women in England being regular smokers in 2008.

Organization and regulation

Health services in England are largely free at the point of use. Established in 1948, the NHS provides preventive medicine, primary care and hospital services to all those “ordinarily resident” in England. Over 12% of the population is covered by PMI, which mainly provides access to acute elective care in the private sector.

Responsibility for publicly funded health care rests with the Secretary of State for Health, who is accountable to parliament. The Department of Health is the central government body responsible for setting policy on the NHS, public health, adult social care and other related areas. The main role of the Department is to support the government in improving the health of the population in England; it sets overall health policy and strategy, as well as dealing with legislation and regulation. The Department of Health operates at a regional level through 10 SHAs, which are responsible for ensuring the quality and performance of local health services within their geographic area. Responsibility for commissioning health services at the local level lies with 151 primary care organizations, mainly PCTs, each covering a geographically defined population of, on average, just over 340 000 people. Since 2005, GPs have also played a role in commissioning through the development of practice-based commissioning.

In the health care sector, most regulatory activity is independent (self-) regulation through a range of bodies. NHS hospitals are in the process of attaining greater autonomy from the Department of Health through achieving FT status, although they remain subject to a system of external audit and inspection that has been developed and extended since 1999. PCTs still operate within a target-based framework, reflecting their responsibility for the use of public funds to meet the health needs of their local populations. The CQC regulates the health care sector through registration, annual inspection, monitoring complaints and enforcement. Health care professionals have retained a significant degree of autonomy in regulating their practice through their professional associations, although there have been significant changes in recent years to strengthen oversight.

Financing

Health services in England are mainly financed from public sources – primarily general taxation and NICs. Some care is funded privately through PMI, – some user charges, cost sharing and direct payments for health care delivered by NHS and private providers.

Health expenditure in the United Kingdom has risen significantly in recent years, with total spending on health care as a proportion of gross domestic product (GDP) increasing from 5.6% in 1980 to 8.7% in 2008. In particular, spending increased rapidly between 1997 and 2008, from 6.6% to 8.7% of GDP, corresponding to an increase in expenditure in cash terms from £55.1 billion to £125.4 billion.

Public sources of finance for health care are allocated by central government to the Department of Health, which is then responsible for the further disbursement of monies. Since 1998, the size of the Department of Health's budget for the following three years has been fixed every two years following a process of negotiation with the Treasury known as the Spending Review. Each year, the Department of Health allocates around 80% of the total NHS budget to PCTs using a weighted capitation formula. Since 1999, there have been significant changes to the way in which PCTs pay for health services, particularly in the hospital sector, with the introduction in 2003–2004 of activity-based funding – developed in England as a system known as PbR. Important changes have also been made to the system of paying GPs and specialist doctors (consultants), with added bonuses for meeting specified targets.

In 2009–2010, of estimated total NHS current expenditure of £99.8 billion, £88.5 billion (88.7%) was expenditure on NHS bodies (e.g. NHS trusts, GPs, dentists), £9.7 billion (9.7%) was on centrally-managed budgets (e.g. Connecting for Health), and £1.5 billion was on funding personal social services (1.5%); in addition the NHS had a capital budget of £5.5 billion.

In terms of out-of-pocket payments, while most NHS health care is free at the point of use, some services are either not covered by the NHS and patients must, therefore, pay themselves (direct payments) or are covered by the NHS but are subject to cost sharing, usually in the form of co-payments. Direct payments cover private treatment in NHS facilities, over-the-counter medicines, ophthalmic care and social care; co-payments cover NHS prescriptions and NHS dental care. Most out-of-pocket payments by individuals are direct, with some 41% devoted to over-the-counter medicines, while user charges for NHS services are the largest part of co-payments, accounting for 13% of the total. Between 1990 and 1997, total expenditure on out-of-pocket payments per capita population in the United Kingdom increased by over 100%, from £62 to £133; between 1997 and 2008 the increase was somewhat less, to £230 per capita.

Delivery of services

Public health in England is primarily the responsibility of the Department of Health; the Chief Medical Officer leads on public health and is responsible for health improvement and protection as well as the nine regional public health groups.

NHS-funded primary care is provided in various ways. The first point of contact for general medical needs is usually self-employed GPs and their practices, typically entering into contractual engagements with PCTs, although GPs may also be employed directly by alternative providers (e.g. commercial sector). Community health services, NHS Direct, NHS walk-in centres, dentists, opticians and pharmacists are part of NHS primary care services. The primary care system also plays a gatekeeping role in determining access to more specialized, often hospital-based, acute health care services.

NHS-funded secondary care is provided by salaried specialist doctors (consultants), nurses, and other health care professionals (e.g. physiotherapists and radiologists) working in government-owned hospitals (NHS trusts). A small private sector exists alongside the NHS, funded through private insurance, direct payments from patients, or publicly funded payments by PCTs and the

Department of Health, and mainly provides acute elective care. To access NHS specialist care, patients require a referral for a consultation from a GP. Patients can also pay out of pocket for a private consultation or be referred through a PMI scheme if they are members of such a scheme.

In addition to secondary care, a range of more specialized tertiary services are also provided by NHS trusts and deal with more complex or rare conditions. These trusts are usually also linked to medical schools or teaching hospitals, as well as being centres of research in their fields. Patients are mostly referred to a tertiary centre by a secondary care specialist, although direct referrals by GPs are also possible. In addition, most tertiary centres also provide some private health care services.

The United Kingdom is a major producer of pharmaceuticals, ranking fourth in the world in 2007 in terms of value of exports, behind Germany, Switzerland and the United States. At the same time, pharmaceutical care is a major component of expenditure on health care in the United Kingdom, both within the NHS, where it accounts for a total of £10.8 billion, and in the private sector: it is estimated that annual expenditure on medicines per head in the United Kingdom in 2008 was £200, which is £12.2 billion in total.

Social care is the statutory responsibility of 152 councils with adult social services responsibilities (known as CASSRs). The organization of long-term care has shifted over time from residential (or institutional) care to care provided in the community, while the provision of care has shifted from the public sector to private- and voluntary-sector organizations. Financing of care is a mix of public, through local government bodies (local authorities or councils), and private, mainly out of pocket with some payments through insurance schemes.

The mental health system in England has developed since 1948 from a system of asylum-based detention to an emphasis on the provision of care in the community for people with mental health problems. The system is a mix of primary care and community-based services supported by specialist inpatient care. Services provided through the NHS are available free at the point of delivery. PCTs have responsibility for both commissioning and sometimes providing mental health services for their local populations.

PCTs are responsible for the provision of NHS dental services in their geographically defined local areas and must ensure that NHS dentistry is available to anyone wishing to access services. Although individuals have these treatment entitlements under the NHS, they may choose to receive a mix of private and NHS treatment within the same episode of dental care.

Reforms and future challenges

The reform programme that developed since 1997 proved to be massive in its scope. Nevertheless, some basic features of the English NHS remained unchanged over this period. It is still largely dependent on tax funding; responsibility for ensuring access to health care rests with central government; and although the private-sector role in provision has expanded, the public sector is still the main provider of care. Access to non-emergency hospital care remains under the control of GPs and a distinction between purchasing (or commissioning) and provision, first introduced by the early 1990s, remains in force, although the nature of both the providing and the purchasing organizations has changed.

Having said that, in addition to the unprecedented level of financial resources put into the NHS since 2000, the most important reform measures introduced since 1997 include the introduction of the PbR hospital payment system; the expanded use of private sector provision; the introduction of more autonomous management of NHS hospitals through FTs; the introduction of patient choice of hospital for elective care; new GP, consultant and dental services contracts; the establishment of NICE, and the expansion of its remit to include the development of comprehensive guidelines for all services; and the establishment of the CQC to regulate providers and monitor quality of services.

The English NHS faces challenges as 2010 draws to a close, with significant restrictions on expenditure and a newly elected government that has announced its intention to introduce further widespread reform.

1. Introduction

1.1 Geography and sociodemography

England is one of four countries that constitute the United Kingdom of Great Britain and Northern Ireland. England, Scotland and Wales make up Great Britain; with the addition of Northern Ireland, these four countries form the United Kingdom (Fig. 1.1). In 2009, the English population was estimated at 51 809 700, constituting 83.8% of the total population of the United Kingdom (ONS 2010a). In 2009, 7.75 million people lived in the capital city, London, making it the most populous city in the EU. The whole of the United Kingdom is spread over 244 820 km^2. It is estimated that in 2010, population density in England was 401/km^2 compared with 4931/km^2 in London (House of Commons 2010a, 2010b).

There are a number of dependent areas associated with the United Kingdom, including Anguilla, Bermuda, British Indian Ocean Territory, British Virgin Islands, Cayman Islands, Falkland Islands, Gibraltar, Guernsey, Jersey, Isle of Man, Montserrat, Pitcairn Islands, Saint Helena, South Georgia and the South Sandwich Islands, and the Turks and Caicos Islands.

The English climate is fairly mild and dry. The south of the country is usually warmer than the north, and the west tends to be wetter than the east. More extreme weather occurs in the mountains and hills, where it can be cloudy, wet and windy. England at its nearest point is just 35 km from France and is linked with France by a tunnel under the English Channel. Much of England is relatively flat, although there are outcrops of hills and mountains mainly in the north of the country: the Lake District to the northwest and the Pennines dividing northwest from northeast. There are also areas of rugged moor, to the north in Yorkshire, the Peak District in the Midlands and Dartmoor to the southwest. The north and the Midlands contain a mixture of industrial and farming communities. The southwest is mainly a farming area with some hill formations and a beautiful coastline. The rest of the country consists of both farmland and light industrial areas.

Fig. 1.1

The United Kingdom and its constituent countries

Source: University of Texas at Austin (2010).

Average household size in England fell from 3.01 persons in 1961 to 2.32 persons in 2006, and is projected to fall to 2.13 by 2031 (Department of Communities and Local Government 2009a). Between 1971 and 2008, the proportion of one-person households in England increased by almost 70% (from 19% to 32%) (Department of Communities and Local Government 2009b).

According to the United Kingdom Census of 2001, 91% of the English population was from a "White" ethnic background, the remainder from other ethnic minorities (e.g. 2% Indian, 1.4% Pakistani). London is considerably more diverse, with 29% belonging to a minority ethnic group (ONS 2003a). About 72% of English residents state their religion as Christian (58% in London), 3% Muslim (8.5% in London), 1.1% Hindu (4.1% in London), 0.7% Sikh (1.5% in London) and 14.6% reported no religious affiliation (15.8% in London) (ONS 2003b).

Table 1.1 provides a range of demographic indicators for England. The population has grown steadily since 1971 and is projected to continue to grow to 60.7 million by 2033. Fig. 1.2 shows the population age structure for men and women in England in 2009. Like the rest of Europe, England has an ageing population. As Table 1.1 shows, the proportion of the population 65 years of age and over increased from 13.4% in 1971 to 16.1% in 2008, while the proportion of people under 14 years fell from almost 23.7% to 17.6%. The population will continue to age and it is projected that 22.2% of people will be aged 65 years and over by 2031 (ONS 2009a).

Table 1.1

Demographic indicators for England, 1971–2008

	1971	1981	1991	2001	2005	2008
Total population (thousands)	46 412	46 821	47 875	49 450	50 466	51 446
Female (%)	51.4	51.3	51.4	51.1	50.9	50.8
0–14 years (%)	23.7	20.3	19.0	18.8	17.9	17.6
65+ years (%)	13.4	15.2	15.8	15.8	15.9	16.1
Old-age dependency ratio[a]	28.1	29.9	30.0	29.7	29.9	30.8
Crude birth rate[b]	15.9	12.8	13.8	11.4	12.1	13.1
Crude death rate[b]	11.5	11.6	11.2	10.0	9.6	9.2
Total fertility rate[c]	2.37	1.79	1.81	1.63	1.79	1.97
Population growth (%)[d]	–	0.07	0.24	0.38	0.58	0.71

Sources: ONS 1997 (for 1971), 2009a (for 1981–2008).
Notes: [a] Percentage of males 65 years and over plus females 60 years and over to working population (defined as males 16–64 years and females 16–59 years); [b] Per 1000 population, all ages; [c] Average number of children that would be born to a woman if between the ages of 15 and 49 years she experienced current age-specific fertility rates (the figure for 1971 is for England and Wales); [d] Compound rate of growth over the previous five years.

Fig. 1.2

England population by sex and age, 2009

Source: Constructed from data in ONS 2010a.

Following a sharp increase between 1994 and 2002 in the number of people seeking asylum each year in the United Kingdom, from 32 830 in 1994 to 84 130 in 2002, applications (not including dependants) fell back to a low of 23 430 in 2007 but grew subsequently. In 2009 there were 24 250 applications (Home Office 2009, 2010).

1.2 Economic context

Macroeconomic indicators for international comparative purposes are usually produced for the United Kingdom as a whole and tend not to be routinely available for England. Table 1.2 provides the United Kingdom indicators, with indicators for England where available.

Table 1.2

United Kingdom macroeconomic indicators, 1990, 1995, 2000, 2005, 2008, 2009

	1990	1995	2000	2005	2008	2009
GDP (£ million, 2000 prices)[a]	760 249	824 722	976 533	1 104 726	1 165 251	1 108 192
GDP per head (£, 2000 prices)[a]	13 283	14 214	16 582	18 291	20 460	19 333
GDP (US$ PPP million)[b]	936 437	1 146 295	1 533 320	1 971 196	2 306 131	2 172 246
GDP per head (US $ PPP)[b]	16 360	19 755	26 037	32 693	37 560	35 153
CPI (= 100 in 2005)	71.5	86.0	93.1	100.0	108.5	110.8
Inflation rate[c]	7.0	2.6	0.8	2.1	3.6	2.2
Exchange rate (US$/GBP)	0.56	0.63	0.66	0.55	0.54	0.64
Total economically active population 16+ years, UK (thousands)[d]	28 925	28 206	29 080	30 148	31 174	31 365
Total economically active population 16+ years, England (thousands)[d]	na	23 718	24 535	25 391	26 240	26 449
Unemployment rate, UK[d,e]	6.9	8.8	5.6	4.8	5.2	7.6
Unemployment rate, England[d,e]	na	8.7	5.4	4.7	5.3	7.7
UK population with <60% of median household income (%)[f]	24	24	24	20	22	22

Sources: Department for Work and Pensions 2010a (for median household income only); ONS 2010b.
Notes: [a] In the ONS source, these series were in 2005 or 2006 prices; they have been adjusted to 2000 prices for comparability with other OECD series; note also that these data reflect any corrections to original data as of August 2010; [b] Purchasing Power Parity data from Eurostat have been applied to GDP at market prices; [c] Percentage change in CPI per year; [d] Seasonally adjusted, March–May (spring) quarters; [e] Percentage of economically active population 16+ years who are not employed; [f] Based on contemporary median household income; income is calculated after a measure of housing costs has been deducted (i.e. rent, water rates, service charges etc.); Years refer to surveys across years, thus 2007 is 2006–2007; CPI: Consumer price index; na: Not available.

As Table 1.2 shows, the United Kingdom's gross domestic product (GDP) in real terms increased by around 46% between 1990 and 2009, from £760 billion to £1 110 billion at 2000 prices. The cash value, measured in pounds or in US dollars purchasing power parity, more than doubled over that period. The value of sterling relative to the US dollar has fluctuated over this period, falling between 1990 and 2000, returning to above its 1990 level in 2008, and then falling again to US$ 1.43 in January 2009 before recovering to US$ 1.56 (ONS 2010b).

Workforce data are available for both the United Kingdom and England (Table 1.2). Between 1995 and 2010, the workforce in England increased by 11.8% (almost 2.8 million people). The unemployment rate in England fell from

8.7% in 1995 to 4.7% in 2005. However, as the global economic downturn took effect, the rate increased and in spring 2010 it stood at 7.8%, still below its level in 1995 (ONS 2010b).

The most common measure of poverty in the United Kingdom is the proportion of individuals living in households whose incomes are below 60% of the contemporary median income. Table 1.2 shows a reduction since 1990 in the proportion of individuals living below this income level, from 24% to 22%. However, there has been a substantial increase in this figure since 1979, when it was 13% (Department for Work and Pensions 2010a). There are also considerable differences based on ethnicity in numbers living in low-income households. For example, in the United Kingdom in 2008–2009, using the measure with housing costs deducted, just 20% of the White population was classified as living in low-income households compared with 60% of Pakistani and Bangladeshi households and 48% of Black Non-Caribbean households (Department for Work and Pensions 2010a).

The EU at-risk-of-poverty rate is based on individuals with below 60% of median income but with housing costs included. Using this definition, the United Kingdom would appear to be in a worse position than most of its neighbours. For example, in 2003, the percentage of individuals in the United Kingdom living in households with income below 60% of median was 18%, compared with an EU average of 15% (based on the EU15, the 15 Member States prior to May 2004), 11% in Finland, 12% in France and 15% in Germany (Eurostat 2007). By 2008–2009, the United Kingdom percentage was unchanged at 18% (Department for Work and Pensions 2010a).

An alternative measure of income inequality is the Gini coefficient, which provides a measure on a 0–100 scale where 0 indicates total income equality and inequality increases as the coefficient increases. The United Kingdom Gini coefficient after housing costs are deducted increased from 37 to 40 (33 to 36 before housing costs are deducted) between 1994–1995 and 2008–2009 (Department for Work and Pensions 2010a).

1.3 Political context

The United Kingdom is a constitutional monarchy governed by a parliament formed of two houses. Democratically elected MPs representing 650 local constituencies sit in the House of Commons. As of October 2010, the House of Lords comprised 629 life peers, 91 hereditary peers and 24 clergy. Elections to the House of Commons take place at least once every five years under a first-past-the-post electoral system. The head of state is a hereditary monarch, Queen Elizabeth II (since 1952).

The head of government, the Prime Minister, is the leader of the party that can command a majority in the House of Commons. The current Prime Minister and leader of the Conservative Party, David Cameron, recently (May 2010) took office in a Coalition Government with the Liberal Democrats, after 13 years of Labour Governments, first under Tony Blair and then Gordon Brown. The main political parties are Labour, Conservative and Liberal Democrats. Prior to Tony Blair taking office in 1997, the Conservative Party had been in power since 1979.

England is divided into smaller administrative regions run by local government (known as local authorities or councils). There are 354 local councils in England and 11 000 town, parish and community councils in England and Wales, run by over 20 000 councillors elected in local elections held every four years. Local councils spend more than £113 billion per year. They make decisions about local services and play an important role in social services, education and leisure.

The United Kingdom is a member of many international organizations including the African Development Bank, Asian Development Bank, Australia Group, Caribbean Development Bank, the Commonwealth, Council of Europe, European Bank for Reconstruction and Development, European Investment Bank, EU, Food and Agricultural Organization, political groupings (G-7, G-8, G-10, G-20), Inter-American Development Bank, International Confederation of Free Trade Unions, International Federation of Red Cross and Red Crescent Societies, International Fund for Agricultural Development, International Labour Organization, International Monetary Fund, International Organization for Migration, North Atlantic Treaty Organization, OECD, Organization for the Prohibition of Chemical Weapons, Organization for Security and Cooperation in Europe, Paris Club, United Nations, United Nations Security Council, Western European Union, World Customs Organization, WHO, World Intellectual Property Organization, and World Trade Organization (WTO).

In 1998, the United Kingdom Government incorporated the European Convention on Human Rights into its law (the Human Rights Act 1998). The government has also signed the General Agreement on Tariffs and Trade (GATT) and numerous international treaties that affect health, for example, the Convention on the Rights of the Child and the International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families.

Organized interest groups such as trade unions are not formally involved in health policy-making in the United Kingdom, although groups such as the British Medical Association (BMA) and the Royal Colleges may exert influence informally, and expert groups may be called upon to assist the government in formulating policy in relevant areas.

1.4 Health status

Life expectancy at birth increased between 1981 and 2008 by 5.1 years for women and 6.9 years for men, reaching 82.1 years and 78.0 years, respectively (Table 1.3). This differential pace of improvement in life expectancy has narrowed the gap between men and women from almost 6 years to 4.1 years.

Table 1.3

Life expectancy and healthy life expectancy at birth in England, 1981–2008

	1981	1991	1995	2001	2006	2008
Life expectancy at birth, females	77.0	78.9	79.5	80.6	81.7	82.1
Life expectancy at birth, males	71.1	73.4	74.3	76.0	77.5	78.0
Healthy life expectancy at birth, females[a]	67.0	68.9	68.9	70.1	70.7	na
Healthy life expectancy at birth, males[a]	64.7	66.3	66.7	67.1	68.7	na

Sources: ONS 2004, 2010c; Smith, Edgar & Groom 2008.
Notes: For each year, these estimates are based on data for three years, averaged and used for the central year (e.g. 2008 is based on the years 2007–2009). [a] The latest figures for healthy life expectancy are for 2006 and relate to three years of the General Household Survey 2005–2007; na: Not available.

Healthy life expectancy, the expected years of life in self-perceived good or fairly good health, is based on a combination of life expectancy and population data from administrative sources and self-reported morbidity data from an annual household survey. Between 1981 and 2006, healthy life expectancy rose by about 3.7 years for women and almost 4 years for men, to 70.7 and 68.7 years, respectively. The difference between life expectancy and healthy life expectancy represents the number of years an individual can be expected to live in poor health. This increased between 1981 and 2006 from 10 to 11 years for women and from 6.4 to 8.8 years for men.

In 2009, there were 459 241 deaths in England (ONS 2010d), of which just over 51.5% were of women. A breakdown of deaths by cause is available for England and Wales combined. There were 491 348 deaths in 2009 in England and Wales, with percentages by cause of:

- circulatory diseases: 32.5%
- malignant neoplasms (cancer): 28.0%
- diseases of the respiratory system: 13.8%
- diseases of the digestive system: 5.1%
- external causes: 3.6%
- infectious diseases: 1.2%.

The four most common cancers (lung, colorectal, breast and prostate) accounted for 46.5% of the total deaths from cancer (ONS 2010d).

Between 1971 and 1997, the age-standardized incidence of cancer per 100 000 population in England and Wales increased by about 14% in men (from 332 to 377) and 34% in women (from 243 to 326), while over the same period the age-standardized mortality rate for cancer fell by 13% in men (from 276 to 240) and 3% in women (from 171 to 166) (Quinn et al. 2001). Between 1995 and 2004, as Table 1.4 shows, age-standardized mortality from all cancers in England fell for both men and women, and this was also true of the main cancer sites: lung, colorectal, breast and prostate. However, the incidence of cancer in men was almost unchanged, and increased in women. This primarily reflects substantial increases in breast cancer in women (by 13%, from 106 to 120) and prostate cancer in men (by 42%, from 67 to 95), although this is offset for men by the large fall in the incidence of lung cancer (by 27%, from 82 to 61).

Table 1.4

Age-standardized cancer incidence and mortality rates per 100 000 population, England, 1995–2004

	All cancers		Lung		Colorectal		Breast	Prostate
	Male	Female	Male	Female	Male	Female	Female	Male
Incidence								
1995	403	329	82	34	54	36	106	67
1998	404	340	74	34	56	37	113	71
2001	410	348	68	34	56	36	118	85
2004	401	343	61	34	54	35	120	95
Mortality								
1995	264	177	73	29	29	19	37	31
1998	249	170	66	29	27	17	34	29
2001	232	162	59	28	25	15	31	27
2004	222	156	54	28	24	14	29	27

Source: Westlake & Cooper 2008.
Notes: These rates are rolling three-year averages (e.g. 1995 is 1993–1995).

Mortality rates have declined for most major disease categories, as Table 1.5 illustrates. Thus, for the United Kingdom, the period between 1971 and 2006 saw a large fall in age-standardized mortality rates for the three major disease categories: respiratory diseases (by 56% for men and almost 30% for women), cancers (by 22% for men and 10% for women) and circulatory diseases (by almost two-thirds for men and women).

Table 1.5

Age-standardized mortality rates per 100 000 population for major diseases in the United Kingdom, 1971–2006

	Respiratory		Cancer		Circulatory	
	Male	Female	Male	Female	Male	Female
1971	201.5	90.9	281.1	174.8	693.6	428.5
1981	186.9	97.7	281.4	182.5	604.1	356.0
1991	118.5	66.7	278.9	186.2	458.2	279.6
2001	98.2	65.4	237.8	166.0	325.8	201.7
2006	89.0	64.1	220.1	156.9	246.2	155.9

Source: Self & Zealey 2008.

1.4.1 Key influences on health status

Key factors commonly recognized as having an impact on mortality and health status in general are levels of cigarette smoking, alcohol consumption and obesity in the population. Table 1.6 illustrates how these factors have changed over time.

Table 1.6

Factors influencing health status in England, 1993–2008

	Alcohol consumption (%)[a]		Cigarette smoking (%)[b]		Obesity (%)[c]		Overweight (%)[c]	
	Male	Female	Male	Female	Male	Female	Male	Female
1993	na	na	28	26	13.2	16.4	44.4	32.2
1998	36	20	28	27	17.3	21.2	45.5	32.1
2003	39	23	27	24	22.2	23.0	43.2	32.6
2008	41	32	24	20	24.1	24.9	41.8	32.0

Source: Information Centre 2009a.
Notes: [a] Proportion of the population aged 16 years and over consuming more than the recommended number of units of alcohol on a single day (4 units for men and 3 for women); [b] Proportion of the population aged 16 years and over who are current smokers; [c] Obesity in adults is defined as the proportion of the population aged 16 years and over having a body mass index (BMI) (≥30 kg/m²; overweight is defined as having a BMI ≥25 but <30 kg/m²); na: Not available.

Alcohol

Alcohol consumption has become a growing health problem in England. The proportion of women drinking more than the recommended number of units in a day increased by 60% between 1998 and 2008 (from 20% to 32%). This problem is more significant among women aged 35–44 years (39% in 2008) and 45–54 years (40% in 2008). However, the number of young women (those aged 16–24 years) who binge drink – defined as consuming twice the recommended number of units of alcohol in a day – increased from 17% in 1998 to 27% in 2008, considerably more than any other age group. For young men, perhaps surprisingly, there was a fall in binge drinking over this period, from 37% to 32%. At the same time, there appears to have been an increase in the proportion of both young women and young men who did not consume alcohol: from 40% and 29%, respectively, in 1998 to 48% and 39%, respectively, in 2008 (Information Centre 2009a).

Alcohol-related deaths have increased steadily in England, from 8.2 deaths per 100 000 male population in 1991 to 15 in 2004, and from 4.4 deaths per 100 000 female population to 7.2 over the same period (rates are age-standardized three-year moving averages). Of these alcohol-related deaths, some 85% were from cirrhosis (Breakwell et al. 2007).

Smoking

There have been considerable reductions in smoking prevalence over the last 36 years. In 1974, 51% of men and 41% of women in Great Britain were regular smokers (Matheson & Babb 2002). This compares with 24% of men and 20% of women in England in 2008. Data for England are available from 1993 to 2008. As Table 1.6 shows, smoking prevalence in England continued to fall, although not as quickly as it had in the previous 20 years. For adult men (i.e. those aged 16 years and over), the percentage of smokers fell from 28% to 24% between 1993 and 2008; for adult women the percentage fell from 26% to 20%. This is true of almost all age groups for both men and women. In 2008, the highest smoking rate was for men aged 25–34 years (34%); women aged 16–44 had the highest rate among all women (25%).

Obesity and being overweight

As Table 1.6 shows, between 1993 and 2008 there was a sharp increase in the proportion of both males and females in England who were clinically obese: by 83% for men and 52% for women. In 2008, 24.1% of males and 24.9% of females in England were classified as obese (body mass index (BMI) (≥ 30 kg/m^2), up from about 13.2% of males and 16.4% of females in 1993. By 2004, England had one of the highest levels of obesity (22.7%) in Europe, at almost twice the EU average of 13.4% (Information Centre 2008a). Between 1993 and 2008, the proportion of females who were overweight remained fairly constant, and the proportion of males fell slightly. Although there are now similar levels of obesity for both males and females, 41.8% of males were considered overweight in 2008 compared with 32% of females.

Childhood obesity in England is also a growing concern, as Table 1.7 shows, having increased between 1995 and 2008, particularly for boys for whom it increased by almost 50%. By 2008, 16.8% of boys and 15.2% of girls aged 2–15 years were obese and altogether 31.4% of boys and 29.2% of girls were either overweight or obese.

The number of people admitted to hospital in England with a secondary diagnosis of obesity rose steeply between 1996–1997 and 2006–2007, with "finished consultant episodes" almost quadrupling from 21 257 to 81 113. This is true for all age groups: for children (i.e. those under 16 years of age), the increase was from 425 to 1282 episodes of care. The situation is similar for those admitted to hospital with a primary diagnosis of obesity: rising from 787 finished consultant episodes in 1996–1997 to 4068 in 2006–2007 (Information Centre 2008a).

Table 1.7

Overweight and obesity among children in England, 1995–2008

	Aged 2–10 years (%)				Aged 11–15 years (%)			
	Obesity[a]		Overweight[a]		Obesity[a]		Overweight[a]	
	Male	Female	Male	Female	Male	Female	Male	Female
1995	9.7	10.6	13.1	12.8	13.9	15.5	13.9	14.3
1998	11.8	12.0	14.8	12.6	16.6	17.8	14.9	15.8
2001	13.6	13.0	15.9	14.5	19.0	18.0	14.3	18.1
2004	16.2	12.8	14.6	15.1	24.3	26.7	12.9	19.7
2008	14.4	13.3	13.8	13.0	20.6	18.3	15.7	15.6

Source: Information Centre 2009a.
Notes: [a] Obesity in children is defined as the proportion who are in the ≥95th United Kingdom BMI percentile for the child's sex and age; Overweight is defined as the proportion who are between the ≥85th and the <95th United Kingdom BMI percentile bands, in both cases compared with 1990 BMI United Kingdom reference data.

1.4.2 Rates of immunization and screening

From 1971 to 2009, there has been a considerable improvement in England in the rate of immunization of children against measles: from 46% of children under 2 years in 1971 to 85% in 2008–2009. The rate peaked in 1996–1997, when 92% of children under 2 years were immunized, and then fell back. This reduction was linked to the introduction in 1998 of the measles, mumps and rubella (MMR) vaccine, which replaced the single-antigen measles vaccine, and the public controversy that arose over claims that linked this new vaccine to Crohn's disease and autism.[1] This resulted in many parents refusing the MMR vaccine and the drop in uptake, as shown in Table 1.8. The government has tried to counter the adverse publicity but uptake still falls short of the WHO recommendation that at least 95% of children receive a vaccine by 2 years of age.

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[1] In 2010 the research underlying this claim, which was published in the *Lancet,* was retracted.

Table 1.8

Immunization rates in England for children under 2 years, 1971 to 2008–2009

					Percentage of children <2 years of age		
	1971	**1980**	**1991**	**1997**	**2000**	**2003**	**2009**
Measles	46	53	87	92	88	82	85
Diphtheria	80	81	92	96	95	94	94
Pertussis	78	41	84	94	94	93	94

Sources: Information Centre 2007a, 2009b.
Notes: Figures for 1971 are for England and Wales. Figures for 1991 and years thereafter refer to the financial year (e.g. 1990–1991). For data after 1991, these figures only refer to children vaccinated with the MMR vaccine; they do not include children vaccinated with a single measles vaccine.

The result of this reduced uptake has been a significant increase in the number of measles cases reported in England, and in August 2008 the government warned of the danger of a measles epidemic. In 2006 there were 736 laboratory-confirmed cases of measles in England, rising to 1331 cases in 2008; in 2009 the number had fallen to 1144 cases, and there were just 292 confirmed cases between January and August 2010. However, there had been just 402 cases of measles in the period between 1996 and 2001 (HPA 2010a-c).

In 2009–2010, the proportion of the target population in England (women aged 25 to 64 years) screened for cervical cancer was 78.9%, a fall compared with the proportion screened in 1999 (82.3%) (Information Centre 2009c, 2010a). At the same time, there was an increase in the proportion of the target population (women aged 50 to 64 years) screened for breast cancer in the previous three years, from 67.7% in 1999 to 70.6% in 2008–2009, although there has been little variation since 2001 (Information Centre 2010b).

The estimated number of people living with human immunodeficiency virus (HIV) in the United Kingdom increased by almost 14% between 2006 and 2008, to 83 000, with an estimated 27% of these undiagnosed. Most were aged 15–59 years (77 350); of that number, 43% (33 300) were men who have sex with men, 33% (25 500) were heterosexual women, 21% (16 200) heterosexual men and 3% (2350) injecting drug users. It is estimated that there were 7298 people newly diagnosed with HIV in 2008, and of these almost 58% were heterosexuals, around 38% were men who have sex with men and 2.3% were injecting drug users. The remaining 2% were infections from mother to child or through blood products. The annual number of people newly diagnosed has increased since 1997, when it was 2764, although it fell between 2005 and 2008 (HPA 2009). However, with the introduction of effective therapies in the 1990s, death rates have remained relatively low despite the increase in incidence. The number of deaths among HIV-infected persons in the United Kingdom fell from 749 in 1997 to 525 in 2008 (HPA 2009). The crude mortality rate (deaths as a proportion of diagnosed persons accessing HIV-related care) fell from 4.7% in 1997 to 0.95% in 2006 (HPA 2007).

Section 6.1.3 contains a detailed discussion of NHS immunization and screening programmes.

1.4.3 Health inequalities

Inequalities in health across socioeconomic groups have been increasing since the 1970s. Data to illustrate this phenomenon are available for England and Wales (ONS 2007). Table 1.9 shows that, for people born between 2002 and 2005, there was a 7.3 year difference in male life expectancy at birth between the unskilled class and the professional class, and a 7.0 year difference among women similarly differentiated by social class. Although life expectancy improved for all classes between 1972–1976 and 2002–2005, the gain in life expectancy at birth for the professional class has exceeded that of the unskilled by 1.9 years for men and 2.2 years for women.

Table 1.9

Life expectancy at birth by social class and sex in England and Wales, 1976–2005

	Males (years)			Females (years)		
	1972–1976	**1987–1991**	**2002–2005**	**1972–1976**	**1987–1991**	**2002–2005**
Professional	71.9	76.2	80.0	79.0	81.1	85.1
Managerial & technical	71.9	75.0	79.4	77.1	80.7	83.2
Skilled non-manual	69.5	74.4	78.4	78.3	80.0	82.4
Skilled manual	70.0	72.7	76.5	75.2	77.9	80.5
Partly skilled	68.3	70.8	75.7	75.3	77.4	79.9
Unskilled	66.5	68.7	72.7	74.2	76.6	78.1

Source: ONS 2007.

Mortality and morbidity risk factors also reveal significant differences across social groups. Table 1.10 shows the variation in adult and childhood obesity across ‘equivalized income groups’ (a quintile measure of household income taking account of the number of people in the household) in England in 2006. For male adults, there appears to be an increase in obesity as income declines – from 21% to 25% – although there is little difference when taking the obese and overweight population as a whole. For female adults, the increase in obesity as income falls is much greater, from 19% for the top income quintile to 32% for the bottom income quintile, and the proportion overweight is fairly consistent across income groups. For children, there would also appear to be a relationship between obesity and income groups; again with the increase in obesity with fall in income being most apparent for girls (from 9% for the top income quintile to 20% for the bottom income quintile).

Table 1.10

Childhood and adult obesity and overweight in England by sex and equivalized household income, 2006

Income group[a]	Adults (16 years and over) (%)				Children (2–15 years) (%)			
	Overweight[b]		Obesity[b]		Overweight[c]		Obesity[c]	
	Male	Female	Male	Female	Male	Female	Male	Female
1	47	31	21	19	14	15	15	9
2	45	34	23	23	15	16	15	12
3	44	33	24	24	14	15	16	12
4	39	31	27	29	15	13	18	17
5	41	32	25	32	11	12	20	20

Source: Information Centre 2008a.
Notes: [a] Equivalized household income is a quintile measure of household income taking account of numbers of people in a household (1 is the highest income group while 5 is the lowest income group); [b] Obesity in adults is defined as the proportion of that population having a BMI ≥30; overweight is defined as having a BMI ≥25 but <30kg/m^2; [c] Obesity in children is defined as the proportion who are in the ≥95th United Kingdom BMI percentile for child's sex and age; overweight is defined as the proportion who are between the ≥85th and the <95th United Kingdom BMI percentile bands, in both cases compared to 1990 BMI United Kingdom reference data.

Table 1.11 shows that while the prevalence of cigarette smoking fell between 2000 and 2006 for all socioeconomic groups in England, it remained almost twice as high among the routine and manual group (29%) compared with the managerial and professional group (15%).

Table 1.11

Smoking prevalence of adults (aged 16+ years) by socioeconomic class, England, 2001–2006

Socioeconomic class	Prevalence (%)					
	2001	2002	2003	2004	2005	2006
Managerial and professional	19	19	18	19	17	15
Intermediate	27	26	26	24	23	21
Routine and manual	33	31	32	31	31	29

Source: Goddard 2008.

On the other hand, the quantity of alcohol consumed appears to show an increase both with higher levels of income and with socioeconomic class. Table 1.12 shows, for Great Britain in this case, that 42% of the managerial and professional class had consumed more than the recommended number of units (3 for women and 4 for men) in a single day in the week of the survey compared with 30% for the routine and manual group; by the government's current definition of binge drinking (6 for women and 8 for men), 21% had exceeded this level in the managerial and professional class compared with 16% for the routine and manual group.

Table 1.12

Alcohol consumption of adults (aged 16+ years) by socioeconomic class, Great Britain, 2006

Socioeconomic class	Percentage	
	>4/3 units[a]	>8/6 units[b]
Managerial and professional	42	21
Intermediate	36	18
Routine and manual	30	16

Source: Goddard 2008.
Notes: [a] More than the recommended number of units of alcohol on a single day (4 units for men and 3 for women); [b] More on a single day than the number of units of alcohol described as "binge" drinking (8 units for men and 6 for women).

1.4.4 Maternal and child health

In 2009, there were an estimated 671 058 live births in England, of which almost 49% were girls. As a proportion of total live births in hospital in 2008–2009, 7% were classified as low birth weight (i.e. less than 2500 g) (Information Centre 2009d). Although 45.6% of births were outside of marriage in 2009, compared with just 9% in 1976, the proportion of live births to two parents living together, whether married or unmarried, has remained relatively stable at around 85% since 1992 (O'Leary et al. 2010).

In England in 2008, 2.8% of deliveries took place in the mother's home (ONS 2009b); of deliveries that took place in NHS hospitals in England in 2008–2009, 24.6% were with caesarean section (Information Centre 2009d), a substantial increase from just 9% in 1980, although the proportion has been relatively stable since 2001 (Richardson & Mmata 2007).

Reflecting the pattern in many parts of Europe, infant and perinatal mortality rates in England have decreased dramatically since 1976. Table 1.13 shows that infant mortality fell from 14.2 per 1000 live births in 1976 to 4.7 in 2008. There was a similar fall in perinatal mortality over the same period, from 17.6 to 7.6 deaths per 1000 live births.

Table 1.13

Indicators of maternal and child health in England, 1976–2008

	1976	1981	1991	2001	2005	2008
Infant mortality rate[a]	14.2	10.9	7.3	5.4	5.0	4.7
Perinatal mortality rate[b]	17.6	11.7	8.0	8.0	8.0	7.6
Maternal mortality rate per 100 000 live births[c]	na	na	10.1 (7.2)	11.4 (6.0)	14.0 (7.1)	na

Sources: Lewis 2007; ONS 2009a.
Notes: [a] Deaths in a child under 1 year of age per 1000 live births; [b] Stillbirths and deaths under 1 week of age per 1000 live births and stillbirths (in October 1992, the legal definition of a stillbirth was changed from a baby born dead after 28 completed weeks of gestation or more to one born dead after 24 weeks; so data prior to this are not strictly comparable with those after); [c] Deaths resulting from pregnancy, childbirth or puerperium (the figures are for the United Kingdom and come from the Confidential Enquiry into Maternal and Child Health (Lewis 2007); figures given are three-year averages for 1988–1990, 1997–1999 and 2003–2005. Figures in parentheses are from official death certificate data alone; na: Not available.

Table 1.14 shows that proportion of conceptions that are terminated by abortion for residents of England and Wales increased between 1991 and 2001, from 19.4% to 23.2%, but had fallen slightly by 2007 to 21.8% (Table 1.14). However, for women under 16 years of age the proportion increased from 51.1% in 1991 to 61.5% in 2007 (ONS 2009a).

Table 1.14

Changes in live births and rates of abortion, England and Wales, 1991–2007

	1991	2001	2005	2007
Total live births (thousands)	699.2	594.6	645.8	690.0
Total live births to teenage mothers (thousands)[a] Percentage of total live births	52.4 7.5%	44.2 7.4%	44.8 6.9%	44.8 6.5%
Percentage of all conceptions aborted	19.4	23.2	22.2	21.8
Percentage of teenage conceptions aborted[a]	34.5	40.4	40.3	42.6

Source: ONS 2009a.
Notes: [a] Teenage defined as under 20 years.

The percentage of total live births where the mother was a teenager (i.e. under 20 years) fell between 1991 and 2007, from 7.5% to 6.5%; however, at the same time, the percentage of conceptions for women under 20 years of age remained relatively constant, at almost 12%. This probably reflects the fact that there has been an increase in the number of conceptions by teenage women that resulted in an abortion, from 34.5% in 1991 to 42.6% in 2007. Over the same period, the proportion of teenage conceptions leading to a maternity has fallen.

Certain behaviours of women during pregnancy are thought to influence maternal and infant health, in particular smoking and alcohol consumption. A recent survey suggests that 17% of mothers smoked throughout their pregnancy in England in 2005, a reduction from 19% in 2000. Mothers in routine and manual occupations and teenage mothers were most likely to smoke throughout pregnancy: 29% and 45%, respectively, in 2005. Around 55% of mothers in England in 2005 consumed some alcohol during pregnancy; this was more prevalent among older mothers and those from managerial and professional occupation groups. However, consumption levels were low, with just 8% of those who drank consuming more than 2 units of alcohol in a week (Bolling et al. 2007).

2. Organizational structure

This chapter provides an overview of how the health care system is organized. It outlines the main participants and their roles and responsibilities. Section 2.1 provides a brief summary of the structure of the health care system in England. Section 2.2 outlines how the system has evolved over time and section 2.3 describes the nature and roles of key organizations. Section 2.4 discusses the extent of decentralization in the system and section 2.5 reviews a range of issues relating to patient empowerment.

The period since 1997 has witnessed a series of organizational changes to the health care system in England designed to shift responsibility away from the Department of Health at the centre to regional and local levels.[1] Major reforms included the creation of PCTs, which are responsible for commissioning health services for geographically defined populations; the introduction of new types of NHS providers, FTs, with greater financial and managerial autonomy; and the greater use of private-sector capacity to deliver publicly funded health care. At the same time the Department of Health created a number of new semi-independent bodies to assist in setting priorities and monitoring standards for different parts of the health care system.

2.1 Overview of the health care system

Health services in England are mainly financed by government through general taxation and NICs and are largely free at the point of use. Established in 1948, the NHS provides preventive medicine, primary care and hospital services to all those "ordinarily resident" in England. Around 13% of the population is covered by voluntary health insurance. In England, this is most commonly referred to as PMI, and henceforth this is the term used in this report. PMI mainly provides access to acute elective care in the private sector (Laing & Buisson 2009).

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[1] In 2010, a Conservative and Liberal Democrat Coalition Government was elected. Its proposed changes to the structure of the NHS are discussed briefly in Chapter 7.

Responsibility for publicly funded health care rests with the Secretary of State for Health, who is accountable to the United Kingdom Parliament. The Department of Health is the central government body responsible for setting policy on the NHS, public health, adult social care and other related areas. The Treasury plays a key role through its influence in setting the national budget for publicly funded health care. Leadership in the Department of Health is provided by the Permanent Secretary, who is responsible to the Secretary of State and parliament for the way the department functions, and the Chief Executive of the NHS, who provides strategic leadership for the NHS and social care.

At a national level, the Department of Health is assisted in setting and monitoring standards and regulating the health system by a range of government and independent bodies, often called "arm's-length" bodies.[2] The most significant of these are:

- *The Care Quality Commission (CQC)* was established in 2009 to take on the roles of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. It promotes quality improvement in the NHS and the independent sector[3] and is responsible for assessing the performance of NHS and independent-sector organizations.
- *Monitor (the Independent Regulator of NHS Foundation Trusts)* regulates FTs.
- *Health Protection Agency (HPA)* is responsible for protecting public health.
- *National Institute for Health and Clinical Excellence (NICE)* was established in 1999, primarily with responsibility for assessing and issuing guidance on new and existing medicines, treatments and procedures in the NHS. Since then, its role has been extended to include guidance on public health.

These organizations are discussed in more detail in Chapter 4.

The Department of Health operates at a regional level through 10 SHAs, which are responsible for ensuring the quality and performance of local health services within their geographic area. In addition, the Department of Health

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[2] The new Coalition Government elected in May 2010 has announced major changes to these bodies with implementation intended to take place over the next four years (see section 7.3 for further details).

[3] The independent sector comprises private-sector, voluntary-sector and community organizations.

and SHAs collaborate with regional government offices, which are central government bodies responsible for regional programmes working across the areas of responsibility of all central government departments. Responsibility for commissioning health services at the local level lies with 151 primary care organizations, mainly PCTs,[4] each covering a geographically defined population of, on average, just over 340 000 people. PCTs are monitored by SHAs and are accountable to the Secretary of State for Health. The Department of Health allocates 80% of the NHS budget to PCTs using a weighted capitation formula that 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. Most publicly funded health services are commissioned by PCTs. Since 2005, GPs have played a role in commissioning through the development of practice-based commissioning (PBC).[5]

NHS-funded primary care is provided in a range of different ways. The first point of contact for general medical needs is usually self-employed GPs and their practices, who are typically engaged through a general medical services contract or a personal medical services contract (these are discussed in more detail in Chapter 3), although GPs may also be employed directly by alternative providers (e.g. the voluntary sector, commercial providers, NHS trusts, PCTs). In addition, community health services (e.g. district nursing, physiotherapy), NHS Direct (a telephone and Internet service), NHS walk-in centres, dentists, opticians and pharmacists are also part of NHS primary care services.

NHS-funded secondary care is provided by salaried specialist doctors (known as consultants), nurses and other health care professionals (e.g. physiotherapists and radiologists) who work in government-owned hospitals known as "trusts". A small private sector exists alongside the NHS, funded through private insurance, direct payments from patients or publicly funded payments by PCTs and the Department of Health; this mainly provides acute elective care. The CQC regulates the independent health care sector through registration, annual inspection, monitoring complaints and enforcement, within the legal framework set out in the Care Standards Act 2000 and subsequent amendments and statutory instruments (see Chapter 4 for more discussion).

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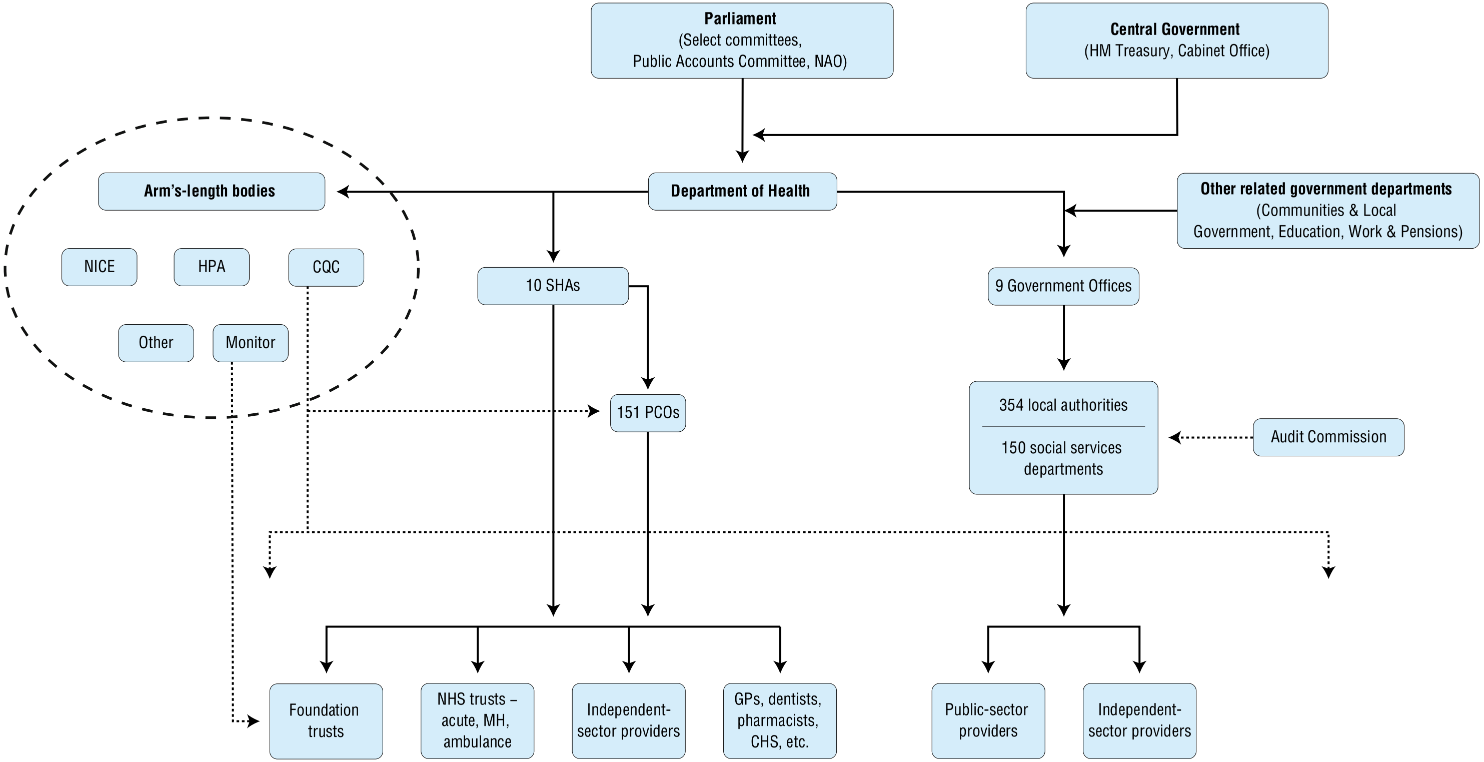
[4] In October 2006 the number of primary care organizations was reduced from 303 to 152; the number was reduced to 151 in April 2010, of which 145 are PCTs and 6 are Care Trusts, whose responsibility extends to social care as well as health care (ONS 2010e).

[5] The new Coalition Government has announced its intention to extend further the commissioning role of GPs, although this is likely to require primary legislation (Department of Health 2010a).

Fig. 2.1
Overview of the health care system in England, 2010



Source: Based on Department of Health 2007a.
Notes: Contractual or managerial relationships shown by continuous lines; Regulatory role shown by dotted lines; CHS: community health services; MH: mental health; PCO: primary care organization.

Other key organizations in the health care system include the BMA and professional groups such as the Royal Colleges (representing different medical and nursing specialties), the British Dental Association (BDA), trade unions representing NHS staff such as UNISON, Unite the Union, the GMB (Britain's General Union), and the Hospital Consultants and Specialists Association, and the NHS Confederation (representing NHS organizations and responsible for negotiating pay agreements with the professional bodies).

Fig. 2.1 shows the organizational structure of the health care system in England in 2010. It should be read in parallel with Fig. 3.1 in Chapter 3, which provides a picture of the financial flows in the English health care system.

2.2 Historical background

The provision of health care in England in the 19th century depended largely on voluntary hospitals and municipal hospitals, the latter run by local government; ambulatory care was provided by doctors working in the community, who functioned very much as modern-day GPs. There was no centrally organized state health care system although a variety of local and central boards were set up at various times to deal with public health and sanitation issues. Mental health services were primarily state funded through a system of county asylums. Health insurance was not common, although there were some mutual insurance funds; usually costs were borne by individuals or through charitable donations.

In the late 19th and early 20th centuries, with the development of trade unions and the establishment of the Labour Party, pressure mounted politically to provide more assistance to the population in matters of health, education and welfare. The Liberal Government of 1906–1914 introduced a compulsory national health insurance scheme in the 1911 National Insurance Act. The scheme covered people in employment and was funded by contributions from employees, employers and the state. It provided for free care from GPs, free prescriptions and treatment for tuberculosis, but it did not cover hospital treatment or childbirth. Although it did not cover workers' dependants, and hence excluded most women and children, one-third of the population was covered. There was a separate system of health care for schoolchildren. The Ministry of Health, established in 1919, consolidated the medical and public health functions of central government, and the coordination and supervision of local health services in England and Wales (Rivett 1998; Lister 2008).

By the end of the 1930s, many commentators recognized the need for changes to the system of health services in the United Kingdom, which was characterized by two hospital systems (the public sector and the voluntary hospitals) operating alongside each other with no coordination of their activities, and the existence of substantial financial barriers to access to health care for many workers, especially women. Building on developments that took place during the Second World War, and in particular the *Beveridge Report* (Beveridge 1942), the Labour Government, in the face of opposition from some parts of the medical profession, succeeded in passing the National Health Service Act in 1946. The NHS treated its first patients on 5 July 1948. The stated objective of the introduction of the NHS was to create equitable access to health care by making health services free at the point of delivery. From the perspective of patients, the two main changes brought about by the NHS were relief from having to pay direct charges for health care and access to health services for large groups who had previously been excluded (Webster 2002).

Throughout the 1950s and 1960s, expenditure on the NHS increased, driven both by demand and by recognition of the need for investment in improved facilities and new technologies. The 1962 Hospital Plan (Ministry of Health 1962) mapped out a national vision of new, larger hospitals (known as district general hospitals) providing services to geographically based populations of up to 150 000 people – although the resulting hospital building programme was only partially delivered as international financial crises in the 1960s and 1970s led to cutbacks in public spending (see section 5.1.1).

In 1968, the Department of Health and Social Security was formed by the merger of the Ministry of Health and the Ministry of Social Security, under the Secretary of State for Social Services. In 1988 the Department of Health and Social Security was once again divided between its two main functions and a Department of Health and a Department of Social Security were set up. The Department of Health today is responsible for health and personal social services in England, including public health matters, and the health consequences of environmental and food issues.

A major reorganization of NHS structures took place in 1974 under the National Health Service Reorganisation Act 1973, which was designed to integrate acute (including the teaching hospitals), community and preventive services within 90 new area health authorities based mainly on the same geography as local authorities, who remained responsible for the provision of social services. In addition, 90 Family Practitioner Committees were established with responsibility for contracting with GPs, dentists, opticians and pharmacists, and regional hospital boards, established under the 1946 National Health Service Act, were replaced by 14 regional health authorities. In the 1970s, there was increasing recognition that the allocation of NHS resources between different parts of England was unequal. This led to the development, through the work of the Resource Allocation Working Party, of methods of allocating financial resources between areas based on need rather than historical patterns (Department of Health and Social Security Resource Allocation Working Party 1976). This is discussed in more detail in section 3.4.

During the 1980s and early 1990s, the Conservative Government introduced a series of initiatives aimed at improving NHS efficiency, including cost-improvement programmes, use of performance indicators, competitive tendering for non-clinical hospital support services, such as cleaning and laundry, income-generation schemes and the introduction of general management to health authorities and hospital units, the last based on the recommendations of the Griffiths Report (Griffiths 1983). Area health authorities were abolished under the Health Services Act 1980 and were replaced by 192 district health authorities – the link with local authority boundaries was broken once again.

In spite of these measures, financial pressures on the NHS continued throughout the 1980s. One of the results was a fundamental change in the structure of the NHS with the implementation of the National Health Service and Community Care Act 1990, which introduced the “internal market” whereby the commissioning and delivery of services were separated. Change was gradual over several years. District health authorities and GP fundholders were established as “purchasers” of health services. The former were responsible for contracting for services to meet the needs of their patients based on geographic areas of residence; the latter provided GP practices with the option of taking responsibility for the purchase of a limited group of services for their practice populations as well as providing primary care services, all within a cash-limited budget. On the provider side, hospitals and community and mental health services, no longer under health authority control, were established as semi-independent, non-profit-making NHS trusts, which were, however, required to show a surplus on their activities and pay capital charges on a proportion of their assets. Contracts were established between purchasers and providers of services. The intention was to increase efficiency by allowing competition between providers on the basis of price and quality (Oliver 2005).

In 1997, the election of a Labour Government led to further changes to NHS structures, although the fundamental division between purchasers and providers was retained. In the years that followed, there were numerous structural reorganizations as district health authorities were replaced by PCTs, regional health authorities by SHAs, and some NHS trusts were given more independence from the Department of Health as FTs. PCTs became responsible for the provision of primary care and many community-based services, including in some areas mental health, and the commissioning of most secondary care for patients in their geographically defined areas. SHAs became responsible for enabling local health bodies to pursue the wider aims of the health care system. New regulatory agencies, such as NICE and the CQC, were introduced to maintain nationally set standards.

Since 1997, there has been a marked increase in private-sector involvement in the provision of services to the NHS, whether through the Private Finance Initiative (PFI), which contracts private firms to build facilities and operate them for the NHS over periods of 30 years or more, or the compulsory introduction of the private sector into NHS provision through “independent sector treatment centres” (ISTCs). A small but significant private sector had always provided services to the NHS but this has become formalized since 2000.

More detail on much of the preceding discussion is provided elsewhere in this report. For further discussion of the historical development of the NHS, see Rivett (1998), Lister (2008) and Webster (2002); the United Kingdom National Archives also provide a useful summary (National Archives 2009).

2.3 Organizational overview

From the outset of the NHS in 1948, the organization of health services in England has undergone a process of continual change and adaptation. The election of a Labour Government in 1997 heralded a series of strategic and organizational changes that were formulated in government white papers outlining structural, managerial and funding changes to the NHS over a period of 13 years. A new Conservative and Liberal Democrat Coalition Government was elected in May 2010 and this appears to signal yet more changes to the structure of the NHS. This section outlines the current roles and responsibilities of the key participants in the health system.

2.3.1 Parliament

The NHS is accountable to parliament through the Secretary of State for Health. Parliament holds the NHS accountable through a range of mechanisms including parliamentary debates, questions by MPs to government ministers, and the work of parliamentary select committees in both the House of Commons and the House of Lords (only Commons committees shadow the work of government departments). These committees examine subject areas by taking written and oral evidence and, after private deliberation, present a report to parliament. They have the power to summon witnesses to give evidence or to produce documents. The key committee involved in holding the NHS to account is the House of Commons Health Select Committee; in addition, the Public Accounts Committee and sometimes the Science and Technology Committee and the Public Administration Committee also address issues relating to the way the NHS operates, although in the case of the last committee, it tends to be as part of a more general inquiry.

Each year, the Health Select Committee holds an inquiry into Public Expenditure on Health and Personal Social Services, in which it is able to consider any aspect of the responsibilities of the Department of Health for the NHS and social care in England. The latest such inquiry reported in January 2010. In addition, the Committee may hold an inquiry into any specific area relating to its remit. Recent reports of inquiries published in 2010 include ones on alcohol, commissioning, social care and the use of overseas doctors in providing out-of-hours services. These reports are often very detailed and include memoranda of evidence submitted by a range of interested parties. Reports from the Public Accounts Committee in 2010 have included tackling problem drug use, improving dementia services and progress in improving stroke care. Reports are considered by the government, which in due course usually produces a response to the issues and recommendations raised by committees.

In addition, a number of other parliamentary groups made up of MPs from different political parties focus on health and health issues. Examples include the Associate Parliamentary Health Group and the All-Party Parliamentary Group on Primary Care and Public Health, as well as groups relating to a wide range of diseases and conditions.

The Secretary of State for Health

The Secretary of State for Health is currently an elected MP (as of January 2011, it is Andrew Lansley) and a member of the Cabinet. He or she has overall responsibility for the NHS and for social care and is assisted by two ministers of state (one for health services and one for care services) and two parliamentary under-secretaries of state, one of whom is responsible for public health and one for quality (Department of Health 2010b).

2.3.2 The Department of Health

The Department of Health has three core roles; it is:

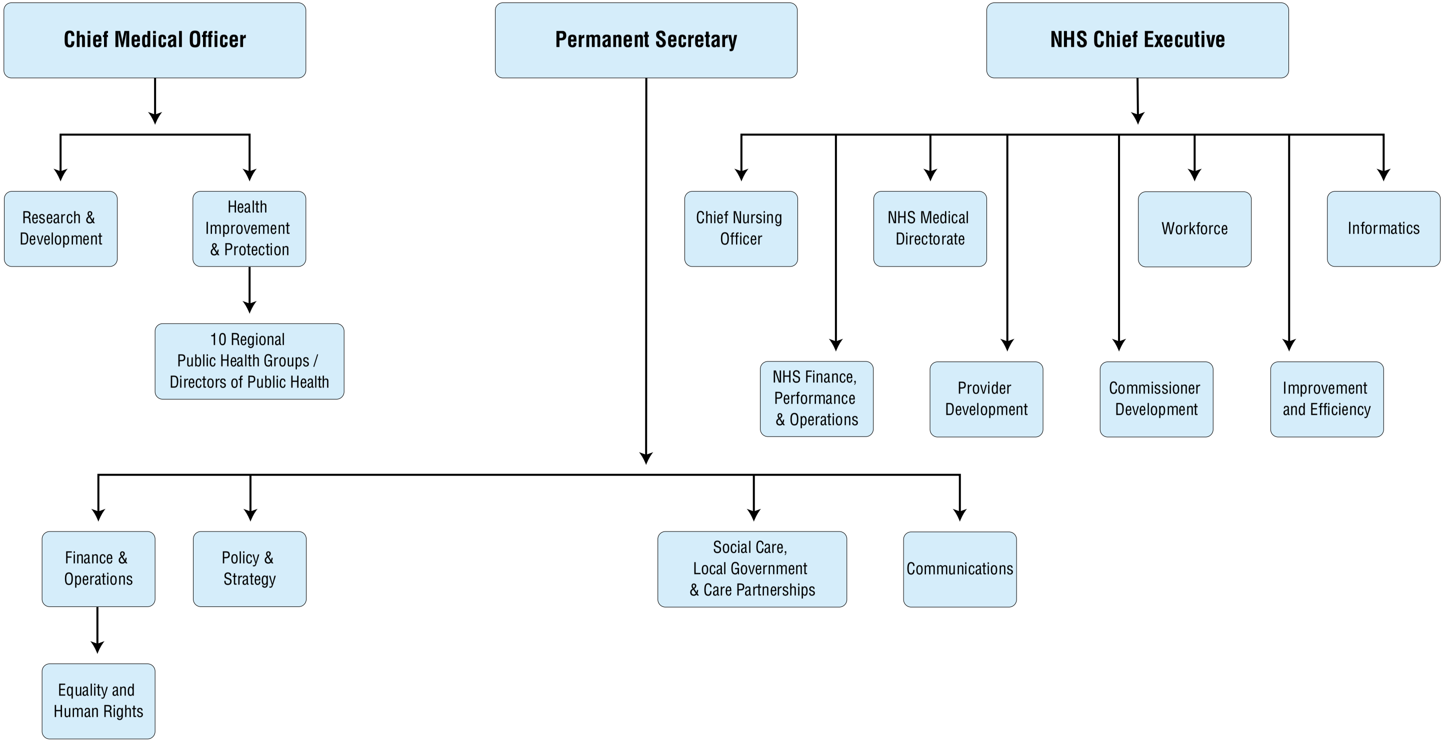
- a department of state, run by the Secretary of State for Health and a civil servant, the Permanent Secretary;
- the national headquarters of the NHS, run by the NHS Chief Executive; and
- the agency responsible for setting policy on public health, clinical quality, health improvement and protection, and many other related topics, run by the Chief Medical Officer.

The main role of the Department of Health is to support the government in improving the health of the population in England. It sets overall health policy and strategy, as well as dealing with legislation and regulation. It negotiates the level of funding for the NHS with the Treasury and allocates resources to the NHS. Although the Department of Health does not directly provide health services, it is responsible for ensuring service quality, building the capacity of the NHS to meet the needs of the population and ensuring value for money. The Department of Health also sets the strategic framework for adult social care and gives advice and guidance to local authorities, whose responsibility it is to manage social care funding. It is also responsible for policies on public health as well as those relating to the health consequences of environmental and food matters.

The current structure of the Department of Health is presented in Fig. 2.2.

The Department of Health is run by a Permanent Secretary responsible for the overall management of the department's business. The NHS Chief Executive is responsible for the management and performance of the NHS, and the Chief Medical Officer is responsible for offering expert advice to the Department of Health relating to public health and clinical quality. The Permanent Secretary to the Department of Health is supported by a Departmental Board comprising the Chief Medical Officer, the NHS Chief Executive, the Director General for Social Care, Local Government & Care Partnerships, the Director General for Department of Health Finance and Operations, and two non-executive members who are intended to provide external input. The Board is primarily concerned with advising on strategic direction as well as ensuring good corporate governance. The Department of Health is also supported by a number of directorates run by directors general, managing directors and national directors, mainly reporting directly to the Permanent Secretary, the NHS Chief Executive or the Chief Medical Officer (Fig. 2.2). In addition there are currently 22 national

Fig. 2.2
Department of Health organizational chart



Source: Based on Department of Health 2010c.

clinical directors and advisers (e.g. for mental health, heart disease and stroke), who are often referred to as Tsars and who are responsible for the implementation of the national service frameworks (NSFs) and major clinical or service strategies in their areas of clinical expertise.

Other government departments working with the Department of Health
The Department of Health works closely with several other government departments. These include:

- the Treasury (the ministry of finance), which allocates the Department of Health's budget for a three-year period on a two-yearly basis following negotiation with the Department; it also draws up a Public Service Agreement (PSA) for the Department, specifying what the Department is expected to provide within its resources over the three-year period;
- the Department for Education, which takes the lead on children's issues particularly with respect to social care;
- the Department for Communities and Local Government, which is responsible for personal social services administered through local government authorities;
- the Department for Business Innovation & Skills, which funds training of medical students and other health professionals; and
- the Department for Work and Pensions, which is responsible for social welfare payments, such as income support, invalidity and disability benefits.

2.3.3 Local government

Local government, often referred to as local authorities or councils, are bodies elected locally every four years. The 354 local authorities in England make decisions about local services and play an important role in the organization and provision of social services and education.

2.3.4 The NHS

As noted above, the NHS is run by a Chief Executive and a Permanent Secretary in the Department of Health. At a regional level, responsibility for the oversight of health services rests with the SHAs, which are accountable to the Department of Health. The Department of Health allocates funds to PCTs responsible for commissioning health care for geographically defined populations. Primary care is provided by a range of organizations: GP practices, NHS Direct, NHS walk-in centres, dentists, opticians and pharmacists. Secondary care is provided by specialist doctors (consultants) and nurses working in ambulance trusts, NHS trusts, mental health trusts and care trusts (see Chapter 6 for more detailed discussion of NHS providers).

SHAs

SHAs were set up in 2002 to manage the NHS on behalf of the Secretary of State. In 2006, their number was reduced from 28 to 10. They are a key link between the Department of Health and the NHS and are responsible for:

- developing plans for improving health services in their local area;
- making sure local health services are of a high quality and are performing well;
- increasing the capacity of local health services so they can provide more services; and
- making sure national priorities (e.g. programmes for improving cancer services) are integrated into local health service plans.

PCTs

PCTs are the NHS organizations responsible for commissioning services for their local geographically defined populations. They contract for NHS and private-sector health services, as well as providing some services directly themselves; they control 80% of the NHS budget. PCTs are monitored by their local SHA and are ultimately accountable to the Secretary of State for Health. They work with other health and social care organizations and local authorities to meet the health needs of their communities.

2.3.5 Executive agencies of the Department of Health and other bodies

The Department of Health is supported by a number of other bodies that vary in their degree of independence from the Department, and hence government. These are often referred to as arm's-length bodies. They are stand-alone organizations that work closely with the local NHS, social care services and other arm's-length bodies to carry out specific functions, which may include regulation of the system, improving standards, protecting public welfare and supporting local health services. They usually have boards, employ staff and publish accounts; they are accountable to the Department of Health and sometimes directly to parliament. Most arm's-length bodies receive substantial funding from the Department of Health. They operate in three key areas:

- regulating the health and social care system and workforce
- establishing national standards and protecting patients and the public
- providing central services to the NHS.

In 2004, the Department of Health carried out a review of the then 38 arm's-length bodies with the purpose of reducing the number to 20, which was achieved, and saving money and staff resources (Department of Health 2004a).[6] In addition, the Department of Health makes use of expert committees know as "advisory non-departmental public bodies", such as the Committee on Safety of Medicines or the Expert Advisory Group on AIDS (Department of Health 2010d).

There is one executive agency: the Medicines and Healthcare products Regulatory Agency (MHRA). Executive agencies are part of the Department of Health with responsibility for particular business areas, and usually with some central funding. The MHRA, established in 2003 as a merger of the Medicines Control Agency and the Medical Devices Agency, regulates – on behalf of the Department of Health – medicines, medical devices, blood and therapeutic products and services derived from tissue engineering. It ensures standards of safety, quality, performance and effectiveness. Although it receives some direct funding from the Department of Health, its income is mainly through trading (almost 90%), most of which is fees from pharmaceutical companies for the licensing of medicines and other services (Medicines and Healthcare products Regulatory Agency 2008).

In addition, there are eight "special health authorities" – independent bodies set up in secondary legislation to provide services to the whole of England, although they may be subject to ministerial direction. The special health authorities provide a national service to the NHS or the public, under Section 11 of the National Health Service Act 1977. The eight[7] special health authorities are:

- NICE
- National Patient Safety Agency (NPSA)
- National Treatment Agency for Substance Misuse
- NHS Blood and Transplant Authority
- NHS Business Services Authority

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[6] A further review was undertaken in 2010 by the new government, with proposals to cut further the number of arm's-length bodies (see section 7.3 for more detail). The descriptions here focus on the current bodies and their functions.

[7] NHS Professionals was a special health authority but became a limited company wholly owned by the Secretary of State for Health in April 2010.

- NHS Information Centre for health and social care
- NHS Institute for Innovation and Improvement (formerly the NHS Modernisation Agency)
- NHS Litigation Authority (NHSLA).

There are also nine executive non-departmental public bodies – these are set up in primary statutes and have a role in the process of delivering health care but are not part of the Department of Health. These nine[8] are:

- Alcohol Education and Research Council
- Appointments Commission
- CQC
- Council for Healthcare Regulatory Excellence (CHRE)
- General Social Care Council
- HPA
- Human Fertilisation and Embryology Authority
- Human Tissue Authority
- Monitor (the Independent Regulator of NHS Foundation Trusts).

Some key special health authorities and executive non-departmental public bodies are described below. See *Department of Health's Public Bodies 2009* (Department of Health 2010d) for more detail on these bodies.

Special health authorities

The National Institute for Clinical Excellence was established in 1999, primarily with responsibility for assessing and issuing guidance on new and existing medicines, treatments and procedures in the NHS. Following its merger with the Health Development Agency in 2005 its role was extended to include guidance on public health. The Health Development Agency had been set up in 2000 to gather evidence and produce advice for policy-makers, professionals and practitioners on matters relating to improving the health of the population and reducing health inequalities, as well as working to transfer evidence into practice.

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[8] The Postgraduate Medical Education and Training Board was also a non-departmental public body but it merged with the General Medical Council in April 2010.

After this merger, the authority was renamed the National Institute for Health and Clinical Excellence although it kept its original acronym, NICE, and it is now responsible for bringing together knowledge and providing guidance on the promotion of good health and the prevention and treatment of ill health. It does this by developing guidelines in three areas of health:

- health technologies: guidance on the use of new and existing medicines, treatments and procedures within the NHS;
- clinical practice: guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS; and
- public health: for those working in the NHS, local authorities and the wider public and voluntary sector, guidance on the promotion of good health and the prevention of ill health.

The role of NICE is discussed further in section 4.1.3 in this report.

The NPSA was established in 2001 with the aim of reducing risk and improving the safety of NHS patient care. It set out to promote a culture of reporting, analysing and learning from things that go wrong in the patient experience, and it manages a national reporting system. In 2005, it also took on the roles of the National Clinical Assessment Service, the Central Office for Research Ethics Committee, as well as responsibilty for the safety aspects of hospital design, cleanliness and food, and the management of contracts for three confidential inquiries (see section 2.5.6 for further discussion of patient safety).

The NHS Business Services Authority was established in 2006 and combines services previously provided by the Dental Practice Board, the NHS Counter Fraud & Security Management Service, NHS Logistics Authority, NHS Pensions Agency and the Prescriptions Pricing Authority. It is the main processing facility for payment, reimbursement and remuneration for NHS patients, employees and affiliated parties.

The NHS Institute for Innovation and Improvement was established in 2005 when it replaced the NHS Modernisation Agency, which was established in 2001 to support the NHS in modernizing services and improving experiences and outcomes for patients. The NHS Institute works at the national level to integrate, promote and support innovation, learning, leadership and improvement in the NHS with a focus on achieving practical outcomes that help the health service to deliver better quality and more effective patient care.

The NHSLA was created in 1995 under section 21 of the National Health Service and Community Care Act 1990 to establish and manage a scheme for meeting legal claims against NHS bodies. Thus, it handles negligence claims against NHS bodies in England; it has also developed a risk-management programme designed to raise standards of care in the NHS and reduce the number of incidents leading to claims. In 2005, it became responsible for handling family health services appeals dealing with the resolution of disputes between primary care practitioners and their PCTs, and for coordinating equal pay claims on behalf of the NHS. The authority also monitors human rights case law for the NHS.

Executive non-departmental public bodies

In April 2009, the CQC took over responsibility from the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission for the regulation of all health and social care in England, whether provided by the NHS, local authorities, the private sector or the voluntary sector (see section 4.1). Its predecessor, the Healthcare Commission, had been established in 2004 to promote quality improvement in the NHS and the private health care sector. It was responsible for regulating health care and assessing the performance of NHS bodies, at that time on the basis of a "star rating" system and coordinating reviews of health care. The Healthcare Commission incorporated all the functions of the former Commission for Health Improvement (CHI), the private and voluntary health care functions of the former National Care Standards Commission and some parts of the Audit Commission's work relating to value for money in health care (Department of Health 2007b).

The Commission for Social Care Inspection had also been established in 2004 with an aim to improve the quality of social care. It incorporated the work of the Social Services Inspectorate, the Social Services Inspectorate/Audit Commission Joint Review Team and the social care functions of the National Care Standards Commission. It was responsible for the regulation, registration, inspection and review of all adult social care services in the public, private and voluntary sectors in England, and it used a system of quality ratings to determine how well services were being provided. Since April 2007, social care services for children have been monitored by the Office for Standards in Education, Children's Services and Skills (Ofsted).

The HPA was set up as a special health authority in 2003, and in 2005 it became an executive non-departmental body, taking on, in addition, the role of the National Radiological Protection Board for radiation protection.

It provides an integrated approach to protecting public health through the provision of support and advice to the NHS, local authorities, emergency services, other arm's-length bodies, the Department of Health and the devolved administrations of the United Kingdom. It aims to protect the population from infectious diseases and other dangers to health, including chemical hazards, poisons and radiation.

Monitor, the Independent Regulator of NHS Foundation Trusts, was set up in 2004 under the Health and Social Care (Community Health and Standards) Act 2003 (the provisions of the Act later became part of the National Health Service Act 2006) to authorize and regulate the new NHS FTs with an aim of ensuring that they were financially strong and well-managed (see section 4.1.3 for further discussion).

Advisory bodies

Several advisory bodies assist the Department of Health in evaluating, investigating and supporting policy. Examples include the Advisory Committee on Dangerous Pathogens, the Gene Therapy Advisory Committee, an Expert Advisory Group on AIDS to advise the Chief Medical Officer, and the Joint Committee on Vaccination and Immunisation. The Advisory Committee on Resource Allocation advises the Secretary of State for Health on the distribution of resources across primary and secondary care to ensure that these fully reflect local population need and operate as fairly as possible.

2.3.6 Independent organizations

There are a number of other organizations that contribute in various ways to the delivery of health care in England. Some of the more important ones are discussed below.

The Audit Commission is an independent body set up under the Local Government Finance Act 1982 to ensure that public money is spent economically, efficiently and effectively in the areas of local government, housing, health, community safety and fire and rescue services. It operates under the Audit Commission Act of 1998, which consolidated Part III of the Local Government Finance Act of 1982 and other relevant legislation. It aims to improve public services, promote good practice and help public services to achieve better outcomes. It appoints independent auditors to regulate and inspect (on the basis of quality and cost-effectiveness) the work of local government and the health sector. It also undertakes comprehensive performance assessment of local bodies in various parts of the public sector; it publishes national performance indicators and carries out national value-for-money studies. The Commission aims to improve the financial management of the NHS through its audit process and national reports. Recent examples of these covered the impact of policy on health improvement programmes for children and the "Payment by Results" (PbR) system of managing financial flows in the NHS.

The National Audit Office (NAO) is an independent body set up under the National Audit Act 1983 to support the work of the Comptroller and Auditor General, who is an Officer of the House of Commons and has the power to report to parliament at his or her own discretion on the economy, efficiency and effectiveness with which government bodies have used public funds (known as Value for Money audits). In addition, the NAO is responsible for auditing the accounts of all government departments and agencies and reporting the results to parliament. In recent years, the NAO has produced reports on a range of issues relating to the NHS in England, including the performance and management of hospital PFI contracts, health inequalities, major trauma care and the National Programme for Information Technology (NPfIT) in the NHS.

The NHS Confederation is an independent membership body for the organizations involved in NHS service provision: PCTs, NHS trusts, FTs and ambulance trusts. It covers 95% of NHS bodies as well as many private-sector providers, and it aims to help its members to improve service provision by influencing policy, implementation and public debate; by supporting leaders through networking; and by sharing information and learning. NHS Employers is the part of the NHS Confederation responsible for workforce and employment issues on behalf of NHS organizations. It acts on employers' behalf in negotiating pay as well as other workforce issues.

The BMA was founded in 1832 and is a voluntary organization that represents doctors from all branches of medicine. Over two-thirds of practising doctors are members, and it has a total membership of over 140 000 in the United Kingdom and overseas. The BMA is an independent trade union and aims to protect individual members and the collective interests of its members. It does not register or discipline doctors: this is the responsibility of the General Medical Council (GMC). Other important trade unions representing NHS staff include UNISON, the BDA, Unite the Union, the GMB (Britain's General Union) and the Hospital Consultants and Specialists Association.

The GMC is the independent body responsible for regulating doctors in the United Kingdom. Its aim is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. It was set up originally under the Medical Act of 1858 and it has been subject to a range of subsequent modifications, most of which are contained within the Medical Act 1983. The GMC has four main roles:

- to keep an up-to-date register of qualified doctors
- to foster good medical practice
- to promote high standards of medical education
- to deal with doctors whose fitness to practise is in doubt.

Many medical and surgical specialties and some other health professions have professional bodies, some of which are known as Royal Colleges, which are responsible for maintenance of standards, representation of their members and other matters relating to the particular specialty. Royal Colleges include the Royal College of Physicians, the Royal College of Surgeons, the Royal College of General Practitioners and the Royal College of Nursing (RCN).

A list of statutory bodies responsible for regulating health professionals is given in section 4.1.

2.3.7 The private sector

There is a small, regulated, private health care sector in England, financed by PMI, direct payments from patients, and NHS contracts. The private sector includes hospitals, clinics and ISTCs. Further discussion is provided in Chapters 3 and 6.

2.3.8 The voluntary and community sector

Charities and the voluntary and community sector have always played a part in the health care system in England. Indeed, before the introduction of the NHS, voluntary hospitals were a major provider of health care. Since then voluntary and community bodies have been involved in the delivery of a range of social and health care services to the public, half of which are paid for from public funds but are also funded through charitable donations and charges. To encourage provision by this sector, in 2004 the government initiated a strategic agreement between the Department of Health, the NHS and the voluntary and community sector to give this sector an even more central role in supporting and providing NHS services (Department of Health 2004b).

It was estimated that around 35 000 voluntary and community organizations provided health and social care in England in 2004–2005, with a total funding of over £12 billion. The majority provided social care, with funding of £7.2 billion compared with £4.7 billion for health care in 2004–2005. Over half of this funding came from the public sector, although the share was higher for social care (62%) than for health care (36%). Just over half of funding (52%) for health care was generated through fees paid by service users (IFF Research Ltd 2007).

2.3.9 The policy formulation process

The framework within which NHS strategy and policy develops is determined by government ministers, who are responsible to parliament for their decisions. The Department of Health is then responsible for the formulation and implementation of strategy and policy for the NHS in England within this given framework. The Permanent Secretary is the principal policy adviser on health and social care policy and strategy, and on all cross-government issues.

The formulation of policy by the Department of Health is overseen by a policy manager, who among other things is expected to establish the evidence base for the new policy. The policy manager consults widely on the proposals, involving a range of key stakeholders; these may include hospital staff, GPs, patients, the public, Department of Health advisory bodies, academics and charitable bodies. Where major policy changes are involved, once the policy has been formulated it will be put out for public consultation, usually for a period of three months. A series of proposals and issues are published and responses are invited from all interested members of the public. Responses are analysed and the Department of Health publishes a response to the consultation and takes forward the development of this policy based on the results of the consultation. In October 2010, there were eight live consultations ranging from the addition of acute oncology measures to the manual for cancer services to various consultations on the new government’s white paper on NHS reform (Department of Health 2010d).

Most new policies do not require legislation. If legislation is needed, the Department of Health usually produces a white paper containing its proposals, which will then lead to parliamentary legislation and eventually a new Act of Parliament, reflecting the policy as it has evolved. Legislation requires the agreement of parliament and on rare occasions parliament has refused to pass a government Bill.

2.4 Decentralization and centralization

England is governed through a centralized parliamentary system consisting of elected representatives from the United Kingdom as a whole. Central government raises taxes and is responsible for the main functions of the state: defence, foreign policy, law and order, education, health, welfare and transport. Elements of the administration of these functions are often decentralized. In addition, there is a range of different types of local authority with different functions and responsibilities; these may be further subdivided into parishes. Local authorities may be responsible for administering education, social services, public transport, planning, council housing (state-provided housing), managing public spaces and collecting rubbish. Again, the administration of these functions is often decentralized.

As discussed in section 2.1, responsibility for health care in England lies with the Department of Health – although local authorities are responsible for the organization of social care within their geographic areas. Health policy is determined at central government level. However, the implementation of policy through various parts of the health system involves some organizational decentralization. This is even more true of adult social care, where the Department of Health may set overall national strategic direction and policy but does not deliver or manage social care directly.

Four forms of decentralization of system organization have been identified (Mossialos, Allin & Thomson 2007):

- *deconcentration,* which involves administrative duties previously performed at central level being moved to local level but remaining subordinate to central government;
- *devolution,* which involves transfer of responsibility and a degree of independence to a local level;
- *delegation,* which involves passing responsibilities to local organizations outside the structure of central government (e.g. nongovernmental bodies);
- *privatization,* which involves the transfer of ownership and government functions from public to private bodies.

2.4.1 Mechanisms for implementation

The level of decentralization varies across the various mechanisms in place for managing the public system of health care provision in England, from funding to responsibility for provision, to service delivery to regulation.

The NHS is highly centralized in terms of its funding, which is a tax-based allocation from the Treasury negotiated centrally. Some funds are also raised at a local hospital level through various charges and income-generation schemes. However, the management of these financial resources to provide services to meet the needs of local populations is devolved to local commissioning bodies (PCTs) whose decisions are accountable indirectly through another subnational layer (SHAs) to the Department of Health. The passing of responsibility for day-to-day management of PCTs to SHAs is a form of deconcentration as SHAs remain directly accountable to the Department of Health. Commissioning decisions at the local level have been devolved further to PBC by GPs, although the responsibility for these decisions still remains with PCTs.

There has always been an element of devolution in the delivery of services in the NHS, although this became more pronounced with the introduction of NHS trusts in 1991 and, more recently, FTs, which are no longer subject to financial and management control from the Department of Health, an explicit devolution of responsibility for hospital management and governance from the centre. FTs are discussed in more detail in Chapter 4. The increase in NHS provision commissioned from the private and voluntary sectors is another example of increased decentralization in the form of privatization of delivery.

The regulation of the health care system in England has largely been delegated to arm's-length bodies that are usually independent of central government. As well as regulating the system, they assist in establishing national standards and protecting the public and patients. Most are directly funded by the Department of Health. Key regulators of service provision are the CQC and Monitor. In addition, the Audit Commission and the NAO perform key financial audit roles and are independent bodies, with the NAO reporting directly to parliament. (More detailed discussion is provided in sections 2.3 and 4.1).

The introduction of the internal market into the NHS by the Conservative Government in 1991 and its extension in recent years by Labour Governments has led to the elements of decentralization described above. The role of the Department of Health has increasingly become one of setting strategic and policy directions to be taken forward by semi-independent devolved local bodies. Nevertheless, the framework within which local bodies commission and deliver services is set by central legislation and statutory regulation, and central control over allocation of resources remains a strong lever for influencing how the NHS system operates. There has also been increased use of NSFs and NICE guidelines (see section 4.1.3) in an attempt to ensure the delivery of clinical "best practice" and/or efficient use of resources throughout the NHS. Moreover, NHS bodies are monitored and measured, if anything more now than ever before, with local management facing what seem like continually changing targets. Management of local NHS organizations may appear autonomous but central government retains ultimate power over them, confined only by existing legislation and contractual obligations.

2.5 Patient empowerment

This section considers how patients relate to the health care system. The rights of patients are examined followed by a discussion of the information available to patients. Section 2.5.3 considers the development of patient choice in the English NHS. This is followed by a discussion of patient safety and compensation, and patient complaint procedures. Finally patient participation, satisfaction and access are discussed.

2.5.1 Patient rights

This section is mainly concerned with the rights of citizens in England relating to the public provision of health care, and the role of the citizen as a patient. People who use private health care may expect, as patients, the same rights as any consumer with respect to delivery, quality and costs of services; however, citizens have no specific right to use private-sector health care other than the professional obligation that clinicians must uphold of providing care in extremis.

Although the establishment of the NHS in 1948 produced “the first health system in any Western society to offer free medical care to the entire population” (Klein 2006), it did not provide a specific set of rights. Citizens were entitled to a local GP and might expect to be cared for in an emergency at any hospital in the United Kingdom; yet clear standards to which the NHS must adhere were not laid out.

Despite the efforts of the Conservative Government in introducing *The Patient’s Charter* in 1991 (Department of Health 1991), and further developments by successive Labour Governments, for most of the NHS’s lifetime there have been no systematic legally enforceable rights with respect to it. Most efforts had resulted in statements of aspirations as to what patients might get in an ideal world, set within a range of targets accompanied by various sanctions and rewards administered by the Department of Health or at a regional level. The patient remained an inactive element in all this, not someone who could take action. There were no clear statements of what a patient ought to receive in various circumstances, with straightforward methods of redress for the patient if this was not forthcoming. Thus, the early *Patient's Charter* set out information about standards of service and patient rights within the NHS on issues such as how long a patient should wait for care, information about services and treatment, and issues relating to privacy and dignity in treating patients. But if services were not delivered appropriately, patients did not usually have any form of legal redress other than through the NHS complaints system. A review of the operation of the Charter for the Department of Health still focused on targets and standards, not on patient rights as such (Dyke 1998) and the Department of Health responded by suggesting that a new NHS Charter should shift its focus from the national to the local level while setting out the underlying and guiding principles of the NHS.

In 2001, the government replaced the *Patient's Charter* with *Your Guide to the NHS* (Department of Health 2001a), but once again the focus of this document was not on rights as such. Instead it addressed patient and staff responsibilities, outlined the main commitments and principles of the NHS and provided information on various aspects of services as well as minimum standards for hospital referrals, waiting times and medical treatment. It also provided an account of the NHS complaints procedures.

However, for the first time, with the publication of the NHS Constitution in 2009, which was subsequently updated in 2010 (Department of Health 2010e), the government established a set of rights for patients, the public and staff with respect to the NHS. These were described as legal rights and, in the case of the public and patients, address seven areas:

- access to health services
- quality of care and environment
- nationally approved treatments, drugs and programmes
- respect, consent and confidentiality
- informed choice
- involvement in one's health care and in the NHS
- complaint and redress.

Access

Citizens have six rights:

- to health care free of charge except for certain limited exceptions agreed by parliament;

- to access local health services;
- to expect the local NHS to put in place sufficient and appropriate services to meet the needs of the local population;
- to seek treatment elsewhere in Europe if there is undue delay in delivery in England;
- not to be unlawfully discriminated against on grounds of gender, race, religion, sexual orientation or disability; and
- to access services within maximum waiting times, or for the NHS to take reasonable steps to offer a range of alternative providers if this is not possible.

Quality
Citizens have two rights:

- to be treated with a professional standard of care by qualified and experienced staff in an approved or registered organization; and
- to expect NHS organizations to monitor and make efforts to improve the quality of health care provided.

National standards for treatments, drugs and programmes
Citizens have three rights:

- to drugs and treatment recommended by NICE if their treating doctor believes they are clinically appropriate;
- to expect local NHS decisions on funding of non-NICE-approved drugs and treatments to be made rationally following a proper consideration of the evidence, with due explanations available; and
- to receive vaccinations that the Joint Committee on Vaccination and Immunisation recommends under an NHS-provided programme.

Respect, consent and confidentiality
Citizens have five rights:

- to be treated with dignity and respect;
- to accept or refuse treatment (i.e. to expect to be asked to give valid consent before any examination or treatment takes place);
- to be given information about any proposed treatment in advance, including any significant risks and any alternative treatments that may be available, and the risks involved in doing nothing;

- to privacy and confidentiality; and
- to access their own health records.

Informed choice
Citizens have three rights:

- to choose their GP practice, and they must be accepted by that practice unless there are reasonable grounds for refusal, in which case they must be informed of the reasons for this;
- to express a preference for a particular doctor within their GP practice, and for the practice to try to comply; and
- to make choices about their NHS health care and to information to support these choices, with options available depending on individual need.

Involvement
Citizens have two rights:

- to be involved in discussions and decisions about their health care, and to be given information to enable them to do so; and
- to be involved in the planning, development and operation of NHS services.

Complaint and redress
Citizens have five rights:

- to have complaints about NHS services investigated and dealt with efficiently;
- to know the outcome of any investigation into their complaint;
- to complain to the Health Service Ombudsman as a final resort;
- to claim for judicial review if they believe they have been directly affected by an unlawful decision or action by an NHS body; and
- to claim compensation where they have been harmed by negligent NHS treatment.

Summary
The rights listed above were almost wholly based on existing legislation as outlined in more detail in *Handbook to the NHS Constitution* (Department of Health 2010f). The Health Act 2009, among other things, placed a statutory duty on NHS organizations to take account of the NHS Constitution when

performing their functions. The handbook also provides advice on how a person might seek redress if one or more of their rights have been violated. The process usually starts with working via NHS procedures but can also involve an independent complaints procedure, referral to external professional bodies such as the GMC, judicial review, court proceedings, or referral to the European Commission in some circumstances.

The NHS Constitution also provided a series of pledges in each of the above-mentioned areas. These are aspirational and not legal requirements, although they could be used in any judicial assessment of what the NHS might reasonably be expected to deliver. The government, under the Health Act 2009, also has a statutory duty to renew the NHS Constitution every 10 years, and the *Handbook to the NHS Constitution* every three years.

2.5.2 Patient information

The range of information available for patients to consult about their own health and health care has developed substantially in recent years. The key source is now the NHS Choices web site (http://www.nhs.uk), which was launched in 2007. This provides patients with a wide range of information about health and health services in general, ranging from the structure and organization of the NHS to information on costs and exemptions of services, performance indicators, waiting times, complaints procedures, access to medical advice and initial assessments from NHS Direct (this service is described below) and contact details of local providers. It also includes the facility for patients to check and compare hospitals (both NHS and private-sector), doctor profiles and performance online. Patients can access information about their conditions and treatment, and the site also provides information that may help them to decide, for example, in which hospital they want to be treated.

Another key source of information for patients is NHS Direct, a telephone helpline set up in England in 1998 to provide a continual (24 hours a day, 7 days a week) nurse-led advice and health information telephone line supplying people with advice and information about health, illness and the NHS. Most NHS Direct call centres are staffed by expert call handlers, who pass the caller to a nurse adviser if they need advice or clinical information, or transfer the caller direct to emergency services if they need an emergency ambulance. NHS Direct includes a web-based facility, NHS Direct Online (http://www.nhsdirect.nhs.uk/), which was established in 1999 and also provides a health information inquiry service and a health encyclopaedia.[9] NHS Direct produced a self-help

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[9] A digital TV service was also developed but responsibility for this was transferred to NHS Choices.

guide which was distributed throughout England in April 2004 and, in updated form, is now part of NHS Direct Online. In addition, there are around 150 NHS Direct Information Points across England that provide the online information free via touch screens with printing options. These are located in public places such as hospitals, pharmacies, libraries and supermarkets. NHS Direct also provides a range of directly commissioned services to NHS bodies, including telephone triage for out-of-hours GP and dental care, and telephone support for patients with long-term conditions.

As well as accessing information about their own health and health care, people are able to obtain detailed information about how the NHS is working. For example, the Department of Health web site (http://www.dh.gov.uk) provides information on health and social care and public health policy, as well as guidance, publications and various sets of statistics. The key source for NHS statistics and analysis is the NHS Information Centre (also known as the Information Centre for health and social care; http://www.ic.nhs.uk). Statistical analysis relating to health and health care can also be found on the Office for National Statistics (ONS) web site (http://www.statistics.gov.uk). Information on best clinical practice and standards within the NHS is available through the NICE web site (www.nice.org.uk). Finally, the CQC provides information on its web site (www.cqc.org.uk) about the performance of NHS and private-sector providers as well as reports of special investigations and consultations that it carries out.

The Freedom of Information Act 2000 requires public authorities to specify the type of information they publish, how it is made available and what access to it will cost. Under the Disability and Discrimination Act 1995, service providers must make reasonable adjustments to ensure accessibility of services. NHS authorities offer, on request, public material in different formats including large print, Braille, audio and a wide range of different language versions. Access to information in a suitable format is available by calling a telephone service or contacting the NHS Information Centre.

2.5.3 Patient choice

In recent years there has been a fundamental change to the way in which choice may be exercised within the English NHS, resulting from the policy direction chosen by Labour Governments since 2000. In theory, patients have always been free to choose a GP within the area in which they lived; they have also been free to be treated at any hospital in the country provided their GP was willing to refer them. However, in practice, the spectrum of choice has not been as great as this implies. Often, it has been difficult to obtain a selected GP in some areas, and most patients relied on the GP's choice of hospital for referral, usually without any consultation as to their views. The introduction of the internal NHS market in 1991, if anything, limited the patient's choice of hospital, as most of the time they were restricted to hospitals with which their district health authority had contracted.

Expanding patient choice of hospital had been a key part of the Labour Government's strategy for the NHS since the publication of The *NHS Plan* in 2000 (Department of Health 2000a). This set out intentions to improve patient choice of GP by increasing accessibility of information about GP practices, and also to allow patients a choice of hospital when they required treatment. The government built on a series of pilot programmes in England, offering selected patients who had waited more than six months for elective surgery the choice of moving to another hospital for faster treatment. The government also consulted on the extension of choice to other areas of the NHS. The result was a decision to extend choice in certain key areas: choice of hospital and appointments; choice of where, when and how to get medicines; access to a wider range of services in primary care; and giving people more say in their treatment (Department of Health 2003a).

By the end of 2004, all patients waiting more than six months for elective surgery were offered the choice of moving to at least one other hospital (an NHS or private hospital or diagnosis and treatment centre) for faster treatment. Patient care advisers contacted eligible patients;[10] a requirement was placed on the NHS to ensure patients were treated before they had waited for nine months; and transport was to be provided for patients who would otherwise have had difficulties getting to the alternative hospital (Department of Health 2003b).

By January 2006, most patients being referred for planned care by their GP were able to choose from at least four hospitals or clinics (where PCTs had established contracts for services). Patients were also able to choose the date and time of their appointment using an electronic booking system called "Choose and Book", which enables GPs and other primary care professionals to book appointments for patients directly from their surgery. In May 2006, the list of choices available to patients was widened to include a national menu of FTs and ISTCs – known as the Extended Choice Network – which was further expanded later in that year (Department of Health 2007c). The intention was to extend the patient's choice of hospital to all NHS hospitals and many private-sector hospitals and, in April 2008, this was achieved. Initially the use of Choose

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[10] By the time Choose and Book was extended throughout the NHS, advisers were no longer part of the system.

and Book was quite limited; however, it is reported that by March 2010, some 58% of GP referrals for outpatient appointments were made through the system (NHS Connecting for Health 2010).

Exercise of choice

In early pilots of patient choice in England, some 66% of patients exercised their choice of moving to another hospital in order to obtain faster surgery (Dawson et al. 2005). As choice has been extended, the Department of Health has looked at how aware patients are of the choices they have. However, recent surveys have given somewhat different results: in one case, a survey of NHS patients found that 93% of patients who were referred by their GP to a hospital specialist said that choice of hospital was discussed (Information Centre 2008b); in another survey, the figure was just 52% (Information Centre 2008c). Survey methodology differed between the two surveys. Neither of these figures can be taken as definitive. However, some explanation is afforded by a more recent report from The King's Fund (Dixon et al. 2010), which found that just under half of patients recalled being offered a choice by their GP even though GPs claimed they always offered choice to their patients. It is probably safe to assume that at least 50% of patients have discussed choice of hospital with their GP when being referred for a specialist opinion.

Equity, quality and efficiency

There has been considerable debate around the policy of choice of hospital. By giving patients more choice of hospital (and more control over the timing of hospital appointments and elective admissions), the aim was to increase NHS responsiveness to patient needs in the expectation that this would result in lower waiting times, improved quality of care and efficiency gains from greater provider competition. It has been argued that choice of hospital, at least in the case of the early experiments, reduced waiting times (Dawson et al. 2007). However, others have noted that waiting times have been decreasing since 2000, so decreases may be attributable to significant funding increases and the implementation of waiting time targets rather than to patient choice, which was only fully introduced in 2004 (Oliver 2005). Gaynor, Moreno-Serra and Propper (2010) suggest that allowing patients choice of hospital for elective care has had some impact on quality of care, as measured by mortality, as well as resulting in reductions in length of hospital stay. On the other hand, Dixon et al. (2010) suggest that patient choice has not had a significant impact on quality, although, at the same time, they acknowledge that "choice appears to impact on quality indirectly, by creating a threat to providers that they may potentially lose patients".

Some commentators have raised questions about the impact of patient choice of hospital on equitable access to care. Analysis of data from the choice pilot projects showed that patients are less likely to choose treatment with an alternative provider if they are older, particularly those aged 60 years and over; have lower education levels; have family commitments; and have an annual income under £10 000 (Burge et al. 2005; Coulter, Maistre & Henderson 2005). Others have claimed, admittedly for the whole package of reforms at that time (increased competition, expanded capacity) and not just choice, that there has not been a "deleterious impact on the equity of waiting times" (Cooper et al. 2009). Recent analysis (Dixon et al. 2010), while not finding inequities in who was offered choice, reported differences in how patients exercised choice as patients with lower levels of education were less likely to opt for alternative providers. Other criticisms of the government's emphasis on patient choice have focused on the danger of raising patient expectations (and costs) to such a level that constraints on investment and funding might eventually compromise core NHS principles such as universality, comprehensiveness and free care at the point of use (Oliver & Mossialos 2005), and on the potential tension between expanding choice for patients and further devolution of purchasing to the level of GP practices, which might restrict patient choice.

2.5.4 Patients and cross-border health care

The issue of cross-border health care has become more pertinent in England in recent years, with European Court of Justice judgments having established that EU citizens should be able to exercise rights to access treatment in other EU states under Article 49 of the Treaty establishing the European Community, which prohibited restrictions on the freedom to obtain services within the EU (now known as Article 56 under the Treaty on the Functioning of the European Union) (Department of Health 2010g).

The European Commission issued a draft Directive in July 2008 (which is still subject to ongoing negotiations between Member States, and with the European Parliament) seeking to clarify and codify existing European Court of Justice case law on when patients can exercise their freedom to obtain health services to which they are entitled in their home Member State in another EU Member State (European Commission 2008; Department of Health 2010g). The Department of Health stated its broad support for the provisions of the draft Directive, which maintained: the responsibility of the home state to decide entitlements to health care; that Member States retain gatekeeper arrangements to ensure that treatment is provided on the basis of clinical need; and that patients who go to another EU country for treatment are only entitled to reimbursement for treatment that would have been an entitlement under the NHS, and only up to the level at which the NHS would have paid for the treatment (Department of Health 2009a). This is now reflected in new Sections 6A and 6B of the National Health Service Act 2006, as inserted into that Act by the National Health Service (Reimbursement of the Cost of EEA Treatment) 2010 Regulations (Department of Health 2010g).

Citizens have always been able to buy health care themselves in other countries throughout the world, but historically there has been little cross-border care provided where the NHS has been responsible for paying for that care. Similarly, the private health care market in England – including NHS private beds – has always attracted self-payers from outside of England. Among the countries of the United Kingdom, there are cross-border health care transactions with reciprocal agreements in place to deal with these (Department of Health 2006a).

The way in which citizens of England may access health care in the European Economic Area (EEA; the other 26 EU countries plus Iceland, Liechtenstein and Norway; Switzerland is also a party to a separate bilateral agreement with the EU) differs from that in the rest of the world, affected as it is by rulings and directives of the European Commission and its associated bodies. In general, NHS patients have no right to treatment outside of the EEA although PCTs, in certain limited circumstances, can commission treatment in countries outside the Area (Department of Health 2008a). There are also bilateral agreements with individual countries: for United Kingdom nationals living in, and nationals of, Armenia, Azerbaijan, Bosnia and Herzegovina, Croatia, Georgia, Gibraltar, Serbia, Montenegro, Kazakhstan, Kyrgyzstan, the former Yugoslav Republic of Macedonia, Moldova, New Zealand, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan; for all residents of Anguilla, Australia, Barbados, British Virgin Islands, Channel Islands, Falkland Islands, Iceland, Isle of Man, Montserrat, St Helena and Turks and Caicos Islands (Department of Health 2006b).

There are two ways in which citizens in England may go abroad specifically for the purpose of treatment within the EEA (and Switzerland) with an expectation of being funded by the NHS: first where an NHS commissioning body decides to commission care abroad for its patients and, second, where a patient makes a request to go abroad for care. The former has been relatively rare but there are examples in recent years; the latter can take two forms: one via an E112 authorization and the other through an Article 56 authorization.

An E112 authorization is issued by the Department of Health, although decisions about whether to offer the service and about the patient's clinical needs are based on the advice of the patient's local health care commissioner. The NHS is liable to pay the full cost of state-provided treatment (if free to the patient in the country of treatment) or the amount reimbursed by the state system (if treatment is not free to the patient) even if these costs are greater than in the United Kingdom. These costs are dealt with directly between Member States. Citizens are entitled to go elsewhere in the EEA and Switzerland for treatment offered by their home health system if they face "undue delay", although they need to be issued with an E112 authorization before leaving the United Kingdom. However, patients may only access forms of health care in other European countries that their local NHS also provides. Around 1000 people from the United Kingdom each year receive care under the E112 route (Department of Health 2010g).

Most health care provided under Article 56 requires prior authorization, which is handled by the local health care commissioner and includes arrangements for refunding the patient, who will normally pay the hospital or health care provider abroad directly for the treatment received – only the other 26 EU countries are part of the Article 56 route. In this case, commissioners are only liable to pay costs equivalent to those of treatment in the United Kingdom, or the actual cost of treatment if this is lower (Department of Health 2010g).

In addition, where English citizens are temporary visitors (e.g. tourists), they are entitled to medically necessary health care through the European Health Insurance Card (E111), or where English pensioners have moved to another Member State they are entitled to treatment. The last category represents by far the greatest proportion of activity and costs abroad. Similar arrangements are in place for citizens of the EU, the EEA and Switzerland with respect to the use of health care in England.

Table 2.1 shows the main costs incurred for treatment of United Kingdom citizens in the EEA. A breakdown by type of care is not available, nor are figures available for England alone. Claims against the NHS for treatment of United Kingdom citizens in other Member States are considerably more than United Kingdom claims against other Member States – of the order of 12 times more. The cost of claims against the United Kingdom increased between 2002–2003 and 2006–2007 by around 90%. Almost 90% of the costs incurred by the NHS are for the treatment of United Kingdom pensioners living outside the United Kingdom. The Department of Health estimated that the total cost of claims in 2007–2008 will have increased to around £710 million (House of Commons Select Committee on Health 2007a).

Table 2.1

EEA health care costs, 2002–2003 to 2006–2007

Claims (£ million)	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
Against UK by other Member States					
Actual cost	26.5	40.1	49.5	59.1	64.1
Lump sum	233.2	273.9	331.9	404.1	426.6
Total	**259.7**	**314.0**	**381.4**	**463.2**	**490.7**
UK against other Member States					
Actual cost	14.2	15.2	18.7	20.6	20.4
Lump sum	17.3	9.9	12.5	14.4	17.7
Total	**31.5**	**25.2**	**31.2**	**35.0**	**38.1**

Source: House of Commons Select Committee on Health 2007a.
Notes: Actual cost refers to the following categories of patients: medically necessary health care for temporary visitors, patients referred specifically for treatment (E112), and some other supplementary categories. Lump sum refers to payments for the cost of treatment of pensioners.

Commissioners of health care in England may also contract for treatment in the EEA. Since 2002, a total of 917 patients have received treatment overseas as part of an overseas treatment programme introduced in the NHS in England. The majority of these referrals were for orthopaedic procedures, with some cardiac procedures as well (House of Commons Select Committee on Health 2007a).

2.5.5 NHS complaints procedures

This section describes the current NHS complaints process and how it has evolved in recent years. An indication is provided of the number of complaints that are made against the NHS. This is followed by a discussion of the resources available to patients to help them through the complaints process – advocacy.

The complaints process

Prior to 2004, the right of patients to complain about NHS services delivered by NHS trusts or family health service practitioners was based on a series of Directions and Regulations (with legal status), which were specific to the different parts of the health service. The complaints mechanism consisted of three tiers: (1) provider trusts and health authorities were required to have written procedures to deal with complaints: this was known as local resolution; (2) they should also have in place an independent review process if required; (3) once these two were exhausted, the patient could then refer the matter to the Parliamentary and Health Service Ombudsman. Finally, none of these processes prevented the patient from pursuing a complaint through the law courts (Department of Health 1996).

The National Health Service (Complaints) Regulations 2004 (S.I. 1768) consolidated the Directions covering complaints about NHS bodies and moved responsibility for the independent review of complaints to the Healthcare Commission. Separate Directions and Regulations relating to complaints handling by primary care practitioners continued to apply (Department of Health 2004c). In January 2006, the Department of Health made a commitment to develop a single complaints system across health and social care by 2009 (Department of Health 2006c). This was followed by the National Health Service (Complaints) Amendment Regulations 2006 (S.I. 2084), which came into force in September 2006 and set out duties of cooperation between NHS bodies and local authorities in handling complaints, and extended the time limit for NHS bodies to respond from 20 to 25 days. In 2009, new regulations were introduced by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (S.I. 309) so that there is now an integrated statutory complaints process for NHS and adult social care services.

As a result, there are now just two tiers for dealing with both NHS and social care complaints: first by local resolution and then, if this does not provide an acceptable resolution, by referral to the Parliamentary and Health Service Ombudsman in the case of NHS services, and the Local Authority Ombudsman in the case of adult social care. If individuals have a complaint about an NHS service or an adult social care service, whether supplied by an NHS body, a primary care provider, an independent provider or a local authority, usually they must complain within 12 months of the event generating the complaint. They are encouraged to raise the matter directly with a staff member with a hope of immediate resolution without recourse to the formal process. Otherwise, complaints may be made electronically, in writing or orally to the body concerned. In the case of the NHS, this is the service provider or the commissioner of care (usually a PCT); in the case of adult social care, it is the local authority or the service provider. A complaint must be acknowledged within three working days and there is an expectation that it will be resolved within six months. If not, then the body responsible is required to review the case, notify the complainant of the reason for the delay and respond as soon as possible thereafter.

If the response to the complaint is not satisfactory, individuals can move to the second stage of the complaints procedure, referring the matter to the Parliamentary and Health Service Ombudsman or the Local Government Ombudsman as appropriate. These are independent bodies. Individuals may also take legal action regarding the same complaint while at the same time using the complaints process described above. In these circumstances the relevant NHS or local authority is expected to try to resolve the complaint in the usual way unless there are clear legal reasons not to do so. Financial compensation is possible through separate legal action, but not through the NHS complaints procedure, although legislation is now in place that may result in such compensation being available in the future (NHS Redress Act 2006; see section 2.5.6 for more detail).

Number of complaints

Table 2.2 shows that the number of complaints about the NHS increased between 1997–1998 and 2009–2010: the number of complaints about hospital and community health services (HCHS) by 14% and the number about GPs and dentists by 33%. The increase in complaints about HCHS occurred mainly in the last year. Most complaints are resolved within the local resolution process, although a small proportion is taken further.

Table 2.2

NHS complaints, 1997–1998 to 2009–2010

	1997–1998	2000–2001	2003–2004	2007–2008	2009–2010
HCHS	88 757	95 734	90 122	87 080	101 077
GPs and dentists	38 093	44 442	43 347	43 942	50 755

Source: Information Centre 2010c.

Over two-thirds of HCHS complaints relate to acute hospital services and a large proportion is concerned with some aspect of clinical treatment. Around 80% of primary care complaints relate to general practice.

Advocates

Local resolution is the first stage of the complaints procedure. Patients may make their complaint directly by speaking to a member of the staff of the organization against which the complaint is directed, or may speak to the Patient Advice and Liaison Service. This service is located in every NHS trust and PCT and is responsible for providing information to patients about the complaints procedure and the Independent Complaints Advocacy Service (ICAS). ICAS was established in England in 2003 to provide free, confidential and independent support to people making a formal complaint about the treatment or service received under the NHS. Trained advocates or caseworkers are available to support clients at all stages of the complaint procedure, from attending resolution meetings to helping with correspondence. Funding, contract management and quality standards for ICAS are provided by the Department of Health. ICAS is provided on a regional basis and contracts have been awarded to three major independent organizations (Department of Health 2007d).

In 2004, the Department of Health prepared a report evaluating the first year of ICAS (Department of Health 2004d). In 2003–2004, the ICAS telephone helplines received 27 000 calls, and 10 422 complainants received full advocacy support; in 2004–2005 29 000 calls were dealt with and 13 000 complainants received full support. Complaints concern three main areas: aspects of clinical treatment, the attitude of staff, and communication or information to patients. ICAS offers contact with an advocate or caseworker within three weeks of a client's request, with priority given to those with an urgent deadline to meet as part of the NHS complaints procedure.

2.5.6 Patient safety and compensation

Individuals can take legal action if they feel they have suffered harm as a result of a breach of the duty of care which the NHS has to its patients. However, there must be proof of clinical negligence and the impact of this negligence. Moreover, clinicians are not negligent if they act in accordance with accepted practice. Usually, claims must be made within three years of the incident.

The NHS in England is responsible for ensuring that the treatment and care delivered to its patients are safe, and it is legally liable for any harm arising from the clinical negligence of its employees. Before 1989, individual clinicians were responsible for claims against them and they were insured against this risk through the Medical Defence Union or the Medical Protection Society. In 1990, the government introduced NHS indemnity for medical and dental staff employed by health authorities (this included staff in NHS hospitals at the time), but not GPs or dentists. The Clinical Negligence Scheme for Trusts was established in 1995 to allow NHS bodies to pool the risk associated with clinical negligence claims, and in November 1995 the NHSLA was established as a special health authority responsible for handling subsequent negligence claims, greater than a minimum value, made against NHS bodies. Its remit has since been extended to include responsibility for all claims, including those relating to incidents that took place before 1995, although funding for earlier claims comes directly from the Department of Health.

Although membership of the Clinical Negligence Scheme for Trusts is voluntary, all NHS trusts, FTs and PCTs are members. The contributions of members to the overall cost of the scheme are based on size and type of trust as well as an assessment of trust risk-management standards and previous claims history. Total contributions are intended to cover overall estimated expenditure for each year, which usually includes the legal costs of the patient as well as that of the NHS trust. The NHSLA has developed sets of risk-management standards for various types of trust – for example, acute, ambulance, mental health, learning disabilities and maternity – against which trusts are periodically assessed (NHSLA 2010a).

In the 1990s, there was a substantial increase in the number of claims in England: between 1990 and 1998, the rate of claims per episode of hospital treatment increased by 72%. In 1999–2000, there were 10 000 new claims and 23 000 claims were awaiting resolution (NAO 2001). After a period of stabilization between 2004–2005 and 2007–2008, when the number of new claims was between 5400 and 5600 per year, there was a significant increase in 2008–2009 to 6088, and again in 2009–2010 to 6652. Outstanding claims had fallen to 11 436 by the end of March 2008, but by March 2010 had increased again to 13 320 (NHSLA 2010a).

The estimated cost of outstanding claims in March 2000 was £2.6 billion, with an estimate of an additional £1.3 billion to cover claims for incidents that had occurred but as yet no claim had been made. The average time taken to resolve a claim was 5.5 years (NAO 2001). The cost of claims has continued to rise and by the end of March 2010 the estimated cost of outstanding claims, including those that had occurred but were not yet reported, was £14.9 billion (NHSLA 2010b). The average time taken in 2009–2010 to resolve recent claims (i.e. those made through the Clinical Negligence Scheme for Trusts) was 1.5 years, although the average time for resolution of incidents that occurred before 1995 remains at 5.5 years (NHSLA 2010a).

The amount paid to patients in resolution of claims and legal costs paid by the NHS increased by 86% from £422.5 million in 2003–2004 to £787.0 million in 2009–2010 (NHSLA 2010a, 2010b). Between 1997–1998 and 2007–2008, considering all clinical claims handled by the NHLSA, 40% were abandoned by the claimant, 43% were settled out of court, 4% were settled in court and 13% were outstanding (NHSLA 2010c).

Reporting adverse clinical events

One in ten patients admitted to NHS hospitals are unintentionally harmed (NAO 2005a). Throughout most of the history of the NHS, the system for reporting adverse clinical events was patchy with no systematic focus on patient safety (Department of Health 2000b). To remedy this, in 2001, the NPSA was established as a special health authority to improve the safety and quality of care through collecting, reporting, analysing and learning from mistakes and problems that affect patients. The NPSA's role was to promote a culture of reporting and learning from mistakes, and it established and managed a non-mandatory national reporting system of adverse events and near misses (Department of Health 2006d). Since 2005, following the government's review of arm's-length bodies, the NPSA has incorporated the work of the National Clinical Assessment Service (supporting local NHS bodies in addressing concerns about the performance of individual doctors and dentists) and the Central Office for Research Ethics Committees (ensuring research is carried out safely) as well taking responsibility for safety aspects of hospital design, cleanliness and food (which was transferred from NHS Estates).

In 2004, the NPSA set up the National Reporting and Learning Service, a national patient safety reporting system that is linked to local trust risk-management systems and provides national trends to the NHS and the public. Separate reporting formats have been developed for staff, patients and the public to report incidents anonymously. There were almost 1.2 million patient safety incidents reported to the Service in 2008–2009, an increase of 14% on the previous year; of this total, 1.2% were recorded as causing severe harm or death and around 70% of these were in acute hospitals. Not all NHS organizations submit reports to the National Reporting and Learning Service on a regular basis (95% reported in the quarter July–September 2009 but only 66% reported in each month). The NPSA does not investigate incidents or involve itself with disciplinary procedures (NPSA 2010a).

There are separate reporting systems for medical device incidents (through the MHRA), adverse drug reactions (through the MHRA), health care-associated infections (through the HPA), and suicide and homicide of people with mental illness (see the National Confidential Inquiry) (Appleby et al. 2001).

The MHRA is responsible for ensuring that medicines and health care products meet the appropriate standards of safety, quality, performance and effectiveness, and are used safely. Suspected adverse drug reactions to prescription medicines, herbal remedies and over-the-counter (OTC) medicines are reported to the MHRA through the Yellow Card Scheme, originally set up for health care professionals but extended to the public in 2005 (forms are available from pharmacies, by phone or online). The MHRA also publishes on its web site anonymous data on suspected adverse drug reactions.

United Kingdom regulations set out the rules for advertising medicines in general and specifically to the public and to health care professionals. Advertising of prescription medicines to the public is not allowed; advertising of OTC medicines to the public is allowed but is subject to regulation (see the Blue Guide (MHRA 2005) for more detail on pharmaceutical regulation and enforcement).

Future developments

In an effort to reduce the costs of litigation over issues of clinical negligence and to provide speedier resolution in many cases, the NHS Redress Act was passed in 2006 enabling the introduction of an NHS redress scheme for less severe cases (those not exceeding damages of £20 000) rather than litigation through the civil courts. The Act allowed for the establishment of a scheme to enable settlement of certain complaints about hospital services involving mainly liabilities from personal injuries or loss arising from a breach of a duty of care, including any omission by a health care professional – whether in England or elsewhere, provided services were supplied as part of the NHS – without the need to go through civil court litigation. Primary care services have been specifically excluded. Members of the scheme may include NHS trusts, FTs and independent providers in England. Where a case falls within the scheme, it was envisaged that the scheme member would investigate the incident, provide an explanation and apology where appropriate, provide a report on the action that has been or will be taken to prevent similar cases arising and, after consultation with the NHSLA, offer financial settlement.

It was not intended that application through the scheme would prevent the complainant from seeking legal redress if not satisfied. Free legal advice, as well as other advice, would be provided to the complainant for the purpose of the scheme. It was also intended that the costs of the scheme would be shared through a system of contributions similar to the Clinical Negligence Scheme for Trusts. The NHSLA would be responsible for the administration of the scheme (Department of Health 2005a). However, as of November 2010, the enactment of this scheme is still awaiting secondary legislation.

2.5.7 Patient participation and satisfaction

This section is concerned with the way in which patients and the public may influence the organization and provision of health services in England. It does not examine the extent to which patients are involved in decisions about their own treatment. Some discussion of patient satisfaction with health care is also provided.

Participation

In recent years there have been several changes in the way in which the public and patients may influence the structure of health service provision at a local level. Clearly, at a national level, the public impact has always been felt through the ballot box at election time.

Before the reorganization of the NHS in 1974, there had been some public representation on health boards through local government councillors. Community health councils were introduced in 1974, with a membership which included elected members representing the interests of the local public. These councils monitored local health services and had rights of inspection of facilities; they advised and were consulted by health authorities on health-related matters, and they could veto proposals involving service redesign (e.g. hospital closures) with the power ultimately to refer matters directly to the Secretary of State for Health. Finally, the community health councils assisted patients in the complaints process and acted as advocates within NHS trusts.

The Health and Social Care Act 2001, while identifying a duty of the NHS to involve the public, abolished community health councils (this took effect in 2003) and set out a new framework to facilitate patient and public involvement in the NHS. The role of the councils was distributed between four bodies. "Patient and Public Involvement Forums" were set up to take over the representative role of the community health councils in reviewing and monitoring NHS bodies. The Patient Advice and Liaison Service and ICAS (see detailed discussion in section 2.5.5) took over the role of advising the public and assisting with patient complaints. Finally, the remit of the overview and scrutiny committees of local authorities was extended to cover health care as well as social care.

The overview and scrutiny committees consist of elected local government councillors and have a range of powers, including the right to request information and/or summon people before them to give evidence, to recommend independent inspection of health care premises, and to be consulted by the NHS where major changes to health services are suggested. The overview and scrutiny committees may ask for a public consultation on service change and have the right of referral of decisions taken by the NHS directly to the Secretary of State for Health (House of Commons Select Committee on Health 2007b).

The Patient and Public Involvement Forums did not last long; their abolition was announced in July 2006 (they were formally abolished in 2007) to be replaced by new bodies known as "Local Involvement Networks" (Department of Health 2006e, 2007e). These were formally established in April 2008 under the Local Government and Public Involvement in Health Act 2007, with many of the powers that their predecessors had held. One distinction is that they are associated with geographic areas corresponding to local authorities (with responsibility for social services) and, although support funding comes from central government, the funding is provided through these local authorities, who must ensure that the networks are set up in their area (£84 million was made available to local authorities for this purpose between 2008 and 2011). Local Involvement Networks consist of individuals, groups and organizations with an interest in local care services. Membership is on a voluntary basis and they are supported by an organization procured and funded by the local authority (Department of Health 2007e). They are intended to promote the involvement of local people in the commissioning, provision and scrutiny of local health and social care services. To this end they:

- obtain the views of local people about their experiences of health and social care services, and their needs for care;
- investigate specific issues of concern to the community;
- request information from health and social care commissioners and providers;
- carry out spot-checks to see if services are working well;
- make reports and recommendations to NHS bodies and receive responses; and
- refer issues to the local overview and scrutiny committee.

As part of the assessment of NHS performance, the Healthcare Commission involved local groups such as the overview and scrutiny committees of local authorities and Local Involvement Networks in commenting on the submissions (known as declarations) of NHS providers for their annual performance review by the Commission. The review process has now changed but the CQC, in reviewing the performance of both health and adult social care providers, still encourages local representative organizations to provide views and information in a more informal way about providers of these services.

Satisfaction

Satisfaction with the NHS has been measured for many years on a regular basis as part of official government surveys as well as in one-off surveys from time to time. More recently, the Labour Government decided that there should be regular surveys of public and patient satisfaction with the NHS in general and also, with particular services, in order to assess how well the NHS is doing overall and how individual parts and organizations within the NHS are doing.

In 2004, the Healthcare Commission took over responsibility for surveys of the NHS in England, initiating a programme of patient surveys covering a wide range of areas including hospital services, maternity services, ambulance services, local health services (GPs and dentists) and mental health services. The CQC continues to coordinate a wide range of surveys on the experiences of people using health care services that are commissioned by the NHS. Table 2.3 indicates that 92% of people surveyed in 2009 who had been inpatients in NHS acute hospitals in England believed that the quality of care they had received was good or better; this proportion has hardly changed since 2002. However, there has been an increase in the proportion rating their care as excellent, from 38% to 44%.

Table 2.3

How acute hospital inpatients in England rated quality of care, 2002–2009

Rating						Percentage
	2002	2005	2006	2007	2008	2009
Excellent	38	40	41	42	43	44
Very good	36	37	36	35	35	35
Good	17	15	15	14	14	13
Fair	7	6	6	6	5	5
Poor	2	2	2	2	2	2

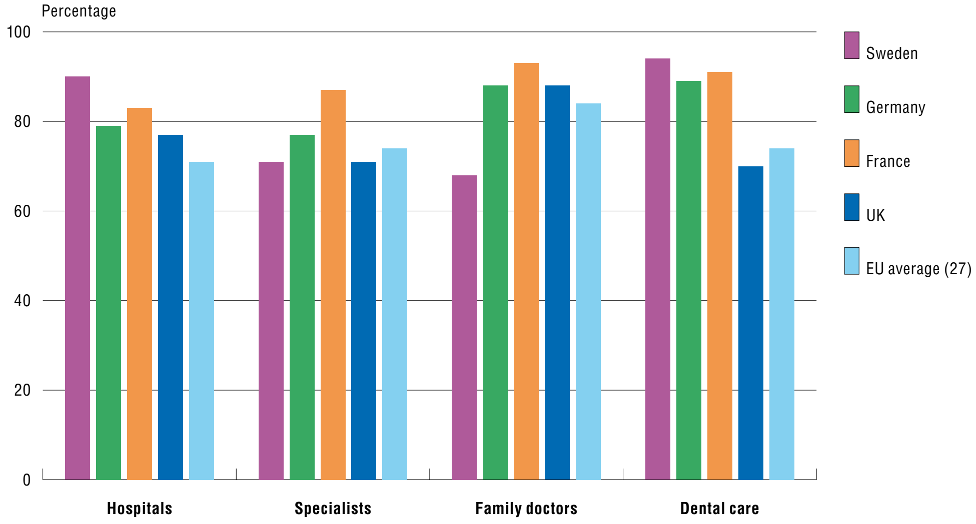
Source: CQC 2010a.
Note: Based on surveys of acute hospital inpatients in the above years.

In a recent review of NHS performance, The King's Fund reported that overall satisfaction with the NHS, based on data from the British Social Attitudes Survey, increased between 1997 and 2007 from 35% to 51% (Thorlby & Maybin 2010). Patients also seem to be satisfied with the services provided by their GPs (Boyle, Appleby & Harrison 2010).

Fig. 2.3 compares the views of people in the United Kingdom regarding the quality of a range of health services with those of people in other EU countries. Fewer people in the United Kingdom (77%) believe that the quality of their hospital services is good than do in Sweden (90%), France (83%) or Germany (79%); the same applies to the quality of medical and surgical specialists except that the proportion is equal for the United Kingdom and Sweden. The position with respect to quality of dental care is somewhat worse, with fewer people in the United Kingdom (70%) believing that the quality of dental services is good than in Sweden (94%), France (91%) or Germany (89%). However, citizens in the United Kingdom take a better view of the quality of their GP or family doctor services, with 88% stating these are good compared with 93% in France, 88% in Germany and just 68% in Sweden.

Fig. 2.3

Percentages of citizens who believe that the quality of health care services is fairly good or very good, United Kingdom and other EU countries, 2007



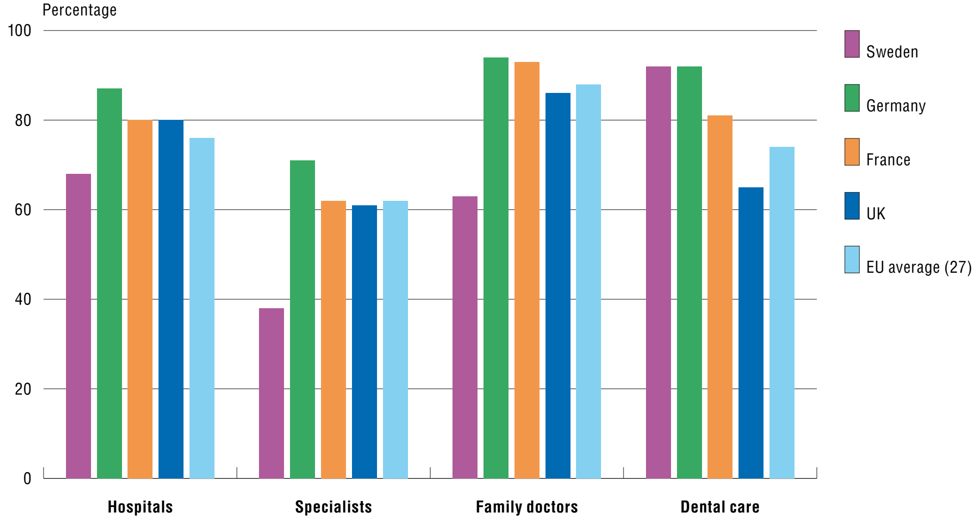
Source: Eurobarometer 2007.

Fig. 2.4 compares the views of people in the United Kingdom regarding ease of access to a range of health services with those of people in other EU countries. People in the United Kingdom have a relatively positive view of ease of access to hospital services (80%) but not to specialist doctors (61%). This is not dissimilar to the position in France: 80% and 62%, respectively; German citizens have a more positive view still: 87% and 71%, respectively, but in

Sweden only 68% of people believe they have relatively easy access to hospitals and 38% to specialists. The position with respect to access to dental care is distinctly worse in the United Kingdom, with only 65% of people believing they have easy access, compared with 92% in Sweden and Germany and 81% in France. Citizens in the United Kingdom believe they have relatively easy access to GPs (86%); this compares with 93% in France, 94% in Germany and just 63% in Sweden. In a more recent international study, Schoen et al. (2009), reporting the results of a 2008 survey, found that "With the exception of waiting times for specialists and some aspects of patient engagement, the United Kingdom … ranked highly on many aspects of primary care access, coordination, and patient-reported errors".

Fig. 2.4

Percentages of citizens who believe access to health care services is fairly or very easy, United Kingdom and other EU countries, 2007



Source: Eurobarometer 2007.

2.5.8 Physical access

People with disabilities are protected by law from discrimination, both as users of services and as employees, under the Disability Discrimination Act 2005, which amended substantially the Disability Discrimination Act 1995. Service providers must change practices, policies, procedures or physical features which make it impossible or unreasonably difficult for disabled people to make use of their services, and also provide aids or services that will facilitate use of services by people with disabilities. The NHS must comply with this legislation and subsequent extensions and amendments.

In 1999, the Department of Health issued a good practice guide *Doubly Disabled* (Department of Health 1999a) on access to services and employment for people with disabilities; this mapped out a timetable for implementation of the requirements of the 1995 Act. At the same time, based on audits of NHS premises, the following significant barriers for people with disabilities were identified: car parking, signage, absence of trained assistants, lack of assistive technology (e.g. loop systems), information in inaccessible media, inaccessible lavatory and bathing facilities, and poor physical access generally. The most significant barrier cited by the majority of disabled people was that of inappropriate staff attitudes and behaviours. It was estimated that the cost to the NHS of dealing with barriers could be between £270 million and £540 million (Freeney et al. 1999).

The Disability Rights Commission Act 1999 established the Disability Rights Commission as an independent body that would act against discrimination and promote equality of opportunity for people with disabilities. From 2000, this body had powers to investigate, to issue non-discrimination notices if unlawful acts were being committed and, ultimately, to seek action by the courts. It was subsequently subsumed into the Equality and Human Rights Commission in 2007 under the Equality Act 2006. This Commission combined responsibilities for acting on various forms of discrimination, including race, disability, gender, sexual orientation, religion and belief, and age.

The Disability Rights Commission investigated health inequalities experienced by people with mental health problems and/or learning disabilities in England and Wales, and in 2006 published a report highlighting the evidence on the stark inequalities people with disabilities face in terms of morbidity, mortality and use of services. The report included a set of recommendations for action (Disability Rights Commission 2006). The Department of Health accepted the need for a programme of work to address issues of inequality and produced an action plan (Department of Health 2007f).

The Disability Discrimination Act 2005 created a Disability Equality Duty on public bodies (including the Department of Health and the NHS), which came into force in December 2006 and required public bodies to have regard to the need to:

- eliminate discrimination against, and harassment of, disabled people;

- promote greater equality of opportunity for disabled people;
- promote positive attitudes towards, and participation in public life of, disabled people; and
- recognize that achieving equality for disabled people will at times require adjustments which will mean treating a disabled person more favourably.

In this way, the 2005 Act allowed positive discrimination in favour of disabled people. It also included a specific duty upon public bodies to publish a Disability Equality Scheme showing how progress in closing gaps of inequality would be tracked over time, setting out action plans to close such gaps, putting in place processes for ensuring disability equality considerations are given proper weight in future decisions, and also showing how disabled people have been involved in the process. In response, the Department of Health produced the Single Equality Scheme, which laid out its plans to meet the requirements of equality legislation, including that relating to disability (Department of Health 2007g). Its intention was to review the scheme every three years and a revised scheme was published in 2009 (Department of Health 2009b). The Department of Health has also provided guidance to NHS bodies, all of whom must comply with their obligations under the same legislation (Department of Health 2007h).

3. Financing

This chapter describes the way in which health care services are financed in England.[1] It begins with a brief analysis of expenditure patterns since 1980. This is followed by a discussion of entitlements to health care. Section 3.3 addresses the source of financing for health and social care. Section 3.4 discusses how decisions are made on the allocation of resources between different types of health care, between different parts of England and between different types of population. Finally, sections 3.5 and 3.6 describe the mechanisms that determine the flows of money around the system, and how these have developed over time.

Health services in England are mainly financed from public sources, primarily general taxation and NICs. However, some care is funded privately: through PMI, by user charges for NHS services although most are provided free, by direct payments by individuals for items such as OTC drugs and medical appliances, or by direct payments by individuals for health care delivered by NHS, private-sector or voluntary-sector providers (Fig. 3.1).

Public sources of finance for health care are allocated by central government (HM Treasury has responsibility for this) to the Department of Health, which is then responsible for the further disbursement of monies. Since 1998, the size of the Department of Health's budget for the following three years has been fixed every two years following a process of negotiation with the Treasury known as the Spending Review.[2]

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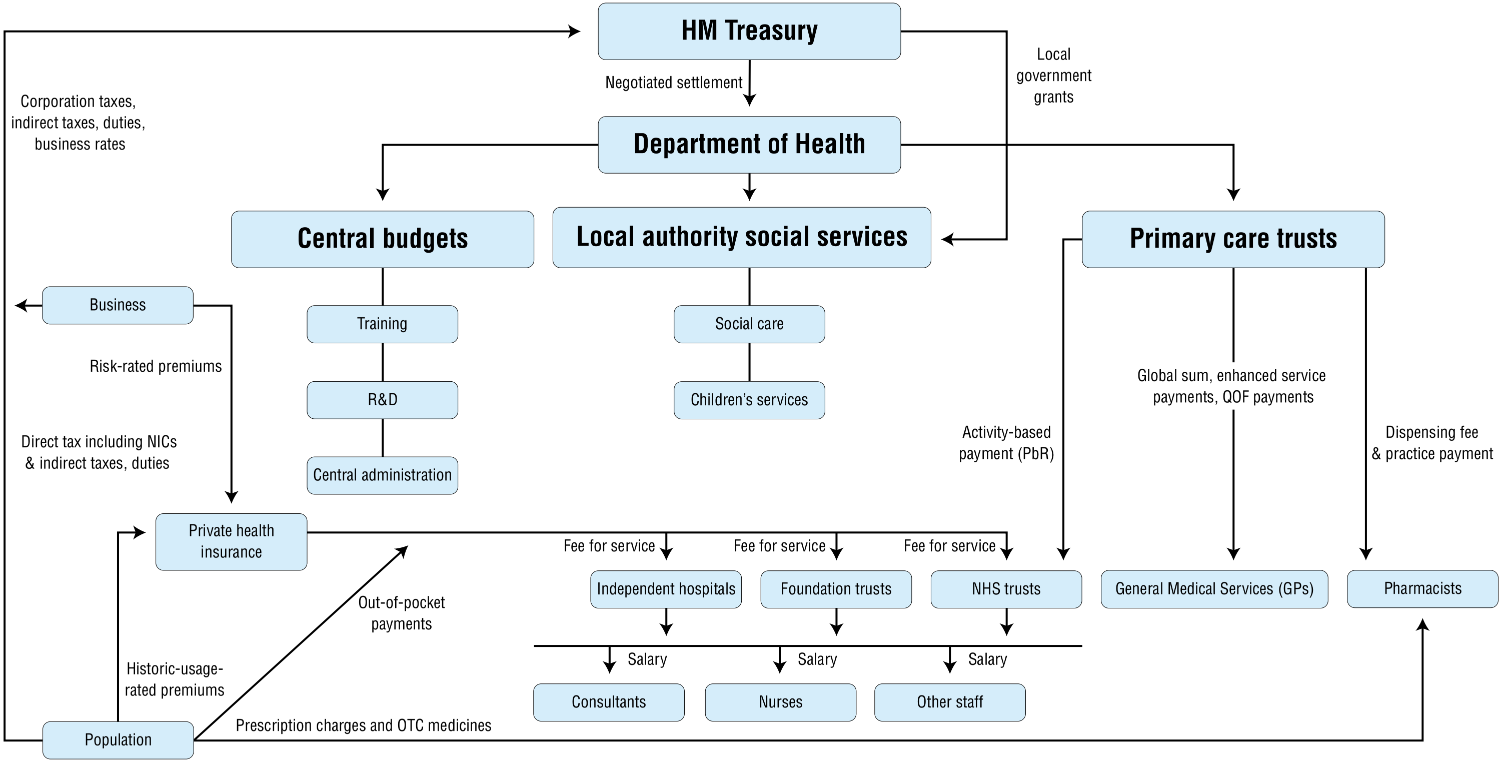
[1] Some information is also provided on financing of social care services.

[2] At longer intervals, HM Treasury may carry out a more in-depth review, which is known as a Comprehensive Spending Review (these occurred in 1998 and 2007). The most recent Spending Review reported in October 2010.

Fig. 3.1

Financial flows in the English health care system, 2010



The NHS publicly funded system consists of organizations that deliver services (service providers) and organizations that contract for (commission) services (mainly PCTs). Each year, the Department of Health allocates around 80% of the total NHS budget to PCTs using a weighted capitation formula. PCTs are responsible for purchasing primary, community, intermediate and hospital-based services from a range of providers, mainly in the public sector but including private- and voluntary-sector providers. Since 1999, there have been significant changes to the way in which PCTs pay for health services, particularly in the hospital sector, with the introduction in 2003–2004 of activity-based funding – developed in England as PbR. Important changes have also been made to the system of paying GPs and specialist doctors (consultants).

3.1 Expenditure on health care

There are relatively consistent time series available on expenditure on health care in the public sector since the NHS began in 1948. However, for the purposes of international comparison, and in a world where health systems are so different, it is total expenditure that is of interest. This consists of spending by government, by individual households and also by the voluntary sector. Definitions of what should be included for internationally comparable estimates of total expenditure on health care were suggested by the OECD in *A System of Health Accounts* (OECD 2000). The intention was that anything spent on health care should be included, regardless of who provides or who pays. However, this makes the use of simple national statistics for comparative purposes more complicated as these figures may not always correspond to OECD definitions.

The ONS has compiled health expenditure figures for the United Kingdom based on the OECD definitions for the period 1997 to 2008 only. Estimates for other years are based on the United Kingdom National Accounts method, which includes only government current and capital expenditure on health care and household expenditure on health care (Table 3.1). To be consistent with the OECD definition, the following would have to be included: expenditure by non-profit-making institutions serving households (mainly charities), expenditure on health care in prisons and in the armed forces, capital expenditure by private-sector health care providers, non-NHS expenditure on nursing care in nursing homes, government benefits paid to those providing home care for their relatives, and occupational health care. The following would be excluded: expenditure on education and training by the NHS and expenditure on research and development (R&D) by the NHS (ONS 2008a).

Table 3.1

Trends in health care expenditure in the United Kingdom, 1980–2008

	1980	1985	1990	1995	2000	2005	2008
Total health care expenditure (% GDP)	5.6	5.8	5.9	6.8	7.0	8.3	8.7
Total health care expenditure per capita (£)	231	369	586	863	1 168	1 719	1 852
Total health care expenditure per capita (US$ PPP)	468	689	960	1 347	1 837	2 701	3 129
Public expenditure on health care (% total)	89.4	85.8	83.6	83.9	79.3	81.9	82.6
Private expenditure on health care (% total)	10.6	14.2	16.4	16.1	20.7	18.1	17.4
Out-of-pocket payments (% total health care expenditure)	8.6	na	10.6	10.9	13.4	11.8	11.1
Private insurance (% total health care expenditure)	1.3	2.5	3.3	3.2	1.6	1.4	1.2

Source: OECD 2010a.
Notes: Only the figures from 2000 onwards are based on the OECD methodology; the rest use United Kingdom National Accounts methods as discussed above. The OECD method tends to produce higher estimates of expenditure on health care than does the United Kingdom National Accounts method; na: Not available.

Health care expenditure in the United Kingdom has risen significantly in recent years. As Table 3.1 shows, total spending on health care as a proportion of GDP increased from 5.6% in 1980 to 8.7% in 2008. In particular, spending increased rapidly between 1997 and 2008, from 6.6% to 8.7% of GDP, corresponding to an increase in expenditure in cash terms from £55.1 billion to £125.4 billion (Haynes 2010).

Health services remain predominantly publicly funded: in 2008, some 83% of expenditure derived from public sources. As Table 3.1 shows, there was a decline in public expenditure as a proportion of total health expenditure between 1980 and 2000 from 89.4% to 79.3%. However, in the period since 2000, public expenditure almost doubled while private expenditure increased by just over 50%, resulting in a shift in the proportion of total spending back towards the public sector. This resulted from the Labour Government's desire to bring spending in the United Kingdom, as a proportion of GDP, closer to the European average. In 2002, the Chancellor of the Exchequer (United Kingdom Minister of Finance) announced plans for a sustained increase in NHS expenditure, with 7.4% annual real growth in the United Kingdom over the five years to 2007–2008, and 7.5% in England (HM Treasury 2002). In 2002–2003, 19.1% of projected government expenditure in the United Kingdom was on health care (HM Treasury 2002).[3] By 2008–2009, this had increased to 22.3% (HM Treasury 2008) but was projected to fall slightly to 22.1% by 2010–2011

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[3] This included spending on the NHS, other health and personal social services.

(HM Treasury 2010). Table 3.2 shows that health care expenditure has grown at more than twice the rate of GDP in most periods since 1973, with the exception of the periods between 1983 and 1988, and 1993 and 1998.

Table 3.2
Five-year annual growth rates (%) in total health care expenditure and GDP in the United Kingdom

	1973–78	1978–83	1983–88	1988–93	1993–98	1998–2003	2003–08
Health care expenditure (%)	4.0	3.4	3.5	4.2	3.0	6.1	4.4
GDP (%)	1.2	1.0	4.0	0.8	3.4	3.0	2.2

Source: Calculations based on OECD 2010a.

Total government expenditure in the United Kingdom as a proportion of GDP has fluctuated somewhat over the last 40 years, reaching a high point of 47.3% between 1980 and 1984 but falling to its lowest point of 41.0% between 1995 and 1999 (Table 3.3). However, over that same period, government expenditure on health care as a proportion of total government expenditure has increased steadily, from 9.6% in the early 1970s to 15.5% between 2005 and 2009.[4] Accordingly, government expenditure on health care as a proportion of GDP has also increased steadily over the same period, from 4.1% to 6.9%.

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[4] This is a more limited definition of expenditure on health care than that used by HM Treasury, and hence the resulting lower figure.

Table 3.3

Relationships between total government expenditure, government health care expenditure and GDP, United Kingdom, five-year averages

	1970–74	1975–79	1980–84	1985–89	1990–94	1995–99	2000–04	2005–09
TGE as % GDP	42.9	45.7	47.3	42.6	43.7	41.0	41.1	46.3
GHE as % TGE	9.6	10.5	10.8	11.5	12.6	13.5	14.7	15.5[a]
GHE as% GDP	4.1	4.8	5.1	4.9	5.5	5.5	6.0	6.9[a]

Source: Calculations based on OECD 2010a.
Notes: [a] Data are for the period 2005 to 2008; GHE: Government health care expenditure; TGE: Total government expenditure.

Data are not available from OECD sources on the proportions spent on the various subtypes of health care within the United Kingdom's total health care expenditure (e.g. inpatient care, outpatient care, mental health, health R&D, health administration) or the various types of input (e.g. staff, utilities, medicines, medical devices) (OECD 2010a). However, more detailed data are available for England and these are used in the next section to show how the composition of government expenditure on health care has changed over time.

3.1.1 England

Turning to England, there is no comparable source of data for total expenditure on health care. There are, however, data available on total government expenditure on health care, and how this is allocated between current and investment purposes, called revenue and capital accounts.

As Table 3.4 shows, total government spending by the Department of Health in England on health care in the financial year 2008–2009 was almost £109.5 billion, an increase since 2001–2002 of almost 88%. Of total expenditure in 2008–2009, 86.4% was spent on the NHS, 12.2% on NHS pensions and 1.4% on personal social services.[5] Although expenditure on the NHS has increased significantly over this period, as a proportion of total budget it has fallen as the amount spent on NHS pension provision more than trebled.

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[5] Most of the funding for personal social services comes directly from local authorities; in 2007–2008 current spending was £19.3 billion, of which £1.2 billion was funded by grants from the Department of Health (Department of Health 2009c).

Table 3.4

Trends in government health care expenditure in England, 2001–2002 to 2008–2009

Expenditure (£ billion)

	2001–02	**2002–03**	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**[a]
Total government health care	58.26	63.27	72.06	77.86	87.91	92.79	101.55	109.43
Total NHS	53.49	57.05	64.17	69.05	75.82	80.56	89.26	94.52
Total PSS	0.82	1.65	1.69	2.18	2.15	1.93	2.08	1.52
Total on NHS pensions	3.95	4.57	6.19	6.40	9.28	10.23	10.17	13.39

Sources: Department of Health 2007i, 2008b, 2009c.
Notes: [a] Estimated outturn figures; PSS: Personal social services.

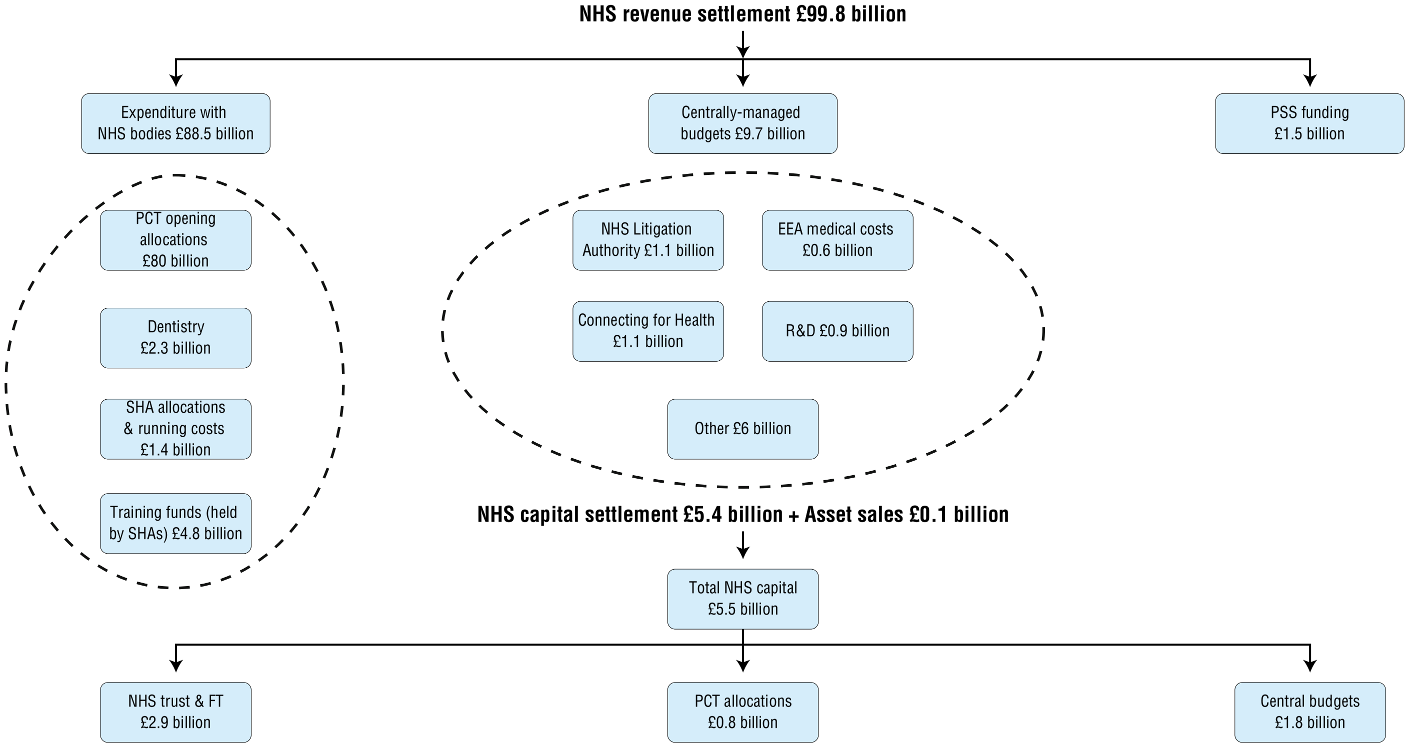
Between 3% and 4% of total government expenditure on health care was spent on capital investment between 2001–2002 and 2008–2009, including covering depreciation of existing assets. It was intended that NHS expenditure would continue to increase up to 2010–2011; total government spending would be over £121 billion, of which expenditure on the NHS would be almost £106 billion (Department of Health 2009c).

Fig. 3.2 shows the distribution of financial resources that was planned for 2009–2010. Of the total NHS budget, over 80% was allocated to PCTs.

Since 2003–2004, total NHS spending has also been broken down according to categories of care known as programme budget categories. These are based on data collected from PCTs and SHAs and show a breakdown of spending based on the WHO *International Classification of Diseases*. Table 3.5 shows the position in 2008–2009: the three main categories of expenditure were mental health (10.8% of the total), problems of circulation (7.6%) and cancers and tumours (5.3%). There is a large category of “other spend”, amounting to 25.7% of the total and comprising general and personal medical services (16.4% of the overall total), and miscellaneous (9.3%). Comparisons across time are not useful as changes have taken place as these categorizations have developed.

Fig. 3.2

Disposition of Department of Health resources, 2009–2010



Source: Department of Health 2009c.
Notes: Amounts may not sum exactly owing to rounding; PSS: Personal social services.

Table 3.5

NHS expenditure by programme budget, 2008–2009

Gross NHS operating costs on	£ million	% of total
Infectious disease	1 417.99	1.5
Cancers and tumours	5 130.99	5.3
Disorders of blood	1 258.92	1.3
Endocrine, nutritional and metabolic	2 529.18	2.6
Mental health disorders	10 477.25	10.8
Problems of learning disability	2 929.04	3.0
Neurological	3 694.95	3.8
Problems of vision	1 668.12	1.7
Problems of hearing	424.19	0.4
Problems of circulation	7 405.73	7.6
Problems of the respiratory system	4 247.08	4.4
Dental problems	3 098.94	3.2
Problems of the gastrointestinal system	4 096.25	4.2
Problems of the skin	1 806.82	1.9
Problems of the musculoskeletal system	4 214.93	4.4
Problems due to trauma and injuries	3 297.86	3.4
Problems of genitourinary system	4 003.69	4.1
Maternity and reproductive health	3 095.95	3.2
Conditions of neonates	1 110.22	1.1
Adverse effects and poisoning	951.72	1.0
Healthy individuals	1 915.16	2.0
Social care needs	3 155.62	3.3
Other	24 884.41	25.7
Total	**96 814.99**	**100**

Source: Department of Health 2010h.

Table 3.6 provides an alternative way of breaking down NHS expenditure: according to spending on key inputs. Salaries and wages are the largest component of expenditure (58.6% in 2002–2003) by SHAs, PCTs and NHS trusts in England.

Table 3.6

Expenditure by SHAs, PCTs and NHS trusts in England, by input, 1998–1999 to 2002–2003

	1998–1999	1999–2000	2000–2001	2001–2002	2002–2003
Revenue expenditure (£ billion)	27.3	30.6	34.0	37.2	44.2
Breakdown (%)	–	–	–	–	–
Salaries and wages	62.5	61.1	60.4	62.3	58.6
Supplies and services, clinical	11.6	11.2	11.4	11.6	10.9
Supplies and services, general	2.6	2.5	2.4	2.3	2.1
Establishment expenses	3.3	3.1	3.2	3.2	2.9
Premises and fixed plant	5.7	5.1	5.2	5.0	4.4
Miscellaneous expenditure	5.4	7.0	9.1	6.9	13.6
Cost of use of capital assets	3.9	5.4	3.3	3.3	3.5
Purchase of health care from non-NHS bodies	4.6	4.2	4.6	4.8	3.5
External contract staff	0.4	0.4	0.4	0.6	0.5

Source: Department of Health web site: http://www.performance.doh.gov.uk/HPSSS/TBL_E3.htm.
Note: these figures have not been made available for years after 2002–2003.

3.2 Population coverage and the basis for entitlement

This section considers who is covered by the NHS, and the nature of their entitlements. Similar issues for PMI schemes are considered in the next section.

The aim of the NHS in 1948 was to provide access to health care to all residents, irrespective of how much, or whether, the individual had contributed to its financing, and this remains largely the case today. The Labour Government's *NHS Plan* (Department of Health 2000a) listed as one of the ten NHS core principles that "the NHS will provide a universal service for all based on clinical need, not on ability to pay". Over time, some user charges have been introduced. These are discussed in detail in section 3.3.

Entitlement to health care under the NHS, however, depends on an individual being "ordinarily resident" in the United Kingdom. This was interpreted by a House of Lords ruling in 1982 (the House of Lords at that time was the highest court of the land) as "someone who is lawfully living in the United Kingdom voluntarily and for a settled purpose as part of the regular order of his or her life for the time being, with an identifiable purpose for his or her residence here and that purpose must have a sufficient degree of continuity to be properly described as settled" (Department of Health 2007j).

The principal regulations governing access to treatment in the NHS in England and Wales for "overseas visitors" (a term applied to all persons not ordinarily resident) are set out in law by the National Health Service (Charges to Overseas Visitors) Regulations 1989 (S.I. 306), with subsequent amendments (S.I. 438 (1991), 1535 (1994), 602 and 909 (2000), 614 (2004), 3306 (2006)).

Generally, overseas visitors are not entitled to receive free NHS treatment, although there are exceptions as laid out in the regulations referred to above. For example, overseas visitors are entitled to free treatment at accident and emergency (A&E) departments or walk-in centres in case of an immediate emergency (not including dental or ophthalmic services) but any subsequent inpatient or outpatient treatment must be paid for; for a wide range of infectious diseases; for sexually transmitted diseases (although in the case of HIV, only diagnostics not treatment is provided free); for family planning services; and for compulsory forms of psychiatric treatment. GPs are also required to provide free treatment in case of an immediate emergency.

The regulations also specify that some categories of overseas visitors are exempt from charges. This mainly relates to either people who are working in the United Kingdom in a particular job (e.g. diplomats), or for a certain period of time, or nationals of other states where there are reciprocal agreements, in particular members of the EEA but also others covered by bilateral agreements. In the case of these agreements, they are intended to cover care that becomes medically necessary during a visit in the opinion of a GP. Elective treatment is usually not covered.

There has been little change in the entitlement of residents of England to access health services in England. However, over time, governments have tightened up the regulations relating to the eligibility of people who are not ordinarily resident in the United Kingdom to access free NHS treatment. The focus has largely been on strengthening barriers to access for illegal immigrants (or others present illegally in the United Kingdom), and also to ensure that overseas visitors do not receive free treatment where they are not entitled to this. The Department of Health has sought to do this first within the hospital sector but has also begun the process in the primary care sector.

Generally, residents of England have not been entitled to receive free health care in other countries except under the kind of reciprocal agreements referred to above. However, there have been changes to the rules regarding access to services in other countries, in particular with respect to other European countries. According to recent guidance (Department of Health 2010g), relating primarily to a European Court of Justice ruling[6] and a subsequent draft European directive, commissioners of health care in England must ensure they have procedures in place to handle requests for residents to go to other European countries for treatment and, equally, providers must be prepared to receive residents of other European countries. The Department of Health now recognizes that people should be able to access health care in other European countries, although a key criterion is whether a patient is experiencing "undue delay" in receiving treatment (see section 2.5.4 for more detailed discussion of these issues).

3.2.1 NHS benefits

Coverage through the NHS is not based on a defined list of benefits. Rather, under the National Health Service Act 1977, the Secretary of State for Health has a duty to provide health services "to such extent as he considers necessary to meet all reasonable requirements". However, for the first time, with the publication of the NHS Constitution for England in 2009, subsequently updated in 2010 (Department of Health 2010e), a set of rights has been established for patients, the public and staff with respect to the NHS. The Health Act 2009 included a requirement that NHS organizations take account of the NHS Constitution when performing their functions. However, this NHS Constitution is primarily a set of rights based on existing legislation (see section 2.5.1 for more detailed discussion).

In the past GPs have always been free to reject any applicant wishing to join their NHS list unless that person was formally assigned by a health authority or PCT. However, under the current GP contract, the contractor "can only refuse an applicant to join its list if it has reasonable grounds for doing so which do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition" (General Practitioners Committee 2004).

The overarching principle of benefits coverage since the inception of the NHS has been that coverage should be comprehensive. In practice, comprehensive means that all health care services that might reasonably be included in the

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[6] The Watts ruling, Judgment of the European Court of Justice (ECJ), 16 May 2006, Case C-373/04.

benefits package will be included. It is not a promise that everything will be covered. In fact, the term "comprehensive" leaves enough space for significant discretion to be exercised by decision-makers in determining which services will be provided through NHS funding. The exercise of this discretion rests with the Secretary of State for Health and, through delegation, the SHAs and PCTs.

In 1952, user charges were introduced for some NHS-funded items (dental care and ophthalmic care), representing a reduction in cover through reduced financial depth of cover. More recently, scope of cover (i.e. benefits covered) has been reduced in the area of long-term care, with the NHS excluding personal care from cover through the introduction of means-testing. For further information on out-of-pocket payments, dental care and long-term care, see section 3.3.3 and Chapter 6.

Local autonomy

Decisions on user charges for patients and on major exclusions are made centrally. Other, less significant (although no doubt equally significant at the level of the individual patient) exclusion decisions are made locally. Although the NHS is a national organization, it is organized and administered on a local basis through PCTs, which purchase or commission health services for their geographically defined populations and make choices about the type and quantity of services to be provided within the constraint of fixed budgets.

Local autonomy in making coverage decisions has led to intra-area variation in the range of services provided; the delegation of explicit responsibility for purchasing and coverage decisions to the local level in 1991, through health authorities and now PCTs, was one of the main reasons for heightened awareness of rationing in the NHS during the 1990s. In recent years, there have been a number of high-profile public debates focusing on decisions by particular PCTs to restrict the provision of certain services for particular individuals.

After the Human Rights Act 1998 was passed (incorporating the European Convention on Human Rights into United Kingdom law) and came into force in 2001, there were fears about the effect the Act might have on local autonomy in the area of health care benefits. The Act makes it unlawful for a public authority (including the Department of Health, NHS bodies and individual doctors working in the NHS) to "act in a way which is incompatible with a Convention right" (Section 6). However, these fears have been largely unfounded. The courts have clearly acknowledged the need of health bodies to set priorities, given limited resources, but they must also be able to demonstrate that their coverage decisions do not discriminate unfairly and have been made in the best interest of the wider community. For example, bans on treatment for specific groups such as smokers might be viewed as illegal under the Act.

Faced with the need to make difficult decisions about coverage, a number of approaches to priority setting have been developed. The government encouraged health authorities and now PCTs to involve the general public in decisions about rationing and priority setting. At the local level, numerous methods for eliciting the public's views have been used, including population surveys, public meetings, focus groups and citizens' juries. Since 2000, the government has sought to address the issue of "postcode rationing" (geographical differences in coverage) through the use of health technology assessment (HTA) by NICE. NICE provides guidelines for NHS purchasers and providers across England and Wales in the following three areas:

- clinical practice (guidance on appropriate treatment and care for given conditions);
- health technologies (guidance on the use and take-up of existing technologies and new technologies); and
- public health (guidance on health promotion and disease prevention).

Until 2002, NHS adoption of NICE guidelines on the use and provision of health technologies was strongly encouraged but not obligatory. NHS organizations in England are now required to provide funding for medicines and treatments recommended by NICE in its technology appraisals, usually within three months of guidance being issued. If NICE recommends that a technology or drug is not adopted, there is an equal obligation for NHS organizations to follow the guidance (NICE 2008). When NICE approves a new technology, resources to provide the technology will come from existing budgets. This may mean reallocating resources from already established areas of provision, and hence a service already covered will be rationed. HTA is discussed in more detail in section 4.2.2.

Controversy arose over the issue of "top-up" payments by patients – primarily for expensive cancer drugs. This involved the payment by patients for drugs not available through the NHS. These patients were then excluded from those elements of their NHS care that would have been free. Following a review of the situation in 2008, this policy was changed so that patients who pay "top-up" fees for additional drugs, under certain circumstances, still receive their care free from the NHS (Richards 2008).

Entitlement to drugs

The Medicines Act 1968 describes three types of drug as available in England:

- those on the General Sale List, which can be supplied by someone other than a pharmacist;
- those that can be supplied usually only through a pharmacy (or other health care professionals such as doctors, dentists, nurses): the OTC drugs; and
- prescription-only medicines (POMs).

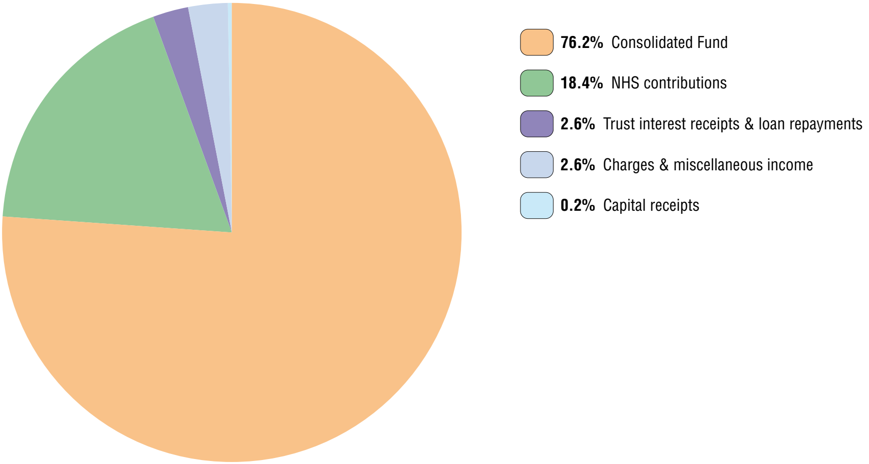
In addition, there are two types of restriction on drugs that can be prescribed through the NHS. The first, known as the "Black List", covers pharmaceutical products that cannot be prescribed by the NHS under Schedule 1 of the National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004 (S.I. 629). This list is provided as Part XVIIIA of the Drug Tariff, produced by the NHS Prescription Pricing Authority. A second list (Schedule 2 of the same regulations), known as the "Selected List Scheme" or the "Grey List", comprises drugs that may be prescribed under certain circumstances, for given groups of patients only, or for certain specific conditions only. This list is also accessible as Part XVIIIB of the Drug Tariff (National Prescribing Centre 2004). Finally, local health care bodies, mainly for reasons of cost, often operate their own "grey list" of drugs that they encourage local GPs not to prescribe.

3.3 Sources of funds

Most revenue for the health care system in England is provided by public sources (general taxation, NICs and some local taxation), with the rest through private sources, primarily PMI, NHS user charges and direct payments for private care (Fig. 3.3). Each of these is considered in turn.

Fig. 3.3

Sources of finance for NHS expenditure, 2006–2007



Source: Department of Health 2006f.
Note: These figures have not been made available after 2006–2007.

As Table 3.1 showed, public expenditure remains the main source of spending on health care in the United Kingdom, at almost 83% in 2008. The NHS is financed mainly through general taxation with an element coming from NICs. Fig. 3.3 shows, 94.6% of financing for the NHS in England in 2006–2007 came from these two sources, 76.2% from the Consolidated Fund (general taxation) and 18.4% from the NHS element of NICs (Department of Health 2006f). The remainder of NHS financing comes from charges and receipts, including land sales and proceeds from income-generation schemes.

3.3.1 Compulsory sources of financing

Most of the funding for health care in England is provided from government receipts mainly accruing through taxation. Taxes tend not to be earmarked for a particular purpose. The economic climate in England, and indeed across the world, changed drastically with a move into recession in the latter part of 2008. The result has been a reduction in expected receipts and a limited increase in discretionary spending in 2009–2010 compared with previous years. Consequently, whereas planned total government receipts for 2008–2009 were £575 billion, just £533.8 billion was raised. It is estimated that there was a further reduction in total receipts in 2009–2010 to £514.6 billion, of which £95.6 billion was generated from NICs, £145.6 billion from income tax and the rest from a range of taxes including corporation, excise, value-added tax (VAT) and property rates (council tax and business rates) (HM Treasury 2010). Although there was an increase in expenditure between 2008–2009 and 2009–2010, from £621 billion to £671 billion, most of this related to social protection, with limited increases expected in health spending, as shown below (HM Treasury 2009a). The latest estimate suggests that total expenditure in 2009–2010 was £669 billion, of which some £119 billion was spent on health and £31 billion on personal social services (HM Treasury 2010).

General taxation

The main source of finance for the NHS in England is general taxation. HM Revenue and Customs is the government department responsible for administering and collecting taxes. The main sources of general taxation are income tax, VAT, corporation tax and excise duties (on fuel, alcohol and tobacco). HM Revenue and Customs provides estimates of the cost of collecting taxes; in 2006–2007 this was 1.25% of total tax take for income tax, 0.6% for VAT and 0.79% for corporation tax, with an overall cost of 1.13% for the whole tax take (HM Revenue and Customs 2007). Although tax compliance levels are uncertain, HM Revenue and Customs estimated that in 2008–2009 there was a total tax loss of some £42 billion, of which £15.2 billion related to VAT revenues; £14.5 billion to income tax, NICs and capital gains tax; and £6.9 billion to corporation tax. It was estimated that in 2008–2009, the total VAT loss was 16% of expected revenue (HM Revenue and Customs 2010).

Income tax had accounted for £153.5 billion of government receipts in 2008–2009,[7] which amounted to 10.7% of GDP. It is estimated that this had fallen to £145.6 billion in 2009–2010 (HM Treasury 2010). The government sets rates of taxation on income in its annual Budget (HM Treasury 2009a). These rates are mildly progressive, with a small income allowance that is non-taxable[8] (in 2010–2011 this was £6475), after which a rate of 20% applied to the first £37 400 earned, a rate of 40% to the next £112 600, and a rate of 50% thereafter. Allowances vary slightly for people over the age of 65 years. Both earned and unearned income are taxable, and there is no ceiling on the level of income which is taxable.

VAT is essentially a sales tax applied to most business transactions that involve the transfer of goods and services. This includes most consumer expenditure, imports and exports, and transfers of goods and services

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[7] This is gross of tax credits, which amounted to £5.6 billion in 2008–2009.

[8] For people with an income more than £100 000, this allowance is reduced by £1 for each £2 above £100 000.

between businesses. The standard rate of VAT has been 17.5% for some years.[9] A reduced VAT rate (5%) applies to certain goods and services (e.g. domestic fuel and power, smoking cessation products) and other items, such as food, books and children's clothes, have a zero rate. VAT in 2008–2009 accounted for £78.4 billion of government receipts, amounting to 5.5% of GDP. It is estimated that this had fallen to £70.1 billion in 2009–2010 (HM Treasury 2010).

Corporation tax is a tax on the profits of businesses. In 2010–2011, small companies (i.e. with annual profits under £1.5 million) paid corporation tax at a rate of 21% while businesses with profits over that level paid tax at 28%. Corporation tax in 2008–2009 accounted for £43.7 billion of government receipts, amounting to 3.1% of GDP. It is estimated that this had fallen to £36.5 billion in 2009–2010 (HM Treasury 2010).

NICs

NICs are compulsory contributions paid by employers, employees and self-employed people on earned income only (i.e. not on pensions, interest or dividends) and 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 (rather than income) with no ceiling on the level of earnings at which they were paid (although the employee rate falls to 1% for earnings over £844 per week). For self-employed people, NICs are levied at 8% on profits over £5715, and 1% on profits over £43 875 (HM Treasury 2010).

NICs are intended to provide an entitlement to contributory benefits such as state pensions, state sickness benefit and unemployment benefit; although entitlement to health care is not an earned entitlement, by a quirk of history at the time of the introduction of the NHS, part of the money collected through NICs is spent on the NHS. For example, NICs are used to fund statutory benefits such as Jobseeker's Allowance, Incapacity Benefit, Bereavement Benefits, Retirement Pension and Maternity Allowance. They are also used to fund the NHS (around 10% of total NIC revenue) although entitlement to NHS treatment is not based on having paid NICs. NICs in 2008–2009 accounted for £96.9 billion of government receipts, amounting to 6.8% of GDP. It is estimated that this had fallen to £95.6 billion in 2009–2010 (HM Treasury 2010).

This proportion has increased significantly in recent years following the decision by the Labour Government in 2002 to provide a substantial increase in expenditure on the NHS, and to fund this through an increase in NICs, which

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[9] In December 2008, it was reduced on a temporary basis to 15% as a response to the global economic crisis, returning to 17.5% in January 2010. In January 2011, it increased to 20%.

would be earmarked for the NHS (House of Commons Library 2002). Thus, in 2003–2004, NICs were increased by 1% for employees, employers and the self-employed; in addition, the ceiling on income to which NICs was applicable was removed and 1% was charged on all income above £595 per week at that time (this level has since increased to £844 per week in 2010–2011).

In general, taxes are not earmarked for health care and so it is no simple matter to identify in England how progressive the payments system for health care is. However, to the extent that the overall tax system is mildly progressive, and that most of expenditure on health care is through public finances then it may also be regarded as mildly progressive. Wagstaff and colleagues (1999) carried out a detailed comparative study for 12 OECD countries of equity in financing health care in which they separated out direct taxes, indirect taxes, social insurance (NICs), private insurance and out-of-pocket payments, and under certain assumptions estimated the overall degree of progressivity, and that attributable to different forms of financing. Based on data from 1993, they found that overall the financing system in the United Kingdom is mildly progressive: in particular, direct taxes are progressive, NICs are also progressive but less so, and indirect taxes are regressive.

However, Townsend (2003) found that direct taxes in 2001–2002 (including social insurance) were progressive in that the 20% of households with the highest equivalized gross income paid 24% of income as direct tax compared with 12% paid by the lowest 20%. On the other hand, indirect taxes were regressive, accounting for 30% of the gross income of the lowest 20% compared with only 10% for the highest 20%. Combined direct and indirect taxes appeared to be regressive as these accounted for 42% of the gross income of the lowest 20% compared with 34% of the highest 20%.

As discussed above, collection through general taxation means that the costs of collection are kept low; funds destined for the NHS are collected as part of the general tax collection process. The general tax-based system of finance does, however, mean that the degree of transparency (i.e. the relationship between individual tax payments and the benefits received from the NHS) is relatively low.

Local taxation

Social services, including home care and residential care, are partly funded by local taxation (council tax and business rates). These taxes do not fund health care. Rates of council tax vary between local authorities and are banded according to the value of the property in which local residents live. Some differential rates are applied depending on the status of the occupiers (e.g. students, single occupants, or people for whom it is a second home). Levels of business rates also vary between local authorities. It is estimated that local business rates accounted for £22.9 billion of government receipts in 2008–2009, and council tax for £24.4 billion, amounting to 1.6% and 1.7% of GDP, respectively (HM Treasury 2010).

3.3.2 PMI

PMI can be categorized as (Mossialos and Thomson 2002):

- *substitutive* in the sense that it provides cover that would otherwise be available from the state but where either state cover is not available to a class of individuals or an individual has opted out;
- *complementary* in the sense of providing cover for services excluded or not fully covered by the state and would typically include cover for co-payments; and
- *supplementary* in the sense of providing cover for enhanced services such as faster access and increased consumer choice.

Supplementary insurance is the dominant form in England.

Individual and corporate markets

PMI is bought either by individuals (and might include cover for dependants) or by groups, usually employers as part of their benefits package for employees. Most employer insurance is provided through insurance companies. However, since the early 1990s, there has been a growth in the number of self-insurer medical schemes administered by third-party administrators,[10] growing from 2.5% to 18.2% of the total employer insurance market between 1992 and 2006 (Laing & Buisson 2007).

Most of the data available on PMI refer to the United Kingdom as a whole. In the United Kingdom, individual insurance represented just 25% of the market (by number of policies) in 2007 (Blackburn 2007). A range of cover is available and, for individual insurance, contracts tend to be renewable on an annual basis. For policies purchased by employers, the employer may pay the whole premium or employees may be required to make a contribution. Cover may be extended to the dependants of employees, and contracts tend to be renewed monthly, six-monthly or annually.

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[10] Self-insurer schemes are ones where medical expenses are paid by the employer either directly or through a trust fund. In some cases these schemes are administered by insurers.

Contribution to total expenditure on health care

The contribution of PMI (as measured by premium income) to total health care expenditure is small relative to that of public expenditure (Table 3.7). According to OECD figures, in 2008, United Kingdom public expenditure amounted to £103.6 billion, or around 83% of the total, while the contribution of PMI was £3.6 billion, or 2.9% of the total (Laing & Buisson 2009).

Table 3.7

United Kingdom expenditure on health care by source, 1997–2008

Expenditure (£ billion)	1997	1999	2001	2003	2005	2007	2008
Public	44.2	51.8	59.4	71.1	84.8	96.7	103.6
Private	10.8	12.5	14.9	17.7	18.8	21.3	21.8
Private as PMI	2.0	2.2	2.7	3.0	3.1	3.4	3.6
Individual market	1.1	1.1	1.3	1.5	1.6	1.8	na
Corporate market	1.0	1.1	1.4	1.4	1.5	1.6	na

Sources: Laing & Buisson 2008, 2009 (for PMI); OECD 2010a (for public and private expenditure).
Note: na: Not available.

Population coverage

Coverage for treatment is on the basis of a private contract between the subscriber (the individual who is buying insurance) and the insurer. At the point of treatment, there is a contract between the insurer and the provider facility, and between the subscriber and the specialist physician or surgeon. These contracts are non-transferable and apply only to the named parties.

At the end of 2008, there were almost 4.4 million subscribers to PMI in the United Kingdom, and cover was extended to a further 3.2 million people (subscriber dependants), giving a total of 7.6 million covered individuals[11] or 12.3% of the United Kingdom population (Laing & Buisson 2008, 2009), a substantial increase on coverage in 1971 of 2.1 million people (Matheson & Summerfield 2000). Most of these – 3.3 million – were employer insurance schemes, with just 1.1 million individual schemes (Table 3.8). Coverage in England in 2006 was 13% (Laing & Buisson 2009). Research suggests that subscribers tend to be aged between 56 and 64 years, male, live in wealthier areas such as London, the east and southeast of England, have post-school education, be employed in a higher occupational status, vote for the centre-right Conservative Party, and belong to higher-income groups (King & Mossialos 2005). Thus, coverage in the southeast of England in 2006 was 18.5%, in London it was 17.5% and in the east it was 16% (Laing & Buisson 2009).

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[11] This includes people on self-insured employer schemes.

Table 3.8
Private medical insurance coverage in the United Kingdom, 1992–2008

	Subscriber numbers (millions)			Total people covered (millions)			Total coverage as % UK population		
	Individual	Corporate	Corporate self-insure	Individual	Corporate	Corporate self-insure	Individual	Corporate[a]	**Total**
1992	1.35	2.02	0.06	2.51	4.15	0.12	4.4	7.2	**11.6**
1998	1.34	2.25	0.19	2.21	4.60	0.42	3.8	7.9	**11.7**
2001	1.21	2.51	0.42	2.04	4.62	0.78	3.5	7.8	**11.3**
2004	1.16	2.44	0.60	1.97	4.55	1.11	3.3	7.6	**10.7**
2005	1.12	2.45	0.61	1.89	4.59	1.10	3.1	7.6	**10.6**
2006	1.10	2.53	0.63	1.80	4.60	1.11	3.0	7.6	**10.4**
2007	1.09	2.59	0.66	1.77	4.69	1.17	2.9	7.7	**10.5**
2008	1.11	2.59	0.67	1.79	4.66	1.20	2.9	7.6	**10.4**

Sources: Laing & Buisson 2008, 2009.
Note: [a] Does not include people on self-insured employer schemes.

The overall level of demand for PMI (excluding employer schemes) fell between 2001 and 2005 by 3.9%, but by 2008 had almost recovered to its 2001 level. This reflects a steady decline in subscriber numbers in the individual market since 1992, which has been offset to some extent by an increase in corporate market subscriber numbers in most years. In addition, employer schemes increased substantially and by 2008 there were almost 0.67 million subscribers to these schemes. The individual market has fallen significantly, from 1.35 million in 1992 to 1.11 million in 2008. This contraction can be related, in part, to growth in the corporate market, with individuals newly covered by their employers giving up their individual cover. It may also, however, reflect a combination of several other factors, including the removal in 1997 of tax relief on PMI for those aged over 60 years, the success of substitutes for PMI such as "self pay", increased coverage of employer schemes and some large premium increases introduced in response to high expenditure on claims (Laing & Buisson 2008, 2009).

Package of benefits

PMI provides cover for "the costs of private medical treatment for what are commonly known as acute conditions that start after the insurance begins" (Association of British Insurers 2008). Most insurers define acute to mean a condition that is likely to respond quickly to treatment. Although cover may be provided for long-term chronic conditions and cancers, the standard product does not usually cover these. Therefore, PMI finances care that is narrower in scope than the comprehensive cover offered by the NHS.

Although insurers are free to determine what benefits they offer, most PMI packages cover surgery as an inpatient or day case, hospital accommodation and nursing care, and inpatient tests. However, outpatient consultations and tests, and therapies such as physiotherapy, are less likely to be covered, or only at a higher price. Most benefit packages have a number of standard exclusions: cover is usually not offered for GP-provided care, A&E care, normal pregnancy, dental services, war risk and typically expensive items such as organ transplant. There is also a more general exclusion of pre-existing conditions (conditions existing at the time of application).

Most insurance companies offer a range of products that cover more than the core "acute care" benefits that are common to all PMI products. These differences in scope of cover are reflected in the price. Cheaper policies may limit cover to treatment for acute conditions and will significantly restrict access to associated outpatient care. They may also incorporate automatic restrictions on choice of treatment facility or place restrictions on the initiation of PMI-financed care, for example, limiting PMI cover to conditions for which the local NHS waiting list is longer than six weeks. PMI mainly pays for patients to attend private hospitals and to a lesser extent NHS private patient units and pay-beds. Payments to private hospitals usually consist of two elements: the facility charge and the specialist fee. The former tends to be reimbursed directly to the provider, while the latter is paid by patients to specialists first and then reimbursement is claimed from the insurer. Insurers operate fee schedules, and the subscriber will often be expected to make up the shortfall if specialist charges are more than the set fee for a given procedure. Facility charges will already have been negotiated between the facility and the insurer.

Calculating premiums

Premium price is determined by four factors:

- scope of cover (discussed briefly above);
- additional product options;
- nature and degree of risk the insurer assumes, which rests on underwriting and risk-rating in the individual market and on experience-rating in the main part of the corporate market; and
- a loading charge reflecting the insurer's profits, administrative costs and reinsurance payments, and also the insurance premium tax, which was set at 5% of the premium in 2009.

Product options

Variations in the product will also affect premium price. Often these options are designed to reduce price, although extending cover to dependants increases the price. The main options are restriction of choice of treatment facility – to a network of approved hospitals, often where the insurer has negotiated a discount – and cost sharing, usually in the form of an excess charge (i.e. an amount the subscriber pays towards the cost of any claim with the insurer paying the balance). Often these out-of-pocket payments are limited in any one year. Recently, the market has offered high-excess policies, thereby attracting subscribers who are content to be covered only for care that is of very high cost. These excess-charge policies are widespread across both the individual and the corporate markets. Fixed-price cover is also now on offer where premiums are fixed for a period of five or ten years (Laing & Buisson 2007).

Nature and degree of risk

The individual and corporate health insurance markets have adopted different approaches to assessing risk: the first tends to calculate risk on an individual basis, the second on the basis of the insured group's previous experience.

PMI insurers assess individual risk in two main ways: full medical underwriting[12] and moratorium underwriting. The former requires the applicant to disclose full medical information relating to past and present health status and care-seeking activities. The insurer then decides which conditions to exclude from cover, assesses the risk and determines the price. Moratorium underwriting involves gathering less information prior to purchase. However, when a claim is made, a range of conditions will have been excluded depending on the conditions of insurance and the individual's medical history (most often conditions suffered in the five years prior to policy commencement are automatically excluded for at least two years). Insurers price risk mainly on age, although other factors such as sex, smoking status and occupational status may be taken into account. Older subscribers are charged higher premiums than younger ones and insurers usually place a ceiling on the age at which new applicants can be accepted. Genetic testing is not currently included as a condition when applying for PMI.

In the corporate market, there is almost no individual underwriting.[13] Instead, the premium is priced on the basis of the claims experience of the group in the previous year. Corporate schemes require cover to be extended to all employees within a given category, for example, to all those at a particular level of seniority or all those in a particular age group, so as to avoid the adverse selection problems that would arise from employers choosing to extend cover only to employees whom they know to be at higher risk of incurring a loss.

Individual insurance policies are guaranteed renewal at the end of the contract year. The premium may be adjusted to reflect any expected changes in aggregate claims expenditure across the insured pool as a whole, general and medical inflation and changes in the loading charge. The premium will also be adjusted if the subscriber moves into a new age category. Renewal of group insurance policies is not guaranteed; the insurer may decide to alter the terms of the contract or refuse to renew if the claims experience has been sufficiently adverse.

Insurer loading

Insurer gross margins aggregated for the industry as a whole – defined as the excess of premium income over claims expenditure – were 23.6% in 2003, their highest level since the late 1970s, and an increase from 20.7% in 1997.

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[12] Underwriting is the term used for the process by which an insurer determines the nature and amount of risk involved.

[13] Although for companies with fewer than 50 employees, insurers may use individual underwriting and risk-rating alongside claims history.

This resulted from margin increases in the corporate market between 1997 and 2002 from 14.7% to 20.4%. The individual market remained relatively constant at around 26%. By the end of 2006, the overall margin had fallen back to 22.5%. Margins remained higher in the individual market than in the corporate market, reflecting more intense price competition in the latter and the ability of insurers in the individual market to pass on price increases without significant reduction in subscriber numbers. However, recent increases in corporate market premiums have led to a narrowing of the gap in margins between the two markets (Laing & Buisson 2007).

Regulation

The market for PMI in the United Kingdom differs from some other European countries in that there is no regulation of the product or of pricing. Formal regulation has historically been limited to financial regulation of the insurance product with the aim of ensuring company solvency. Since January 2005, however, partly in response to the need to incorporate the EU Insurance Mediation Directive (European Parliament and Council 2003) into United Kingdom law, there has also been formal regulation of insurance sales and administration.

The Office of Fair Trading (the regulatory agency responsible for consumer protection) had been critical of the industry in the United Kingdom and highlighted three major areas of concern: the difficulty of product comparison in terms of value for money, lack of clarity in moratorium underwriting, and the failure of insurers to provide information on past and likely future premium increases (Office of Fair Trading 1996, 1998). In January 2004, the General Insurance Standards Council, the industry's self-regulatory body, introduced a "Practice Requirement" for insurers selling PMI. This partly required insurers to include a common-format core benefits table in their product literature to aid product comparison, and to improve the information and advice provided in relation to moratorium underwriting. This Practice Requirement was in place for one year only as the General Insurance Standards Council was disbanded in January 2005 and regulation of insurance sales became a function of the Financial Services Authority. Regulation is in the spirit of the Practice Requirement but makes more stringent demands on the provision of information and advice at the point of sale. The Financial Services Authority also ensures that insurers have adequate finances in place and appropriate systems of financial control (Laing & Buisson 2007).

All insurers are also required to have a complaints system. If a complaint is not resolved, the consumer can complain to the Financial Ombudsman Service. There are no tax incentives to encourage people to buy PMI. Tax relief was introduced for subscribers aged over 60 years in 1990 under a Conservative Government but this was abolished by a Labour Government in 1997.

Industry composition and performance

The PMI industry is a mixture of provident (not for profit) associations and commercial (for profit) companies. This distinction, however, appears insignificant in terms of market behaviour and in terms of the operation of regulatory oversight. The largest insurer is BUPA (a provident provider), with over 42% of the market in 2006 as measured by premium income; next is AXA PPP with a 24% share; and then Norwich Union and Standard Life. These four between them accounted for 83.5% of the market in 2006 (Laing & Buisson 2007). Private hospital charges are the outcome of bilateral confidential negotiations between insurers and providers. In some cases, insurers may also be significant providers of private services (e.g. BUPA).

Future developments

In the corporate market, product development has centred on health-management processes – as part of enhanced benefit plans – designed to promote health and to identify illness earlier on. These include information and counselling services, online advice services, screening, rehabilitation services, occupational health services, physiotherapy and health promotion. Any resulting savings in claims expenditure can be passed on to the purchaser in the form of a reduced premium or reduced premium inflation. Another recent development has been the introduction of menu-based schemes so that employers can select from a choice of options in addition to core cover for their workforce.

Recent developments in the individual market have seen some insurers offering screening and also the appearance of products that reward subscribers – by reducing their premiums – who pursue healthy activities such as exercising. Another development has been the introduction of products that allow subscribers to combine PMI with other forms of insurance, such as critical illness insurance, or with saving plans such as medical savings accounts. Some companies have also begun to extend NHS “top-up” plans to high-cost treatments such as new cancer drugs (Laing & Buisson 2007).

3.3.3 Out-of-pocket payments

Most NHS health care is free at the point of use. However, some services are either not covered by the NHS and patients must, therefore, pay themselves (direct payments) or are covered by the NHS but subject to cost sharing usually in the form of co-payments. Informal payments are not a feature of the health system in England.

Direct payments cover private treatment in NHS facilities, OTC medicines, ophthalmic services and social care; co-payments cover NHS prescriptions and NHS dental care. Most out-of-pocket payments by individuals are direct, with some 41% devoted to OTC medicines; user charges for NHS services are the next largest part, accounting for 13% of the total. For further information on OTC medicines and PMI, see sections 6.6 and 3.3.2 respectively. Between 1990 and 1997, total expenditure on out-of-pocket payments per capita population in the United Kingdom increased by over 100%, from £62 to £133; between 1997 and 2008, the rate of increase in expenditure was somewhat less, in total increasing by 73% to £230 per capita (OECD 2010a).

Table 3.9 provides an overview of out-of-pocket payments for different types of care, as well as the mechanisms in place to minimize financial barriers to access. These range from outright exemptions for some groups of people to reduced rates, caps on overall spending and insurance policies. Each type of care is discussed in more detail below.

Table 3.9

Overview of out-of-pocket payments for different types of health care

Type of payment	Type of care	Protection mechanisms
Direct payments	Private treatment in NHS trusts or private hospitals and clinics (self-pay)	PMI policies
	Ophthalmic services	Exemptions, reduced rates (NHS vouchers)
	Social care	Exemptions, reduced rates, private long-term care insurance policies
	OTC medicines	None
Co-payment (flat fee per prescription)	NHS prescriptions	Exemptions, reduced rates (pre-payment)
Co-payment (three fees according to complexity of course of treatment)	NHS dental care	Exemptions, maximum charge for complex courses of treatment

Private treatment (self-pay)

Direct payments for private treatment are mainly for acute elective surgical procedures. Most expenditure on private acute hospital care in the United Kingdom is funded through PMI (61% in 2008), although self-payers accounted for 14% of the total.[14] The proportion has fallen considerably since 1981 when it constituted 28% of the total. It is estimated that the value of the self-pay market in 2008 was £448 million (Laing & Buisson 2009).

The self-pay market had grown between 1992–1993 (13% of total private acute) and 2006 (18%) partly in response to perceptions about the quality of NHS treatment, encouraged by intense media publicity about shortages and waiting lists for NHS treatment. However, this changed as the public became more aware of substantial improvements in NHS waiting times. In addition, NHS use of the private sector also grew significantly between 2006 and 2008, from 14.5% of the total private acute market to over 23% (Laing & Buisson 2007, 2009).

Private hospitals have made their services more accessible to patients without PMI, through, for example, fixed price packages in which the total cost of the treatment is agreed in advance, even if unexpected complications arise, thus reducing uncertainty about the size of the eventual bill. However, fixed price packages usually only apply to routine surgical procedures such as hip and knee replacements, cataract surgery and hernia operations and are much less likely to be available for medical conditions such as cancer treatment. Independent advisory services have been established to help patients to locate an appropriate provider in return for a fee, and some PMI companies now offer special self-pay packages.

Ophthalmic services

Universal ophthalmic services are not available under the NHS. Instead, eligibility for free NHS-funded sight tests and assistance with the purchase of glasses are targeted at certain groups. Charges were introduced for glasses in 1952 and, in 1988, the free NHS sight test was abolished except for certain groups – children, students and adults on low incomes. In 1999, entitlement to free tests was also extended to people aged 60 years and over (Department of Health 2006g). Most ophthalmic services are now provided on a commercial basis by private opticians. The majority of tests are carried out according to a protocol agreed with the Department of Health.

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[14] NHS expenditure accounted for another 23.1% and the rest is mainly from non-UK patients.

Free sight tests are available to children (i.e. people aged under 16 years), full-time students aged 16–19 years, people aged 60 years and over, people on low incomes, people who are diabetic, and people who have, or are at risk of having, glaucoma. There were approximately 10.5 million free sight tests in England in 2006–2007, estimated to be almost 70% of the total sight tests carried out in that year; over 40% of free tests were for people aged 60 years and over.

Children, young people in full-time education, people aged 60 years and over, and people on low income are also entitled to assistance with the cost of their glasses or contact lenses through an optical voucher system, as are people who are prescribed complex lenses. There were approximately 3.8 million vouchers issued in 2006–2007, almost 65% of which were for people with low incomes (Information Centre 2007b).

Social care

In England, social care services are provided through local government – local authority social service departments – and are subject to user charges on the basis of means-testing (with the exception of nursing costs in nursing homes). More detail of the structure of service provision is provided in section 6.8.

For many years, the distinction between health and social care was blurred as many local authorities did not charge for domiciliary social care and much long-term nursing care was provided free by the NHS in long-stay wards and community hospitals. However, the decline in long-stay hospital bed provision and increase in residential and nursing home care provision since the 1980s has led to a shift from services that are free at the point of use to services that are means-tested (House of Commons Select Committee on Health 2005).

Currently, all those requiring social care are subject to a needs assessment carried out by the local authority in collaboration with the individual, their family and potential providers. People assessed as being eligible for a package of home or residential social care must then undergo a means test, which takes into account the individual's income and capital assets, including the value of equity in their home, but not the income and assets of spouses and children. In 2010–2011, anyone with assets in excess of £23 250 must meet the costs in full; anyone with assets in excess of £14 250 must make a contribution towards the costs of nursing home or residential care from their assets until such point that assets are reduced to below this amount. In addition, an individual is required to pay towards the cost from any pension income received (Department of Health 2010i).

It has been estimated that, on average across all users, 57% of the costs of long-term care is provided by public expenditure: 6% by the NHS (for nursing care in nursing homes), 46% by local authorities and 5% by disability benefits. The remaining 43% comes from private user charges. Users in the highest income quintile meet just over two-thirds of the proportion of their care costs from their own resources, compared with under 45% in each of the other income groups. Owner-occupiers contribute around one-half of the costs from their own resources, compared with around one-quarter for non-owners. Local authorities meet 42% of the care costs of owner-occupiers compared with 66% for others (Hancock et al. 2007).

The existence of user charges for social care and the way in which the level of payment is determined through means-testing are controversial issues. Some argue that they break an implicit social contract between the government and older people. The debate as to whether long-term care should be a public or private responsibility continues (see section 6.8 for more discussion).

OTC medicines

By their nature, payments for OTC medicines are direct payments by the individual. No eligibility criteria for free OTC medicines apply, although some patients may receive prescriptions for medicines that are also obtainable as OTC drugs without a prescription, and this may reflect some informal system based on their perceived need.

NHS prescription charges

NHS prescription charges are a form of co-payment operating in the NHS in England (these charges have been abolished in Wales and Northern Ireland, and will be phased out in Scotland by April 2011). Legislation was passed in 1949 giving the power to charge for prescriptions, but user charges for prescriptions were first introduced in 1952 and have been in place since then, apart from a period between 1965 and 1968 when there was no charge.

The level of the prescription charge has increased sharply over time. Between 1979 and 1999, the price increased from £0.20 to £5.80 (in real terms this was a 500% increase). More recently, the government has ensured that any increase in the prescription charge is no more than the rate of inflation (Department of Health 2008c). In 2002, the Prescriptions Pricing Authority became responsible for administering the prescription charge regime, processing prescriptions and authorizing payments. In 2006, the Prescriptions Pricing Authority became part of the NHS Business Services Authority, a special health authority, and is now known as the NHS Prescription Services.

The prescription charge is set at a flat fee that is not related to the amount prescribed or the actual cost of the prescribed item to the NHS. The charge is £7.20 per item (from 1 April 2010), which is about 72% of the average total prescription cost (in 2008). However, widespread exemptions from prescription charges are in place, and, as a result, about 50% of the population are exempt from charges. Around 94% of all prescription items were dispensed free of charge in 2009, an increase from 85% in 1996–1997. People exempt from charges include children (i.e. those aged under 16 years), full-time students aged 16–19 years, people aged 60 years and over, pregnant women and women who have given birth in the previous 12 months, people with specified medical conditions, and people on the NHS low-income scheme. In April 2009, patients undergoing treatment for cancer were added to the list of exemptions. People aged 60 years and over account for almost 60% of free prescriptions (Information Centre 2008d). In addition, prescriptions for contraceptives are free.

Patients who require a large number of items prescribed over a period of time can obtain a reduced charge by buying prescription pre-payment certificates, which provide a fixed cost for a period of 3 or 12 months during which the patient may obtain an unlimited number of items with no further payment. In April 2010, the pre-payment certificate cost £28.25 for three months and £104 for 12 months. In 2006–2007, a charge was paid for 11.4% of all items dispensed: 7.1% at the point of supply and 4.3% using a pre-payment certificate. By 2009, a charge was paid at the point of supply for only 6% of all items dispensed (Information Centre 2010d).[15] Nevertheless, despite these exemptions and the availability of pre-payment certificates, there is evidence that patients are deterred from using prescription medicines (House of Commons Select Committee on Health 2006a).

NHS dental care

NHS dental services are another example where co-payments apply. The NHS general dental services are provided by independent dentists under agreements made with local health authorities. More detail of the structure of service provision is provided in section 6.12. Almost half the population of England was registered with an NHS dentist in March 2006, 45% of adults and 64% of children; this is a fall from the figures in 1997, when over 54% of the population were registered (Information Centre 2006a).

There are currently (as of 1 April 2010) three charging bands for NHS dental treatment.

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[15] Data are no longer available that allow a distinction to be made between pre-paid and free items.

Band 1: £16.50. This includes examination, diagnosis (e.g. X-rays) and preventive care; it also includes scale and polish if required; urgent care also costs £16.50.

Band 2: £45.60. This includes all necessary treatment covered under band 1 plus additional treatment such as fillings, root canal work or extractions.

Band 3: £198. This includes all necessary treatment covered under band 2 plus more complex procedures such as crowns, dentures or bridges.

These three charging bands are part of a new contract for NHS dental services introduced in 2006, which replaced a scheme of fees per item, where patients were charged up to 80% of the NHS cost of their treatment up to a maximum of £384 per course of treatment (Department of Health 2004e). Under the new system, the maximum charge for a complex course of treatment has fallen from £384 to £198.

Most dentists offer services to both NHS and private patients. In recent years, disputes between dentists and government over the level of charges for NHS dental treatment have prompted some dentists to withdraw entirely from NHS work, while others have reduced the amount of NHS work they undertake. Consequently, although the whole population is entitled to NHS dental treatment, in practice, people in many areas find it increasingly difficult to obtain treatment from NHS dentists and must rely on private dental treatment. As a result, private insurance for dental treatment has expanded rapidly in recent years. The total private dental market is worth some £3 billion per year and is estimated to be at least equal to the value of the NHS dental market (House of Commons Select Committee on Health 2008a).

NHS user charges

The NHS in England raised over £3 billion in 2005–2006, mostly through various user charges paid by patients (House of Commons Select Committee on Health 2007a). With the devolution of responsibility for health care in the United Kingdom, the system of charges differs between England, Scotland, Wales and Northern Ireland. Some form of charges has existed since 1952, and currently the main user charges in England are for private treatment in NHS trusts, NHS prescriptions and NHS dental care. In addition, funds are also raised through charging inpatients for bedside telephones and televisions, and also through hospital car parking charges.[16]

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[16] An indirect charge for NHS inpatient care was abolished in April 2003; up to then, individuals who were in receipt of a state pension or income benefit lost a proportion of this income if they spent more than six weeks in hospital.

Table 3.10 shows the breakdown of NHS user charges in England by type of service. The amount collected in NHS trust fees and prescription charges increased by over 50% between 1996–1997 and 2005–2006; dental charges, on the other hand, have not increased by as much, although the figure for 2005–2006 may reflect changes made under the new dental contract.

Table 3.10
NHS user charges in England, 1996–1997 to 2005–2006

Category of charge	**1996–1997**	**2000–2001**	**2003–2004**	**2004–2005**	**2005–2006**
					£ million
NHS trust private patients	235.7	316.6	383.9	349.0	364.7
NHS trust other fees	152.4	266.0	136.8	228.1	230.9
Dental charges	383.0	453.1	483.6	465.9	409.8
Prescription charges	295.7	386.9	428.3	424.6	426.9
Total	**1 066.8**	**1 422.6**	**1 432.6**	**1 409.4**	**1 432.3**

Sources: House of Commons Select Committee on Health 2006b, 2007a.
Note: Figures are not available for later years.

Protection mechanisms for eligibility and NHS charges

Entitlements to NHS services or help with NHS costs have been dealt with in the sections above. Help may be available for prescriptions, sight tests, glasses and contact lenses, dental treatment and also for travel to receive NHS treatment under the care of a consultant, depending on age or medical grounds or by being in receipt of one of the exempting benefits or tax credits. The government states that these are based on the principle that those who can afford to contribute should do so, while those who are likely to have difficulty in paying should be protected (Department of Health 2008d). The leaflet HC11, *Help with Health Costs,* gives details of reduced rates and exemptions from charges (NHS Forms Orderline 2009).

Implicit protection mechanisms include substitution of cheaper or generic drugs by pharmacists and substitution of private for NHS prescriptions by GPs. As around 60% of prescribed items cost less than the charge, it has been suggested that some GPs advise patients to buy a particular item over the counter or offer them a private prescription (Walley 1998). Complementary PMI covering the cost of user charges is not generally available in the United Kingdom. In 2001, prescription charge evasion was estimated to account for 6% of total prescription costs, amounting to £150 million (Counter Fraud and Security Management Service 2001).

The range of exempt conditions for prescription charges has been criticized. The Labour Government was unwilling to reconsider the list of prescription charge exemptions on medical grounds. However, in 2006, the House of Commons Select Committee on Health published a critical report on NHS charges (House of Commons Select Committee on Health 2006a). In its response to this report, the government requested the Department of Health to undertake a review of the current exemptions for prescription charges (Department of Health 2006g). In partial response to this, the range of exempt conditions was extended in April 2009 to include people being treated for cancer or the effects of cancer or cancer treatment (Department of Health 2009d). In addition, the Department of Health commissioned a review of the options for introducing exemption charges for people with long-term conditions, which was given to government ministers in November 2009 and published in May 2010 (Gilmore 2010). This report recommended that a number of additional exemptions be brought in as soon as possible, but the Spending Review in October 2010 decided not to implement these recommendations.

3.4 Pooling and allocation of funds

As discussed in section 3.3.1, funding for the NHS in England comes mainly from general taxation. Some money is raised from NHS charges that are collected locally. In some cases these remain at the level of the collector (e.g. revenue from pay-beds is retained by NHS trusts); in other cases, it is pooled at the level of the Department of Health (e.g. revenue from NHS prescription charges). Revenue raised through PMI is a separate matter. It is collected by individual health insurance companies and is not pooled with NHS resources. This section focuses on the pooling and allocation of NHS resources.

3.4.1 Pooling agencies and allocation

HM Revenue and Customs is responsible for the collection of taxes and NICs. Government expenditure is directed by the Treasury through government departments. Each department, including the Department of Health, negotiates a budget for the following three years, usually on a biannual basis in a process known as the Spending Review.[17] In 2007, there was a Comprehensive Spending Review that set out the spending plans of the Department of Health for the three years from 2008–2009 to 2010–2011, with spending intended to increase by 4% each year. The most recent Spending Review reported in October 2010, this

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[17] In some years there is a more detailed review known as a Comprehensive Spending Review.

time covering the four years, 2011–2012 to 2014–2015, and providing virtually no real increase in funding over this period. Prior to 1998, departmental budgets had been allocated for one year at a time; the change to a three-year cycle was intended to encourage greater stability and long-term planning.

The Department of Health allocates over 80% of the total NHS budget directly to PCTs, which are responsible for commissioning services to meet the needs of their local populations. PCTs commission activity from acute trusts, FTs, care trusts, mental health trusts and other health care providers – including from the private and voluntary sectors. PCTs cover populations that are based on a fixed contiguous geographic area, on average just over 340 000 people. PCTs do not compete for patients; the population for whom they are responsible is determined by the geographic area that they cover. Allocations of funds to PCTs from the Department of Health are not usually provided for particular services or purposes such as mental health or cancer care. PCTs themselves allocate their own budgets to service providers through contractual mechanisms, which are described in section 3.5 of this chapter. Mostly, these have been and still are based on historical patterns of provision, although PCTs are able to determine their own planning criteria so long as these fit within the overall operating framework of the Department of Health.

It was noted in section 3.1 that the remaining funds allocated to the NHS are held in a central budget, part of which is also distributed to PCTs to spend locally. The remainder is used to finance health and miscellaneous services provided centrally (specific public health functions and support to the voluntary sector) and Department of Health administration, or allocated to SHAs and NHS provider trusts directly as operational or strategic capital or is to fund specific developments or projects. The Department of Health's budget also provides some funds to local government bodies (local authorities) for the purpose of providing social care (mainly for older people, people with mental health problems and people with learning disabilities). These funds are in addition to allocations that local government bodies already receive from central government as part of their annual settlements.

The Ministry of Defence provides health services for the armed forces deployed through the uniformed Defence Medical Services. The NHS and the Defence Medical Services have an agreement to work in partnership to ensure a deployable operational medical capability and fit and healthy armed forces personnel (Department of Health and Ministry of Defence 2005).

3.4.2 Mechanisms for allocating central government funds

The budget mechanism used by the Department of Health to allocate funds to PCTs is based on an approach known as "weighted capitation". This is a development of the methods produced by the Resource Allocation Working Party in the late 1970s (Department of Health and Social Security Resource Allocation Working Party 1976). The Department of Health's original aim was to address geographical inequities in hospital supply and better match resources to local needs. This has since been refined and extended to two objectives: to provide equal access to health care for people at equal risk and to contribute to the reduction of health inequalities.

Based on statistical estimates of the needs of the population served, target budgets are calculated for different regions of England. The factors used to weight the capitation payments (i.e. to adjust them to match local need or risk factors) have been progressively refined, with major changes in 1995 (Carr-Hill et al. 1994), 2003 (Sutton et al. 2002) and 2009 (Department of Health 2008e). Also, the formula has been extended to encompass almost all services commissioned by PCTs, including hospital and community services, mental health services, maternity services, GP and other family health services, and prescribing services.

Originally, only age structure, local input costs (to reflect unavoidable geographical variations in the cost of providing services) and standardized mortality rates were used to adjust capitation allocations. However, a series of more complicated adjustments are now made, including a range of health status measures and social factors, and a specific health inequalities measure. The formula has become more sophisticated in terms of the statistical techniques used and is under continual development and refinement through the work of the Department of Health's Advisory Committee on Resource Allocation. The current formula outlined below is based on a report by this committee in December 2008 (Department of Health 2008f).

The structure of weighted capitation

The weighted capitation formula consists of three key components: HCHS, prescribing, and primary medical services (PMS); there is also a specific adjustment for emergency ambulance costs. A range of elements are built into the formula with the intention that allocations reflect the health care needs of individual geographic areas. For each component of the formula, the key elements used to weight allocations are:

- a needs element, which relates both to age and a number of socioeconomic factors indicative of need for health care;
- an additional needs element relating to health inequalities; and
- a market forces factor (MFF), which allows for differences in "unavoidable costs of providing health care".

These various indices are combined by the Department of Health to produce a "unified weighted population" for each PCT in the country. This in turn is used to produce a target allocation of resources for each PCT.[18] Based on 2006–2007 expenditure, the national weights for the three components for allocations in 2010–2011 are:

- HCHS 76.3%
- prescribing 12.4%
- PMS 11.3%.

Each component is described in more detail below.

HCHS

For HCHS, the formula is split between factors associated with need for acute services, need for maternity services, need for mental health services and need for services for HIV/acquired immunodeficiency syndrome (AIDS). Resources are allocated on the basis of need for acute services according to total population covered with adjustments for age-related need for 18 age bands, a health inequalities factor and unavoidable costs. Twelve factors relating to need for acute services were used to provide weights for the 18 age bands: age-specific death rate, standardized proportion of people aged 16–74 years with no qualifications, proportion of young people not staying in education, standardized limiting long-term illness, proportion of people aged over 60 years claiming pension credit, proportion of low-birth-weight births, income deprivation affecting children, proportion under 16 years claiming Disability Living Allowance, proportion of people claiming New Deal for Young People, proportion of people claiming Disability Living Allowance, proportion of people claiming Incapacity Benefit/Severe Disablement Allowance, and proportion of people aged over 60 years claiming Disability Living Allowance. The new acute formula for 2009 introduced a single unified index for age and additional need. For each age band only a small number of the 12 factors are used.

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[18] The population base for PCTs includes prisoners, armed forces and asylum seekers, although national average needs weighting is assumed for these groups. Population projections are also adjusted to take account of specific plans to increase housing substantially in some parts of England.

For maternity services, there are just two factors that provide weights: proportion of low-birth-weight births and mean house price. The formula for increased need for mental health services comprises an element relating only to age, which is based on the 18 age groups, and additional factors relating to need: a comparative mortality factor for people aged less than 65 years, proportion of people aged over 60 years claiming income support, housing domain scores, and a psychosocial morbidity index. The morbidity index derives from analyses of individual level data from the Health Survey for England. For HIV/AIDS, two separate formulae are calculated. The first, relating to treatment and care, is based on a survey of HIV infections that provides data on numbers of infections at PCT level. The second, relating to prevention, is based on a weighted combination of the population aged 15–44 years and the infected population.

The various elements of the HCHS index are weighted according to estimated expenditure in the following proportions: acute 67.5%, maternity 2.9%, mental health 16.1%, HIV/AIDS treatment 0.8%, and HIV prevention 0.2%. There is an additional weighting of 12.4% for health inequalities which is discussed below.

Prescribing and PMS

The formula for the prescribing component comprises an element relating only to age, based on nine age groups for males and for females, and an element for additional factors relating to need: standardized limiting long-term illness, proportion of people claiming disability living allowance, low-income scheme index, and low-birth-weight births. The formula for PMS also comprises an element relating only to age, based on nine age groups for males and for females, plus additional factors relating to need: standardized limiting long-term illness and standardized mortality ratio for those aged under 65 years.

There is a further adjustment to the weighted capitation formula, the emergency ambulance cost adjustment, which reflects the unavoidable cost variations of delivering emergency ambulance services in different areas. This is based on a rurality index, reflecting increased costs in rural settings, a scale factor reflecting reduced costs as total number of ambulance journeys increases, and a case-mix factor reflecting increased costs as the proportion of journeys that are emergencies increases.

Health inequalities

A health inequalities formula is then applied as a way of allocating resources to meet the government’s objective of reducing health inequalities. The formula used is a measure of disability-free life expectancy, defined as expected years of life free from limiting long-standing illness or disability; this combines data on life expectancy with data on limiting long-term illness and compares this with a benchmark figure for disability-free life expectancy of 70 years. The health inequalities index is applied to all elements of the HCHS component except mental health and HIV/AIDS, for which it is considered inappropriate. Mental health already includes an adjustment for unmet need and HIV/AIDS is based primarily on estimates of the infected population. An arbitrary additive weight of 15% is applied to the health inequalities formula, resulting in an actual weight of 12.4% – taking into account that mental health and HIV/AIDS are excluded from this weighting. The health inequalities formula is also applied to the prescribing and PMS components of the overall formula with a weight of 15% in each case.

MFF

As noted above, the NHS formula takes account of cost differences through the MFF. This calculates unavoidable differences in cost between different local health service areas. It is assumed that there are no differences in prescribing costs as the price of drugs does not vary by location. Separate MFF formulae are calculated for HCHS and PMS.

The MFF for HCHS calculates differences in costs between areas on the basis of four factors: staff; medical and dental London weighting; land; and buildings. "Other costs" (e.g. equipment, consumables, drugs) are assumed not to vary across England. The MFF for each PCT is a weighted average of the MFF for each of the providers from which it commissions, mapped from provider to PCT through a purchaser–provider matrix. Costs are dominated by the staff element, which accounts for 56.1% of total costs. Medical and dental London weighting accounts for a further 13.8%; land accounts for 0.6%, buildings for 3.0% and "other costs" for 26.5%.[19]

The MFF for PMS calculates differences in costs between areas on the basis of five factors: GP pay, practice staff, land, buildings and other costs. Other costs are assumed not to vary across England. Costs are dominated by the GP pay and practice staff elements, which account for 44.9% and 30.7%, respectively, of total costs. Land accounts for 1.2%, buildings for 5.8% and other costs for 17.5%.

Targets

Currently, the weighted capitation formula determines a target rather than the actual budget. In addition to the formula, the Department of Health considers:

- recurrent baselines: the actual current allocations PCTs receive;

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[19] These other costs are assumed not to vary across providers.

- distance from target: the difference between the weighted capitation amount and the recurrent baseline amount; and
- pace of change policy: ministers decide the level of increase all PCTs will receive to deliver national and local priorities and the level of extra resources required by PCTs "under target" to move them closer to their weighted capitation target allocations.

At present, some PCTs are funded above the target allocation and some below. There are always areas of the country that have been detrimentally affected when the formula has changed, and often this has been seen as a largely political decision. However, the funding formula aims to provide resources that reflect local needs in order to allow equal access to health care for individuals at equal risk, and also to bring about more equal health outcomes. Instead of simply enabling equity in access to health care services, the aim is to achieve social as well as geographical equity in health.

In summary, the allocation of resources to PCTs is prospective based on expected expenditure and involves fixed budgets.

3.5 Purchasing and purchaser–provider relations

This section outlines current relations between purchasers and providers of NHS-funded health care in the hospital sector. More detailed information on the nature of purchaser–provider relations in primary care and the specific methods used to pay for health care in that sector are provided in section 3.6. The relationship between PHI providers and private-sector hospitals was discussed briefly in section 3.3.2.

Before 1990, the NHS in England was based on an integrated model in which there was no separation between the commissioning or purchasing role and the provision of hospital services. Health authorities responsible for populations within fixed geographic areas were accountable for an overall budget that paid for the services of hospitals, which were also theoretically under their control. GPs, on the other hand, have always operated as independent providers of primary care services and were paid through separate Family Practitioner Committees, which were not then part of the health authorities. The fundamental change came in 1991 with the implementation of the National Health Service and Community Care Act 1990 when the Conservative Government introduced a contractual model by establishing the "internal market", a split between the "purchasing role", which remained with health authorities, and the "providing role", which became the responsibility of newly formed NHS trusts. This split led to the introduction of contractual relations between purchasers and providers and the transformation of state-owned and controlled hospitals into semi-independent non-profit-making organizations known as NHS trusts. At the same time, the government established GP fundholding, which transferred the commissioning role for certain services, mainly hospital-based elective services, to groups of GPs.[20] GP fundholders became purchasers of services on behalf of their patients as well as having more autonomy over prescribing and diagnostic tests, and continuing to provide primary care services to their patients. By the time fundholding was abolished in the late 1990s, around 50% of GP practices were fundholders (Propper, Croxton & Shearer 2000).

Purchasers (health authorities and GP fundholders) commissioned services from NHS trusts on the basis of contracts. It was expected that as the contracting system became established, purchasers would move from using block contracts (specifying access by health authority residents to a range of services in return for a defined sum of money) to cost-and-volume contracts (specifying that a provider would supply a given number of treatments or cases at an agreed price) and cost-per-case contracts (defined at the level of the individual patient, thereby linking expenditure with activity). However, most purchasers resorted to the use of "sophisticated block contracts", typically involving the payment of an agreed sum for access to a defined range of services or facilities. In some cases, payments were also related to length of stay. Actual sums of money agreed in the contracts were based on historical data reflecting the amount necessary to fund a defined level of activity. Efforts were made to refine hospital costing practices so that contract prices would more accurately reflect costs (Oliver 2005).

This system of contracting represented a major cultural shift in the NHS. When it was in opposition, the Labour Party had been critical of the internal market, in particular the extra management costs it introduced. However, the new Labour Government of 1997, while stating the internal market had "wasted resources administering competition between hospitals" and announcing the abolition of the internal market and GP fundholding, retained the contractual framework of its predecessors with some initial modifications (Department of Health 1997).

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[20] There were extensions to fundholding, particularly the total purchasing pilot scheme, which involved the delegation of budgets to fundholding practices by their local health authorities to purchase potentially all HCHS (Smith et al. 2004).

In 1999, the Department of Health introduced geographically defined "primary care groups" comprising GPs and other health care professionals who would operate as subcommittees of health authorities and hold budgets to purchase all health services for their populations. In 2001, the Department of Health announced that, by 2002, the primary care groups should become statutory bodies in their own right called PCTs, which would replace health authorities and eventually take over management of the entire NHS purchasing budget, thus placing decision-making at a more local level (Department of Health 2001b). By 2004, 303 PCTs had been established covering the whole of England (House of Commons Select Committee on Health 2006c).

In 2004, the Department of Health introduced the concept of PBC. PCTs were required (from April 2005) to make available to GP practices (who volunteered) indicative commissioning budgets, with a strong emphasis on PCTs ensuring uptake. Under this system of "practice-level budgets", the intention was that GP practices would commission care for their patients using an "indicative budget". Commissioning resources remained formally under the control of the PCT, but power to allocate these resources passed to practices. PCTs continue to manage the contracts on behalf of their practices (Department of Health 2004f). The Department of Health aimed to achieve 100% coverage by December 2006, and PCTs were expected to put in place systems to achieve this (Department of Health 2005b). Financial incentives were introduced to encourage practices to engage in PBC, and PCTs provided indicative budgets for their GP practices. By the end of 2006, the great majority of practices were sufficiently engaged in PBC to claim their financial incentives (Department of Health 2007i).

The Department of Health also announced new roles and responsibilities in commissioning, with a focus on the reconfiguration of key organizational structures, resulting in a reduction in the number of SHAs from 28 to 10 and the number of PCTs from 303 to 152 (the number reduced to 151 in April 2010). The role of PCTs in directly providing patient services (mainly community health services such as district nursing) was to be reduced to a minimum by December 2008. Under these arrangements, PCTs were accountable to their local communities and to the Secretary of State through SHAs. The main role of PCTs was to:

- improve the health of the community and reduce health inequalities;
- secure the provision of safe, high-quality services;
- manage contracts on behalf of their practices and public;

- engage with local people and other local service providers to ensure patients' views are properly heard and to provide coherent access to integrated health and social care services;
- act as provider of services only where it is not possible to have separate providers, with arrangements for separating out decisions on commissioning from provider management; and
- to provide emergency planning.

3.5.1 Contracting

Initially, NHS trusts were commissioned by PCTs on the basis of service level agreements that were not legally binding rather than contracts. Some service level agreements clearly specified the volume and cost of services to be provided, but most relied on less sophisticated block agreements based mainly on historical funding patterns and locally-negotiated annual increases. To encourage provider competition, PCTs were allowed to contract selectively with any NHS provider, and any disputes between PCTs and trusts were resolved by the Secretary of State for Health.

In 2003–2004, the government introduced a new approach to commissioning health services called PbR. PbR is a form of activity-based funding involving "healthcare resource groups" (HRGs), the English equivalent of diagnosis-related groups. Contracts between PCTs and providers reflect this new way of measuring services or activities. More detailed information on PbR is provided in section 3.6.1 below.

The Department of Health developed four standard contracts for use between PCTs and NHS trusts, FTs and private-sector providers when commissioning acute hospital services (including specialized services), mental health and learning disabilities services, community health services and ambulance services. These were published in January 2010 for implementation from April 2010 (Department of Health 2010j). The standard acute contract has been in use since 2007 (Department of Health 2008g). Legally binding contracts have now replaced service level agreements when PCTs commission services from NHS trusts, FTs and private-sector providers. In these cases, disputes are no longer subject to resolution by the Secretary of State for Health but could potentially involve resolution through the courts. In the case of FTs, contracts are managed within their own specific financial regime, which requires them to be financially self-reliant. Some parts of the contract are mandatory while other elements can be determined by local agreement (Department of Health 2008h).

Commissioning from the private sector

The NHS has always used private hospital providers to supplement its own provision. However, as Table 3.11 shows, total expenditure on the purchase of health care from non-NHS bodies has increased substantially, from £1.11 billion in 1997–1998 to £6.66 billion in 2008–2009. Over half of that expenditure in 2008–2009 purchased care from the private sector; 34% covered purchases from local authorities and 8% from the voluntary sector.

Table 3.11

Expenditure on health care in England from non-NHS providers, 1997–1998 to 2008–2009

	Total expenditure (£ million)
1997–1998	1 108.2
2000–2001	1 549.2
2003–2004	3 315.9
2006–2007	4 997.8
2007–2008	6 013.3
2008–2009	6 661.5

Source: House of Commons Select Committee on Health 2010a.

This increase reflects a decision by the government to encourage greater use of the private sector. In 2000, the Department of Health signed an official concordat with the independent health care sector that encouraged NHS commissioners to use private hospital capacity (as well as intermediate care) where it represented value for money or where NHS patients were in need of faster treatment, although use of the private sector was not mandatory at this point (Department of Health 2000c). At the end of 2002, the government decided to commission a number of ISTCs to treat NHS patients who required straightforward elective care, a key aim being to introduce more mixed provision of services (Department of Health 2002a). ISTCs were introduced in two waves – in 2003 and 2006 – following an extended programme of national procurement. Funding for commissioning of services from ISTCs was provided centrally and PCTs were encouraged to send patients to these private-sector providers (House of Commons Select Committee on Health 2006d). However, expenditure on ISTCs by PCTs is small relative to total PCT spending on health care from non-NHS providers, standing at 5.5% (£352 million) in 2008–2009 (House of Commons Select Committee on Health 2010a).

With the introduction of the patient choice programme in the NHS, the government envisaged wider commissioning of private-sector provision for NHS patients (Department of Health 2003b). Any provider who could deliver services to NHS standards at the NHS tariff could apply to be included in the list of choices of hospital offered to patients for elective referral (Department of Health 2005c). It became mandatory for PCTs to allow their patients a choice from at least one private-sector provider when being referred for elective care. From 2006, the use of private-sector providers increased, particularly through the Extended Choice Network and the Free Choice Network, which included NHS and private-sector providers (Department of Health 2007c). Since April 2008, NHS patients requiring an elective referral have had "free choice" of provider, being able to choose from a wide list of NHS and private-sector providers from anywhere in England, provided that these organizations meet NHS eligibility criteria (i.e. they comply with the standard conditions of the NHS acute contract and are paid at the NHS tariff) (Department of Health 2008a). In addition, since April 2010, all providers of services to the NHS must be licensed by the CQC (see section 4.1.2 for more discussion of the role of the CQC).

3.6 Payment mechanisms

Since 2002 there have been important reforms to the way in which the NHS contracts, both with health service providers and with NHS employees. As mentioned in section 3.5, PbR, introduced in 2003–2004, is a new activity-based funding system for contracting that involves the use of national tariffs for HRGs.

Contracts governing remuneration and working conditions for specialist doctors (consultants) and GPs were also reformed, in 2003 and 2004, respectively. In 2004, the NHS reached agreement on a new pay structure for other staff. Known as "Agenda for Change", this applied to all employed NHS staff except doctors and dentists (who were covered by separate pay review bodies) and senior managers.

This section outlines these reforms and describes the current mechanisms used to pay for the provision of health services and to pay health service personnel (GPs, consultants, dentists, pharmacists, nurses, midwives and other NHS staff).

3.6.1 Paying for health services

This section focuses on payment mechanisms for the commissioning of services from hospitals. As primary care is predominantly provided by GPs, paying for primary care is covered in the following section (3.6.2).

PbR

As discussed above, before 2003, hospitals were mainly paid using a system of annual block contracts, with an agreed sum of money for a given amount of activity. Under this system, prices were usually negotiated locally and providers were paid a fixed amount irrespective of the work they actually carried out, so there was no direct relation between activity, case mix and payment. Some PCTs agreed locally-negotiated cost and volume contracts, with varying degrees of sophistication, but these were the exception rather than the rule.

In 2002, the Department of Health proposed a movement to a national tariff for hospital activity over five years (Department of Health 2002b). The PbR system was introduced in England in 2003–2004. This introduction of a regulated national tariff price was a major change in the financial regime for the NHS. Instead of block contracts for activity (which are insensitive to the volume and nature of activity), hospitals were to be paid for the activity they undertook. The government argued that this would introduce stronger incentives to ensure improved performance. Claiming that the experience of the internal market in the 1990s indicated price competition did not work and merely led to excessive transaction costs, the government proposed to use new HRG benchmarks to establish a standard tariff for the same treatment regardless of provider. Local commissioning would focus on volume, appropriateness and quality, not price, as price would be fixed using regional tariffs to reflect unavoidable differences in costs in different parts of the country. The intention was to move over time to a system where all activity is commissioned against a standard tariff using either HRG or other appropriate measures that differentiated activity according to case mix. However, this has proved difficult and has not been achieved. Mental health services,[21] critical care, community health services and ambulance services remain outside the scope of PbR, and even within the acute hospital setting, many activities are excluded; by 2009–2010, just £26 billion of NHS activity was paid for under PbR (House of Commons Select Committee on Health 2010a).

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[21] A set of currencies for measuring mental health activity was introduced in 2010–2011, but not as part of the mandatory PbR system (Department of Health 2010k).

PbR was introduced first for elective care, and then emergency care, A&E and outpatients; FTs were used as a form of pilot for the overall health care provider system. By 2006–2007, the tariff was extended across all NHS providers to cover admitted patient care, outpatient and A&E attendances (Boyle 2007). In 2006, a number of private providers also came under the scope of PbR with the introduction of the Extended Choice Network, which offered choices to patients from FTs, wave 1 ISTCs and phase 2 ISTCs that had bid specifically to be providers for the Extended Choice Network. There were also contracts with wave 1 ISTCs and phase 2 ISTCs where PCTs paid for activity commissioned from the independent sector up to the level of tariff prices, and a central budget was used to cover any differences. In 2008–2009, private-sector organizations supplying services under the Free Choice Network also came under the scope of PbR.

The national tariff is adjusted by an MFF to account for unavoidable differences in costs across regions (e.g. regional variation in wages and other costs of service delivery). As a result, for 2010–2011 tariffs, there was a difference of almost 32% between the hospital with the lowest and that with the highest MFF (Department of Health 2010l).[22] PbR, as it stands, has tended to reinforce the delivery of care in acute hospital settings. To enable the unbundling of the care pathways which equate to acute hospital spells, so that care can be delivered in a multitude of different settings, the Department of Health has issued, at various times, sets of indicative unbundled tariffs relating to both care pathways and the use of diagnostics, and has provided guidance in support of the unbundling of services. For example, in 2009–2010, indicative unbundled tariffs were introduced relating to the rehabilitation aspects of several HRGs (e.g. stroke, pneumonia and hip replacement). However, unbundling remains a non-mandatory part of the system (Department of Health 2010l).

Based on proposals developed by the Audit Commission (Audit Commission 2006), the Department of Health introduced a Code of Conduct (last revised in February 2010) for the PbR system (Department of Health 2010m). This sets the principles under which the system should operate and provides an assurance framework for PbR. The assurance framework focuses on improving the quality of the patient-level data underpinning PbR. The Secretary of State for Health requires all NHS bodies (SHAs, NHS trusts, FTs and PCTs), as well as private-sector providers operating PbR, to comply with the Code. Boards of all organizations operating PbR are encouraged to adopt the Code and contracts for services commissioned under PbR must be consistent with the Code.

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[22] In earlier years, the difference was as much as 45% (Boyle 2005a).

3.6.2 Paying health care personnel

This section considers the contractual arrangements for payments to health care personnel in the NHS. Payment mechanisms in the private sector are also discussed briefly where pertinent.

Until relatively recently, most decisions about policies with respect to human resources, including negotiations about pay and conditions, were handled on a national basis by the Department of Health. In 2004, a new body – NHS Employers – was set up to handle these matters. Intended to devolve decision-making away from the Department of Health, NHS Employers is part of the NHS Confederation, but with its own governance arrangements (NHS Employers 2008).

In 2004, a collective agreement – commonly referred to as Agenda for Change – was reached on a new pay system. This adjusted the pay scale for all directly employed NHS staff except senior managers and those covered by the Doctors' and Dentists' Pay Review Body and it began to be applied nationally from December 2004 (Department of Health 2004g). In parallel, contracts for consultants underwent significant reforms in 2003 and those for GPs in 2004. New contracts were also introduced for dentists in 2006 and community pharmacists in 2004. These new arrangements are discussed in some detail below in terms of the following staff groups: NHS consultants, GPs, nursing and midwifery staff under Agenda for Change, dentists and pharmacists.

The NHS consultant contract

NHS consultants (specialists) are salaried NHS employees. The key elements of the NHS consultant contract remained largely unchanged until proposals were introduced by the Labour Government in 2003 with the intention of increasing productivity. Since 1948, NHS consultants have been entitled to work in private practice as well as for the NHS. Consultants on full-time contracts were permitted to earn from private practice up to 10% of their NHS pay. Otherwise, part-time NHS consultants could practise privately without restriction in return for giving up payment of one-eleventh of their NHS salary. Services provided to privately insured patients were normally charged on a fee-for-service basis. It was estimated that in 1992 around 70% of NHS consultants in the United Kingdom were also practising privately (Competition Commission 1994); by 2006 this estimate had fallen to 55% (NAO 2007a).

Maynard and Bloor (2003) observed that "the *NHS Plan* expressed the government's aim of a fundamental overhaul of the national contract for UK hospital specialists, 'to reward and incentivise those who do most for the

NHS' ". The key aim expressed by the Department of Health in several policy documents through 2001 and 2002 was to introduce more direct management of the performance of consultants through the introduction of fee-for-service payments, combined with further restrictions on private practice (Department of Health 2001c, 2002c, 2002d). The doctors resisted but eventually in October 2003 a new contract was agreed of which the key elements were:

- a full-time commitment of 40 hours per week;
- voluntary evening and weekend non-emergency work and extension of annual leave after seven years of service;
- a salary consisting of five elements: basic pay, additional programmed activities, on-call supplements, clinical excellence awards payments and other fees and allowances; and
- no restriction on earnings from private practice.

A full-time commitment consists of 10 "programmed activities" per week, each four hours long (three hours in premium time, which is defined as between 7 pm and 7 am). The clinical excellence awards, allocated by a peer-review process, supplement (often substantially) the salaries of NHS consultants. However, they are not allocated on the basis of any objective measure of activity or work effect. The new contract has been described as a BMA "victory" because of the enhanced personal income of NHS consultants, little emphasis on reducing variations in activity and no limits to private practice (Maynard & Bloor 2003).

The new contract for consultants included an increase in the basic salary scale (which was between £52 600 and £68 505 in 2002–2003) to between £65 035 and £88 000 in 2003–2004. Average consultant salary increased by over 8% per year, from £86 746 in 2002–2003 to £109 974 in 2005–2006. By 2006, 89% of consultants were on the new contract; the average number of programmed activities per consultant job plan fell from 11.17 in 2004 to 10.83 in 2005 (NAO 2007b). By March 2010, the average whole-time equivalent (WTE) consultant salary had increased to £120 200 under the new contract, and 96% of consultants were on the new contract (Information Centre 2010e).

The combination of NHS and private earnings for consultants has led to debate about potential perverse incentives. It has been argued that allowing specialists to practise privately may limit the time available for and commitment to NHS patients. Under the new contract, there is no restriction on earnings from private practice, although new guidelines require consultants to inform employers of their private practice commitments and prohibit consultants from using NHS facilities or staff for private practice without the agreement of their NHS employer. Part of the impetus behind the new consultant contract was to tackle the existence of variation in activity rates among NHS consultants in England. For example, among consultant surgeons, the top (most active) 25% of consultants have activity rates that are 60–85% higher than the bottom (least active) 25% (Bloor, Maynard & Freemantle 2004). There is little evidence so far that the new contract has led to increases in consultant productivity (NAO 2007b).

The Department of Health looked at introducing a fee-for-service model for consultants and commissioned a pilot of various fee-for-service schemes in 2003. However, on the basis of a report on these pilots published in 2005, which concluded that none of the schemes produced any significant activity gains, the Department of Health announced it had no further plans for a fee-for-service model for consultant pay (NAO 2007b).

Consultants' contracts (both new and pre-2003) are determined on the basis of negotiation between the Central Consultants and Specialists Committee of the BMA and the NHS Confederation. Current salary scales for NHS consultants are determined by government, taking into account the recommendations of the Review Body on Doctors' and Dentists' Remuneration.

The new GP contract

GP contracts are now negotiated between the body representing GPs (the General Practitioners Committee of the BMA) and the body representing employers (NHS Employers, part of the NHS Confederation). In England there are four possible contract types for GP services:

- general medical services contracts: practices contract with their PCTs on a nationally negotiated basis (covering about 50% of GPs);
- personal medical services: practices contract with their PCTs on a locally negotiated basis, so that service requirements and quality indicators are agreed between practice and PCT (covering about 45% of GPs);
- alternative provider medical services: PCTs contract with providers other than GP practices for the provision of GP services (there are a few of these with private health care companies); and
- PCT medical services: GP practices are run directly by the PCT.

Prior to 1998, most GPs were independent contractors under the general medical services contract initiated in 1990, which was a nationally negotiated contract between government and individual GPs based on a statement of fees and allowances known as the Red Book. This provided for payment to GPs for certain services performed (e.g. night visits), for reaching targets (e.g. immunization targets) and for some basic allowances for operating costs; in addition, there was a capitation fee for patients registered, adjusted for age distribution of patients and level of deprivation of practice area. The last accounted for around 50% of GP income. Although the regulations changed over time, the nature of the contractual framework remained relatively constant.

In 1998, under the National Health Service (Primary Care) Act 1997, a new locally negotiated personal medical services contract was piloted with the intention of addressing the issue of areas with too few doctors. GP practices were able to negotiate greater flexibility through local contracts with PCTs based on meeting particular quality measures and the needs of their local populations.

The Department of Health outlined in the *NHS Plan* (Department of Health 2000a) the need for a new GP contract that would improve patient access to care and ensure that payments to GPs reflected performance. The BMA, representing GPs, agreed that a new contract was required. After a series of lengthy negotiations between the NHS Confederation on behalf of the Department of Health and the BMA, a new general medical services contract was agreed in 2003, and came into force in April 2004. This new legal contract is with GP practices not individual GPs (NAO 2008a). GPs who are partners in a practice (around 73% of GPs) share the practice profits after expenses have been paid; non-partner GPs are paid a salary by the practice as before.

The key features of the new contract were payments for essential services (global sum), enhanced services, out-of-hours care and the Quality and Outcomes Framework (QOF):

Global sum
Payment for a core set of essential services with allocations to practices through the Carr-Hill formula (Department of Health 2004h), which aimed to link practice funding to patient needs based on a statistical model taking account of sex and age distribution of patient population, additional needs relating to morbidity and mortality of the population, the number of newly registered patients to reflect increased usage in their first year, numbers of patients in nursing or residential homes to reflect extra costs, extra costs associated with London, and the unavoidable costs of delivering services in rural areas and in areas of higher living costs. The core set of essential services is not stated specifically but GPs are expected to cover the management of patients who are ill or believe themselves to be ill, including management of chronic disease and the terminally ill. Practices were also given a Minimum Practice Income

Guarantee to ensure there was no loss of income in the first few years of the contract, with an intention that it would gradually be phased out. At first, over 90% of practices received this payment, but by 2010–2011 this had reduced to 61% (NHS Employers 2010).

Enhanced services

Extra payments for enhanced services which GP practices can agree with the PCT to deliver. These are intended to go beyond the essential features of general practice and may require specialist skills. The PCT is given a "spending floor" for the commissioning of these services, which may be exceeded. Three types of services have been defined:

- *directed:* services that all PCTs must commission to cover their population (although individual practices are not obliged to offer them); governed by national specifications and prices, including, for example, services such as child immunization as well as the development of better patient access;
- *national:* services that PCTs can choose to commission, governed by national specifications and prices, including, for example, minor injury treatment, and again individual practices are not obliged to offer them;
- *local:* services that PCTs can choose to design and commission, with room for local negotiation of standards and prices, including, for example, services for people with learning difficulties; again individual practices are not obliged to offer them.

Out-of-hours care

The new contract removed the responsibility of GPs for out-of-hours care (i.e. providing care outside of core hours, defined as 8 am to 6.30 pm). Practices can now choose to provide out-of-hours care under a separate contract; if they choose not to, they lose an average of £6000 per GP. Since the mid-1990s, GPs could delegate responsibility to GP cooperatives or other providers for their out-of-hours provision and 95% had done so by 2004; under the new contract, just 10% of GP practices in January 2005 were providing out-of-hours care for their own patients (NAO 2006).

QOF

Extra payments are provided for GP services linked to achievement of quality standards by the practice. This was intended as a key new way that payments would be linked to performance. The QOF is a set of indicators that provide 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. Practices that are part of the primary medical services scheme are usually rewarded according to criteria agreed locally with their PCT. QOF scores are recorded by practices electronically and submitted to their PCT; a sample of scores is audited by the PCT to ensure probity (Information Centre 2009e).

The QOF has four main components (NHS Employers and General Practitioners Committee of the British Medical Association 2009):

- *clinical standards:* 86 indicators covering 20 clinical areas, including coronary heart disease, stroke or transient ischaemic attacks, hypertension, diabetes, chronic obstructive pulmonary disease, epilepsy, cancer, mental health, hypothyroidism and asthma (69.7% of total score in 2009–2010);
- *organizational standards:* 36 indicators covering records and information about patients, information for patients, education and training, practice management and medicines management (16.8% of total score in 2009–2010);
- *experience of patients:* three indicators covering the services provided, how they are provided and patient involvement in service development plans (9.2% of total score in 2009–2010); and
- *additional services:* nine indicators covering four service areas including cervical screening, child health, maternity and contraceptive services (4.4% of total score in 2009–2010).

A practice's entitlement to quality payments is determined through a quality scorecard, with a total of 1000 points available. In 2006–2007, based on current average list size, each point was worth £125 per practice with an average weighted population. These quality targets are monitored by the Information Centre and were used for assessment purposes by the Healthcare Commission.[23] The QOF is subject to annual negotiation between the General Practitioners Committee of the BMA and NHS Employers; relatively minor revisions have occurred. There were no changes to the QOF in 2010–2011. NICE was given responsibility from April 2009 for prioritizing, developing and reviewing QOF indicators. These will be made available for consideration by the General Practitioners Committee of the BMA and NHS Employers during their contract negotiations. In future, PCTs may also be able to select additional indicators that reflect local priorities (Department of Health 2009e).

Other funding for GP practices

In addition, funding has been made available to GP practices for increased expenditure on premises, information technology (IT), pensions, payments to recognize seniority and assistance with recruitment and retention.

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[23] The Healthcare Commission was subsumed within the Care Quality Commission in April 2009.

Increased expenditure on GP services

The Department of Health intended a significant increase in expenditure on GP services as reflected in the Department of Health's Gross Investment Guarantee to GPs for this period, increasing spending from £4.9 billion in 2002–2003 to £6.9 billion in 2005–2006. No such commitment was given for the period after 2006–2007. However, the new contract has cost significantly more than was budgeted and by 2005–2006 actual spending was over £7.7 billion (NAO 2008a). The main causes of overspending were: overperformance on the QOF (the Department of Health underestimated what practices would achieve); the additional costs of providing out-of-hours care, which again were underestimated; and overspend by PCTs on areas such as locum costs and seniority payments.

Pre-tax, take-home pay for GPs in England (including NHS and private sources) increased by 58% between 2002–2003 and 2005–2006, from £72 011 to £113 614. The average pay for a general medical services partner increased to £110 054 and for a primary medical services partner to £121 375. This does not take account of funds surrendered where practices opted out of out-of-hours care. Salaried GPs did not benefit to the same extent, their income rising only in line with inflation (NAO 2008a).

Contract negotiation

Some elements of the contract are negotiated annually between NHS Employers and the BMA (e.g. the elements of the QOF and enhanced services). In addition, the two sides have undertaken a two-stage review of the contract. The outcome of the first stage, reached with the agreement of the Department of Health, introduced: a number of amendments to the QOF; additions and changes to enhanced services (PBC, access, information management and technology, and patient choice and booking); a new patient experience survey; and an additional investment of £132 million in IT systems and premises. It was also agreed that there would be no inflationary uplift to the basic payment structure for 2006–2007 (reflecting value for money concerns with the original general medical services contract). It was agreed to continue with the existing Carr-Hill formula for the allocation of the Global Sum (NHS Employers 2005; NHS Employers and General Practitioners Committee of the British Medical Association 2005). The review of this formula reported in 2007 with a number of recommendations for changes to the formula (NHS Employers and General Practitioners Committee of the British Medical Association 2007). Consultation on possible changes took place in 2007, but at the time of writing changes had not been implemented. The old formula has been applied to all allocations since 2008–2009.

GPs in rural areas

There are elements in the new contract that deal with the specific needs of GPs in rural and remote areas of the country. For example, as referred to above, the Carr-Hill allocation formula includes a specific adjustment for the rural nature of a practice. The new flexibility for PCT and practice-based salaried options may also be particularly useful in rural and remote areas. GPs in rural areas may be paid for immediate care and first-responder services as an enhanced service. The staffing of community hospitals and minor injury services, an integral part of many GP practices, particularly in rural or remote areas, will be commissioned and funded from PCT budgets.

GPs in deprived areas

The new contract also recognizes the additional workload involved in providing care in deprived inner city areas through the morbidity factor in the Carr-Hill formula. Areas with fewer doctors also gain from the allocation of money on the basis of patient need rather than the number of doctors. Practices will be able to seek to provide a range of enhanced services for the specific needs of their population.

Nurses, midwives and other NHS staff

As mentioned above, the salaries of most staff groups in the NHS are negotiated on the basis of a pay structure, often referred to as Agenda for Change, which was introduced in late 2004. Nurses, midwives and health visitors form the largest group in the NHS workforce and are salaried employees working either for NHS hospital trusts or, in the case of community nurses, midwives, health visitors and other therapists (e.g. physiotherapists, occupational therapists), for PCTs. GP practice nurses may be paid according to the same pay structure but this is a decision for the GP practice employing them.

The new NHS pay system remains a national framework but differs from its predecessors in that a wide range of individual jobs are evaluated on a similar scale. There is also a mechanism for pay supplements in regional labour markets where recruitment is difficult. Two new pay spines were introduced: one for staff within the extended remit of the Pay Review Body for Nursing and Other Health Professions and the second for other directly employed NHS staff. Doctors and dentists and the most senior managers are dealt with differently, as explained elsewhere in this section. These arrangements replaced the large number of separate occupational pay spines that had existed, and members of staff were assigned to one of the pay bands on the basis of the job weight as measured by a formal NHS Job Evaluation Scheme. The *NHS Job Evaluation Handbook* sets out the basis of job evaluation and is continually updated (the last update was in February 2010). Standard arrangements were introduced for certain core terms and conditions, including hours of work, overtime, antisocial hours and annual leave. In addition, a formal system for career and pay progression was introduced across all staff (Department of Health 2004g).

Contract negotiations take place on an annual basis. The RCN, representing the nursing workforce, and the Department of Health and NHS Employers, on behalf of NHS trusts and PCTs, present their positions with supporting evidence to the NHS Pay Review Body, which then makes a set of recommendations that informs the offer made by government. Other trade unions also present their cases to the NHS Pay Review Body at this time on behalf of the staff groups that they represent. Nurses employed outside the NHS (e.g. by private hospitals or care homes, or by schools or private companies (as occupational health nurses)) are not subject to contracts agreed by the RCN, although it recommends that they should benefit from an annual pay increase equal to that negotiated by the RCN for NHS nurses. The minimum starting salary for registered nurses in 2010–2011 was £21 176, with a distribution of pay rates from £13 653 to £97 478 covering health care support workers to nurses in senior management roles (RCN 2010).

Implementation of the new pay system was compulsory across the NHS with the exception of general practice. GP practices provide their own terms and conditions for their staff, including practice nurses, but are being encouraged to implement the new NHS pay system as this would ensure pay parity across the NHS and may make transfer of staff easier between general practice and other NHS services. Many practices have implemented the NHS pay system; for those who have not, there is an expectation that practices will ensure their employment standards comply with good human resources practice in line with NHS pay system principles.

NHS dentistry

In the United Kingdom at the end of 2007, there were approximately 35 400 registered dentists[24] and 21 700 registered dental professionals (e.g. nurses, hygienists, technicians) (GDC 2008a). There were 22 003 dentists providing dental services in primary care settings in 2009–2010, most of whom (72%) operated under the general dental services contract (Information Centre 2010f). Historically, dentists have not been employed by the NHS but have acted as independent contractors who choose where to locate their practices and how much, if any, NHS treatment they provide. PCTs cannot force dentists to take on

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[24] Not all of these would be practising dentists; in 2009 there were just 23 000 members of the British Dental Association (British Dental Association 2010).

NHS patients, although almost all dentists provide some NHS services. Dentists working in NHS hospital dental services and NHS community dental services are salaried employees.

Until 1990, the NHS paid fees to dentists on an item-of-service basis (under the provisions of the General Dental Service Regulations); under a new general dental services contract in 1990, a capitation fee for each registered NHS patient was introduced in addition to fees for service (NAO 2004). However, these arrangements gave dentists little financial incentive to improve the quality of their services or provide wider oral health promotion advice and education. There was also a risk of overtreatment. Moreover, patients were experiencing problems accessing NHS dentistry as, in the early 1990s, dentists reduced their commitment to the NHS and developed their private practice work, partly in response to cuts in fees imposed by government.

In 1998, the Department of Health, under the National Health Service (Primary Care) Act 1997, piloted new systems for paying dentists: the "personal dental services" contracts. The pilots were based on locally negotiated contracts between dental practices and commissioners and aimed to influence the location of dental practices and how much NHS treatment was provided. Different payment systems were tested under these pilot schemes. By September 2004, some 2500 dentists were working under such contracts.

In 2002, the Department of Health proposed major changes in NHS dentistry (Department of Health 2002e). PCTs were to become responsible for the NHS dentistry budget and local commissioning of services. After consultation and negotiation between the government and the BDA (the professional association and trade union representing dentists in the United Kingdom), a new general dental services contract was introduced in 2006. PCTs became responsible for commissioning dental services according to an assessment of local needs.

The patient charging system was simplified (as described in section 3.3.3 above) and payments for dentists were based not on fee for service but on the number of "units of dental activity" (UDA) completed where UDAs are calculated as a system of points for various banded dental activities.

The new contract is negotiated locally between PCTs and dental practices. PCTs commission an annual total of treatment from dentists measured in UDAs and pay 12 monthly payments. If a dentist was already employed under the old contract, the number of UDAs commissioned reflects the dentist's previous activity. However, new dentists must negotiate with PCTs a target number of UDAs that they are expected to deliver and the payment per UDA the PCT would make. If the dentists do not meet the target, then the PCT is able – with some discretion – to "clawback" their funding. NHS dentists who had been employed under the old contract were also set UDA targets by their PCT but with a guarantee until April 2009 that their income would not drop below pre-April 2006 levels, whether or not they achieved the target.

The Dental Practice Board was responsible for approving payments to dentists and monitoring activities but since 2006 this role has passed to the NHS Business Services Authority. In 2005–2006, a dental practice owner, on average, received an annual income, net of costs, of £114 000 (House of Commons Select Committee on Health 2008a). By 2008–2009, this had increased to £131 500 (Information Centre 2010f), although this may not be strictly comparable with earlier years as it is affected by the contractual and definitional changes that occurred. Most dentists work in both NHS and private practice, although this may be changing as dentists unhappy with the new contract once more focus on private practice. On average in 2005–2006, dentists earned 42% of their income from the NHS and 58% from private practice. Private dental treatment is paid for directly by the patient on a fee-for-service basis or through a private insurance plan (House of Commons Select Committee on Health 2008a).

Pharmacists

In 2005, there were around 26 000 pharmacists practising in Great Britain, of whom some 70% worked in the community, almost 22% in hospitals, and most of the remainder in primary care, industry or academia (Hassell, Seston & Eden 2006). Hospital pharmacists are salaried employees of NHS trusts and, as such, are subject to the new NHS pay system, Agenda for Change, introduced in 2004. There were 10 475 community pharmacies in England in March 2009: 62% of these were part of pharmacy chains owning six or more premises and 38% were independent, although many of these consisted of more than one premises (Information Centre 2009f). Total funding for community pharmacy in 2010–2011 was £2.49 billion, of which £0.5 billion was the retained profit of pharmacies (i.e. the agreed target difference between what they pay for drugs and the reimbursement price they receive from the Department of Health). The remainder, some £1.99 billion, is paid through a number of fees and allowances, some of which constitute the global sum paid centrally and some of which are paid locally by PCTs from their budgets (Pharmaceutical Services Negotiating Committee 2010a).

The two main payments are a dispensing fee per item which contributes 37–45% of total fees and allowances depending on the size of pharmacy, and practice payments which contribute between 29–36%.[25] The former is part of the global sum paid centrally; the latter is paid by PCTs. The Department of Health sets the level of dispensing fees in negotiation with the Pharmaceutical Services Negotiating Committee (which represents community pharmacies in England and Wales for terms and conditions, pay and development of services); the basic dispensing fee per item in April 2010 was £0.90. The practice payment also relates to quantity dispensed but at a fixed sum in the first three bands up to 2240 items per month and then at a fixed fee of just under £0.71 per item. However, pharmacies are required to have minimum levels of dispensing support staff if they are to receive the full payment. In addition, pharmacies can earn a number of other special fees and allowances, the largest of which is an establishment payment from central funding of £23 280 per year for those that dispense more than 2240 items per month, rising to a maximum of £25 100 for those that dispense 3000 or more items, as well as an annual fee for repeat dispensing, payments for advanced services, and payments for IT and electronic prescribing (Pharmaceutical Services Negotiating Committee 2010b).

In 2004, a new community pharmacist contract was developed following negotiation between the Pharmaceutical Services Negotiating Committee, the Department of Health and the NHS Confederation (Pharmaceutical Services Negotiating Committee 2009). Under the new national contract, which took effect in 2005, most community pharmacies provide services on the basis of three levels of service: essential, advanced and local enhanced.

Community pharmacies must provide essential services – dispensing, health promotion and lifestyle advice, support for self-care, disposal of medicines and directing to other services. A pharmacy may also provide advanced services as long as the pharmacist and premises are accredited. Currently, the only advanced service is a medicines use review service when a pharmacist reviews a patient's use of their medicines, offers advice on appropriate use to promote adherence and may recommend changes in medicine to that patient's GP. Essential and advanced services are commissioned nationally. A pharmacy may also provide local enhanced services, which are commissioned locally by PCTs and can include smoking cessation schemes, supervised administration of drugs like methadone and minor ailment schemes, where a person with a condition such as a cough or cold, who would otherwise have visited a GP, can visit a pharmacy for NHS treatment without the need to see her or his GP for a prescription (Department of Health 2005d).

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[25] Although these proportions will vary as the fees are subject to negotiation.

While progress has been made in introducing many of the elements of the new contract, the government is currently looking to extend the role of community pharmacists in line with the 2005 framework (Department of Health 2008i), which may lead to further changes in the community pharmacist contract.

4. Regulation and planning

This chapter provides an account of the main regulatory mechanisms in the English health care system, as well as a description of the way that health services are planned. It concludes with some discussion of the organization of health care information, and the contribution of health-related R&D in England.

4.1 Regulation

This section reviews the governance and regulation of:

- third-party payers and their role as purchasers of health care
- the purchasing process
- providers of health care
- health care professionals.

Regulation can take place in a number of ways, including self-regulation, regulation by parliament or local authorities, regulation through courts and tribunals, regulation by central government departments and regulation by regulatory agencies (Baldwin & Cave 1999). In the health care sector, much of what is observed is independent regulation through a range of bodies (Table 4.1). NHS hospitals are in the process of attaining greater autonomy from the Department of Health (see the discussion relating to FTs in section 4.1.3), although they remain subject to a system of external audit and inspection that has been developed and extended since 1999. PCTs still operate within a target-based framework, reflecting their responsibility for the use of public funds to meet the health needs of their local populations. Health care professionals had retained a significant degree of autonomy in regulating their practice, although there have been significant changes in recent years; these are discussed in section 4.1.4.

Table 4.1

Decentralization of functions and regulatory institutions in England

Function	Type of decentralization	Regulatory institution
Set standards	Centralization	Department of Health
	Delegation	NICE
Monitoring	Delegation	CQC, Audit Commission, NAO, NPSA, Monitor
	Deconcentration	SHAs
	Devolution	Local government overview and scrutiny committees
Enforce regulation	Privatization	GMC, General Dental Council (GDC), Nursing and Midwifery Council, General Pharmaceutical Council, General Optical Council, General Chiropractic Council, General Osteopathic Council, Health Professions Council
	Delegation	CQC, General Social Care Council, Monitor
	Deconcentration	NHS trusts

Source: Adapted from a categorization in Baldwin & Cave 1999.

4.1.1 Governance and regulation of PCTs (third-party payers)

In England, the majority of health care expenditure is provided by government.[1] Funds are allocated to PCTs who are then responsible for the commissioning of health care for their geographically defined populations, as well as, in some cases, providing services themselves (mainly community health care such as district nursing). In addition to commissioning acute and community health services, their responsibility includes contracting for PMS, primary dental services, primary ophthalmic services and pharmaceutical services. PCT performance is monitored and where appropriate managed by their local SHAs, although ultimately PCTs are responsible to the Secretary of State for Health.

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[1] This section focuses on health care funded by the public sector; arrangements for regulation of PMI are discussed in section 3.3.2.

PCTs are a part of the NHS and have a board with a majority of non-executive members.[2] The chairman and non-executive members of the PCT are currently appointed by the Appointments Commission, a non-departmental public body to whom the Secretary of State for Health has delegated this power. The board has a maximum of 14 members excluding the chairman, of whom a maximum of seven can be non-executive members and a maximum of seven executive members, but the number of executive members must not exceed the number of non-executive members. Executive members must include the chief executive, the director of finance, the chairman of the "professional executive committee" (see below for a description of this committee) and the director of public health. In addition, there should be at least one person, but not more than three, appointed by the chairman of the PCT following nomination by the professional executive committee. There may also be other executive members of the PCT appointed by the chairman and non-executive members of the PCT (Department of Health 2006h).

Each PCT has a professional executive committee whose role is to assist the PCT in the exercise of its functions, in developing strategy and policy and in developing and monitoring clinical governance and quality standards. The PCT appoints the membership of the professional executive committee, with a maximum of 18 members and including at least one GP, one nurse and one other person who is a health professional. Members must include the chief executive and the director of finance, one or two people employed by a relevant local social services authority, at least one public health member and professional members,[3] who should be in the majority (Department of Health 2003c).

Finance

The Department of Health allocates over 80% of the total NHS budget directly to PCTs, which are responsible for commissioning services to meet the needs of their local populations (see section 3.4). PCTs are expected, through a series of negotiations with local service providers, to ensure the availability of health care to meet the needs of their populations within this fixed budget. Resources are also made available to PCTs for capital purposes, although the majority of capital investment funding is the responsibility of the NHS provider organizations.

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[2] The executive members are known as officers and are employed by the PCT or hold a paid office.

[3] A professional member is defined as a health care professional involved in the provision of services to people for whom the PCT is responsible (Department of Health 2007k).

Commissioning

PCTs set local priorities in consultation with their local communities and partner organizations (i.e. NHS and independent-sector providers, and local authorities). A PCT is able to set its own strategic framework for commissioning and providing services so long as this fits within the overall operating framework of the Department of Health (see section 4.2.1 for more detailed discussion of the planning process). Financial allocations from government are not usually provided for particular services or purposes – although they can be ring-fenced. PCTs have a statutory obligation to fund clinical decisions within recommendations from NICE contained in Technology Appraisal Guidance. They are also expected to implement NSFs. The financial implications of NSFs are taken into account in the allocations to PCTs and hence PCTs are expected to ensure adequate provision in their budgets.

The Department of Health, through the SHAs, monitors the work of the PCTs. In addition, the Healthcare Commission provided annual measures of the performance of PCTs against standards set by the Department of Health both on services that the PCT provides and those that it commissions, including ways of improving public health. In April 2009, the CQC took over responsibility from the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission for the regulation of all health and social care in England, whether provided by the NHS, local authorities, the private sector or the voluntary sector. The CQC now assesses provider and commissioner performance using indicators of quality agreed nationally with the Department of Health based on core standards, world class commissioning, and other national commitments known as "vital signs" (see section 4.2.1 below) (Department of Health 2008h).

PCTs also provide some health services directly. However, by April 2009, PCT provider services were required to be in a contractual relationship with their PCT commissioning function based on the same business and financial rules as applied to all other providers and using the national contract for community health services in order to separate out the commissioning role from the providing role, and hence avoid potential conflicts of interest (Department of Health 2008h). PCTs were not required to divest themselves of the provision of local community health services, but if a PCT continues to provide services there must be clear arm's-length separation between its provider role and commissioning role. A range of different forms of community health service provision are now in place, including direct arm's-length provision PCTs, community FTs, NHS-contracted arrangements with existing FTs, social enterprises (e.g. Industrial and Provident Community Benefit Society) and commercial organizations (Department of Health 2009f).

Some very specialized services with low numbers of users are either commissioned regionally by 10 Specialized Commissioning Groups or, where the degree of specialization requires, nationally by the National Commissioning Group. These groups provide access to treatment or investigation of a very specialized nature or for patients who have rare conditions. In some cases where physical resources are not available in England, the National Commissioning Group commissions services in other countries. In 2007–2008, the National Commissioning Group spent a total of £261.2 million and covered 38 services including heart and lung transplantation, liver transplantation and craniofacial surgery; in the same year, the Specialized Commissioning Groups as a whole spent £3.2 billion on specialized services (National Specialised Commissioning Group 2008).

4.1.2 Governance and regulation of the purchasing process

PCTS now use standard national contracts to commission acute services from providers (see section 3.5 for more detail). These contracts create legally binding agreements between PCTs and NHS trusts, FTs, private-sector providers and voluntary-sector providers. The acute contract should include a payment framework requiring a proportion of providers' income to be made conditional on quality and innovation – this is known as a Commissioning for Quality and Innovation Framework. Since April 2009, for certain operative procedures, providers were also expected to report on "patient-reported outcome measures" (PROMs) (Department of Health 2008j).

PCTs must also ensure that the procurement of clinical services is undertaken fairly, transparently and non-discriminatorily and using the official portal for advertising and contracting known as Supply2Health. Where complaints about alleged breaches of the Department of Health's Principles and Rules of Co-operation and Competition (official guidance on contract governance) cannot be resolved through a local disputes process, they may be referred to SHAs and – if not resolved by them – to the independent Co-operation and Competition Panel (Department of Health 2008g, 2010n).

New standard contracts have also been established for mental health and learning disabilities, community health services and ambulance services (Department of Health 2010j). As part of community health services contracting, PCTs must describe services in terms other than professional groups. Initially the following terms were to be used:

- health and well-being
- children and families
- acute care provided in the community
- long-term conditions
- rehabilitation
- end-of-life care.

PCTs are responsible for ensuring the provision of the whole range of primary care services for their populations. The contractual arrangements are described in some detail in section 3.6.2. Services provided by individual professionals – GPs, dentists, pharmacists – are governed by nationally negotiated contracts.

PMI

Most companies who provide PMI also sell a range of other types of insurance. As discussed in section 3.3.2 above, the market for PMI in the United Kingdom differs from some other European countries in that there is no regulation of the product or of pricing. However, recently, more formal regulation of insurance sales and administration has been introduced. In January 2005, regulation of insurance sales became the responsibility of the Financial Services Authority, which makes stringent demands regarding the provision of information and advice at the point of sale and also ensures that insurers have adequate finances in place and appropriate systems of financial control (Laing & Buisson 2007).

4.1.3 Governance and regulation of providers

The provision of publicly funded health care is discussed extensively in Chapters 5 and 6. Hospital-based care is mainly provided through NHS trusts or FTs. The former are publicly owned and directly accountable to the Secretary of State for Health. They have a similar governance structure to that of PCTs with a board consisting of a non-executive chairman and at least five non-executive members, all currently appointed by the Appointments Commission, and up to five executive members, including the chief executive, the finance director and the medical director (NHS Appointments Commission 2003). Similarly, FTs are managed by a board of directors. However, they have a board of governors, the majority of whom are elected by members – a member can be anyone who lives in the local area, works for the FT or has been a patient or service user. FTs are regulated by an independent body known as Monitor (see below).

Most primary care is provided by independent GP contractors, dental contractors, ophthalmic contractors and pharmacists. Chapters 5 and 6 have more detailed discussion of the organization of these services; section 4.1.4 below discusses the regulation of the professionals involved in the delivery of these services.

Key regulatory bodies

Providers of NHS services are regulated by a number of bodies[4] in a range of ways to ensure quality and efficiency of provision. Organizations currently involved include:

- CQC
- Audit Commission
- NAO
- NICE
- NPSA
- Monitor
- Department of Health
- SHAs.

These organizations were described in section 2.3; here the focus is on their regulatory role.

CQC

The inspection, monitoring and performance rating of the quality and financial efficiency of NHS services has passed through several hands since the introduction in 1999 of CHI the first independent body assigned these tasks. CHI was reinvented as the Commission for Healthcare Improvement in 2004 becoming known as the Healthcare Commission. In April 2009, it was superseded by the CQC, which is now responsible for regulation and inspection of all health care providers (NHS, private sector and voluntary sector). Since April 2010, a common set of regulations has applied across all providers in England under the Health and Social Care Act 2008. Until then, for most

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[4] The Conservative and Liberal Democrat Coalition Government elected in May 2010 has stated its intention to abolish some of the current regulatory bodies, although their functions are expected to be retained in one form or another (section 7.3 discusses this in more detail).

purposes, all providers were registered under the Care Standards Act 2000. Now the CQC has a responsibility to license all health and social care providers to ensure they are meeting some essential common quality standards.

Thus, the CQC is responsible for licensing, monitoring and inspection of all health and adult social care, and has enforcement powers (e.g. fines, public warnings, suspension or cancellation of registration and prosecutions) that may be invoked if the legal requirements of registration, including quality standards, are not met. The CQC has also continued the work of the Healthcare Commission in monitoring the quality and safety of service provision, undertaking special reviews of particular services, pathways of care or themes where there are general concerns about quality, as well as investigating where there may be serious or urgent causes for concern. The CQC publishes an annual report on the quality of health and adult social care services in England (CQC 2010b).

Audit Commission

The Audit Commission is concerned with the financial health and probity of NHS bodies. It aims to improve public services, promote good practice and help public services to achieve better outcomes. It does this through independent audit on the basis of quality and cost-effectiveness of the financial management of NHS bodies as well as of the work of local government in the health and social care sector. It also undertakes comprehensive performance assessment of local bodies in various parts of the public sector, publishes national performance indicators and carries out national value-for-money studies.

NAO

The NAO is concerned with the economy, efficiency and effectiveness with which all government bodies use public funds. It is also responsible for auditing the accounts of all government departments and agencies and reporting the results to parliament.

NICE

NICE has operated within the NHS since 1999 and is responsible for bringing together knowledge and providing guidance on the promotion of good health and the prevention and treatment of ill health. It does this by developing guidelines in three areas of health:

- health technologies: guidance on the use of new and existing medicines, treatments and procedures within the NHS;
- clinical practice: guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS; and

- public health: guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector.

The key role of NICE is in the determination of whether interventions provided within the NHS (drugs and other technologies, procedures, clinical guidelines, and to some extent, systemic interventions) are safe, effective and cost-effective. Since 2000, NICE has published several hundred such reports. NHS service providers are required to implement NICE guidance and findings. NICE was given a new role in April 2009 to assist in improving quality in the NHS by setting quality standards and advising on indicators for the QOF under which general practice operates (see section 3.6.2 for discussion of this framework).

NPSA

Established in 2001, the NPSA is not a regulator as such. Rather, it promotes a culture of reporting, analysing and learning from things that go wrong in the patient experience, and it manages a national reporting system. It has evolved over time and currently there are three divisions:

- the National Clinical Assessment Service
- the National Reporting and Learning Service
- the National Research Ethics Service.

The National Clinical Assessment Service works with health bodies and individual practitioners where there is concern about the performance of a dentist, a doctor or a pharmacist. The employer, the contracting body or an individual practitioner can contact the Service for help in clarifying concerns, understanding how they arise and supporting their resolution. The National Clinical Assessment Service is an advisory body not a regulator; the referrer retains responsibility for handling the case throughout the process (NPSA 2007).

The National Reporting and Learning Service is a national patient safety reporting system linked to local provider risk-management systems and provides national trends to the NHS and the public. Submission is voluntary though widespread; the NPSA does not investigate incidents or involve itself with disciplinary procedures. The role of the National Research Ethics Service is to protect the rights, safety, dignity and well-being of research participants and to facilitate ethical research that is of potential benefit to participants, science and society. It does this through a system of ethical review of research by its NHS research ethics committees combined with provision of guidance, training and a quality assurance framework for research ethics (National Research Ethics Service 2009).

Monitor

There is an additional element in the regulatory process that was specifically created for FTs. The Independent Regulator of NHS Foundation Trusts, known commonly as Monitor, was set up in 2004 to authorize and regulate FTs with an aim of ensuring that they are financially strong and well managed. Monitor is an executive, non-departmental public body appointed to oversee FTs and consists of up to five members appointed by the Secretary of State for Health. It is independent of the Secretary of State but must behave in a way that is consistent with the duties of that office. It is accountable to parliament, reporting on an annual basis (Boyle 2005b).

Monitor is responsible for authorizing the creation of FTs. This is a form of licence, setting out the conditions under which the FT will operate which relate to:

- governance arrangements for the trust, including constitution of membership, board of governors and board of directors;
- authorized services: the goods and services that the trust will be expected to deliver as agreed by the regulator;
- the limits on the amount of money that the trust is allowed to borrow: the trust can borrow from private sources but must be within a "prudential borrowing limit" as defined by the regulator; and
- the limits on the assets which the trust is allowed to sell: the trust can sell assets and use the income to develop its service provision, but this is subject to some assets being "protected" from such sale, as agreed with the regulator.

Monitor may intervene where an FT is in significant breach of the terms of its authorization, or is at risk of failing to meet national standards and targets, to stop such a breach. This may involve the removal of any or all directors or members of the board of governors and appointment of interim directors and members of the board. Monitor will also intervene where an FT is in financial difficulty (Monitor 2008a). These powers have been used, though sparingly.

Department of Health

The Department of Health continues to play a role in the regulation and monitoring of the provision of health care. In particular, the Department introduced NSFs, starting with mental health in 1999, which set standards for NHS bodies to attain. Since then NSFs have been issued in the following areas: mental health, older people, coronary heart disease, children, young people and maternity services, diabetes, long-term neurological conditions and renal services. NSFs are designed to provide a consensus around good practice in various areas of care and hence reduce variation in the quality of services provided. Providers are expected to work within these NSFs and targets are set which providers are required to attain.

As part of an increased focus on quality within the NHS (Department of Health 2009g), the Health Act 2009 required from April 2010 all health care providers who deliver services for the NHS to publish "quality accounts" that provide a picture of the quality of performance of that provider. The final form for these accounts was laid out in statutory regulations (National Health Service (Quality Accounts) Regulations 2010, S.I. 279). The accounts should include three parts:

- a statement on the quality of care offered by the organization;
- a statement of the degree of compliance with national and regulatory priorities, and a description of at least three future priorities for quality improvement, and how these will be monitored;
- a third part which will be determined locally based on consultation with stakeholders.

The first sets of accounts covering the period 2009–2010 are available on the NHS Choices web site.

SHAs

SHAs continue to play a role in the oversight of local health economies as discussed in section 4.1.1 above and also in relation to planning (see section 4.2.1 below). They are a key link between the Department of Health and the NHS, responsible for:

- developing plans for improving health services in their local area;
- making sure local health services are of a high quality and are performing well;
- increasing the capacity of local health services so they can provide more services; and

- making sure national priorities (e.g. programmes for improving cancer services) are integrated into local health service plans.

4.1.4 Regulation of health care professionals

The majority of health care professionals are regulated by professionally led statutory bodies. These regulators protect and promote the safety of the public by setting standards of behaviour, education and ethics that health professionals must meet, and by dealing with concerns about professionals who are unfit to practise owing to poor health, misconduct or poor performance. Regulators register health care professionals who are fit to practise in the United Kingdom and can remove professionals from the register and prevent them from practising where they consider this to be in the best interests of public safety.

The regulators maintain a register of individuals who meet standards of training and who are, therefore, permitted to use a protected professional title; they set standards of training and education, including in many cases requirements for continuing professional development (CPD). They also establish standards of practice or codes of conduct and they monitor and enforce standards of practice by taking action against professionals who are not fit to practise.

There are eight professional self-regulatory bodies in England:

- General Chiropractic Council, regulating chiropractors;
- GDC, regulating dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists;
- GMC, which was established in 1858 and regulates doctors;
- General Optical Council, regulating optometrists, dispensing opticians, student opticians and optical businesses;
- General Osteopathic Council, regulating osteopaths;
- Health Professions Council, regulating the members of 13 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists/orthotists, radiographers, and speech and language therapists;
- Nursing and Midwifery Council (formerly the United Kingdom Central Council for Nursing, Midwifery and Health Visiting), regulating nurses, midwives and health visitors; and

- General Pharmaceutical Council,[5] regulating pharmacists and pharmacy technicians and registering pharmacy premises in England, Wales and Scotland.

These bodies maintain lists of professionals who are allowed to practise in the name of their particular professions, and also consider allegations of misconduct or unfitness to practise owing to ill health. In addition, there may be other professional bodies or associations that perform roles complementary to that of the regulating bodies. In 2003, the Council for the Regulation of Health Care Professionals (known as the CHRE) was established with the power to:

- monitor how the health professions regulators perform their functions;
- carry out an annual performance review of each regulator; and
- refer cases to court where decisions are considered too lenient and, in particular, investigate and where necessary refer the final-stage decisions of regulators on the fitness to practise of professionals to the High Court (the Court of Sessions for Scotland or the High Court of Justice for Northern Ireland).

However, the system of statutory professional regulation had been called into question by a number of high-profile failures (see the report of the Bristol Royal Infirmary Inquiry into deaths of children undergoing cardiac surgery (Kennedy 2001); the Fifth Report of the Shipman Inquiry *Safeguarding Patients: Lessons from the Past – Proposals for the Future* (Smith 2004), which dealt with the criminal actions of Dr Harold Shipman; and the inquiries into the conduct of Richard Neale (Matthews 2004), Clifford Ayling (Pauffley 2004), and Michael Haslam and William Kerr (HM Government 2005)). As a result, the government set out to reassure the public by reforming the system of regulation in the health care sector. In 2007, *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century* (Secretary of State for Health 2007), laid out a series of reforms of the regulation of health care professionals designed to address key areas of concern, particularly the independence of the regulators and the need for revalidation of all professionals. The independence of the regulators was to be enhanced by including equal numbers of lay and professional membership on bodies and by introducing more accountability to parliament.

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[5] The General Pharmaceutical Council took over this role from the Royal Pharmaceutical Society of Great Britain in September 2010. The leadership role of the Royal Pharmaceutical Society will also be provided by a new body, which at the time of writing was under development.

Changes to regulation were implemented in the Health and Social Care Act 2008. This Act, among other measures, created a new independent body for adjudication of cases of fitness of purpose for the health professions, the Office of the Health Professions Adjudicator, which is an independent statutory body charged with the hearing of cases, thereby separating adjudication of fitness of purpose from investigation and prosecution. This applies to the eight regulators listed above as well as the General Social Care Council.[6]

The Act also set the standard of proof across all health and social care regulators; this is to be the civil standard of proof as this is regarded as most appropriate for a protective jurisdiction such as professional regulation. The Act made it mandatory for regulators to be composed of at least an equal number of lay members as professionals. In addition, the Act required designated bodies to appoint "responsible officers" who would have responsibilities relating to the regulation of doctors. Designated bodies are defined for this purpose as bodies that provide, or arrange for the provision of, health care, or employ, or contract with, doctors. Therefore, senior doctors will be appointed as responsible officers to monitor the conduct and performance of local doctors and to take whatever immediate action is needed to safeguard patients, and to provide a link to the national processes of the GMC.

In addition, the CHRE, which oversees the eight professional self-regulatory bodies in England,[7] was given enhanced powers to scrutinize the handling of fitness-to-practise cases by regulators (Secretary of State for Health 2007). In particular, CHRE is expected to develop common protocols for local investigations across all the regulators, with guidance to employers on when such cases should be referred to the national regulator.

Revalidation

All statutorily regulated health professions are required to have in place arrangements for the revalidation of their professional registration through which members can periodically demonstrate their continued fitness to practise.

For doctors, revalidation will have two core components: relicensure and specialist recertification. For relicensure, all doctors have a licence to practise that must be renewed every five years and that enables them to remain on the medical register. Moreover, to ensure objectivity, the appraisal process will

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[6] The General Social Care Council, established in 2001, is a non-departmental public body whose members are chosen by the Appointments Commission; it has responsibility for registering social care workers and regulating their conduct, training and education.

[7] It is also responsible for oversight of the Pharmaceutical Society of Northern Ireland, which regulates pharmacists in Northern Ireland.

include "summative" elements which confirm that a doctor has objectively met the standards expected. Specialist recertification will apply to all specialist doctors, including GPs, requiring them to demonstrate that they meet the standards that apply to their particular medical specialty. These standards will be set and assessed by the medical Royal Colleges and their specialist societies, and approved by the GMC. Revalidation will be applied to all practising doctors, not just those working in the NHS.

Other health care professionals in England fall into one of three groups for revalidation purposes.

- *Employees of an approved body,* for example nurses or paramedics working in an NHS organization or a licensed private-sector or independent-sector provider. The evidence to support revalidation will be provided as part of the normal staff management and clinical governance systems, with employers providing recommendations to the professional regulators.
- *People, including self-employed contractors, performing services commissioned by NHS primary care organizations,* for example dentists. The revalidation processes will be carried out under the supervision of either the NHS commissioning organization or, particularly where it is necessary to take an overview of both NHS and private work, the regulatory body, but in either case with appropriate collaboration between the two bodies.
- *All others,* for example, osteopaths. The relevant regulatory bodies will develop direct revalidation arrangements.

For doctors, the government had determined that there should be a separation of investigation and prosecution from adjudication so as to ensure public and professional confidence in the independence of the decisions made by the adjudicator. Hence, in January 2010, the government established the independent body created by the 2008 Act, the Office of the Health Professions Adjudicator, to adjudicate on fitness-to-practise cases involving the medical profession, and eventually other health professionals.[8] It was intended that doctors and the GMC would have a right of appeal to the High Court against the decision of the independent body. For all the other regulators, the new independent body was also charged with establishing a central list of people, vetted and approved for all adjudication panels, chosen by the Appointments

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[8] The Office of the Health Professions Adjudicator was to become operational in April 2011 but this is now subject to further consultation.

Commission for their expertise and specifically trained to undertake these duties in a fair and impartial manner. Regulatory bodies would be able to draw on this list in order to conduct independent adjudication panels within their own organizations.

4.1.5 Other regulatory bodies

There are other regulatory bodies whose responsibilities extend to health care and public health issues.[9] These include the following, which are discussed briefly:

- MHRA
- NHS Business Services Authority
- NHSLA
- Human Fertilisation and Embryology Authority
- Human Tissue Authority
- National Institute for Biological Standards and Control
- Food Standards Agency.

MHRA

The MHRA is an executive agency of the Department of Health and is responsible for regulation of medicines, medical devices, blood and therapeutic products and services derived from tissue engineering; it ensures standards of safety, quality, performance and effectiveness (see section 6.6.1 for more detailed discussion of the way it operates). The MHRA works closely with the European Medicines Agency (EMEA), which is responsible for the evaluation of medicinal products and for granting marketing authorizations at an EU-wide level.

NHS Business Services Authority

The NHS Business Services Authority combines services previously provided by the Dental Practice Board, the NHS Counter Fraud & Security Management Service, NHS Logistics Authority, NHS Pensions Agency and the Prescriptions Pricing Authority. It is the main processing facility for payment, reimbursement and remuneration for NHS patients, employees and affiliated parties, and it also investigates and prosecutes fraudulent acts.

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[9] The review of arm's-length bodies that reported in late 2010 may result in the abolition of some of these and the transfer of their functions to other bodies or government departments over the subsequent four years. However, at the time of writing, these organizations continue to carry out the roles described here.

NHSLA

The primary responsibility of the NHSLA is to handle negligence claims against NHS bodies in England; it is also responsible for handling family health services appeals dealing with the resolution of disputes between primary care practitioners and their PCTs, and for coordinating equal pay claims on behalf of the NHS. It also monitors human rights case law for the NHS.

Human Fertilisation and Embryology Authority

The Human Fertilisation and Embryology Authority is an executive non-departmental public body that acts as the regulator for the United Kingdom overseeing the use of gametes and embryos in fertility treatment and research. It licenses fertility clinics and centres carrying out in vitro fertilization, other assisted conception procedures and human embryo research. It sets the Code of Practice standards for United Kingdom centres providing fertility treatment and carrying out human embryo research, and it also provides guidance on how centres can meet these standards. This Code contains specifications for compliance with the law (including the European Tissues and Cells Directives) and with standards of good professional practice. It inspects licensed centres to assess compliance with the Code of Practice.

Human Tissue Authority

The Human Tissue Authority is an executive non-departmental public body that regulates the removal, storage, use and disposal of human bodies, organs and tissue from the living and the deceased for a number of purposes including research, transplantation, education and training, as set out in the Human Tissue Act 2004. The Human Tissue Authority is also responsible for approving donation of solid organs and bone marrow from living donors. It is the competent authority under the EU Tissue and Cells Directive for regulating human application establishments.

National Institute for Biological Standards and Control

The National Institute for Biological Standards and Control is a centre of the HPA,[10] a non-departmental public body. It is responsible for the standardization and control of biological medicines such as vaccines and products made from blood and tissues, ensuring they are safe and effective. The National Institute for Biological Standards and Control provides testing of biological medicines to ensure compliance with product specifications, operating as an Official Medicines Control Laboratory of the EU for release of medicines on to the EU market.

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[10] Until April 2009, the National Institute for Biological Standards and Control was managed through the National Biological Standards Board, which was abolished under the Health and Social Care Act 2008.

Food Standards Agency

The Food Standards Agency is a non-ministerial government department set up under the Food Standards Act 1999 to protect public health in relation to food. It reports annually to parliament. It is responsible for food safety, nutrition, diet and food standards through the enforcement of EU and national food legislation and other United Kingdom legislation covering the composition and labelling of foods, chemical safety, food hygiene, control of foodstuffs, and trading and marketing standards. The Agency works with local authority food law enforcement officers to make sure that food law is applied appropriately and it sets out the rights and responsibilities of enforcement authorities and food businesses; it also helps to ensure that food safety and legal requirements are maintained and monitored. It audits local authority monitoring of food businesses and collates data on local authority enforcement activity.

4.2 Planning, health information management and health-related research

This section considers the approach to planning in the English health care system. Some discussion is also provided of health technology assessment and how information is used. The section concludes with a discussion of recent developments in the funding of health-related research. The focus is primarily on the provision of publicly funded care.

4.2.1 Planning

There is no formal national plan for the NHS in England; however, the Department of Health provides the framework within which individual health care organizations operate, and it also specifies the key targets that all organizations must strive to attain. Within this overall approach, the individual provider and purchaser (or commissioner) organizations must produce their own plans, which are scrutinized by the regional health tier of government (the SHAs) and the Department of Health.

Other organizations involved in the health care delivery system such as NICE and the CQC are expected to produce strategic plans that will meet their statutory requirements and these are also scrutinized by the Department of Health.

Department of Health

The Department of Health produced the *NHS Plan* in 2000 (Department of Health 2000a). This was not a plan per se but a publication setting out aspirations for the NHS over the following five years. Targets were set for growth in real resources – staff and buildings – to match the increase in funding announced in March 2000; at the same time, the introduction of new management and IT systems was announced. The delivery of this "plan" has required substantial changes in the way in which services are delivered. Nevertheless, the planning structures, although using different nomenclature, are broadly similar: the Department of Health at the centre using regional tiers to manage and monitor the delivery of care for local populations. Arguably, there is a degree of greater autonomy in the delivery of care, and this is especially true of the growing division that has emerged between commissioning and delivery of all health services, and in the greater use of the private sector.

The Department of Health usually works within a three-year planning cycle determined by a government-wide Spending Review, mostly on a biannual basis, which allocates resources between government departments for a three-year period (see section 3.4.1). The most recent Spending Review reported in October 2010 and covered the four years from 2011–2012 to 2014–2015. In addition, there are more detailed, less frequent reviews known as Comprehensive Spending Reviews. The most recent was in 2007. This set a number of targets in the form of PSAs and Departmental Strategic Objectives.

For the first time, these PSAs were set at a cross-departmental level; although individual government departments were given lead responsibilities for individual PSAs, the responsibilities of other contributing departments were made clear (HM Treasury 2007). Thus, the Department of Health has specific responsibility for two PSAs: Better Health for All and Better Care for All. It was also given responsibility for three Departmental Strategic Objectives:

- to ensure better health and well-being for all: helping people to stay healthy and well, to empower people to live independently and tackling health inequalities;
- to ensure better care for all: the best possible health and social care when and where you need help, giving you choice and control; and
- to provide better value for all.

Progress by the Department of Health against these objectives has been measured on an annual basis using a set of 44 indicators (Department of Health 2008k). Within the context of the overall budget determined by the

Comprehensive Spending Review and these high-level objectives as represented by this set of indicators, the key planning instrument at the national level is the NHS Operating Framework. The operating framework for 2010–2011 sets out (Department of Health 2009h):

- the key priority areas for the NHS
- system levers and enablers
- the financial constraints
- the planning framework and timetables.

The operating framework places the responsibility for delivery of health care for local populations with PCTs as commissioners of services, although, clearly, care can only be successfully delivered in cooperation with NHS and other providers. The Department of Health provides a set of national priorities but also expects PCTs to devise a set of local priorities for which they are held to account.

The national priorities in 2010–2011 were to:

- improve cleanliness and reduce health care-acquired infections
- improve access for patients
- keep adults and children well by improving their health and reducing health inequalities
- improve patient experience and staff satisfaction and engagement
- prepare a response to national emergencies such as an influenza epidemic.

PCTs

The Department of Health has established a "vital signs" framework (Department of Health 2008l) which sets out, for PCTs (and SHAs), groups of targets designated in three tiers:

- *tier 1:* prescriptive national commitments in the sense that each PCT or SHA must achieve a particular target, for example, the 18-week wait from referral to treatment;
- *tier 2:* national commitments but where PCTs might make differential contributions, for example, mortality rates;
- *tier 3:* commitments agreed locally.

These targets include almost all of the 44 indicators that the Department of Health itself is responsible for in relation to central government.[11] PCTs set local priorities in consultation with their local communities and partner organizations (i.e. NHS and independent-sector providers, and local authorities). PCTs are then responsible for commissioning health services for their local populations.

Each PCT first produces an overall strategic plan for the following year that will underpin their operational plan and financial plan. It must then produce an operational plan for that year that reflects both national and local priorities and is consistent with its contracts with providers of services and with other plans relating to the local population, such as the "joint strategic needs assessment" with local authorities.[12] These operational plans must ensure that activity, finance and workforce plans are consistent and can be reconciled. Therefore, PCT commissioners must assure themselves that NHS provider organizations have fully integrated the operational, financial and workforce implications within their business and service plans, and should provide a comprehensive assessment of the workforce risks. PCT workforce development strategy is discussed later in this section.

In addition, all NHS organizations – PCTs and NHS trusts – must produce an annual financial plan. These plans are brought together and scrutinized by the local SHA, which will then submit to the Department of Health for its scrutiny an overall plan for the SHA based on these local plans.

The PCT must also contribute to the production of a "local area agreement" (every three years) that reflects the joint strategic needs assessment, and contains health outcome targets (Department of Health 2007l). A local area agreement sets out the priorities for action in a particular local area. It is an agreement between central government and organizations in that area. Central government is represented by the regional government office and the local area by local authorities and other organizations such as PCTs, police, businesses, voluntary and community groups. These, together, form a group known as a "local strategic partnership". This partnership draws up a "sustainable community

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[11] The new Conservative and Liberal Democrat Government issued a revision to the 2010–2011 Operating Framework in June 2010. This included the removal of the 18-week waiting time targets for elective care, the access targets for primary care and an adjustment to A&E waiting time targets (Department of Health 2010o).

[12] Since April 2008, PCTs have had a statutory duty to work with their local authority to produce a "joint strategic needs assessment". This identifies the health and well-being needs and inequalities of the local population and is intended to inform more effective and targeted service provision and, in particular, the long-term commissioning strategies of PCTs and their collaborative work with their community partners.

strategy" setting out the priorities for its area, and it aims to get the whole community involved in developing and implementing the strategy and the local area agreement (Department of Communities and Local Government 2008).

All NHS organizations are also expected to prepare medium-term financial plans: SHAs, PCTs and NHS trusts must prepare and submit plans to the Department of Health before the beginning of each financial year; FTs must submit plans to Monitor on an annual rolling basis. These plans must include funding and expenditure, balance sheet and cash flow projections for the next three years, a three-year strategic outlook and a commentary covering key assumptions and sensitivity analysis (Audit Commission 2008).

Service development

So, a mix of national and local priorities determines the development of services across England. In some cases, all areas would be expected to develop similar forms of services. Examples of this are the use of PFI or public-private partnerships, or more recently the development of polyclinics. But local organizations are also free to develop services in ways best suited to the needs of the population they serve, provided that they are able to show that in doing so they still meet national and local targets. The Department of Health monitors the performance of PCTs against all elements of their "vital signs" framework.

NHS provider trusts

NHS provider trusts are required to provide health services that are high quality and accessible. Trusts with teaching responsibilities should also provide a suitable environment for teaching and research. NHS trusts must produce business plans that indicate how they will meet access and workforce targets and quality standards within agreed budgets. Previously, they contracted with PCTs through service level agreements, but these were replaced by legally binding contracts (see section 3.5). As indicated above, they are expected to produce medium-term financial plans.

The planning process for FTs differs from that of NHS trusts. FTs must submit an annual three-year plan to the FT regulator, Monitor, covering three areas: finance, governance and mandatory services. The financial aspect of the plan should include a three-year strategic overview including risk assessments, as well as financial projections for the three years and an assessment of the last year's actual performance against planned. Governance covers a report on the membership of the trust as well as self-certification against a range of financial and non-financial requirements. The FT must also report on its performance on the mandatory services it must provide and any risks of failure in this area (Monitor 2008b).

Capital planning

Although there is no centralized capital planning process for the NHS, by setting budgets, priorities and targets for investment, central government determines to a large extent the overall levels and pattern of investment in the NHS, albeit individual NHS organizations make the decisions at local level that determine the ultimate shape of this investment. Hence, the government was able to claim in *Rebuilding the NHS – A new generation of healthcare facilities* (Department of Health 2007m) that “This government is undertaking the largest hospital building programme in the history of the NHS”.

The *NHS Plan* laid out government plans for investment in hospital and primary care buildings. Although, in theory, individual NHS organizations determine their own investment needs based on a review of the services they provide and their view of future requirements and demand for their services, in practice, they cannot ignore the direct and indirect influences of the government of the day. Business plans supporting investment are reviewed by each organization against its own set of priorities, which take into account existing national and local priorities so as to determine proposed investment allocations. However, NHS trust capital plans must be agreed with the responsible SHA and, ultimately, the Department of Health. Internally generated cash is now the primary source of capital funding for NHS trusts – and has been for some time for FTs – with additional finance provided through interest-bearing loans. NHS trusts can also apply for working capital loans from the Department of Health, but those loans must be affordable over an agreed time period with principal repayments made from operating surpluses and improvements in working capital.

PCTs must also develop capital plans – agreed with their SHAs – for developing services for which they are responsible; these then inform the capital allocations from the SHA. In 2009–2010, there was £500 million available to fund PCT local capital schemes as well as £100 million brought forward from 2010–2011 to upgrade up to 600 GP surgeries to support training in practices.

Workforce planning

Most workforce planning takes place at the local provider level: NHS trust, FTs, private-sector and voluntary-sector providers, and PCTs. Providers respond to the commissioning requirements of PCTs and plan to ensure that the appropriate workforce is in place. A PCT produces a combined service and workforce plan for its local health economy based on provider plans. SHAs are responsible for ensuring that local organizations have effective workforce planning systems; thus SHAs combine PCT plans to develop integrated regional service and workforce plans.

The Department of Health with the Department for Business Innovation and Skills is the national commissioner of places for medical and dental undergraduates and low-volume specialty professions. It also monitors SHA workforce plans and, based on these, allocates funding for workforce development, education and training, as well as taking a long-term strategic view of workforce planning in the context of policy developments and the labour situation worldwide. In addition, SHAs commission education and training based on their plans and also assure the quality of that education (Department of Health 2008m).

Effective planning

Since 2000, the NHS has undergone a number of reforms designed to improve access to, and the quality of, patient care. These involved considerable structural and organizational changes, as well as an emphasis on increased choice for patients and more competition between providers. The nature of these reforms and their implementation are discussed in detail in Chapter 7. However, a recent joint report by the Audit Commission and Healthcare Commission (2008) found mixed results across different areas of England and concluded that:

> Progress on the implementation of the reform programme has been limited by several factors. These include two major structural reorganizations; under-developed commissioning capacity; and weaknesses in the infrastructure to support and monitor the reforms, particularly in regard to data collection.

As the end of 2010 approached, if anything, these three issues highlighted by the commissions – excessive structural reorganization, underdeveloped commissioning capacity and weak infrastructure – became even more pertinent, as is discussed in Chapter 9.

4.2.2 HTA

There is a formal programme of HTA managed and funded by the NHS. This was set up in 1993 to produce high-quality research information on the costs, effectiveness and broader impact of health care technologies for those who use, manage and provide care in the NHS. In 1999, the HTA programme began to provide dedicated support for the work of NICE by commissioning both primary research and technology assessment reviews; in 2005, its work was extended to support the public health goals of disease prevention and health promotion. It is now part of the National Institute for Health Research (NIHR).

The HTA programme is managed by the NIHR Evaluation, Trials and Studies Coordinating Centre, which is part of the Wessex Institute based at the University of Southampton. The programme considers different forms of technology, including evaluating drugs such as antidepressants or antibiotics; devices such as pacemakers or dialysis machines; procedures such as surgical techniques or acupuncture; counselling; care settings such as general practice, hospitals or care homes; and screening programmes such as for prostate cancer, sexually transmitted diseases or stroke. Methods range from evidence synthesis to large-scale primary research projects. Final reports are peer reviewed by independent experts and published in the journal series *Health Technology Assessment.*

The HTA programme commissions research to provide the scientific evidence for national NHS decision-making bodies and policy customers such as NICE, national clinical directors, the Chief Medical Officer and the National Screening Committee (NSC). Almost 220 reports have been produced for NICE.

A large number of evaluations have been carried out in recent years. Between 40 and 50 reports are published each year; since 1997 (according to the HTA web site at the time of writing), there have been 551 evaluation reports published. Between 1993 and 2008, more than £245 million was spent on the HTA programme, divided between the following areas:

- cancer: £60.4 million
- mental health: £29.6 million
- primary care: £22.0 million
- medicines for children: £17.2 million
- stroke: £12.9 million
- diabetes: £7.9 million
- dementias: £13.9 million
- other: £134.2 million.

The HTA programme's budget in 2008 was over £52 million (NIHR Health Technology Assessment programme 2009).

Identifying priorities

Priorities for research are identified in various ways:

- direct consultation: suggestions are invited from service users, the Royal Colleges and specialist societies, NHS commissioners and managers, and researchers. In addition, it is open for anyone to suggest a topic;
- extracting research recommendations from syntheses of evidence: NICE guidance and the outputs from the NHS time-limited programmes are routinely scanned for research recommendations, and completed reviews in the Cochrane Library are also scanned to identify gaps in current knowledge;
- reconsidering important topics that did not receive sufficiently high priority to be commissioned previously; and
- horizon scanning: this may identify important technologies, both new and changes of use of existing, that will soon be available to the NHS; technologies are identified through focused routine scanning and working with the National Horizon Scanning Centre.

The choice between suggested research areas is determined by expert advisory panels with final decisions being approved by the "Prioritization Strategy Group".

4.2.3 Information systems

This section describes the development of management information in the NHS and includes some discussion of the use of information on health services activity, including waiting times and patient satisfaction; and on quality, including measures of health status and health outcomes, and adverse events and errors. Also discussed is the use of the Freedom of Information Act to ensure public access to information held by the Department of Health and NHS bodies.

Data collection

Most data collected in the NHS are related either to financial systems or to monitoring central or local targets. More recently, there is evidence of the development and use of information to manage more cost-effective delivery of health care. Within the acute sector, NHS trusts are required to collect datasets that describe various aspects of activity, and these must be submitted to the Department of Health, as described below. Data relating to general practice have tended to be almost always related to the financial payment system for GPs. This remains true of the current QOF system (see section 3.6.2), which is still for the purpose of determining payments although the data are more patient centred. Data are also collected on community-based care services such as district nursing, although these tend to be aggregated (i.e. not at a detailed patient level). The same is true of social care services provided through local authorities.

In the past, quality aspects of care have been indirectly measured through items such as length of hospital stay. Currently, the drive to improve quality of care in the NHS has resulted in the development of more direct measures of quality of clinical care and patient satisfaction with care (including, most recently, PROMs), which are now part of the mandatory data requirements for organizations supplying care for NHS patients; this is true for both NHS and independent-sector providers.

Mainly, it is the suppliers of care who collect the information although there are data requirements that PCTs must meet relating to their performance as commissioners of care; however, these do not relate to the direct provision of care except in the role of the PCT as a provider, a role which has been reduced. A large part of the data collected, though not all, is submitted to the Department of Health. These data are then analysed and disseminated widely, usually in aggregated form such as numbers of types of operation, average waiting times or proportions of day cases. Some datasets are also made available to providers and commissioners of care as well as for research purposes.

A key aspect of data collection is to feed into the financing systems, PbR and QOF; these are described in some detail in sections 3.6.1 and 3.6.2. All NHS providers must ensure that their "patient administration systems" provide the information required by the Department of Health, and, in particular, the defined contract datasets. PCTs are expected to ensure that their local providers are compliant (Department of Health 2007n). NHS trusts are expected to provide the Department of Health, for financial planning and monitoring purposes, with a substantial quantity of financial data relating to income and expenditure, capital assets and spending; balance sheets; and summaries of expenditure on the workforce and agency staff. These must be provided on a quarterly basis as well as at the end of the financial year.

The development in recent years of IT systems to support the delivery of patient care in the NHS is described in some detail in section 5.1.4. In 2002, the Department of Health put forward a national strategy for IT, establishing the NPfIT with the task of developing, procuring and implementing an integrated IT infrastructure for the whole of the NHS – from hospital trusts to general practice – by 2010. In 2005, the Department of Health established a new organization, Connecting for Health, as the single national IT provider for the NHS, being responsible for implementing a range of new IT systems across the NHS.

Connecting for Health has led on the development of standard data systems across all NHS providers. Information on care provided to all patients by NHS trusts and PCTs, and to NHS patients by private-sector providers, is specified in "commissioning data sets" as defined in the *NHS Data Dictionary* and must be submitted each quarter to the Secondary Uses Service, which is then able to make these data available nationally. These data are at patient level and cover all patients admitted to hospital or treated as outpatients or an A&E attendance by NHS providers and PCTs, including patients receiving private treatment, as well as NHS patients treated electively in the independent sector and overseas. ISTCs are responsible for providing commissioning data sets for admitted patient care and outpatient attendances; the NHS commissioning body is responsible for the provision of the appropriate central returns and datasets for other independent-sector activity for NHS patients (Connecting for Health 2008). These data are used for a range of purposes including contracting via the PbR system, monitoring contracts and their impact on health, benchmarking, and service planning and development.

NHS providers are also expected to provide more detailed clinical datasets covering particular specialties, conditions or procedures. These include acute myocardial infarction, cancer registration and national cancer waiting times, radiotherapy, diabetes, mental health and the national joint registry. In some cases, the delivery of data is a national requirement (e.g. cancer waits and registration, mental health); in others, there is an expectation that data will be submitted (e.g. the national joint registry). These data, which are mostly at the patient level, are used for national and local performance management, planning, clinical governance, and monitoring of NSFs.

In addition, providers must submit data to the Department of Health at a more aggregated level as central returns, mainly for monitoring purposes. These returns encompass a wide range of information including A&E, elective care flows and stocks, outpatient attendances, diagnostics waiting times and cancelled operations.

Connecting for Health also worked to develop a system to support the QOF payment framework for general practice (see section 3.6.2 for more detailed discussion). A new national IT system – the Quality Management and Analysis System – was implemented in 2005, allowing individual practices and PCTs to look at their QOF status using aggregated information for each practice.

The Quality Management and Analysis System contains national data rather than patient-specific data, but this allows GP practices to analyse the data they collect about the services and the quality of care they deliver.

The NPSA is responsible for an NHS-wide system known as the Reporting and Learning System through which NHS staff report adverse events or incidents (section 4.1.3 discusses other aspects of the role of the NPSA). Incidents may relate to treatment or diagnostic failures, patient accidents as well as issues with medicines or devices. Mostly, these reports are collations of staff reports to local reporting systems, although a small number are direct reports from staff via the Internet. However, it is not mandatory for providers to ensure incidents are reported and for many organizations there are few if any incidents reported. The NPSA provides feedback to providers on incidents reported as well as a routine analysis of total incidents reported (NPSA 2009).

In addition, information on adverse drug reactions – essentially side-effects – is collected from staff and patients by the MHRA through the Yellow Card system. This allows reporting via the Internet as well as in hard copy, and includes reports on POMs, OTC medicines, immunizations and medicines administered in hospital or day-case settings.

The development of IT within the NHS has seen the introduction of web sites providing key information to the population. The main sources are:

- NHS Choices: allows the public to search and find details of local NHS services, including where to find their nearest GP, pharmacy, dentist or optician, as well as providing comparative information on hospital and doctor performance; since October 2008 it has also included access to NHS Direct Online;
- NHS Direct Online: provides patient advice and information online;
- The National Electronic Library for Health: provides access to clinical evidence for "informed patients" as well as health care professionals; and
- HealthSpace: online personal health organizer that allows people a secure place on the Internet to store personal health information that they may wish health professionals to know, such as details of their medications or food preferences.

These sources are discussed in more detail in section 2.5.2.

The Freedom of Information Act

The Freedom of Information Act 2000 requires public bodies (including the Department of Health, NHS bodies, any person providing general or personal medical or dental services, or any person providing pharmaceutical or ophthalmic services as part of the NHS, and local government bodies) to specify the type of information they hold, how it is made available, including time limits, and the cost accessing it. Public bodies have a duty to publish the range of information that they proactively make available without any need for a Freedom of Information request, how such information can be obtained and what the charges are. Public bodies must respond with the information requested, if available, not later than 20 working days after receipt of the request. They do not have to provide information if the estimated cost of doing so is above a certain threshold, although they can if they wish or they can ask for a payment to do so: currently the threshold is £600 for central government and parliament, and £450 for other public bodies. Bodies can pass on charges associated with providing the information (e.g. photocopying and postage), which are known as disbursements.

The Freedom of Information Act also established exceptions to the duty to disclose information and introduced arrangements for enforcement and appeal. One exception is any information that would, or would be likely to, endanger the physical or mental health or safety of any individual. Also personal information relating to the applicant is exempt but only because such data are covered instead by the Data Protection Act 1998 as amended by the Freedom of Information Act 2000. Under the Data Protection Act 1998, individuals can access information held upon themselves by public bodies and hence are expected to apply for access to this personal information through this Act. Individuals thus have the right of access to all personal data held upon them; there is also a duty of accuracy and security on all holders of such information – the Data Protection Act applies to all organizations not just public bodies. The Act applies to any personal information, thus going beyond the original terms of the Data Protection Act, which related mainly to automated data systems.

There are a number of other exemptions to the Freedom of Information Act such as items prejudicial to the national security or defence, or to national economic or financial interests, but these generally are not relevant for bodies providing health services. Information is also exempt if it can be reasonably obtained through other means (e.g. reports published by a PCT or NHS trust; or death, birth or marriage certificates). Information held by a government department is exempt if it is relevant to the formulation or development of government policy. However, once a decision on government policy has been made, the statistical information underlying it is not exempt except where it would be prejudicial to the effective conduct of public affairs. In practice, this can result in considerable amounts of information not being made available under the Act. The same exemption applies to information held by other public bodies.

A considerable amount of information is considered exempt under provisions relating to commercial interests or to information provided in confidence. Therefore, information constituting a trade secret or that would prejudice the commercial interests of anyone, including the public body holding the information, is exempted from the Act. If the provision of information would be a breach of confidence, either one created by contract or by the circumstances in which it is provided, it also is exempted from the Act. In relation to health care, there are many cases where information has not been provided on grounds of commercial confidentiality; these mainly relate to the involvement of the private sector in the delivery of health care for the NHS. However, no systematic review of such access, or lack of it, is available.

Finally, the disclosure of any information that would be incompatible with European Community obligations is also exempt. The Information Commissioner is responsible for the enforcement of the Freedom of Information Act and, in particular, to ensure that public bodies comply with their duties under the Act.

The statutory right to access under the Act became operational in January 2005. Recent research indicates that the public in general are aware of their rights under the Freedom of Information Act and the Data Protection Act; in 2008, 79% of public bodies had received a request for personal information in the previous 12 months, and 41% had received more than 10 requests (Social and Market Strategic Research 2008). Research shows that over two-thirds of bodies in 2006 turned down some requests for information under the Freedom of Information Act, and of these around half turned down some requests because personal information about staff was involved, 33% on grounds of commercial sensitivity, 12% because of the costs of providing information, and 11% because the information was already available in another way (Information Commissioner's Office 2007).

In response to the requirements of the Freedom of Information Act, the Department of Health produced a publication scheme in 2009 explaining the information made routinely available, how it can be accessed, and whether a charge is made (Department of Health 2009i). This document provides web-links to a wide range of relevant documents and statistical sources. In addition, the Department of Health provides a limited list of responses to Freedom of Information requests since the Act became active in January 2005. In 2006, there were 860 releases of documents and data in response to requests for information (Department of Health 2007o). However, there is no aggregated information available on the nature of requests, or on how many were refused and why. Other NHS bodies are also subject to the Freedom of Information Act and, therefore, are required to produce a publication scheme and provide responses to Freedom of Information requests. FTs, ISTCs, and private-sector and voluntary-sector providers that supply NHS services are also treated as public bodies in terms of the Freedom of Information Act.

4.2.4 R&D

Health-related research in England is funded by a range of bodies including central government, the Medical Research Council and other research councils, the NHS, charities and industry. All NHS-funded research streams were brought together in 1997 as the NHS R&D levy. This led to the development of a number of national research programmes. These included the Cochrane Collaboration, the Centre for Reviews and Dissemination, the HTA programme, the Service Delivery and Organisation programme, and the New and Emerging Applications of Technology programme (Department of Health 2006i).

It was estimated in 2006 that total expenditure on health-related research in the United Kingdom was £7.35 billion, of which £5 billion was from industry, £1.7 billion from government and £650 million from charitable donations. Of government funding, £860 million went to government departments, of which the majority (£680 million) went to the Department of Health; the rest of government funding went to higher education funding councils, mainly for medical schools (£400 million) and research councils, the major one being the Medical Research Council (£440 million) (Department of Health 2006i).

Following the recommendations of the Research for Patient Benefit Working Party (2004), the UK Clinical Research Collaboration was set up by the Chancellor of the Exchequer (United Kingdom Minister of Finance) in 2004 as a partnership of the major bodies that influence and fund health-related research, with the aim of providing a coherent United Kingdom approach to the funding of health-related research. The UK Clinical Research Collaboration, which includes the key United Kingdom research funding bodies, academic departments, the NHS, regulatory bodies, industry and patient groups, analysed the nature of funding in 2004–2005 by 11 of the main health-related research funding bodies: Department of Health (England); Research and Development

Office for the Northern Ireland Health and Personal Social Services; Chief Scientist Office, Scottish Executive Health Department; Wales Office of Research and Development for Health and Social Care, Welsh Assembly Government; Medical Research Council; Biotechnology and Biological Sciences Research Council; Engineering and Physical Sciences Research Council; Economic and Social Research Council; British Heart Foundation; Cancer Research UK; and the Wellcome Trust.

The UK Clinical Research Collaboration found that around 66% of the combined research funding from the funding bodies is spent on understanding normal function and processes, and investigating the determinants of the cause and development of diseases and conditions; 16.6% is spent on treatment development and evaluation; and a relatively low proportion is spent on primary prevention of disease and promotion of well-being. Levels of funding by disease category tend to reflect the relative importance of diseases as measured by disability-adjusted life-years (DALYs) for the United Kingdom: exceptions are respiratory, gastrointestinal and oral diseases, which have lower funding than their DALY rates would suggest, and infection, which has more funding (UK Clinical Research Collaboration 2006).

The Department of Health published a national health research strategy in 2006, *Best Research for Best Health* (Department of Health 2006i), in which, among other things, it announced the creation of the NIHR,[13] the National School for Primary Care Research[14] and a clinical research network across diseases and patient needs, plus increased investment in facilities for experimental medicine. The NIHR acts as a virtual research facility providing the framework for health-related research across the NHS and university sectors, and it works to identify innovative ways of preventing, diagnosing and treating disease (NIHR 2008). At the same time, NICE works to evaluate these innovations to assess their clinical and cost-effectiveness and the NHS Institute for Innovation and Improvement works to ensure that agreed innovations are implemented in the NHS.

As part of the coordination of research efforts in England, clinical research networks have been established. These NIHR research networks include the primary care research network and six specific clinical research networks: cancer, stroke, diabetes, medicines for children, mental health, and, dementias and neurodegenerative diseases. Two more general networks, the NIHR

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[13] The NIHR was established in April 2006.

[14] The National School for Primary Care Research was established in May 2006 with an annual budget of £3 million.

Comprehensive Clinical Research Network and the NIHR Comprehensive Research Network, were established in April 2009. In addition, a network for clinical genetics has been established (NIHR 2009a).

In April 2008, the NIHR established 12 biomedical research centres within NHS and university partnerships to drive progress on innovation and to translate biomedical research into clinical research that benefits patients. There are seven centres that cover a specific clinical or research area – cancer, mental health, ophthalmology, ageing, microbial diseases, paediatrics and child health, and genetics and developmental medicine – and five comprehensive centres that cover a broader spectrum of clinical areas. These centres were funded for five years from April 2007 and total funding is £100 million per year. This funding is additional to, and separate from, any other NHS R&D funding received. In October 2006, "experimental cancer medicine centres" were established across the United Kingdom with funding of £35 million over five years from the NIHR, Cancer Research UK and the health departments of Scotland, Northern Ireland and Wales. In May 2008, a School for Social Care Research was also established with funding of £3 million per year for five years.

In addition, the NIHR established two Research Centres for NHS Patient Safety and Service Quality with a focus on safety, quality and effectiveness of services. The purpose of these centres, which have total funding for five years from April 2007 of £9.5 million, is to promote improvements in quality, effectiveness and safety of NHS services. Also, development grants have been awarded of £800 000 covering a three-year period to two NHS hospitals to support their research on patient safety and quality of services (NIHR 2007).

The HTA programme – now part of the NIHR – was established in 1993 to produce high-quality research information on the costs, effectiveness and broader impact of health care technologies for those who use, manage and provide care in the NHS. In 1999, the HTA programme began to provide dedicated support for the work of NICE by commissioning both primary research and technology assessment reviews; in 2005, its work was extended to support the public health goals of disease prevention and health promotion.

The NHS Service Delivery and Organisation programme – also now part of the NIHR – was established in 1999 to consolidate and develop the evidence base on the organization, management and delivery of health care services, and to promote the uptake of evidence in practice so as to increase the quality of patient care, ensure better patient outcomes and contribute to improved population health. The programme funds research around a number of key themes including change management, management practices, health organizations, models of service delivery, e-health, health care commissioning, workforce issues, public health services, patient-centred and carer-centred services, and integrated health and social care. In April 2009, the management of the research commissioning arm of the programme moved to the NIHR Evaluation, Trials and Studies Coordinating Centre at the University of Southampton, which also manages the HTA Programme.

Dissemination

The Department of Health is developing ways of using research evidence to support decision-making by patients, professionals and policy-makers, making this evidence available, and encouraging its uptake and use. Two key modes of dissemination are the International Cochrane Collaboration and the NHS Centre for Reviews and Dissemination.

The UK Cochrane Centre, founded in 1992, facilitates and coordinates the preparation and maintenance of systematic reviews of randomized control trials of health care as a part of the Cochrane Collaboration, an independent international organization. The major product of the Collaboration is the *Cochrane Database of Systematic Reviews,* published quarterly. The United Kingdom is the biggest contributor to the database and 22 Cochrane Review Groups are based and funded in the United Kingdom. The Cochrane Library, part of the *Cochrane Database,* contains over 2000 completed reviews. This is a key way in which the United Kingdom is able to share its research knowledge with the rest of the world.

The Centre for Reviews and Dissemination, founded in 1994 and based at the University of York, provides information about the impact of individual health care interventions as well as the delivery and organization of health care. The Centre provides the infrastructure to produce systematic reviews of research evidence on health and public health questions in response to requests for assistance from policy-makers and health care professionals. Its findings are widely disseminated both in the United Kingdom and internationally.

In addition, the NIHR established the Invention for Innovation (i4i) research programme in 2008 to assist in the identification of new health care technologies and accelerate their development as health care products. It incorporated the work of two existing research streams, the New and Emerging Applications of Technology programme and the Health Technology Devices programme, both of which were intended to stimulate research into new technologies to meet the needs of patients with a view to the generation of both intellectual property and cost-reducing products and interventions.

In October 2008, funding of £88 million for a five-year period was allocated to nine NIHR Collaborations for Leadership in Applied Health Research and Care. These are collaborations between universities and local NHS organizations with the aim of identifying effective new health interventions and helping to translate these into routine clinical practice, with particular emphasis on the investigation of new treatments and new ways of working in specific clinical areas, including heart disease, stroke, diabetes and obesity (NIHR 2009b).

5. Physical and human resources

This chapter describes the physical infrastructure in England, comprising health care facilities and equipment, and how this is determined. It goes on to discuss the use of human resources within the health care system and how this is planned and regulated.

5.1 Physical resources

This section addresses the planning, supply and distribution of physical resources in England.

Section 5.1.1 begins by discussing the planning of hospital provision in England in recent years and goes on to review the number and distribution of hospitals. Since the early 1950s, there has been a continuous decrease in bed numbers in all specialties, particularly in the psychiatric sector, although the number of acute care beds has stabilized somewhat since the early 1990s. At present, the supply of acute beds per capita is among the lowest in Europe, and the proportion of private beds is also very low (estimated for the United Kingdom at 6.5%).

Section 5.1.2 describes the current status of health care facilities, and goes on to discuss the financing of capital infrastructure and how this is regulated. In 2008–2009, most capital investment was provided from central government funds (71%, including expenditure by FTs), although private finance through PFI, introduced in 1992, accounted for over 25% and land sales accounted for 3.5% (House of Commons Select Committee on Health 2010a).

The purchasing and regulation of medical devices is discussed in section 5.1.3, and information on the supply of high-technology diagnostic equipment is also provided. This indicates a relatively low supply of computed tomography (CT) and magnetic resonance imaging (MRI) scanners in England compared with the rest of Europe, although since 2000, the number has increased substantially. In section 5.1.4, the use of IT in the health care system is described, focusing on the 10-year NPfIT in England initiated in 2002.

5.1.1 Infrastructure

This section provides a discussion of the development of hospital infrastructure in England since 1948; it goes on to compare the hospital bed complement with other European countries and considers how this has changed over time.

Hospitals

When it was established in 1948, the NHS inherited a disparate assortment of municipal hospitals from the local government sector and voluntary-sector hospitals. The 1946 National Health Service Act nationalized hospital infrastructure and centralized the responsibility for financing and planning its improvement within regional hospital boards responsible to what was then the Ministry of Health.[1] However, it was not until the publication of the 1962 Hospital Plan that an attempt was made to organize the existing infrastructure into some form of national system of provision. According to Harrison and Prentice (1996):

> the Plan proposed that each district of around 100 000 – 150 000 people should have a hospital – … a district general hospital – in which all but a few specialties … were represented. … small hospitals were to be retained, particularly in less densely settled parts of the country. The hospital service … would be in three tiers, with the vast majority of work done in the middle one, the district general hospital.

The higher tier consisted of more specialized facilities while the lower was a range of facilities providing services such as care for older people. However, the scale of investment in hospital buildings fell short of original plans. The financial crisis of the mid-1970s led to a cutback in the hospital building programme, and by the time the Department of Health and Social Security (as it was then known) produced its consultation document on the future shape of hospital provision (Department of Health and Social Security 1980), as Harrison and Prentice (1996) noted, it was clear that planning had to proceed on a piecemeal basis.

Nonetheless, there have been significant reductions in the number of hospitals since the inception of the NHS in 1948. Between 1959 and 1989–1990, the number of hospitals in England (excluding psychiatric hospitals) fell from

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[1] See Rivett (1998) for a detailed account.

2138 to 1185 (Harrison & Prentice 1996). Most of these were small hospitals of less than 250 beds although over 10% consisted of 500 beds or more. Between 1990 and 1994 some 245 more hospitals were closed, of which 60 were acute hospitals and 14 were maternity hospitals (Harrison & Prentice 1996).

Although aggregate figures are no longer published on the number of NHS hospitals in England, each NHS trust provides a detailed report on the size, condition and cost of its estate. This information is held centrally as the Hospitals Estates and Facilities Database. The latest data available, for 2009–2010, suggest that there were 166 acute and single-specialty NHS trusts, 55 mental health and learning disabilities trusts and 10 care trusts.[2] There were also 11 ambulance trusts. Trusts may operate off one or more separate hospital sites; the total number of acute and specialist care hospital sites reported by acute and single-specialty trusts was 332 in 2009–2010 (Information Centre 2010g).

Although the distribution of hospital facilities across England has not been addressed through a central plan, government policies over the years have impacted on the numbers of hospitals in different parts of the country. The location of new hospitals has been subject to an element of control, both through the allocation of funds for capital investment and by the allocation of funds for day-to-day running of health care services (known as revenue allocations). The distribution of financial resources ultimately will determine the ability of local communities to sustain hospital services. The rules governing the allocation of funds for investment are discussed in section 5.1.2. Although there was always intended to be a relationship between need for services in an area and the allocation of funds for capital investment, in many cases political factors have been equally important.

As a result of financial crises in the 1970s, developments in service provision in subsequent years have been driven by a desire to deliver health care in more cost-effective environments; the resulting drive to reduce health care costs has been interpreted as a movement away from provision in acute settings into more ambulatory care settings such as GP practices and other community facilities. This has been coupled with a drive to increase the speed with which patients are moved through hospital (i.e. faster throughput) and more use of ambulatory care even in acute settings, which is reflected in the substantial growth in the number of day cases over this period. Nevertheless, there has been strong resistance at the local level to hospital closures as these have been seen as (in effect) removing easy access to health care. Hence, although it has been

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[2] Some care trusts also operate as PCTs; in April 2010, there were six of these.

government policy for many years to facilitate the closure of acute hospitals and moving care into the community, this has not resulted in major reductions in acute beds, as can be seen from Fig. 5.1.

Although local health economies have had nominal responsibility for making decisions about hospital closures, in practice, central government has steered these changes with a firm but ineffective hand. Where distribution was perceived to be poor, for example in the tertiary sector where there was an excess supply of specialist beds in London, various ad-hoc attempts were made by governments to tackle this, although implementation of change was painfully slow. Currently, it is the role of the SHA to consider any significant changes to the distribution of hospital services in the region for which it is responsible. PCTs, often in collaboration with NHS trusts, put together business plans to justify changes in hospital facilities (which may include shifting services between sites, reducing provision on some sites or closing some sites altogether). These business plans are assessed by the SHAs and sometimes may be referred to central government (see section 5.1.2 for more detailed discussion).

High-profile hospital closures and bed shortages, combined with continually increasing waiting lists, led some politicians, and some commentators, to believe that hospital downsizing had gone too far. The Department of Health initiated a National Beds Inquiry in 1998 to review the situation and concluded that a small increase in bed numbers was required (Department of Health 2000d). So, in contrast to policies of the previous two decades, the new Labour Government appeared to embrace an increase in hospital provision, although this was to be short-lived. The *NHS Plan* (Department of Health 2000a) focused on improving hospital buildings, promising to replace or update 100 hospitals by 2010 which was achieved by October 2008 (Department of Health 2008n, 2009c) – as well as an increase of 7000 hospital and intermediate-care beds.

By June 2009, 104 hospitals had been replaced or updated (Department of Health 2009c); the PFI accounts for 77 of these projects (section 5.1.2 discusses PFI). Furthermore, the development of more localized community services – including establishing community hospitals or retaining existing ones – emerged as a government priority in *Keeping the NHS Local* (Department of Health 2003d) and *Our Health, Our Care, Our Say* (Department of Health 2006c). The focus of reform in *High Quality Care for All* (Department of Health 2008o) was on improvements in quality of care. Increased specialization combined with more localized care, where possible, is likely to impact on the nature of hospital infrastructure; however, it remains to be seen in what way (Chapter 7 discusses these reforms).

Hospital beds

In 1950, there were 271 000 acute beds available in NHS hospitals in England, which was 6.6 beds per 1000 population. By 1971, that number had almost halved to 149 000 beds, which is 3.2 per 1000 population. Over the following 20 years, the reduction in acute beds slowed so that by 1989–1990 there were 121 170 acute beds, at 2.5 per 1000 population (Boyle & Smaje 1992). Since then, there has continued to be a steady decline and by 2009–2010 there were 100 621 beds, at 1.9 per 1000 population. If beds for geriatric patients[3] are added, the total number increases to 2.3 beds per 1000 population, which still represents a substantial fall from the equivalent figure of 3.6 beds per 1000 in 1989–1990 (Department of Health 2009j, 2010p).

Fig. 5.1 shows there has been a significant decline in the total number of NHS beds available in England, from 270 000 in 1989–1990 to 158 000 in 2009–2010. Most of this fall, of approximately 112 000 beds, has resulted from reductions in the number of beds available for people with mental health problems (from 59 300 to 25 600), for people with learning disabilities (from 26 400 to 2800), and for people in geriatric wards (from 48 700 to 20 900). Nevertheless, as indicated above, the number of acute hospital beds has also fallen over the same period, by almost 20 550 beds, though this has been partially compensated by an increase from 2900 to 11 200 in beds for care of acute patients as day cases.[4]

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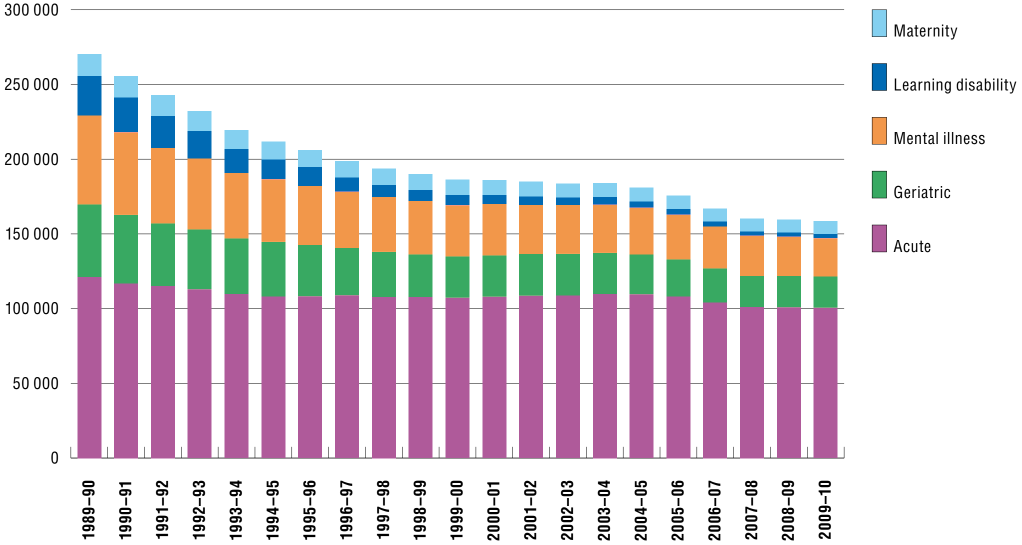
[3] This somewhat archaic term is still used in the NHS to describe older people requiring care.

[4] Day cases are patients with acute conditions who do not occupy a bed overnight. They are usually planned admissions for elective procedures.

Fig. 5.1

Average daily number of available beds, by sector, England, 1989–1990 to 2009–2010



Source: Based on data from Department of Health 2009j, 2010p.

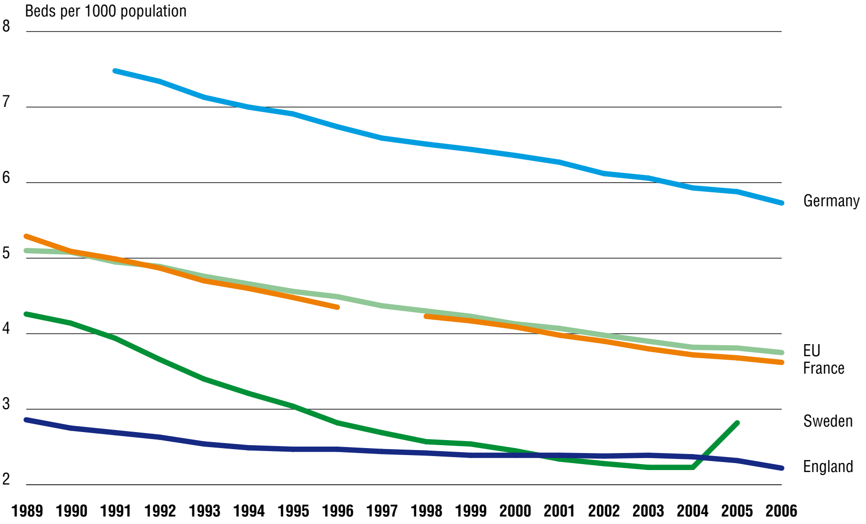
The shift away from hospital-based care for people with mental health problems and learning disabilities has resulted in the proportion of NHS beds designated as acute increasing from 45% in 1989–1990 to 64% in 2009–2010. Most of the reduction in acute beds occurred in the period to 1994–1995; since then, there has been little change except between 2005–2006 and 2007–2008, when there was a reduction of 7034 beds.

Beds for maternity care show a similar pattern, with a fall from 14 706 in 1989–1990 to 8392 in 2009–2010. Most of this is explained by a reduction in the time women spend in hospital once the baby is delivered. The average length of stay for a maternity case fell from 5.5 days in 1981 to 3.1 days in 1991–1992 to 2.1 days in 1998–1999 (Matheson & Summerfield 2000). Looking at the distribution of postnatal stays, by 2005–2006, 51% of women left hospital within a day of giving birth, compared with 45% in 1998–1999 and 21% in 1989–1990 (Richardson & Mmata 2007).

The decline in the number of beds is a trend common across industrialized countries, although it is particularly dramatic in England. Thus, although the number of hospital beds per head of population is low in England relative to other European countries, there have also been significant reductions in bed numbers in other countries since 1989. By 2006, the number of acute and maternity hospital beds in England had fallen to 2.2 per 1000 population. As Fig. 5.2 shows, this compares with other countries in western Europe such as Germany (5.7), France (3.6) and Sweden (2.8 in 2005), and the EU average of 3.8 (based on EU15 countries).

Fig. 5.2

Acute and maternity care beds per 1000 population in England and selected European countries, 1989–2006 (latest available year)



Sources: European data based on European Health for All database, updated August 2009 (WHO Regional Office for Europe 2009); English data based on Department of Health 2010p.
Notes: Definitions of acute beds may vary slightly between countries; in some cases private and public sector beds are included, although not for England; maternity beds are included alongside acute in these international comparisons. The EU average is based on the EU15.

Politically and economically, since 1989, there has been pressure to reduce the number of beds in the acute hospital sector, and indeed the number of acute hospitals. In addition, it has been argued that the quality improvement associated with increased clinical specialization requires increased volumes of activity and hence fewer hospital sites (Farrington-Douglas & Brooks 2007), although the evidence for this view is disputed (Byrne & Ruane 2007). To some extent, a reduction in bed numbers has been facilitated by clinical developments that have enabled patients to be treated safely with shorter periods of stay in hospital, or as day cases. However, at the same time, there has been a substantial increase in activity in hospitals, which, to some extent, explains the fact that the number of acute beds remained constant between 1994–1995 and 2005–2006 although there has been a fall since then.

Finally, the number of private beds as a proportion of the total is very low in England compared with some other European countries. For example, according to the WHO, in 2006, 35% of beds in France, 27% of beds in Germany and 21% in the EU as a whole were private. The most recent WHO data relating to the United Kingdom are for 1999, when private beds were 4% of the total (WHO Regional Office for Europe 2009). In England in 2007–2008, there were 130 200 available beds in acute trusts (i.e. acute, geriatric and maternity beds), and it is calculated that there were an additional 35 700 beds in the other United Kingdom countries, giving a total of 165 900. It is estimated that in 2007 there were 9572 acute beds available in the private sector in the 304 independent acute hospitals in the United Kingdom (Laing & Buisson 2007), suggesting that in 2007 private beds in the United Kingdom as a whole formed 5.8% of the total. If, in addition, the 70 dedicated NHS private patient units with a further 1180 beds are included in the private total, the proportion of private beds increases to 6.5%.

Licensing of hospitals and other health care facilities

The CQC is responsible for the regulation and inspection of all health care providers, including NHS, private sector and voluntary sector. This includes private hospitals, independent clinics, hospices, anywhere that provides medical treatment under anaesthesia or sedation, dental treatment under general anaesthesia, childbirth (or maternity) services, medical services, termination of pregnancies and cosmetic surgery (see section 4.1.3 for more detailed discussion of the CQC's role).

The MHRA is responsible for regulation and licensing of medicines, medical devices, blood and therapeutic products and services derived from tissue engineering (see section 6.6.1, for more detailed discussion of the way it operates). NICE is responsible for determining whether interventions provided within the NHS – drugs and other technologies, procedures, clinical guidelines and, to some extent, systemic interventions – are safe, effective and cost-effective (see section 4.1.3).

5.1.2 Capital stock and investment

This section provides a discussion of the current state of hospitals in England, the funding of capital investment, how NHS providers pay for capital and how investment decisions are made.

Current hospital building stock

As noted above, there has been a considerable decline in the number of hospitals in the English NHS since its inception in 1948. Some existing hospital building stock is quite old although there has been a substantial drive to improve its condition since the mid-1990s, mainly through procurement of new hospital buildings. In 1997, 50% of the NHS estate was built before 1948; by 2007 this had reduced to 20%, with 88 major hospital schemes having opened during this period at a value of £4.9 billion (Department of Health 2007m). While there has been a concentration of these new developments around urban centres of population, all areas of England have acquired new hospital facilities.

When NHS trusts were established during the 1990s, they were given responsibility for the capital assets that were required for their long-term operation. The remainder of NHS assets formed what was known as "retained estate". A large part of this was sold off in subsequent years and the Department of Health continues to dispose of surplus estate. In April 2000, the replacement value of NHS capital assets was estimated at £76 billion, and its value in existing use at £23 billion. Most of this estate (95%) was managed by NHS trusts (NAO 2002).

Until 2004, NHS Estates, an executive agency of the Department of Health responsible for strategy and policy relating to the health care built environment, maintained an asset register for all NHS estates and monitored and reported on all property-related transactions: valuation, disposal and residual estate management costs. This function moved to the Department of Health Estates and Facilities Division in 2005. At the local level, NHS trusts have estate strategies that must fit with the overall estate and investment plans that are produced by SHAs and reviewed annually (Department of Health 2003e). Since 1999–2000, all NHS trusts have had a statutory duty to report on the condition of the estate and facilities for which they are responsible.[5] These data are collated by the Information Centre on behalf of the Department of Health and provide the input for a number of indicators of the condition of NHS estate. In addition, trusts have been required to provide a survey of the condition of their estate as part of the process of inspection.

The estimated backlog of investment (i.e. the funds required to maintain health facilities at an appropriate standard) rose sharply during the late 1990s and was estimated by the *NHS Plan* in 2000 to be over £3 billion. By 2008–2009,

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[5] FTs are required to provide most but not all of the same information.

as a result of the hospital replacement and renewal programme referred to above, this figure had been reduced to approximately £1.8 billion (Information Centre 2010h).

Funding capital investment

The Department of Health defines capital expenditure as funds used on the acquisition of land and premises, and individual works for the provision, adaptation, renewal, replacement or demolition of buildings, items or groups of equipment and vehicles and so on. This section deals primarily with investment in hospital buildings. In this context, capital expenditure consists of investment in new hospital stock and the ongoing costs of maintaining buildings throughout their life-cycle.

Investment in NHS capital is provided primarily through allocations of public funds to local health economies. In recent years, first with the introduction of the PFI and then with FTs (see below), there has been a change in the way that new capital investment is funded, although ultimately government is responsible for providing the funds in the long term to support any investment in new capital stock.

Fig. 5.3 shows the changes in investment in capital stock in the NHS since 1990–1991 and indicates the source of funds for this investment. A key new element in this period was the growth of the PFI as a way of funding investment;[6] based on the data underlying Fig. 5.3, it is estimated that by 2008–2009 the PFI was the source of over 25% of investment. Nevertheless, investment from public sources also increased substantially during the period, from £1.6 billion in 1990–1991 to £4.6 billion in 2008–2009. Moreover, planned public expenditure on capital was £5.6 billion in 2009–2010.

The Conservative Government of the early 1990s attempted to introduce "private finance" to the health sector, primarily as a way of delivering major NHS capital projects. Although these efforts ran aground on the concerns of the commercial banks regarding who would bear risk if private schemes went bust, by 1997, when a new Labour Government came to power, most of the issues had been resolved. In the last resort, government would underwrite the risk.

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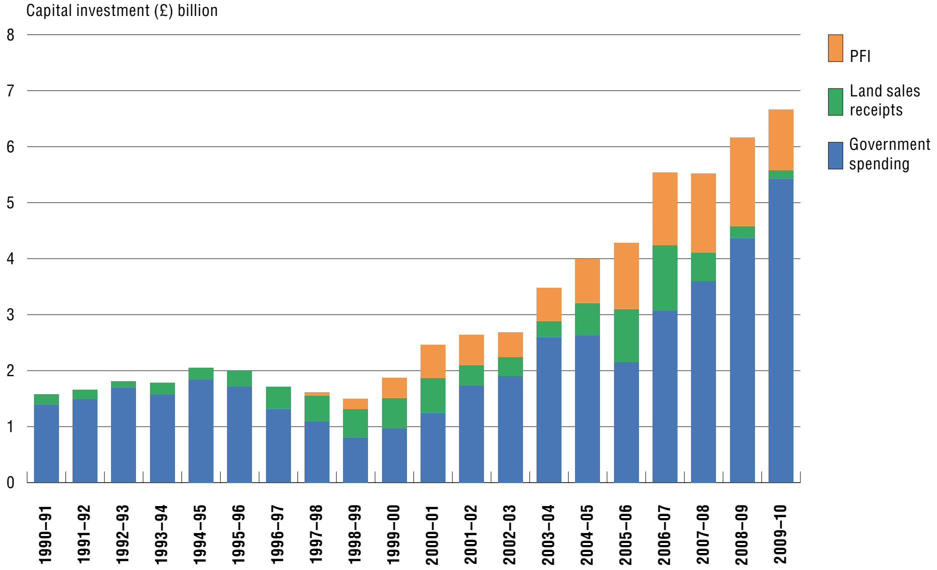
[6] The example of the PFI in the United Kingdom has been followed in many parts of the world.

Fig. 5.3

Sources of capital investment in the NHS in England, 1990–1991 to 2009–2010



Sources: Department of Health 2008b, 2009c; House of Commons Select Committee on Health 2006b, 2008b, 2010a.
Note: All years are actual figures except 2009–2010, which is planned outturn.

Since 1997, all major capital schemes in the NHS (at first mainly hospitals) have been required to consider the use of private finance by testing the value for money of a PFI option against the use of public sector capital. PFI has usually involved competition between providers of serviced health care buildings against a tender issued by the NHS, where the private sector agrees to finance, design, build and operate (non-clinical aspects) a hospital for an NHS trust. Providers formed for this purpose legal entities known as Special Purpose Vehicles. Often contracts were for 30 years or more (Boyle & Harrison 2000).

In most cases, the comparison between the PFI option and its equivalent using public sector finance (known as the public sector comparator) has indicated that the PFI option will provide best value for money once the transfer of risk from the public to the private sector is taken into account. The Labour Government argued that the PFI transfers risks such as cost or time overruns to the private sector, and that the private sector is more capable of handling such risk; consequently, the process is delivered more efficiently. However, the estimated difference has often been relatively small, and has relied fundamentally on the valuation set on risk transfer (Boyle & Harrison 2000).

The PFI has not been without controversy. On the one hand, critics argue that it is unclear whether it offers any clear advantage in terms of lower costs. PFI financing costs are higher than would be the case with public funding, and often there is no apparent reduction in building and operating costs (Gaffney et al. 1999a, 1999b; Hellowell & Pollock 2009). The tendering process is also long, expensive and time consuming, and adds an additional cost for the NHS. Moreover, there is evidence of cost-creep after the selection of the preferred bidder when the competitive discipline has gone (NAO 2007c).

On the other hand, the government has argued that the PFI enabled more investment to be made available to the NHS than would have happened if Treasury funds alone had been relied upon. The Treasury has been concerned to keep government spending within the fiscal framework established to meet the 1997 Stability and Growth Pact criteria for management of the Eurozone.[7] It was argued that the use of private finance is "off balance sheet" and hence does not affect government borrowing requirements. However, commentators at the time questioned whether PFI schemes could properly be regarded as off balance sheet. This is an issue to which the government has been forced to return, particularly with the introduction of International Financial Reporting Standards in the production of government accounts. The NAO pointed out that if International Financial Reporting Standards principles are applied to PFI projects then, in fact, the majority will be on balance sheet (NAO 2008b).

Furthermore, the question remains of whether the buildings that have been rapidly built will be fit for purpose in the medium term, partly because of the poor quality of some of the buildings and partly because the way health care is delivered is likely to change over time in the light of new technology. Nevertheless, under PFI, a large number of new hospital schemes have come to fruition, and, as pointed out above, a total of 104 hospitals had been built or renewed (77 using PFI) between 1997 and mid-2009, and a further 28 are under construction (Department of Health 2009c).

The majority of investment remains funded by central government. In the past, at an aggregate level, funds for capital investment in the NHS in England were allocated on a regional basis by the Department of Health from central government resources with an aim to deliver an equitable distribution of health care facilities. Thus, all NHS trusts, SHAs and PCTs received capital allocations

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[7] Over the economic cycle, the government would borrow only to invest, and public sector net debt as a proportion of GDP would be held at or below 40%. However, the impact of the recession in 2008 and 2009, and the substantial sums expended to underwrite the banking sector, made this stance untenable. Public sector net debt stood at 44.0% in 2008–2009, was estimated to be 53.5% in 2009–2010 and is forecast to reach 61.9% in 2010–2011 (HM Treasury 2010).

for each year consisting of operational capital for direct investment in facilities to cover depreciation, strategic capital allocated to SHAs for distribution to trusts and PCTs for large-scale investment prioritized according to the assessment of the strategic body, and central programme capital allocations aimed at particular investment objectives such as developing IT systems.

However, the introduction of NHS FTs in 2004 brought a fundamental change to the treatment of NHS capital. Capital investment by FTs is financed locally, either through the reinvestment of cash generated by each FT from income for activity or through interest-bearing loans. These loans may come from the private sector (commercial banks) or from government through the Foundation Trust Financing Facility. Monitor, the independent regulator, allocates a "prudential borrowing limit" to each FT, basing its decision on the trust's ability to pay back the money it borrows. Loans drawn down from the Department of Health's loan facility are on commercial terms.

A similar system of so-called prudential-based capital allocations has operated for all NHS trusts since 2007–2008, and for PCTs since 2008–2009, instead of relying on operational and strategic capital allocations for the maintenance and replacement of their assets – although some capital funds are still made available to PCTs and NHS trusts from centrally held resources (Department of Health 2008b). So, internally-generated cash is the primary source of capital funding for NHS trusts, with additional finance also provided through interest-bearing loans. An NHS trust's capital plans are agreed with its responsible SHA. NHS trusts can also apply for working capital loans from the Department of Health, provided that these are affordable over a reasonable time-period and that principal repayments are made from operating surpluses and improvements in working capital. In addition, PCTs develop their own capital plans, which are agreed with their SHAs, and these inform their capital allocations (Department of Health 2008h).

The government intended that all NHS trusts should become FTs. However, these changes were slow to take effect; by September 2010, there were 131 FTs in the NHS (Monitor 2010). FTs in 2007–2008 only accessed £100 million of capital funding out of £2.5 billion available to them (Audit Commission and Healthcare Commission 2008). Nevertheless, their total gross capital expenditure in 2008–2009 was £1.25 billion, compared with £906 million in 2008; this was partly offset by receipts from the sale of assets of £74 million, compared with £62 million in 2008 (Monitor 2009a).

In Fig. 5.3, government spending includes this FT capital expenditure. The other main source of capital investment is receipts from land sales, which have varied considerably over the period. The proceeds of asset sales are retained by the FT or by the local SHA in the case of NHS trust or PCT land sales (unless the NHS trusts and PCTs are "high performing" in which case these types of trust may retain a portion of the proceeds). The "debt" on the land owned by trusts must be repaid to the Treasury if the land is sold.

How NHS providers pay for the use of capital

Under HM Treasury rules, each government department is expected to pay for the use of its assets. Hence, when NHS trusts were introduced in 1991 they were required to make a capital-related payment (capital charges) each year to the Treasury based on the value of their existing capital assets – known as public dividend capital. These payments were introduced to encourage trusts to make economic choices about the best use of their capital. Originally, trusts were required to pay an annual return to government of 6% of the estimated value of their net capital assets in addition to an annual depreciation charge on these assets. However, in April 2003, this charge was reduced to 3.5% in line with the Treasury's decision to reduce the public discount rate from 6% to 3.5% (HM Treasury 2003). FTs also pay for their use of capital through interest on any loans which they take out or PFI payments. In addition, they are expected to pay interest on their public dividend capital in the same way as other NHS trusts (Monitor 2009b).

How investment decisions are made

Previous sections have described broadly how resources are made available for capital investment, and how NHS providers pay for the use of this capital. There is no longer a formal central prioritization process for large capital schemes.[8] Instead, local providers are responsible for initiating local investments, with their decisions subject to a regulatory framework specified by HM Treasury and developed further by the Department of Health. This indicates when NHS bodies may initiate capital investment without reference to higher authorities, and provides rules for ensuring good business practice (Department of Health 2007p). However, there are different rules for FTs, which are not subject to delegated limits; rather, they can invest within their prudential borrowing limits, as described above.

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[8] A body, the Capital Prioritisation Advisory Group, was set up in 1997 to examine and prioritize larger capital investment schemes but this is no longer in operation.

Most capital investments are initiated by NHS trusts or PCTs (although some investment is carried out by SHAs). The process they follow and their decision-making must comply with the principles of the *NHS Capital Investment Manual* (Department of Health 1994a), and subsequent guidance added to it, as well as other NHS good practice guidance.

Trusts and PCTs are expected to produce a strategic outline case (SOC), an outline business case (OBC) and a full business case (FBC) for large schemes that are referred to the Department of Health. Trusts and PCTs may approve their own business cases up to limits of between £3 million and £12 million depending on their turnover and recent performance ratings. For higher levels of investment, SHAs are responsible for approval of business cases in their areas for capital schemes up to £35 million. The Department of Health can approve business cases for sums less than £100 million; above that, Treasury approval is required.

The SOC is the first stage, setting out the case for a new investment in terms of resulting improvements in health services and presenting the strategic options for capital development. Following successful approval of its SOC, the trust carries out an options appraisal in which options are reviewed against non-financial criteria. Government guidance requires that all options are compared with a "do minimum" option. The process of reducing options to a single preferred choice is presented in the OBC.

Once the OBC is approved, the planning of the facility enters a phase of detailed programming, focusing on elaborating the chosen option. This plan is put forward for approval in the form of the FBC and includes details of architectural design, the precise distribution of capacity within the hospital and the range of services to be provided. If private finance is requested, there are guidelines at the OBC and FBC stages for appraising the value for money and the viability, desirability and achievability of procurement through the PFI compared with conventional procurement.

In addition, the Office For Government Commerce gateway project review process is applied to all Department of Health projects as well as those of its associated arm's-length bodies and high-risk and some medium-risk projects within the NHS; most hospital reconfiguration proposals are included. This is a check on the quality of the business planning processes and comprises short reviews by independent experts at six key stages: strategic assessment, business justification, procurement strategy, investment decision, readiness for service and benefits evaluation. These gateway reviews are intended to highlight risks and issues that, if not addressed, would threaten successful delivery of the programme or project (HM Treasury 2004).

The procurement of large pieces of medical equipment in the NHS funded by capital investment is considered in section 5.1.3 below.

GP premises

The *NHS Plan* (Department of Health 2000a) set a target of 500 new primary care centres plus replacement or refurbishment of 3000 GP premises. To facilitate this, the government extended the use of private finance into the primary care sector with the introduction of the Local Improvement Finance Trust (LIFT) in 2001 with an initial aim of designing and implementing local building programmes to improve or replace primary care premises, although this has been extended to include premises for more broadly based community health and social care. This is a joint venture between local health bodies, private-sector partners and a national body, Community Health Partnerships, a private limited company owned by the Department of Health.[9]

Local public–private companies (known as LIFTcos) have been created with 60% ownership by the private sector, 20% by local health bodies and 20% by community health councils. These bodies develop and make available managed facilities for the delivery of primary care under commercial leasing agreements. Start-up funding of £195 million of public money was made available by the Department of Health (NAO 2005b). There have been four waves of investment, resulting in 49 LIFT schemes; by October 2010, there were 275 LIFT buildings open or under construction with an overall investment of £2.3 billion (Community Health Partnerships 2010).

Although most GP premises are privately owned, NHS funds, as well as private funds under the LIFT initiative, support capital investment in these assets. GPs are eligible for reimbursement from NHS funds for the costs of the facilities they use, including recurring premises costs (such as business rates), refurbishments and rent. These are paid for from the funds of local PCTs. In the case of new capital developments, funds are allocated to a "lead PCT", which, in conjunction with the SHA, prioritizes the development of premises in the area.

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[9] Community Health Partnerships was known as Partnerships for Health until November 2007.

5.1.3 Medical equipment, devices and aids

This section looks at the way in which medical equipment is procured and highlights some recent attempts to rationalize this process. Figures are also provided on the availability of some of the more expensive items of equipment; as data are not available at an aggregate England level, the position of the United Kingdom is compared with that in the rest of Europe.

Procurement

In the early years of the NHS, individual organizations were responsible for their own procurement process. In the late 1980s, a more centralized process began to develop with the setting up of procurement bodies within the old regional health authorities. However, the establishment of the NHS Purchasing and Supply Agency (NHS PASA) as an executive agency of the Department of Health in 2000 signalled a switch to a more centralized approach.

NHS PASA acted as a centre of expertise in purchasing goods and services for the health service and advised on policy and the strategic direction of procurement across the NHS. The agency contracted on a national basis for products and services "strategically critical" to the NHS and helped to aggregate purchasing power to produce greater economies than would be achieved by contracting on a local or regional basis. NHS PASA worked with NHS trusts and SHAs and managed 3000 national purchasing contracts, affecting around half of the £7 billion spent in the NHS in England on purchasing goods and services, including office furniture, pharmaceuticals and medical equipment. The last item was managed by the Medical Equipment Directorate, which procured a range of products, including orthopaedic, surgical instruments and radiology equipment such as CT scanners and MRI units.

In 2002, an Audit Commission review of purchasing and supply practices in NHS trusts had found that there was no consensus on which goods and services should be bought nationally, by inter-trust consortia or locally (Audit Commission 2002a). National contracts were available for a range of goods and services but the degree to which trusts used them varied. Although government policy was that trusts should support the use of national contracts, the Audit Commission found that some trusts were using NHS PASA national contracts as the starting point for their own negotiation to obtain a short-term price advantage. It concluded that this was advantageous to those trusts as long as only a small minority of trusts were involved. If large numbers of trusts were involved, purchasing power in the NHS as a whole could be jeopardized.

Identifying a need for collaborative procurement, in 2002, NHS PASA launched its report *Modernising NHS Supply,* which prompted the development of "supply management confederations", organizations coterminous with SHA boundaries (NHS PASA 2002). After a review of the NHS supply chain, the Commercial Directorate of the Department of Health launched the Supply Chain Excellence Programme in March 2004. This three-year programme focused on the restructure of the whole NHS supply chain to gain efficiencies and improve the effectiveness of supply management in the NHS.

As part of this general procurement initiative, the Pharmaceutical Supply Chain Project was launched, aimed at improving the procurement of generic drugs. This was to be achieved through the development of regional NHS bodies known as "collaborative procurement hubs" with the ability to provide a regional procurement focus, and targeted to achieve £270 million savings by 2007–2008. These hubs consist of NHS trusts and PCTs (normally within the same SHA or regional boundary) collaborating to make the most effective procurement and supply-chain decisions (in conjunction with NHS PASA, or its successor organizations, and other organizations) so as to provide best value for stakeholders within their respective health economies.

In 2009, a new commercial operating model was introduced into the NHS in England (Department of Health 2009k), with four main components:

- regional commercial support units to offer commercial expertise to providers and commissioners of care, and provide a single point of contact for private-sector and voluntary-sector supplies;
- local procurement hubs of the NHS Supply Chain aligned with these regional commercial support units;
- closure of NHS PASA with its functions distributed between Buying Solutions, an executive agency of the Office for Government Commerce, and the commercial support units; and
- within the Department of Health, the Procurement Investment and Commercial Division replaced the Commercial Directorate and the Private Finance Unit, and the Strategic Market Development Unit took responsibility for leadership and support to commissioners in market analysis and market making, as well as developing the new Cooperation and Competition Panel.

The Procurement Investment and Commercial Division became operative immediately. The distribution of NHS PASA functions – mainly to Buying Solutions – was completed early in 2010 and the organization ceased to exist at the end of March 2010. Funding for purchases of equipment is provided through central government funding (see the above discussion of capital funding). Decisions on the purchase of equipment are made locally by NHS trusts and PCTs and must follow the same financial governance framework as any investment decision.

Availability of imaging technologies

Historically, the public sector in the United Kingdom has had relatively few CT scanners and MRI units per head of population compared with other OECD countries. However, as Table 5.1 shows for the United Kingdom, the number of both imaging technologies has increased in recent years. Moreover, in England, there has also been a substantial increase in the number of MRI units in the NHS, from 110 to 299, between 1997 and 2008 (House of Commons 2009a).

Table 5.1

CT scanners and MRI units per million population, United Kingdom, 2000–2008

	2000	2001	2002	2003	2004	2005	2006	2008
CT scanners	4.5	5.8	7.1	6.7	7.0	7.5	7.6	7.4[a]
MRI units	4.7	5.2	4.8	4.4	5.0	5.4	5.6	na

Source: OECD 2010a.
Note: [a] Estimate; na: Not available.

Fig. 5.4 shows some international data from 2007, the latest year for which comparative data are available. The data for the United Kingdom include only CT scanners and MRI units located in NHS facilities, unlike the other countries, where private-sector facilities are included.[10]

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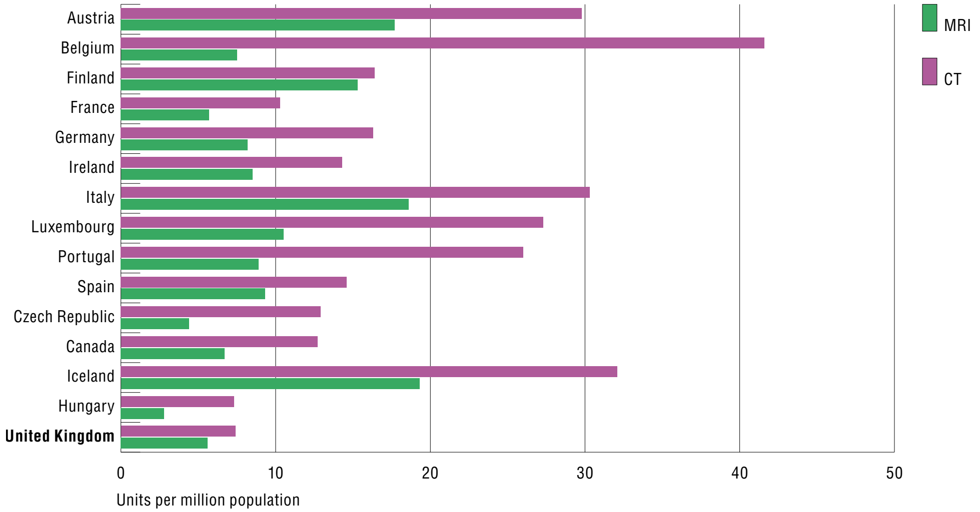
[10] According to OECD database definitional descriptions, there were an estimated 55 CT scanners and 88 MRI units in the private sector in England in 2006 (OECD 2009).

Fig. 5.4

CT scanners and MRI units per million population, United Kingdom and selected countries, 2007



Source: OECD 2010a.
Note: Only CT scanners and MRI units located in NHS facilities are included for the United Kingdom, but figures for other countries include the private sector.

The NHS Improvement Plan in 2004 (Department of Health 2004i) had committed the Department of Health to ensuring that all patients referred to a specialist doctor were seen and treated within 18 weeks (see discussion of waiting times in section 6.4). It was clear that this would require a substantial reduction in the time that people were waiting for diagnostic tests. The Department of Health addressed the issue of long waits for diagnostic tests in a number of ways. A capacity-planning exercise was conducted with SHAs in 2004. This demonstrated that more diagnostic services were required in order to meet waiting time targets for hospital treatment. Capacity plans showed that between 2004–2005 and 2007–2008, MRI activity needed to increase by more than 100% and CT activity needed to increase by 33%.

To achieve this, the NHS committed to inject an extra £2 billion into diagnostics over five years from 2006–2007, half of which was to be used for national procurement of diagnostic services from the private sector. The Diagnostics Futures programme of R&D work, carried out between April 2005 and April 2006, was a project initiated by the Department of Health to support the capacity-planning framework for diagnostics and underpin the delivery of the 18-week target. It aimed to ensure the NHS uses the most up-to-date diagnostic techniques available, and that the correct levels of diagnostic capacity are available. In July 2004, the private-sector provider Alliance Medical Limited was contracted to provide 12 mobile MRI units to the NHS, which would supply some 635 000 scans in total over the five years to July 2009 at a cost of £3.68 million (Department of Health 2004j).

In 2005, the Department of Health introduced Choice of Scan, which was intended to allow patients who faced long waits for scans the choice of an alternative provider and hence to reduce waits for tests. By April 2007, if a patient did not have an appointment for an imaging scan within 13 weeks, they were to be offered the choice of having a scan with another provider (including the private sector) within that maximum time. These measures have had a great impact on the length of time people now wait for diagnostic tests in the NHS. There has been a substantial increase in the number of all types of test, and in particular MRI scans and CTs. Between 1995–1996 and 2008–2009, the number of MRI scans performed within the NHS increased by almost 400% while the number of CT scans increased by almost 100%. Ultrasound scans also increased over the same period by nearly 90%. These figures take account of the use of private-sector providers by the NHS although this is only a small fraction of the total. The result is that by 2008–2009 numbers of MRI scans and CT scans performed per 1000 population in England had increased to 34 and 65, respectively, and somewhat more than this once non-NHS-funded private-sector provision is taken into account (Department of Health 2009l).

5.1.4 Information Technology

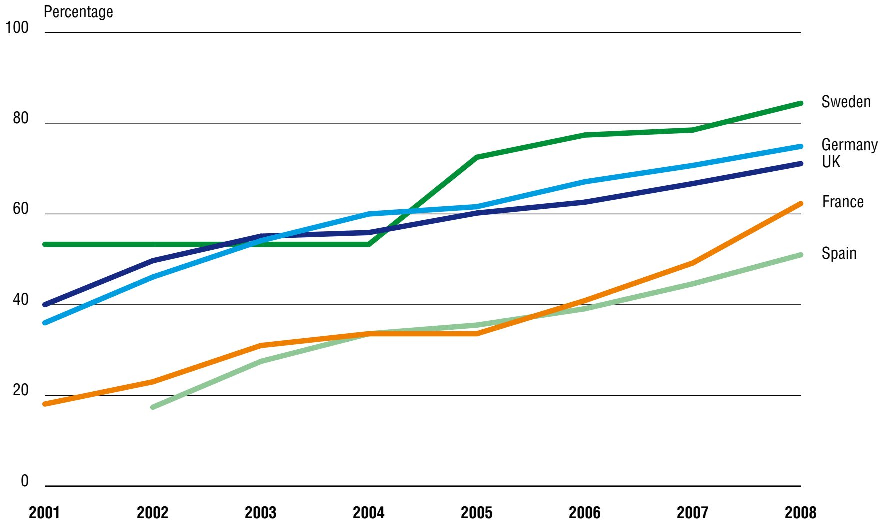
This section considers the use of IT within the health sector. In recent years, there has been a considerable growth in the use of IT in general, and access to the Internet in particular. The proportion of households in the United Kingdom that have access to the Internet increased from 55% in 2005 (ONS 2008b) to 73% in 2010 (of which, the great majority had broadband access). In 2010, 77% of the population aged 16 years and over had recently accessed the Internet (within the last three months). However, there are significant differences by age group, with only 32% of the 65+ age group having recently accessed the Internet compared with 97% of those aged 16–24 years. In fact, by 2010, there were still 21% of women and 16% of men who had never accessed the Internet, and 60% of those aged over 65 years (ONS 2010f).

Of people accessing the Internet, 39% claimed to have used the Internet to access health-related information. People tend to access the Internet from more than one location: 95% have accessed from home while 41% have accessed from their place of work (other than home), and 13% from a place of education (ONS 2010f).

Most European countries have seen an increase over time in the proportion of households with access to the Internet. As Fig. 5.5 shows, Internet access in the United Kingdom is relatively high compared with some countries, although Germany and Sweden have higher access levels.

Fig. 5.5

Percentage of households with Internet access, United Kingdom and selected European countries, 2001–2008



Sources: OECD 2009 (data for 2001 to 2007), 2010b (data for 2008).

The development of integrated IT systems in the NHS

Over the last 60 years, the development of IT systems to help with the delivery of patient care in the NHS has been piecemeal with organizations developing their own solutions, and a wide range of IT systems and providers used. Until recently, it had been left to each NHS trust to decide what IT systems were needed and how much money should be allocated to IT. Spending on IT was low. There was no overall system-wide approach and so hospitals developed their own small stand-alone systems. The lack of any common standard combined with few financial incentives resulted in inconsistent IT development. Similarly, although 96% of general practices were computerized by 1996 (Pemberton et al. 2003), a wide range of different systems were in place, which, while enabling the smooth running of the GP's core business, did not link to the wider NHS.

In 1998, the Department of Health committed to the development of electronic patient health records for all citizens and, in addition, online access and an integrated information system across GPs, hospitals and community services (Department of Health 1998a). In October 2002, the Department of Health established the NPfIT to take forward its national strategy for IT with the task of developing, procuring and implementing an integrated IT infrastructure – from hospital trusts to general practice – by 2010. Since then, there has been a major push to develop such an integrated IT infrastructure for the whole of the NHS, although with somewhat limited success.

In 2005, the Department of Health established a new organization, Connecting for Health, as the single national IT provider for the NHS, being responsible for implementing a range of new IT systems across the NHS. These included:

- NHS Care Records Service (NHS CRS)
- Choose and Book
- Electronic Prescription Service (EPS)
- New National Network (N3)
- e-mail and directory service (NHSmail)
- Picture Archiving and Communications Systems (PACS)
- GP payment systems
- delivering existing IT products and services to the NHS.

In 2007, SHAs became accountable for the delivery of the NPfIT, with NHS Connecting for Health supporting delivery; this was part of the NPfIT Local Ownership Programme with responsibility split geographically between three local programmes. In 2008, NHS Connecting for Health also became responsible for NHS Choices, a web site that supports patient health care and acts as a portal to the Choose and Book service discussed below. In 2009, Connecting for Health became part of the Department of Health Informatics Directorate (Robertson et al. 2010).

NHS CRS

A key part of the new IT programme is the provision of the NHS CRS. It is intended that the medical records of all patients will be held electronically, linking primary and secondary care with 24/7 live interactive data accessible at any NHS location to authorized staff and patients. The "NHS number", a unique 10-digit identifier issued for each patient, is the cornerstone of this electronic health record system.

Key to the development of the NHS CRS is the creation of the Spine, which will be a national database of key information about the health and health care of patients. It is intended that the Spine will store personal demographic information as well as summarized clinical information, such as a patient's allergies and visits to A&E departments; this is known as the "summary care record" (SCR). The purpose of the SCR is that wherever and whenever a patient seeks care from the NHS in England, those treating that person will have secure access to summary information to assist with diagnosis and care. Health care professionals will only be able to access the Spine via a smartcard (similar to chip-and-pin debit and credit cards), which will be issued by registration authorities. The Spine is also intended to bring together all local IT systems within the national programme, and Connecting for Health has installed a new national network to support the transfer of clinical data between sites (NHS Connecting for Health 2007). Since 2007, the SCR has been developed across a number of "early adopter" and other sites in England; however, by March 2010, only around 1.24 million individual records had been produced, indicating that there remains a long way to go (NHS Connecting for Health 2010).

Choose and Book

Choose and Book is an initiative that allows patients to book a hospital appointment at a date and location of their choice (see section 2.5.3). The implementation timetable for this new service fell behind schedule, one of the main problems being that many GP practices needed new integrated computer hardware to run Choose and Book efficiently. However, by March 2009, 88% of acute hospitals had a patient administration system that was compliant for Choose and Book and that had received an electronic referral, and 96% of all GPs had used Choose and Book to send an electronic referral (Department of Health 2009c). In March 2010, 58% of GP outpatient referrals were made through Choose and Book (NHS Connecting for Health 2010).

EPS

The EPS is another part of the national development of IT systems. This is intended to allow prescriptions to be sent electronically from the person prescribing to the dispenser and then to the Prescription Pricing Authority, reducing reliance on paper prescriptions. Drugs prescribed for use in hospital will not be included in the service, although many hospital providers are developing their own electronic prescribing systems (NHS Connecting for Health 2009a). Initially, it was intended that the service would be fully operational by the end of 2007. However, by March 2009, only just over 30% of prescriptions were issued electronically, although 80% of GP practices and pharmacies had the technology to operate the service. The implementation across the whole system continues (Department of Health 2009c).

New National Network

It was also intended to set up a national network for the NHS (the New National Network) to link all NHS organizations in England via the Internet, thus enabling reliable and secure exchange of data.[11] The network, which provides IT infrastructure, network services and broadband connectivity for the NHS, is now operating across over 40 000 NHS sites, including 11 000 services for mobile and community workers (Department of Health 2009c).

NHSmail

Connecting for Health also aimed to set up a new e-mail and directory service for NHS organizations (NHSmail) to provide a central, secure e-mail service that would allow speedy and secure exchange of information across the NHS. This was launched in October 2004 as a secure encrypted e-mail and directory system (www.nhs.net). However, initially the NHS was slow to take up the service and many trusts stayed with their local e-mail systems; by 2009, there were just 197 000 active NHSmail users (Department of Health 2009c). However, this had grown by March 2010 to almost 500 000 registered users (NHS Connecting for Health 2010).

PACS

Another aspect of Connecting for Health was the introduction of PACS whereby X-rays and scans would be captured, stored, distributed and displayed as electronic digital images capable of being sent and viewed at many NHS locations. The PACS is capable of providing full access to digital images in NHS organizations throughout England. Such images would also eventually form part of the NHS CRS of each patient. Implementation, intended by March 2007,

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[11] Between 2004 and 2007, the New National Network replaced NHSnet, an earlier private NHS communications network (NHS Connecting for Health 2009b).

was achieved in all NHS acute trusts in England by 2008; however, the sharing of information across all NHS organizations, as well as with the private sector, was unlikely to be available until 2011 (Department of Health 2009c).

GP payment systems

Connecting for Health has also supported the development of a system, the Quality Management and Analysis System (see section 4.2.3), to support and provide feedback to individual practices and PCTs on the new QOF for general practice, which forms part of the new general medical services contract (see section 3.6.2). The system was implemented in 2005 and collects national data, computes national disease prevalence rates and calculates the points and payment value earned. GPs can use the system to analyse the data they collect about their own services and quality of care (e.g. maternity services or chronic disease management clinics).

In addition, Connecting for Health has supported the development of GP2GP, a system that allows the electronic transfer of the medical records of a patient who moves from one GP practice to another.

Local implementation

Originally, Connecting for Health grouped the SHAs into five geographic areas known as clusters, and contracts were awarded to IT consortia known as Local Service Providers for each cluster: these consortia were to supply new local systems to NHS hospitals. The products to be supplied included new patient administration systems, electronic test ordering and browsing, maternity care and theatre management systems, and it was intended that the new systems would link via the Spine to provide an accessible network of information. However, implementation has been slow. Contracts were awarded to four suppliers but financial issues have resulted in only two remaining and these are responsible for delivery across the whole of England.

Criticisms

Throughout its existence, the NPfIT has been surrounded by controversy (House of Commons Select Committee on Health 2007c). It has been argued that it represented an overcentralization of the process as well as of the data itself, that the appointment of Local Service Providers was overly restrictive and that trusts should be able to choose between a number of potential IT system providers. The cost-effectiveness of the programme has been questioned, as well as the extent of cost-overruns (Hayes 2009). Recent estimates from the Department of Health suggest that delivery of the NHS CRS will be as late as 2014–2015, four years behind schedule. The programme of work was ambitious; moreover, suppliers have struggled to meet the needs of individual

NHS organizations while providing a national system (House of Commons Public Accounts Committee 2009). Recent estimates of costs suggest a total cost for the programme of £12.7 billion, of which £6.8 billion relates to core local contracts for IT systems, £665.8 million is due to additions to the scope of the programme (e.g. PACS) and £1.6 billion is central costs. In addition, local costs associated with the project are estimated at £3.6 billion. Actual overall expenditure (central and local) to March 2008 is estimated to be £3.55 billion, reflecting the slower than planned delivery of the CRS (NAO 2008c).

Other NHS web sites

The development of IT within the NHS included the introduction of web sites providing key information to the population. The main site is *NHS Choices*, which incorporates a number of sites that have been developed for the NHS in England. It allows members of the public to search and find details of local NHS services, including where to find their nearest GP, pharmacy, dentist or optician. People can also access information on hospital waiting times and outcomes, maps to find the nearest hospital, parking and public transport. *NHS Direct Online,* which provides patient advice and information to over 42 million online visitors per year, can also be accessed via this web site as well as independently (NHS Direct 2010).

Health Information Resources (www.library.nhs.uk) provides access to clinical evidence for "informed patients" as well as health care professionals.[12] *NHS Evidence* (www.evidence.nhs.uk) also provides access to clinical and non-clinical information including evidence, guidance and government policy. In addition, a new online personal health organizer, *HealthSpace* (www.healthspace.nhs.uk), provides a secure place on the Internet for people to store personal health information that they may wish health professionals to know, such as details of their medications or food preferences. It is intended that eventually it will be linked to wider NHS IT systems, offering patients the ability to view their SCR securely online. It also currently provides people with access to Choose and Book and it is intended to be linked to the EPS when this is fully operative.

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[12] Health Information Resources was known as the National Library for Health.

5.2 Human resources

This section discusses the use of human resources for the provision of health care in England. It begins with a description of changes in numbers over time, identifying a significant increase in the numbers of health care personnel over the last 10 years, largely in line with government targets (section 5.2.1). Section 5.2.2 describes human resource planning arrangements in England, and the focus on the use of targets for increasing capacity. Finally, section 5.2.3 summarizes the training and registration procedures for doctors, dentists, nurses and other personnel, also indicating the typical career path for doctors.

The NHS workforce in England in 2009 was over 1.43 million, most of whom belong to trade unions. All NHS health care professionals are registered at the United Kingdom level. Health care professionals also work in the private sector, mainly in care homes and nursing homes, but also in private acute hospitals and clinics.

5.2.1 Trends in levels of human resources

Expansion of the NHS workforce has been a key feature of government policy since 2000 (see section 5.2.2 below), and in recent years it has grown significantly (Table 5.2). The total number of people employed within the NHS increased by over 375 000 between 1996 and 2009, at an average annual rate of 2.4%. There was a significant growth in the number of doctors, particularly registrars; there was also a significant rise in the number of managerial staff, whose number doubled. Nursing staff is the largest group of health care personnel, making up over 29% of the total workforce.

Doctors

In England, the total number of doctors working in the NHS was 140 897 in 2009 (132 683 WTE), which represents an increase of 54 313 since 1996 or a 3.8% annual increase over this period (Table 5.2). Of the total number of doctors, 40 269 were GPs (including GP retainers and registrars) of whom almost 46% were women (Information Centre 2010i). Included in the total number are 1978 doctors who specialize in public health medicine and 1551 dentists who specialize in dental public health (Information Centre 2010j); section 6.1 discusses these public health professionals. The increase in the total number is even more substantial when compared with earlier figures. Thus, in 1975, there were 35 460 NHS hospital medical and dental staff (28 517 WTE), which had increased to 48 593 (40 253 WTE) by 1990.

Table 5.2

NHS workforce in England by headcount, 1996, 2001, 2008, 2009 and average annual change, 1996–2009

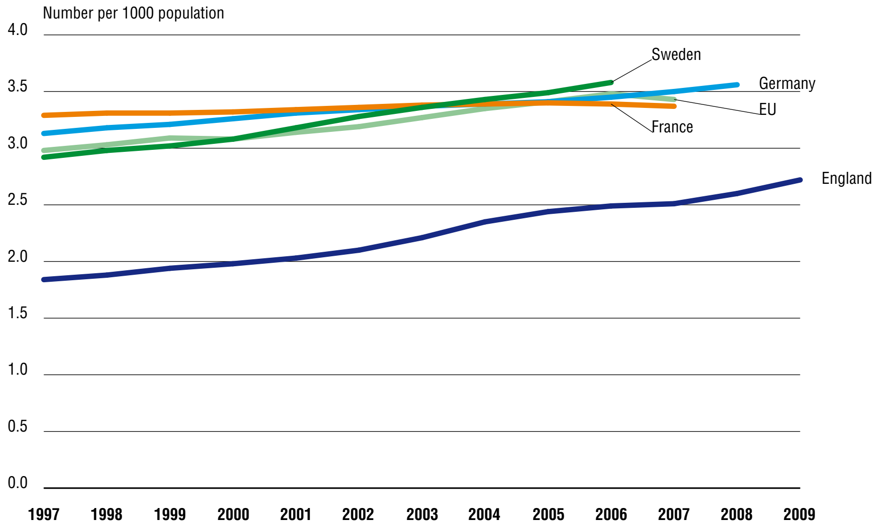
	1996	2001	2008	2009	Average annual change (%)
Doctors	86 584	100 319	133 662	140 897	3.8
Consultants[a]	20 402	25 782	34 910	36 950	4.7
Registrars[b]	11 385	13 220	35 042	37 108	9.5
Other doctors in training[b]	17 483	19 572	14 136	14 394	–1.5
Other medical and dental staff	8 198	9 910	11 854	12 176	3.1
GPs	29 116	31 835	37 720	40 269	2.5
Nurses	319 151	350 381	408 160	417 164	2.1
Nurses and midwives	301 253	330 535	386 112	395 229	2.1
Practice nurses	17 898	19 846	22 048	21 935	1.6
Other	94 320	105 910	142 558	149 596	3.6
Allied health professionals	43 906	57 001	71 301	73 953	4.1
Other scientific, therapeutic and technical staff	50 414	53 240	71 257	75 647	3.2
Ambulance staff	14 720	14 855	17 451	17 992	1.6
Support to clinical staff	281 897	325 890	355 010	377 617	2.3
NHS infrastructure support	174 165	179 783	219 064	236 103	2.4
Central functions	70 621	81 439	105 354	115 818	3.9
Hotel, property and estates	82 280	70 920	73 797	75 624	–0.6
Manager and senior manager	21 264	27 424	39 913	44 661	5.9
Other GP practice staff	79 481	84 473	92 436	92 333	1.2
Other non-medical or unknown	6 183	1 224	353	364	–
Total	**1 056 501**	**1 167 166**	**1 368 693**	**1 431 996**	**2.4**

Sources: Information Centre 2007c, 2010i.
Notes: [a] Includes directors of public health; [b] Modernising Medical Careers programme introduced new training grades (Modernising Medical Careers 2009). In 2007, these changes produced a change in "registrar group" numbers, which increased, while "senior house officer" numbers decreased.

The OECD Health Database 2010 (OECD 2010a) provides some comparative data for European countries including the United Kingdom. The position in England is very similar to that of the United Kingdom in that it has among the lowest number of doctors per 1000 population in the EU despite the increasing trend between 2000 and 2009, from almost 2 to 2.7 practising doctors per 1000 population. This compares with an average for the EU15 countries of over 3.4 in 2007. Fig. 5.6 compares the position in England with that in France, Germany and Sweden, all of which have substantially more doctors per head of population even though the rate of increase in the number of doctors has been greater in England over the last 10 years.

Fig. 5.6

Doctors per 1000 population in England and selected countries, 1997–2009



Sources: OECD 2010a; Information Centre 2010i.
Note: EU average is for the EU15.

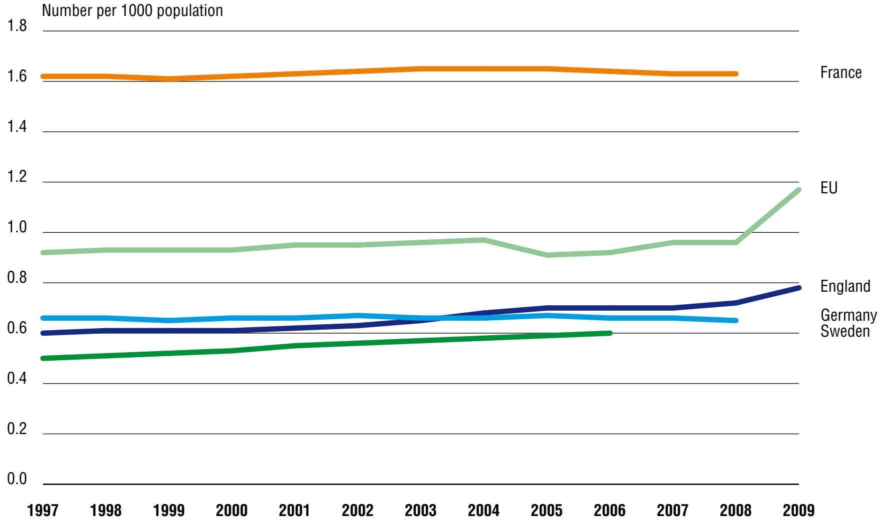
Fig. 5.7 provides similar comparative data for GPs (based on estimated resident population for England), showing that the number of GPs per head of population in England is substantially less than that in France and the EU average, although greater than the number in Sweden and Germany. There were almost 0.8 GPs per 1000 population in England in 2009.

Nurse, midwives and health visitors

The total number of nurses, midwives and GP practice nurses (5.3% are GP practice nurses) working in the NHS in England was 417 164 in 2009 (336 007 WTE). The number of nurses increased by just over 98 000 from 1996, representing an annual growth rate of 2.1% (Table 5.2).

Fig. 5.7

GPs per 1000 population in England and selected countries, 1997–2009



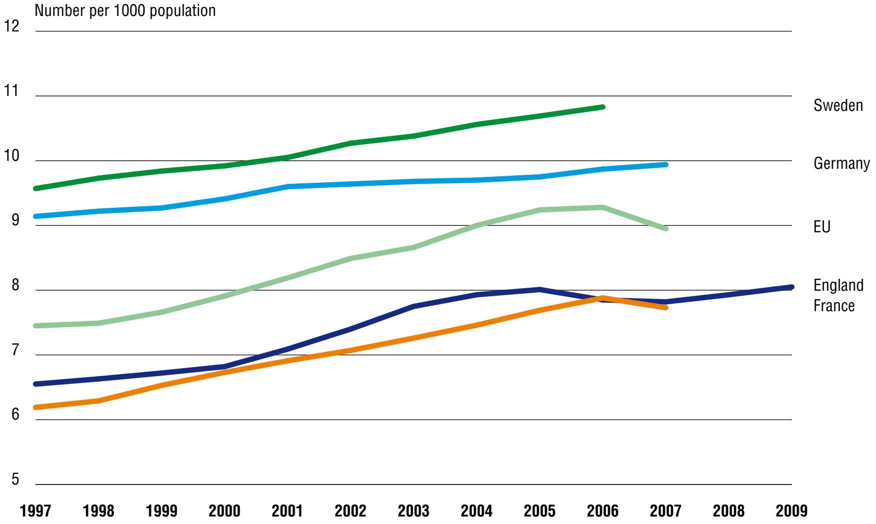
Sources: Information Centre 2009g, 2010i; OECD 2010a.
Note: EU average is for the EU15.

The OECD Health Database 2010 (OECD 2010a) also provides comparative data on numbers of nurses for European countries, including the United Kingdom. England figures have been added for comparison, although it is difficult to compare like with like as definitions of nurse numbers across each country are not wholly compatible.

England has among the lowest number of nurses per 1000 population in the EU despite an increasing trend between 1997 and 2009, from 6.6 to 8.1 nurses per 1000 population. This compares with an average for the EU15 countries of 9.0 in 2007. Fig. 5.8 compares the position in England with that in Germany and Sweden which have substantially more nurses per head of population, and France which has a similar number of nurses per head.

Fig. 5.8

Nurses per 1000 population, England and selected countries, 1997–2009



Sources: OECD 2010a; Information Centre 2010i.
Note: EU average is for the EU15.

Dentist

In 2009, there were 4342 (3301 WTE) dentists working in NHS hospitals and community services, including dental public health, an increase of 22% from 3567 (2464 WTE) in 1997 (Information Centre 2010j, 2010k). The number of dentists working in general dental services, personal dental services or trust-led dental services contracts in the community (which excludes those referred to above) has increased by 34% from 16 470 to 22 003 in 2009–2010 (Information Centre 2008e).[13] Over that same period, the resident population per dentist has fallen from 2955 to 2355. This is equivalent to an improvement from 0.36 dentists per 1000 resident population to approaching 0.43 per 1000.

However, this overestimates the number of people for whom dentists are responsible. In 1997, just 54% of the resident population was registered with an NHS dentist; this had fallen to 49% by 2006. Thus, the average list size for an NHS dentist had fallen from 1388 in 1997 to 1131 in 2006. Registration is now not part of the NHS dental contract, and so this measure has been replaced by patients seen by an NHS dentist in the previous 24 months. The number of

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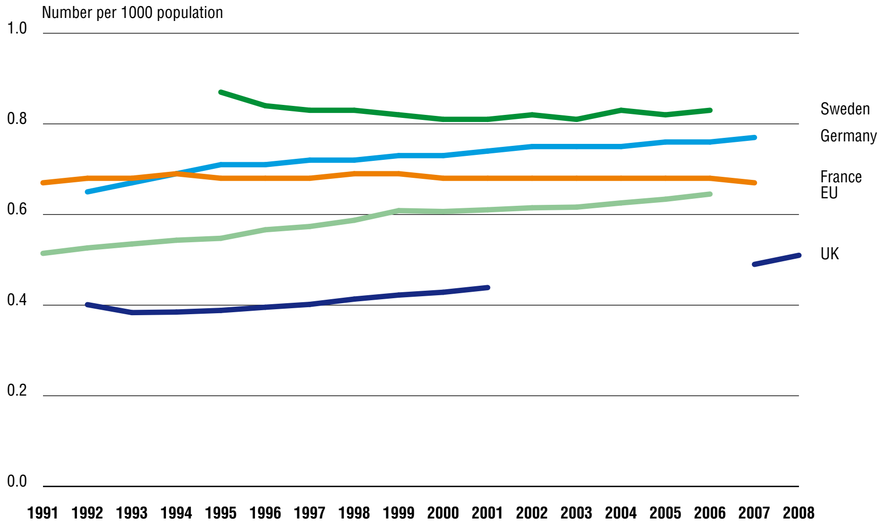
[13] Workforce definitions have changed over this period and, therefore, figures are not wholly comparable.

patients seen by an NHS dentist in England increased from 28.1 million (55.8% of the population) in March 2006 to 28.5 million (55.4% of the population) in June 2010 (Information Centre 2010k).

Comparative European data on numbers of dentists by country suffer from significant differences in the way in which these figures are recorded, the major ones being whether the private sector is included and whether dentists working in hospitals are included – prior to 2007, data for the United Kingdom included neither; since 2007, dentists working in hospitals have been included. Mindful of this, Fig. 5.9 provides a comparison of the United Kingdom – based on OECD and WHO data – with France, Germany and Sweden (as well as the EU15 average) all of which appear to have considerably more dentists per head of population. The supply of dentists in the United Kingdom was estimated at 0.51 dentists per 1000 population in 2008 (OECD 2010a); the European Health for All database provides data for the United Kingdom (not England) up to 2001 (WHO Regional Office for Europe 2009). Section 6.12 provides a more detailed discussion of the supply of dentists in England.

Fig. 5.9

Dentists per 1000 population, United Kingdom and selected countries, 1991–2008



Sources: WHO Regional Office for Europe 2009 (United Kingdom and EU); OECD 2010a (Sweden, Germany and France).
Note: EU average is for the EU15.

Pharmacists

The number of working pharmacists per 1000 population in England is close to the EU average. In 2008 it was 0.6 (Seston & Hassell 2009) compared with 1.2 in France in 2007, 0.6 in Germany in 2007 and 0.7 in Sweden in 2006 (OECD 2009). In 2008, there were 43 244 registered pharmacists in Great Britain, of which 37 303 were in England. Around 17.5% of total pharmacists were registered as "not practising". Of those registered as "practising", over 93% were actually working as a pharmacist, 4.1% were in industry and 2.8% were academics; of working pharmacists, 71% were community pharmacists, 21.4% were working in hospital and 7.2% were in primary care (Seston & Hassell 2009).

In England, NHS pharmacists are included as part of the total scientific, therapeutic and technical staff. In September 2009, there were 15 369 (13 547 WTE) pharmacists working for the NHS – up from 9815 (8657 WTE) in 2000 – and 3758 (3320 WTE) pharmacist support staff (Information Centre 2010l). In March 2009, there were 10 475 community pharmacies in contract with PCTs in England (Information Centre 2009f).

The provision of pharmaceutical services is controlled by government with local enactment through PCTs, who must maintain a list of bodies that provide pharmaceutical services to the NHS (National Health Service (Pharmaceutical Services) Regulations 2005, S.I. 641).[14] This list states the address of the provider at which the service is offered and opening days and times. There are no specific geographic or demographic distributional criteria governing the number of pharmacies in an area. However, the PCT must be satisfied that it is "necessary or desirable" to grant an application to open a new pharmacy and will consider whether there is already an adequate choice of services in that area. There are four exceptions to this rule: premises are exempt if they are in one-stop primary care centres; in large out-of-town shopping centre developments, provided these are not part of a primary shopping area in a city, town or on the edge of a city or town; if they will stay open for at least 100 hours per week; or if they provide essential services but not at those premises (i.e. by mail order or the Internet), which is known as distance-selling premises. Pharmacies must also obtain permission for additional premises, relocations and the supply of pharmaceutical services in addition to the ones originally listed. A pharmacy may be owned by an individual pharmacist, a company whose partners are pharmacists or a private limited company managed by a pharmacist.

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[14] Different regulations apply to doctors and dentists who dispense medicines.

5.2.2 Human resource planning in the NHS

At the national level, planning for future availability of human resources is the responsibility of the Department of Health and the Department for Business Innovation and Skills. These respond to workforce plans developed at local level by PCTs, which are brought together by SHAs at the regional level. There have been changes in the arrangements for NHS workforce planning since 2000 (see section 4.2.1 for further discussion of current mechanisms). However, it has been argued that there remains a lack of coordination of planning across different staff groups, in particular medical and non-medical, and a failure to ensure the consistency of financial, service and workforce plans (House of Commons Select Committee on Health 2007d; Imison, Buchan & Xavier 2009).

The *NHS Plan* in 2000 identified shortages of skilled staff as one of the main challenges facing the NHS (Department of Health 2000a). The 2002 Wanless report (Wanless 2002) agreed that England did not have sufficient doctors and nurses. The government responded by making an explicit commitment to increase the NHS workforce by 2008, establishing specific staffing growth targets: 35 000 more nurses, midwives and health visitors; 15 000 more consultants and GPs; and 30 000 more therapists and scientists (Table 5.3). The human resources element of the *NHS Plan* was set out in a national NHS human resources strategy (Department of Health 2002d).

By 2008 (Tables 5.2 and 5.3), these broad staffing targets had been met. Thus, there were 15 000 more consultants and GPs than there were in 2001, almost 56 000 more nurses and midwives, and almost 37 000 more therapists and scientists. The target for increased medical school places was also met. There are 21 medical schools in England, four of which opened between 2000 and 2003, as well as four new centres of medical education, which operate in collaboration with existing medical schools. The intake of medical students increased from 3749 in 1997 to 6030 in 2003 (Department of Health 2004k).

There has always been a significant number of overseas doctors and nurses working in the NHS in England, and until recently the Department of Health had actively encouraged international recruitment of doctors, nurses and other staff to meet growing staff requirements. Currently, some 36% of doctors in England have been trained outside of the United Kingdom and some 30% outside of the EEA and Switzerland, an increase from 24% in 1998 (Information Centre 2009g). However, the expansion of training places for doctors and nurses since 2000 has led to greater self-sufficiency in the workforce in England, resulting in the government changing immigration rules to make it more difficult for overseas staff (outside the EEA and Switzerland) to come to England to work.

Table 5.3

NHS staffing and training targets (headcount) for England, 2000–2008

Staff levels and training places	Target for increase by 2004 (from 2001 baseline)	Target for increase by 2008 (from 2001 baseline)
Doctors		
Consultants	7 500	15 000[a]
GPs	2 000	
GP registrars	550[b]	
Specialist registrars	1 000	
Medical school places	Up to 1 000[c] more places in addition to 1 100 already coming on stream	1 900
Nurses, midwives and health visitors		
Nurses and midwives	20 000[d]	35 000[e]
Training places	5 500	8 000
Therapists and scientists		
Therapists	6 500	
Therapists and scientists		30 000
Training places for therapists and other key professional staff	4 450[f]	

Sources: Department of Health 2000a, 2002d.
Notes: [a] The 2008 target includes both consultants and GPs; [b] Increase of 100 from the figure of 450 in the *NHS Plan*; [c] Target by 2005; [d] From 2000 baseline; [e] This increase refers to nurses, midwives and health visitors; [f] From 1999 baseline.

The government attempts to manage the number of overseas workers entering various occupations through the use of "shortage occupation lists". It is advised in this task by the Migration Advisory Committee, which reviews shortages (or likely shortages) of skilled workers in a range of occupations. The most recent report of this Committee in 2010 (Migration Advisory Committee 2010) resulted in the Home Office UK Border Agency publishing a revised list of occupations where shortages would allow the use of overseas staff (Home Office UK Border Agency 2010). Only consultants in a small number of selected specialties[15] are now included on this list, as well as non-consultant, non-training medical posts in anaesthetics, emergency medicine, general surgery, intensive care medicine, obstetrics and gynaecology, paediatrics, and trauma and orthopaedic surgery. Among nursing staff, only neonatal intensive care nurses, theatre nurses and operating department practitioners are identified as shortage occupations, and among social workers only those working in children's and family services. Skilled senior care workers are also included.

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[15] Among others, these include haematology, neurology, obstetrics and gynaecology, paediatric surgery, general and old-age psychiatry, and paediatric dentistry.

Some clinically based biological scientists and biochemists are also identified, as well as clinical psychologists, pharmacists, some categories of medical radiographer, nuclear medicine technologists and radiotherapy technologists, speech language therapists and orthoptists.

5.2.3 Training and registration

This section considers the training of four categories of health care staff in England: doctors, dentists, nurses and midwives, and other health care professionals.

Doctors

There are three stages in the training of doctors: undergraduate medical education, postgraduate medical education and CPD.

Undergraduate training

There are currently 22 medical schools in England – with a wide geographic spread – that are able to award their own medical qualifications (GMC 2010).[16] People wishing to become doctors must undertake a five-year university course leading to a degree in medicine (or a four-year "fast degree course" in the case of students who have already graduated in other fields or have equivalent qualifications). Some medical schools offer pre-medical courses to students – mainly those who have specialized in arts subjects – thereby extending the course to six years. Medical schools are allowed to take only some 7.5% of each year's entry from countries outside the EU (GMC 2009).

The GMC is the statutory body responsible for undergraduate training and also for the first year of the Foundation Programme, which leads to full registration as a doctor. The GMC sets out the standards for medical training, including the knowledge, skills, behaviours and attitudes that potential doctors must demonstrate (GMC 2003). Successful students are awarded a medical degree that allows them to practise during a subsequent period of training. They are eligible for inclusion on the provisional GMC medical register and for a licence to practise. Provisional registration allows them to undertake the first year of postgraduate training.

Postgraduate training

Once medical students graduate, usually the next step is to enter, as an employee, a further two-year training programme known as the Foundation Programme.

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[16] There are also four in Scotland; in addition, the University of St Andrews in Scotland provides training for the first three years of a medicine course but the remaining two years are provided elsewhere. There are two in Wales and one in Northern Ireland.

This programme was introduced in August 2005, replacing the previous system whereby medical graduates went through a pre-registration house officer year and a first year of senior house officer training. Until April 2010, the GMC was responsible for approval and quality assurance of the first year of the Foundation Programme while the Postgraduate Medical Education and Training Board was responsible for the second year. In April 2010, the Postgraduate Medical Education and Training Board was merged with the GMC, thereby bringing the regulation of medical training and education under one body. The programme is coordinated through the UK Foundation Programme Office. Postgraduate deaneries, of which there are 12 in England, are responsible for implementing and managing the programmes through foundation schools, which bring together medical schools, the local deanery and NHS trusts for this purpose; they offer foundation doctors training in a range of different settings and clinical environments (UK Foundation Programme Office 2007).

A doctor who has successfully completed a two-year foundation programme is eligible to apply for specialty training. Since August 2007, these training posts have been known as specialty registrars; prior to this they were known as specialist or GP registrars: this reflects a change in the curriculum in August 2007. After a period of training which can last from five to seven years, a certificate of completion of training confirms the satisfactory completion of a United Kingdom programme of training and makes a doctor eligible for inclusion on the GMC's Specialist or GP Registers. This is a requirement if a doctor is to take a consultant post in the NHS or work as a GP. Doctors follow a curriculum that is set by the various specialty colleges, subject to the approval of the Postgraduate Medical Education and Training Board/GMC. This training programme conforms to relevant EU standards and meets and mainly exceeds most EU training time requirements (Postgraduate Medical Education and Training Board 2008).

CPD

There are major changes currently taking place in the regulation of doctors in England following the publication by the government of *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century* (Secretary of State for Health 2007); these are described in more detail in section 4.1.4. Doctors will be subject to revalidation, which will take the form of renewal of a licence to practise and specialist recertification. This applies to all doctors, those working in the NHS and privately. From 16 November 2009, all doctors wishing to practise in England (and the United Kingdom as a whole) are required to have a licence to practise.[17] This is subject to renewal every five

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[17] According to the GMC, over 218 000 doctors were licensed at that date.

years. Specialist recertification will apply to all specialist doctors, including GPs, requiring them to demonstrate that they meet the standards that apply to their particular medical specialty. These standards will be set and assessed by the medical Royal Colleges and their specialist societies, and approved by the GMC.

Doctors have a responsibility through CPD to maintain and develop their knowledge and skills across all areas of their practice. The revalidation process described above is now the means by which doctors can demonstrate the maintenance of their skills. At the same time, doctors are encouraged to develop and extend their knowledge and skills throughout their careers. The GMC has a duty to encourage doctors in their CPD and has produced guidance, *Good Medical Practice,* on what is expected of doctors (GMC 2006). This lays out principles and advice relating to good clinical care; the maintenance of good medical practice; teaching, training, appraising and assessing; relationships with patients; working with colleagues; being honest, open and trustworthy; and in matters relating to the doctor's own health. The GMC expects doctors to follow this guidance.

Since 2001, all NHS consultants are expected to be appraised annually as part of their NHS employment contract, usually by the clinical director appropriate to their specialty within the NHS trust where they work.[18] Since 2002, GPs have also been expected to be appraised annually, usually by a GP appointed for the purpose by the responsible PCT. If a consultant works in private-sector hospitals as well as the NHS, then since 2007 the NHS trust appraisal system is expected to incorporate the consultant's private practice. Doctors who work wholly in the private sector are not covered by this system.

The career path of doctors

The career pathway for doctors has largely been outlined above in discussing the educational pathway that doctors follow. Once a doctor has graduated, two years of foundation training follow, after which, if successful, the doctor becomes a specialty registrar for four to five years undergoing specialist training before becoming a consultant in an NHS hospital, taking a non-consultant specialist post, taking a post in the private sector or becoming either a GP provider (in contract with a PCT to provide services, either alone or in partnership with other GPs) or a salaried GP (working for a GP provider).

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[18] Appraisal also applies to consultants in public health medicine and doctors occupying non-consultant career posts (associate specialists, staff grades) although this was not actually introduced until April 2003.

Dentists

As with doctors, there are three stages in the training of dentists: undergraduate medical education, postgraduate medical education and CPD. There are currently 11 undergraduate dental schools in England – with a wide geographic spread – that are able to award their own dental qualifications (GDC 2008b).[19] People wishing to become dentists must undertake a five-year university course leading to a degree in dentistry. On completion of this training, dentists may register with the GDC, which then allows them to practise as a dentist. Further training is required if a dentist is to be registered on a specialist list.[20] Most specialist dentists work in hospitals. Other dental professionals include dental hygienists, dental nurses, dental technicians, dental therapists and orthodontic therapists, all of whom must be registered with the GDC (see section 6.12).

In much the same way as doctors, dentists now have a responsibility through CPD to maintain and develop their knowledge and skills. This process is driven by the GDC, which is developing a revalidation process that will include compulsory CPD (GDC 2006). The GDC has also produced guidance, *Standards for Dental Professionals,* on what is expected of dental practice, providing principles and advice relating to good clinical care (GDC 2005).

Nurses and midwives

The Nursing and Midwifery Council sets the standards and guidelines for, and provides quality assurance for, nursing, midwifery and health-visiting education. Training to become a nurse or midwife is provided through either a pre-registration diploma or degree course offered by universities, with placements in local hospital and community settings. From September 2013, all courses will be at degree level. The first year introduces the basic principles of nursing through a Common Foundation Programme. Students then specialize in adult, children’s, mental health or learning disability nursing. Diploma courses last three years; degree courses last three or four years. Part-time courses are also available lasting five or six years and there are also accelerated courses, usually at least two years in length, for graduates who have a health-related degree.

Often entrants to diploma courses are expected to have qualifications up to the English A level. However, for those without sufficient qualifications, the nursing cadet scheme, run by various NHS trusts, provides an initial training programme, successful completion of which gives a competence-based qualification, the National Vocational Qualification, at level 3 or “Access to nursing” qualification.

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[19] There are also three in Scotland, one in Wales and one in Northern Ireland.

[20] There are currently 13 specialist lists, including orthodontics, paediatric dentistry, oral and maxillofacial surgery, restorative dentistry and dental public health.

Students can then go on to a university nursing diploma course. On completion of training, nurses, midwives and specialist community public health nurses (mainly health visitors, school nurses and occupational health nurses) must register with the Nursing and Midwifery Council if they want to practise in their chosen field.[21] Re-registration with the Nursing and Midwifery Council is required every three years; nurses must undertake a minimum of five days or equivalent of learning activity every three years and maintain a personal professional profile containing details of their professional development. The Nursing and Midwifery Council is also responsible for specifying standards of proficiency for nurses, midwives and specialist community public health nurses.

Other health care professionals

Other health care professionals – often known as allied health professionals – include a broad range of disciplines, with differing training programmes, including, for example, radiographers, speech and language therapists, occupational therapists, operating department practitioners, physiotherapists and chiropodists. Most of these require a three- or four-year university degree course. On completion of these courses, professionals must register with the Health Professions Council in order to practise.

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[21] In 2008, there were almost 630 000 registered in England, almost 90% of whom were female (Nursing and Midwifery Council 2008).

6. Provision of services

6.1 Public health

This section discusses the delivery of measures designed to improve public health in England. Acheson, borrowing from Winslow's much earlier attempt (Winslow 1920), defined public health as "the science and art of preventing disease, prolonging life and promoting health through organized efforts of society" (Acheson 1988). In the sense of Acheson's definition of public health, everyone is involved in its delivery in one way or another. However, in a more formal sense, most aspects of public health have become the responsibility of government; section 6.1.1 describes how the public health function operates in England. This is followed in section 6.1.2 with a discussion of health protection. Section 6.1.3 deals with health promotion and education, including immunization and screening. Section 6.1.4 considers the delivery of occupational health services. Finally, section 6.1.5 considers how health inequalities have been tackled in England. There is some discussion throughout of the role of other sectors outside health in delivering public health. Public health depends on a range of factors beyond just the delivery of health care; these include child and adult poverty, housing and educational circumstances, employment opportunities, environmental issues, traffic safety and food safety.

6.1.1 Organization of public health services

Public health in England is primarily the responsibility of the Department of Health; the Chief Medical Officer leads on public health and is responsible for health improvement and protection as well as the nine regional public health groups. While the Department of Health's description of its focus on public health has changed over the years, one of its primary objectives remains "to promote better health and well-being for all – helping people to stay healthy and well, and empowering them to live independently – and tackle health inequalities" (Department of Health 2009c).

The key elements for which the Department of Health is responsible are:

- health protection programmes (e.g. immunization, infectious disease surveillance)
- health improvement programmes (e.g. smoking reduction)
- reducing health inequalities.

Each of these is discussed in some detail in later sections. In addition, health service quality improvement has been suggested as a key element of public health (Hunter, Marks & Smith 2007) and this also is a responsibility of the Department of Health. Quality issues are discussed throughout this report and so are not covered separately in this section.

Organizational structures

The Department of Health does not deliver services but works through the NHS, local authorities and currently the HPA, as well as other government departments and the private and voluntary sectors, recognizing that education, employment, economic status, transport, environment and housing all have an impact on public health.

At a regional level, each SHA has a director of public health, who is usually medically qualified and is often also the SHA's medical director (10 in all) with responsibility for ensuring that the NHS delivers on its public health objectives. In addition, the nine regional public health groups mentioned above and led by the corresponding SHA director of public health[1] are co-located in each regional government office. The NHS is required to work in partnership with other regional and local bodies including the corresponding regional government offices and development agencies.[2] There are other national and regional bodies – whose role is discussed in more detail in later sections – that contribute to the delivery of public health, including the HPA and its regional equivalents, various national screening bodies, the eight regional Public Health Observatories[3] and NICE.[4] At a local level, each PCT is responsible for the delivery of the government's public health objectives, and the lead for this is taken by the PCT's director of public health.

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[1] Within the Government Office for the South East, there is a joint appointment between the directors of public health in the South East Coast SHA and the South Central SHA.

[2] Regional government offices are central government bodies that manage regional programmes working across the areas of responsibility of all central government departments; regional development agencies have responsibility for economic development within each region.

[3] These are local public health resources that bring together and make available information that is usable at a local level and provide local health surveillance.

[4] NICE took on the role of the Health Development Agency in 2005 and publishes public health guidance with which NHS bodies are expected to conform.

Who delivers public health?

Most of the frontline services that support public health priorities are delivered through NHS staff working in hospitals, primary care and the community (e.g. immunization programmes, screening checks and smoking cessation clinics). The Department of Health (2003f) identified three main categories of people whose work contributes to public health:

- specialists: public health consultants and specialists who work at a strategic or senior management level or at a senior level of scientific expertise;
- wider community: people with a role in health improvement and reducing inequalities (e.g. teachers, local business leaders, social workers, transport engineers, housing officers, local government and voluntary-sector staff, as well as doctors, nurses and other health care professionals); and
- public health practitioners: professionals who spend most of their time in public health practice (e.g. health visitors, environmental health officers, community development workers) and those who use research, information, public health science or health promotion skills in specific public health fields.

A key distinction is often made between public health specialists who are medically qualified and those who are not. In the past, a medical qualification was seen as a prerequisite for working as a specialist in public health but this is no longer the case, with one-third of the members of the Faculty of Public Health not medically qualified (Hunter, Marks & Smith 2007). Thus, specialist public health practitioners may be required to draw on a range of expertise, including epidemiology, environmental health, disease prevention and health promotion, health psychology, statistics, economics, medical sociology and social policy, biology, nursing and medicine (Department of Health 2001d).

The Faculty of Public Health maintains professional standards for the discipline of public health and oversees the quality of training and professional development of public health specialists in the United Kingdom; it is also developing revalidation methods for the public health workforce. A Faculty of Public Health survey in 2005 suggested that there were 900 public health consultants working in England, of whom 517 were consultants in public health medicine. There was a high level of variation between areas of the country, from 11.2 per million population in the East Midlands to 28 in London for all public health consultants, and from 7.9 to 13.1 for the same areas for consultants in public health medicine (Gray & Sandberg 2006).

Key public health objectives

The focus of the Conservative Government of the 1990s on public health was established in *Health of the Nation* (Secretary of State for Health 1992) setting targets for coronary heart disease and stroke, cancer, mental illness, HIV/AIDS and sexual health and accidents (Gabbay 1992). In 1999, the Labour Government also introduced targets to be achieved by 2010 for coronary heart disease and stroke, cancer, mental illness and accidents (Secretary of State for Health 1998, 1999a) and, in *Reducing Health Inequalities: an Action Report* (Secretary of State for Health 1999b), required local health authorities to produce plans to reduce inequalities in health. The *NHS Plan* in 2000 (Department of Health 2000a) announced the government's intention to set a national target for reducing the gap in infant and early childhood mortality and morbidity between socioeconomic groups and to target inequalities later in life. The Labour Government recognized that improvement required a combination of specific health policies dealing with cancer and coronary heart disease, action to reduce levels of smoking and deal with communicable diseases, and broader government policies addressing child poverty, unemployment and education. In addition, the *NHS Plan* announced action to be taken on improving diet and nutrition.

Two national health inequalities targets were announced in 2001:

- for children under 1 year of age: by 2010 to reduce by at least 10% the gap in infant mortality between manual groups and the population as a whole; and
- for health authorities: by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

The government also stated an expectation that the national infant mortality rate would fall below 5 deaths per 1000 live births by 2006 (Department of Health 2001e). In 2003, the government reaffirmed its target for reducing inequalities in health by 10% by 2010 for these two specific measures: life expectancy at birth and infant mortality (detailed targets given above; Department of Health 2003g) and monitored progress against these targets throughout the rest of the decade.

The government made public health one of seven domains for which core and developmental standards would be monitored by the Healthcare Commission. The standards covered the need for systematic and managed disease prevention and health promotion programmes, and action on health and inequalities (Department of Health 2004l). It also made cooperation on public health with local authorities and other local organizations a core requirement for NHS bodies. New targets were introduced focusing on changing lifestyle behaviours, for example smoking cessation (Department of Health 2004m).

A key strategic objective for the Department of Health remains to promote better health and well-being for all: helping people to live healthier lives and empowering them to stay independent for longer; and tackling inequalities (Department of Health 2009c). This objective was translated into five indicators:

- the all-age, all-cause mortality rate as a proxy for life expectancy;
- the gap in the all-age, all-cause mortality rate between the "spearhead group" (the fifth of areas with the worst health and deprivation indicators) and the England average;
- the smoking prevalence: to reduce adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less;
- the number of adults (aged 18 years or over) per 100 000 population supported to live independently at home either directly through social care or via organizations that receive social services grants; and
- the access to psychological therapies: to improve access by increasing the proportion of people with depression and/or anxiety disorders who are offered psychological therapies.

In addition, the Department of Health identified the following as national public health priorities:

- alcohol harm reduction
- childhood obesity
- health inequalities
- infant mortality
- response to sexual violence
- sexual health
- teenage pregnancy
- tobacco control
- vaccination and immunization
- children and young peoples' psychological well-being and mental health.

6.1.2 Health protection

The key national organization currently dealing with the protection of the public's health is the HPA, which was set up as a non-departmental government body in April 2005 under the Health Protection Agency Act 2004. The Act defines the role of the HPA as "to protect the community against infectious disease and other dangers to health". The key roles of the HPA are:

- to reduce dangers to the public health from infectious diseases;
- to reduce dangers to the public health from chemical and radiation hazards;
- to ensure a national level of emergency preparedness for a range of events (e.g. the release of chemical, biological, radiological or nuclear substances);
- to provide local health protection services in England;[5]
- to provide support to others who have health protection responsibilities and advise other government departments.

The work of the HPA is carried out through a number of subdivisions: the Centre for Infections deals with communicable disease surveillance and specialist microbiology; the Centre for Radiation, Chemical and Environmental Hazards undertakes research, runs training courses and provides expert information and advice on protection from risks of radiations, as well as on health effects from chemicals in water, soil and waste, and provides information and support to the NHS on toxicology; the Centre for Emergency Preparedness and Response is responsible for emergency response and carries out applied microbiological research; and the National Institute of Biological Standards and Control, which merged with the HPA in April 2009, is responsible for the standardization and control of biological medicines such as vaccines and products made from blood and tissues, and also acts as the Medicines Control Laboratory providing testing services to ensure compliance with product specifications (HPA 2010d).

The HPA also provides local and regional services as specialist support to prevent and reduce the impact of infectious diseases, chemical and radiation hazards and major emergencies.[6] There are 26 health protection units and nine regional centres. The regional centres approximate to the 10 SHA regions with

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[5] The HPA has a United Kingdom-wide role but separate bodies provide local services in the other countries of the United Kingdom.

[6] PCTs are responsible at the local level for the health protection of their populations.

the exception that South East Coast and South Central SHAs are combined as the South East regional centre. These centres coordinate activities of local health protection units and assist NHS regional directors of public health to manage major incidents. Each regional centre includes specialists in epidemiology, microbiology, emergency planning, chemical hazards and poisons.

The health protection units are involved in various activities: local disease surveillance, alert systems, investigation and management of health protection incidents and outbreaks, and delivery and monitoring at local level of national action plans for infectious diseases. Each unit has specialist nurses, doctors and consultants in communicable disease control available 24/7. In addition, local information is gathered to create a picture of diseases and other hazards, which is used in planning and coordinating work. The health protection units are supported by regional health emergency planning adviser teams, environmental public health units and surveillance teams, as well as the regional microbiology network for laboratory analysis.

Health emergency planning adviser teams in each region provide support and advice in the event of a major incident and liaise with the NHS, local authorities, emergency services, utility companies and other relevant industries. They also develop plans to deal with major events as well as running training and emergency response exercises.

The HPA also has a regional microbiology network providing eight regional clinical and public health laboratories (in all regions except the East Midlands), mainly based in large NHS teaching trusts where the nature of specialist services requires on-site specialist microbiology support. These provide a wide range of clinical and public health microbiology tests for the NHS and the health protection units as well as providing testing facilities for food, water and environmental samples for local authorities and other stakeholders. They are supported by 37 collaborating laboratory sites across the regions.

The health protection units are involved in proactive work (to prevent health incidents happening) and reactive work (to minimize risk once an incident has occurred). The former includes working with the NHS to provide effective immunization programmes, helping to prevent health care-associated infections (e.g. methicillin-resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* (*C. difficile*) and advising immigration authorities on travel-related health issues. Reactive work includes advising how to stop infectious diseases such as meningitis, hepatitis or measles from spreading; carrying out risk assessments to find out how outbreaks occurred, and recommending ways to prevent them happening again; tracing people who may have come into contact with, or be carrying, an infectious disease or be contaminated with chemicals or radiation; and, compiling statistics on notifiable diseases (e.g. mumps and measles) (HPA 2010d).

Environmental and communicable disease functions
Communicable disease surveillance is the continuous monitoring of frequency and distribution of disease and death from infections that can be transmitted from human to human or from animals, food, water or the environment to humans, and the monitoring of risk factors for those infections. The Centre for Infections provides specialist and reference microbiology and microbial epidemiology, coordinates the investigation of the cause of national and uncommon outbreaks, and advises government on the risks posed by various infections and how to respond to international health alerts.

Regional epidemiology units are responsible for monitoring infectious diseases and chemical and environmental hazards. These units advise regional directors of public health, regional government offices, NHS trusts, consultants in communicable disease control, clinicians, nurses, microbiologists and environmental health officers on communicable disease surveillance and infection control. They also work with local Public Health Observatories.

Data are collected by each unit on statutory notifications of infectious diseases; reports of sexually transmitted infections; laboratory reports of infectious diseases such as MRSA, *C. difficile,* tuberculosis, meningitis, blood poisoning, food poisoning; and antenatal screening for hepatitis B, HIV and syphilis infections, and rubella immunity.

6.1.3 Health promotion and education

A range of health promotion and education activities are carried out within the NHS in England in pursuit of government public health priorities. This section focuses on the immunization and screening programmes. These are mainly delivered free through the NHS, although both immunization and screening are also provided by the private sector.

Immunization
England has a comprehensive range of immunization programmes freely available through the NHS. The result has been substantial falls in the numbers of people recorded with diseases that are potentially avoidable. Section 1.4.2 has some discussion of improvements in immunization rates for children since 1971, and of the issues that have arisen during this period.

The Joint Committee on Vaccination and Immunisation is the Standing Advisory Committee, independent of the Department of Health, with statutory responsibility to advise the Secretary of State for Health on the provision of national vaccination and immunization services. This advice is brought together in a report known as the *Green Book,* the latest edition of which was published in 2006 but which is updated on a regular basis (Salisbury, Ramsey & Noakes 2010). Immunization is not compulsory for individuals; health professionals are required to obtain individual consent for immunization and, in the case of children (aged less than 16 years), this is usually given by a parent although a child can give his or her own consent provided that child fully understands what is involved (this is referred to as being "Gillick competent").

All health care professionals who advise on immunization or administer vaccines must be trained in immunization, including the recognition and treatment of anaphylaxis, and have a duty to maintain and update their professional knowledge and skills. The MHRA has responsibility for monitoring the safety of all marketed medicines including vaccines, and suspected adverse events following the use of vaccines are reported to the MHRA (see section 6.6.1 for a discussion of the general role of the MHRA). Where an individual suffers severe mental and/or physical disablement as a result of immunization, that person may be eligible for a payment of £120 000 under the Vaccine Damage Payment Scheme.[7] The scheme covers a range of vaccinations (e.g. measles, mumps, rubella, polio, tuberculosis) (Salisbury, Ramsey & Noakes 2010).

The national immunization programme mainly covers three groups:

- children
- older people and people with particular conditions or lifestyles
- health care and laboratory staff.

The current childhood immunization programme (as of October 2010) is intended to provide protection against diphtheria, tetanus, pertussis, *Haemophilus influenzae* type b (Hib), polio, meningococcal serogroup C (MenC), measles, mumps, rubella and pneumococcus. In addition, there are selective childhood immunization programmes that target children at particular risk of certain diseases (e.g. hepatitis B, tuberculosis, influenza and pneumococcus).

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[7] The scheme also covers severely disabled individuals where disability results from immunization of their mothers against any of the eligible diseases while pregnant.

Older people (aged 65 years or more) are offered routinely a single dose of pneumococcal polysaccharide vaccine if they have not previously received it, as well as an annual influenza vaccination. Vaccinations (e.g. for Hib, MenC, influenza, pneumococcus and hepatitis B) may also be offered to any adult with an underlying medical condition (e.g. chronic respiratory disease) or those at higher risk because of their lifestyle.

Finally, it is recommended that health care and laboratory staff are offered particular vaccinations both to protect them and to avoid transmission of diseases between patients. All staff should be up to date with their routine immunizations (e.g. tetanus, diphtheria, polio and MMR). In addition, vaccines against tuberculosis, hepatitis B, influenza and chickenpox or herpes zoster should be offered to health care staff working in certain areas or with certain groups of patients. Laboratory and pathology staff should also be up to date with routine immunizations as well as immunization against specific organisms depending on their risk of exposure.

Since 2008, there has been an addition to the vaccination programme with the introduction of immunization against the human papillomavirus for females before they reach an age when the risk of this infection increases and they are at subsequent risk of cervical cancer. Vaccination is offered for girls aged between 12 and 13 years. For girls aged 14 to 18 years, a catch-up vaccination campaign is in progress. This vaccination is not routinely recommended for women aged 18 years or over (Salisbury, Ramsey & Noakes 2010).

Screening

Another key aspect of public health is screening selected parts of the population in order to identify potential problems or diseases. Mostly, this is provided through the NHS, although there is a significant level of private-sector screening also available in England. It is provided in NHS hospitals, by GP practices as well as by special screening units.

The United Kingdom NSC was set up in 1996 to recommend programmes of screening that all four countries of the United Kingdom should undertake.[8] In doing so, the NSC considers a wide range of evidence for each programme with the intention of ensuring that the programme will do more good than harm. The NSC advises both on the case for implementing new population screening programmes as well for continuing, modifying or withdrawing existing ones. It uses a broad range of evidence from within and outside the NHS. It also agrees standards for new programmes and advises on their implementation in the NHS.

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[8] At that time there were over 300 screening programmes available; what was offered varied between local health authority areas (National Screening Committee 1998).

The NSC has developed a set of criteria for appraising the viability, effectiveness and appropriateness of screening programmes, focusing on four key aspects.

> *Condition.* This should be an important health problem/condition whose epidemiology is adequately understood with a detectable risk factor, disease marker, latent period or early symptomatic stage. In addition, all cost-effective primary prevention interventions should have been implemented as far as practicable.
>
> *Test.* This should be simple, safe, precise and validated, and the distribution of test values in the target population should be known and a suitable cut-off level defined and agreed. The test should be acceptable to the population, and there should be an agreed policy on further diagnostic investigation of individuals with a positive test result and on the choices available to those individuals.[9]
>
> *Treatment.* There should be an effective treatment or intervention for patients identified through early detection, with evidence of early treatment leading to better outcomes than late treatment, and there should be agreed evidence-based policies covering which individuals should be offered treatment and what that treatment is.
>
> *Screening.* There should be evidence from high-quality randomized controlled trials that the screening programme is effective in reducing mortality or morbidity. There should be evidence that the complete screening programme is clinically, socially and ethically acceptable to health professionals and the public. The benefit from the screening programme should outweigh the physical and psychological harm caused by the test, diagnostic procedures and treatment.

In addition, screening programmes are expected to provide value for money. Assessment against this criteria should consider evidence from economic analyses and the effective use of available resources, and all other options for managing the condition should have been considered, such as improving treatment or providing other services, so as to ensure that a more cost-effective intervention could not be introduced or current interventions increased within the resources available.

The NSC requires a plan to be in place for managing and monitoring any screening programme and an agreed set of quality assurance standards. Adequate staffing and facilities for testing, diagnosis, treatment and programme

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[9] Equivalent criteria are applied where the screening is for a mutation.

management should be available prior to the commencement of any screening programme. Evidence-based information, explaining the consequences of testing, investigation and treatment, should be made available to potential participants to assist them in making an informed choice (National Screening Committee 2010).

The NSC has reviewed 105 potential or current screening programmes and has recommended systematic population screening in 27 cases:

- *adults* (5): breast cancer, cervical cancer, bowel cancer, diabetic retinopathy and abdominal aortic aneurysm;
- *children* (3): growth disorder, hearing impairment and vision defects including amblyopia, refractive error and strabismus;
- *newborn* (10): congenital cataracts, congenital heart disease, congenital hypothyroidism, cryptochidism, cystic fibrosis, developmental dislocation of hip, hearing, medium-chain acyl-coenzyme A dehydrogenase deficiency (MCADD), phenylketonuria and sickle cell disease; and
- *antenatal* (9): Down's syndrome, fetal anomalies, hepatitis B, HIV, neural tube defect, rubella susceptibility, sickle cell and thalassaemia, syphilis and Tay Sachs disease.

Screening for breast cancer and for cervical cancer has been available through the NHS for some years; national NHS screening programmes were introduced in 1988. Screening for breast cancer is offered every three years to all women aged between 50 and 70 years;[10] screening for cervical cancer is offered every three years to all women aged between 25 and 49 years and every five years to those aged between 50 and 64 years. A national screening programme for bowel cancer was introduced in 2006 and is offered every two years to all adults aged between 60 and 70 years; people over 70 years can request a free test. Screening for diabetic retinopathy is offered on an annual basis to all people with diabetes aged 12 years and over. The national screening programme for abdominal aortic aneurysm was introduced in 2009 and is being piloted in several areas of England, with complete coverage anticipated by 2013. Screening will be provided to men aged 65 years and over.

Screening of newborn babies for a number of the conditions listed above has been available through the NHS for many years. This has been formalized into two programmes. The first, the NHS Newborn and Infant Physical Examination Programme, provides a physical examination of babies (heart, hips, eyes and

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[10] In 2012, the age range will be extended to 47–73 years.

testes) within 72 hours of birth to check for problems or abnormalities, with a follow-up at 6 to 8 weeks of age. The second, the Newborn Bloodspot Screening Programme, provides screening for all babies aged 5 days for phenylketonuria, congenital hypothyroidism, sickle cell disease, cystic fibrosis and MCADD.

All pregnant women are offered an ultrasound scan to screen for fetal anomalies and a biochemical test for Down's syndrome. The anomaly scan is performed in most hospitals in England at around 18 to 20 weeks of gestation. Again, this has been formalized through the introduction of the NHS Fetal Anomaly Screening Programme. The NHS Infectious Diseases in Pregnancy Screening Programme offers screening to all pregnant women for hepatitis B, HIV, rubella susceptibility and syphilis. The NHS Sickle Cell and Thalassaemia Screening Programme offers screening for sickle cell disease for all newborn babies and screening during pregnancy for all pregnant women. In addition, antenatal screening is recommended for anaemia, asymptomatic bacteriuria, blood group and Rhesus D status, red cell alloantibodies and pre-eclampsia, and for psychiatric illness in women with a history of mental illness.

Screening in the private sector

Private-sector health screening is also widely available in England for a range of conditions and diseases, including those offered by the NHS but also extending to others which the NSC has not recommended (e.g. osteoporosis and brain natriuretic peptide blood test screening for heart failure). Individuals may pay out of pocket or through their PMI. While private-sector clinics or hospitals can offer tests that are not recommended by the NSC, they are regulated by the CQC in the same way as other health care providers (see section 4.1.3 for more discussion of the CQC). Data are not available on how much is spent on screening in the private sector.

6.1.4 Occupational health services

There is no national occupational health service in England. The Health and Safety Executive is the body responsible for enforcement of health and safety law in the workplace. All employers have a legal responsibility to protect the health and safety of their employees but there is no statutory responsibility on employers to provide occupational health services, although they are required to have in place competent people to manage health and safety. There is a significant difference in provision of occupational health services between public-sector and private-sector organizations. Research carried out in 1992 indicated that just 8% of private-sector employers used health care professionals to treat or advise about health problems at work, compared with almost all public-sector employers. More recently, it has been estimated that just 34% of the United Kingdom workforce has occupational health service coverage (Faculty of Occupational Medicine of the Royal College of Physicians 2006). Nevertheless, around 50% of the workforce has access to health care professionals at work. Within the private sector, 68% of large employers use professionals but only 5% of employers with less than 25 employees do (Health and Safety Executive 2000a).

The Employment Medical Advisory Service, part of the Health and Safety Executive, in addition to inspection and enforcement, gives occupational health advice to a wide range of groups, including employers and employees. The service staff, both doctors and nurses, are trained occupational health professionals (Health and Safety Executive 2000b). The Health and Safety Laboratory, another part of the Health and Safety Executive, also provides specialist advice on health and safety issues to a wide range of employers. The Health and Safety Executive and the Health and Safety Commission published a health and safety strategy in 2000 on behalf of the government, the aim of which was to reduce ill health resulting from the workplace, primarily through better compliance with existing legislation (Health and Safety Commission & Health and Safety Executive 2000).[11]

There is a range of private-sector occupational health service providers, as well as company in-house providers; the NHS also provides some occupational health services. There is a strong occupational health service within the NHS to safeguard the health and safety of NHS employees, including GPs and their staff. In 2001, NHS Plus was established with the aim of providing occupational health services to small and medium-sized employers and at the same time to improve provision of occupational health services within the NHS. Most commonly, occupational health providers are doctors or nurses, some with specific occupational health qualifications. A range of other health care professionals may also be involved including physiotherapists, counsellors and occupational hygienists.

6.1.5 Tackling health inequalities

The need to tackle inequalities in health has been recognized by government for many years. Yet health inequalities between socioeconomic groups have been increasing in England since the 1970s, both in terms of broad outcomes such as life expectancy and contributory factors such as obesity and smoking prevalence (see section 1.4.3 for more details).

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[11] The Health and Safety Executive and the Health and Safety Commission merged in 2008.

As early as 1980, Black and colleagues (1980) had reported on the key health inequalities. Acheson's report in 1998 confirmed the persistence of these inequalities, noting that the solution did not lie with the health sector alone and recommending that the new Labour Government take action on a number of fronts, including education, employment, housing and the environment. A key recommendation was that, as part of a health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities (Acheson 1998). In 2010, another report on the state of inequalities in health in England covered many of the same areas as its predecessors (Marmot 2010).

As discussed in section 6.1.1, the issue of health inequalities has been a key focus of government since at least 1998, with several clear national targets; in addition, local health bodies with responsibility for population health have set their own sometimes quite formidable targets.[12] At the local level, PCTs, in partnership with local authorities and other bodies, were tasked with ensuring that these targets were met. The result has been a number of local and national initiatives in different parts of the country throughout the last decade. Thus "health action zones" were introduced in 1998 in 26 local areas of England, with an aim to improve public health by developing partnerships across government and with other sectors. Sure Start was introduced in deprived areas in 1999 to provide support to disadvantaged families with young children by increasing availability of child care, improving health and emotional development for young children, and supporting parents as parents and in their aspirations towards employment. "Healthy living centres" were introduced into deprived areas in 1999, again with the aim of promoting health and improving access to mainstream services for those who may not currently use them; "healthy towns", aimed at improving people's food choices and encouraging healthy activity, were introduced in nine towns in 2008. These initiatives had mixed results (House of Commons Select Committee on Health 2009a; Secretary of State for Health 2009).

Have targets been met?

Progress against the two key targets discussed in section 6.1.1 has been monitored regularly by government. Although by 2008 the Department of Health was able to report absolute improvements in these target areas, both looked like falling short of their relative target endpoints, to improve by 10%

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[12] Many seem to believe they can be the best in Europe.

against a national figure; this failure was even though the original second target had been changed to "for local authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead group) and the population as a whole" (Department of Health 2008p).

In 2004–2006, the relative gap in life expectancy between the groups for males was 2% wider than at the baseline, while for females it was 11% wider. Similarly, for infant mortality, although the gap between routine and manual groups and the whole of the population has recently started to narrow, it is still wider than the 13% gap recorded at the 1997–1999 baseline (Department of Health 2008p). The baseline rate for infant mortality in 1997–1999 was 6.3 per 1000 live births for the routine and manual group and 5.6 for all: there was a 13% difference. To reduce this by 10% by 2010 required a reduction in the difference between the groups as shown in the 2009–2011 data to around 12%. By 2004–2006, the relevant figures were 5.6 and 4.8, showing an increased gap of 17% (Department of Health 2008q).

For life expectancy, the target has been monitored for males and females separately. The baseline rate for female life expectancy in 1995–1997 (the baseline year is different for this target) was 78.3 years for the "spearhead group" and 79.7 years for all: there was a 1.77% difference. For this to be reduced by 10% by 2010 required a reduction in the difference between the two groups as shown in the 2009–2011 data to around 1.59%. By 2004–2006, the relevant figures were 81.6 and 80.0, showing an increased gap of 1.96% (Department of Health 2008r). More recent data, for 2007–2009, show this gap has increased to 1.99% for females (ONS 2010c).

6.2 Patient pathways

Different examples of patient pathways are discussed in the sections that follow, particularly those on primary care (section 6.3), secondary and tertiary care (section 6.4) and emergency care (section 6.5).

6.3 Primary care

Primary health care in England is essentially the system of health care available outside of the hospital setting, often in close physical proximity to the people it serves. It may take many forms and is provided by a range of health care professionals. It has two essential characteristics: in most cases it provides the first point of contact for a person seeking advice on, or treatment of, a health concern and it provides continuous access to general medical care for common conditions and injuries, often with a designated health care professional taking primary responsibility for that person. The system also tends to play a gatekeeping role in determining access to more specialized, often hospital-based, acute health care services.

This section describes the organization of primary care services in England, their general availability and accessibility and the quality of this provision. Some comments on recent developments are provided and an indication of the future direction for primary care, although this is covered more fully in Chapter 7. Health promotion and disease prevention, although usually considered as part of primary health care, have been discussed extensively in section 6.1 and so are not covered in this section.

6.3.1 Organization of services

The GP is seen as the focal point for all primary care services in England; however, primary care is provided by a range of health care professionals and organizations, some of which operate as part of the general practice system (e.g. practice nurses, therapists) and some having a distinct role of their own (e.g. walk-in centres, NHS Direct, community health service providers). Responsibility for the coordination and delivery of primary care services rests with PCTs, which must ensure that the appropriate range of services is available to their populations.[13] This is achieved through the planning and contracting process in which PCTs engage with various service providers, and their oversight by PCTs of the various professionals and organizations that provide these services (this is discussed in more detail in Chapters 3 and 4). Most primary care is provided through the NHS public system, although there is also a sizeable private sector paid for either through PMI or out of pocket. The extent of private provision varies between different elements of primary care, as is discussed below.

Key providers

The focal point for primary care is the GP or the GP practice consisting of a group of GPs working together. GPs provide a range of preventative, diagnostic and curative primary care services. They are usually the first point of contact for a person and also act as gatekeepers to secondary care, although people can attend the A&E department in an acute hospital if they believe their condition is

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[13] In addition, PCTs contract for the delivery of hospital-based acute services for their populations.

sufficiently urgent. The primary health care team based around general practice may include doctors, nurses, physiotherapists, counsellors, speech therapists and administrative staff.

Most GPs are independent self-employed contractors. Most GP practices now contract with PCTs on the basis of a general or a personal medical services contract. In addition, there are "alternative provider medical services" contracts that allow PCTs to contract with providers other than GP practices for the provision of GP services – there are a few of these with private health care companies – and PCT Medical Services in which PCTs run GP practices directly. PCTs maintain lists of doctors who are allowed to provide primary care services for NHS patients in their areas; these are known as primary care performer lists. A GP must be on such a list to provide services to NHS patients.

In 2009, there were 40 269 GPs (36 085 WTE) working in 8228 GP practices in the NHS, of whom 46% were women. Most GPs (71%) are in a contractual relationship with a PCT; 18% work within practices as salaried GPs and the remainder (11%) are training in general practice. Around 5% of GPs work in single-handed practices (i.e. with no partner) although they may employ a salaried GP or a GP trainee. In addition, there were 21 935 (13 582 WTE) practice nurses working in GP practices (Information Centre 2010m).

As Fig. 6.1 shows, the number of WTE GPs in England has increased by 39% since 1989, from less than 26 000 to over 36 000.[14] At a time when the population increased by just 9%, this has led to a reduction in GP list size. In 1951, the average list size was 2506 in the United Kingdom.[15] Fig. 6.2 shows a decline in list size in England of almost 29% between 1989 and 2009 from 1999 to 1432 (Audit Commission 2002b; Information Centre 2010n). Stated another way, in 2009 there were approximately 70 GPs per 100 000 registered patients.

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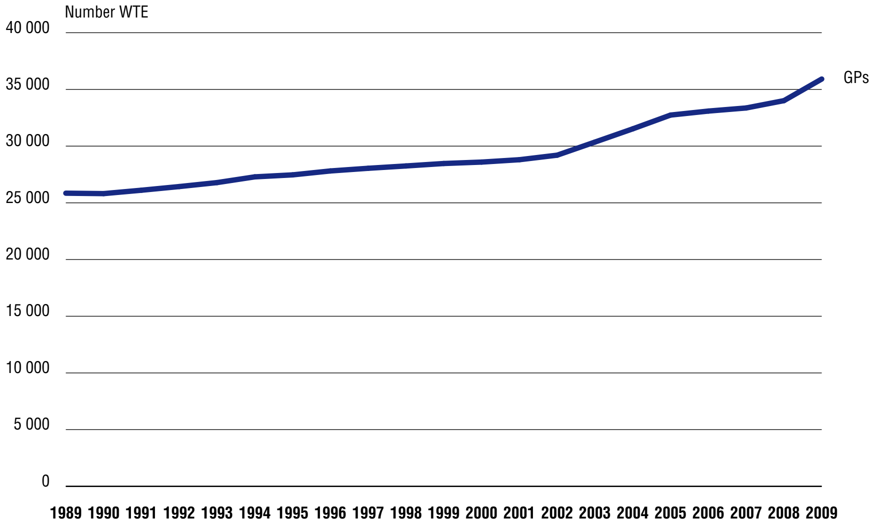
[14] The number of WTE GPs has increased more slowly than the total headcount: between 1994 and 2009 the number of WTE GPs increased by only 23% compared with a headcount increase of 32%.

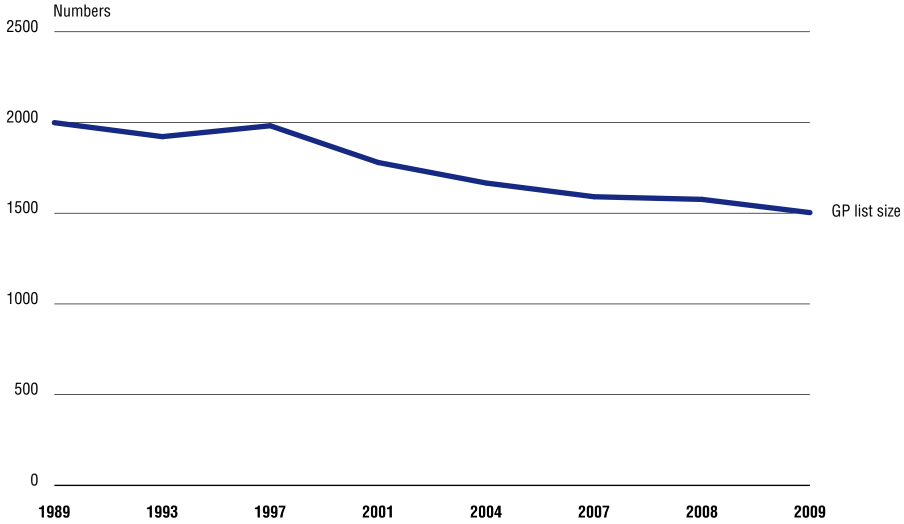
[15] However, actual list size is probably somewhat less than this as the population calculated from list size for all GP practices is over 5% more than the official estimate of the population of England.

Fig. 6.1
Number of GPs (WTE) in England, 1989–2009



Source: Information Centre 2010m.

Fig. 6.2
GP list size in England, 1989–2009



Sources: Audit Commission 2002b; Information Centre 2010m, 2010n.

There is a limited amount of private general practice. GPs on contract with the NHS may have private patients, although they are not permitted to see patients on their NHS list privately or to issue NHS prescriptions to private patients. It is estimated using General Household Survey data that approximately 3% of GP consultations in Great Britain in 2007 were with private practitioners (ONS 2009c).

NHS-funded primary care is also provided by a number of other organizations: through alternative providers (e.g. the voluntary sector, commercial providers, NHS trusts or other PCTs), through direct PCT provision of community health services, and through NHS Direct (a telephone and Internet service), NHS and private-sector walk-in centres, dentists, opticians and community pharmacists. The private sector has an increasing involvement in the delivery of NHS care, as well as providing some privately funded care.

NHS Direct is a telephone and web-based helpline set up in England in 1998 to provide a 24/7 nurse-led advice and health information service. It acts as a first point of call for many people and where necessary routes them to the most appropriate resource to deal with their health concerns. It became an NHS trust in April 2007 and received over 5 million calls in 2008–2009 (section 2.5.2 has more detail).

NHS walk-in centres were introduced in 2000 and there are now over 90 in England. These are essentially a variant on a minor injury unit although they may act more as a substitute for GP services. Most are managed by PCTs, are open 365 days a year but not 24 hours a day, and are nurse led. They provide services for minor illnesses and injuries (e.g. infection and rashes, fractures and lacerations, stomach upsets, cuts and bruises, and burns and strains). Of the 90, seven are walk-in centres in transport hubs (mainly railway stations) that are provided by the private sector through a direct Department of Health contract. In total, these centres treat around 3 million patients a year (NHS Choices 2009).

Other health care staff

Besides doctors, key staff involved in the delivery of primary care include practice nurses, district nurses, midwives, health visitors, and other health care professionals such as physiotherapists, chiropodists and occupational therapists.

Practice nurses work within GP practices and are usually registered general nurses. They may provide a range of services including immunization, chronic disease management, health promotion and health assessments of older people.

A number of other health care professionals may work within GP practices. These include a range of therapists (e.g. occupational therapists, physiotherapists, chiropodists).

District nurses are registered general nurses who provide skilled nursing care for patients in their own homes. They are usually employed by community health service providers, which were mostly part of PCTs although this has changed (see section 4.1.1), to monitor the health care needs of patients and deliver appropriate packages of care. Often they are based in GP practices and visit patients in their own homes or residential setting. Health visitors are also registered general nurses but they have had further training to specialize in visiting families with babies and very young children in their own homes, or older people. They also hold clinics in GP practices and health centres and are usually employed by community health service providers. They advise on the prevention of ill health and health promotion. In 2009, there were 9930 district nurses (8203 WTE) and 10 859 health visitors (8519 WTE) employed by the NHS in England. The number has fallen considerably since 1998 – for health visitors by 14% and district nurses by 30% (Information Centre 2009h, 2010l).

Midwives are registered general nurses who have undertaken further training focused on women's health during and after pregnancy and childbirth. They provide services to pregnant women and are responsible for mother and child for 28 days following delivery. They are usually employed by NHS trusts. In 2009, there were 26 451 midwives (20 236 WTE) employed by the NHS in England, an increase of 16% since 1998 (Information Centre 2009h, 2010l). Dentists, ophthalmic medical practitioners, optometrists and community pharmacists also deliver primary care services on behalf of the NHS. Their roles are discussed in detail in Chapters 2 and 5, and sections 6.6 and 6.12.

6.3.2 Access to services

Primary care in England is the source of a wide range of ambulatory health care, mostly provided through GP practices. Thus, GPs are usually the first point of contact for an individual and deal with most general medical issues, with the ability to refer on to more specialized care when required. They provide a range of diagnostic services, some minor surgery and family planning, as well as care for acute and chronically ill patients, and people who are terminally ill. Obstetric care, prenatal care and perinatal care are arranged through general practice. GPs also provide preventive services such as vaccination, immunization and cancer screening, as well as health promotion such as general advice on healthy living or smoking cessation clinics. GPs mostly issue pharmaceutical prescriptions that are dispensed in pharmacies but some also dispense pharmaceuticals themselves. GPs also provide sickness certification for their patients. In addition, staffing of community hospitals and minor injury services is an integral part of many GP practices, especially those in rural or remote areas.

GP consultations mainly take place in the surgery – in 2008 around 86% of the total, with 11% by telephone and 3% in the patient's home. The number of home visits has fallen considerably: from 22% in 1971 down to 6% in 1998. The average number of GP consultations per year in 2008 (for Great Britain) was 5 per person, although older people tend to use GP services more frequently; the average number of consultations with a practice nurse has increased since 2000 and by 2008 was 2 per person (ONS 2010g). Out-of-hours care (i.e. care provided outside of the core hours of 8 am to 6.30 pm) is now usually not the responsibility of an individual's GP practice but is provided through a range of other providers including groups of GPs as well as other private-sector providers. Also, increasingly, community pharmacists are acting as a first point-of-call resource for many people, providing advice as well as dispensing prescription drugs.

GPs also act as gatekeepers to secondary or specialist care, both ambulatory hospital care (known as day cases in England) and hospital-based care. However, individuals can attend the A&E department of an acute hospital without any referral if their condition seems to them sufficiently urgent. It has often been argued that people frequently attend A&E when their need is not urgent (Coleman, Irons & Nicholl 2001). This may be because their access to primary care services is poor, because they are not aware of how best to use the services available or simply it may be more convenient for them to attend their local hospital.

In 2009–2010, there were 19.8 million new attendances at A&E in England,[16] an increase of almost 59% from 12.5 million in 1996–1997 (Department of Health 2010q) (see section 6.5 on emergency care for more detail on the use of A&E). It has been claimed that as much as 23% of these attendances are inappropriate in the sense that they could have been dealt with elsewhere – primarily by a GP (Lowy, Kohler & Nicholl 1994). To some extent, this problem may have been aggravated by improvements in waiting times at A&E; currently, few people wait more than four hours to be dealt with.

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[16] This has included A&E, minor injury units, walk-in centres since 2003–2004, and some services provided by the private sector since 2008–2009.

Choice of GP

Every United Kingdom citizen has the right to be registered with a local doctor (GP) and to consult their GP practice without charge. GPs have always been free to reject any applicant wishing to join their NHS list unless that person was formally assigned by a health authority or PCT. However, a GP practice "can only refuse an applicant to join its list if it has reasonable grounds for doing so which do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition" (General Practitioners Committee 2004). Moreover, patients can choose a doctor within the GP practice as their assigned doctor. However, in reality, patients are often seen by whichever GP happens to be available at the time. People can move from one practice to another without giving a reason although the new practice can refuse their application. Similarly, a GP can ask a patient to find another GP (i.e. remove the patient from the list). This should usually happen only if there has been an irretrievable breakdown in the doctor–patient relationship – in the most extreme cases where the patient is violent, threatening or abusive – or if the patient has moved outside of the practice's geographic area. In 2007–2008, just 1142 people switched GP at their own request compared with over 75 000 people who were transferred at the request of the GP (Information Centre 2009i).[17] There are no accurate figures available on the proportion of the population that is registered with a GP; however, often people who are homeless or in temporary accommodation will not be registered.

Geographical equity

The Medical Practices Committee was established at the outset of the NHS in 1948 to regulate entry of GPs into areas so as to create a more equitable distribution of GP resources.[18] However, problems remain in deprived areas, especially in the north of England, which have long been undersupplied with doctors. The Medical Practices Committee was abolished in 2002; the intention of government was that unequal distribution of GPs would be addressed locally by PCTs through the procurement from alternative providers of new capacity in areas undersupplied with doctors, including from private operators, social enterprises and GP- or nurse-led cooperatives. Central resources have also been provided to support PCTs in these initiatives (Department of Health 2006c).

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[17] These figures do not reflect the total turnover in a practice's population (i.e. the number of new patient registrations plus the number of patient deductions as a percentage of the total practice population), which can vary anywhere between 2% and 20% of the total.

[18] The measurement of equity is affected by the definition of population covered, how this is weighted for need and, to a lesser extent, alternative definitions of GPs (Hole et al. 2008).

Average GP list size in 2009 was 1432 registered patients, but there remains considerable geographical variation, from an average list size of 1031 for GPs in a rural area such as Oxford PCT to 1860 in Bexley PCT, part of Greater London, a difference of 80%. Although many rural areas tend to have smaller list sizes, there is also a marked preponderance of smaller list sizes in cities, particularly in some parts of London (Information Centre 2010n).

6.3.3 Quality of primary care

The Labour Government pledged a substantial increase in the number of GPs and also set new targets for the NHS: guaranteed access to a primary care professional within 24 hours and a primary care doctor within 48 hours to be attained by the end of 2004 (Department of Health 2000a). A survey found that the latter target was still only being met for 87% of patients in 2007–2008 (Information Centre 2008c). According to the same survey, 87% of patients in 2007–2008 reported that they were satisfied with their ability to get through to their doctor's surgery on the telephone; 77% of patients who wanted to book ahead for an appointment with a doctor reported that they were able to do so; 88% of patients who wanted an appointment with a particular doctor at their GP surgery reported that they could do this; 82% of patients said they were satisfied with the current opening hours of their practice; and 52% of patients who were referred by their GP to a hospital specialist reported that their GP discussed choice of hospital with them (Information Centre 2008c).

A key way in which the quality of primary care in the NHS is monitored is through the QOF, which was introduced in 2004. This programme provides extra payments for GP services linked to achievement of quality standards by the GP practice (see section 3.6.2 for further discussion of how GPs are paid). The QOF is a set of indicators that provides a score upon which is based the distribution of extra funds to practices. QOF scores are recorded by practices electronically and submitted to their PCT; a sample of scores is audited by the PCT to ensure probity.

The QOF had four main components in 2010–2011:

- clinical standards: 86 indicators covering 20 clinical areas (69.7% of total score in 2010–2011);
- organizational standards: 36 indicators (16.8% of total score in 2010–2011);
- experience of patients: three indicators (9.2% of total score in 2010–2011); and

- additional services: nine indicators covering four service areas, including cervical screening, child health, maternity and contraceptive services (4.4% of total score in 2010–2011).

A practice's entitlement to quality payments is determined through a quality scorecard, with a total of 1000 points available. Attainment of the quality targets is monitored by the Information Centre, which publishes details of the overall performance of GP practices in England.

In addition, as part of the CQC's periodic review,[19] the performance of PCTs is monitored on a number of indicators reflecting compliance with core standards, performance against national priorities and existing commitments, and quality of financial management. Key national targets relating to primary care were set in the *NHS Plan* (Department of Health 2000a) and included guaranteed access to a primary care professional within 24 hours, and a doctor within 48 hours; performance measures included patient-reported access to out-of-hours care and measures of extended opening hours for GP practices. GP practice quality on access to services is now assessed on performance against three targets measured through quarterly patient surveys (CQC 2009a):

- getting an appointment with a GP within two weekdays;
- getting an appointment with a GP more than two weekdays in advance; and
- being very or fairly satisfied with GP opening hours.

Community health services are also part of the CQC's periodic review and are expected to comply with core standards, perform against national priorities and existing commitments and ensure quality of financial management. Dental, ophthalmic and pharmaceutical services receive less formal attention from the Department of Health, although there are also some performance targets in these areas. Moreover, PCTs have a responsibility for ensuring the quality of all services provided for their populations. All professions are also subject to revalidation of their practices by their regulatory bodies (see section 4.1.4).

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[19] This has replaced the annual health check of NHS bodies that was carried out by the Healthcare Commission in previous years.

6.4 Secondary and tertiary care

Secondary and tertiary care are provided mainly in hospital settings by specialist doctors working with a range of other health professionals (e.g. nurses, therapists, diagnostic professionals). Patients may stay overnight in the hospital or, as is increasingly the case, are treated as day cases. Most of this care is provided and paid for by the public sector although there is also a sizeable private sector. The NHS also provides some private care (i.e. care not paid for by the state). In addition, some care is provided for the NHS by private-sector hospitals, with this growing in proportion over the last eight years as the Labour Government actively pursued a mix of private and public provision (see Chapter 7 for further discussion). To access NHS specialist care, patients require a referral for a consultation from a GP, although they may also be admitted as an emergency. Patients can also pay out of pocket for a private consultation or be referred through a PMI scheme if they are members of such a scheme.

This section focuses on the organization of secondary care in England – including some discussion of maternity care, care for children and tertiary care – and provides data on general availability and accessibility of services, and on measures of the quality of care. There is also some discussion of the relationship between secondary care, primary care and social care. Emergency care is covered in section 6.5.

6.4.1 Organization of services

Secondary care

NHS secondary care is mainly provided by salaried specialist doctors (known as consultants), doctors in training, nurses, and other health care professionals (e.g. physiotherapists and radiologists) who work in government-owned hospitals known as "trusts". In 2004, a new form of governance for NHS trusts was introduced – NHS FTs – under the Health and Social Care (Community and Health Standards) Act 2003. These are independent public benefit corporations controlled and run locally, not centrally, and with more freedom to retain surpluses and to recruit and employ their own staff. The intention was that all NHS trusts would eventually become FTs once they had met criteria relating to their financial and business performance. This has been a slow process and as of September 2010 there were 131 FTs, of which 40 were mental health trusts (Monitor 2010).

FTs have the freedom to invest and disinvest and are, therefore, separate from the capital regime of the NHS. They can also sell assets that are believed to be surplus to requirements, within the agreed regulatory framework, and they can retain surpluses with the aim to improve services instead of these going back to central government. They may also have some advantages in recruiting and retaining staff because of more flexible working conditions and more flexible remuneration methods. FTs are regulated differently from NHS trusts but essentially are expected to meet the same clinical and organizational standards. Chapter 4 provides a more detailed discussion.

What are known as general acute trusts tend to provide both acute (urgent) hospital services as well as elective care in most specialties; some provide services in just one specialty (e.g. orthopaedic, cancer, children's services) and often are regional or national centres for more specialized care. Some trusts, frequently referred to as teaching or university hospitals, are attached to universities and help to train health care professionals. Acute trusts can also provide services in the community through health centres and outreach clinics. In 2009–2010, there were 146 acute NHS trusts, 20 single-specialty trusts, 55 mental health and learning disability trusts and 10 care trusts. Trusts may operate from one or more hospital sites; the total number of acute and specialist care hospital sites reported by acute and single-specialty trusts was 332 in 2009–2010 (Information Centre 2010g).

Staff are directly employed by both NHS trusts and FTs. Staff members include doctors, nurses, midwives and health visitors, pharmacists, physiotherapists, radiographers, occupational therapists and psychologists, as well as non-clinical staff (e.g. receptionists, porters, cleaners, specialists in IT, managers, engineers, caterers and domestic and security staff). Between one-third and one-half of doctors – depending on the nature of the hospital – are consultants; in addition, most hospitals employ a number of other fully qualified doctors including associate specialists, specialty doctors and staff grade doctors. The remainder, known as "doctors in training", are qualified doctors consisting of the registrar group (specialty registrars, specialist registrars, senior registrars, registrars), senior house officers and house officers, and foundation programme doctors years 1 and 2. Most general acute hospitals are organized according to clinical directorates, with these consisting of a range of specialties. In September 2009, in England as a whole, 37% of hospital-based doctors (36 950, headcount figure) were consultants. Over two-thirds of these were in one of four clinical groups: surgical (18%), general medicine (22%), psychiatry (12%) and anaesthetics (15%) (Information Centre 2010i).

General acute hospitals usually provide emergency as well as elective care. However, since 2002, there has been some separation of emergency from elective care within the NHS through the introduction of "treatment centres". These were established in April 2002 to provide elective surgical and diagnostic testing within facilities that were ring-fenced from use for emergency care and hence benefited from increased certainty around flows of patients. The treatment centres were initially managed by NHS trusts, but in 2003 the government announced a programme of ISTCs with a similar structure and purpose, although more controversially with guaranteed income levels irrespective of the quantity of care delivered (see Chapter 7 for more discussion of this policy). The Department of Health initially expected 46 NHS treatment centres to be operative by December 2004, and in addition, 17 ISTCs by the end of 2005; in all, 80 treatment centres were opened across England (Department of Health 2005e). In February 2009, there were 33 ISTCs in operation as well as two mobile units providing MRI scans and cataract operations (House of Commons 2009b); by December 2009, a total of 35 ISTCs were open and these had delivered around 1.5 million diagnostic tests and 2 million operative procedures since starting in April 2005 (Department of Health 2010r).

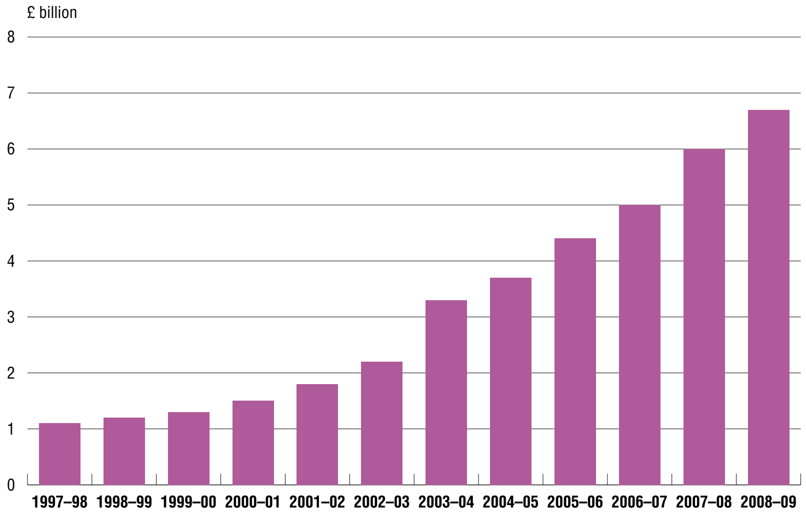
Private-sector provision of secondary care

A small private sector exists alongside the NHS, funded through PMI, direct payments from patients or publicly funded payments by PCTs, NHS trusts and the Department of Health; this sector mainly provides acute elective care. The public sector has always used private-sector providers for some elective and diagnostic procedures. However, since 2000, there has been a growth in the amount of NHS-funded activity provided by the private sector as a result of government policy to introduce a more mixed economy of provision (Department of Health 2000c), as well as efforts to increase NHS-funded capacity from 2003 onwards (see the introduction of ISTCs above as well as further discussion in Chapter 3).

Fig. 6.3 shows the growth in total expenditure by all NHS organizations on services from non-NHS bodies from 1997–1998 to 2008–2009, an increase of over 500% in this period. Between 2001–2002 and 2008–2009, the proportion of NHS expenditure that purchased care from non-NHS bodies more than doubled, from 3.4% to 7.1%. In 2008–2009, £6.4 billion was spent by PCTs on non-NHS health care, an increase of £1.7 billion over two years. Over £3.4 billion of this was spent on care provided by other private-sector providers (£3.1 billion) and ISTCs (£314 million) (House of Commons Select Committee on Health 2010a).

Fig. 6.3

NHS expenditure on health care supplied by non-NHS bodies, 1997–1998 to 2008–2009



Source: House of Commons Select Committee on Health 2010a.

As discussed in section 5.1, private-sector beds, including NHS pay-beds, form only a relatively small proportion of total acute beds in England compared with other EU countries. In 2007, there were 304 private-sector acute hospitals, providing 9572 beds; estimated expenditure on private-sector acute hospital care was almost £3 billion (Laing & Buisson 2007).

NHS hospitals also offer private services in the form of NHS "pay-beds" and NHS "amenity-beds". Amenity-beds (or rooms) are usually just rooms fitted more comfortably than standard NHS facilities; a fee is charged to the patient for the room but there is no charge for the clinical care delivered. Pay-beds, on the other hand, are essentially private health care delivered by the NHS, with similar charging structures to those in private-sector acute hospitals. Often, these will be within dedicated private patient units. Income from both pay- and amenity-beds is part of the NHS trust's overall revenue stream.

In 1949, there were over 12 500 pay- and amenity-beds in the NHS, a small proportion of total beds, and by 1963 private beds were just 1% of total NHS acute beds (Stevens 1966). The number of pay-beds has fallen considerably since then so that by 1986 there were less than 3000 private pay-beds in the NHS in England (Nicholl, Beeby & Williams 1989), a similar number to that reported by the House of Commons Select Committee on Health (2002). Income to NHS trusts and FTs in 2007–2008 from private patients (including non-reciprocal patients from overseas) was £430 million (Monitor 2008c; NAO 2008d), amounting to a considerable proportion of estimated total acute private-sector income.

Maternity and children's services

In 2004, the Department of Health published a NSF covering children, young people and maternity services. The maternity standard suggested a 10-year programme for improvement with an emphasis on women having easy access to supportive, high-quality maternity services designed around their individual needs and those of their babies (Department of Health and Department for Education and Skills 2004). In 2007, the Department of Health introduced a choice guarantee for women so that all women would be able to choose the type of care they receive – whether a home birth, midwifery-led or an obstetric unit – together with improved access to services and continuity of midwifery care and support (Department of Health 2007q).

Most maternity services in England are provided by consultant-led obstetric units within NHS trusts with access to emergency services if required.[20] In addition, services are provided in midwife-led maternity units, some of which are located on trust sites, although most are free-standing. In 2007, there were 148 NHS trusts providing obstetric maternity services (of which 65% had only obstetric units) and two providing just midwifery-led services. There were around 673 000 births in England in 2008 (ONS 2009a), most of which took place in obstetric units (93%), with 3% in midwifery units attached to hospitals, 2% in free-standing midwifery units and 2% at home (Healthcare Commission 2008a).

As Fig. 6.4 shows, between 1987–1988 and 2009–2010, the number of maternity beds per 100 000 population declined steadily, from 33.7 to 16.2, as women spent less time in hospital having their babies. Official figures for the number of obstetric specialists are not given as such but are provided for obstetrics and gynaecology combined. In line with other specialties, the number of specialists (consultants) increased by 58% between 1999 and 2009; the number of births increased between 1999 and 2008 by 14%: the number of consultants per 1000 births in 2008 was 2.3. Between 1998 and 2008, the number of registered midwives increased by just 12%.

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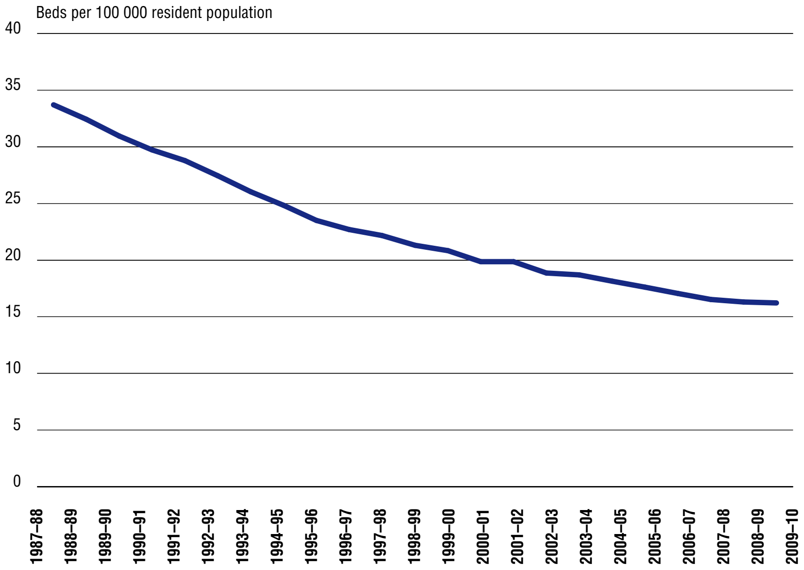
[20] There are also some private-sector maternity units, most of which are concentrated in London and the southeast. However, data are not available on activity in this sector.

Fig. 6.4

Available maternity beds per 100 000 resident population, England, 1987–1988 to 2009–2010



Source: Calculations based on Department of Health 2010p.

Around 10% of babies require additional care in a neonatal unit, often because of low birth weight or being premature. This care may be provided on the same site or it may require transfer to a special unit. In England in 2007, there were 180 neonatal units based in NHS trusts and FTs, which were structured into 23 regional networks. Each unit is designated as providing care at one of three levels, indicating the type and intensity of the care provided: (1) special care; (2) high-dependency care; and (3) intensive care. The total number of neonatal cots in 2006–2007 was 3521: most units were level 2 (50%) or level 3 (29%); however, most cots were level 1 (60%) (NAO 2007d).

The NSF covering children, young people and maternity services (Department of Health and Department for Education and Skills 2004) set standards for child-specific services, including that all young people should have timely access to age-appropriate advice and services; those with complex needs, and/or physical and mental disabilities, should receive coordinated, high-quality family-centred services; and, in respect of secondary care, young people who require hospital services should receive high-quality care in appropriate settings. In 2009, the Department of Health published its child health strategy, although its main focus was not on acute hospital care (Department of Health and Department for Children, Schools and Families 2009).

Most general acute hospitals provide services for children. In addition, there are single-specialty hospitals that mainly provide tertiary services (see below). Official figures for paediatric beds are not available. However, the headcount number of specialists (consultants) increased by 78% between 1999 and 2009, from 1355 to 2416. In 2007–2008, there were over 1 million admissions to hospital of children aged 14 and under, 3 million attendances in A&E of children under 16 years of age and 4.5 million outpatient appointments. Over 500 000 children each year are admitted to hospital as emergency patients (Healthcare Commission 2008b).

Tertiary services

In addition to secondary care provided by NHS hospital trusts throughout England, a range of more specialized "tertiary services" are also provided by NHS trusts to deal with more complex or rare conditions. The Department of Health has defined specialized services as those provided in relatively few specialist centres to catchment populations of more than a million people. However, within this group there is a further distinction between those "very specialized" services where the client group consists of perhaps just scores of people, and the rest. Tertiary services are not provided in every hospital but tend to be located in areas of higher population density such as London, Birmingham or Manchester (Carter 2006). These trusts are usually also linked to medical schools or teaching hospitals providing undergraduate and postgraduate medical education, as well as being centres of research in their fields. Patients are mostly referred to a tertiary centre by a secondary care specialist, although direct referrals by GPs are also possible. In addition, most tertiary centres also provide some private health care services.

Services are provided both by single-specialty hospitals and by general acute hospitals, which are also usually teaching hospitals. These hospitals also provide secondary services, although in the case of single-specialty hospitals their main focus is on more complex and rare conditions. Tertiary care centres include the following specialties: orthopaedics, plastic surgery and burns treatment centres, oncology, cardiothoracic, organ transplantation, women's care, children's care, neurology and neurosurgery, ophthalmology, rheumatology, dentistry and ear, nose and throat (ENT); services include kidney transplantation, services for haemophilia and services for very rare cancers.

There are 34 specialized services identified by the National Specialised Commissioning Group (2010) in the Specialised Services National Definitions Set. It is estimated that specialized services accounted for around 10% of PCT expenditure on hospital services in 2004–2005: approximately £3.48 billion (Carter 2006). Specialized services are commissioned either regionally by one of 10 Specialized Commissioning Groups or nationally by the National Commissioning Group depending on the rarity of the conditions. There are around 50 hospitals providing various specialized or tertiary care services in England.

6.4.2 Access to services

All geographic areas have access to secondary care in one or more NHS specialist hospitals. An individual's access is usually mediated through that person's GP (see section 6.3.2). However, the availability of services as measured by beds, doctors and nurses per head of population varies considerably between regions, as does the ease of access as measured by average distance travelled for care. Although beds in individual hospitals are often associated with particular consultant specialties, they may be used by a patient of any specialty when there are shortages, and often they are. Moreover, data collection in England at a national level has tended to be at a higher level, with wards designated, for example, as acute, elderly, maternity, mental health; hence, it is not possible to distinguish availability by specialty, or even by whether these are elective or emergency beds. Nevertheless, overall availability of beds in acute hospitals may act as a proxy for access to services.

The average daily number of available acute hospital beds has fallen over time in England from 121 170 in 1989–1990 to 100 621 in 2009–2010, although this has been partially compensated by an increase in beds for care of acute patients as day cases:[21] from 2900 to 11 200 (see section 5.1.1 for data sources and more detailed discussion of this trend). Although the number of available acute beds has fallen over time, there has been an increase in activity, which is shown by an increase in hospitalization per head of population (i.e. hospital utilization rates). Hospitals have coped with increased activity within a reduced bed stock because of three factors: (1) increased occupancy of existing beds; (2) reduced stays in hospital (i.e. lengths of stay); and (3) increased number of patients who do not need an overnight stay (i.e. are treated as day cases). In English NHS hospitals, there has been a major increase in the number of day-case procedures performed (in 2008–2009, 73% of elective procedures

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[21] Day cases are patients with acute conditions who do not occupy a bed over night. They are usually for planned admissions for elective procedures.

were day cases), combined with a falling length of stay for patients admitted (in 2008–2009 the average length of stay for emergency patients was 3.3 days and that for elective inpatients was 3.0 days) and an increase in the acute bed occupancy rate, from 79% in 1996–1997 to 86% in 2008–2009 (Department of Health 2008s, 2009m).

These trends suggest the use of bed numbers has become an increasingly inaccurate indicator of the capacity of a hospital to treat patients. Hospitalization rates have also increased over the period from 1998–1999 to 2008–2009, as Fig. 6.5 illustrates. Thus, both inpatient and day-case hospitalization rates have increased, although, as the figure shows, there was little change until 2002–2003. On average, the total rate increased by around 2.5% per year. This represents a reduction in the rate of growth compared with the previous four years from 1994–1995 to 1998–1999, when hospitalization had grown at over 6% per annum (Boyle & Hamblin 1997).

Fig. 6.5

Hospitalization rate per 1000 resident population, England, 1998–1999 to 2008–2009

Source: Calculations based on activity data from the Information Centre web site and ONS population statistics (*see* http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1008).
Note: These hospitalization rates include all specialties except maternity.

There is considerable variation in the availability of acute beds between different parts of England. For example, while average acute bed availability in England in 2009–2010 per 1000 resident population was 1.9, this varied between

1.5 in the South East Coast and East of England SHAs to 2.4 in the North East SHA. Acute bed occupancy also varied from 79% in the North East to almost 90% in the South East Coast (Department of Health 2010s).

Staffing

Staffing levels are also an indicator of ease of access to services. Detailed analysis of overall staffing levels is provided in section 5.2, showing a substantial increase in most types of staff employed by the NHS in England since 2000, resulting from specific government targets aimed at increasing capacity across the board. Nevertheless, there are substantially more doctors per head of population in other EU countries than in England: 2.7 doctors per head in 2009 compared with an average of 3.5 in the EU15 countries in 2006 (see section 5.2). The position is similar for nursing staff.

There has also been some variation in the level of growth in staffing both between specialties and between different regions of the country. Moreover, some areas were starting from a position of fewer members of staff than others. Overall, the number of consultants increased by 58% between 1999 and 2009; most specialties witnessed increases over 50%, with clinical oncology, anaesthetics, paediatrics and general medicine showing the greatest increases.

Looking at variation between areas of England in 2009, the average number of hospital doctors varied almost twofold between the East Midlands SHA (1.6 doctors per 1000 population) and London (2.8), and a similar situation exists for consultants. This partly reflects the greater number of teaching hospitals in London. Variation in the size of the nursing workforce is less pronounced, though still important. Thus, the average number of nurses per head of population in England was 7.7 in 2009 but this varied by over 40% from 6.4 in the South East Coast and South Central SHAs to 9.0 in the North East.

6.4.3 Quality of services

Secondary and tertiary hospital services, whether provided by the public or private sector, are regulated by the CQC (see section 4.1.3). All providers must be registered with the CQC, which also carries out periodic reviews of the performance of NHS trusts. In addition, the CQC and its predecessor, the Healthcare Commission, carry out special service reviews; for example, in 2010, the CQC looked at the quality of care for people who have had a stroke.

The CQC published an overview of 2009 NHS performance that included aspects of secondary and tertiary care. Performance against a waiting time target of 18 weeks from referral by a GP to a hospital specialist to start of elective treatment had improved substantially: 89% of trusts achieved the target of a maximum wait of 18 weeks in 2008–2009 (CQC 2010b). There have also been falls in the number of health care-associated infections, in particular with MRSA and *C. difficile* in hospitals: episodes of MRSA in English hospitals fell by 59% (from 1092 to 444 cases) between October–December 2007 and October–December 2009, while episodes of *C. difficile* fell by 51% (from 12 248 to 6009 cases) over the same period (HPA 2010e). Yet, although performance has improved, there is considerable variation between acute trusts, with 5% assessed as being weak in terms of quality and 3% as weak in terms of financial management; in addition, some 33% of private-sector providers failed to meet core or service-specific national minimum standards (CQC 2010b).

Standardized mortality rates within hospitals are also an important indicator of quality, although their use in England is not without controversy (Kafetz & Bedford 2009; Department of Health 2010t; Lilford & Pronovost 2010). The Department of Health has also published some data at trust level on survival rates for particular operations (Department of Health 2008t), and the CQC uses indicators of mortality for groups of patients defined by the care they receive (e.g. patients admitted with a stroke or a hip fracture) and routinely looks at mortality outliers for English trusts (CQC 2009b).

Waiting times

The length of time people wait for an elective procedure has always been an issue for the NHS. For many years, the focus was on the overall number of people waiting for a procedure, which by 1998 was over 1.3 million, as well as how many people waited longer than a specified period, sometimes as much as 18 months. Little attention was paid to the overall wait, that is, the wait including how long people waited for an outpatient appointment once referred by their GP to a specialist (Harrison & Appleby 2005).

As discussed in Chapter 7, the overall waiting time from referral by GP to start of elective treatment became the key target for the NHS in 2004, and a maximum wait of 18 weeks was set.[22] Fig. 6.6 shows that performance for England as a whole has improved significantly against this target. Most patients referred to a specialist are not admitted for an operation: in December 2009 only around 25% of patients who completed their referral pathway were admitted for treatment; the rest (non-admitted) start and complete treatment as an outpatient (Department of Health 2010u). Fig. 6.6 shows that the proportion of non-admitted patients who started treatment within 18 weeks increased substantially between August 2007 and March 2008, since when it continued to

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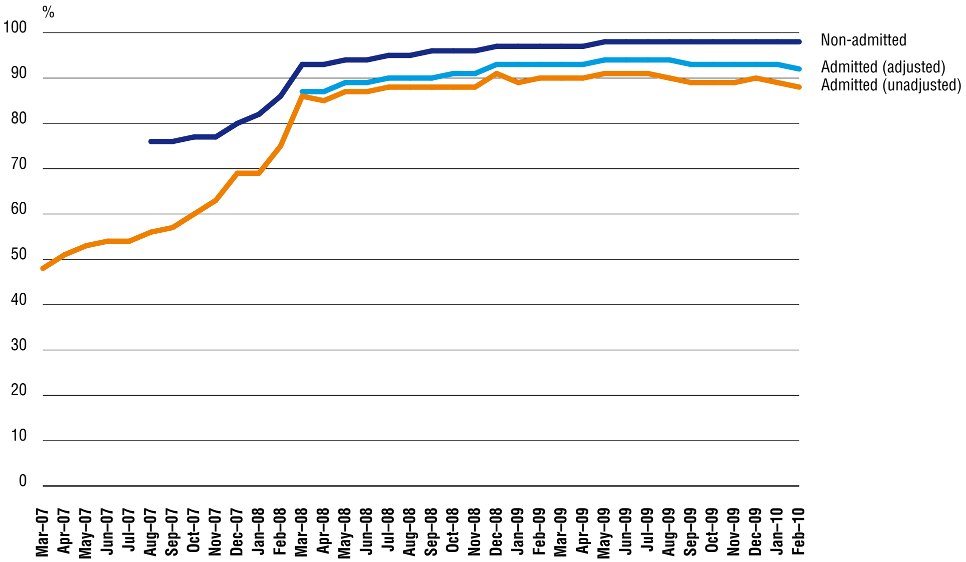
[22] However, the target was taken as met if achieved for 95% of non-admitted patients and 90% of admitted patients.

rise so that by February 2010, 97.8% of patients were dealt with within 18 weeks. The proportion of admitted patients (i.e. those requiring an elective procedure who have an operation within 18 weeks) also increased substantially between March 2007, when the unadjusted figure was 48.3%, and February 2010, when the unadjusted figure was 88% and the adjusted figure was 92%.[23] The median wait for admitted patients in December 2009 was 7.7 weeks; the median wait for non-admitted patients was 4.2 weeks (Department of Health 2010u).

Fig. 6.6

Proportion of patients seen within 18 weeks, England, March 2007 to February 2010



Source: Department of Health 2010v.
Note: These time series reflect when data was first collected in this way.

There is some variation in performance both for individual specialties and in different parts of England. For example, in February 2010, taking admitted patients (adjusted), 88.5% were treated on target in the South East Coast SHA compared with 94.3% in the North East; for non-admitted patients less variation is observed, from 96.7% in the South East Coast to 98.4% in the North East. For the gastroenterology and thoracic medicine specialties, 99.2% of admitted patients (adjusted) in England were treated on target compared with just 85.2% for orthopaedics; for non-admitted patients, again less variation is observed, from 97% in neurology to 98.7% in thoracic medicine (Department of Health 2010v).

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[23] The adjusted figures became available after March 2008, when data began to be collected on an adjusted basis, that is, taking account of legitimate pauses of the waiting-time clock of some patients.

6.4.4 Relationship between secondary, primary and social care

The interface between secondary care and primary care has always been problematic within the English NHS, with primary care appearing the poor relation as the bulk of expenditure remained within the acute hospital sector. From the early 1970s, various governments have aimed to provide so-called seamless care as patients pass through the system from GP to hospital and back to being cared for in community settings (Marks 1993). The interface with social care – with its independent sources of funding and management within local government – has been even more problematic (see section 6.8 for a discussion of the interface between health and social care).

In addition, there has been a desire to shift care from the acute sector to care delivered nearer to the patient. There is a crucial distinction between such shifts in care, with two scenarios capturing the changes envisaged: (1) a shift where it is intended that the same work is done elsewhere (e.g. outpatient follow-up by a GP or a practice nurse rather than in the acute hospital, or postoperative care provided in the home rather than hospital) and (2) a shift where work is provided in or close to the patient's own home environment and thus prevents or forestalls the need for work in the acute sector (e.g. closer monitoring of people with chronic conditions preventing emergency admissions or A&E attendances).

In England, there are various examples of both these kinds of shift in the balance of care, with substitution between hospital care and care delivered in primary or community care settings. Examples include hospital-at-home, home care or intermediate care teams; shared care schemes between specialists and GPs (e.g. diabetes, asthma, intermediate hospital care, the development of integrated care, specialist outreach services); and forms of substitution for hospital care (e.g. diagnostic testing in general practice, nurse-led schemes, self-care and diagnosis through "expert patient programmes") (see Rogers et al. (2007) for more detail on "expert" patients).

The Department of Health in *Our Health, Our Care, Our Say* (Department of Health 2006c) set out its aim to provide care in more convenient local settings including the patient's home by shifting resources from acute hospitals to community hospitals. In particular, the Department emphasized the need to increase the quantity and quality of primary care in underserved deprived areas. Changes to the PbR tariff were envisaged to provide incentives to support the shift of care out of hospital, and the Department of Health set out to work with clinicians to define clinically safe pathways within primary care for a range of specialties (e.g. dermatology; ENT; and orthopaedics).

This policy was reflected in a report by the National Director for Primary Care in 2007, *Keeping it Personal,* which emphasized the need to bring care closer to home for patients (Colin-Thomé 2007). In 2008, the Department of Health set out proposals for integrated care pilots so that primary and community care clinicians could work with acute hospitals to deliver seamless care (Department of Health 2008u). In April 2009, the Department of Health launched a programme of 16 integrated care pilots designed to cross boundaries between primary, community, secondary and social care. Examples include GP-led service development of specialist intermediate care teams for patients with dementia, and various chronic disease management services, with teams including people from across the health care boundaries (e.g. hospital consultants, GPs, community health staff and social care staff) (Department of Health 2009n).

6.5 Emergency care

There is no precise definition of emergency care in use within the NHS system in England. Rather, from a patient perspective, the emergency care system in England is understood to comprise those services that are in place, readily accessible and have the capacity to deal with the majority of urgent health needs of an individual. An individual with an urgent health problem has the option of contacting a range of different services within the formal health system, from a GP, a walk-in centre, a minor injuries unit, an urgent care centre, NHS Direct, a local pharmacist, a local mental health team, the A&E department of an acute hospital or the ambulance service by dialling 999.

From a provider perspective, A&E and the ambulance service are generally understood to be emergency care services, and also emergency treatment may require an operation and or a stay in hospital. The other sources of care – often now referred to as part of the urgent care system – are, in effect, potential points of first contact with the health care system and may sometimes be the most appropriate service for an individual. However, in an emergency – which may be life threatening or have severe or catastrophic consequences if not dealt with quickly – the individual will have to be routed to a part of the system that can provide an emergency response.

When a person experiences an urgent health problem, from a severe headache to sudden chest pains, or ongoing hip pain to a broken leg, a range of options are available. Fig. 6.7 indicates the key elements of the emergency and urgent care system in England. Some services are available at any time (indicated in red in the figure) and include ambulance services, the A&E department, NHS Direct, GP out-of-hours services[24] and community pharmacies, of which at least one in an area will be open 24/7. Other services are available for a limited number of "office" hours, which vary depending on the provider (indicated in green in the figure) and include minor injury units, walk-in centres, urgent care centres, GP in-hours services and most community pharmacies. Individuals may respond differently to similar urgent health problems, and clearly the time and day when they choose to access services affects their choice of provider. This section is primarily concerned with what are commonly regarded as emergency care services: A&E, ambulance services and emergency hospital care. Urgent care services are discussed in other sections of this chapter as well as elsewhere in this report, with the exception of walk-in centres, minor injuries units and urgent care centres, which are addressed briefly in the context of the use of A&E services.

Prompt provision of emergency care is one of the most important requirements of any health care system. For many years, NHS provision of emergency care in England has been criticized for failing to meet basic standards relating to availability and time waiting in inappropriate circumstances. Often, the NHS has faced unmanageable surges in emergency admissions, particularly in the winter months, rises in A&E attendances and increased demand on ambulance services; this has led to unacceptable delays in care, and there is evidence that this remains an issue (Ramesh 2010).

The *NHS Plan* (Department of Health 2000a) set a number of targets to improve emergency care, and in 2001 the Department of Health set out its plans in *Reforming Emergency Care* (Department of Health 2001f). Targets included:

- ambulance response times to improve so that an ambulance responds to 75% of calls to life-threatening emergencies within eight minutes; and
- no-one waits more than four hours in an A&E department from arrival to admission to a bed in the hospital, transfer elsewhere or discharge, with average length of waiting to be 75 minutes.

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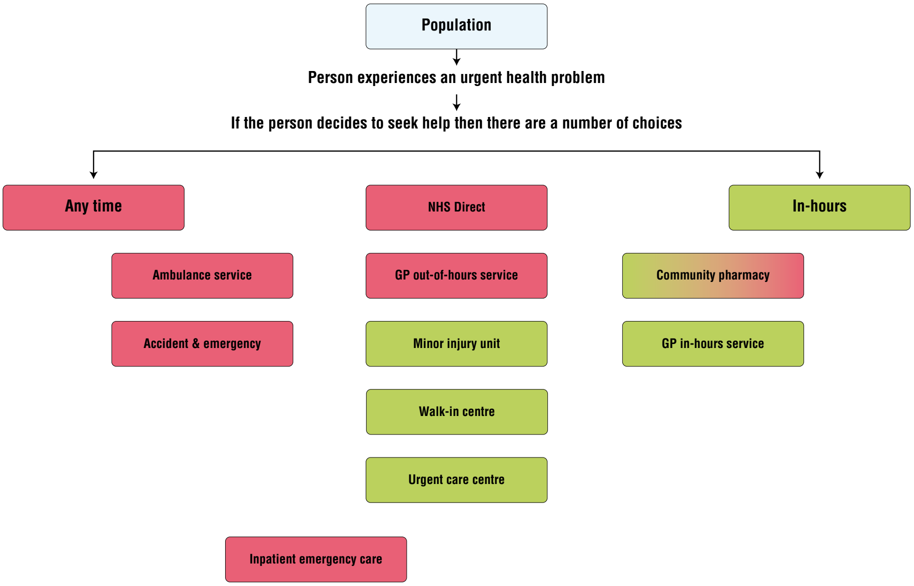
[24] The term GP out-of-hours services reflects historical provision; it is probably more correct now to refer to these as primary care out-of-hours services as there are a number of different providers.

Fig. 6.7

The emergency and urgent care system in England



Note: Services available at any time are indicated in red; services available for a limited number of "office" hours are indicated in green.

In 2007, Alberti, who was then the Department of Health's National Director for Emergency Access, reported on progress made in achieving these targets (Alberti 2007). Changes in performance on key targets are discussed in section 6.5.3.

6.5.1 Emergency care system

Emergency health care

Almost all emergency health care is provided through the NHS. There are private emergency care centres where patients can be seen immediately by a doctor or nurse, a wide range of diagnostic tests are available and the patient can usually be admitted immediately as an emergency patient. Some of these can be accessed through self-referral; others require referral from a GP – in which case it is questionable whether they are really emergency care centres. The private sector is also involved in the delivery of urgent care services both as part of the NHS system and separately to private patients. Data on private provision are not routinely available, and hence private provision is not covered in detail in this section.

NHS A&E departments are open 24/7 throughout the year, are consultant led and have full resuscitation facilities. Most cover all types of emergency (type 1) but there are some single-specialty A&E departments (type 2; e.g. for ophthalmology and for dentistry). In 2008–2009, there were 155 NHS trusts providing A&E services and minor injury clinics (sometimes called urgent care centres) and 101 PCTs providing mainly walk-in centres (Information Centre 2010o).[25] However, there are 590 NHS A&E departments in England (House of Commons 2009c) as some NHS trusts manage several A&E departments.

People usually attend A&E departments with new problems; however, some people attend as an unplanned follow-up,[26] although the number of these has declined significantly in recent years. Fig. 6.8 shows that there has been a considerable increase in new attendances at A&E departments in England between 1991–1992 and 2009–2010, growing by 80%; at the same time, the number of follow-ups has fallen by 69%, leading to an overall increase in A&E attendances of 54%. Most of the increase in new attendances (53%) has taken place since 2002–2003. However, a substantial number of these are attendances at NHS walk-in centres or minor injury units (type 3). These are intended to deal with relatively minor problems (e.g. sprains, cuts, stomach pain), are usually not 24/7 facilities and are usually nurse led. Walk-in centres tend to be managed by PCTs. The latest figures suggest there are 225 minor injury units and 93 walk-in centres in England; in addition, every PCT is opening a GP-led health centre that will provide services similar to those available in walk-in centres (NHS Choices 2010).

Data that differentiate between A&E departments and the less comprehensive services provided by walk-in centres and minor injury units are not freely available, and so it is impossible to calculate what the actual increase in attendances at A&E over this period has been. However, the Department of Health has stated that attendances at walk-in centres are around 3 million (NHS Choices 2010). Moreover, calculations based on the number of PCT-recorded attendances suggest that in 2008–2009 at least 4.35 million attendances were at minor injury units or walk-in centres. The Healthcare Commission confirmed that most of the increase between 2002–2003 and 2007–2008 was in this area (Healthcare Commission 2008c). Therefore, attendances at A&E departments have increased by considerably less than Fig. 6.8 suggests, perhaps by as little as 15% since 1991–1992.

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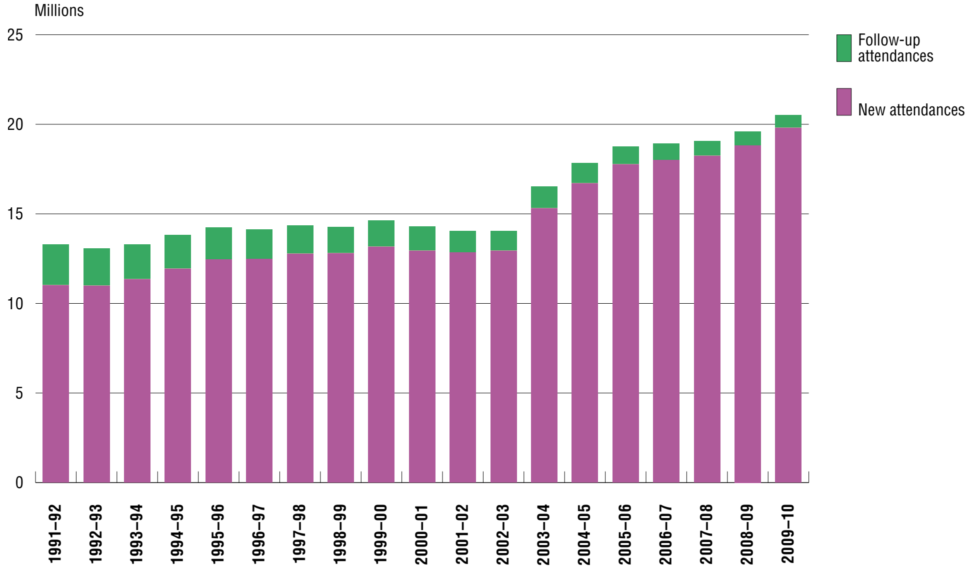
[25] NHS-funded private-sector services are included as part of services provided to the NHS by PCTs.

[26] Planned follow-ups are technically regarded as outpatient appointments.

Fig. 6.8

Attendances at A&E departments in England, 1991–1992 to 2009–2010



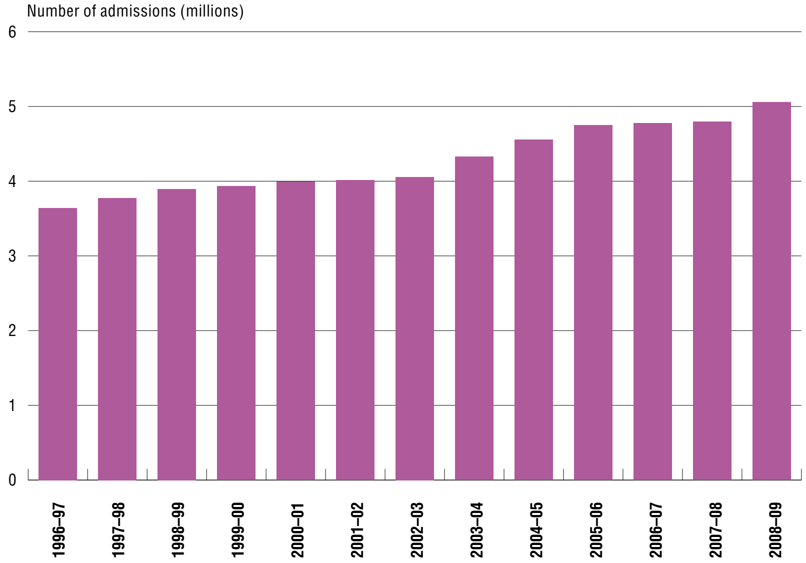
Source: Department of Health 2010q.
Notes: Attendances at walk-in centres were included from 2003–2004 and hence the large increase in that year, and attendances at NHS-funded private-sector services were included from 2008–2009.

Emergency admission to hospitals

Many attendances at A&E result in an admission to hospital as an emergency patient, although patients can be admitted as emergencies in other ways: by a GP, from a consultant outpatient clinic or from another hospital. Fig. 6.9 shows a growth of almost 40% in emergency admissions between 1996–1997 and 2008–2009, an annual rate of 2.8%. Most of this has occurred since 2002–2003, with an increase in the latest year by 5.4%.

Fig. 6.9

Emergency admissions in England, 1996–1997 to 2008–2009



Source: House of Commons Select Committee on Health 2010a.
Note: These are NHS admissions based on first finished consultant episode.

Critical care beds

Most people admitted as an emergency occupy a bed in a standard ward in an acute hospital, which may be associated with a particular specialty. However, a proportion of patients with severe injuries or life-threatening conditions may require more specialized care, which would usually be delivered in critical care beds. Three levels of critical care have been identified: level 1 is for patients at risk of their condition deteriorating or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the critical care team; level 2 is for patients requiring more detailed observation or intervention, including support for a single failing organ system or postoperative care and those stepping down from higher levels of care; and, level 3 is for patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This last level includes all patients with complex medical conditions requiring support for multiorgan failure (Department of Health 2000e). Often level 2 is referred to as high dependency and level 3 as intensive care. In 2009, the Department of Health set up a programme to develop regional trauma networks within each SHA so that appropriate levels of critical care would be delivered in specialized units linked to other parts of the emergency care system (NAO 2010a).

The number of critical care beds in England has increased by 65% from 2240 in March 1999 to 3685 in January 2010, at an annual rate of 2.3%. However, two-thirds of this increase has been high-dependency rather than intensive care beds and so the ratio of one to the other is now almost 1:1 as opposed to over 2:1 in favour of intensive care beds in 1999 (Department of Health 2010w). There are 193 hospitals with A&E departments that can deal with major trauma (NAO 2010a).

Ambulance services

There are currently 11 NHS ambulance trusts in England responsible for the delivery of emergency ambulance services.[27] This involves responding to emergency calls (999), providing on-scene clinical care and transporting patients to hospital. In 2008–2009, there were 7.48 million calls to the ambulance service, resulting in 6.15 million emergency responses (NAO 2010a).

Calls to the ambulance services are dealt with initially by an emergency medical dispatcher who triages the call by urgency into one of three categories, A (immediately life threatening), B (serious but not immediately life threatening) or C (neither serious nor immediately life threatening), each having a target response time. Most responses are by emergency ambulances that have a crew of two emergency care assistants or one emergency care assistant and one paramedic. Single-response vehicles or fast-response vehicles are also used. These are motorbikes or cars, usually crewed by an emergency care assistant, paramedic or doctor, that get to the scene more quickly than an ambulance and can assess the situation and provide care until an ambulance arrives. The patient will then be transferred to a hospital A&E if necessary, often the nearest one, but sometimes based on the ambulance crew's assessment of severity of condition and level of care required.

Fig. 6.10 suggests there has been a considerable increase in the number of calls to ambulance services in England in the period between 1994–1995 and 2008–2009. However, there is a discontinuity in the data, as shown in the figure. As well as responding to emergency calls from individuals, ambulances are required to take patients to hospital where a doctor, midwife or other health care professional has identified the patient's need as urgent. Previously, such an event would have been recorded as an urgent journey rather than an emergency. Since April 2007, these calls have been dealt with in the same way as any emergency call, with patients triaged into categories A, B or C, and these are now included as calls to the ambulance service. This is reflected in the exceptional increase in calls between 2006–2007 and 2007–2008. Nevertheless,

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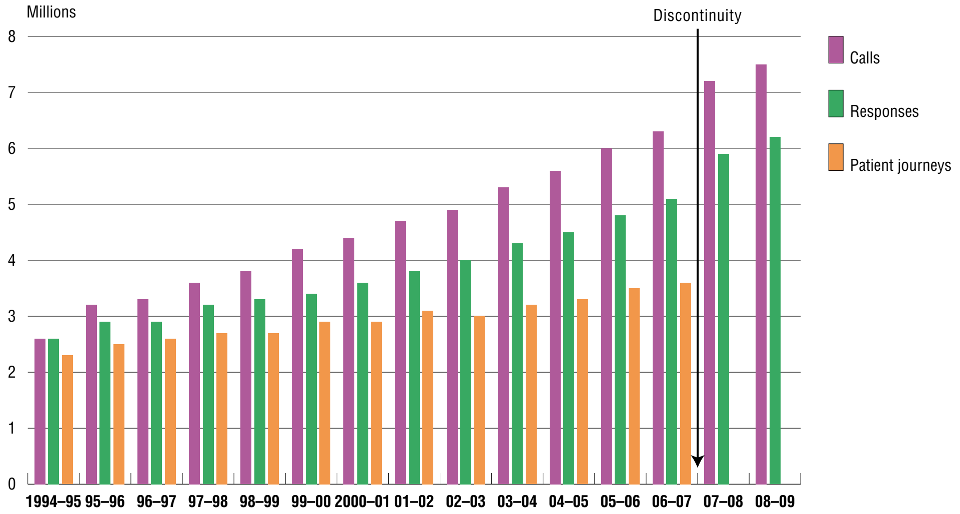
[27] There has been a reduction in the number of trusts as services have been consolidated into larger units. This figure also excludes ambulance services provided on the Isle of Wight, which are part of the Isle of Wight PCT.

the data still suggest considerable growth in demand over the whole period, increasing by an average of almost 7.7% between 1994–1995 and 2006–2007, and by 3.5% between 2007–2008 and 2008–2009.

Fig. 6.10

Calls, responses and patient journeys, NHS ambulance services in England, 1994–1995 to 2008–2009



Source: Information Centre 2005a, 2009j.
Note: Calls from 2007–2008 include both calls from individuals and calls from a health care professional to take a patient to hospital where the patient's need is considered as urgent. Patient journey is when the patient is then taken to hospital.

Over this period, the proportion of calls resulting in the attendance of an emergency vehicle (response) declined, rapidly at first, until 1999–2000, since when it has remained at around 80%. The proportion of responses to emergency calls where the patient is then taken to hospital (patient journey) has declined steadily from 87% in 1994–1995 to 70% in 2006–2007.[28] As Fig. 6.10 illustrates, demand, as measured by calls received, has increased significantly more quickly (143%) than vehicles dispatched (94%) or patient journeys to hospital (57%).

In addition, two services not funded by the NHS but provided on a voluntary basis may also be called upon by NHS ambulance trusts. Helicopter emergency medical services are provided by 18 air ambulance charities, although the NHS pays for the clinical staff. These are used in remote locations or sometimes to

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[28] Since 2006–2007, urgent and emergency calls have not been separately identified and hence patient journeys for emergency calls cannot be identified for 2007–2008 and 2008–2009.

get a response to a patient more quickly (e.g. in central London). The British Association for Immediate Care provides doctors on a voluntary basis to help where a major incident has occurred (e.g. a serious road accident).

The NHS also provides patient transport services, most often between a patient's home and a hospital or between two hospitals. These are not part of emergency services and are provided by both NHS ambulance trusts and by private-sector operators.

Funding of emergency services

Most expenditure on emergency care is funded by the public sector. However, data are not routinely available on expenditure on emergency care services per se. A Department of Health press release in 2009 claimed that the amount spent on A&E services increased from £0.75 billion in 1997–1998 to £1.7 billion in 2007–2008 (Department of Health 2009o).[29] The Healthcare Commission suggested £1.1 billion was spent on emergency ambulance services, although it was not clear to which year this referred (Healthcare Commission 2008c).

6.5.2 Access to emergency services

Access to NHS emergency services in England is free. However, utilization of services varies across the country. This section considers the variations in the use of emergency hospital services, including the number of A&E doctors and ambulance services. Where available, variations in staffing figures are provided as these may also act as an indicator of variation in access.

Hospital and A&E services

The number of A&E consultants in England more than doubled between 1998 and 2009 from 422 (408 WTE) to 938 (906 WTE) (Information Centre 2009g, 2010i). As shown in Fig. 6.8, there has been an increase in the use of A&E departments since 1991–1992, although most of the increase was not in standard A&E type 1 departments. Data on local provision are not routinely available. However, it is possible to consider variation in utilization of services between different parts of the country. In 2008–2009, the average number of attendances per 1000 population at all A&E department types was 381; however, there was an almost twofold variation between regions of the country, from 275 in the East Midlands SHA to 513 in London. Some of this difference may reflect the use of services by non-residents as London attracts a large number of commuters (Department of Health 2010q).

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[29] Expenditure on A&E services by PCTs in England was £1.73 billion in 2007–2008 in the NHS summarized accounts (NAO 2008d).

There is also considerable variation between different parts of England in the number of people admitted as emergencies through an A&E department. The number of emergency admissions per 1000 resident population in England as a whole is 62; however, this varies by almost 100% between the South Central SHA, where 42 are admitted per 1000 resident population, to the North West SHA where 80 are admitted (Department of Health 2010x).

Turning to availability of critical care beds there is also considerable variation across England. In January 2010, while the average number of critical beds in England per 100 000 population was 7.2, this figure ranged from less than 6 across the south and east of England to over 11 in London and over 9 in the areas covered by the North East SHA.

Ambulance services

The 11 ambulance trusts serve populations in quite different geographic locations: some such as London almost exclusively urban, some rural and some a mix of both. Moreover, all provide services to visitors: in the case of cities such as London a substantial increase in population takes place every working day; in other areas, such as the southwest, the population is swelled by tourist numbers at popular holiday periods. This makes the concept of served, catchment or resident population less valid; nevertheless, taking the population served as indicated by the ambulance trusts themselves, there is some variation in use and type of services – and also in performance, as shown in the next section.

The total number of ambulance staff in England increased by 53% between 1998 and 2009, from 21 034 (19 678 WTE) to 32 284 (30 302 WTE). Of these, 17 922 (56%) in 2009 were qualified ambulance staff (e.g. emergency care practitioners, paramedics, ambulance technicians), and the remaining 14 362 (44%) were trainees and general support staff. The size of the latter group more than doubled between 1998 and 2009, while the increase in qualified staff was just 21%.[30] The average number of ambulance staff per 100 000 resident population increased from 43.1 to 62.8 between 1998 and 2009; however, looking just at qualified staff, the increase over this period was much less, from 30.3 to 34.8 (Information Centre 2009h, 2010l). There is some variation across England in the number of ambulance staff relative to population, varying from 54.5 per 100 000 resident population in London to 69.2 in the Yorkshire and Humber region (Information Centre 2010p).[31]

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[30] There were some changes to definitions in 2006 that affected categorization between qualified and non-qualified staff that makes values before 2006 not directly comparable with those after.

[31] However, London would appear to have a much higher proportion of qualified staff than other parts of the country.

There is considerable variation in demand on emergency ambulance services across the country. For example, although the average number of calls per 1000 resident population in England was 145 in 2008–2009, this varied almost 100% between regions: from 108 to 190 calls. The resulting responses to incidents varied less, from 91 to 132, around an England average of 118, indicating differences between regions in the number of calls to which a response vehicle is sent. The number of urgent and emergency journeys in the same period per 1000 served population varied between 61 in the area covered by the South Central Ambulance Trust to over 100 in the North East, North West and London Trusts, with an average for England as a whole of 88. There is also considerable variation between regions in the number of planned journeys provided by NHS trusts (essentially patient transport services) per 1000 served population, from 37 to 415, with an England average of 185; however, some of this may reflect differences in the use of private-sector services.

6.5.3 Quality of emergency services

The quality of emergency hospital services is regulated in the same way as other health care providers, by the CQC (see section 4.1.3). In 2008, the predecessor of the CQC, the Healthcare Commission, carried out a review of all urgent and emergency care services in England – all types of A&E services, emergency ambulance services, out-of-hours GP services and to a lesser extent NHS Direct and urgent GP services delivered in normal surgery opening hours – producing individual reports for each of the then 152 PCTs, as well as a report on performance in England as a whole. The review looked at access and delivery of these services, how they are coordinated and how they are managed, and it found some variation between PCTs in performance against national targets. Moreover, issues of coordination of emergency and urgent care remained a significant issue, as well as the gathering and effective use of information to ensure coordination of care for individual patients and the ability to monitor performance against national targets and guidelines (Healthcare Commission 2008c).

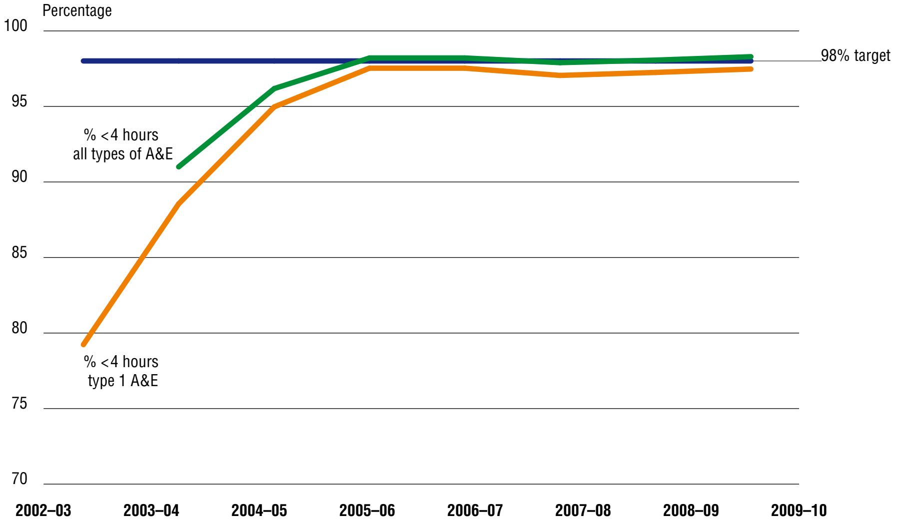
As already stated, the Department of Health uses several targets relating to emergency care to assess the performance of NHS providers: the key ones relate to the length of time people wait in A&E departments and ambulance response times. These are discussed below.

Waiting in A&E

Long waits in A&E have been a perennial problem for the NHS. It was not unusual in the 1990s for people to wait up to 24 hours or more in A&E. But a key target for the NHS in recent years has been to prevent people waiting too long, with four hours set as a maximum wait. This has been monitored closely over the last eight years on a quarterly basis. The results are shown in Fig. 6.11 for England as a whole. Hospital A&E departments (type 1) were expected to process 98% of patients attending A&E within four hours.[32] Initially, performance was quite poor, with less than 80% of patients processed within the target time; however, over 97% has been achieved since 2005–2006, although the target of 98% has continued to prove elusive. In 2009–2010, average compliance for England as a whole was 97.5%, with little variation between SHAs; in two SHAs 98% was achieved while the worst SHA also managed to achieve 96.7%.

Fig. 6.11

Percentage of A&E attendances in England with a waiting time of less than four hours, 2002–2003 to 2009–2010



Source: Department of Health 2010y.
Notes: See text for A&E department types; figures given for 2002–2003 are based on the final three quarters.

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[32] This target is monitored on the basis of total attendances including unplanned follow-ups.

Fig. 6.11 also shows compliance with the target for all A&E attendances, including those at type 2 (single specialty units, which comprise only a small proportion of the whole) and type 3 (minor injury units and walk-in centres). When these are added to the type 1 units, compliance has been marginally better throughout this period, with 98% achieved in most years since 2005–2006.

Waiting for an ambulance

Another key target for NHS emergency care is the speed of response of emergency ambulance services. Versions of this have been monitored for many years, although over time the form that monitoring has taken has changed in several key ways.

Call prioritization was introduced to the ambulance service between 2000 and 2001 (Department of Health 2001g). Emergency 999 calls to the ambulance service are now prioritized into three categories on the basis of how serious the need is perceived to be:

category A: immediately life threatening, when a response should reach 75% of calls within 8 minutes;

category B: serious but not immediately life threatening, when a response should reach 95% of calls within 19 minutes;

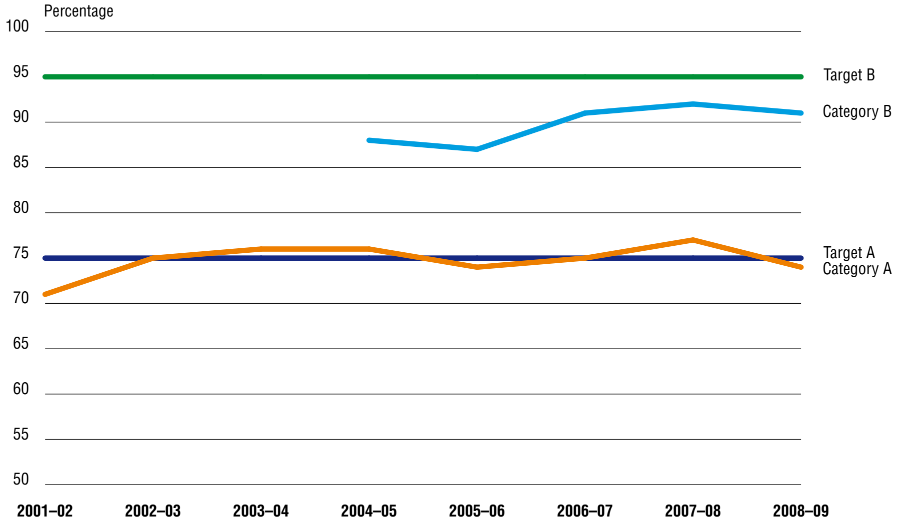
category C: not serious or life threatening, in which case performance requirements are set locally.

Until April 2006, different targets were set for urban and rural areas for category A and B calls, but now all areas are expected to achieve the same targets (Information Centre 2007d). From April 2007, data reflect the fact that urgent calls are prioritized in the same way as emergency calls and thus form part of the target. Finally, there has been a change in how response time is measured. Before April 2008, response times were measured from the point when a series of details were taken: these included the caller’s telephone number, exact location of the incident and the nature of the chief complaint, which could take anything up to 90 seconds; since 2008, response times are measured from when the call is presented to the control room telephone switch. Hence, the clock measuring time taken to respond starts earlier.

Fig. 6.12 shows how ambulance services have met targets in England between 2001–2002 and 2008–2009. In the case of category A calls, 75% have been met within the eight-minute target in most years since 2001–2002, even in 2008–2009 when the measurement of response time was changed. On the other hand, for category B calls (which have only been measured since 2004–2005), the 19-minute target has been met for around 91% of calls, still failing to achieve the 95% target. There is some variation in performance between regions. For category A calls, seven ambulance trusts achieved compliance with the target yet one other trust achieved just 68% of calls within eight minutes; for category B calls, three trusts achieved 95% but one trust achieved only 85%.

Fig. 6.12

Percentage of ambulance calls in England meeting target, 2001–2002 to 2008–2009



Source: Information Centre 2009j.

6.6 Pharmaceutical care

The production of pharmaceuticals is a significant element of the United Kingdom economy, with total industry turnover in 2007 of approximately £15.9 billion and employing 67 000 people (ONS 2009d). In 2007, total United Kingdom pharmaceutical exports were £14.6 billion and total imports were £10.3 billion, giving a trade surplus of £4.3 billion (Association of the British Pharmaceutical Industry 2009a). At the same time, pharmaceutical care is a major component of expenditure on health care in the United Kingdom, both within the NHS, where it accounts for a total of £10.8 billion, and in the private sector: it is estimated that annual expenditure on medicines per head in the United Kingdom in 2008 was £200, which is £12.2 billion in total (Association of the British Pharmaceutical Industry 2009b).

This section deals only with drugs dispensed in the community[33] and focuses on the organization of pharmaceutical care in England. It includes a discussion of the structure of the industry producing pharmaceuticals in the United Kingdom. A description is also provided of the way in which the industry is regulated, including pricing control systems. Distribution, sale and reimbursement for pharmaceuticals are also discussed, as are policies to improve the cost-effectiveness and quality of prescribing. This section concludes by providing data on the usage of pharmaceuticals, and on the number of pharmacies, indicating relatively good access for most of the population. Much of the discussion is true of the whole of the United Kingdom as well as England.

6.6.1 Organization of the pharmaceutical sector

The United Kingdom is a major producer of pharmaceuticals, ranking fourth in the world in 2007 in terms of value of exports behind Germany, Switzerland and the USA. Producers in the United Kingdom distribute their output either directly to United Kingdom pharmacies or through wholesalers; recently there has also been distribution through the Internet. In addition, drugs may be supplied by parallel traders (these are known as parallel imports), who export brands from lower-priced to higher-priced countries in the EU (Office of Fair Trading 2007).

The Medicines Act 1968 described three types of pharmaceutical product available in England: (1) those on the General Sale List, which can be supplied by someone other than a pharmacist; (2) those that can be supplied usually only through a pharmacy (or by other health care professionals e.g. doctors, dentists, nurses); and (3) POMs. The first two types are often referred to as OTC drugs.

Market regulation

This section considers licensing and regulation of all forms of medicines. The MHRA is the body responsible for licensing (the process of market authorization) all pharmaceutical products whether classified as POMs or OTCs. Products cannot be marketed without a licence. Licensing is based on United Kingdom law but must also conform with EU legislation on medicines,[34] and hence the MHRA works closely with the EMEA. The MHRA is an executive agency of the Department of Health; although it receives some direct funding

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[33] Hospital prescribing accounted for almost 29% of the total cost of drugs to the NHS in England in 2008 (Information Centre 2009k).

[34] EU legislation takes precedence over the Medicines Act 1968, its Instruments and Orders, which are amended from time to time to align with any new EU requirements.

from the Department of Health, its income is mainly through trading (almost 90%), most of which is fees from pharmaceutical companies for the licensing of medicines, and other services (MHRA 2008).

The MHRA authorizes clinical trials of drugs that take place in the United Kingdom. It also assesses the results of trials – to see that the medicine works as intended and is safe – to determine whether a new medicine should be given a licence for use in the United Kingdom. Medicines are also licensed by the EMEA, which ensures that they are available across all Member States of the EU. In addition, pharmaceutical producers and any wholesalers, including medicine importers, must satisfy the MHRA that the manufacture, distribution and supply of the medicine meet the required safety and quality standards. The MHRA also licenses new forms of existing medicines, new uses for existing medicines, such as for different patient groups or different conditions, and the reclassification of medicines from POM to OTC use. The MHRA is also active in monitoring the safety and quality standards of pharmaceutical products and can take these out of the supply chain if there is sufficient evidence for concern.

United Kingdom regulations set out the rules for advertising medicines in general, and specifically to the public and to health care professionals. Advertising of prescription medicines to the public is not allowed; advertising of OTC medicines to the public is allowed but is subject to regulation. More detail on pharmaceutical regulation and enforcement is provided in *The Blue Guide* (MHRA 2005).

Complementary and alternative medicines

Complementary and alternative medicine (CAM) – which in the past was largely unregulated – has a somewhat different regulation structure. Manufactured herbal medicines (i.e. those that are industrially produced and sold over the counter) must either meet the safety and quality standards of the Traditional Herbal Medicines Registration Scheme (which was introduced to comply with the European Directive on Traditional Herbal Medicinal Products (2004/24/EC)) or must obtain a licence.[35] Registered manufacturers are legally obliged to monitor the safety of their products once they are on the market. In the same way as for other medicines, importers and wholesalers must also obtain authorization in order to sell. However, herbal medicines that are made up and supplied on an individual-patient basis following face-to-face consultation require neither a licence nor registration (MHRA 2007).

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[35] There have been exceptions for some products that were legally on the market before April 2004; however, by April 2011 the rules will apply to all manufactured herbal medicines.

Homeopathic medicines are authorized through “Product Licenses of Right”, with certificates of registration under the Simplified Registration Scheme, or through the National Rules Scheme. Many of the products with Product Licenses of Right (which were licences granted to existing products under the Medicines Act 1968) carry indications, mainly for minor conditions suitable for self-medication. However, registered products, which are assessed only for safety and quality, are not permitted to be labelled with therapeutic indications. To ease the rules that apply to licensing of medicines generally, and in accordance with the European Directive (2001/83/EC), the National Rules Scheme was introduced in 2006. This allows homoeopathic medicinal products to be registered with indications for the relief or treatment of minor symptoms or minor conditions in humans (i.e. symptoms or conditions that can ordinarily and with reasonable safety be relieved or treated without the supervision or intervention of a doctor). Indications for serious conditions are not allowed (MHRA 2003, 2006).

Internet supplies

High-street pharmacies in the United Kingdom have to be registered with the regulatory body, the General Pharmaceutical Council.[36] While many registered pharmacies have online facilities and work within the law, unregistered organizations also operate on the Internet. A United Kingdom web address is no guarantee that the pharmacist is working out of the United Kingdom and/or is registered with the General Pharmaceutical Council. It is, therefore, impossible to guarantee the quality or effectiveness of all prescribed medicines ordered online, and especially those ordered without a prescription. The Internet is one of the sources of the increasing trade in fake or counterfeit medicines and devices.

Patent protection

Drugs manufactured in the United Kingdom are generally protected by patents. However, patents tend to be country specific. Patents can be established in the United Kingdom through the Intellectual Property Office (formerly known as the Patent Office), which is an executive agency of government. The United Kingdom is compliant with the World Trade Organization agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Patents established through the European Patent Office under the European Patent Convention are valid throughout Europe.

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[36] The General Pharmaceutical Council took over the regulatory role from the Royal Pharmaceutical Society of Great Britain in September 2010.

In general, patents last for 20 years from the date of patent grant, although matters are more complicated in the case of drugs. In Europe, a patented drug can get a supplementary protection certificate to extend protection from the point at which the patent expires for up to five years. This is intended to compensate the pharmaceutical company for the fact that authorization of the drug (i.e. safety approval) can take some years to achieve.

Manufacturers of generic medicines can use the original brand manufacturer's regulatory approval if they can demonstrate that the generic version is bioequivalent to the approved medicine. However, this requires testing of the original drug. To avoid patent infringement if the generic manufacturer conducts clinical trials on a patented product before the patent has expired, the "Bolar" exemption was introduced, allowing necessary tests and trials without these amounting to patent infringement. The United Kingdom implemented these changes in October 2005.

6.6.2 Price controls

Different price control schemes apply depending on the status of the medicines. These are voluntary agreements to which most pharmaceutical companies sign up. In addition, there are reserve statutory powers to control the prices of medicines and levels of profits where a company is not part of a voluntary scheme, based on sections 260 to 266 of the National Health Service Act 2006.

The Pharmaceutical Price Regulation Scheme

The Pharmaceutical Price Regulation Scheme (PPRS) is a voluntary, non-contractual agreement for the purposes of section 261 of the National Health Service Act 2006, negotiated between the United Kingdom government departments and the Association of the British Pharmaceutical Industry on behalf of the pharmaceutical industry. The scheme, which typically lasts five years, controls the pricing of all licensed, branded drugs sold to the NHS throughout the United Kingdom. Some form of scheme to limit prices and profits of branded medicines has existed since 1957. The scheme does not cover generic products or branded products available without prescription (i.e. OTC medicines) unless these are prescribed (see discussion of price controls for generic drugs below). The aim is to ensure that the NHS obtains drugs at fair prices while promoting a strong industry capable of developing new and improved medicines through R&D. The scheme applies to manufacturers of medicines and, in the case of suppliers with affiliates outside the United Kingdom, the subsidiary company with a place of business in the United Kingdom.

The PPRS set out to control costs by agreeing a limit on the profits that individual companies could earn from the supply of medicines to the NHS. At the same time, the scheme recognized the need for manufacturers to make sufficient return on their investment in R&D of new drugs. The 2005 scheme set a profit target of 21% as the return on capital (ROC) that a company could earn from sales of NHS medicines, but profits could be retained within a 40% margin of the ROC (i.e. up to 29.4%). On the other hand, if a company forecasts a profit less than 40% of the ROC it can increase its prices but only to achieve a forecast up to 65% of the original ROC. For companies with a low capital base (i.e. if sales exceed average assessed home capital employed by a factor of 3.5 or more), sales rather than capital base is used to determine the profit target, with a target of just 6% as the return on sales. The scheme requires quite complicated calculations to assess overall costs and ROC. Excess profits must be repaid to the Treasury or prices decreased to come within the target tolerance. The 2005 scheme also required a price reduction of 7%, and no price increases were allowed for 12 months unless these were cost neutral for that company. However, a report by the Office of Fair Trading (2007) noted that:

> The PPRS profit control has had very little, if any, effect on constraining companies' behaviour: repayments of excess profits have been negligible … about 0.01% over the 1999–2004 scheme. Price increases agreed on grounds of insufficient profitability have also been negligible.

In the same report, the Office of Fair Trading recommended that the 2005 profit-cap and price-cut scheme be replaced with a value-based pricing scheme in which the prices the NHS pays for medicines reflect the therapeutic benefits they bring to patients, taking the form initially of ex-post, value-based pricing, which would retain freedom of pricing for companies but would replace company-wide profit controls and price cuts with a series of reviews of the cost-effectiveness of individual drugs or drug classes conducted some years after launch; and eventually ex-ante value-based pricing, involving, in addition to ex-post reviews, a fast-track ex-ante assessment of a new drug's cost-effectiveness before launch.

In 2009, a new PPRS was established to operate for not less than five years (Department of Health 2009p). Two price cuts were agreed – 3.9% in February 2009 and 1.9% in January 2010 – with small increases amounting to 0.5% in the following three years. Companies were allowed to agree with the Department of Health to deliver up to 2% of the price cut by making a payment to the Department. Companies can also reduce prices differentially or even increase prices (known as modulation) provided the required overall reduction is attained.

With some limited exceptions, companies may not increase the price of any medicine without the Department of Health's prior approval, and this will not be given if estimated and forecast profits for the current and following financial years, respectively, are above 40% of the ROC target. Companies are free to price new products as they see fit, conditional on it not causing forecast profits to exceed ROC tolerance. Companies are required to provide data to demonstrate the required overall price reductions in the primary care and secondary care sectors taken as a whole.

As in the 2005 scheme, the target ROC remains at 21% based on the historical average value of capital employed, and the margin of tolerance at 40%, with the same arrangement for companies with a low capital base. To reflect the cost of R&D, there is a maximum allowance of 22% of NHS sales, made up of a flat rate of 12% and a variable rate of 10% (based on innovation and paediatric medicines), when assessing price increases, and 30%, made up of a flat rate of 20% and variable of 10%, when assessing profitability. A marketing allowance is also provided of 2% of NHS sales as well as a flat payment of £500 000 when assessing price increases and 4% as well as a flat payment of £1 million when assessing profitability.

The Scheme introduced a particular form of generic substitution in NHS primary care whereby pharmacists and other dispensers can fulfil a prescription for a branded medicine by dispensing an equivalent generic medicine. In doing this they are able to override the doctor's choice of drug. This scheme came into effect in January 2010.

Responding to the Office of Fair Trading recommendation for value-based pricing, two new arrangements were also put in place in the 2009 scheme: flexible pricing[37] and patient-access schemes.

> *Flexible pricing.* This allows a company to increase or decrease its original list price once only up to a maximum of 30% in light of new evidence, or for products launched after 2 September 2007 an unlimited amount where a different use is developed that impacts on value.
>
> *Patient access schemes.* These allow companies to propose schemes that show improved cost-effectiveness of a drug where in the first instance medicines are not found to be cost and clinically effective by NICE. There are two types of scheme: (1) a financially based scheme, where most simply the company changes the list price of the product or, if the list price is unchanged, offers discounts linked to, for example, numbers or

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[37] Flexible pricing applies only when medicines are subject to NICE appraisal, and a review by NICE is required to determine whether the revised price provides value to the NHS.

type of patients treated, response of patients treated or number of doses required; and (2) an output-based scheme where additional evidence may show extra value justifying a price increase, or a risk-sharing scheme where outcomes are measured (patient-reported or clinical outcome measures) and price adjustments and or cash transfers are made in one or both directions between the company and the NHS.

Generic medicines

The PPRS does not apply to generic medicines, that is, those marketed with or without a brand name where the patent of the original product has expired. In August 2000, the Department of Health, in response to substantial price increases for generic medicines, introduced a maximum price scheme for generics, stipulating a set of maximum prices at which these medicines could be sold to community pharmacies or dispensing doctors (Department of Health 2000f). This continued until 2005 when the scheme[38] was adjusted to allow for changes in prices of generics over time, and hence to reflect the average market price of manufacturers or wholesalers after discount. Data to amend prices in line with market changes are provided by members of the schemes to the Department of Health every quarter: included for each medicine are income generated net of discounts, volume sold, any discounts or rebates and a list of trade prices. Generic medicines solely intended for sale to the public without a prescription and products included in the list of substances not to be prescribed and dispensed in NHS primary care are not included (Department of Health 2005f).

Members of the scheme are free to set prices to wholesalers or dispensing contractors; however, they must be prepared to explain any changes to prices. The price of new generic products introduced should be no more than that of the equivalent, branded medicine at the date of its patent expiry. The Department of Health sets a drug tariff that determines the rate at which it reimburses dispensers for medicines supplied under NHS prescriptions; this is based on data including the volume-weighted average selling price derived from the information supplied by the manufacturers (Department of Health 2005f).

Prices of OTC products are not regulated but are open to competition between providers. Parallel trade is a source of price competition for pharmaceutical companies in the United Kingdom, although the direction of price advantage depends very much on fluctuations in exchange rates. Applying the average exchange rate between 2000 and 2004, United Kingdom prices in 2004 for branded medicines, although considerably less than in the United States, tended

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[38] There are in fact two voluntary schemes, Scheme M for manufacturers and Scheme W for wholesalers.

to be higher, on average, than those in the rest of Europe with the exception of Germany and Ireland. However, by 2008, when the pound had fallen significantly against both the euro and the dollar, applying the average exchange rate between 2004 and 2008, United Kingdom prices were substantially less than in the United States; lower than those in Germany, Ireland and Sweden; similar to those in Belgium and Finland; and higher than those in Austria, Spain, France, the Netherlands and Australia (Department of Health 2009q). Parallel imports accounted for more than 14% of sales in 2005 and were estimated to have cost the United Kingdom industry around £1.3 billion (Association of the British Pharmaceutical Industry 2006).

6.6.3 Distribution and sale of pharmaceuticals

Manufacturers mainly distribute drugs to wholesalers who then sell these on to pharmacies as well as dispensing doctors. Approximately 85% of drugs dispensed in pharmacies are supplied by wholesalers; the remainder are supplied directly by manufacturers or by parallel importers of drugs. As described in the previous section, manufacturers' prices are controlled for both branded and generic drugs. Drugs supplied by manufacturers to wholesalers are usually discounted by around 12.5%, and a large part of this is passed on to pharmacies: on average about 10.5% depending on volume (Office of Fair Trading 2007).

The provision of retail pharmaceutical services is controlled by government through PCTs, which maintain a list of bodies that provide pharmaceutical services to the NHS. A pharmacy may be owned by an individual pharmacist, a company whose partners are pharmacists or a private limited company managed by a pharmacist (see section 5.2). In addition, a small proportion of drugs are dispensed and sometimes administered by dispensing GPs.

Pharmacies supply drugs to patients either for a fixed prescription charge or free (see section 3.3.3 for a fuller discussion). They are then reimbursed through the Prescription Pricing Authority at the manufacturer's list price for branded and at the Drug Tariff price for generic drugs, but less a "clawback" designed to ensure that some of any difference between the price paid for the drug by the pharmacy and what it is reimbursed goes back to the NHS. The level of clawback is set on a monthly basis and varies between pharmacies from 5.6% to 11.5% depending on the size of claims,[39] but, on average, the clawback is estimated to be 9.2%. The pharmacy contract negotiated between the Department of Health and the Pharmaceutical Services Negotiating Committee includes an agreed margin of retained profit for pharmacies, which was £500 million in 2010–2011

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[39] The Department of Health assumes that larger pharmacies can achieve lower prices for their supply.

(Department of Health 2005d; Pharmaceutical Services Negotiating Committee 2009, 2010a). The clawback is adjusted through the year in an effort to achieve this overall agreed aggregate retained margin; however, in effect, an individual pharmacy's margin depends on the actual prices it purchases at and its own clawback level, and so may differ somewhat from the average (Office of Fair Trading 2007). Therefore, considering the composition of the price paid for drugs on average and taking into account the clawback, it is estimated that if the total price paid by the NHS were £100, the pharmacy would receive around £1.40, the wholesaler around £2.20, and the manufacturer around £96.40 of this.

Pharmacists also receive a dispensing fee per item (90p in April 2010), which contributes between 37% and 45% of their total fees and allowances depending on the size of pharmacy, and practice payments, which contribute between 29% and 36%. These aspects of the NHS community pharmacy contract are discussed in some detail in section 3.6.2.

6.6.4 Cost-effective consumption of pharmaceuticals in the NHS

As described in section 3.2.1, there are two types of restriction on drugs that can be prescribed through the NHS: the Black List, which contains pharmaceutical products that cannot be prescribed, and the Grey List, which is drugs that may be prescribed under certain circumstances, for given groups of patients only, or for certain specific conditions only. Local health care providers also often operate their own grey list of drugs that they encourage local GPs not to prescribe.

The NHS budget for pharmaceuticals is part of the overall PCT budget, which is allocated through a weighted capitation formula (described in section 3.4.2). Although the proportion for pharmaceuticals is not ring-fenced, the PCT is aware of how much it has received for this purpose and overall its budget is cash-limited; hence, there is an incentive to reduce costs. However, it is the GP who decides on what to prescribe within the restrictions described above. GPs are encouraged to prescribe generically and there has been a considerable growth in this practice since 1995.

However, the GP contract (see section 3.6.2) impacts only indirectly, if at all, on GP prescribing behaviour. Some PCTs have in place local financial incentives that have had some cost-saving impact, as have local formularies and prescribing advisers. In addition, as also discussed in section 3.6.2, pharmacists may be paid to review a patient's medication and suggest changes to that patient's GP. Peer pressure is also increasingly important as information on prescribing behaviour has been made more widely available. NICE is intended to act as a fourth hurdle for drug use in England and Wales, introducing formal evaluation of the cost-effectiveness of drugs (see section 4.1.3 for further discussion of NICE). GPs are aware of NICE guidance on drugs, but without any requirement to follow this, it has so far had limited impact on primary care prescribing.

6.6.5 Usage of pharmaceuticals and access to pharmacies

Pharmaceuticals are a major component of expenditure on health care in the United Kingdom, both within the NHS, where it accounts for a total of £10.8 billion, and in the private sector: as stated above, it is estimated that annual expenditure on medicines in the United Kingdom in 2008 was £12.2 billion in total (Association of the British Pharmaceutical Industry 2009b).

There were 886.0 million NHS prescription items dispensed in England in 2009, compared with 513.2 million in 1998, an increase in average items per head of population from 10.5 to 16.4 (almost 63%). At the same time, total net ingredient cost in 2009 was £8.54 billion (or £6.64 billion at 1998 prices) compared with £4.70 billion in 1998, an increase in real terms of 41%; in fact, average net ingredient cost decreased in real terms by 18%, from £9.16 per prescription item in 1998 to £7.49 per prescription item in 2009, or £9.64 in 2009 prices (Information Centre 2009l, 2010d).

There were 10 475 community pharmacies in England in March 2009, 62% of which were part of pharmacy chains owning six or more premises and 38% of which were independent, although many of these consisted of more than one premises (Information Centre 2009f). In 2005, there were around 26 000 pharmacists practising in Great Britain, of whom some 70% worked in the community, almost 22% in hospitals and most of the remainder in primary care, industry or academia (Hassell, Seston & Eden 2006). The number of working pharmacists per 1000 population in England is close to the EU average (see section 5.2). According to the Department of Health, 99% of the population are within 20 minutes of a pharmacy by car and 96% by walking or using public transport. Moreover, in March 2007, 96% of the population in the 10% most deprived areas in England were within 10 minutes of a pharmacy by walking or public transport, compared with 84% in March 2006 (Department of Health 2008i).

6.7 Intermediate care and rehabilitation

This section considers the provision of intermediate care and rehabilitation in England. Most of this is provided through the public sector although there is also some private-sector activity. Intermediate care is defined by the Department of Health (2002f) as "a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living". This definition includes rehabilitation services – described variously as the restoration of function, capability, independence or physical and mental health (Nocon & Baldwin 1998) – within intermediate care. Although services have generally been aimed at the care of older people, intermediate care is also provided for a range of health conditions, in particular for people with mental health problems (see section 6.11).

Intermediate care has been provided – although in a somewhat ad hoc way – within the NHS in England for many years. To increase provision and ensure a more equitable balance across the country, one of the standards set in the Department of Health's *National Service Framework for Older People* was that older people should have access to both a range of intermediate care services, thereby promoting their independence and preventing unnecessary hospital admission, and effective rehabilitation services to enable early discharge from hospital and prevent premature or unnecessary admission to long-term residential care (Department of Health 2001h).

According to the NSF, intermediate care services should be targeted at people who would otherwise face unnecessarily prolonged hospital stays or avoidable admission to acute care, long-term residential care or continuing NHS inpatient care. Services should be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active treatment and rehabilitation, designed to maximize independence and to enable people to remain or resume living at home. Finally, services should involve short-term interventions, typically lasting no longer than six weeks and often just one to two weeks, and cross-professional working within the framework of a single assessment process and shared protocols (see section 6.8 for further discussion of the NSF).

This section describes the current provision of intermediate care services in England, considers availability and access, and describes some measures of quality of these services.

6.7.1 Organization of services

Since 2001, intermediate care in England has developed through cooperation between the NHS and local government. Intermediate care is planned at a local level as part of jointly agreed three-year implementation and investment plans between PCTs and local authorities, with a strategic focus on preventing avoidable acute hospital admissions and beginning discharge and rehabilitation planning at the earliest possible opportunity during an acute hospital admission. Every PCT is expected to develop an appropriate range of services to meet local needs (Department of Health 2001i). Section 75 of the National Health Service Act 2006 consolidated existing NHS legislation regarding the ability of NHS and local authority partners (e.g. social services, housing, leisure) to work together. This allows the pooling of funds to be spent on agreed projects for designated services, delegation of commissioning of a service to one organization, and integrated provision from management to delivery level.[40]

There is a mixed economy of provision – primary and secondary health care and social care – involving the public, voluntary and private sectors. Commissioning has been undertaken jointly by the NHS and local government, often through pooled budgets. The delivery of intermediate care services is intended to be free, although there can be difficulties in distinguishing similar elements of care, which are sometimes part of an intermediate care package and sometimes part of a local authority's usual provision to individuals (e.g. home care, temporary residential care). Since the Community Care (Delayed Discharges etc.) Act 2003, local authority social services are not allowed to charge for community equipment and intermediate care services, thereby ensuring that these services are free to users whether provided through the NHS or local authorities.

A wide and disparate range of services are described as intermediate care. Thus, intermediate care can include rapid response teams, hospital-at-home services, residential rehabilitation and reablement units, supported discharge and day-care rehabilitation. It takes place in a number of locations including rehabilitation units, post-acute nurse-led wards, general medical wards, rehabilitation wards, short-term community housing or sheltered housing, short-term nursing homes or residential care homes, outpatient clinics, day facilities, and also in a person's own home. It may involve various forms of rehabilitation, convalescence, ongoing medical care, prevention and maintenance.

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[40] Partnership working is also allowed in a number of areas in addition to intermediate care (e.g. care of children, care of older people and care of people with mental health problems).

6.7.2 Availability and accessibility of services

The *NHS Plan* provided a total investment of £900 million for intermediate care and set the following targets for expansion of intermediate care services by 2004 (Department of Health 2000a):

- 5000 extra intermediate care and 1700 supported non-residential intermediate care places;
- rapid response teams and other avoidable admission prevention schemes;
- 50 000 more people enabled to live at home through additional home care and other support; and
- carers' respite services extended to benefit a further 75 000 carers.

By 2004 there were 8687 intermediate care beds, an increase of 4245 from the *NHS Plan* baseline (4442 in 1999); and, there were 17 339 intermediate care places, an increase of 10 190 on the 1999 baseline of 7149. In 2004, the number of people receiving intermediate care was 331 721, almost three times the corresponding number in 1999 (Philp 2004).

There are no data routinely available on the quantity and nature of intermediate care services in England. Services differ significantly across England in terms of:

- size
- function, whether they are aimed at avoiding admission or supporting discharge
- provision of 24/7 care
- location of care
- provider of care
- throughput.

Intermediate care is mainly provided to older people, although services for younger adults are also available in many areas. There is significant variation in how the official definition of intermediate care is implemented across the country; often, existing services such as home help or community rehabilitation have been relabelled as intermediate care. However, the majority of intermediate care services are concerned with providing support for discharge from inpatient hospital care; this is in spite of evidence that admission avoidance schemes are reported to have lower costs and achieve larger gains in quality of life.

Most local systems are concerned with moving from collections of individual services to single integrated systems (Intermediate Care National Evaluation Team 2006).

6.7.3 Quality of services

In addition to the increase in the provision of intermediate care services noted above, there are signs that improvements have been made in the standard of care. Typical indirect indicators of quality include general measures such as delayed transfers of care[41] as well as specific measures such as discharge times following admission for stroke (within 56 days) and for fractured neck of femur (within 28 days). In 2002, the government announced in *Delivering the NHS Plan* (Department of Health 2002c) its intention to reduce the number of people who are ready and safe to leave hospital but unable to do so because their care needs have not been assessed or their package of onward care has not been put together. This was to be achieved by introducing a system whereby local authorities pay when a patient is subject to delayed hospital discharge. The Community Care (Delayed Discharges etc.) Act 2003 provided for local authorities to pay acute hospitals for each day that a patient remained in hospital where the cause of the delay in discharge was the responsibility of the local authority.

Delayed discharges from acute hospitals in England reduced substantially from 6419 (5117 for people aged over 75 years) in December 2001 to 2619 (1930) in June 2004. The rate of delayed discharges for people aged over 75 years also fell from 12% in September 2001 to 4.4% in July 2004 (Philp 2004). However, as Fig. 6.13 shows, the rate of reduction in the number of delayed discharges slowed down thereafter to almost zero – this is confirmed by the CQC report on the state of health care and adult social care in England (CQC 2010b).

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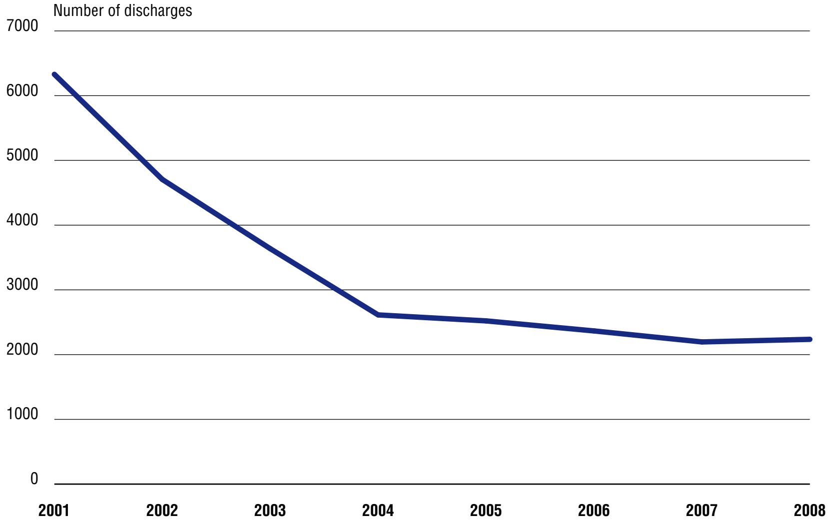
[41] Delayed transfer of care (this was known as delayed discharge) is a proportion defined as the total number of patients occupying an acute bed in a year whose transfer of care is delayed divided by the total number of patients occupying an acute bed in a year.

Fig. 6.13

Average number of delayed discharges, England, 2000–2001 to 2007–2008



Sources: Analysis based on House of Commons Select Committee on Health public expenditure reports: 2003, 2004a, 2004b, 2006e, 2010a.

The most common reasons for delays are that the patient is still awaiting assessment, is receiving non-acute treatment, or there is an inability to set up a care package in a residential or nursing home or in the patient's own home, all of which would seem to indicate some failure of coordination of services.

There is considerable variation across England in the rate of delayed discharge per occupied bed: in England as a whole in 2005–2006, the proportion of delays was 2.1% but this varied from 0.5% to 4.2% across the country (House of Commons Select Committee on Health 2010a). The CQC reported even greater variation in levels of delayed discharge occurring in 2009 (CQC 2010b).

Since 2004, there has been an increase in use of council-funded intermediate care to enable people to go home after discharge from hospital. The number of people receiving non-residential care has risen by more than 40% from around 85 000 to 122 000. The number receiving corresponding residential care increased by more than 20% over the same period, from around 27 000 to 34 000. The proportion of people aged 65 years and over who were still at home after 91 days following discharge from hospital into rehabilitation services is taken as a measure of the achievement of independent living; this is another key target for local authorities and is thought to provide an indication of the quality of intermediate and rehabilitation services. In England in 2008–2009, 78% of people who used rehabilitation and reablement services following a hospital admission achieved independence on the above definition. However, once again there was considerable variation in this proportion across England, from 53% to 100% (CQC 2010b).

6.8 Long-term care

This section describes long-term care provision in England for older people, people with physical disabilities and people with learning disabilities. Care for people with mental health problems is discussed in section 6.11, and intermediate care and rehabilitation in section 6.7.

The organization of services is discussed in section 6.8.1. This includes some discussion of the public–private mix of provision, the growth in "direct payments", and issues around coordination and integration of health and social care services. Availability and access to services and how these may vary across England are discussed in section 6.8.2. The role of the CQC in regulating providers and assuring quality of care is discussed in section 6.8.3. Finally, section 6.8.4 deals with the thorny issue of how long-term care should be financed.

6.8.1 Organization of long-term care

Social care is the statutory responsibility of 150 Councils with Adult Social Services Responsibilities (known as CASSRs). The organization of long-term care has shifted over time from residential (or institutional) care to care provided in the community, while the provision of care has shifted from the public sector to the private and voluntary sector. Financing of care is a mix of public, through local government bodies (local authorities or councils), and private, mainly out of pocket with some payments through insurance schemes. This section considers the current provision of care and how this has changed over time.

Residential care

Residential (personal) care or nursing care is provided in residential care homes, nursing care homes, or dual purpose homes that provide both.[42] All nursing care and most residential care is provided by the independent sector – either voluntary or private organizations – with the remainder provided in homes run by local authorities (known as council-staffed homes).

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[42] In the past, there was considerable provision of care in NHS long-stay hospitals, but there is now very little.

Most residents of homes are provided with some financial support by local authorities and are, therefore, known as (local authority) supported residents. In 2008–2009, of the total number of supported residents, 65% were receiving independent residential care, 26% nursing care and 9% care in local council homes (Information Centre 2010q). Unsupported residents are those who are assessed to pay the full cost of their care, or residents in independent-sector homes whose fees are paid fully by social security benefits (e.g. housing benefit), private means or any combination of these.

Recipients of long-term care form five groups: people with physical disabilities, frailty and sensory impairment; people with learning disabilities; people with mental health problems; people who misuse substances; and, vulnerable people. The last three groups are not covered in this section. The first group includes both older people and younger people with physical disabilities: a distinction is made between these in the analysis that follows.

Considering just the first two groups, Table 6.1 shows the total number of people who received some form of institutional service in England in 2008–2009. Of the 191 000 people aged over 65 years (excluding people with learning disabilities), 35% received nursing care and 65% received residential care.[43]

Table 6.1

Number of people (supported residents) receiving institutional care in England, 2008–2009

Service	**Physical disabilities, frailty and sensory impairment**		**Learning disabilities**
	Aged >65 years	Aged 18–64 years	All ages
Nursing care	67 000	4 600	3 100
Residential care	124 000	6 300	38 400
Total	**191 000**	**10 900**	**41 500**

Source: Information Centre 2010q.

Based on an estimate of the mid-2008 England population, around 2.3% of people aged over 65 years received some form of supported institutional services: 0.8% in nursing care and 1.5% in residential care.[44]

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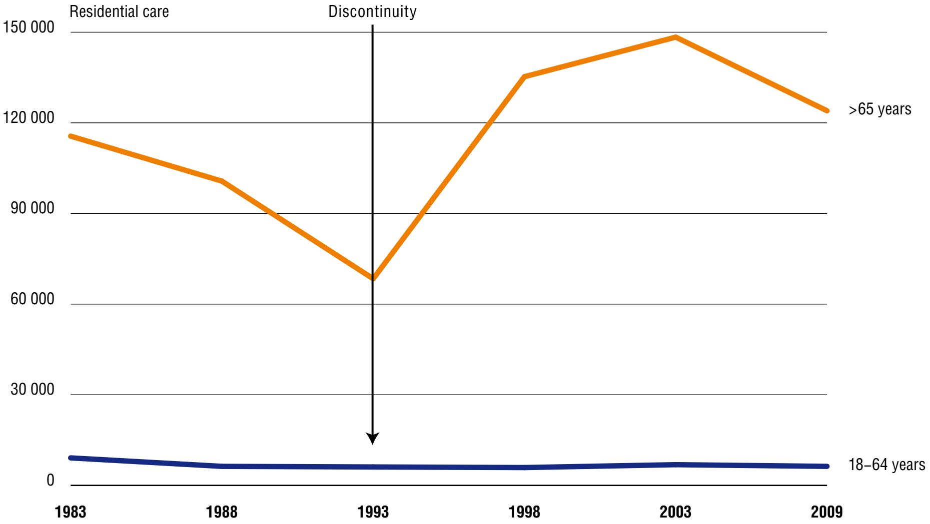
[43] In 2007–2008, 56% had received independent-sector residential care and 9% local-authority residential care (Information Centre 2008f).

[44] In 2007–2008, 1.35% of the older population were in independent-sector residential care and 0.21% in local-authority residential care (Information Centre 2008f).

Fig. 6.14 shows changes between 1983 and 2009 in the number of people supported by local authority funds receiving residential care in England. However, changes to methods of data collection throughout the period as well as significant policy changes – in particular the National Health Service and Community Care Act 1990, which made local authorities responsible for the organization and funding of social care – mean that comparisons over time must be viewed with caution. Nevertheless, it appears that the number of supported residents receiving residential care fell considerably between 1983 and 1993. This was followed by a period of growth so that by 1998 there were approaching 140 000 residents. The number continued to rise to 2003 but has since fallen back below the level in 1998. Between 1998 and 2009, the number of people in nursing care remained relatively stable, increasing from 70 275 to 71 600 (Department of Health 2002g, 2003h; Information Centre 2010q).

Fig. 6.14

Changes in number of people (supported residents) receiving residential care in England, 1983 to 2009



Sources: Department of Health 1994b, 2002g, 2003h; Information Centre 2010q.

Community care

Considerably more social care is now delivered in community settings, mainly day care in hospitals or day centres, meals at home, home care (or home help), planned short breaks (or respite care[45]), professional support such as nursing

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[45] Since 2007–2008, respite care has been recorded as a service for carers (see section 6.9).

services or chiropody, and equipment and adaptations. In addition, some people receive direct payments with which they can buy whatever form of care they wish (see below).

As Table 6.2 shows, almost 1.22 million people in England received some form of community-based social care in 2008–2009, of whom almost 74% were over 65 years of age. Across all age groups, services most used were home care, equipment and adaptations, professional support and day care. People aged under 65 years tended to use a significant amount of day care. Again, based on an estimate of the mid-2008 England population, some 10.9% of people aged over 65 years received one or more forms of community-based social care: 5.1% home care, 4.8% equipment and adaptations, and 2.4% professional support. Some people received more than one service.

Table 6.2

Comparison of the estimated number of people receiving community-based services in England between 2002–2003 and 2008–2009

Service			**2002–2003**			**2008–2009**
	18–64 years	>65 years	**Total**	18–64 years	>65 years	**Total**
Day care	120 000	159 000	**279 000**	72 000	89 400	**161 400**
Meals	13 000	199 000	**212 000**	6 400	100 400	**106 800**
Home care	99 000	497 000	**596 000**	90 000	423 100	**513 100**
Professional support	166 000	204 000	**370 000**	192 000	42 000	**195 800**
Equipment and adaptations	92 000	307 000	**399 000**	67 000	118 600	**400 100**
Other	41 000	62 000	**103 000**	32 000	62 200	**94 200**
Direct payments	7 000	2 000	**9 000**	42 000	32 300	**74 300**
Total	**464 000**	**1 215 000**	**1 679 000**	**315 000**	**901 100**	**1 216 100**

Sources: Analysis based on Information Centre 2005b, 2010q.
Note: The total number of clients is less than the total for each service as some clients receive more than one service.

Table 6.2 also shows that in recent years there has been a decline over time in the number of people using community-based services. The total number of clients has fallen by 28%, and the total number over 65 years by 26%. However, at the same time, the quantity of services has increased, reflecting a tendency to target resources on people with higher dependency levels in order to avoid their institutionalization. Therefore, while Table 6.2 shows that the number of people receiving home care had fallen by 14% from 596 000 in 2002–2003 to 513 100 in 2008–2009, the total number of contact hours of home care increased by 32%, from 151.1 million in 2003–2004 to 200.2 million in 2008–2009, and the average number of hours per person increased by 31% from 263 to 344 hours. Some 34% of people accessing home care in 2008–2009 received more than 10 hours per week (Information Centre 2010q).

The NHS also provides care in community settings (e.g. district nursing, health visiting, occupational therapy). Where appropriate these are discussed elsewhere.

Direct payments and individual budgets

Direct payments are payments from local authorities to individuals that allow those individuals to decide how to spend an agreed budget to meet their assessed care needs, hence giving them control over the way the services they are assessed as needing are delivered. The local authority allocates the individual a budget for this purpose equivalent to the authority's estimate of the reasonable cost of securing provision of services subject to any sum paid by the individual. It is intended that the direct payment is sufficient to allow the individual to buy a service of a standard that the authority considers reasonable to fulfil the needs for the service to which the payment relates. There is no limit on the maximum or minimum amount of a direct payment either in the amount of care it is intended to buy or value of the payment.

Direct payments were introduced in 1997 under the Community Care (Direct Payments) Act 1996 and were initially only available to eligible people aged 18–64 years; this was widened in 2001 to embrace other groups including older people and carers. In 2003, local authorities were given a duty to offer direct payments as an option to people who use services (Department of Health 2003i). The Health and Social Care Act 2008 extended the scope of direct payments further to include adults lacking capacity to consent to their receipt. Exclusions previously placed upon individuals subject to mental health legislation and to provisions of criminal justice legislation relating to mental disorder were lifted (Department of Health 2009r).

In the Green Paper *Independence, Well-being and Choice,* the Department of Health committed to the introduction of individual budgets and a pilot scheme began in 2005 (Department of Health 2005g).[46] These individual budgets were similar to direct payments but individuals did not have to take direct responsibility for managing a cash budget; instead they were able to choose how their care needs were met and by whom but the local authority retained responsibility for commissioning services. In addition, an individual's

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[46] This commitment was reinforced in the White Paper *Our Health, Our Care, Our Say* (Department of Health 2006c). An evaluation of these pilots was published in 2008 (Glendinning et al. 2008a).

entitlements to financial resources from several sources were brought together as a single individual budget: these may include various disability grants, Department for Work and Pensions funding, as well as social care funds.

The Department of Health stated that eventually all individuals eligible for publicly funded adult social care would have a personal budget, thereby providing a clear allocation of funding from which individuals could choose how best to meet their needs (Department of Health 2008v). However, there remains some confusion as to whether these budgets would encompass more than just social care resources. The government claimed that, in the past, the terms "individual budget" and "personal budget" had been used synonymously but, for the purpose of national implementation, personal budget would now be the term used and this would relate to social care funding only. Individual budget is now the term used for a notional amount of funding from a variety of sources, which may include social care funding as well as other sources (House of Commons Select Committee on Health 2010b).

Although much emphasis was placed on the development of direct payments and individual budgets, the take-up of direct payments remains very low. For example, the CQC reported that just 86 000 adults used direct payments in 2008–2009. This was just 4% of gross local authority expenditure on care; moreover, in 38% of local authorities (53) less than 5% of people receiving care used direct payments (CQC 2010b).

The mix of public and private-sector provision

As indicated above, there has been a substantial shift in the delivery of both residential and community-based care between the public sector and the independent sector – mainly private. Thus, almost all nursing care is now provided by the independent sector; most NHS long-stay hospital provision has gone. In addition, most residential care is provided by the independent sector: in 2007–2008, just 13% was provided by local authorities compared with 87.5% in 1992–1993 (Department of Health 1994b; Information Centre 2008f). A similar picture emerges for community-based services. In 2008–2009, for example, 81.4% of home-help hours was supplied by the independent sector, compared with 67% in 2003–2004 (Information Centre 2010q).

Integration of health care and social care

From the outset of the NHS in 1948, health care and social care have been separated: social care is the responsibility of elected local authorities whereas health care has been the responsibility of the Department of Health, administered at different points in time by various types of health bodies (e.g. hospitals, health authorities or health care commissioners, regulators); health care is generally free at the point of use whereas there has always been a substantial element of user charges associated with social care, through the means-testing system described below. While the need for coordination of health and social care services has long been recognized – see the 1989 White Paper *Caring for People* (Department of Health 1989) – the reality over the last 60 years has been a rather dysfunctional national system with local pockets of good practice based more on individual behaviour and willingness than a structure that encourages collaboration across health and social care boundaries (NHS Confederation 2010).

The new Labour Government in 1997 had declared an intent to "break down the Berlin Wall between health and social care" (e.g. Secretary of State for Health, Frank Dobson; House of Commons Select Committee on Health 1998). As early as 1998, the government suggested the need for joint working between health and social care at three levels: strategic planning, service commissioning and service provision (Department of Health 1998b). Since then, the Department of Health has established various integrative elements including comprehensive area assessments, joint strategic needs assessments, local area agreements, local strategic partnerships and Total Place. At the same time, at the local level, the NHS and local authorities have established integrated care networks, joint teams, co-location of teams, Partnerships for Older People pilots (known as POPPs), integrated care pilots, as well as joint appointments and joint commissioning partnerships between the NHS and local authorities.

The Health Act 1999 enabled health and social care organizations to work in partnership by creating a duty of cooperation between NHS bodies and local authorities, providing a statutory mechanism for strategic planning and providing new operational flexibilities to allow NHS bodies and local authorities to enter into joint arrangements for the purchase or provision of health and health-related services, including social care. In particular, section 31 of the Act enabled NHS and local authorities to pool resources, delegate functions and resources from one party to another and to act as a single provider to supply both health and local authority services. Subsequently, the Health and Social Care Act 2001 introduced NHS care trusts – mainly working in mental health – with the power to work across health and social care boundaries.

In 2005, the Care Services Improvement Partnership was established to integrate a range of initiatives that supported the development of health and social care for older people, people with mental health problems, people with learning disabilities, people with physical disabilities and for children and families. The 2006 White Paper *Our Health, Our Care, Our Say* (Department of Health 2006c) emphasized the need for greater integration of health and social care, and in 2007 *Putting People First* (HM Government 2007) set out further the need for collaboration between central and local government and between health and social care, and introduced three years of ring-fenced funding of approximately £0.5 million in total from 2008–2009 for this purpose: the Social Care Reform Grant. A key element again was partnership working between the NHS and local authorities, utilizing the joint strategic needs assessment undertaken by local authorities, relevant PCTs and NHS providers. A collaborative approach led by the Department of Health was established between six government departments: the Treasury, the Department of Health, the Department for Communities and Local Government, the Department for Work and Pensions, the Department for Innovation, Universities and Skills (as it was known then), and the Department for Children, Schools and Families (as it was known then). It also involved local government, social care professionals, providers and the regulators.

Issues around the development of intermediate care – services intended to prevent avoidable hospital admissions, assist discharge from hospital and prevent avoidable admission to residential care – also required significant coordination between health and social care services (see section 6.7).

6.8.2 Availability and accessibility

Local authorities have a responsibility to ensure that the needs for social care of people living in their areas are met. In particular, they have a statutory duty to assess the needs of individuals who may require social care and to provide support to people who meet local eligibility criteria. They must also make information on community services available to the public. However, eligibility criteria are determined locally and are often dependent on availability of local funding: there is no national entitlement to a given level of services for a particular level of dependency. This leads to considerable variation between different areas of England, as shown below.

In 2003, the Department of Health produced the Fair Access to Care Services framework intended to address some of this variation. This was issued under section 7(1) of the Local Authority Social Services Act 1970 and provided four threshold criteria under which services could be made available: (1) critical, where life is in danger or serious abuse or neglect has occurred or might occur; (2) substantial, where individuals are unable to perform most personal care; (3) moderate, where individuals are unable to perform some personal care; (4) low, where individuals are unable to perform one or two personal care tasks (Department of Health 2003j). The framework makes no reference to age, gender, ethnic group, religion, disabilities, personal relationships, location, living or caring arrangements, although these factors may need to be taken into account as needs are assessed and services considered: in this way the availability of informal and unpaid care may be taken into account (section 6.9 has further discussion of informal care).

The guidance does not prescribe threshold criteria or ensure different councils make equivalent decisions based on levels of need. Evidence suggests considerable variation remains as councils have shifted their focus to those with highest needs while increasing their eligibility criteria for care (Department of Health 2010z).

If a local authority determines that its eligibility criteria are met, then it has a duty to provide or commission residential accommodation where appropriate and also the power to provide or commission non-residential services as it determines appropriate. This process is usually managed by a social worker. If a local authority decides to provide non-residential care then it must first offer the individual direct payments in lieu of services to meet their assessed needs – provided that the person has been assessed as willing and able to manage direct payments. Where services are commissioned or provided to an individual, the local authority is also obliged to produce a written care plan for the individual.

Paying for care

Social care is not provided free as a universal right. If a package of care is agreed, then the ability of the individual to pay for their own care is assessed through a process of means-testing: the individual's ability to pay is assessed by an examination of the value of assets (including own home if applicable) and income. In the case of residential care, the council has a statutory duty to charge the individual based on their income and assets; in the case of non-residential care the charge, if any, is at the council's discretion.

The local authority must set a "standard rate" that it will pay for a person in residential accommodation, which should be the full cost to the local authority of providing the accommodation. The standard rate for accommodation in homes not managed by the local authority should be set at the gross cost to the local authority of purchasing the accommodation under a contract with the independent-sector home.[47] Thus, the standard rate may vary between authorities.

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[47] Nursing care provided as part of a package of care in a nursing home is paid for by the NHS (House of Commons Select Committee on Health 2010b). A 2003 census estimated the number of people eligible as more than 125 000 (Department of Health 2004n).

The ability of the individual to pay for residential care is assessed using national thresholds. Therefore, if an individual has assets worth more than a given upper threshold – this was £23 250 in 2010–2011 – that person would be expected to pay the full standard rate until their assets were reduced to below that level. There is also a lower threshold – in 2010–2011 this was £14 250 – below which all of the cost of care is borne by the local authority. If the value of assets lies between the upper and lower thresholds, then the individual must contribute to the cost of their care at a rate per week of 0.4% of the difference between the value of their assets and £14 250 (this amounts to a maximum of £36 per week). Assets may include the house in which the individual is living if this is owned by that individual, which would almost always take the individual above the upper threshold.[48] In addition, an individual must contribute almost all (they are allowed to retain a personal expenses allowance, which was £22.30 in 2010–2011) of their "assessed income", which includes pensions, social security benefits and a wide range of other sources, as payment towards the standard charge (Department of Health 2010i).

Local authorities can determine how much – if at all, although almost all do charge – they will charge for non-residential services (e.g. home care, meals-on-wheels) within guidelines issued by the Department of Health. These state that charges reflecting costs are preferable to those based on broad usage bands, although these may be acceptable for services such as meals at home or day care. Also, charges should be low enough to avoid reducing an individual's income below the basic income support level plus 25%. Moreover, account may be taken of an individual's savings or other capital – although not the individual's home – in determining charges in the same way as is done for residential care, and many authorities have adopted this system (Department of Health 2003k).

It is also possible for individuals to arrange their own packages of care independently of social services by approaching directly home care providers or care homes. In such cases there are no public contributions except where part of the care is designated as nursing care, in which case it should be funded by the NHS.

Workforce and expenditure

The number of staff working in local authority social services in England has fallen in line with the shift of care from the public sector to the private sector. However, as might be expected, the number of WTE social workers increased by 26% between 1999 and 2009, from 35 800 to 45 000 (Information Centre 2010r).

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[48] There are exceptions to this rule, the most common being if the spouse or partner of the individual continues to live in the property.

Total public expenditure on social services for adults in 2008–2009 was £16.1 billion; of this, 47% was spent on residential care, 40% on non-residential care and 12% on assessment and care management. Spending, in real terms, more than doubled between 1994–1995 and 2008–2009. Of total spending in 2008–2009, 56% was on older people, 24% on people with learning disabilities, 10% on people with physical disabilities and 7% on people with mental health needs. Since 1994–1995, there has been a shift in total public spending towards people with learning disabilities (17% in 1994–1995) and away from older people (65% in 1994–1995) (Information Centre 2010s).

There is considerable variation in access to care across different local authorities. The CQC reported that in 72% of local authorities in 2008–2009 individuals' needs had to be substantial (70%) or critical (2%) before they were considered for social services support. Since 2005–2006, there had been a marked increase in this proportion (CQC 2010b). Moreover, there are also significant differences in the levels of charges, particularly for non-residential care (Wanless 2006). The Audit Commission also reported large variations across local authorities in the average weekly spending on social care services, some spending up to three times the England average per person on services such as meals, day care and residential care (Audit Commission 2010).

6.8.3 Quality and regulation

In 1998, the Department of Health published *Modernising Social Services* (Department of Health 1998c), which set out a programme to improve the coordination, consistency, flexibility and efficiency of social care. From this there emerged sets of minimum quality standards for individual services and a new system of registration and inspection.

The CQC is now responsible for the regulation and inspection of all social care providers in England:[49] care homes providing personal or nursing care, domiciliary care agencies, nursing agencies and adult placement schemes (section 4.1.3 discusses the overall role of the CQC). Social care providers are subject to sets of minimum standards established by the Department of Health under section 23 of the Care Standards Act 2000 and subsequent regulations, which were due to be amended in 2010 under the Health and Social Care Act 2008 with a focus on safety and quality of provision. All providers are inspected and given a quality rating from poor to excellent, reflecting performance on delivery of care, safety, handling of complaints and management and administration of services, as laid out in the national minimum standards for each type of service.

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[49] Taking over this role in April 2009 from the Commission for Social Care Inspection.

6.8.4 Financing long-term care

There has been, and is a continuing, debate on the financing of long-term care, particularly for older people (Keen 2008). Moreover, since the 1980s, the decline in provision of long-stay hospital beds and increase in provision of residential and nursing home care has led to a shift from services that are free at the point of use to services that are means-tested (House of Commons Select Committee on Health 2005). Whereas services provided by the NHS are usually supplied free, a large part of social care is paid for by individual users themselves, depending on their ability to pay. The contribution of user charges to social care finance has been estimated at 43%, the rest being met from the public purse (Hancock et al. 2007). Section 3.3.3 provides some further discussion of the financing of social care.

The key issues are how long-term care will be funded in the future as the proportion of older people in the population in need of care increases and what should be the balance between private and public funding. Various funding options exist: from public funding for all social care, to partial funding (e.g. for personal care or non-residential care), to limits on the amount paid by the individual with the public purse making up the rest, to some form of partnership between the state and the individual where costs are shared for those needing care, to social insurance where the state acts as insurer and is willing to provide a package of care for people in the insurance scheme, or finally, to private insurance that would operate in a similar way to social insurance. In addition, it is possible to tinker with the parameters of the current system of means-testing.

Since 1997, there has been a series of studies and reports on the funding of long-term care. The Royal Commission on Long-term Care (1999) reported on the system of paying for long-term care, recommending the introduction of free personal care, but not free "hotel" costs (i.e. food and lodging in the case of residential care). However, this was not acted upon in England, although Scotland introduced free personal care in 2002. In 2006, the Wanless review of social care considered, among other things, various ways of funding social care, and came down broadly on the side of a so-called partnership approach[50] to funding social care, with the public purse covering a proportion of the cost of the care package and the remainder of the costs being met by the individual, although the report recognized that there was little to choose between some forms of mean-testing, free personal care and partnership funding (Wanless

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[50] This amounted to public funding of a guaranteed minimum level of care, with any additional care required being funded through contributions in some given proportions from the individual and the public purse.

2006). Wanless also suggested that there should be significant increases in the amount of resources devoted to social care if high-quality care was to be provided.

In 2009, the government finally published the Green Paper, *Shaping the Future of Care Together,* addressing the issue of funding of long-term care (Department of Health 2009s) and introducing the concept of a National Care Service, with an intention following consultation to produce a white paper in 2010 setting out reforms. Three main approaches to funding were considered for consultation:

- partnership approach: sharing the cost of care between individuals and the state;
- insurance approach (voluntary): allowing individuals to choose to take out protection against the risk of having high care and support costs; and
- comprehensive insurance approach (compulsory): all individuals aged over the state retirement age (in April 2010 this was 65 years for men and 60 years for women) who can afford to would be required to pay in and would receive totally free care and support in return.[51]

All three options involve an element of means-testing. The voluntary insurance system includes the entitlements to public funding of the partnership approach but would help individuals to cover additional costs through insurance. The government ruled out options where all care is paid for through tax-based public funding or through funding by individuals themselves.

Funding would cover only basic care and support costs (i.e. to meet an individual's assessed needs) with an option that people may pay for additional care if they wish. Hotel costs would not be covered. However, the government proposed a universal deferred payment mechanism to meet these costs, which would put a charge on an individual's estate when that person dies rather than having to sell the home when they need residential care. It would still be necessary to assess the needs of an individual and the government intended to establish a standardized national needs assessment process, with the level of need at which an individual would qualify for public funding set nationally, and also with the proportion of an individual's care package funded publicly set nationally. However, how much is actually spent on an individual's care package

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[51] This resembles a ring-fenced tax system where the tax falls only on older people (Humphries, Forder & Fernandez 2010).

could continue to be determined at the local level by the local authority, taking account of local circumstances, or could be set at a national level to be applied across the whole of England. This choice was also a matter for consultation.

In March 2010, in response to the consultation, the Labour Government published the White Paper *Building the National Care Service* (Department of Health 2010aa), in which, among other things, it determined that a form of the comprehensive funding mechanism should be introduced, with a commission to be established to advise on implementation. However, implementation was overtaken by the election of a new government in May 2010. In April 2010, the Personal Care at Home Act 2010 was passed, which provided free personal care at home for those with the highest care needs.

6.9 Services for informal or unpaid carers

Informal care[52] is unpaid care provided to family, partners, friends or others. The definition of unpaid care for the purposes of the 2001 Population Census was "looking after, giving help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability or problems relating to old age". However, as the NAO has pointed out, there is no one clear definition of a carer, and hence accurately estimating numbers in the population can be difficult (NAO 2009a).

Services for informal carers are most often accessed through local authority social services departments, though some are provided by the NHS. The main form of financial entitlement for carers is the Carer's Allowance. In the past, informal care has been mainly associated with care for people with physical disabilities or learning disabilities, older infirm people and people with mental health issues. However, there has been increasing recognition in recent years of the importance of informal care for people with a range of health conditions.

Section 6.9.1 considers the development of policy in England in recent years relating to informal care. This is followed by a discussion of the level of provision of informal care (section 6.9.2) and what financial entitlements are available to informal carers (section 6.9.3). In section 6.9.4, the availability of services for informal carers is discussed.

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[52] Commonly known as unpaid care.

6.9.1 The development of policy on informal care

Various forms of informal care have always existed in England, for example, in the sense of adults looking after elderly parents, one spouse looking after another. However, for many years, there was little formal recognition of the importance of this care and little or no support for informal carers. Tax allowances were introduced in 1967 and various attendance and care allowances in the 1970s (Cook 2007). Following on from the 1989 White Paper *Caring for People* (Department of Health 1989), the community care reforms of the early 1990s with their emphasis on shifting care out of institutions into the community led to recognition of the importance of carers in the context of future health and social care policy.

Legislation

The Carers (Recognition and Services) Act 1995 introduced the concept of a carer's right to an assessment of ability to deliver care; therefore, carers providing substantial care on a regular basis were given the right to an assessment of their needs separate from that of the person they were supporting. However, local authorities were not empowered to provide services to carers following an assessment of their needs. This was addressed by the Carers and Disabled Children Act 2000, which allowed carers to receive services from local authorities in their own right, even if the person being cared for refused to be assessed, and introduced direct payments to carers in lieu of such services. The Carers (Equal Opportunities) Act 2004 imposed a statutory duty on local authorities to inform carers of their rights to assessment and to consider their wishes with respect to leisure activities, education, training and employment when carrying out carer assessments.

At the same time, employment law was changing in ways that facilitated informal care. The Employment Act 2002 gave parents of disabled children under 18 years the right to request flexible working arrangements. This was later extended to all carers through the Work and Families Act 2006.

Policy

In 1999, the Department of Health produced a national strategy for carers that focused on three key elements: information, support and care for carers (Department of Health 1999b). The emphasis was on enabling carers to combine paid work and caring. A new "Carers Special Grant" was introduced in England to fund new services allowing carers a break from caring (House of Commons Work and Pensions Committee 2008). Funding was ring-fenced until

April 2004; by 2010–2011, £256 million was made available for this purpose (Department of Health 2008w), a more than 10-fold increase compared with the £20 million when it was introduced in 1999–2000 (Audit Commission 2004).

In 2007, the Department of Health announced a new deal for carers following on from the White Paper *Our Health, Our Care, Our Say* (Department of Health 2006c). A range of measures were introduced to support carers including:

- establishment of a national helpline for carers;
- specific funding for the creation of an expert carers programme; and
- specific funding for short-term home-based respite care for carers in crisis or emergency situations.

In 2008, the Department of Health produced a new National Carers' Strategy (HM Government 2008) setting out a vision for supporting carers. Initially, £255 million was committed: £150 million towards planned short breaks for carers; up to £38 million towards supporting carers to enter or re-enter the job market; and £6 million towards improving support for young carers. Other commitments included pilots to explore annual health checks for carers, the ways in which the NHS can better support carers and ways to provide more innovative breaks for carers; training for GPs; a more integrated and personalized support service for carers; and accessible information and targeted training for key professionals.

In addition, the role of informal care was increasingly recognized in relation to the provision of health care more generally. Thus, a number of the Department of Health's NSFs (e.g. Mental Health, Care for Older People, Care for People with Long-Term Conditions) included guidelines relating to carers. The Community Care (Delayed Discharges etc.) Act 2003 provided that, where the carer has asked for an assessment, the local authority social services department must assess and, after consultation with the NHS body, determine what services it will provide for a carer when the person they care for is ready for discharge. The new GP contract in 2004 provided a small financial incentive to GPs to support carers by including in the QOF whether a GP practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment. The NHS operating framework in 2008–2009 (Department of Health 2007r) for the first time made specific reference to supporting carers, stating that "PCTs should aim to create a more personalised service that provides … support for carers by … recognising their need for breaks from caring".

Legal obligations on families

Unlike some European countries, there is no general obligation under English law to provide financial support to relatives, with the exception of spouses and under-age children; similarly, there is no obligation to provide care, and so, for example, children do not have to provide care for parents with care needs, or pay for any that is required. Doubts have been expressed around the extent to which key forms of family relationships (e.g. spouse or filial) can be relied upon as the basis for the provision of informal care in the future as the nature of kinship relationships changes as does the structure of the population in terms of age, marital status, childlessness and employment (Pickard et al. 2000).

6.9.2 Levels of provision of unpaid care

As pointed out above, obtaining accurate estimates of the number of carers can be difficult. The most recent Population Census in 2001 reported that there were 5.2 million unpaid carers in England and Wales, approximately 10% of the total population (Standing Commission on Carers 2009).[53] A recent estimate from the NAO of 6 million unpaid carers in the United Kingdom continues to rely on the 2001 Census (NAO 2009a). Other sources of data include various General Household Surveys (this is now known as the General LiFestyle Survey), and the English Longitudinal Study of Ageing and Family Resources Surveys.

Although there are a large number of carers, most provide quite a limited amount of care time per week. A more detailed study of carers using the General Household Survey 2000 found that 72% of carers in Great Britain spent less than 20 hours per week caring for someone, 16% spent between 20 and 50 hours, and 11% spent 50 hours or more. Moreover, caring was most often practical help (e.g. meal preparation, shopping (71%), keeping an eye on the person cared for (60%), or providing company (55%)), with just 26% providing assistance with personal care, 22% administering medicines and 35% providing physical help (e.g. with walking) (Maher & Green 2002).

Again, for Great Britain, there are more female carers (61%) than male (39%) providing care for 20 hours a week or more: moreover, 45% of all such care is provided by spouses and 41% is provided by children or spouses of children; 72% is provided by people aged less than 65 years. In addition, in 75% of cases, carer and cared-for live in the same household (Maher & Green 2002).

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[53] This differs significantly from estimates obtained from the General Household Survey 2000, which suggested as much as 16% of the population in Great Britain are unpaid carers (Maher & Green 2002); this may reflect definitional differences.

Most carers (62%) reported they were looking after someone with a physical disability only; 6% were caring for someone with a mental disability only, and 18% someone with both a mental and a physical disability. Most of the others (14%) said that the person was receiving care because they were old. However, considering just the age of the person receiving care, 70% of people being cared for were aged 65 years or more. There is some regional variation in the number of informal carers: in London carers formed just 11% of the population compared with 20% in the northeast (Maher & Green 2002).

6.9.3 Financial entitlements

The main financial benefit for carers in England is the Carer's Allowance (formerly known as the Invalid Care Allowance), which was set at £53.90 per week in 2010–2011. Only people who look after someone for 35 hours or more a week are entitled to this benefit, and the person being cared for is expected to be quite disabled, which is determined by being in receipt of a qualifying disability benefit (i.e. Disability Living Allowance paid at either the middle or higher rate for personal care), Attendance Allowance paid at any rate, or Constant Attendance Allowance paid as an addition to a war pension or industrial disablement benefit (Department for Work and Pensions 2009).

The carer must also be over 16 years, not in full-time education and must not earn more than £100 a week (in 2010–2011). In addition, the carer must not be in receipt of a range of benefits that in sum would amount to more than the Carer's Allowance, including Incapacity Benefit, contribution-based employment and support allowance, state retirement pension, widow's and bereavement benefits, Maternity Allowance, Severe Disablement Allowance and contribution-based Job Seeker's Allowance. The allowance is intended partially to replace income foregone as a result of caring activities – although it clearly bears no relation to any reasonable estimate of likely lost earnings. It is an entitlement irrespective of national insurance contribution. Indeed, carers who receive Carer's Allowance also receive national insurance credits and these credits contribute towards their state retirement pension, as well as to the state second pension. In some cases, if the carer receives Carer's Allowance this will reduce the benefits received by the person to whom the care is delivered. In particular, a disabled person would no longer be entitled to a severe disability premium if the Carer's Allowance is being paid.

Carers receiving means-tested benefits (e.g. income support, housing benefit, pension credit) are also entitled to an additional payment of £30.05 per week, known as a carer premium or "additional amount". Carers are entitled to this payment even if they do not receive the carer's allowance because they are in receipt of other benefits, provided they have applied for the allowance. Carers can also take a break from caring for up to 4 weeks in every 26 and still be paid the carer's allowance. People on state pensions may be entitled to carer's allowance although often the size of their pension will exclude them.

In April 2010, new national insurance carer's credits were introduced for carers who care for at least 20 hours a week (with other conditions similar to those for carer's allowance). It is estimated that approximately 240 000 people will accrue state second pension entitlement and approximately 160 000 people will qualify for an increased basic state pension as a result (Standing Commission on Carers 2009).

In May 2008, 883 000 people in Great Britain satisfied the rules for carer's allowance, although just 481 000 (54%) received it; the rest were entitled to more than one non-means tested benefit (e.g. state pension); 469 200 also received the carer premium or additional amount. It is estimated that approximately £2 billion is spent on these various aspects of the carer's allowance (NAO 2009a). There has been a considerable increase in the number of people receiving Carer's Allowance: the number in England grew by almost 34%, from 332 780 in August 2003 to 444 650 in November 2009. Most of these people (over 94%) are of working age (Department for Work and Pensions 2010b).

6.9.4 Services for informal carers

Services for informal carers are most often accessed through local authority social services departments. There is also some NHS provision – day care in hospitals – although the amount of this has declined considerably in recent years.

Assessments

As discussed above, all carers have the right to an assessment of their needs as a carer, either jointly with the person they care for or separately, and these are carried out by local authority social services departments. In 2008–2009, approximately 441 000 carers in England were offered an assessment by local authority social services and 90% (398 000) took up the offer, of which 256 000 were assessed or reviewed jointly with the person for whom they were caring and 142 000 separately. There has been an increase in the number of offers of assessment and the number actually assessed since 2005–2006, when approximately 380 000 carers were offered an assessment, of whom 87% (332 000) took up the offer (Information Centre 2006b, 2010q).

In 2008–2009, 355 000 carers received a service – including information and advice only (148 000) – again showing an increase from 282 000 in 2005–2006 (Information Centre 2006b, 2010q). Most carers receiving services care for adults with a physical disability (249 000), followed by carers of adults with mental health issues (55 000). Services for carers tend to be of three types: specifically aimed at the carer, such as breaks (respite) from care; other specific carer services (e.g. carer support groups, driving lessons, moving and handling classes); or care aimed primarily at the individual being cared for, such as home care or district nursing.

On the basis of current published data, it is difficult to differentiate between care provided as a result of a carer assessment and care provided more generally. Where possible this distinction is made but overall levels of service provision are also discussed.

Breaks from caring

Most services specifically for carers take the form of breaks from caring (respite care). This is provided in a number of ways, the most common being day-care services and institutional respite care. An Audit Commission survey of people caring for older people reported that between 58% and 68% of carers had some kind of break from caring in the previous 12 months, and 66% of those who did not have a break would have liked one (Audit Commission 2004).

Day-care services

Day care can act as a form of respite care for carers, allowing them a break while the individual being cared for spends time in a day hospital or day centre. In the past, a considerable amount of day care was provided by NHS hospitals as well as in day-care centres provided by local authorities and the voluntary and private sectors. Thus, there were over 4.6 million attendances at NHS day-care facilities in 2002–2003 for what amounted to around 94 000 people. Most of this care was for people with mental health issues or older people with dementia (60%); those with learning disabilities and geriatric medical needs were the other main users (Department of Health 2000g).

In 2008–2009, the total number of people receiving day care funded through local authority social services – this might be provided by the voluntary or private sector as well as local authorities themselves – was almost 166 000, of whom 81 000 (49%) were aged 65 years and over. The number has fallen since 2002–2003, when 279 000 people were receiving day care, of whom 159 000 were aged 65 years and over (Information Centre 2005c, 2010q).

Institutional respite care

Overnight respite care can be provided in the home of the person being cared for, although more commonly it is in a residential facility, such as a residential or nursing home, or in an NHS intermediate care setting or community hospital. In 2008–2009, there were planned short breaks for 22 000 people, of whom 14 000 were aged 65 years and over. By comparison, the number of people receiving overnight respite that was not in the client's home in 2002–2003 was 76 000, of whom 54 000 were aged 65 years and over. In addition, perhaps as much as 3% of the home care received by 596 000 people in 2002–2003 would have constituted overnight care in the client's own home (Information Centre 2005b,c, 2010q).

Services provided for the person cared for

In addition to services provided as a result of carer assessments, to some extent carers may benefit from services provided to the person for whom they are caring (section 6.8 has more detail on these activity levels). In particular, carers have suggested that home-care services provide significant benefits to them as well as the person cared for (Audit Commission 2004). However, there is evidence that access to a range of services is less frequent where carers are living with the person they care for. Therefore, whereas 41% of all people being cared for received visits from health, social or voluntary services, 23% of those living with their carer received such visits compared with 50% of those living in a different household from the person looking after them. This applied to all services: only 15% of those living with a carer received visits from health care practitioners compared with 38% of those who lived alone, and 9% received home help and meals-on-wheels compared with 31% of those living alone (Maher & Green 2002).

Other services

Carers who want to work are able to access mainstream Jobcentre Plus services.[54] However, the NAO reported that these services fall short of carers' requirements (NAO 2009a). As noted above, the Department of Health in 2008 committed £38 million to support carers who wanted to combine caring and paid employment. The funds will be used to provide care partnership managers in each Jobcentre district with a strategic role to build partnerships with relevant organizations, assess demand for support and encourage development of local services such as replacement care, and ensure advisers have comprehensive up-to-date knowledge, skills and local information to effectively support carers. The funds will also be used to train personal advisers on carers' issues so they

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[54] Jobcentre Plus is an executive agency of the Department for Work and Pensions that supports people of working age to get jobs.

can be better at helping carers to obtain employment while continuing to care; and to support replacement care costs while carers receive training (Carers UK 2009).

6.10 Palliative care

This section considers the provision of palliative care in England. Section 6.10.1 discusses briefly the development of government policy on palliative care. Section 6.10.2 reviews the organization of services, section 6.10.3 considers access to services, and, finally, section 6.10.4 looks at the quality of care provided and how it is regulated.

Following on from earlier WHO definitions (National Council for Hospice and Specialist Palliative Care Services 2002), palliative care has been defined as:

> … the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is to achieve the best quality of life for patients and their families.

This definition was adopted by the National Institute for Clinical Excellence (as NICE was then known) in its guidance on cancer services (NICE 2004a). Usually, palliative care refers to treatment of symptoms where cure is no longer considered an option. Some people may live for many years with an incurable disease and lead a life of good quality with effective palliative care. A key focus is controlling pain and other symptoms. Provision of adequate pain relief is important for all patients, but this section is primarily concerned with palliative care as it applies to people with incurable diseases.

6.10.1 Palliative care policy

Over the last 45 years palliative care in England has mainly been developed and provided through the voluntary sector.[55] For much of this time, government took little responsibility for this aspect of care, and national policy in this area has been a late developer. In the 1990s, NHS health authorities (who at that time were the commissioners of health services) were expected to produce palliative care strategies and to monitor contracts for local provision (National Council for Hospice and Specialist Palliative Care Services 2000). However, by 2000, only a third of health authorities had strategies in place and provision across the country was uneven (Department of Health 2000h). Since then, through

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[55] The Department of Health also uses the term end-of-life care, which covers palliative care and supportive care.

a series of policy initiatives, the government has provided a more coherent strategic approach to palliative care. Although initially the focus was on cancer services, the government now recognizes the importance of promoting end-of-life care for all patients regardless of disease or where they live (Department of Health 2008x), and of promoting integration of palliative care into the wider health care system.

The NHS Cancer Plan (Department of Health 2000h) recognized the need to provide more publicly funded support for hospices and specialist palliative care services, and to expand specialist provision in hospices, hospitals and the community. An extra £50 million per year was made available by 2004, and subsequently became part of the baseline funding of PCTs (NAO 2008e). In 2003, the Department of Health announced the allocation of £12 million over three years from 2004 to 2007 to an NHS End of Life Care Programme to improve the quality of care at the end of life and enable people to be cared for and die in the place of their choice. Best practice in palliative care for cancer patients and patients with HIV/AIDS was to be applied to other conditions (e.g. heart failure, chronic obstructive pulmonary disease, renal conditions), through shared training of staff as well as providing more opportunities for involvement and training of primary care teams and staff in palliative care (Department of Health 2003a; NHS End of Life Care Programme 2006). A subsequent national review in 2007 also recognized the need for greater dignity and respect at the end of life: all SHAs were required to produce a vision of the clinical pathway for end-of-life care (Darzi 2007). The Department of Health's end-of-life care strategy in 2008 recommended a care pathway approach to commissioning and delivering an integrated service; there was a commitment to provide an extra £286 million over two years to PCTs to improve end-of-life care services (Department of Health 2008x).

6.10.2 Organization of services

The development of palliative care in England has been driven largely by the voluntary sector. Palliative care is provided by the NHS and the voluntary sector mostly through voluntary-sector hospices and is available for adults and for children. Care is provided both in residential settings, such as hospices and hospitals, and in the community in various ambulatory settings, as well as in an individual's own home.

Specialist palliative care is provided by multidisciplinary teams, which may include consultants in palliative medicine, nurse specialists, specialist social workers and experts in psychological care. These team members are trained to advise on symptom control and pain relief and to give emotional, psychosocial and spiritual support to patients, their families, friends and carers. They will also support the work of other health care staff in providing palliative care. General palliative care is provided by non-specialist staff (e.g. GPs, district nurses, hospital doctors, ward nurses, allied health professionals and staff in care homes).

Residential palliative care for adults is provided mainly in voluntary-sector hospices, with less than 20% of beds in NHS hospital inpatient units (in 2009), while all residential palliative care for children is provided in voluntary-sector hospices. A range of care is also provided in the community. Thus, home care is provided, consisting of community palliative care nurses providing support, assessment and advice to patients in their own home, often working with other more general care providers (e.g. GPs, district nurses). This has been extended to hospice-at-home services which may provide a more extended multidisciplinary service to individuals in their own home. In addition, patients can attend day-care centres – which will often be in hospices – and these again provide support, assessment and advice as well as an opportunity for social interaction and support while allowing the individual to remain in their own home.

Bereavement support services are generally available throughout England. These are provided mainly by hospices and specialist voluntary organizations such as Cruse Bereavement Care, often using volunteer staff; some NHS organizations also provide bereavement support. A study by Help the Hospices (2006) suggested that the value contributed by volunteers to hospice services is over £112 million, or some 23% of the total cost of running the hospices.

Table 6.3 shows the most recent estimate of palliative care available in England (for January 2009). There were a total of 173 units for adults, consisting of 40 NHS hospitals and 133 voluntary-sector hospices, providing inpatient palliative care to adults in 2629 beds (2139 in the voluntary sector and 490 in NHS hospitals), and 36 units and 269 beds for children all in the voluntary sector. There is also a range of services available in the community: from 226 home care services, 95 hospice-at-home services, 228 hospital support teams, 25 hospital support nurse services and 225 day-care centres.

Table 6.3
Palliative care in England, January 2009

(a) Hospice and palliative care inpatient units

	Voluntary		NHS	
	Units	**Beds**	**Units**	**Beds**
Adults	133	2139	40	490
Children	36	269	0	0

(b) Community and hospital services

Home care	Hospice at home	Day-care centres	Hospital support nurse services	Hospital support teams
226	95	225	25	228

Source: Help the Hospices 2009.

Table 6.4 reveals the position for England in 2005–2006, as reported by the National Council for Palliative Care (2007), and shows broadly similar figures. The figures reported for England by the NAO in 2008, 155 independent adult hospices (with 2150 beds) and 40 NHS adult hospices (with 450 beds), suggest that there may be some lack of comparability between different data sources at different times (NAO 2008e).

Table 6.4
Palliative care in England, 2005–2006

(a) Hospice and palliative care inpatient units

	Units	Beds
Adults and children	167	na

(b) Community and hospital services

	Home care	Day-care centres	Hospital support services
	257	193	249

Source: National Council for Palliative Care 2007.
Note: na: Not available.

Funding

It is estimated that total expenditure on adult palliative care in 1999 was around £300 million, of which £170 million was provided by the voluntary sector (House of Commons Select Committee on Health 2004c). The contribution of the NHS before 2003 to the annual running costs of voluntary-sector hospices was estimated at just under 30% (National Council for Hospice and Specialist Palliative Care Services 2004). More recent estimates suggest that total expenditure on palliative care services was around £612 million in 2006–2007, of which total spending on voluntary-sector services was £500 million and total spending on NHS services was £112 million. PCTs funded approximately 26% of voluntary-sector services (£130 million), with the remainder coming from public donations and fund-raising activities (NAO 2008e). In general, individuals do not pay for palliative care services whether provided through the NHS or by the voluntary sector.

While there has always been some financial support from the NHS for voluntary-sector palliative care, this was not systematic and hence support was piecemeal across the country, with the proportion funded by the NHS varying considerably between areas. However, as indicated in section 6.10.1, the introduction of a more coherent NHS policy towards palliative care has resulted in the NHS taking more strategic, and with that more financial, responsibility. The result is that voluntary-sector hospices providing palliative care services have begun to act more like contractual providers to PCTs.

The Department of Health intended to bring palliative care into its PbR scheme (see section 3.6.1) by 2008–2009, with national tariffs for a range of services. However, progress has been slow and palliative care was still not included in the 2010–2011 national tariffs. Instead, palliative care is commissioned by PCTs through locally negotiated contracts. The Treasury has stated that, where the voluntary sector is involved in delivering services to the public sector, this should be based on full cost recovery, including all relevant overheads. However, the NAO found that 97% of hospices claimed that when they provided services for the NHS, their full costs were not met by PCTs (NAO 2008e).

6.10.3 Access to palliative care

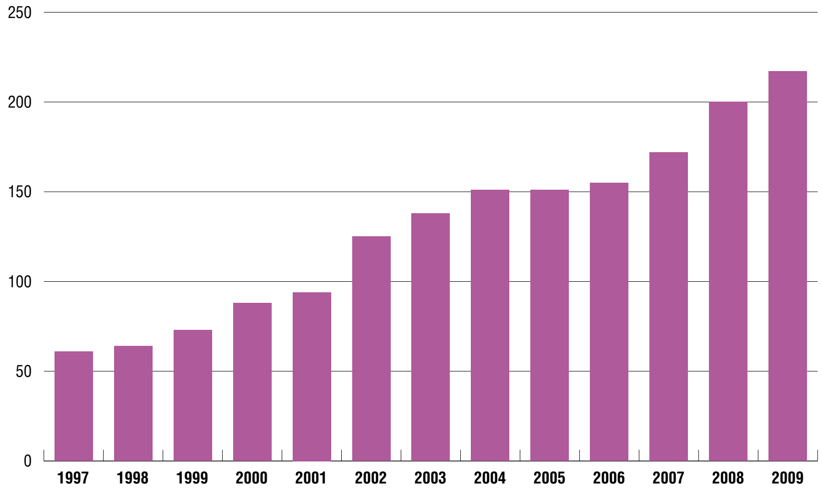
Access to palliative care has been uneven in terms of different areas of the country, different disease groups, different age groups and ethnicity. Even now, still over 95% of patients in hospices have cancer; older people appear to have less access to palliative care, as do people from black and minority ethnic groups and people with complex needs (House of Commons Select Committee on Health 2004c). This might be expected given that until recently there has been no coordinated strategic approach to the commissioning and delivery of palliative care services. It may change as a result of the Department of Health's end-of-life strategy (Department of Health 2008x), which has emphasized the importance of an integrated approach to planning, contracting and monitoring palliative care services across the health and social care spectrum. Yet PCTs are still expected to contract locally for appropriate levels of services and there is little evidence to suggest that inequities in access have been overcome.

Staffing and resources

Fig. 6.15 shows significant growth in the number of WTE palliative medicine consultants working in the NHS in England, increasing more than 350% from just over 60 in 1997 to 217 in 2009. However, differences in access across the country are indicated by considerable variation in the number of WTE palliative care medical staff across the regional SHAs in 2009: from 3.5 doctors per million population in the South East Coast SHA to 11.4 in Yorkshire and the Humber SHA, and from 1.8 consultants per million in South East Coast SHA to 5.8 in the North East SHA – a difference of over 300% for both consultants and all doctors (Information Centre 2010j).

Fig. 6.15

Number of palliative medicine NHS consultants (WTE) in England, 1997 to 2009



Source: Information Centre 2010j.

Funding

There is wide variation in both levels of expenditure on and quantity of palliative care commissioned by PCTs. Recent surveys suggest that the difference in spending by PCTs on specialist palliative care per death range from £154 to £1684, with an average of £504. Similarly, the number of palliative care beds commissioned by PCTs in voluntary-sector hospices ranges from 0 to 67, with an average of 11.4; the number of WTE staff working in hospital palliative care teams varies from 1 to 100, with an average of 11.5; and the number of WTE staff in community palliative care teams ranged from 1 to 135, with an average of 15.6 (NAO 2008e).

6.10.4 Quality of palliative care

Palliative care providers have been subject to general NHS audit and inspection for some time and now come under the CQC regime (section 4.1.3 describes this system). In addition, various pathways and frameworks have been developed locally and adopted more widely for the delivery of high-quality care (e.g. Gold Standards Framework, Liverpool Care Pathway). NICE issued guidance on palliative care for patients with cancer in 2004. Nevertheless, it is only with the increased priority given to end-of-life care by the Department of Health that national standards are being developed.[56]

In late 2008, the Department of Health consulted on a set of quality markers across a range of organizations involved in end-of-life care: PCTs, primary care, acute hospitals, community hospitals, care homes, specialist palliative care inpatient services, specialist end-of-life care services in the community, ambulance services and out-of-hours services. These markers were not intended to be mandatory but to provide guidance. They addressed issues such as assessment of population need; ensuring availability of appropriate care, including 24/7 care; communication with and involvement of patients, their relatives and carers, and development of a care plan; coordination of care; standardization of approaches to care; and monitoring of service provision. The Department of Health produced this set of markers and measures in 2009 (Department of Health 2009t).

People still have difficulty accessing palliative care services quickly. The NAO found “a lack of prompt access to services in the community leads to people approaching the end of their life being unnecessarily admitted to hospital” and highlighted the need for both palliative care services and medicines to be available on a 24/7 basis (NAO 2008e). The Department of

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[56] The Department of Health prefers to call these quality markers rather than standards (Department of Health 2009t).

Health has recognized this in setting quality markers for out-of-hours end-of-life care. Thus, medical practitioners providing out-of-hours care should be competent in general palliative care, including pain management, with access to specialist palliative care and appropriate drugs where necessary (Department of Health 2009t).

The Department of Health is also developing a set of outcome measures for end-of-life care that will include place of death;[57] audits of care given to recently deceased patients, for example, the "National Care of the Dying Audit – Hospitals", based on the Liverpool Care Pathway (Marie Curie Palliative Care Institute Liverpool and Clinical Standards Department of the Royal College of Physicians 2009); surveys of bereaved relatives using an adaptation of the survey tool VOICES (Views of Informal Carers: Evaluation of Services); and surveys to evaluate services.

Place of death

Most people would prefer to die at home, but for most people this is not the outcome. As Table 6.5 indicates, approximately 65% of all deaths in England in 2008 occurred in a hospital or other communal establishment for the care of the sick,[58] 20% at home and 5% in hospices; the remaining 10% died in other communal establishments (e.g. prisons, psychiatric hospitals, hotels, lodging houses, aged persons' accommodation), in someone else's private house or in another public location (e.g. street, cinema) (ONS 2009e). Looking just at people who died from cancer in 2008, relatively more died in hospices or in their own home, 16.4% and 25.8% respectively, with just 52.4% dying in hospital; this is perhaps not surprising given that almost 93% of deaths in hospices are from cancer.

Nevertheless, these figures are a poor reflection of where people say they would prefer to die (National Council for Palliative Care 2006). Table 6.5 indicates that 56% of people would prefer to die at home, 24% in a hospice and just 11% in a hospital. However, these results should be treated with caution as they are based on a survey of healthy people.

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[57] The proportion of deaths at home is already a local measure of performance or "Vital Sign" in many areas (see section 4.2.1 for discussion of the Vital Signs system).

[58] NHS and non-NHS settings, including nursing homes, establishments for the elderly and chronically sick, homes or hostels for people with learning disabilities and maternity hospitals.

Table 6.5

Preferred place of death in the United Kingdom, 2003, and actual place of death of English residents, 2008

	Preferred place of death (%)	Place of death, all causes (%)	Place of death, cancer[a] (%)
Home	56	19.9	25.8
Hospice	24	5.0[b]	16.4
Hospital	11	64.9	52.4
Care home	4	–	–
Other	5	10.1	5.4

Sources: National Council for Palliative Care 2006 (preferred place of death); ONS 2009e (place of death).
Notes: [a] England and Wales in 2008; [b] The ONS states that, of approximately 200 hospices, most are separately located or "free-standing"; a small number are found within NHS hospitals but, as these are not identified separately at death registration, ONS is unable to include deaths that occurred in them with deaths in free-standing hospices and so they are included as hospital deaths (ONS 2009e). This indicates that the ONS figure is an underestimate of deaths in hospices, which may be as many as 6% given that in 2009 there were 40 NHS inpatient units in England offering palliative care.

There is considerable variation between regions of England. For example, in 2008, just 3.4% of deaths in East Midlands SHA and North East SHA were in hospices, compared with 7.4% in the South East Coast SHA. However, 21% of deaths in North East SHA took place at home compared with just 18.4% in the South East Coast SHA. In London, 68.5% of deaths occurred in a hospital or other communal establishment for the care of the sick, compared with the England average of 65%. In England as a whole and in all regions there are notable differences between men and women in place of death. Thus, for England, 23.3% of men die at home compared with 16.8% of women – almost 40% more. Differences of a similar magnitude are seen across the country with just one exception – in London, 20.9% of men die at home compared with 16.3% of women (28% more men). There are less marked differences in the proportion of men and women who die in hospices, although men are still more likely to die in a hospice than women.

6.11 Mental health

The mental health system in England has developed since 1948 from a system of asylum-based detention to an emphasis on the provision of care in the community for people with mental health problems. These developments are discussed in more detail in section 6.11.2. The mental health system in England is a mix of primary care and community-based services supported by specialist inpatient care. Recent policy developments are discussed in section 6.11.1. This is followed by a description of the organization of services (section 6.11.2). Access to services is discussed in section 6.11.3 and, finally, there is a short section on actions to tackle stigma and discrimination (section 6.11.4).

6.11.1 Mental health policy

There have been major changes in the way in which mental health services are delivered in England since 1997 based on the implementation of the NSF for Adult Mental Health, which was produced by the Department of Health in 1999 (Department of Health 1999c). The National Institute for Mental Health in England was established in 2002, with responsibility for the implementation of mental health policy. In April 2009, this responsibility was transferred to the National Mental Health Development Unit, with SHAs providing support for regional and local delivery.

The NSF for Adult Mental Health dealt only with adults of working age (NSFs for children and older people are discussed below) and put forward seven standards relating to various aspects of mental health.

- Mental health promotion:

  standard 1: services should promote mental health for everyone, and combat discrimination.

- Primary care and access to services:

  standard 2: any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed, and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if required;

  standard 3: any individual with a common mental health problem should be able to make 24/7 contact with the local services necessary to meet their needs and receive adequate care, and be able to use NHS Direct for first-level advice and referral on to specialist helplines or to local services.

- Provision of effective services for people with severe illness:

  standard 4: all mental health service users on a Care Programme Approach (CPA)[59] should receive care that optimizes engagement, anticipates or prevents a crisis, and reduces risk; they should have a copy of a written care plan that includes the action to be taken in a crisis by the service user, their carer and their care coordinator, and advises their GP

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[59] The CPA was introduced in 1991 and consisted of four key elements: assessment, production of care plan, assignment of key worker and regular review (Department of Health 1990).

how they should respond if the service user needs additional help; the care plan should be regularly reviewed by their care coordinator, and the user should be able to access services 24/7 every day of the year;

standard 5: each service user who is assessed as requiring a period of care away from their home should have timely access to an appropriate hospital bed or alternative bed or place, which is in the least restrictive environment consistent with the need to protect them and the public, as close to home as possible, with a copy of a written after-care plan agreed on discharge that sets out the care and rehabilitation to be provided, identifies the care coordinator, and specifies the action to be taken in a crisis.

- Provision for carers of people with mental health problems:

  standard 6: all individuals who provide regular and substantial care for a person on a CPA should have an assessment at least on an annual basis of their caring, physical and mental health needs, and have their own written care plan, which is given to them and implemented in discussion with them.

- Prevention of suicide:

  standard 7: local health and social care communities should prevent suicides by ensuring the previous six standards are met as well as supporting local prison staff in preventing suicides among prisoners, ensuring staff are competent to assess the risk of suicide among individuals at greatest risk and developing local systems for suicide audit to learn lessons and take any necessary action.

The implementation of the NSF required considerable improvements in community-based care as well as the introduction of new types of community teams and an expansion in the numbers of professionals providing care in the community. Emphasis was also placed on working with other non-health sectors that address the needs of people with mental health problems, including housing and employment. Moreover, continuity of care was put at the centre of service developments, with the CPA designed to ensure that all people discharged from inpatient care services would receive a care plan and be assigned a community key-worker. The NSF emphasized the multidisciplinary nature of teams working with individuals.

The delivery of mental health care was also addressed in the *NHS Plan*, which spelt out a number of targets (Department of Health 2000a). The main theme relating to mental health was to strengthen the system of community-based care, and hence encourage the shift of care away from old acute-based wards to care in local communities (Appleby 2007). This required the development of new kinds of care team, often expanding on best practice elsewhere in England or on examples from other countries. At the same time, cooperation between the NHS and local authorities was encouraged. Local Implementation Teams are now responsible for planning and commissioning services. These consist of PCTs and local authorities with social care responsibilities, providers of mental health services (NHS trusts and local authority social services) and service users and their carers.[60] Services are often provided by specialist NHS community mental health trusts[61] but can also be provided by private- and voluntary-sector bodies.

The *NHS Plan* set out a number of targets relating to the provision of mental health care in the community. These included the recruitment of:

- 335 crisis resolution teams (CRT) to provide immediate response to people in mental health crisis;
- 220 assertive outreach teams (AOT) to provide intensive support for hard-to-reach groups in their own homes or other community settings;
- 50 early intervention teams (EIT) to provide expert assessment and care for people experiencing their first onset of psychosis, mainly young people;
- 1000 new graduate primary care mental health workers to work with GPs treating common mental health problems;
- 500 more community mental health staff to work with GPs, NHS Direct and in A&E departments; and
- 700 more staff to increase breaks for carers and strengthen carer support networks.

The *NHS Plan* also set out an intention to provide 500 more secure beds and 320 more beds in 24-hour staffed units, plus, for people with severe personality disorders, 140 new secure places, 75 special rehabilitation hostel places and 400 extra staff. In addition, to get people out of high-security hospitals (who do not need to be there), 200 long-term secure beds in the community supported by an additional 400 community staff providing intensive support to recently discharged patients were required. Actual provision is discussed in section 6.11.2. In addition, the *NHS Plan* set a specific target of a 20% reduction in the suicide rate by 2011.

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[60] In June 2010, there were 146 Local Implementation Teams (Mental Health Strategies 2010).

[61] Combined social care and mental health trusts have also been set up.

Specific polices relating to the care of older people and of children also reflected priorities for mental health. *The National Service Framework for Older People* (Department of Health 2001h) included a standard to promote good mental health in older people and to treat and support those older people with dementia and depression. More detailed clinical guidance was provided jointly by NICE and the Social Care Institute for Excellence (NICE and SCIE 2006). This promoted a coordinated and integrated approach between health and social care – that included the needs of carers – with memory assessment services as the single point of referral for all people with a possible diagnosis of dementia. In 2009, the Department of Health produced a national dementia strategy that recognized the shortcomings in the existing system of care and put forward strategies for improvement through increased awareness of the condition, earlier diagnosis and intervention, and higher quality of care (Department of Health 2009u). Local services are expected to deliver improvements in care within the context of this strategic guidance. However, a report by the NAO in early 2010 (NAO 2010b) was sceptical of likely progress, finding that mechanisms required to bring about large-scale improvements were not in place and, in particular, that dementia was not a national NHS priority.

The National Service Framework for Children, Younger People and Maternity Services included a specific standard relating to the mental health and psychological well-being of children. This stated that all people under 18 years with mental health problems or disorders should have access to timely, integrated, high-quality, multidisciplinary mental health services to ensure effective assessment, treatment and support for themselves and their families. It also specified there should be policies in place and staff trained to care in hospital for children and young people with mental health needs (Department of Health 2004o).

The NSF emphasized that all staff working with children and young people should be able to make a contribution to their mental health promotion and early intervention, providing appropriate interventions and specialist referral when problems are identified. In particular, the NSF recommended the development of multidisciplinary teams within Child and Adolescent Mental Health Services (CAMHS), located in a range of settings. These teams provided direct care and increased support for primary care services, with local services having 24-hour cover and mental health assessments undertaken within 24 hours or during the next working day where a child's needs are urgent. The development of "care networks" was put forward as an option for increasing access to highly specialized care for children with severe mental health disorders.

A new Mental Health Act was passed in 2007 that aimed to safeguard the rights of individuals with mental health problems while at the same time ensuring that people with serious problems that threaten their own safety or that of others could be treated irrespective of consent both in institutions and in the community (see section 6.11.3 for more discussion). In particular, the introduction of "Community Treatment Orders" allowed imposition of compulsory community treatment regimes.

A more recent innovation has been the introduction of direct payments for people with mental health conditions,[62] allowing them to receive cash from local authorities instead of the mental health services that would have been funded by local authority social care budgets. They are then able to buy services directly based on their understanding of their own needs. The uptake of direct payments by people with mental health needs remains low but is likely to increase as local authorities respond to their duty to offer the option of direct payments to eligible individuals (Department of Health 2006j); and as the system of direct payments reacts to the extension in November 2009 to individuals who lack the capacity to consent to the making of direct payments, and to the removal of exclusions that applied to people subject to various provisions of mental health legislation (Department of Health 2009r). A somewhat similar scheme, which has been piloted in several local authority areas, is individual budgets. This brings together funding from a range of entitlements due to an individual from various sources (e.g. local authority social care, housing-related support services, adaptations and equipment budgets, NHS budgets). In this case, the individual has flexible control over how the funds are spent, with no requirement to spend according to the original source of the cash (Glendinning et al. 2008b).

NICE guidelines for depression and anxiety disorders first published in December 2004 suggest that psychological therapies such as cognitive behavioural therapy and interpersonal therapy are clinically effective and should be available to NHS patients (NICE 2009). Access to these therapies has for some time been problematic, with long waiting times in some parts of the country. In 2006, the Department of Health set up a programme to extend the use of such therapies throughout England: *Improving Access to Psychological Therapy*. Pilot psychological therapy projects were launched. The 2007 Comprehensive Spending Review allocated £33 million to the programme in 2008–2009, £70 million in 2009–2010 and £70 million in 2010–2011; at least 20 new therapy centres were to be developed in 2008–2009 (Department of Health 2007s, 2008y).

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[62] Direct payments and individual budgets are available to a range of client groups (e.g. older people, children with physical or learning disabilities, carers).

6.11.2 Organization of services

As with other health services, there is a distinction between services provided in acute hospital settings and services provided in the community; the latter includes ambulatory care provided by GPs, specialist teams, other mental health professionals, as well as temporary or more permanent residential care provided in a range of settings. Since the early 1980s, there has been a deliberate move away from acute mental health care in hospital and asylum settings to community-based care.

Mental health services are provided by a mixture of NHS, local authority, voluntary-sector and private-sector providers, with increasing provision by the voluntary and private sectors. Services provided through the NHS are available free at the point of delivery. PCTs have responsibility for both commissioning and sometimes providing mental health services for their local populations. Most mental health services are funded through the NHS or by local authorities (whose funding comes from central government grants supplemented by local taxes). Local authorities fund some specialist housing, education and social services, as well as some mental-health-related social services, including home support, day services, residential services, independent living schemes and social work support. Increasingly, some health and social care services are provided by local authorities in partnership with health services through various joint working arrangements. Some services provided by local authorities are not available free of charge but instead are subject to means-testing.

Inpatient care

Inpatient care is provided in acute inpatient wards in a range of facilities, including general acute hospitals, psychiatric hospitals (which may be private) and separate purpose-built units. These provide care and support, including residential accommodation, for people in periods of acute psychiatric illness. There are also psychiatric intensive care units for people compulsorily detained – often in secure conditions. Inpatient treatment is also provided in high- and medium-security facilities that cater mainly for people convicted of a criminal offence (see the discussion below on forensic mental health services).

A range of accommodation services are also available to help individuals to live more independent lives in community settings. These include supported housing schemes, staffed or unstaffed group or care homes, short-term hostels and adult/family placement schemes. Respite care services are also available to give family carers the opportunity to have time off from their caring responsibilities (see section 6.9 for discussion of informal care).

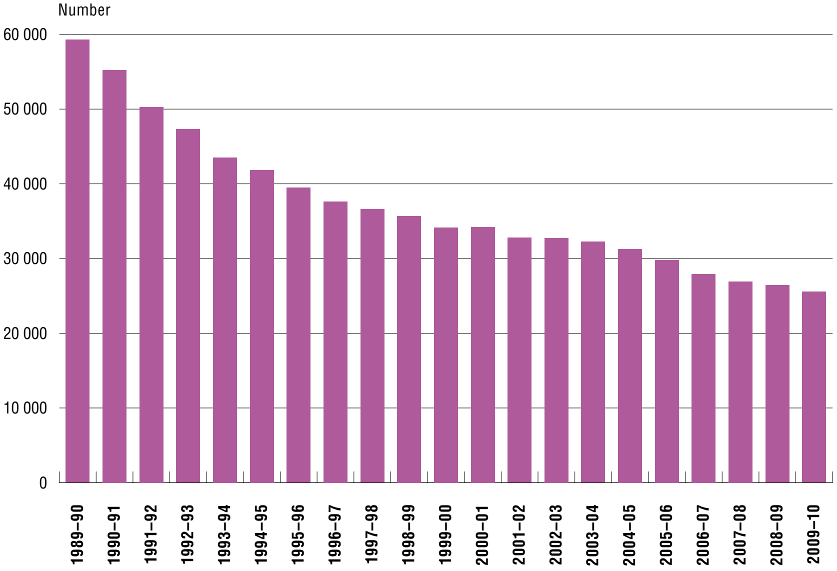
Availability of residential accommodation

Data on the number of inpatient beds for psychiatric care in the private and public sectors is not collected centrally. However, a national adult mental health service mapping exercise has been undertaken on behalf of the Department of Health for several years. This provides detailed data on both infrastructure and the availability of mental health care professionals in England at a local level (Lee & Glover 2008).

The number of beds provided directly by the NHS has continued to fall over time: in 1989–1990, there were approximately 59 300 NHS inpatient beds provided for mental health care. As Fig. 6.16 shows, by 2009–2010, this had fallen to 25 560 beds, of which 67.4% were for adults of working age, 30.3% for older people and 2.3% for children. Of the total, 67.7% were short stay, 18.9% were long stay and 13.4% were beds in secure units (Department of Health 2010s).

Fig. 6.16

Average daily number of available beds for mental health care, England, 1989–1990 to 2009–2010



Source: Department of Health 2010p.

In addition, the NHS manages a small number of residential care beds in nursing homes, residential care homes and group homes that are available for the care of people with mental health problems.[63] In 2009–2010, there were approximately 1202 beds available in such homes (Department of Health 2010bb). However, a large part of residential bed services is provided by the private sector. The Department of Health provided comparable data on the private sector up to 2000–2001, which indicated that, in addition to 34 200 NHS-provided beds and 1280 residential care beds managed by the NHS, there were a further 28 780 beds in private nursing homes and hospitals, 37 780 in staffed residential homes for adults and 2320 in small registered residential homes: a total of 104 370 beds available for people of all ages with mental health problems (Department of Health 2001j).

Data from the Department of Health's Combined Mapping Framework for Mental Health Services for March 2009 are presented in Table 6.6. These show that there were 51 035 beds available for adults of working age. Of these, 20% were in acute inpatient units or wards, 26% in supported housing facilities promoting independent living, 19% in registered residential care homes, 8% in nursing care homes and over 6% in a range of secure units. Data provided do not indicate the extent of private- and voluntary-sector provision, although this clearly continues to play an important role. There is considerable variation in the distribution of NHS and local-authority-supported residential and inpatient adult mental health beds across the regional SHAs: total adults beds per 100 000 working-age population vary from 0.8 in South East SHA to 8.0 in London SHA, with an England average of 1.6.

In 2008–2009, there were 16 100 individuals detained in hospital, of whom 77% were in NHS facilities (including three high-security hospitals) and the remaining 23% in private hospitals. There were 28 673 formal admissions to NHS facilities (including high-security hospitals) and independent hospitals: 93% were admissions under the civil provisions (Part 2) of the Mental Health Act 1983 and 7% were made under the criminal justice system. In addition, there were a further 19 052 detentions after an informal admission to hospital (Information Centre 2009m).

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[63] This does not include residential beds managed by other agencies such as local authority social services.

Table 6.6

Available adult mental health beds by service type, March 2009

Service type	Beds	Percentage of total
Acute inpatient unit/ward	10 072	20
High-secure psychiatric hospital	188	0.4
Regional medium-security unit	1 228	2
Local low-security service	1 772	3
Local medium-security service	450	1
Local psychiatric intensive care unit	937	2
Residential rehabilitation unit	2 510	5
NHS 24-hour nurse-staffed care	868	2
Non-NHS registered nursing home	3 075	6
Registered residential care home	9 729	19
Supported housing	13 405	26
Staffed group home	743	1
Unstaffed group home	528	1
Crisis accommodation	591	1
Hostel	1 377	3
Adult/family placement scheme	372	1
Personality disorder service	85	0.2
Short-term breaks/respite care service	238	0.5
Psychological therapy services	19	0.0
Other accommodation services	2 323	5
Other continuing care	254	0.5
Other community services	271	1
Total	**51 035**	**100**

Source: Care Services Improvement Partnership 2009.

Community mental health services

Community mental health services include a range of different services. There has been a gradual expansion in numbers and types of care in line with the NSF's aim of providing improved care in community settings, especially for the most vulnerable individuals in the community who otherwise would be at risk of requiring inpatient care. The principal types of service available through the NHS are listed below. Community mental health teams or primary care mental health services are usually the main providers of care to mental health service users in the community; the other types listed are often part of one of these. Community mental health services comprise:

- community mental health teams: multidisciplinary teams providing assessment and care to people with mental health problems in their homes or in the community, and support to primary care services;
- primary care mental health services: groups of workers, single worker or cluster of staff (may be mental health nurse practitioners, primary care facilitators and graduate primary care mental health workers) who work as a team to help GPs to support and treat people with common mental health problems;
- CRTs: multidisciplinary teams providing 24/7 intensive short-term support for people in mental health crisis in their own home or a crisis house;
- AOTs: provide intensive support on a continuing basis for severely mentally ill people in their homes or other community settings, involving a team approach, defined client groups and planned long-term working with individuals;
- EITs: provide expert assessment and care for people experiencing their first onset of psychosis;
- home or community support services: usually not mental health professionals, providing support to people with mental health problems, and their families;
- rehabilitation or continuing care teams: multidisciplinary teams providing service to meet the needs of people with long-term serious mental health problems;
- gateway workers: experienced mental health clinicians who provide assessment and triage for people in acute or impending mental health emergency;
- graduate primary care workers: staff trained in brief therapy techniques who work with GPs to manage and treat common mental health problems;
- support time and recovery workers: workers who through extensive time input develop individual relationships with service users developing joint assessments of the individual’s needs and strengths; and
- community development workers: workers whose role is to support and facilitate community groups and networks to enhance the capacity of black and minority ethnic groups to deal with mental illness and the inequalities inherent in services provided (see the later discussion in section 6.11.3 on access for black and minority ethnic groups).

Mental health workforce

Table 6.7 shows a total of almost 101 500 WTE staff employed in adult mental health services in England in March 2009. Of these, almost 36 000 are nurses, 5700 are medical staff, over 6000 are social workers, some 5200 are therapists and just over 2850 are psychologists. There are over 13 750 managers or administrative staff, plus an assortment of other staff, which includes carer support workers, support time recovery workers, gateway workers, graduate primary care workers, community development workers, day-care officers, employment officers and education officers.

Table 6.7

Staffing levels for adult mental health services, England, March 2009

Staff type	WTE number	Staff per 100 000 working-age population[a]
Medical staff	5 698	18
Nurses	35 894	112
Psychologists	2 853	9
Therapists	5 210	16
Social workers	6 074	19
Other	31 997	100
Managers and administrative	13 759	43
Total staff[b]	**101 485**	**317**

Source: Care Services Improvement Partnership 2009.
Notes: [a] Estimated using mid-year 2008 population estimates; [b] Volunteer staff are not included in these figures.

There is considerable variation in the number within each staff group per 100 000 working-age population across the regional SHAs: from 13 to 28 medical staff, from 87 to 145 nurses, from 5 to 17 psychologists, from 12 to 23 therapists, from 46 to 178 others, from 29 to 62 managers and administrative staff, and, finally, from 212 to 440 total staff, a difference of over 100%.

Staffing of new community mental health services

There has been a considerable expansion in the number of people working in new ways in the community. As Table 6.8 shows, in England by March 2009, for AOTs and EITs the number of services exceeded the number of teams targeted in the *NHS Plan*, and for CRTs it was close to the target. However, access to these teams varies across England. For example, the number of staff per 100 000 working-age population in 2009 varied between SHAs: from 12.8 to

18.2 for CRTs, from 7.0 to 10.4 for AOTs, and from 3.7 to 8.3 for EITs. Taking staff in all three services together, there was a variation between SHAs from 25 to 37 per 100 000 working-age population.

Table 6.8
CRTs, AOTs, EITs, England, March 2009

Service type	Number of services	Number of staff	Staff per 100 000 working-age population[a]
CRT	276	5 098	16.0
AOT	244	2 690	8.4
EIT	152	2 002	6.3

Source: Care Services Improvement Partnership 2009.
Notes: [a] Estimated using mid-year 2008 population estimates.

There has also been expansion in new types of staff member (see the list above), such as graduate primary care workers, gateway workers, carer support workers, support time and recovery workers, and community development workers. Table 6.9 shows the numbers of such staff in England in March 2009.

Table 6.9
New types of community mental health staff, England, March 2009

Staff type	Number of staff	Staff per 100 000 working-age population[a]
Graduate primary care	847	2.7
Gateway workers	273	0.9
Staff with gateway function	3 136	9.8
Carer support	1 463	4.6
Support time recovery	3 372	10.6
Community development	447	1.4

Source: Care Services Improvement Partnership 2009.
Notes: [a] Estimated using mid-year 2008 population estimates.

Psychological treatment services have also expanded in line with the NSF objective of improving access to psychological therapies, and in response to the Improving Access to Psychological Therapy programme. In March 2009, the average number of psychologists (consultant, clinical, assistant and counselling) per 100 000 working-age population was just under 9. In addition, there were, on average, 2.4 psychotherapists per 100 000 working-age population. Again, there is considerable variation across SHAs, the number of psychologists ranging from 5.5 to 16.5 and the number of psychotherapists from 0.9 to 3.5.

CAMHS

Services for children and adolescents (aged under 18 years) tend to be provided by specialist teams provided by CAMHS. Services are organized according to a four-tier framework (Barnes et al. 2009).

> *Tier 1, primary care.* This comprises a range of professionals (e.g. GPs, school nurses, teachers) who are likely to be the child's initial contact with professionals.
>
> *Tier 2, professionals working independently within a network.* This includes clinical child psychologists, child psychiatrists and community child psychiatric nurses, who will make assessments that may trigger treatment or identify severe or complex needs.
>
> *Tier 3, a specialist service for children and adolescents with severe, complex and persistent disorders.* This is usually multidisciplinary teams made up of a range of professionals, including social workers, community psychiatric nurses and child psychotherapists. These teams provide assessment, treatment and management of conditions.
>
> *Tier 4, essentially a tertiary service.* This includes day units, highly specialized outpatient teams and inpatient units for older children and adolescents with severe mental illness or at suicidal risk.

Each year, a service mapping exercise is performed on behalf of the Department of Health. This reported that in 2007 there were 1047 specialist CAMHS teams (covering tiers 2 to 4 services). These consist of generic teams, which are either multidisciplinary or single-disciplinary groups of staff covering a defined geographic area; targeted teams who provide services for children with particular problems or who require particular types of intervention; dedicated worker teams who are CAMHS professionals working with non-specialist teams; and tier 4 teams who provide longer-term or more intensive provision either as inpatient care or as outreach support. The number of targeted teams has been increasing since 2003, whereas the others have remained broadly constant. However, considering just tier 4, there was some reduction in services in 2007, with the number of commissioned inpatient beds at 621, the number of day places 368, the number of intensive home support places 724, but a growth in the number of intensive foster care placements to 87 (Barnes et al. 2009).

There were 10 375 WTE staff in CAMHS teams in 2007, of which nurses were the largest professional group, with 22% of the workforce; doctors accounted for 11%, clinical psychologists 12% and administrators 15%. The CAMHS workforce grew by 34% between 2003 and 2007. The number of care staff in CAMHS teams per 100 000 total population was 13.2 WTE in 2007, although this varies across SHA regions from 9.3 to 17.1 (Barnes et al. 2009).

Forensic mental health services

Forensic mental health services provide specialized assessment, treatment, rehabilitation and after-care to offenders (or people at risk of offending) with mental health problems (Jobbins et al. 2007). These services are provided within high-, medium- and low-security hospital settings. The main roles of the forensic mental health service are:

- assessment, management and treatment of high-risk mentally disordered offenders in the community, hospitals and prisons;
- assessment, support and treatment of victims, especially those who develop dangerous behaviour;
- provision of advice and collaborative working with psychiatrists, GPs, lawyers, police officers, prison staff, social workers and probation officers; and
- provision of evidence and reports for legal purposes.

Most services are provided within NHS medium- and low-security units, although some services are provided in private-sector units and within prisons (since April 2006 the commissioning of prison health care has been an NHS responsibility). There are three high-security NHS hospitals covering England and Wales: Ashworth, Broadmoor and Rampton. Ashworth provides services only for men. In addition, there are medium- and low-security units throughout the country (NHS East Midlands et al. 2009).

6.11.3 Access to mental health services

This section first considers the rights of individuals under mental health legislation in England. It then looks at access to services in terms of overall levels of expenditure and how these vary across England. Finally, access to services for people from minority ethnic groups, refugees and asylum seekers is considered.

Legislation to safeguard human and legal rights

Earlier legislation relating to the circumstances in which individuals are detained and treated without their consent was superseded by the Mental Health Act 1959, which made the process for compulsory admission for psychiatric treatment a medical decision rather than one for the courts, and gave local councils responsibility for the social care of people who did not need inpatient treatment. The Mental Health Act 1983 dealt mainly with the compulsory treatment and detention of people with mental health problems. It excluded people deemed to be mentally ill "by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs". The Act set out processes and provided safeguards regarding detention in hospital and compulsory treatment for people considered mentally ill, covering those with learning disabilities, psychopathic disorders and mental illness. It allowed individuals to be detained against their will for 28 days if two doctors agree to their committal, and for up to six months with the consent of their nearest relative. This order could be renewed after six months and then annually. An individual might also be admitted under an emergency order on the recommendation of a doctor. An appeals process against detention was in place, but it could be slow and cumbersome. Medication for mental disorders could be prescribed and administered to some categories of patient detained under the Mental Health Act without consent for a period of three months, but after that only in certain circumstances.

The 1983 Act with its focus on hospital care soon became outdated as the delivery of mental health care in community settings grew. Following years of consultation, objection and controversy, mainly around compulsory treatment for individuals and detention if considered a threat to the public, a new Mental Health Act was passed in July 2007. This Act contained a number of safeguards in respect of the human and legal rights of individuals. It also extended the rights of victims by amending the Domestic Violence, Crime and Victims Act 2004, and it introduced "deprivation of liberty safeguards" by amending the Mental Capacity Act 2005. This last change was in response to a 2004 European Court of Human Rights judgment (the Bournewood judgment) regarding the detention of an individual against the wishes of his carers in breach of articles of the European Convention on Human Rights (European Court of Human Rights 2004).

The main purpose of the 2007 Act is to ensure that people with serious mental problems that threaten their health or safety, or the safety of the public, can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others. Mental disorder is now defined as "any disorder or disability of the mind". The Act introduced a new "appropriate medical treatment" test, which applies to all longer-term powers of detention. People may not be compulsorily detained or their detention continued unless medical treatment that is appropriate to the patient's mental disorder and all other circumstances of the case is available to that patient.[64] The role of the nearest relative in giving consent for detention and/or treatment where an individual is incapacitated was revised so that individuals in civil partnerships can play this role; patients were also given the right to apply to a county court to displace the nearest relative, and county courts could act independently to displace a relative not considered suitable for this role.

Community Treatment Orders were introduced; these are used in the supervised discharge from hospital of individuals into the community, allowing the imposition of compulsory treatment regimes, with the possibility of recall to hospital if necessary. These orders run initially for six months and are renewed for a further six months and then annually. The Act also provides that the Secretary of State for Health must provide independent advocacy services for all detained patients, guardianship patients and patients subject to Community Treatment Orders, and service providers should inform patients that advocacy services are available. Advocates have the right to meet with patients in private, and also with health care professionals. They have access to patient records only where a capable patient gives consent or, in the case of an incapable patient, where such access would not conflict with a decision made by a deputy, court, etc, and where the person holding the records agrees that such access is appropriate.

The Act introduced a capacity threshold for the imposition of electroconvulsive therapy with a requirement that a second doctor must approve this treatment for any individual aged 18 or less. Except in an emergency, electroconvulsive therapy may not be given to a patient who has the capacity to refuse consent to it, and it may only be given to an incapacitated patient where it does not conflict with any advance directive or decision of the patient's designated representative. Revisions to the appeals process in respect of detention were also made, including an automatic referral of cases to the Mental Health Review Tribunal.

In addition, the Act for the first time ensured that no child under 16 years is treated on an adult ward, and placed a duty on hospital managers to ensure that all patients under 18 years are placed in suitable settings, unless needs dictate otherwise.

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[64] This replaced the "treatability test", which required that treatment should be likely to alleviate an individual's condition or prevent deterioration.

Expenditure on mental health services

To some extent, access to mental health care is determined by the level of expenditure on services. However, assessing total public expenditure on mental health services in England is complex as funding is fragmented, coming not only from the NHS budget but also from local authorities and other government departments (e.g. the Department for Education and the Department for Work and Pensions). In addition, there is a small amount of private expenditure on mental health services as well as pharmaceuticals. Data from a range of sources are presented below.

According to Department of Health programme budget data, some £10.5 billion (10.8%) was spent on treating people with mental health problems in 2008–2009; this was from a total gross NHS budget of £96.8 billion. This figure does not include the treatment of individuals within general and personal medical services. Looking just at HCHS expenditure, some £6.6 billion (14%) was spent on care of people with mental health problems of a total HCHS gross budget in 2006–2007 of £46.9 billion. This includes mental illness, child and adolescent psychiatry, forensic psychiatry, psychotherapy and old-age psychiatry (including the elderly mentally ill), as well as community mental health services and single specialty hospitals (Department of Health 2008b). In addition, £987 million was spent by local authorities on adults with mental health problems; a proportion of the £8.52 billion expenditure of local authorities on older people would also have been attributable to mental health issues (Department of Health 2008b).

Data from the Department of Health's annual review of expenditure on mental health services for 2009–2010 are presented in Table 6.10. Of the total, some 82% is NHS expenditure and 18% is local authority spending. Similarly, most provision is NHS (around 69%), with 24% supplied by the non-statutory sector and just 7% by local authority social services. The largest element of expenditure goes on secure and high-dependency services (15.4%), followed by clinical services (14%), community mental health teams (11.6%), continuing care (9.4%) and access and crisis services (9%). Expenditure on the last has grown most in real terms since 2002–2003: by 162%. This compares with increases of 141% on secure and high-dependency services, over 100% on psychological therapies, 74% on mentally disordered offenders and 72% on home support. Since 2002–2003, the estimated real increase in total expenditure on mental health services is approximately 43%: from £4.4 billion to £6.3 billion at 2009–2010 prices (Mental Health Strategies 2010).

Table 6.10

Estimated expenditure on adult mental health services in England, 2009–2010

Service	Expenditure[a] (£ million)	Percentage of total expenditure
Access and crisis services	543	9.0
Accommodation	462	7.7
Carers' services	27	0.45
Clinical services	838	14.0
Community mental health teams	696	11.6
Continuing care	566	9.4
Day services	156	2.6
Direct payments	18	0.30
Home support services	110	1.8
Mental health promotion	3	0.05
Other community and hospital professionals	93	1.5
Personality disorder services	30	0.50
Psychological therapies	292	4.9
Secure and high-dependency	924	15.4
Mentally disordered offenders	59	0.98
Support services	63	1.05
Indirect, capital charges and overheads	1 121	18.7
Total	**6 001**	**100.0**

Source: Based on data from Mental Health Strategies 2010.
Note: [a] Estimated unreported expenditure is excluded from these figures.

Total expenditure[65] on all mental health services per head of working-age population in England in 2009–2010 was around £198. However, there is considerable variation between different parts of England, with total spending varying between £148 in the South Central SHA area to £278 in the London SHA area. Weighting expenditure to take account of the different needs and costs of different areas (using an MFF, an emergency ambulance cost adjustment and a mental health need index) reduces the variation to between £175 and £211 (Mental Health Strategies 2010).

Looking at the three *NHS Plan* priority development areas for mental health, CRT, AOT and EIT services, Fig. 6.17 shows an increase in real expenditure in England on all three elements from £118 million to almost £494 million between 2002–2003 and 2009–2010. The largest absolute increase in expenditure was

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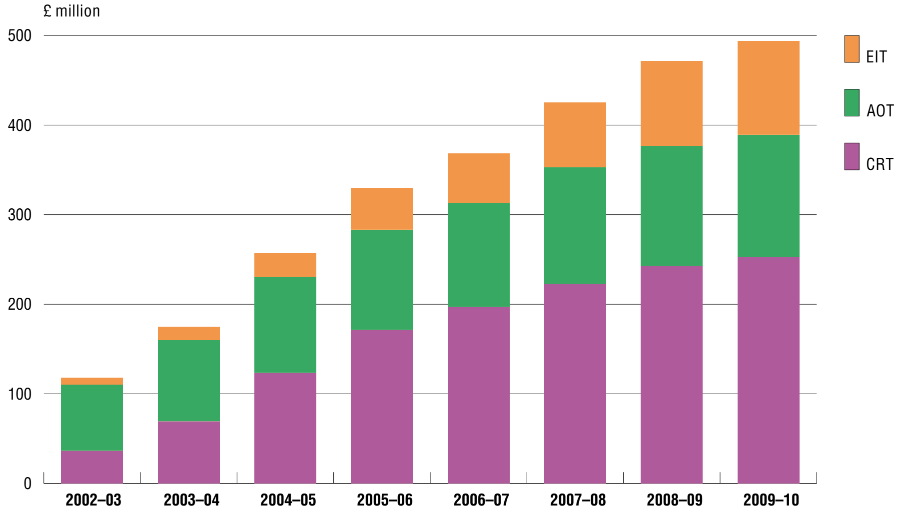
[65] Taking the sum of reported and unreported expenditure as estimated by Mental Health Strategies (2010).

on CRTs, from £36.5 million to £252.5 million; expenditure on EIT services increased from £7.6 million to £104.3 million; and, expenditure on AOT services increased from £73.9 million to £137.1 million. As a proportion of total mental health expenditure, spending on these services increased from 2.7% to 7.8% between 2002–2003 and 2009–2010 (Mental Health Strategies 2010).

Fig. 6.17

Real expenditure at 2009–2010 prices (£ million) on mental health priority development services in England, 2002–2003 to 2009–2010



Source: Based on data from Mental Health Strategies 2010.

Based on a Department of Health mapping exercise for children's services, NHS and local authority expenditure on CAMHS in England in 2006–2007 was estimated at £523 million.[66] This is a growth of 62% since 2003–2004, when spending was £322 million. Moreover, expenditure was planned to continue to increase in 2007–2008 to £565 million. Of this, around 20% is managed by local authorities, with most of the rest provided from PCT budgets. Average CAMHS spending per capita population aged under 17 years was over £47 in 2006–2007, an increase of 13% on 2005–2006. However, per capita spending varied across SHA regions, from £32 to £74 (Barnes et al. 2009).

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[66] Results for 2007–2008 were published in April 2010 (Barnes et al. 2010) but did not cover local authority expenditure on CAMHS.

Services for black and minority ethnic communities, refugees and asylum seekers

For many years mental health services in England were criticized as failing to meet the needs of black and minority ethnic communities. This is in spite of the Race Relations (Amendment) Act 2000, which explicitly prohibits discrimination on racial grounds in all functions of public authorities, and also includes private or voluntary agencies acting on behalf of public bodies. A systematic review of ethnic variations in the use of mental health services found that black people are consistently overrepresented among hospital inpatients; moreover, black people on inpatient wards were four times more likely to have experienced a compulsory admission compared with white people (Bhui et al. 2003). More recent studies show little or no improvement, with continued overrepresentation of people from black and minority ethnic communities (Raleigh et al. 2008; Wilson 2009).

In 2005, the Department of Health, reacting to yet another inquiry (Blofeld et al. 2003) into the failings of the service, produced a national strategy on mental health services for black and minority ethnic communities to tackle inequalities in access for this group (Department of Health 2005h). The strategy set out three areas where action was required:

- developing more appropriate and responsive services that take account of cultural sensitivities;
- better local community engagement with black and minority ethnic populations through 500 new community development workers; and
- better monitoring of services and dissemination of information on good practice.

Delivering Race Equality was part of the programme of work of the National Institute for Mental Health in England.[67] By March 2009, almost 450 community development workers were in place. Local initiatives have included 17 focused implementation sites to tackle discrimination and inequality within their areas and four "enhanced pathways into care" sites to improve mental health pathways for black and minority ethnic groups. Between 2005 and 2008, 79 community engagement projects were initiated aiming to develop skills and competencies of people and groups in the non-statutory sector and develop partnerships between non-statutory and statutory bodies. As part of the overall programme, there has been a considerable improvement in information available at a local level on ethnicity and mental health services use (Wilson 2009). The national

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[67] Replaced by the National Mental Health Development Unit in April 2009.

strategy also recognized the need to develop specific services to meet the needs of asylum seekers, refugees and victims of torture, and this became part of the *Delivering Race Equality* programme. Nationally, much remains to be done if the NHS is to provide equal access to a full range of effective services appropriate to the ethnicity or culture of service users.

6.11.4 Actions to tackle stigma and discrimination

A key standard in the NSF was to end discrimination on the grounds of mental health. In 2004, the National Institute for Mental Health in England produced a strategic five-year programme to tackle stigma and discrimination on the grounds of mental health, and set up SHiFT – which is now part of the National Mental Health Development Unit – to take forward this programme (National Institute for Mental Health in England 2004). At the same time it also set up the National Social Inclusion Programme to take forward work on social inclusion (National Social Inclusion Programme 2009).

These programmes have attempted to reduce stigmatizing attitudes and discriminating behaviour through targeting different groups: young people; the public and the media; public sector bodies; and private, voluntary and professional organizations. Initiatives have been taken forward in several areas: employment, housing, income and benefits, community participation, education, social networks and direct payments. These have involved collaboration between government departments (e.g. Education, Justice, and Work and Pensions), as well as private- and voluntary-sector organizations.

In 2006, the Department of Health launched *Action on Stigma* (Department of Health 2006k) to tackle discrimination in the workplace. This initiative, delivered jointly by SHiFT and the National Social Inclusion Programme, set out the benefits of helping individuals return to work and highlighted principles of best practice for employers to adopt to promote mental health and avoid discrimination. Various other anti-stigma and discrimination initiatives are being taken forward including *Time to Change* and *Moving People*. SHiFT is focused on two key areas, employment and the media. Work has already taken place on employment issues aimed at improving the recruitment and retention of people with mental health problems. SHiFT is also working to improve media reporting, encouraging more positive representations of people with mental health problems. A handbook on best practice for reporting mental health tackles particularly the coverage of violence and suicide, and this has been distributed to thousands of journalists. In addition, a new PSA target (target 16) that includes employment and settled accommodation outcomes for people with severe and enduring mental health problems was set; other socially excluded groups were also included. This requires local authorities and health bodies to work together to ensure that mental health employment and settled accommodation targets are achieved.

6.12 Dental care

This section provides an overview of the provision of dental care in England: section 6.12.1 discusses briefly the development of government policy on dental care; section 6.12.2 reviews the organization of services; section 6.12.3 considers access to services; section 6.12.4 looks at how quality is assured; and, finally, section 6.12.5 considers preventative dental care programmes.

6.12.1 Dental care policy

With the introduction of the NHS in 1948, free public dental health care became widely available in England. In 1951, patient charges were introduced mainly as a cost-containment measure, and in subsequent years charges were expanded to cover over 25% of costs. Extremely poor dental health in England resulted in considerable demand on services. However, 10-year surveys of dental health have shown major improvements so that by 1998 people under 30 years of age had low levels of decay and restorative needs; on the other hand, people aged between 30 and 65 years have had high disease levels treated by fillings and other restoration, and so were likely to have high future maintenance needs, whereas a large proportion of those over 65 years of age had no teeth and use dentures.[68] Moreover, in recent years, individuals have become increasingly concerned not just with the health of their teeth but also their appearance, and this will impact on expectations of what NHS dentistry should deliver (Steele et al. 2009).

Until the introduction of a new contract in 1990, the basis for paying NHS dentists was on item of service, which tended to focus providers on delivery of services rather than the overall oral health of the population, and some commentators felt this led to an increase in unnecessary treatments. The 1990 contract introduced a partial capitation basis for payment of NHS dentists, which encouraged the registration of patients. However, issues mainly with remuneration resulted in a decline in access to NHS dentists as many dentists moved to total or partial private practice; subsequent reforms have

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[68] The survey for 2008 was postponed until 2009 and it was expected that preliminary results would be released in December 2010.

tried to address this problem. Since 1997, the Labour Government, in line with its general approach to NHS policy, emphasized the need both to devolve responsibility for care to the local level and to ensure quality of dental care, and it was also concerned to place prevention at the heart of the service. A new contract emerged in 2006 that devolved responsibility to PCTs for contracting services, simplified patient charging and changed the remuneration system to an annual amount for NHS dentists to deliver an agreed quantity of work (see section 6.12.2 for further discussion). This seems to have pleased nobody and if anything provoked more disquiet within the profession and failed to improve access to NHS dental services. Expenditure on private dental care is at least as much as that of the NHS (House of Commons Select Committee on Health 2008a). A recent review of dental services in England (Steele et al. 2009) suggested that there should be more emphasis on quality of care and prevention and these should be measured and included within the payment mechanisms of the existing contract. In February 2010, the Department of Health set up an implementation board and announced the launch of a wave of pilots to take forward the recommendations of the Steele review, beginning in April 2010 (Department of Health 2010cc).

6.12.2 Organization of dental services

The dental service in England consists of three parts:

- secondary and tertiary dental services in acute hospitals (and some single-specialty hospitals), providing specialist advice[69] and treatment for more difficult and complex problems, usually referred by general dental practitioners or GPs;
- community dental services, providing care in community settings – community clinics, patient’s own home, nursing homes – for patients who would find it difficult to use general dental practices (e.g. young children with learning difficulties, some older people, people with severe physical disabilities or mental health issues), as well as providing screening of schoolchildren for dental decay and delivering oral health promotion; and
- general dental services, providing a range of ambulatory services in local community settings to meet most dental health needs.

Undergraduate and postgraduate education and training of dentists provided through dental schools aligned with hospitals is covered in section 5.2.3.

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[69] The main dental specialties are oral and maxillofacial surgery, orthodontics, restorative dentistry and paediatric dentistry.

Hospital and community dentists tend to be NHS employees, although there are also private-sector dental facilities offering a range of specialist care. General dental services are provided by both the NHS and the private sector. Often, general dental practitioners provide both NHS and private dental care from the same office and sometimes to the same patient.

PCTs are responsible for the provision of NHS dental services in their geographically defined local areas and must ensure that NHS dentistry is available to anyone wishing to access services. In addition, individuals are entitled to immediate access to urgent dental care when required. Individuals have the right under the NHS – subject to a set of co-payments discussed in section 3.3.3 – to all treatment clinically necessary to keep teeth, gums and mouth healthy, including dentures, root canal treatment, crowns and bridges, preventive treatment (e.g. scale and polish, appointment with dental hygienist, fluoride varnish or fissure sealants), white fillings and, for people under 18 years, orthodontic care (e.g. braces to straighten teeth). Although individuals have these treatment entitlements under the NHS, they may choose to receive a mix of private and NHS treatment within the same episode of dental care.

General dental practitioners act as independent contractors and choose where to locate their practices and how much, if any, NHS treatment to provide. PCTs cannot force dentists to take on NHS patients, although almost all dentists provide some NHS services. Under the 2006 contract, a dentist who takes on an NHS patient is expected to provide a written treatment plan for certain types of work (bands 2 and 3, see below) and should confirm details and costs of any treatments that it is intended to provide. Although this could be a mixture of NHS and private treatment, patients are not obliged to agree to private treatment but should receive appropriate treatment under the NHS.

In the early 1990s, patients had experienced problems accessing NHS dentistry as dentists reduced their commitment to the NHS and developed their private practice work, partly in response to cuts in fees imposed by government. The Department of Health responded by piloting new systems for paying dentists – personal dental services contracts – and eventually a new general dental services contract was introduced in 2006 whereby PCTs became responsible for commissioning dental services according to an assessment of local needs. Funding to PCTs for dental services was ring-fenced based on historical usage.

The patient charging system was simplified and payments for dentists were based not on fee for service but on the number of UDAs completed (see section 3.6.2). In addition, patients were no longer required to register with individual dentists; between 1990 and 2006, part of dental remuneration was linked to the number of patients registered. The new contract is negotiated locally between PCTs and each individual dental practice with PCTs commissioning an annual total of treatment from dentists measured in UDAs and paying 12 monthly payments. Where a PCT holds a contract with a dentist to deliver an agreed level of dental service, this dentist is known as a provider (also known as a dental practice owner).[70] If this dentist subcontracts all the work to other performers (i.e. does not actually perform NHS dentistry), the dentist is known as "provider only". A provider may also act as a performer (i.e. deliver dental services), and is then known as a "providing performer". Dentists who deliver dental services but do not hold a contract with the PCT themselves (i.e. they work for a "provider only" or "providing performer" dentist) are known as "performers only".

In 2005–2006, a dental practice owner received, on average, an annual income net of costs of £114 000. Also, on average, in 2005–2006, dentists earned 42% of their income from the NHS and 58% from private practice. Private dental treatment is paid for directly by the patient on a fee-for-service basis or through a private insurance plan (House of Commons Select Committee on Health 2008a). By 2007–2008, a dental practice owner in England and Wales received, on average, an annual income net of costs of £126 800 (Information Centre 2009n). By 2008–2009, this had increased to £131 500 (Information Centre 2010f).

6.12.3 Access to dental care

Access to NHS dental care is determined both by availability of NHS dentists within local areas and ability (and willingness) of individuals to meet NHS charges for care. As already indicated, there have been concerns for some time about lack of access to NHS dentists in many areas of England. Private dental care is also widely available in many parts of the country, although costs are likely to be prohibitive for many people.

Staffing levels

There were approximately 35 400 registered dentists[71] and 21 700 registered dental professionals (e.g. nurses, hygienists, technicians) in the United Kingdom at the end of 2007 (GDC 2008a). There were 21 041 dentists operating under the general dental services contract in 2006–2007 (House of Commons Select

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[70] The contract could also be held by an NHS trust or by a private company.

[71] Not all registered dentists are practising; in 2009, there were just 23 000 members of the BDA (British Dental Association 2010).

Committee on Health 2008a). In September 2009, there were 4342 (3301 WTE) dentists working in England in NHS hospitals and community services, including dental public health, an increase of 22% from 3567 (2464 WTE) in September 1997 (Information Centre 2008e, 2010j). Of these, 910 (778 WTE) were consultants and 1028 (997 WTE) were in training in 2009, compared with 618 (489 WTE) and 741 (695 WTE), respectively, in 1997; this is an increase of 47% and 39%, respectively.

There was an increase of 36% from 1997 to 2009 in the number of dentists working on general dental services, personal dental services or trust-led dental services contracts in the community (16 470 to 22 003) (Information Centre 2006a, 2010k).[72] Over that same period, the resident population per dentist fell from 2955 to 2355. This is equivalent to an improvement from 0.36 dentists per 1000 resident population to 0.43. However, this overestimates the number of people for whom dentists are responsible. In 1997, just 54% of the resident population was registered with an NHS dentist; this had fallen to 49% by 2006. Therefore, the average list size for an NHS dentist fell from 1388 in 1997 to 1131 in 2006. However, registration is not part of the 2006 contract, hence this measure has been replaced by patients seen by an NHS dentist in the previous 24 months. The number of patients seen by an NHS dentist in England increased from 28.1 million (55.8% of the population) in March 2006 to 28.4 million (55.1% of the population) in March 2010 (Information Centre 2010k).

Comparative EU data (provided in section 5.2.1) on numbers of dentists per head of population by country suggest that the United Kingdom has considerably fewer than other EU countries. However, as noted there, these data suffer from significant differences in the way in which figures are recorded, the major ones being whether the private sector is included and whether dentists working in hospital are included: the United Kingdom data include neither whereas those of most other countries do.

The number of NHS dentists has always varied considerably across England, and this remains the case. In March 2010, in the South East Coast and London SHAs there were 0.5 dentists per 1000 population compared with 0.4 in the East Midlands and the West Midlands, a difference of around 25% (Information Centre 2010k). At the PCT level, differences are even greater: from 1.16 dentists per 1000 in the best-provided PCT to as low as 0.34 in the worst.

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[72] As the workforce definitions also changed considerably over this period, these figures are not wholly comparable.

Section 2.5.7 indicated that people in the United Kingdom in 2007 had a relatively poor view of access to dental care compared with other EU countries, with only 65% of people believing they have easy access compared with 92% in Sweden and Germany and 81% in France.

Charges for dental care

Charges for NHS dental care may potentially affect the ability of people to access services. Almost since its inception, there have been charges for NHS general dental care, although hospital and community dental services are free. Between 1996–1997 and 2008–2009, the amount collected in NHS dental charges increased from £383 million to £571 million (House of Commons Select Committee on Health 2010a; see also section 3.3.3).[73] However, a large part of the population is entitled to free care because of age or by being in receipt of one of the exempting benefits or tax credits; 48% of patients receive free care, which amounted to just over half of total care delivered in 2007–2008 according to a recent report (Steele et al. 2009). The remainder of the population receives subsidized care where prices are regulated within a national framework of patient charges with the following three charging bands for NHS dental treatment (in April 2010):

band 1: £16.50 includes examination, diagnosis (e.g. X-rays) and preventive care, plus, if required, scale and polish; urgent care also costs £16.50;

band 2: £45.60 includes all necessary treatment covered under band 1 plus additional treatment such as fillings, root canal work or extractions; and,

band 3: £198 includes all necessary treatment covered under band 2 plus more complex procedures such as crowns, dentures or bridges.

Of the total collected in charges in 2008–2009, 28% was to cover the cheapest activity level (band 1), 39% the next (band 2) and 28% the third (band 3), with the remaining 5% covering urgent care treatments (Information Centre 2009o).

Private dental care is usually paid for either through private insurance plans or through out-of-pocket payments. Insurance takes two basic forms: (1) dental capitation plans whereby individuals pay a fixed amount per year for either a basic package with an individual dentist that covers examination and hygiene but not restorative work or a package that also covers a range of treatments if required (e.g. fillings, crowns, etc.); and (2) dental insurance whereby individuals pay a fixed amount per year and their costs of treatment by any NHS or private dentist are covered up to an agreed level. Prices are not

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[73] In 2008–2009, this was 22% of the £2.57 billion total expenditure on general dental services.

regulated but are determined by the supplier. Data on the size of the private market are not readily available. The Office of Fair Trading (2003) reported that the market was worth over £1 billion in 2001 – an increase of 60% since 1997 – with around 7 million regular patients. Most practices provided both NHS and private care, with just 210 out of 11 000 being solely private in 2001. However, later estimates suggest that the total private dental market is worth some £3 billion per year and is at least equal to the value of the NHS dental market (House of Commons Select Committee on Health 2008a). There has been a large increase in the number of people with dental care insurance in the United Kingdom in recent years: by 2008, there were an estimated 3.4 million people insured at a cost of £543 million with 81.5% on dental capitation plans paying fees of £472 million and 18.5% having dental insurance paying £71.5 million[74] (Blackburn 2009).

Variations in access to services

Although the whole population is entitled to NHS dental treatment, in practice, people in many areas have found it increasingly difficult to obtain treatment from NHS dentists and, therefore, must rely on private dental treatment. Just under half the population of England was registered with an NHS dentist in March 2006: 45% of adults and 64% of children; this had fallen since 1997 when over 54% of the population was registered (Information Centre 2006a). Over the same period, between 1997 and 2006, the proportion of the population that had accessed NHS general dental services in the previous 12 months fell from 54% to 49%; for adults the fall was even greater, from 53% to 45% (House of Commons Select Committee on Health 2008a).

With the new contract removing the necessity to register, the Department of Health introduced a new measure of access. In the two-year period to March 2006, around 55.8% of the population had accessed NHS general dental services. By December 2007, this had fallen to 53.7% (House of Commons Select Committee on Health 2008a), and by March 2009, still only 53.8% of the population accessed general dental services in the previous two-year period (Information Centre 2009o). However, as with the number of NHS dentists, the proportion of the population that accesses NHS dental care varies considerably across England. For example, in March 2009 in the South Central SHA, just 45% of people had seen an NHS dentist in the previous two years compared with 61% in the North East SHA, a difference of nearly 35%. At the PCT level, differences are even greater, from 21% to 76% having seen an NHS dentist

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[74] Denplan is the largest private provider of dental care, with 1.9 million registered patients.

in the previous two years. Those areas with the greatest number of dentists per head of population do not necessarily correspond with those where the population makes most use of services (Information Centre 2009o).

The latest Adult Dental Health Survey in the United Kingdom, in 1998, indicated that 18% of adults received private dental care compared with just 6% in 1988. Again, there was considerable variation across the country, with 24% receiving private care in 1998 in the south of England, 9% in the north and 18% in the midlands (ONS 2000).

6.12.4 Quality of dental care

Quality of dental care is assured through a range of mechanisms. The GDC is the body responsible for regulation of dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists. PCTs are also required to monitor the quality of the services for which they contract. In addition, the CQC will be responsible for the regulation and inspection of all dental care providers – including NHS and private sector – as part of its general remit. Chapter 4 provides more detailed discussion of the role of regulators in general. As noted in section 2.5.7, in 2007, just 70% of people in the United Kingdom believed the quality of dental services was good, compared with 94% in Sweden, 93% in France and 88% in Germany.

GDC

The GDC maintains lists of professionals who are allowed to practise and also considers allegations of misconduct or unfitness to practise owing to ill health. Dentists and dental professionals have a responsibility through CPD to maintain and develop their knowledge and skills, and this is a requirement if they are to remain registered to practise. This process is driven by the GDC, which is also developing a revalidation process that includes compulsory CPD. The GDC has also produced guidance on what is expected of dental practice, providing principles and advice relating to good clinical care. In addition, the Dental Complaints Service, set up by the GDC in 2006, deals with complaints about private dental care services and can make recommendations regarding fee refunds or remedial treatment as well as changes in individual dental practice, although it has no formal powers to enforce recommendations.

Monitoring by PCTs

PCTs have a duty to improve the oral health of their populations and increase access to quality services (Department of Health 2009v). A key measure of access is the number of patients who have seen an NHS dentist in the previous two-year period, and all PCTs are assessed on this, taking performance at

31 March 2006 as a baseline. The Department of Health has also established a Clinical Effectiveness and Outcomes Group to develop quality indicators for dental pathways and dental health outcomes. In particular, indicators are being developed with respect to access; appropriate assessment of oral health; treatment and recall; and quality of outcomes. In addition, the Department of Health set up the Dental Access Programme, which has contributed to the development of key performance indicators as well as advising PCTs on procurement and contract management.

NHS Dental Services – part of the NHS Business Services Authority – has produced a set of measures of access, activity, quality and value for money known as Vital Signs (NHS Dental Services 2008). These are reported to PCTs, SHAs and the Department of Health on a quarterly basis at PCT and individual dental practice contract level. Access is again measured by proportion of patients who have seen an NHS dentist in the previous two-year period, differentiating between adults and children. Activity is measured as number of UDAs against the quantity commissioned. Gross and net projected expenditure compared with budget is taken as an indicator of value for money. The following quality measures have been developed.

1. Re-attendance within three months. The proportion of patients whose previous course of treatment ended three months or less prior to a new course of treatment is taken as a measure of poor care as a patient who has completed treatment, and hence is "dentally fit" would not be expected to require a consultation within three months.
2. Re-attendance between three and nine months. This may indicate recall of patients is too early.
3. Proportion of band 1 urgent attendances. This may indicate an issue with quality of diagnosis or treatment planning if it is high or it may indicate patients are not able to access urgent treatment if it is low.
4. Proportion of attendances scheduled where treatment was provided as a free repair or replacement item. A high level may indicate an issue with quality of treatment, while a low level may indicate an issue for patients being able to access this service.
5. Proportion of attendances scheduled where treatment was provided as a continuation[75] of a previous same or higher banded course of treatment. A high level may indicate an issue with diagnosis, planning or quality of treatment while a low level may indicate an issue for patients being able to access this service.

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[75] A continuation is where extra treatment is provided for a charge-paying patient within two months of completing a course of treatment.

6. Proportion of patients completely or fairly satisfied with their treatment.
7. Proportion of patients satisfied with the time they had to wait for an appointment.

The NHS Dental Service also provides a risk-based monitoring system known as the Dental Reference Service; PCTs can request the Dental Reference Service to visit a practice for the purpose of reviewing quality, resulting in a formal written report detailing the outcome of the review.

CQC

The CQC is responsible for regulation and inspection of all health care providers – including NHS, private sector and voluntary sector. By April 2011, both NHS and private-sector dental care providers must register with the CQC, demonstrating that they meet some common quality standards. A PCT or an acute NHS hospital providing dental care had to register by April 2010, and independent hospitals that provide dental care were required to register by October 2010. The CQC also monitors registered providers to ensure ongoing compliance with the conditions for regulation and 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 also undertakes reviews of service provision, pathways of care and particular themes, and publishes information on the quality of local health and adult social care services. However, dental care has not featured.

6.12.5 Prevention programmes

The importance of public health prevention programmes to the improvement of oral health is well recognized. The Department of Health noted the impact of a range of factors on oral health: poor diet and nutrition with excess consumption of sugar; poor oral hygiene; the positive impact of fluoridation of water; traumatic injury; and tobacco and alcohol consumption (Department of Health 2005i).

There have been major advances in the oral health of the population of England. In 1968, around 37% of the population had no teeth; by 1998 this had fallen to just 11%. Moreover, the oral health of younger people has improved considerably over the same period and on some measures it is the best in Europe. However, there are significant differences between the oral health of different social classes, among both adults and children. There remains much to do (Department of Health 2005i).

The widespread introduction and marketing of fluoride toothpaste in the 1970s was one of the main reasons for the improvement in oral health. Encouraging good dental hygiene and the use of fluoride, both in toothpaste and as a varnish applied to teeth, helps to prevent tooth decay. Fluoridation of water is another key factor. Currently, only 10% of the population in England receives fluoridated water. The Department of Health has required SHAs to encourage fluoridation and in February 2008 announced £14 million of funding for the following three years to allow the NHS to extend fluoridation of water, subject to consultation with local people (Department of Health 2008z).

The Steele report (Steele et al. 2009) re-emphasized the importance of prevention programmes, particularly fluoridation, as part of a coordinated public health approach to oral health. Also suggested were more active local programmes (i.e. at PCT level) to promote good oral health among local populations, encourage smoking cessation and improved diets, and to monitor behaviours such as regular brushing with fluoride toothpaste.

6.13 Complementary and alternative medicine

This section considers the use of CAM in England. CAM has been defined as a group of diverse medical and health care systems, practices and products that are not generally considered to be part of conventional medicine (National Center for Complementary and Alternative Medicine 2007). Complementary medicine is used alongside conventional medicine (e.g. acupuncture) whereas alternative medicine is used in place of conventional medicine (e.g. the use of herbal products to treat cancer rather than surgery, radiation or chemotherapy). Although scientific evidence exists regarding CAM therapies, for most, questions remain as to whether they are safe and whether they work for the diseases or medical conditions for which they are used.

CAM comprises a range of therapies including homeopathic medicine; naturopathic medicine; traditional Chinese medicine and Ayurveda; meditation, prayer and mental healing; use of natural substances such as herbs, minerals and nutrients (e.g. dietary supplements, herbal products, aromatherapy, shark's cartilage); chiropractic or osteopathic manipulation, and massage; and qi gong, reiki, therapeutic touch, acupuncture and electromagnetic-field-based therapies. A comprehensive list of CAM therapies is provided by the Cochrane Collaboration Complementary Medicine Field (Center for Integrative Medicine of the University of Maryland School of Medicine 2010). Manheimer & Berman (2008) provide a similar list together with a brief description.

Section 6.13.1 considers the development of government policy on CAM in England. Section 6.13.2 provides an overview of CAM services; this is followed by a discussion of access to services (section 6.13.3) and, finally, some discussion of the quality and regulation of CAM (section 6.13.4).

6.13.1 Policy on CAM

Various types of CAM have been available in England, predating the creation of the NHS in 1948. Increased use of CAM services in England led to government interest in regulating the way services are provided, as well as increased interest in the efficacy of various types of service. A House of Lords Select Committee report in 2000 considered use, regulation, training and research and NHS provision of CAM (House of Lords Committee on Science and Technology 2000). It found the evidence base for many therapies weak. The Committee recommended:

- strengthening of the regulatory framework to ensure practitioners are properly trained and supervised;
- therapies should be paid for by the NHS only if referred by an NHS GP and should be well-regulated;
- more information and guidance on CAM should be provided to the public; and
- there should be legislation to control the unregulated herbal sector.

Osteopathy and chiropractic manipulation had been regulated for some time and in 1999 were brought under the terms of the Health Act 1999 relating to regulation of health care and associated professions. The government accepted the House of Lords Select Committee's recommendation that acupuncture and herbal medicine should be similarly regulated, and a series of consultations to achieve this were initiated (Department of Health 2001k); eventually, the Department of Health set up a steering group in June 2006 to look into the statutory regulation of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systems (e.g. Ayurvedic medicine), with respect, in particular, to education and training, registration and fitness to practise (Department of Health 2008aa).

Around the same time, the government undertook a more general consultation into the regulation of doctors and nonmedical health care professionals (see section 4.1.4). In 2007, the government introduced a series of reforms of the regulation of health care professionals (Secretary of State for Health 2007) that were implemented in the Health and Social Care Act 2008. Key for the regulation of CAM was that statutory regulation of emerging professions should take place through existing regulatory bodies; in the case of CAM this would seem to be the Health Professions Council, and this was the recommendation of the Department of Health's steering group in what became known as the Pittilo Report (Department of Health 2008aa).

A further report looking more generally at regulation of health care professionals identified a range of options for regulation, including statutory, voluntary or mandatory self-regulation; light-touch or "buyer beware", which puts the onus on the consumer; and mandatory or voluntary licensing. The emphasis was on maintaining safe care for the public while ensuring regulation is proportionate to the risk of treatment (Extending Professional Regulation Working Group 2009). In July 2009, the Department of Health issued yet another consultation on the Pittilo recommendations to regulate acupuncture, herbal medicine and traditional Chinese medicine (Department of Health 2009w), which opened up some of the questions around the degree of regulation and how it should be achieved. However, at the time of writing, the results of the consultation are yet to be reported. More discussion of the regulation of individual therapies is provided in section 6.13.4 on mechanisms for assuring quality of care.

6.13.2 Organization of services

The major CAM services (by volume of consumption) are massage therapy, osteopathy, aromatherapy, chiropractic manipulation, homeopathy, reflexology, acupuncture and herbal medicine (Thomas & Coleman 2004). Most CAM services are provided by the private sector. Private therapists tend to operate independently, sometimes in shared facilities with other therapists; a small proportion work from GP practices or health centres. There are also independent specialist CAM centres that contract with the NHS as well as providing care to private patients (e.g. the Centre for Complementary and Integrated Medicine in Winchester, which provides homeopathy, acupuncture, herbal medicine and nutritional medicine). These centres often use staff trained in conventional medicine.

In addition, there are three NHS homeopathic hospitals in England:[76] the Royal London Hospital for Integrated Medicine (part of University College London Hospitals and until September 2010 known as the Royal London Homeopathic Hospital), Bristol (part of University Hospitals Bristol) and

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[76] The homeopathic hospital in Tunbridge Wells closed in 2009. There is also a homeopathic hospital in Scotland, the Glasgow Homoeopathic Hospital.

Liverpool Department of Homeopathic Medicine (part of Liverpool PCT). These facilities have been part of the NHS since 1948. The Royal London Homeopathic Hospital provides a range of CAM including homeopathy, acupuncture and chiropractic manipulation, and latest figures suggest it treated 33 000 NHS patients in 2007–2008. Bristol and Liverpool provide only homeopathy and treated 5000 and 7000 patients, respectively (British Homeopathic Society 2009).

People who access CAM services mostly self-refer. However, NHS GPs also refer patients to CAM practitioners, sometimes with the NHS paying for the consultation. A study in 1995 suggested 40% of GP practices provided access for their patients to some form of CAM (House of Lords Committee on Science and Technology 2000). CAM therapies funded by the NHS can be part of an integrated service provided in NHS hospitals by NHS-employed health care professionals, or they can be provided through NHS contracts with self-employed private practitioners: the latter are more common in primary care settings. There are many examples within the NHS where CAM therapies are provided as part of an integrated approach to cancer care and / or to end-of-life care, with over 50% of oncology departments and hospices offering five or more therapies, and around 33% of patients with cancer using some form of complementary therapy (NICE 2004b). However, a survey in 2004 found that only around 20% of women and 5% of men with cancer had tried complementary therapies (NAO 2005c).[77]

Staffing

There is no definitive measure of the total number of therapists in England. Difficulties arise because for many therapies there is no requirement to register and, moreover, therapists may practise several CAM therapies. In addition, often health care practitioners such as doctors, nurses and physiotherapists also provide some CAM services. Estimates in early 2000 in the United Kingdom varied from 30 000 to 60 000 CAM therapists; other estimates suggest the number increased from 13 500 to 40 000 between 1981 and 1997 (Andrews & Hammond 2004).

More recent figures for some professions are shown in Table 6.11. For osteopathy and chiropractic manipulation, these are fairly reliable figures of the number of people qualified to practise as professions these are regulated by statutory bodies. In 2009, there were 3577 registered osteopaths in England (4198 in the United Kingdom), and there were 2489 chiropractors in the United Kingdom. Since 2004, the number of registered chiropractors has increased

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[77] Provision and usage may be greater as these figures are based on relatively old research.

by almost 25%. The position for other therapists is less clear as membership is voluntary and there are often several professional bodies to which a therapist can belong. For example, the Association of Reflexologists had 7000 members in the United Kingdom in 2009; the British Acupuncture Council had 3000 members while the British Medical Acupuncture Society had 2700 members. There were 1500 members of the Society of Homeopaths and 1400 members of the Faculty of Homeopaths. In addition, according to the British Homeopathic Society, there are 400 GPs who provide homeopathic treatment to their patients, treating around 200 000 NHS patients a year. A survey of nurses in 2005 found 10% provided additional services such as complementary therapies, counselling and training (Ball & Pike 2005).

Table 6.11

Number of CAM staff in selected therapies, United Kingdom and England, 2009

	UK (England)	Source
Osteopathy	4 198 (3 577)	General Osteopathic Council
Chiropractic	2 489	General Chiropractic Council
Acupuncture	3 000	British Acupuncture Council
	2 700	British Medical Acupuncture Society
Homeopathy	1 500	Society of Homeopaths
	1 400	Faculty of Homeopathy
Reflexology	7 000	Association of Reflexologists

There are no definitive figures for the amount spent on CAM therapies in England. Recent estimates in 2009 suggested the value of the complementary medicines market in the United Kingdom was £213 million (Mintel 2009).

6.13.3 Access to CAM services

The extent of use of CAM services in England is not routinely collected; most figures quoted are estimates based on survey data and most of these are somewhat out of date. Nevertheless, this section provides some indication of access to services and how this varies across England.

A survey of the use of the main CAM therapies – acupuncture, chiropractic manipulation, homeopathy, medical herbalism and osteopathy – in England in 1998 found 10.6% of the population visited a therapist in the previous year, amounting to 22 million visits in total. If reflexology, aromatherapy and herbal and homeopathic remedies bought over the counter for self-administration were included, the proportion using CAM in the previous year was 28.3%. Moreover, 46.6% of people had used one of these in their lifetime. It was estimated that 10% of these 22 million contacts were provided through the NHS; the rest were mainly paid for out of pocket, at an estimated cost of £450 million per year (Thomas, Nicholl & Coleman 2001).

A survey of use of 23 named CAM therapies in 2001 covering England, Scotland and Wales similarly found 10% of people had received CAM therapy in the previous year, and 5% had used one of the five therapies: osteopathy, chiropractic manipulation, homeopathy, acupuncture and herbal medicine. Similar levels of use were found in each country. No individual therapy was used by more than 2% of the population. However, of individuals using CAM, most used more than one therapy in the year (Thomas & Coleman 2004).

It was estimated that just under 50% of NHS general practices in England in 2001 were providing access to CAM services, through their own primary care team (30%), referral to an NHS service (27%) or by contracting with an independent practitioner working in the practice (12%). However, often the range of services available was quite narrow: estimates for 2001 suggest that 34% of general practices offered provision or referral for acupuncture, 21% for homeopathy and 23% for osteopathy or chiropractic manipulation; some 43% of PCTs in 2004 offered some form of CAM (Smallwood 2005).

Access varies across England. In 2003–2004, PCTs in the London region provided access to the most CAM therapies (67 services in 31 PCTs), while PCTs in the Trent SHA provided least (8 services in 21 PCTs). In London, 87% of PCTs report some access to CAM therapies compared with just 52% in the northern regions. Moreover, the evidence suggests that many PCTs do not provide access to CAM services throughout the geographic area for which they are responsible: 61% in London compared with 29% in the South West SHA (Smallwood 2005).

Acupuncture was the most common therapy provided within the NHS (17%), followed by osteopathy (13%), homeopathy (12%), therapeutic massage (10%) and aromatherapy (10%). Most CAM services paid for by the NHS were provided by nonmedical complementary practitioners (54%), followed by GPs (18%), practice nurses (2%) and others (26%). In addition, the most common treatment setting for NHS CAM services was primary care (48%), followed by secondary care (28%) and others (24%): these are community-based settings including local community hospitals, hospices, and practitioners' own premises (Smallwood 2005).

Most private-sector access is paid for by individuals out of pocket, and hence is dependent on ability to pay. However, some CAM services are covered by PMI policies. Thus, the General Osteopathic Council found that 80% of osteopaths are funded privately; however 10.4% of funds for osteopathic services were provided by PMI: according to the Council, most PMI policies fund some osteopathy (General Osteopathic Council 2010). There is no systematic source of information on general coverage of CAM services by PMI.

6.13.4 Quality of services

As discussed above, two therapies are part of the statutory regulatory system: osteopaths are regulated by the General Osteopathic Council and chiropractors are regulated by the General Chiropractic Council. Although the Department of Health seemed to have decided on the statutory regulation of acupuncture, herbal medicine and traditional Chinese medicine, these matters remain undetermined.

So, unlike in most EU countries and the United States, there is largely no statutory regulation of CAM services in England (and the rest of the United Kingdom). Instead, CAM service providers have tended to set up professional bodies, with voluntary membership, setting standards for training, safe practice and professional conduct (Mills 2001). Therefore, most CAM providers remain subject only to the rules of their voluntary professional bodies. These may publish formal codes of ethics and practice, registers of their members and provide professional indemnity and public liability insurance; however, formal disciplinary codes, sanctions, procedures and published complaint procedures are not always clear. There has been a lack of consistency in voluntary standards.

To rectify this, the Department of Health supported the establishment of the Complementary and Natural Healthcare Council in January 2009, the purpose of which was to establish a voluntary register of CAM practitioners. The register now covers massage therapists and nutritional therapists, shiatsu, Alexander technique, aromatherapy, reflexology, yoga therapy, sports therapy, Bowen therapy and naturopathy. Individuals may choose to register with it but do not have to do so. It was intended to add other therapies in 2011, including cranial sacral therapy, healing, reiki, microsystems acupuncture and hypnotherapy.

Different issues arise when CAM is practised by regulated health care professionals (e.g. doctors, nurses, chiropodists), perhaps alongside their existing service. A House of Lords report in 2000 recommended that in such cases patients be treated to standards comparable to those set out for that particular therapy by the appropriate single CAM regulatory body (House of Lords Committee on Science and Technology 2000). The Nursing and Midwifery

Council has issued guidelines for nurses who provide complementary therapies. Similarly, members of the Faculty of Homeopathy are health care professionals who have completed postgraduate training in homeopathy. They are regulated by their relevant professional body (e.g. doctors by the GMC) and are required to abide by the code of conduct of their professional body. They are required to maintain their competencies in both their conventional and homeopathic training and practice to retain their membership of the Faculty of Homeopathy.

The regulation of sales of CAM is discussed in section 6.6.

7. Principal health care reforms

In 1997, a Labour Government came to power. Its manifesto had only made a commitment to reduce the number of people waiting for hospital treatment by 100 000. However, in its first health White Paper, *The New NHS: Modern, Dependable,* the government made it clear that it intended to reform the English NHS fundamentally (Department of Health 1997).

The reform programme that developed over the following 13 years proved to be massive in its scope. Nevertheless, some basic features of the English NHS remained unchanged over this period. It is still largely dependent on tax funding; responsibility for ensuring access to health care rests with central government and the public sector is still the main provider of care, although the private-sector role in provision has expanded. Access to non-emergency hospital care remains under the control of GPs and a distinction between purchasing/commissioning and provision, first introduced by the previous government, remains in force, although the nature of both the providing and the purchasing organizations has changed.

This chapter has three sections. Section 7.1 describes the national policy framework as developed between 1997 and 2010. Section 7.2 describes some of the policies that were directed at changing the way that services were delivered and the balance of care between different parts of the system. Finally, section 7.3 looks ahead to what the new government elected in 2010 might do.

Table 7.1 summarizes the main milestones in the development of the NHS from 1997 to mid 2010.

Table 7.1

Major NHS policy statements and reform measures, 1997–2010

	Reform/Policy Statement
1997	The Labour Government publishes its first health White Paper, *The New NHS: Modern, Dependable.* The NHS "internal market" is dismantled along with GP fundholding.
1998	The NHS Performance Assessment Framework is introduced. NHS Direct begins operation.
1999	NICE is established. CHI is established. CHI is reinvented as the Commission for Healthcare Improvement (known as the Healthcare Commission) in 2004. In April 2009 it was superseded by the CQC. The first NSF is published (on mental health). The White Paper *Saving Lives: Our Healthier Nation* is published. The Health Act 1999 introduces a duty of partnership for NHS and other health-related bodies. Health Improvement Programmes are introduced.
2000	The *NHS Plan* outlines significant and rapid funding increases that are unprecedented in the history of the NHS, with a focus on expanding NHS capacity and increasing staff numbers. It also outlines major principles for the NHS and sets out concrete quantitative targets (e.g. for waiting times) as the focus of the extra spending. A concordat is signed allowing greater use of private-sector providers to alleviate waiting lists and increase NHS capacity in the hospital sector.
2001	The NHS Modernisation Agency is established to support the NHS in modernizing services and improving experiences and outcomes for patients; this became the NHS Institute for Innovation and Improvement in 2005.
2002	SHAs are established (their number was reduced from 28 to 10 in 2006). PCTs are introduced to take over responsibility for commissioning all local health care services from health authorities (their number was subsequently reduced from 303 to 151). Patient choice of hospital is reintroduced initially on a pilot basis and subsequently universally. The process of commissioning independent-sector treatment centres and extra diagnostic facilities begins in order to provide more elective surgery in areas with long waiting lists.
2003	The Health and Social Care (Community and Health Standards) Act 2003 introduces a new form of organization for hospital services, known as FTs, which have greater autonomy than standard NHS trusts. PbR is introduced as a means of hospital payment. The Government publishes *Keeping the NHS Local – a New Direction of Travel,* outlining plans to alter the balance of care between hospital and community-based services.
2004	PBC is introduced to work in tandem with the commissioning functions of PCTs. Legislation opens the way for private companies to provide general medical services (i.e. GP and related services) and to increase the role of the voluntary and not-for-profit sector in the provision of health care. The *NHS Improvement Plan* is published: new waiting time targets are set.
2006	As the market in health care delivery develops, the Department of Health issues guidance on how services should be commissioned and how providers should behave. An updated set of guidance was issued in 2010. The White Paper *Our Health, Our Care, Our Say* and its implementation strategy are published, with a view to switching some hospital services to community settings.
2007	The Local Government and Public Involvement in Health Act 2007 creates a requirement for a joint needs assessment between health and local authorities. The World Class Commissioning framework is established, along with a Commissioning Framework for Health and Well-Being, which outline effective joint commissioning of services by health and local authorities. NHS Choices is launched as part of the NHS website. The new Mental Health Act is passed, aimed at safeguarding the rights of individuals with mental health problems. The White Paper *Trust, Assurance and Safety: Regulation of Health Professionals* is published.

	Reform/Policy Statement
2008	The Darzi report, *High Quality Care for All,* is published, indicating, among other things, that NICE would be asked to develop a comprehensive set of guidelines for all services, complementing the coverage provided by NSFs. The Government announces that each PCT must establish at least one health centre in which both primary and secondary care services are available.
2009	The NHS Constitution is published and the accompanying Handbook sets out a number of pledges regarding waiting times. The Government's commitment to greater use of the private sector appears to wane as an intention to give NHS facilities "preferred provider" status is announced. In addition to its performance monitoring role, the CQC is given a new power to license all providers, both public and private, and including primary care providers as well as hospitals.
2010	The new Conservative Liberal Democrat Coalition Government publishes a White Paper that signals major reforms ahead, as well as an intention to reduce the number of arm's-length bodies in the health sector.

7.1 National policy framework

This section describes the development of policy in England since 1997, first between 1997 and 2000, then from 2000 to 2007 and, finally, from 2007 until the general election in May 2010.

7.1.1 Abandoning the market, 1997–2000

The Labour Government's first step was a negative one. The White Paper *The New NHS: Modern, Dependable* announced its intention to undo, at least in part, the major reforms introduced by its predecessor. In particular, it rejected the notion of a market in health care, which the earlier reforms had attempted to create, on the grounds that it wasted resources on unnecessary administration and diverted the NHS from "properly focusing on the needs of patients" (Department of Health 1997). In its place, it promised what it termed "integrated care, based on partnership and driven by performance", rejecting both the "command and control system" of the 1970s and the market system of the 1990s. As shown below, it subsequently came to adopt both these alternatives.

The new system was based on six principles (Department of Health 1997).

1. To renew the NHS as a genuinely national service with patients getting fair access to consistently high quality, prompt and accessible services throughout the country.
2. To make the delivery of health care against new national standards a matter of local responsibility.

3. To get the NHS to work in partnership by breaking down organizational barriers and forging stronger links with local authorities.
4. To drive efficiency through a more rigorous approach to performance and by cutting bureaucracy.
5. To shift the focus onto quality of care so that excellence is guaranteed to all patients, and quality becomes the driving force for decision-making at every level of the service.
6. To rebuild public confidence in the NHS as a public service, accountable to patients, open to the public and shaped by their views.

By aiming to ensure that the NHS provided "fair access to consistently high quality, prompt and accessible services" (principle 1) the government acknowledged that, in 1997, patients often had to wait a long time to be treated, that quality was sometimes poor and that, while the NHS was nominally a national service, in practice, standards varied widely from one part of the country to another. By identifying the need to improve performance (principle 4), it acknowledged that the resources available for health care would always be competing with other uses of public funds and hence there was need to demonstrate they were being used effectively. Principle 5 acknowledged that the quality of care in the NHS had sometimes been poor and so standards generally had to be raised.

Principles 2 and 3 reflected the government's new "vision" of how the NHS should be run: that change should be driven by clinicians with the needs of the patient paramount. Finally, principle 6 recognized that, although as a public service the NHS was nominally accountable to parliament, in practice, most of the activities of the NHS were not systematically scrutinized.

In addition, the government sought to create closer working relationships with local authorities. In rejecting the internal market established by the previous Conservative Government, the Labour Government offered in its place a system based on joint planning at local level. Arguing that the old arrangements had encouraged fragmentation, it proposed (Department of Health 1997) that:

> To overcome this fragmentation, in the new NHS all those charged with planning and providing health and social care services for patients will work to a jointly agreed local Health Improvement Programme. This will govern the actions of all the parts of the local NHS to ensure consistency and coordination. It will also make clear the responsibilities of the NHS and local authorities for working together to improve health.

The White Paper went on to introduce a duty of partnership:

> To give substance to the cooperation necessary to bring about improvements in health there will be a new statutory duty of partnership placed on local NHS bodies to work together for the common good. The Government intends to place on Local Authorities a duty to promote the economic, social and environmental well being of their areas.

The duty of partnership was brought in by the Health Act 1999. In the same year, Health Improvement Programmes were introduced. These were intended to provide the focus for agreeing local health strategies, joint investment plans and better links between health and social care at an operational level. New flexibilities were introduced over budgets, commissioning and provision, designed to reduce the barriers created by the continuing separation of responsibilities for health and social care.

Subsequently, a number of further initiatives were taken designed to promote cooperation between health and local authorities. PCTs were charged with improving links between health and the policy areas for which local authorities were responsible, including not only social care but also children's services, public safety and regeneration. After this, the Local Government and Public Involvement in Health Act 2007 created a requirement for a joint needs assessment between health and local authorities, and a Commissioning Framework for Health and Well-Being was introduced that set out the steps health and local authorities should take to commission services more effectively together (Department of Health 2007t).

The White Paper announced a large number of policies designed to promote its objectives. Some of these policies were subsequently abandoned or radically changed. Others have remained in place up to the present day. Yet others have been "recycled" in a different form. The main enduring changes announced by the White Paper were:

- the introduction of NSFs "to help ensure consistent access to services and quality of care right across the country";
- the establishment of NICE "to give a strong lead on clinical and cost-effectiveness, drawing up new guidelines and ensuring they reach all parts of the health service"; and
- the establishment of CHI "to support and oversee the quality of clinical services at local level, and to tackle shortcomings".

NSFs

NSFs were intended to:

- set national standards and define service models for a specific service or care group;
- put in place programmes to support implementation; and
- establish performance measures against which progress within an agreed time scale would be measured.

A subsequent White Paper, *A First Class Service: Quality in the New NHS* (Department of Health 1998d), stated that: "Each National Service Framework will set out where care is best provided and the standard of care that patients should be offered in each setting". The concept of an NSF derived from an earlier report on cancer services. This defined three levels of care needed to provide high-quality, comprehensive cancer services throughout the country: primary care, to provide appropriate referral and follow-up care for cancer patients; designated cancer units in many district general hospitals to support clinical teams with facilities and expertise to manage the commoner cancers; and designated cancer centres in regional hospital centres to provide expertise in the management of all cancers for local patients and of the less common cancers as referral centres, and to provide specialist support services, such as radiotherapy, for cancer units (Department of Health and Welsh Office 1995). The development of NSFs is described in more detail below.

NICE

The establishment of NICE was also intended to raise care standards. According to *A First Class Service* (Department of Health 1998d):

> By establishing NICE, the Government will take responsibility for helping to clarify, both for patients and professionals, which treatments work best for which patients and those which do not. For the first time in the history of the NHS the Government, working with clinical bodies, will systematically appraise medical interventions before these are introduced into the NHS. Clear, authoritative, guidance on clinical and cost-effectiveness will be offered to front line clinicians.

As this extract shows, the government's intention was to ensure treatment decisions were based on the best clinical evidence available. To this end, NICE has published guidelines, based on systematic reviews of the available evidence, on the use of particular medicines or other forms of treatment and on the way that services for a particular user group should be designed. The aim of the second of these roles is close to that of NSFs: however, initially, neither NICE nor the Department of Health took active steps, as they did with NSFs, to promote the implementation of NICE guidelines. The role of NICE was extended in 2005 to include the publication of guidance on the promotion of good health and the prevention of ill health (covered in more detail in section 4.1.3).

In some instances, NICE concluded that certain drugs should not be available on the NHS – or only in restricted circumstances. Out of 370 technology appraisal recommendations between March 2001 and July 2010, 39 were refusals, 24 were assessed as being appropriately used only in a research context and a further 62 were approved but with conditions attached to their use; 247 were approved without any form of condition (NICE 2010).

Clinical governance and CHI

The government's third innovation was to establish a system, within each NHS provider, for ensuring that clinical decisions were soundly based through a process known as clinical governance. A new duty, parallel to that for finance, was created for the chief executives of NHS trusts to ensure the quality of care that their trusts provided.

According to *A First Class Service* (Department of Health 1998d):

> For the first time, the NHS will be required to adopt a structured and coherent approach to clinical quality, placing duties and expectations on local health care organisations as well as individuals. Effective clinical governance will make it clear that quality is everybody's business.

To oversee and support the introduction of clinical governance, the White Paper proposed that CHI should be established. This was to:

- provide national leadership to develop and disseminate clinical governance principles;
- independently scrutinize local clinical governance arrangements to support, promote and deliver high-quality services, through a rolling programme of local reviews of service providers;
- undertake a programme of service reviews to monitor national implementation of NSFs, and review progress locally on implementation of these frameworks and NICE guidance;
- help the NHS to identify and tackle serious or persistent clinical problems, with CHI having the capacity for rapid investigation and intervention to help put these right; and
- over time, increasingly take on responsibility for overseeing and assisting with external incident inquiries.

The role of CHI gradually extended over time (and its name and scope changed, see section 4.1.3 for more detail) but its establishment meant that for the first time all NHS provider and purchaser organizations were subject to systematic external review on clinical as well as financial performance. Prior to this, internal NHS review processes introduced in the 1980s were in use. Department of Health officials examined the performance of regional bodies, and the regional bodies that of district bodies and hospitals. The performance of local health authorities was compared using a range of performance indicators, such as throughput, length of stay and day-case rate.[1] NHS performance was already monitored by a number of other bodies including the NAO, which reported to parliament, the Audit Commission, the National Confidential Enquiry into Perioperative Deaths, run by the Royal College of Surgeons, and the Clinical Standards Advisory Group. However, all of these looked at specific clinical topics. Financial issues apart, none of these monitored the overall performance of NHS providers or purchasers.

The role of CHI was complemented by The NHS Performance Assessment Framework introduced at the same time (Department of Health 1998d) and revised following consultation in 1999 (Department of Health 1999d). Prior to this, a large number of performance indicators bearing on specific activities were available and a crude activity measure covering the bulk of the NHS budget was regularly published; so too, following the introduction of maximum waiting time targets in the 1990s, were data relating to waiting times and waiting lists for hospital treatment.

The NHS Performance Assessment Framework (Department of Health 1998d) introduced six dimensions against which performance would be assessed:

- health improvement
- fair access
- effective delivery of appropriate health care
- efficiency
- patient and carer experience
- health outcomes of NHS care.

The implementation of the framework required a series of indicators against which performance could be assessed. Examples relating to patient and carer experience of the NHS include:

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[1] In 1987 there were around 2500 such indicators (Mannion et al. 2010).

- patients who wait more than two hours for emergency admission
- patients with an operation cancelled for nonmedical reasons on the day of, or after, admission
- delayed discharge from hospital for people aged over 75 years
- first outpatient appointment for which the patient did not attend
- outpatients seen within 13 weeks of referral
- proportion of those on a waiting list waiting 12 months or more.

The intention was that local health authorities and NHS trusts would use the Framework to monitor service delivery against plans for improvement across the six areas and that government ministers and the NHS Executive would use it to assess the performance of the NHS as a whole and account for the use of public resources. The role of CHI was to carry out local reviews to check that systems to monitor, assure and improve clinical quality were in place and to address poor performance (Department of Health 1998d).

7.1.2 More financial and physical resources, 2000–2007

These new initiatives gave a clear indication of the government's intention to improve NHS performance, particularly in respect of the quality of care. But they were supported by only a modest increase in total NHS spending between 1997 and 2000. In 2000, the government concluded that significant improvements in NHS services required a rapid and substantial increase in the NHS budget. It was apparent that in some areas, such as cancer care, the NHS lagged far behind other countries. The government, therefore, issued the *NHS Plan* (Department of Health 2000a), stating:

> To tackle these problems, the government has decided to make an historic commitment to increase the funding of the NHS over the next four years. The Prime Minister's announcement in March of large, sustained investment in the NHS provides the funding that doctors, nurses, dentists, therapists, managers and other staff have called for over the years.

When the Prime Minister announced that the NHS budget would be rapidly increased, he stated that spending on the NHS should be increased up to the level of the EU average at the time. To do this required an extra 2% of GDP to be devoted to the NHS, an unprecedented increase.

The *NHS Plan* (Department of Health 2000a) set out 10 new principles on which future health policy was to be based.

1. The NHS will provide a universal service for all based on clinical need, not ability to pay.
2. The NHS will provide a comprehensive range of services.
3. The NHS will shape its services around the needs and preferences of individual patients, their families and carers.
4. The NHS will respond to different needs of different populations.
5. The NHS will work continuously to improve quality services and to minimize errors.
6. The NHS will support and value its staff.
7. Public funds for health care will be devoted solely to NHS patients.
8. The NHS will work together with others to ensure a seamless service for patients.
9. The NHS will help to keep people healthy and work to reduce health inequalities.
10. The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

These principles, however, did little to indicate what specific policies the government was to pursue. But in other respects, the *NHS Plan* was very specific: it set out quantitative targets for where the extra cash would be used. These were:

- 7000 extra beds in hospitals and intermediate care
- over 100 new hospitals by 2010 and 500 new one-stop primary care centres
- over 3000 GP premises modernized and 250 new scanners
- clean wards – overseen by “modern matrons” – and better hospital food
- modern IT systems in every hospital and GP surgery
- 7500 more consultants and 2000 more GPs
- 20 000 extra nurses and 6500 extra therapists
- 1000 more medical school places
- child care support for NHS staff, with 100 on-site nurseries.

These physical targets were largely met within the time scale set for each, and hence the NHS's capacity to treat expanded rapidly from 2000 onwards. The next issue the government faced was how to ensure that the extra resources would be deployed effectively.

The very notion of an *NHS Plan* implied a large degree of central direction, and over the years following its publication, there remained a strong central drive to determine where the extra resources should be used. The most obvious sign of this was the introduction of nationally determined targets. The previous Conservative Government had set targets for waiting times and for health improvement. The waiting time targets were not very demanding and those set for health improvement were not rigorously enforced. The key changes made by the Labour Government were the introduction of many more targets, some of them very demanding, and a management performance regime, implemented by the regional arms of the Department of Health, designed to ensure they were met.

The initial set of national aims and targets was:

- to reduce the maximum wait for an outpatient appointment to three months and the maximum wait for inpatient treatment to six months by the end of 2005;
- to ensure that patients receive treatment at a time that suits them in accordance with their clinical need: two-thirds of all outpatient appointments and inpatient elective admissions would be pre-booked by 2003–2004 on the way to 100% pre-booking by 2005;
- to guarantee access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004;
- to secure year-on-year improvements in patient satisfaction, including standards of cleanliness and food as measured by independently audited surveys;
- to reduce substantially the mortality rates from major killers by 2010; from heart disease by at least 40% in people aged under 75; from cancer by at least 20% in people aged under 75; and from suicide and undetermined injury by at least 20%;
- to narrow the health gap in childhood and throughout life between socioeconomic groups and between the most deprived areas and the rest of the country, with specific national targets to be developed with stakeholders and experts early in 2001; and

- to reduce treatment costs to the level of the best (i.e. lowest) over five years, with agreed milestones for 2003–2004.

These national targets, however, represented only the "tip of the iceberg" of central direction. The NSFs, as they developed, set standards for each service; examples include specified increases in the volume of activity for treatment of heart disease and tougher waiting time targets for cancer.

In addition, new targets were brought in as new problems emerged. For example, patient safety did not feature in the 1997 White Paper but from 1999 onwards, reducing the risks to patients from treatment, particularly in hospitals, became the subject of a number of policy initiatives and national targets. In 2001, a new body, the NPSA, was established tasked with promoting patient safety across the NHS (see section 4.1.3) and targets were introduced for what was then perceived as the most serious risk: hospital-acquired infections.

The Department of Health continued to set national targets that "have to be met" right up to 2010.[2] The set published in the NHS Operating Framework for 2009–2010 (Department of Health 2008h), and repeated in the 2010–2011 Framework (Department of Health 2009h), was as follows:

- improving cleanliness and reducing health care-associated infections;
- improving access through achievement of the 18-week referral to treatment pledge and improving access (including at evenings and weekends) to GP services;
- keeping adults and children well, improving their health and reducing health inequalities;
- improving patient experience, staff satisfaction, and engagement; and
- preparing to respond in a state of emergency such as an outbreak of pandemic flu, learning from our experience of swine flu.

Although this list is much shorter than the original set, the influence of the Department of Health still remains strong throughout the NHS, much greater than this short list suggests.

Towards a new framework

Even while central direction was growing in the light of the *NHS Plan* (Department of Health 2000a), a quite different policy also started to emerge involving the devolution of decision-making away from the centre. In the words

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[2] These reflected the Department of Health's PSA targets agreed with the Treasury (see section 4.2.1).

of the *NHS Plan*: “The centre will not try and take every last decision. There will be progressively less central control and progressively more devolution as standards improve and modernisation takes hold”.

In the years immediately following the publication of the *NHS Plan*, these words rang hollow. The targets set in the Plan dominated the agenda of the local NHS. Gradually however, and despite the persistence of strong central direction, over the following years a number of reforms were introduced that were designed to allow greater freedom to local health services to make their choices over the allocation of health resources and also to give patients a greater degree of choice and control over their care.

The 1997 White Paper *The New NHS: Modern, Dependable* (Department of Health 1997) had explicitly rejected the internal market introduced by its predecessor, describing it as a “misconceived attempt to tackle the pressures facing the NHS”. The government initially emphasized patient choice and the need to expand capacity to meet waiting time targets, rather than provider competition, but in practice its reforms led to the creation of a market in health care, particularly for elective care, involving both NHS and private-sector providers, with users gaining some of the rights associated with “customers” rather than patients.

The main elements of the new framework were:

- demand-side reforms: strengthening local purchasers (commissioners) and giving users choice and rights;
- supply-side reforms: reductions in controls on providers, and the introduction of new providers;
- transactional reforms: primarily financial reforms (i.e. new payments systems) but also new contractual arrangements; and
- system management reforms: expansion of the role of independent regulators.

Demand-side reforms

The previous Conservative Government had introduced for the first time in the English NHS a distinction between providing and purchasing, as part of the reforms established by the National Health Service and Community Care Act 1990, required to create an internal market within the NHS. The main purchasers were the local health authorities, but GPs, singly or in groups, could also choose to purchase care – mainly elective procedures – on behalf of their patients, an arrangement known as GP fundholding. Not all GPs chose to do so (see section 2.2).

Commissioning services

The 1997 White Paper indicated that the government intended to abolish GP fundholding on the grounds that it was inequitable. There was some evidence that it had enabled fundholders to get more rapid access for their patients: while to some that might seem to suggest it was effective, to the Labour Government, it "created unfairness" (Department of Health 1997). However, the government did preserve the purchasing role, but in a different form. The Department of Health (1997) announced:

> Health Authorities will devolve responsibility for direct commissioning of services to new Primary Care Groups as soon as they are able to take on this task. Such an approach provides a "third way" between stifling top-down command and control on the one hand, and a random and wasteful grass roots free-for-all on the other.

It took a number of reorganizations for the structure of purchasing to be settled in its present form (as of May 2010). The key change from the original Labour plans was the abolition of health authorities and the creation of PCTs (Department of Health 2001b) with the following remit:

> PCTs will have a clear lead in developing local services and will be able to tailor services to local needs. If this is to be achieved successfully PCTs will need to fully engage their frontline staff and local communities and partners in their plans for improving health and health services. The opportunity for PCTs as primarily local organisations to engage and empower local communities, patients and frontline staff should bring improvements in local services.

There were 151 PCTs in England at the time of the 2010 election, with an average population of just over 340 000, about half the number originally created. Around 70% of these were coterminous with local authorities that have social service responsibilities, which it was hoped would facilitate joint planning.

As noted above, the government abolished GP fundholding, but it still wished to engage GPs in purchasing. In 2004, it launched PBC. This was intended to engage all GP practices and other primary care professionals in the commissioning of services, or to provide feedback on the commissioning decisions of PCTs (Department of Health 2004p). In principle, PBC provides a framework that local clinicians, mainly GPs, can use to:

- develop a greater range of more integrated services in community settings, designed around the needs of individuals;
- secure greater investment in upstream interventions that keep people healthy for longer, prevent ill health and reduce health inequalities; and

- drive continuous quality improvement and innovation across the whole system, securing better value for money in the process.

PCTs remained the budget-holders with overall accountability for health care commissioning. However, PCTs and practice-based commissioners were expected to work together (Department of Health 2009x):

> PCT commissioning and PBC should form part of an integrated system where the health investment plans for the wider population dovetail with the health investment plans for local practice populations. The most successful PCTs will secure high-quality care by focusing on strategic outcomes and being able to devolve increasing responsibility to clinicians to achieve these outcomes. The most successful PBCs will inform, influence and complement the strategic direction of PCTs and be an integral part of world class commissioning.

Despite the rhetoric relating to purchasing, evidence of its impact during the 1990s and into the next decade was very limited. The creation of PCTs and the subsequent reduction in their number was intended to strengthen commissioning in the belief that larger organizations would have more intellectual and financial clout and hence more influence over provider behaviour. However, the government realized that more needed to be done and, therefore, it introduced in 2007 what it termed World Class Commissioning, in recognition of the fact that the PCTs had not, up to that point, played a significant role in determining the allocation of resources (Department of Health 2007u).

The vision for World Class Commissioning (Department of Health 2007u) was expressed in terms of 11 areas where PCTs should be able to demonstrate competence:

- locally lead the NHS
- work with community partners
- engage with public and patients
- collaborate with clinicians
- manage knowledge and assess needs
- prioritize investment
- stimulate the market
- promote improvement and innovation
- secure procurement skills
- manage the local health system
- make sound financial investments.

The 1997 White Paper had recognized that it was not appropriate for health authorities, covering relatively small populations, to purchase services such as heart transplants, which are available in only a few hospitals. Reviews carried out in the 1990s had shown that some parts of the country were not well provided. In 1999, the government established national commissioning arrangements to ensure that all parts of the country had access to services of this kind, but subsequently responsibility was handed to PCTs. However, this change was found to have been unsuccessful so new commissioning arrangements were introduced. Under these, services for client groups with very small numbers were commissioned by a National Commissioning Group and others by SHAs (see section 6.4 for further detail).

User choice and rights

The 1997 White Paper and the *NHS Plan* both sought to put users at the centre of the NHS. The main proposals in the White Paper concentrated on speedier access to services, including the establishment of a 24-hour telephone advice line, NHS Direct. Over time, however, a number of proposals were introduced that were designed to support patients in making choices about their treatment, to give them explicit rights and to enable them to care for themselves. These reforms, in effect, allocated part of the purchasing role to individuals.

Patient choice. Patients had enjoyed choice of hospital prior to the reforms of the 1990s but ironically those reforms had made it harder for patients to be treated away from their local hospital. From 2002 onwards, the government resurrected patient choice of hospital (section 2.5.3 discusses the development of patient choice).

Information. A number of initiatives were taken to improve the information available to patients. These included requiring NHS providers to publish information about the services they offered and the creation of a web site, NHS Choices. NHS Choices contains clinical information, information on NHS services available in each part of the country and many other health-related topics, including briefings and advice on clinical issues (see section 2.5.2).

Patient rights. Unlike insurance-based systems in other countries, the NHS has defined neither the package of services that it should provide nor the service "contract" it has with its users. From the outset of the NHS, all citizens enjoyed a right to be registered with a GP. They could also access emergency care whenever needed. Further rights, expressed in terms of target times relating to access, had been introduced by the Conservative Government prior to 1997. As noted above, the Labour

Government introduced more targets and extended the scope of patient choice. Formally, none of these created rights: that is, failure to deliver did not create a "right of redress". Subsequently, in 2009, patient rights were systematically set down, for the first time, in the NHS Constitution (see section 2.5.1 for more detail). These rights contained little that was new. However, the *Handbook to the NHS Constitution* set out a series of pledges relating to waiting times for cancer treatment, waiting times in A&E, speed of emergency ambulance response and access to various services, including GPs, revascularization and chest pain clinics (Department of Health 2010f).

Self-care. NHS Direct was set up in 1998 to offer advice to patients to enable them to self-care or, if necessary, advise them to seek professional help. This service was directed at "one-off" incidents. Other self-help initiatives have been targeted at people with chronic conditions with the aim of enabling them to care for themselves. The most prominent was the Expert Patient Programme (Department of Health 2001l) originally announced in the 1999 White Paper *Saving Lives: Our Healthier Nation* (Department of Health 1999e) and in the *NHS Plan*. This introduced for the first time at national level support for people with long-term conditions to enable them to "self-manage" after suitable training. The programme was subsequently handed over to a community interest (i.e. not-for-profit) company to promote and extend it.

Supply-side reforms

The National Health Service and Community Care Act 1990 had provided for the creation of provider trusts for hospitals and community services other than general practice. Up to that point, hospitals had been administered by district health authorities. Under the new arrangement, trusts enjoyed some degree of independence from NHS central, regional or local management. They had their own board of directors, accounts and financial responsibilities and, in principle, were free to see patients from any part of the country. By the end of the 1990s, most hospital, mental health and community services (other than GPs) were provided by trusts as opposed to directly managed units (i.e. units that were the responsibility of health authorities).

The Health and Social Care (Community and Health Standards) Act 2003 provided for a new form of organization for hospital services, known as FTs. These FTs enjoy greater scope for raising funds for capital investment than NHS trusts. They also enjoy freedom from direct control by the Secretary of State for Health. Instead they are formally accountable to their local population.

However, they remain subject to national targets and their performance is closely watched by their own regulator, Monitor. The regulator can intervene if financial performance is poor. Monitor also has the role of deciding which NHS trusts are suitable to be given foundation status (see section 4.1.3).

When PCTs were created they were given responsibility for community-based services – in other words, at that time, the purchaser–provider split was not applied to these services. By 2009, however, they were required to ensure that, at a minimum, there was clear arm's-length separation between the PCT commissioning function and these provider services. In some cases, these services amalgamated with NHS trusts or FTs. In others, new organizations have been established. In principle, therefore, community services can form part of the market for health care services (see section 4.1.1).

New providers

The NHS has always made some use of private-sector providers, most recently to help meet waiting time targets or to provide community services (e.g. for those with mental health problems). In the *NHS Plan* (Department of Health 2000a), the government stated its intention to reach a concordat with the private sector:

> Public funding for the NHS will increase substantially over the next four years. The private and voluntary sectors have a role to play in ensuring that NHS patients get the full benefit from this extra investment. By constructing the right partnerships the NHS can harness the capacity of private and voluntary providers to treat more NHS patients.

Subsequently, a concordat was signed (Department of Health and Independent Healthcare Association 2000) covering three areas:

elective care: for example, allowing NHS doctors and nurses to use operating theatres and facilities in private hospitals, or the NHS to buy certain services from the private sector;

critical care: for example, allowing the NHS and the private sector to be able to transfer patients to and from each other whenever clinically appropriate; and

intermediate care: for example, allowing the private and voluntary sectors to develop and make available facilities to support the government's strategy for better preventive and rehabilitation services.

From 2002 onwards, however, the government began actively to encourage the development of private-sector capacity. Initially claiming this would support achievement of the waiting time targets, it began a process of commissioning extra capacity for treatment of elective patients and diagnostics from private-sector suppliers in any part of the EEA. As a result of this and subsequent rounds, a number of ISTCs (and similar facilities for diagnostics) were established to provide elective operations such as cataract removal, hip and knee joint replacement and heart surgery, where waiting lists and waiting times had been long (see section 6.4.1).

In 2004, the government introduced legislation that opened the way for private companies to provide general medical services (i.e. GP and related services). In addition, as part of a government-wide initiative to involve the voluntary and not-for-profit sectors in the provision of public services, measures were taken to increase their role in health care. For example, the Social Enterprise Investment Fund was set up in 2007 as part of the government's plans for stimulating expansion in the role of social enterprise in the provision of health and social care.

Despite this commitment to opening up the NHS to "any willing providers", by late 2009 the government appeared to be backing off from this apparent desire to introduce market forces into the NHS. The then Secretary of State for Health indicated that existing NHS services should have "preferred provider" status – effectively ruling out competitive tendering for services unless NHS performance was poor. However, the implementation of this policy was interrupted by the general election in May 2010.

Transactional reforms

The introduction of patient choice required the introduction of a new mechanism for paying hospitals. From the 1990s onwards, purchasers contracted with hospitals for their services, but typically in a block form (i.e. for a whole service). From 2003–2004 onwards, a system known as PbR was introduced, which operated at the level of the individual operation as did activity-based systems used in other countries. Prices are set in a national tariff determined by the Department of Health. Initially the tariff focused on elective care, but over time its scope was developed to include a greater proportion of hospital services and it was always intended to extend it to community health care services.

The tariff has been seen as a tool to promote a number of objectives. It was initially set at the average cost of each treatment at NHS hospitals. However, the annual uplift of the tariff (the increase in prices) has been kept below the expected rate of inflation in order to compel providers to reduce their costs. In addition, modifications have been introduced to reward providers for improvements in quality and patient experience (see section 3.6.1 for more detail on PbR).

System management reforms

A key element in the government's plan to reduce the central role was to create new organizations independent of the Department of Health that could monitor performance and take action if poor performance was identified. Explicit, albeit general, standards were introduced against which performance could be judged, and rules were introduced defining how commissioners and providers should behave within a market context.

Regulation

As noted above, prior to 1997, review of NHS performance was mainly an internal process with varying numbers of indicators used for the task. There was no external body responsible for systematic and regular monitoring of health care – except financial stability – against agreed standards of service quality, and for publishing the results. One exception was mental health. The Mental Health Commission established in 1983 did regularly monitor standards of mental health care and had the power to close down unsatisfactory services.

Also, as noted above, the 1997 White Paper provided for the establishment of CHI. This subsequently became the Healthcare Commission and, in 2009, the CQC. The Healthcare Commission introduced what was termed "star ratings" to assess the performance of trusts. It also conducted studies of particular services and regularly reported on the NHS as a whole. Where very poor performance was detected, it could intervene. It also published annual reviews of performance across the NHS as a whole, and in particular, of services such as maternity care.

The CQC was given a new power, to license all providers, both public and private, including primary care providers as well as hospitals. However, it continues to discharge the monitoring role of the Healthcare Commission, intervening where poor performance has been detected. (Chapter 4 has a more detailed discussion of the role of the regulators.)

Setting standards

In 2004, following publication of the *NHS Improvement Plan* (Department of Health 2004i), the Department of Health published proposals for what the 1997 White Paper had termed a "standards driven system". The aim was to move away from a system based on national targets to one in which (Department of Health 2004q):

- standards are the main driver for continuous improvements in quality
- there are fewer national targets
- there is greater scope for addressing local priorities

- incentives are in place to support this system
- all organizations locally play their part in service modernization.

Two types of standard were defined:

- *core standards:* which bring together and rationalize existing requirements for the health service, setting out the minimum level of service patients and service users have a right to expect; and
- *developmental standards:* which signal the direction of travel and provide a framework for NHS bodies to plan the delivery of services that continue to improve in line with increasing patient expectations.

The core standards cover the following areas:

- safety
- clinical and cost-effectiveness
- governance
- patient focus
- accessible and responsive care
- care environment and amenities
- public health.

Core standards were expressed in general terms, leaving it to the regulator (at that time the Healthcare Commission) to determine how adherence to the standards was to be determined.

System management

By 2006, the elements of a market in health care delivery were in place. The Department of Health, therefore, issued guidance on how services should be commissioned and how providers should behave (Department of Health 2008bb). An updated set of guidance was issued in 2010. These rules were designed to promote competition but at the same time not destroy cooperative behaviour of the kind required to make care networks, such as those introduced for cancer care, work. In 2008, the Department of Health also established the Co-operation and Competition Panel to advise on the implementation of the rules in particular cases (e.g. when trusts wish to merge or wish to take over a primary care provider) (Department of Health 2008bb). The Panel made independent recommendations to the Department of Health, SHAs and Monitor, on how cases should be resolved. By 2010, it had supported the merger of a small number of hospital trusts with GP and other community services.

However, the Department of Health (along with SHAs) remained the main system manager. In particular, it determined the level and structure of the national tariff and other financial rules (e.g. those determining the financial duties of NHS trusts): Monitor is responsible for those relating to FTs.

7.1.3 Grinding to a halt, 2007–2010

In 2007, the government commissioned Ara Darzi, a distinguished surgeon, to carry out a review of the NHS to determine what further changes were necessary in the light of broad changes in society, including an older population, rising consumer expectations linked to quick convenient access to information through the Internet, and advances in treatment combined with the changing nature of the burden of disease, often linked to lifestyle choices (e.g. smoking, drinking, diet and exercise).

Darzi's report, *High Quality Care for All* (Department of Health 2008o) set out a number of objectives:

- help people to stay healthy: the NHS needs to work with its national and local partners more effectively, making a stronger contribution to promoting health, and ensuring easier access to prevention services;
- empower patients: the NHS needs to give patients more rights and control over their own health and care, for more personal care;
- provide the most effective treatments: patients should have improved access to the treatments they need supported by improved diagnostics to detect disease earlier; and
- keep patients as safe as possible: the NHS must strive to be the safest health system, keeping patients in environments that are clean, and reducing avoidable harm.

These objectives reflected those of the 1997 White Paper and the *NHS Plan*: the report signalled no basic change of direction. Similarly, its proposals did not set out a radically different course, although some specific ideas did break new ground. These included the following:

- every PCT should commission comprehensive well-being and prevention services, in partnership with local authorities, with the services offered personalized to meet the specific needs of their local populations;

- NICE to be expanded to set and approve more independent quality standards, and a new National Quality Board to offer transparent advice to government ministers on what the priorities should be for clinical standard setting by NICE; and
- systematic measurement and publication of information on the quality of care with measures to include patients' own views on the success of their treatment and the quality of their experiences as well as measures of safety and clinical outcomes; and all registered health care providers working for, or on behalf of, the NHS required by law to publish "quality accounts" just as they publish financial accounts.

The last of these reflected the report's theme that quality should be the main focus for the NHS, and that clinicians should become the main drivers of change. Subsequently, steps were taken to develop quality measures such as PROMs, to introduce quality accounts, and also to link part of the payments made to hospitals under PbR to the quality of care they offered.

In the following year, the government set out its view of issues the NHS should seek to address (Department of Health 2009y). It acknowledged that despite 11 years of continuous reform there was:

> … considerable room for improvement. Convenience for the system too often takes precedence over convenience for patients. There is still too much variation in the quality and safety of care, for example in stroke care … [and] there are cases where care has fallen below acceptable standards. There is much more to do in terms of access, for example to increase the very poor screening rates for patients with disabilities, and to do so in a way that is centred on the needs and personal situation of the patient, not at the convenience of the service. There is still too much care organised in hospitals, which best practice shows could be organised around patients at home or in community settings. Care provided by different professionals and organisations is insufficiently well integrated around patients. While improved quality and reduced costs have resulted from some improvements, such as the reductions in rates of MRSA, this now needs to apply more broadly. Overall, services are not as preventative, people-centred and productive as they could be.

Despite this list of shortcomings, the government did not propose any major new reforms. Instead it reasserted (Department of Health 2009y) the basic approach set out in *High Quality Care for All*:

> Our commitment remains to implement the vision set out in *High Quality Care for All* and put quality at the heart of the NHS. The NHS must treat all its patients safely and effectively, ensuring that their experience of the care they receive is as positive as possible. Providing high-quality care for all patients has always been important to clinicians. This is now the basis on which the whole system must be organised – and as productively as possible. Delivering this vision across the NHS will require co-ordinated, complex action, driven from every part of the system, starting with every clinical team, and leading to fundamental change.

By the time of the 2010 election, it began to look as though the government had run out of steam as far as major reforms were concerned. Despite the long list of weaknesses set out above, no new proposals were put forward to deal with them. In May 2010, a new government came to power with new ideas. These are discussed briefly in the final section of this chapter.

7.2 Reform of services

The rapid expansion of the NHS budget after 2000 allowed the capacity of the NHS in terms of staff numbers to be increased rapidly. The targets for workforce numbers were soon met. These underpinned the drive to reduce waiting times by making it possible to raise activity levels (see section 6.4.3). However, the government recognized from the outset that simply increasing the volume of services was not enough. The way that services were provided also needed to change. Two main themes emerged: the redesign of specific services and a change in the balance of care away from hospitals.[3]

To assist in these reforms, the *NHS Plan* had also announced that a Modernisation Agency would be established to promote service redesign, recognizing that "targeted expert support to spread best practice and stimulate change locally" was required. In 2005, the Agency was dissolved and its main functions transferred to a new organization – the NHS Institute for Innovation and Improvement. These two bodies developed a vast range of advice on how to improve efficiency and raise quality. Examples include the publication of guides to improved performance such as *10 High Impact Changes* (NHS Modernisation Agency 2004), which promoted the expansion of day surgery, improvements in hospital discharge processes designed to reduce lengths of stay and the elimination of bottlenecks in access to diagnostics.

7.2.1 Service redesign

The initial focus of government policy was, as noted above, on NSF- and NICE-defined guidelines in order to raise service quality and reduce variations between different parts of the country. By 2010, the services covered by NSFs included mental health (Department of Health 1999c), coronary heart disease (Department of Health 2000i), older people (Department of Health 2001h),

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[3] The government also set out a series of reforms in public health together with a range of targets; these are discussed in some detail in section 6.1 and so are not addressed here.

diabetes (Department of Health 2001m), children and maternity (Department of Health and Department for Education and Skills 2004), renal (Department of Health 2004r), and long-term conditions (Department of Health 2005j).

The government also recognized that more services could be provided outside hospitals, partly to make access easier but also by targeting those most at risk of emergency admission, to avoid the need for hospital admission.

NSFs

Each NSF, based on the best evidence of clinical effectiveness and cost-effectiveness together with the views of users, sets out to establish principles for the pattern and level of service required and the standards of care that should be available. It was assumed that the NSFs would take 10 years to be fully implemented. Each NSF is led by a national clinical director, but responsibility for implementation remained local in the light of local priorities. Regular updates are published to assess progress. In addition, strategies were introduced for a number of other conditions, including stroke, chronic obstructive pulmonary disease, end-of-life care, dementia, adult autism, and musculoskeletal conditions. Finally, *High Quality Care for All* (Department of Health 2008o) indicated that NICE would be asked to develop a comprehensive set of guidelines so that all services would be covered.

The reform of services introduced in the NSFs and other strategies typically involved changes to the organization of hospital services and better definition of the care pathways for individual patients across hospital and community care services. The NHS *Cancer Reform Strategy*, for example, proposed that specialist centres should be established for cancer in a limited number of hospitals and that cancer networks be established covering populations of between 1 and 2 million people. These networks took some time to be established but by 2010 they covered the whole country and the proportion of patients treated by specialist surgeons in specialist facilities had risen sharply (Department of Health 2008cc).

7.2.2 Changing the balance of care

Some of the changes in service design arising from the NSFs and other service strategies proposed changes in the balance of care between different settings. This was particularly true of mental health, following the implementation of the NSF for Adult Mental Health. This NSF envisaged an expansion of community-based services, particularly those offering a "crisis" response and a reduction in inpatient treatment. Moreover, the new Mental Health Act passed in 2007 set out to safeguard the rights of individuals with mental health problems while at the same time ensuring people with serious problems that threaten their own safety or that of others could be treated irrespective of consent, both in institutions and in the community.[4]

In addition, the government introduced a number of policies specifically designed to alter the balance of care between hospital and community-based services, and between professionals and patients. The Department of Health (2003d) published *Keeping the NHS Local – a New Direction of Travel*. This stated that,

> The mindset that "biggest is best" that has underpinned many of the changes in the NHS in the last few decades, needs to change. The continued concentration of acute hospital services without sustaining local access to acute care runs the danger of making services increasingly remote from many local communities.

In 2006, the government published a White Paper, *Our Health, Our Care, Our Say* (Department of Health 2006c), which proposed that some hospital services be switched to community settings. The implementation plan issued the same year set out the following goals (Department of Health 2006l):

- better prevention and early intervention for improved health and well-being;
- more choice and a stronger voice for individuals and communities; and
- tackling inequalities and improving access to services.

Under the first goal, the government stated its intention to bring about:

- reduction in the prevalence of damaging underlying determinants of health (e.g. smoking and obesity) and associated service usage;
- reduction in numbers of people out of work or unable to work owing to ill health or dependency;
- shift in resources and in planning emphasis to prevention and early intervention, supported by robust cost–benefit analysis;
- increased self-care and condition management among service users; and
- support for more people who need care living in their own homes.

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[4] These reforms are discussed in some detail in section 6.11 and so are not addressed here.

Under the second goal, the intention was for:

- service users and their carers to have more say over where, how and by whom their support is delivered, and better access to information that helps them to make their own choices about this;
- individuals and their communities to be able to influence the shape and delivery of local services, and to trigger action to look at problems; and
- people using services to be more satisfied with their overall experience of care.

And finally, under the third goal, the intention was:

- more services being provided in the community through:
  - promoting emotional health and well-being, and stronger services and support for people to help prevent physical and mental illness;
  - ensuring people are discharged from hospital with appropriate community support;
  - better support for individuals in their own home through services and using new technologies, preventing unnecessary admissions into residential or hospital care;
  - more services moving out of acute hospitals into community settings, where services can be delivered safely and secure benefits to service users.
- improved range of services for urgent care;
- streamlined GP registration and appointments processes to improve access and convenience; and,
- local health and social care communities working together to understand and address inequalities.

In 2006, £750 million was allocated to investment in community hospitals, and a number of pilot schemes were established to test out specific schemes for moving care out of hospitals. Subsequently, *High Quality Care for All* (Department of Health 2008o) announced that each PCT would establish at least one health centre in which both primary and secondary care services should be available.

One of the drivers of this switch was the perception that the needs of patients for treatment were changing towards treatment of chronic conditions. In 2005, the Department of Health set out the NHS and Social Care Long Term Conditions Model (Department of Health 2005k), the aim of which was to:

- embed into local health and social care communities an effective, systematic approach to the care and management of patients with long-term conditions;
- reduce reliance on secondary care services and increase provision of care in a primary, community or home environment; and
- provide patients with long-term conditions with high-quality care personalized to meet their individual requirements.

The model itself had three levels. Level 3 was case management, where the aim was to identify the most vulnerable people, those with highly complex multiple long-term conditions, and use a case management approach to anticipate, coordinate and join up health and social care. Level 2 was disease-specific care management and involved providing people who have a complex single need or multiple conditions with responsive, specialist services using multidisciplinary teams and disease-specific protocols and pathways. Level 1 was supported self-care, which involved helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively.

The immediate aim was to reduce emergency bed-days by 5% between 2003–2004 and 2008, primarily through focusing on people at level 3. A number of schemes were developed at local level supported by research into methods of identifying people at risk of being admitted to hospital. The target was achieved; although these schemes may have contributed to this, no overall evaluation of the causes has been undertaken.

Although the structure of primary care was not fundamentally changed, the government instigated a number of measures designed to make it easier to access primary care services. These included increasing the number of GPs in “under-doctored” areas and target times for accessing all GP services (see section 6.3.2). In addition, a number of policies were introduced to make it easier to access care outside hospital, including the introduction of GPs with special interests, walk-in centres and extended roles for pharmacists and nurses, including prescribing rights.

7.3 Conclusions

From 1997 onwards, the Labour Government introduced a series of major reforms to the NHS and related services. Chapter 8 assesses their impact.

A new government was elected in May 2010, a coalition of Conservatives and Liberal Democrats. This government published a White Paper, *Equity and Excellence: Liberating the NHS* in July 2010 that signalled major changes ahead (Department of Health 2010a). However, it is far too soon to assess its likely impact: many proposals are expressed in general terms, leaving a great deal of the detail to be worked out. The White Paper retained much of the rhetoric of previous governments: it thus included a commitment to "an NHS that is available to all, free at the point of use, and based on need not the ability to pay"; a commitment to promoting equality as "the NHS is about fairness for everyone in society"; a commitment to increase health spending in real terms in each year of the parliament; and a promise to uphold the NHS Constitution. However, the White Paper noted:

> Current statutory arrangements allow the Secretary of State a large amount of discretion to micromanage parts of the NHS. We will be clear about what the NHS should achieve; we will not prescribe how it should be achieved. We will legislate to establish more autonomous NHS institutions, with greater freedoms, clear duties, and transparency in their responsibilities to patients and their accountabilities. We will use our powers in order to devolve them.

In practical terms, the main legislative reforms announced by the White Paper (Department of Health 2010d) could be far reaching as SHAs, PCTs and NHS trusts are swept away. Reforms proposed include the following 13 areas.

1. Enabling the creation of a Public Health Service, with a lead role on public health evidence and analysis.
2. Transferring local health improvement functions to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health.
3. Placing the Health and Social Care Information Centre, currently a Special Health Authority, on a firmer statutory footing, with powers over other organizations in relation to information collection.
4. Enshrining improvement in health care outcomes as the central purpose of the NHS.
5. Making NICE a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and extend its remit to social care.

6. Establishing the independent NHS Commissioning Board, accountable to the Secretary of State, paving the way for the abolition of SHAs. The NHS Commissioning Board will initially be established as a Special Health Authority; the Bill will convert it into an independent non-departmental public body.
7. Placing clear limits on the role of the Secretary of State in relation to the NHS Commissioning Board, and local NHS organizations, thereby strengthening the NHS Constitution.
8. Giving local authorities new functions to increase the local democratic legitimacy in relation to the local strategies for NHS commissioning, and support integration and partnership working across social care, the NHS and public health.
9. Establishing a statutory framework for a comprehensive system of GP consortia, paving the way for the abolition of PCTs.
10. Establishing HealthWatch as a statutory part of the CQC to champion services users and carers across health and social care, and turning Local Involvement Networks into local HealthWatch.
11. Reforming the FT model, removing restrictions and enabling new governance arrangements, increasing transparency in their functions, repealing FT de-authorization and enabling the abolition of the NHS trust model.
12. Strengthening the role of the CQC as an effective quality inspectorate.
13. Developing Monitor into the economic regulator for health and social care, including provisions for special administration.

However, despite their radical nature, these proposals represent a development of many of the previous government's policies, such as shifting the balance of power away from the centre and down to localities; developing a market in health care; giving clinicians, particularly GPs, a greater role in running the NHS; giving patients more effective choices; and developing the role of local authorities in promoting and protecting health.

The White Paper also stated an intention to reduce the number of arm's-length bodies in the health sector, amending their roles and functions; examples of this have already been seen with the announcement in July 2010 of the intended abolition of the Appointments Commission, the CHRE, the General Social Care Council, the HPA, the NPSA, the National Treatment Agency for Substance Misuse and the NHS Institute for Innovation and Improvement (Department of Health 2010dd), as well as a further announcement in August 2010 of the intended abolition of the Audit Commission. The new government introduced a Health and Social Care bill in January 2011 to provide the legislative framework for its proposed reforms and it is currently before parliament.

Acknowledgment

This chapter was co-written with Anthony Harrison.

8. Assessment of the health system

This chapter provides an assessment of the performance of the health system in England since 1997. It begins with a section describing the broad objectives of the Labour Government, before going on to consider, in turn, performance against six criteria: access, equity, allocative efficiency, technical efficiency, quality and health improvement. The chapter concludes with an indication of overall performance.

8.1 Government objectives

The Labour Government's first White Paper, *The New NHS*, reflected in its very title the intention to introduce major changes to the organization of the NHS, with a view to improving its performance (Department of Health 1997). However, this document did not set out a list of single objectives or high-level goals against which performance can be assessed. Some of those it did set out concerned intermediate goals such as strengthening partnership working between different parts of the NHS and between the NHS and local authorities. Furthermore, at this stage, it did not set out specific targets against which progress could be measured. However, it is possible to discern in *The New NHS*, and subsequent plans and white papers, a number of themes that provide a framework against which success (or otherwise) can be assessed.

> *Access*. The White Paper noted that "patients often wait too long to be treated". In 1997, the waiting list for elective hospital care was over 1 million and it was widely recognized that waiting times could be measured in months and years rather than days and weeks. At that time, however, a full picture of the extent of treatment delay was not available.

Equity between different parts of the country. The White Paper promised to "renew the NHS as a genuinely national service. Patients will get fair access to consistently high quality, prompt and accessible service right across the country". Although attempts had been made by 1997 to ensure a fair distribution of resources across the country, with some degree of success, official reports during the 1990s had shown that there were considerable variations in quality and quantity of treatment between the best-served and the least-well-served areas.

Efficiency. The White Paper identified a need to drive "efficiency through a more rigorous approach to performance and by cutting bureaucracy so that every pound in the NHS is spent to maximise the care for patients". This definition focuses on "technical efficiency" rather than "allocative efficiency". This White Paper said that the government would "build on the increasingly important role of primary care". In subsequent policy documents, more specific commitments to changing the balance of resources were made.

Quality. The White Paper promised "high quality care" with "excellence guaranteed to all patients". The background to this objective was the acknowledgement that "quality is variable" (i.e. sometimes poor). A number of reports published prior to 1997 by the Clinical Standards Advisory Group, the Audit Commission and others had identified shortfalls in the quality of care available.

Health outcomes. The White Paper tasked health authorities in conjunction with local authorities, with "improving overall health and reducing health inequalities".

As revealed in Chapter 7, the mechanisms the government introduced to promote these broad goals changed over the years. Many of the proposals in *The New NHS* were abandoned or overturned, sometimes more than once. The precise definition of these objectives changed over time, but the same broad themes identified here can still be found in subsequent government statements.

8.2 Access

8.2.1 Policy on access

Nearly all health services in England are free at the point of delivery and have been so since the foundation of the NHS. The main exceptions are prescription drugs and some optical and dental services; however, the impact of charges for these has been mitigated by various forms of exemption and controls over their level (see section 3.3.3). Nevertheless, some people, particularly those just above the exemption limit, are deterred from consulting a GP, from taking up a prescription if they do or from using it in line with the recommended frequency or dosage (House of Commons Select Committee on Health 2006a). The government acknowledged this and went on to change the rules governing the low income exemption and also to extend the exemption from charges to cancer patients, covering drugs administered in community settings. However, it never responded systematically to the core criticism made in a report from the House of Commons Select Committee on Health (2006a) that there was no underlying logic to the current system of exemptions.

Nevertheless, in 1997, the main obstacle to easy access was not charges but delay. By 1998, waiting lists for hospital treatment were at a record level and long waiting times were still common, although the longest waits – over two years – had been eliminated by measures taken by the previous government. Delays were also common when patients wanted to see a GP or went to an A&E department. The new government had pledged to reduce waiting lists in its manifesto but it went on, in the *NHS Plan* and subsequent policy statements, to set new targets for waiting times covering hospital inpatient treatment, A&E departments and GP consultations. A number of policies were introduced to ensure they were met: the effectiveness of these measures is assessed in the second part of this section.

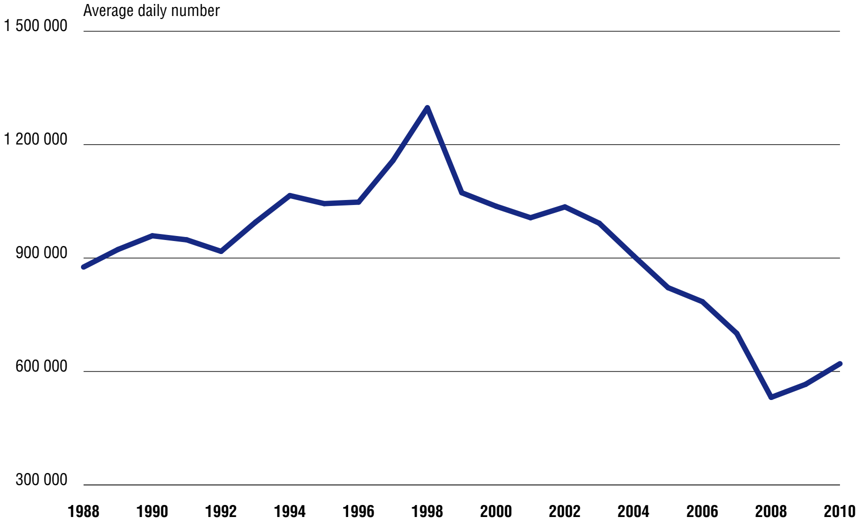
Even where services are free at the point of delivery, users may nevertheless incur costs, principally those related to transport, to gain access to them. Reducing these costs was never a government priority, but section 8.2.3 briefly sets out developments in this area.

8.2.2 Reducing waiting times

The new Labour Government had made an election pledge to reduce the numbers waiting for hospital treatment by 100 000. This reduction was achieved by March 2000 and further reductions followed. By 2008, the number waiting was as low as it had been in the 1970s when there was considerably less activity. However, there has been an increase since 2008 so that it now stands at over 620 000 (Fig. 8.1).

Fig. 8.1

Total inpatient waiting list, March 1988 to March 2010



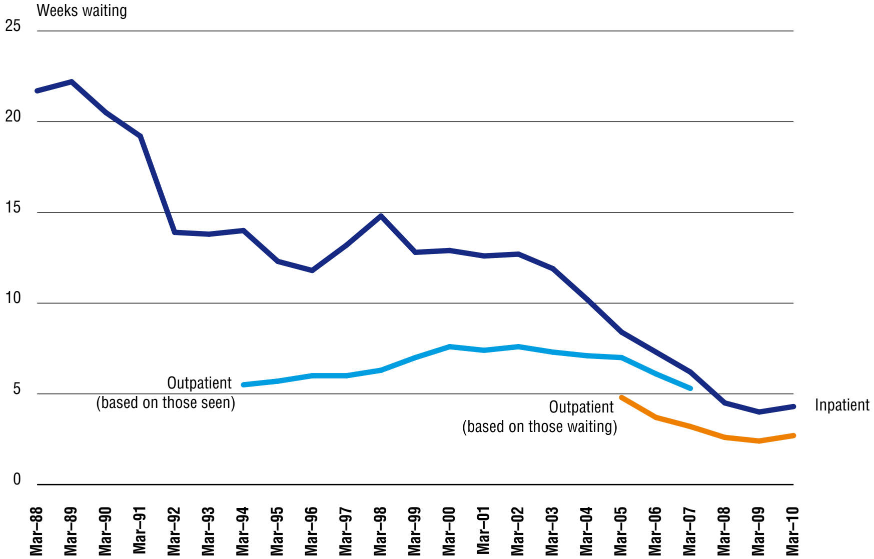
Source: Department of Health 2010ee.

The government went on in the *NHS Plan* to set targets for initial consultation and treatment, involving a halving of the maximum waiting time for outpatient appointments from over 6 months to 3 months and a reduction from 18 to 6 months for the maximum waiting times for treatment. As Fig. 8.2 shows, the median wait for inpatient treatment has fallen considerably since March 2002, from 12.7 weeks to 4.3 weeks in March 2010; outpatient waits have also fallen over the same period.

However, these targets were superseded when, in 2004, the government announced its intention to introduce an 18-week referral-to-treatment target for all conditions treated by a consultant, to be achieved by the end of 2008. This was an "end-to-end" target covering all stages of the care pathway: similar targets had already been set for cancer in the *NHS Cancer Plan*: an "end-to-end" target of 62 days and a 31-day target from diagnosis to treatment (Department of Health 2000h). The 18-week target covered all delays, including those waiting for diagnosis.

Fig. 8.2

Median waiting times for inpatients and outpatients, 1988–2010



Sources: Department of Health 2010ee; House of Commons Select Committee on Health 2010a.
Notes: Between March 1994 and March 2007, outpatients waits were recorded based on the waits of people actually seen in that quarter (in March 2007, collection of data in this form was dropped); between March 2005 and March 2010 outpatient waits were collected based on how long people on the waiting list had been waiting at the end of the quarter.

As Fig. 6.6 (Chapter 6) shows, performance for England as a whole improved significantly against this target so that 97.8% of non-admitted patients (i.e. those found after consultation and/or investigation not to need treatment) were dealt with within 18 weeks by February 2010, as were 92% of admitted patients. By December 2009, the median wait for admitted patients was 7.7 weeks; the median wait for non-admitted patients was 4.2 weeks (Department of Health 2010u).

Waiting in A&E departments

The *NHS Plan* set a four-hour maximum wait target for all patients seeking care in A&E departments. This was subsequently modified to allow a small proportion of patients (e.g. those where diagnosis was difficult), to remain longer before being treated. As a result, acute hospital A&E departments were expected to process 98% of patients attending A&E within four hours. Since 2005–2006, over 97% has been achieved although the target of 98% has continued to prove elusive. In 2008–2009, average compliance for England as a whole was 97.2% with little variation between regions; in only one region was 98% achieved while the worst region still managed to achieve 96.6% (see Fig. 6.11, Chapter 6).

Waiting in general practice

The *NHS Plan* stated that patients would be able to see a primary care professional within 24 hours and a GP within 48 hours. This target has not yet been fully met. The GP Patient Survey 2008–2009 found that 89% of patients were able to see a GP within 48 hours and 81% could book an appointment more than two days ahead. Around 83% of patients said they were satisfied with GP opening hours (Boyle, Appleby & Harrison 2010).

It is not possible to provide a full account of how these reductions were achieved but it is clear that as far as waiting for hospital treatment was concerned, the increase in NHS budgets allowed a substantial increase in the number of operations and diagnostic tests carried out (Harrison & Appleby 2009). Between 1998–1999 and 2008–2009, the total number of elective procedures carried out in hospitals rose from 5.4 million to 7 million, with growth in some specific procedures much greater: cataracts 73%, hip replacement 47% and percutaneous transluminal coronary angioplasty 227% (Information Centre 2010t). From 1998–1999 to 2009–2010, the number of MRI scans quadrupled from just over 0.5 million to almost 2 million and CT scans almost trebled from 1.25 million to 3.72 million (Department of Health 2010ff).

Active performance management by the Department of Health and its regional arms combined with the targets – a regime that came to be known as "targets and terror" (Propper et al. 2007) – was also important. It ensured that every senior NHS manager or clinician was aware that the targets had to be met. In addition, extensive programmes of technical support, initially from the Modernisation Agency and subsequently the NHS Institute for Innovation and Improvement, assisted hospitals to increase their capacity to treat patients and to redesign their care pathways so as to reduce unnecessary delays.

The targets for GP access were also supported by an increase in resources. The number of GPs, particularly in areas that had insufficient doctors, was increased substantially: in Chapter 6, Fig. 6.1 shows the increase in the number of GPs and Fig. 6.2 shows the reduction in list size. By 2009, 50 new GP-led health centres were open and there were 65 new practices in areas that previously did not have enough doctors. In addition, financial incentives were offered to GPs to open for longer hours. By July 2009, more than 77% of practices had agreed to open longer at evenings or weekends, compared with 38% in the year before (Department of Health 2008dd, 2009z).

Ease of access was also promoted through a programme of walk-in centres in main streets or at transport hubs for those, particularly those in work, who might find conventional opening hours inconvenient. There are now over 90 of these. The government also increased the number of places at which people could access some primary care services by extending the role of community pharmacists. The number of medicines available over the counter or under the control of a pharmacist was increased – most notably this included simvastatin – and the new pharmacy contract introduced in 2005 opened the way for local purchasers to commission additional services, such as smoking cessation advice or treatment of minor ailments from community pharmacists over and above the pharmacists' dispensing role (Department of Health 2005d). The government also made it easier for new entrants to enter the market, particularly if they were prepared to open more than 100 hours a week or were located in out-of-town shopping centres. There are now 450 100-hour pharmacies and 46 pharmacies in out-of-town shopping centres (Information Centre 2009f).

NHS Direct was established in 1998 to enable patients to access telephone advice at any time of day. The usage of this service is high, with over 5 million calls per year and some 42 million Internet contacts, particularly among the more affluent (NHS Direct 2010). This is discussed further in section 2.5.2. The initial hope was that availability of telephone advice would reduce the load on GP services; however, it appears to have generated new demand. Most callers are referred on to other parts of the NHS, and while a majority of these do require active treatment, about one quarter do not (Byrne et al. 2007).

8.2.3 Other obstacles

Transport costs

In principle, the NHS offers free transport services to hospital facilities for patients with severe medical problems, and some financial support is available for those able to travel but with low incomes. However, many patients were not aware of the support available (National Association of Citizens Advice Bureaux 2001) and the application process for repayment of travel costs was cumbersome. Subsequently, the government issued a revised scheme in 2008 and extended it to include patients travelling as a result of a GP or dentist referral. The House of Commons Select Committee on Health also found that parking charges at hospitals presented a problem for users requiring frequent visits for treatment (House of Commons Select Committee on Health 2006a). The government announced in December 2009 that it intended to tackle this issue but no proposals were made before the general election in May 2010.

Physical access

As noted in Chapter 7, the White Paper, *Our Health, Our Care, Our Say* (Department of Health 2006c), proposed a number of initiatives designed to promote the transfer of some services from hospital sites to other settings such as GP premises or new specially built health centres, and the expansion of the numbers of GPs and pharmacists with special interests capable of providing specialist advice. In 2008, a commitment was made that a new health centre (or polyclinic) should be established in each PCT area to provide a base for the transfer of hospital services.

Despite these measures a report by the Audit Commission (2009) found no evidence to show that PCTs had been successful in moving care out of hospitals and, as Fig. 6.9 and Fig. 6.5 (Chapter 6) show, use of hospitals continued to rise: between 1996–1997 and 2008–2009 by almost 40% in the case of emergency admissions; and between 1998–1999 and 2008–2009 by almost 30% for elective admissions. Calls to ambulances and A&E attendances have also increased over a similar period (see sections 6.4 and 6.5).

8.2.4 Summary of access issues

Waiting times for most NHS hospital and primary care services have been substantially reduced since the late 1990s. However, for some services based outside hospital, such as physiotherapy, waiting times can be very long as these were not included in the 18-week target. Some people are still not able to see their GP quickly and conveniently and some users are still deterred from using services by cost or other obstacles, although the proportion of the population affected is small and lower than in other comparable countries (Schoen et al. 2009).

8.3 Equity

Equity in health systems can be measured in a number of ways: equity in how the resources used in the health sector are raised; and geographical equity, and equity for different societal classifications (e.g. by social class, ethnicity, age and gender), in terms of both equal access to health care for individuals at equal risk and equal health outcomes. Equity in the sense of equal access to care for individuals at equal risk has been a consistent aim of government policy, as is discussed below; less clear is the extent to which it has been achieved.

8.3.1 Policy on equity

For most of the life of the NHS, equity has been interpreted as "equal access for equal need". As already noted, the introduction of charges for prescription drugs and other services violated this principle, but successive governments, anxious to maintain the revenue charges generated, remained reluctant to do away with them.

A further threat to this principle arose from NICE's decision not to recommend use of some drugs within the NHS. Those able to afford private health insurance have been able to enjoy more rapid access to care and so the health care system as a whole has not been committed to the equity objective. For the most part, this form of inequity has been accepted without giving rise to great political controversy and patients have been able to move freely between the private and public systems. However, the decisions of NICE to exclude some drugs from the NHS package led to a sharp controversy over the boundaries between the two. Some patients denied drugs on the NHS paid for them privately – but then found they had to pay for those elements of NHS care that would have been available free of charge.

Following a report from Mike Richards, the lead clinician for the NHS Cancer Plan (Richards 2008), the government accepted that, under certain conditions, patients paying for drugs not available on the NHS should be able to access (free) NHS services for the rest of the care they needed.

As noted in section 3.4.2, the distribution of financial resources to local areas has been based on the aim of achieving a form of geographical equity. Various changes in the allocation formula since 1976 were mainly designed to measure need better. In 2008, a new element was introduced into the formula to take into account the existence of inequalities in health status in different parts of the country (Department of Health 2008f). As a result, the formula now serves two objectives: equal access to health care for people at equal risk and a reduction in health inequalities.

8.3.2 Has equity been achieved?

This section considers how far equity has been realized in the health system.

Equal access for equal need

The White Paper *The New NHS* promised "that patients will get fair access to consistently high quality, prompt and accessible services right across the country" (Department of Health 1997). A range of policies have been put in place to address this issue.

The resource allocation formula

In principle, the resource allocation formula makes this objective feasible, but in practice it does not succeed in doing so. There are two main reasons for this. First, actual allocations do not coincide with what should be allocated based on the formula. Governments have been reluctant to make major shifts in any one year so any move towards an improved measure of equity (when the formula has been revised) has been deliberately slow. As a result, some areas are above and some below their target allocation at any one time.

Second, the formula does not tie local areas to a specific use of resources at the broad sector level (e.g. primary, secondary), the disease group level (e.g. cancer, mental health) or the procedure level (e.g. cataract removal, coronary artery bypass graft). As a result, wide variations between different parts of the country persist in the way that resources are used (Donaldson 2007). To some degree, this may be ascribed to local choice, which the financial allocation system is designed to allow, or variations in needs not properly reflected in the allocation formula. However, the extent of variation is hard to justify in these terms.

National guidelines, frameworks and strategies

As noted in Chapter 7, the government introduced a number of measures designed to ensure a uniform standard of service relative to need across the whole country. The main instruments for achieving this were to be through the issue of evidence-based clinical guidelines by NICE, and a series of NSFs designed to set out how care should be provided for major user groups.

Some national strategies have yet fully to take effect but even where NSFs or strategies have been in place for most of the last 10 years, recent reports have identified wide variations between areas in availability of services. Examples include cardiac care (Green & Miles 2009), diabetes (Information Centre 2010u), lung cancer (Information Centre 2009p) and rheumatoid arthritis (NAO 2009b). A review of PCT performance by the Healthcare Commission confirmed the existence of variations in availability of a number of other services, including crisis services for the mentally ill, education programmes for diabetes and coronary heart disease registers (Healthcare Commission 2008b).

Other services have not been the subject of national strategies and, not surprisingly, some of these also display wide variations in availability. Recent reports on trauma care (NCEPOD 2007; Intercollegiate Group on Trauma Standards 2009), allergy services (Hazeldine et al. 2010), muscular dystrophy (All Party Parliamentary Group for Muscular Dystrophy 2009), multiple sclerosis (Royal College of Physicians 2008), Parkinson’s disease (All Party

Parliamentary Group for Parkinson's Disease 2009) and falls and bone health services (Royal College of Physicians 2009) have revealed major service gaps and variations between areas.

In 2008, a commitment was made in *High Quality Care for All* (Department of Health 2008o) to introduce service standards for all services, but as the studies referred to above indicate, such a commitment falls short of guaranteeing that standards will be met.

Equity for different societal classifications

Although government policy has been concerned with improving outcomes for people from lower socioeconomic groups, there has been little effective policy directed specifically at ensuring the fair use of resources across such groups (i.e. equity of access) and the same applies to other classifications (e.g. by ethnicity, age, gender). A review of the literature looking specifically at differences by socioeconomic group in use of services in Great Britain found that "The utilisation of GP services is broadly equitable, but that of specialist services relative to need tends to favour the better off" (Dixon et al. 2007).

Reflecting on differences in health outcomes in England measured in terms of life expectancy and disability-free life expectancy, Marmot (2010) found that these are closely related to socioeconomic position and, moreover, that efforts to reduce health inequalities require action across all the social determinants of health. A House of Commons Select Committee on Health inquiry (2009a) also concluded:

> Health in the UK is improving, but over the last ten years health inequalities between the social classes have widened – the gap has increased by 4% amongst men, and by 11% amongst women. Health inequalities are not only apparent between people of different socio-economic groups – they exist between different genders, different ethnic groups, and the elderly and people suffering from mental health problems or learning disabilities also have worse health than the rest of the population.

Section 8.7 provides more evidence of this effect. However, it is difficult to find evidence of the impact of recent government policies. Again, the House of Commons Select Committee on Health (2009a), while acknowledging that "the causes of health inequalities are complex, and include lifestyle factors – smoking, nutrition, exercise … and also wider determinants such as poverty, housing and education", is quite damning of recent government policy:

> Governments have spent large sums of money on social experiments to reduce health inequalities, but we do not know whether these experiments have worked or whether the money has been well spent. … All the reforms we have discussed are experiments on the public and can be as damaging (in terms of unintended effects and opportunity cost) as

unevaluated new drugs or surgical procedures. Such wanton large-scale experimentation is unethical, and needs to be superseded by a more rigorous culture of piloting, evaluating and using the results to inform policy.

Equitable financing of health care

Equity in health systems can be measured in terms of the way that the resources used in the health sector are raised. By this measure, the NHS in England is equitable in comparison to most other health care systems as it is almost entirely reliant on a mildly progressive tax system (see discussion in section 3.3.1). As noted above, however, some services do attract a charge, and despite measures to reduce their impact, for some of their users the financial system is not equitable.

8.3.3 Summary of equity issues

With some exceptions, noted in the previous section, the NHS remains an equitable system as far as financing is concerned, and a commitment to ensuring the equalization of financial resources relative to needs in each part of the country remains in place. But the availability of services in different parts of the country continues to be highly variable in ways that cannot be justified in terms of variations in the need for care. Moreover, there is little or no evidence that equity in terms of other societal classifications has improved over this period.

8.4 Allocative efficiency

Markets are often assumed to ensure the appropriate allocation of resources between different potential uses through the operation of prices: this is known as allocative efficiency.[1] Where the price mechanism does not operate, as is the case in the NHS, then whether more resources should be allocated to particular types of service provider (referred to as sectors in section 8.4.1), diseases or conditions (referred to as services in section 8.4.2) or population groups is problematic. Historical distributions of resources have tended to dominate. The government has made various attempts to change the way resources are used but the evidence for any change in direction being more efficient (e.g. from hospital to community settings) is quite limited.

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[1] However, the existence of market imperfections (e.g. externalities, asymmetrical information) causes this to break down.

The bulk of NHS resources are allocated to local purchasers. In principle, they can choose how to deploy them in the light of the needs of their local population. It follows that the budgets for hospitals, general practice or other community-based services are not fixed centrally or by any other mechanism. The same is true for specific conditions: spending on mental health or cancer, although sometimes supplemented by ad hoc injections of funding from the Department of Health, emerges from decisions made at local level either by providers reacting to the demands they face or purchasers deciding to spend more in particular areas.

However, it would be wrong to suggest that the pattern of spending is entirely under the control of local providers and purchasers. As noted in section 8.3, the government has attempted through NSFs, NICE guidelines, centrally determined targets and other similar measures to guide the allocation of local resources into what it has judged to be productive uses. In addition, as noted in section 8.2, the government introduced a number of policies designed to promote easier access, some of which have resulted in shifts in the balance of care between sectors. However, the changes in allocations that have taken place reflect a series of unrelated initiatives rather than a single grand plan to bring about a different set of allocations to those prevailing in 1997.

Moreover, often it is unclear or unknown what the "true" purpose of government policy has been. For example, the shift of care from acute to community settings has long been a policy of successive governments. This may result in improvements in allocative efficiency if the delivery of care in the community is seen to be an improvement and, therefore, more valuable; but it may also be viewed as a more technically efficient way of delivering the same service (i.e. if community provision is known to be cheaper).

Changes in the balance of care between sectors, between services and between resources (inputs) are discussed below.

8.4.1 Balance between sectors

For data reasons, it is no longer possible to describe how the balance of spending has changed in recent years between hospitals and other services. The most recent figures suggest that acute care absorbed 56% of the HCHS budget in 2003–2004 (House of Commons Select Committee on Health 2006b).

Data gaps also make it impossible to define the share of the total NHS budget absorbed by tertiary services, for which, in any case, there is no accepted definition. However, the measures described in section 6.4 did imply a strengthening of services at the tertiary level for client groups containing very small numbers. In addition, the expert advisory group report on cancer issued in 1995 had concluded that English cancer services were not sufficiently specialized (Department of Health and Welsh Office 1995). The *NHS Cancer Plan* (Department of Health 2000h) called for the establishment of cancer networks, each of which was to have tertiary centres to deal with the rarer cancers. Other similar initiatives were taken in respect of services such as heart disease and stroke, although they have yet to be fully implemented across the whole of the NHS in England.

Elective services

In both the secondary and tertiary sectors, increases in demand for elective and emergency care have led to increases in the resources employed to meet them. Detailed analysis of overall staffing levels is provided in section 5.2 and shows that there has been a substantial increase in most types of staff employed by the NHS in England since 2000, resulting from specific government targets aimed at increasing capacity across the board.

Some of these extra resources were devoted to elective care in order to bring down waiting times for treatment. The Department of Health made some ad hoc allocations of funds from the Department of Health direct to purchasers, but the bulk of extra funding came out of overall allocations. It was used to pay for more operations and more diagnostic episodes. Including planned treatments (i.e. elective care not forming part of the waiting list), Department of Health data suggested the Department had estimated in 2004 that an extra £1.4 billion would be required to meet the 18-week target: £1 billion on treatment and the rest on diagnostics. However, it is not possible to say whether actual expenditure was in line with these figures (Department of Health 2005l; Harrison & Appleby 2005).

Emergency services

Since 1997, hospitals have also been faced with increases in demand for emergency treatment, both in A&E departments and as hospital admissions. As a result, extra physical and human resources have had to be devoted to these areas although data are not available to estimate the scale of this.

As noted in Chapter 7, the government set a target for reducing the number of bed-days taken up by emergency admissions. It also introduced measures to speed up discharges, including major investment in intermediate care facilities and a system of “fines” whereby local authorities were required to pay for the extra costs when patients were ready to go home but no place was available either in intermediate or in long-term care.

The number of emergency bed-days has declined, but it is not possible to link this decline to the measures outlined above: probably all have contributed to some degree. However, as noted above, the number of admissions has continued to rise, particularly short admissions of less than a day. It has been suggested that these reflect hospitals admitting patients to avoid breaching the four-hour A&E target. However, it also seems to reflect sensible policies designed to reduce the load on inpatient beds, for example, the introduction of observation wards where patients can be kept until diagnosis is clear and discharged home if their condition allows it.

As the bed-day target indicates, the government formed the view that too many resources were going into hospital emergency services and that it would be more efficient from the viewpoint of the NHS as a whole for more patients to be treated in the community, or their need for treatment avoided by anticipatory measures. However, the evidence suggests that these measures have had only limited impact and may have cost more than they saved (Purdy & Griffin 2008).

Ambulance services

The government also made important changes to the operation of the ambulance services with the aim of reducing the number of patients being taken to hospital for treatment. Historically, the service operated a "scoop and run" policy, but a number of steps were taken to extend the role of ambulance staff to offering care on the spot. *Taking Healthcare to the Patient: Transforming NHS Ambulance Services* (Department of Health 2005m) promised that the ambulance service would become a mobile health care resource, with paramedics able to provide a number of treatments on the spot.

The number of emergency calls to ambulance services more than doubled between 1999 and 2009 (see Fig. 6.10). However, the proportion of those calls that resulted in conveyance of the patient to a hospital fell between 2003 and 2009.

8.4.2 Balance between services

As noted above, the government announced various NSFs and strategies for major disease areas. These entailed extra spending on the services concerned, both to meet increases in demand, in the case of cancer, for example, and to raise standards of provision. In some cases, particularly mental health, the aim was to reshape the service away from an emphasis on inpatient care towards use of rapid community response teams.

However, wide variations remain across PCTs in the amounts spent per capita on major services; for example, average expenditure on cancer is £82 per capita in England but varies between PCTs, from £43 to £151 per capita (Martin, Rice & Smith 2008). Research into variations in spending on cancer has been unable to establish clearly why differences between different parts of the country in per capita spending on this service emerge even after allowing for differences in the number of people being treated for cancer (Appleby et al., in press). One possible reason is that the spending data are themselves not reliable.

An analysis of NHS programme budget data by Martin and colleagues (2008) suggests that areas with higher levels of spending – holding the need for health care constant – on individual programmes of care (e.g. cancer, circulatory disease) achieve better health outcomes. They also found that expenditure on circulatory disease yields greater benefits in terms of life-years saved than expenditure on other programmes.[2] However, these results are based on a single year's data and, as noted above, it is not clear how reliable the data are.

In all the areas covered by NSFs, subsequent monitoring reports from both government and regulators have identified improvements in the services available. However, although there have been changes (improvements) in services, no evidence has been provided that the resulting allocation of resources is, therefore, more efficient; nor has there been any attempt to identify the effect of policy as opposed to pre-existing trends. Moreover, it could be argued that the emphasis on these services led to neglect of others. As noted in section 8.3, services for some client groups have remained poorly developed even where NICE guidelines were published and it was only towards the end of the period that systematic policies towards some conditions (e.g. dementia) were developed.

Care for chronic conditions

As noted in Chapter 7, as waiting times started to fall, the government shifted its attention to long-term conditions, in recognition of the ageing of the population and also of the burden of emergency admissions that inadequate care for long-term conditions can generate. The GP contract was changed in 2004 so as to link GP pay to specific activities, including monitoring of chronic conditions such as diabetes and heart disease. As a result, the number of patients registered as diabetics under the care of GPs rose rapidly (although it is estimated that many diabetics are not yet registered) and the number of patients with cardiovascular problems receiving statins also increased (see section 3.6.2

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[2] The authors acknowledge the limitations of using programme budget data, particularly the potential for different practice across PCTs in assigning spending to programmes.

for a more detailed discussion of the new contract). Thus, all GP practices in 2009–2010 kept a register of their patients who are diabetics (Information Centre 2010v), and the statin simvastatin was the most commonly dispensed drug in 2009 (at over 37 million items), having increased by over 10% in just one year (Information Centre 2010d).

8.4.3 Balance between resources

As has been discussed elsewhere in this report, the *NHS Plan*, supported by rapid increases in the overall financial resources available to the NHS, led to rapid growth in the workforce and improvements to the capital stock, including medical equipment, and to other resources such as medicines. While the *NHS Plan* contained specific proposals for increases in the medical workforce and capital investment, it did not, however, justify the particular increases proposed: hence there was no explicit justification of the balance of resources it proposed.

Capital investment

The fabric of the hospital sector was recognized as being poor after decades of low levels of investment. The same was true of primary care premises, many of which were poorly designed. The commitments made in the *NHS Plan* have largely been realized. Over 100 hospitals have been rebuilt – some one-third of the total, and around 230 primary care premises modernized (see section 5.1.2).

However, the government made its commitment without carrying out a serious review of the changing role of the hospital. The National Beds Inquiry, published prior to the *NHS Plan*, argued that hospitals could continue to lose beds (although this conclusion was rejected by the government) but it did not attempt to define the kind of hospitals that would be required (Department of Health 2000d). As a result, some hospitals built since 1997 may already be surplus to requirements either in whole or in part.

Workforce

The *NHS Plan* committed the government to an expansion of the workforce: as Table 5.3 (Chapter 5) shows, these plans were realized. By 2008, there were 15 000 more consultants and GPs than there were in 2001, almost 56 000 more nurses and midwives, and almost 37 000 more therapists and scientists. The intake of medical students increased from 3749 in 1997 to 6030 in 2003. Overall, the number of consultants increased by 58% between 1999 and 2009; most specialties witnessed increases over 50%, with clinical oncology, anaesthetics, paediatrics and general medicine showing the greatest increases.

Despite these increases, there are still substantially more doctors per head of population in other EU countries than in England: 2.0 doctors per head in 2009 compared with an average of 3.5 in the EU15 countries in 2006 (see section 5.2). The position is similar for nursing staff.

Against this background, there may have been a prima facie case for expansion. However, the *NHS Plan* did not attempt to justify its proposals for increases in medical and other staff and, although it recognized the need to match the new standards of care that would flow from the NSFs with the numbers of staff required to implement them, it did not seek to direct staff to one service area rather than another. In particular, there were no close links to proposals made for the expansion of services in specific areas.

Medicines

As discussed in section 8.5.1, the government negotiated price reductions with the pharmaceutical industry and supported the substitution of generic for branded drugs. However, the number of items prescribed grew steadily. There were 842.5 million NHS prescription items dispensed in England in 2008 compared with 513.2 million in 1998, an increase in average items per capita from 10.5 to 16.4 (over 56%). The result was that expenditure on medicines rose steadily, reaching £8.33 billion in 2008 (see section 6.6).

The government (as noted above) established NICE to provide advice, among other things, on the effectiveness of medicines in the form of clinical guidelines for the treatment of specific conditions. At local level, most purchasers employ pharmaceutical advisers to promote effective prescribing and the NSF for older people set targets for the introduction of medication reviews. In 2005, special payments came into operation to encourage pharmacists to carry out reviews of patients' medication regimens.

Despite these measures, there remain concerns about the effective use of medicines. Compliance with medication regimes remains poor (McGraw & Drennan 2004) and there is also evidence of poor prescribing decisions within hospitals and care homes (Barber et al. 2009; NPSA 2010b).

8.4.4 Summary of allocative efficiency issues

The rapid increases in funding from 2000 onwards enabled the NHS to devote extra resources to nearly all services. These enabled improvements to be made in the level and quality of care where service shortfalls had been identified (e.g.

heart disease and cancer). Other services did less well and some needs were neglected until very recently. As a result, major variations remain in service levels between different parts of the NHS.

By 2010, the government had succeeded in making major and much needed improvements to the hospital capital stock and also in enlarging the workforce. The attempt to shift resources away from hospitals to community-based services appears to have had only limited success with the exception of mental health, where the balance was successfully changed from inpatient to community care.

8.5 Technical efficiency

Increases in technical efficiency are usually attained through better use of existing resources (inputs). This may come about by using resources more appropriately within the same set of technologies – eradicating what in lay terms are often thought of as inefficiencies; or by technological development or innovation – resulting in new ways of doing things that are more efficient in the sense that they use fewer resources to produce the same level of service. Reductions in resource costs, where these are achieved through improved procurement methods for example (but not through overall market factors), also promote efficiency as they allow more care to be delivered with the same input of financial resources.

The Conservative Government, in power until 1997, had already introduced reforms of the purchasing of supplies and regular reviews of the cost of pharmaceutical products, set annual cost-improvement targets covering the NHS as a whole, introduced competitive tendering for hospital ancillary services and encouraged sales of land and buildings no longer needed to provide care. Therefore, when the Labour Government came to power a commitment to improve NHS use of resources was already in place.

When setting out how the *NHS Plan* was to be implemented, the government explicitly acknowledged that the NHS had to justify the increase in budget that accompanied the Plan; *Delivering the NHS Plan* (Department of Health 2002c) states:

> The extra resources provided by the 2002 budget need to be backed by new mechanisms to ensure that the public gets the best value for money … we expect to see improvement in NHS productivity of 2 per cent per annum.

This efficiency target was raised in subsequent years to 3%. This section examines performance on various elements of efficiency improvement and concludes with an examination of what has happened to overall measures of productivity.

8.5.1 Reducing the cost of resources

The impact of changes in the costs of pay, goods and services, and pharmaceuticals are examined in turn.

Pay

As noted above, the *NHS Plan* promised increases in the number of doctors, nurses and other professionals. However, the pay of medical and nursing staff was largely determined by their respective pay review bodies and in any case pay rises were required to attract people, particularly nurses, into the NHS. The combination of higher staff numbers and higher pay meant that a significant proportion of the increase in resources that flowed to the NHS after 2000 was absorbed by pay costs. Wanless et al. (2007) estimated that 43% of the £43.2 billion cash increase in NHS resources between 2002–2003 and 2007–2008 was absorbed by higher input costs.

The government attempted to raise staff productivity by renegotiating their contracts. The consultant contract was renegotiated in the hope that it would lead to better use of their time. The GP contract was also renegotiated with the aim of creating a closer link between workload and remuneration (section 3.6.2 discusses these contracts). However, the new agreements have been almost entirely ineffective in terms of reducing the cost of the medical inputs to hospital and community care (NAO 2007b).

For around 1.1 million other staff, the pay system was reformed with the aim of making it easier to introduce more efficient and effective working methods, estimated at the time to be worth a year-on-year increase in productivity of some 1.1% to 1.5%. However, as with medical staff, the NAO (2009c) could find no evidence of any such gains.

Goods and services

In principle, by virtue of its size, the NHS should be able to extract favourable terms from its suppliers. The establishment of the NHS PASA as an executive agency of the Department of Health in 2000 was intended to exploit this potential. It enabled about half of the £7 billion spent in the NHS in England on purchasing goods and services to be purchased centrally.

With the introduction of a new commercial operating model in 2009, NHS PASA was abolished (see section 5.1.3). Substantial savings of around £500 million were claimed for the measures taken while it was in operation. The new arrangements were intended to promote more centralized purchasing and were forecast to make further substantial savings (Department of Health 2009k).

Pharmaceuticals

Different price control schemes have applied to NHS medicines depending on their status. In the case of branded drugs, the Labour Government, like its predecessor, sought to reduce prices directly by regular negotiations with the industry through the PPRS. However, this scheme does not apply to generic medicines, where the patent of the original product has expired (see section 6.6.2 for detailed discussion of pricing in both cases).

The prices the NHS pays are low relative to most OECD countries (Department of Health 2009q). The Department of Health has claimed that the latest PPRS will save £350 million in 2009 and £550 million per year subsequently. It is also planned to reduce the cost of drugs to the NHS through ad hoc deals over particular expensive drugs that might otherwise be judged to be too expensive for use in the NHS (see Chapter 6).

The PPRS bears only on branded drugs. In August 2000, the Department of Health, in response to substantial price increases for generic medicines, introduced a maximum price scheme for generics, stipulating a set of maximum prices at which these medicines could be sold to community pharmacies or dispensing doctors (Department of Health 2000f). This continued until 2005 when the scheme was adjusted to allow for changes in prices of generics over time (Department of Health 2005f).

Despite its support for the pharmaceutical industry in the United Kingdom, the government took further the existing commitment to promote generic prescribing. In 1999, the Department of Health set targets for increasing the use of generic drugs, which were achieved by 2003; further targets followed. The rate of generic prescribing was almost 83% in 2009 compared with 66% in 1999. The rate actually dispensed increased over the same period from 48% to 66% as drugs that are prescribed generically are not always available to be dispensed generically (Information Centre 2010d).

Although there has been an increase in average number of prescription items per head of population between 1998 and 2008, from 10.5 to 16.4 (over 56%), average net ingredient cost decreased in real terms by 15%, from £9.16 per prescription item in 1998 to £7.79 per prescription item in 2008 (which is £9.88 in 2008 prices) (see section 6.6.5).

8.5.2 Improving efficiency through different modes of service delivery

The government did not set local cost-reduction targets analogous to those set for waiting times. The main drive to change the way that services were delivered came from the need to meet the waiting times targets. From 1998 onwards, a number of programmes, including the "Action On" series and the "Care Collaboratives", had focused on particular operations or specialties, all of which were designed to promote and support new ways of delivering care, such as the wider use of day surgery, which had already been shown in the 1990s to lead to lower costs while maintaining quality and patient satisfaction.

In addition, as noted in Chapter 7, the Modernisation Agency (subsequently the NHS Institute for Innovation and Improvement) has provided support to trusts in making the required changes on the ground. The result has been a mass of advice on a wide range of operational issues that, although still mainly targeted on reducing waiting times, has also demonstrated the scope for cost reductions in other services, through increases in the day-case rate for elective care, reductions in length of stay in hospital and higher occupancy rates for acute hospital beds (see section 6.4.2).

Official estimates suggest that the NHS saved £500 million in the first nine months of 2008–2009 by reducing the average length of hospital stay (HM Treasury 2009b). However, estimates based on work done by the NHS Institute suggest that there is considerable potential for improvement through further reductions in lengths of stay and other operational changes (NHS Institute for Innovation and Improvement 2009).

The introduction of PbR in 2003–2004 provided the government with a lever to reduce costs by adjusting the level of tariffs charged – the prices hospitals receive for the services they deliver. In most years, it has allowed the average cost of hospital services to rise in money terms but not in real terms. There was no cash uplift to tariff levels between 2009–2010 and 2010–2011 following a cash uplift of just 1.7% in the previous year (Department of Health 2010gg). However, there is a suspicion that the introduction of the tariff has led to better recording of activities, leading to an expansion of costs. Thus, the effect of the tariff on overall hospital costs may be less than any reduction in the real cost of the tariff would suggest.

Recent research (Gaynor, Moreno-Serra & Propper 2010) suggests that the introduction of a market in health care services – in particular the policy allowing patients choice of hospital for elective care – has had some impact on quality of care as measured by mortality, as well as resulting in reductions in length of hospital stay. However, no data are available to demonstrate its impact on costs. The same is true of the introduction of specialist elective treatment centres.

Skill mix

In principle, increases in pay can be offset by substituting cheaper for more expensive grades of staff. Within hospitals, both pharmacists and nurses have been enabled to take on senior roles: the number of health care assistants – substituting for registered nurses – more than doubled between 1999 and 2009 (Information Centre 2010w). However, the number of nursing assistants or auxiliaries fell from 2004 onward.

In the community, there was also a substantial increase in pharmacy support staff, such as technicians (Information Centre 2010l). Within general practice, the WTE number of practice nurses grew by 27% between 1999 and 2009, and some medical activities were transferred to them – although there has been a steady fall in the number of nurses since 2006 (Information Centre 2010m). The extent of this shift and the impact on costs of service delivery is unknown.

Capital

As already noted, the government embarked on a major capital programme designed to modernize hospitals and other health care facilities. In 1997, a large part of the capital stock dated back to Victorian times and was frequently in a poor state of repair. Much of this programme was financed through PFI, whereby the private sector raised the initial capital and the NHS paid for the use of the assets for 30 or more years. In principle, the private option should have been used only if it offered lower costs than public (i.e. Treasury) finance. However, there is no evidence to suggest that hospital costs have been reduced: in fact, hospitals financed through private finance have proved to be at a disadvantage in cost terms within the NHS market as it developed from 2002 onwards (see section 5.1.2).

The building of new facilities and the reduction in the number of hospital beds meant there was scope for selling off some of the NHS estate. The *NHS Plan* set a target of £600 million sales and this was met by the end of 2003–2004. Sales have continued at around the same level up to 2008–2009. As a result of the sales that have already taken place, the total land area occupied by the NHS estate fell by almost 10% between 1999–2000 and 2008–2009, from 8600 to 7800 hectares, although the internal floor area of the buildings appears to have increased by some 10% (Information Centre 2010h). The value of the estate has risen rapidly as a result of the new building programme, thereby offsetting any reduction in capital employed that was achieved through sales.

8.5.3 Measuring productivity

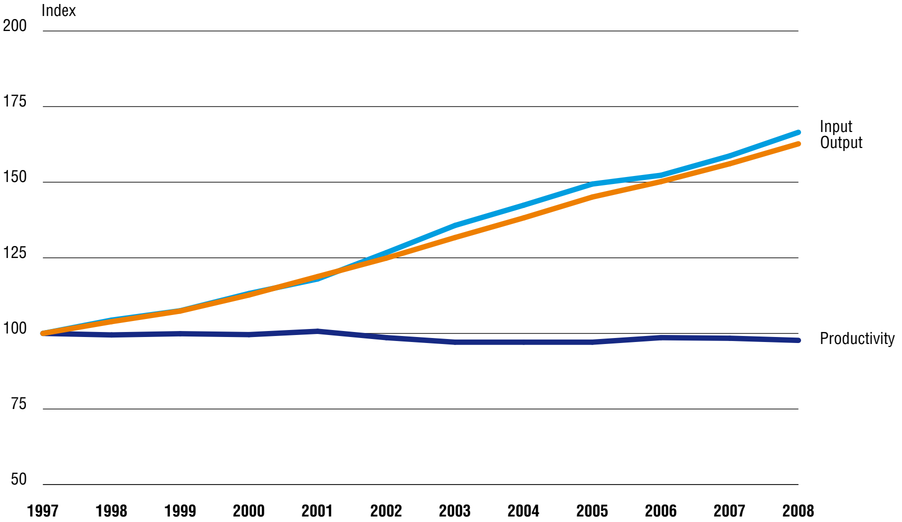
Measuring overall increases in productivity in the NHS is no easy matter given the lack of prices for most services produced. Prior to June 2004, a simple measure of health output was used that reflected movements in 16 different activities or services, including inpatients, day cases, outpatients, GP consultations and prescriptions, with the aggregate index being a simple weighting based on how much was spent on each activity: a cost-weighted activity index. However, this was not comprehensive, and each individual series was at a high level of aggregation. There has been a concerted attempt to improve the measurement of public-sector productivity as a whole, resulting in considerable changes to measurement as well as attempts to include measures of quality as well as simple output (Atkinson 2005).

According to the most recent measure, which includes an element for quality improvements in output, NHS output in the United Kingdom increased rapidly between 1997 and 2008, at over 4.5% per annum, but less rapidly than the increase in inputs used to produce it, which increased by almost 4.75% per annum. These figures are relevant to England as the pattern of productivity change in the United Kingdom mainly reflects changes in England (Peñaloza et al. 2010). The result, as Fig. 8.3 shows, is that NHS productivity as a whole has fallen over this period by an average of over 0.2% per annum.

Productivity fell sharply in 2002 and 2003, with the only significant increase happening in 2006. Productivity declined again in 2007 and 2008 and remains 2.7 percentage points below its level in 1997 (Fig. 8.3) (Phelps et al. 2010). This fall in productivity primarily results from a central failure to control costs, particularly the pay costs mentioned above. Input costs rose by over 25% in the four years alone between 2001 and 2005. It is not possible to make definite links between these changes and any particular policies and it is perhaps telling that there has been no official attempt to do so.

Fig. 8.3

Changes in NHS productivity in the United Kingdom, 1997–2008



Source: Phelps et al. 2010.

Peñaloza et al. (2010) suggest that quality adjustments accounted for an average of 0.6 percentage points growth a year in output between 1995 and 2008 (0.66 between 2002 and 2009). Without this adjustment, the decline in productivity would have been even greater. These adjustments relate mainly to improvements in acute hospital care: short-term survival rates, health gain following treatment in hospital and impact on health gain as a result of changes in waiting times for health treatment. There are also some small gains associated with improved outcomes in primary care and the results of patient experience surveys.

There are differences in productivity across the different health care sectors. For example, for HCHS, and not adjusting for quality, Peñaloza et al. (2010) found an average fall in productivity between 1995 and 2008 of 1.4%, and 1.7% for the period between 1997 and 2008. For family health services (primarily general practice), the average fall in productivity between 1995 and 2008 was less, 0.5%, and between 1997 and 2008 was just 0.2%.

Finally, the most recent measure of changes in the productivity of adult social care in the United Kingdom shows an average fall per annum in productivity of 1.5% between 1997 and 2008. While output increased by, on average, 1.3% per annum, inputs increased by more, 2.8% per annum. This measure takes no account of any changes in quality (Phelps et al. 2010).

8.5.4 Summary of technical efficiency issues

The government succeeded in reducing some of the input costs of health care delivery. However, it failed to do so overall, primarily because of its failure to control pay costs and to use its staff, particularly medical staff, more effectively. There were also changes in the way that services were delivered, although many of these (e.g. increased day-case rates), were simply following a well-established trend. As a result, the best available measures suggest that productivity fell during the period under review.

8.6 Quality of care

This section considers the performance of the system in terms of quality of services and care delivered. As Chapter 7 made clear, the assurance and improvement of the quality of clinical services has been a key area of government policy over the last 13 years. Before looking at some measures relating to the quality of the health care system, a brief description of the government's approach to quality is provided.

8.6.1 Policy on quality

The new Labour Government in 1997 made quality a key focus. *A First Class Service* (Department of Health 1998d) required the NHS to adopt a coherent approach to clinical quality. Whereas previously NHS organizations were required to adopt processes that would ensure financial probity, the concept of clinical governance now came to the fore – with the expectation that NHS managers would be responsible for the quality of services delivered. This was written into the legislation in the Health Act 1999 as "It is the duty of each Health Authority, Primary Care Trust and NHS trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals".

At the same time, CHI was set up in 1999 as the body responsible for advising on improvements in the quality of services, reviewing performance and where necessary investigating specific issues. Over the next 10 years, as this body became first the Healthcare Commission and then the CQC, its remit and influence expanded (earlier chapters discuss its role in various areas).

The government also aimed to improve the quality of care provided by the individual professional. The scandals arising at the Bristol Royal Infirmary (Kennedy 2001) and the behaviour of individual clinicians such as

Harold Shipman (Smith 2004) led to the White Paper *Trust, Assurance, and Safety* (Secretary of State for Health 2007), which made a large number of recommendations designed to reduce the chances of such events recurring. Some of its recommendations (e.g. those relating to the structure of the GMC) were brought in quickly. However, by 2010, one of the key proposals – that all health professionals should be subject to a process of revalidation – had still not been implemented fully.

As government policy developed, quality remained at its core, and many of the targets that were established in this period reflect this. Nevertheless, for all the rhetoric about quality, it was clear that safety issues still remained. In 2009, Stafford General Hospital (part of Mid-Staffordshire Foundation Trust) was found to have excessive mortality levels – up to 400 extra deaths – between 2005 and 2009 (Francis 2010); and in 2007 it was found that, Maidstone & Tunbridge Wells NHS Trust had high levels of *C. difficile* infection over a period of years, resulting in an estimated 60 deaths (Healthcare Commission 2007).

When Darzi carried out his review of the NHS for government in 2007, the fact that quality remained a core issue was reflected in its title, *High Quality Care for All* (Department of Health 2008o). However, Darzi did not attempt an overview of recent progress. Although on the whole positive about what had been achieved, nevertheless he reported that "local clinical visions found unacceptable and unexplained variations in the clinical quality of care in every NHS region".

As noted in Chapter 7, *High Quality Care for All* included a requirement that NHS organizations publish "quality accounts", in some way similar to financial accounts, as well as recommending the introduction of a new National Quality Board to work with NICE in setting quality standards. In addition, it proposed quality payments based on patients' own assessments of the success of their treatment and the quality of their experiences, so that funding for hospitals would begin to reflect the quality of care that patients receive. *The Operating Framework for 2009/10* (Department of Health 2008h) continued to reflect the theme of *High Quality Care for All*. Ensuring cleanliness so as to reduce levels of health care-associated infections was one of five national priorities, as was improving the patient experience. The extent to which this focus on quality was reflected in the performance of the health system is discussed in the next section.

8.6.2 Measures of quality in the health system

The quality of the health system can be looked at in several ways. At the level of the individual service, does it deliver care that is clinically acceptable (which may not always be clearly defined), that is safe for patients (which is probably a subset of the first) and that patients find acceptable? Similarly, at the level of the individual episode or incident of care delivery, does that episode meet the above criteria? Finally, when the system is considered as a whole, does the care delivered over time and often by several organizations meet the above criteria? This last consideration introduces the need for coordination of care within the system and how well this works.

Following *High Quality Care for All*, steps were taken to develop a wider range of quality measures and, in 2010, the first set of PROMs were published.[3] However, despite the government's emphasis on quality, it did not ensure that measures were available that would provide a comprehensive picture of quality across the NHS as a whole. Nevertheless, elements of quality have been introduced into more recent ONS measures of NHS productivity to reflect improved survival rates in hospitals as well as shorter waiting times. Also various guidelines (NSFs, NICE) and many professional publications embody measures of process, but their exact relationship with outcome is not always clear. Similarly, the QOF payment mechanism for GPs (see section 3.6.2) was designed to provide incentives for GPs to ensure key clinical and organizational processes were in place, with a hope that this would result in better quality care for patients.

While acknowledging that quality can encompass a wide range of factors, including ease of access to services (a part of the patient experience that is covered elsewhere in this chapter), the focus of this section is a limited number of measures, mainly those for which data are more widely available. These provide some insight into how the health care system in England has performed and whether there has been substantial improvement in recent years.

Clinical quality

Population mortality rates from common diseases are a key measure of the quality of the health system. However, these are affected by factors other than how well the health delivery system itself works, as opposed to hospital mortality rates, which are likely to be more closely associated with quality of care (however, see the discussion below). Hence, this section does not consider improvements in overall population mortality rates; these are covered in the next section on health improvement.

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[3] The potential of PROMs is discussed by Devlin & Appleby (2010).

There is a wide range of measures that point to how effective the system is in clinical terms. Many of these relate to the existence of systems that are in place and are likely to result in high-quality care (process measures). For example, a National Stroke Audit has taken place since 1998 based on an agreed set of organizational and clinical standards of care (Clinical Standards Department Royal College of Physicians of London 2010). The latest report suggests that there have been major improvements in stroke care in the last five years, such as the introduction of stroke units. However, the audit does not attempt to relate what are essentially process measures to the outcome achieved. Similarly, the Lung Cancer Audit (Information Centre 2009p) reveals low resection rates overall but does not identify how many lives could have been saved if everyone who might benefit from resection received that form of treatment.

The CQC and its predecessors have published annual reports on how well providers and commissioners have performed. The last one in 2010 continued to find variation in the quality of care, with particular issues around safety of care, training of staff and records management, and it was concerned about organizations that do not meet current minimum standards or that persistently failed to improve (CQC 2010b). These data confirm that some parts of the NHS are not performing well in clinical terms even if some are.

Standardized mortality rates

Standardized mortality rates, particularly within hospital settings, are often used as a measure of quality and safety of clinical care, although not without controversy (Kafetz & Bedford 2009; Department of Health 2010t; Lilford & Pronovost 2010). The Department of Health has published some data at trust level on survival rates for particular operations: elective repair of abdominal aneurysm, emergency repair of abdominal aneurysm, elective hip replacement and elective knee replacement (Department of Health 2008t). The CQC also uses indicators of mortality for groups of patients defined by the care they receive (e.g. patients admitted with a stroke or a hip fracture) and routinely looks at mortality outliers for English trusts (CQC 2009b).

An analysis of data on deaths within 30 days of emergency admission to hospital with stroke shows significant improvements for England as a whole in recent years (National Centre for Health Outcomes Development 2010a). The age–sex indirectly standardized mortality rate improved, on average, between 1999–2000 and 2008–2009 by 3.2% per annum, resulting in a 25% improvement overall. However, there remain large differences between regions of the country with the North West, East Midlands, West Midlands and East of England SHAs performing worse than average. A similar analysis of deaths within 30 days of emergency admission to hospital with fractured proximal femur also shows some improvement for England as a whole: of almost 2% per annum between 1999–2000 and 2008–2009, resulting in an improvement of over 16% overall (National Centre for Health Outcomes Development 2010b).

Patient safety

Patients expect care to be safe, and this again has been a focus of policy concern in recent years with, as noted above, the CQC finding variations in this aspect of care. The NPSA, established in 2001, is the key focus for issues of patient safety in the NHS (see section 4.1.3) and provides advice and guidelines as well as producing national performance data. These data mainly report safety incidents by provider organizations (also known as adverse events or near misses). Staff are encouraged to report such incidents[4] and the result has been a significant increase in numbers. Thus, between July 2008 and June 2009, there were over a million serious incident reports, compared with 920 000 in the previous 12 months. Most of these occur in hospital settings with just a very small number reported in general practice. Concerns remain about the significant number of organizations where there appears to be underreporting (CQC 2010b).

According to the national incident data, most of these patient safety incidents do no harm to patients. The House of Commons Select Committee on Health (2009b) reported that 65% of incidents in England are "no harm" incidents, 25% are "low harm" incidents, around 5% "moderate harm", less than 1% involve serious harm and less than 0.5% (around 3500) involve the death of a patient. However, it is generally accepted that there is widescale underreporting of incidents and the Committee suggested:

> The evidence, particularly that from case note reviews, both in England and internationally, indicates that the extent of medical harm is substantial, even on a conservative estimate, and that much is avoidable. International studies suggest that about 10% of all patients who are admitted to hospital suffer some form of harm.

The Committee concluded that it was not possible to judge how far patient safety policy has been successful without more reliable data regarding how much harm is done to patients. The NAO reported in 2005 that a retrospective study of patient records in two English hospitals found 10.8% of patients experienced an adverse incident; of which almost half were judged to have been preventable. These adverse incidents contributed to death in 8% of cases.

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[4] Currently an increase in the number of incidents is seen as an indication of greater awareness of safety issues and openness to admit mistakes; at some point in the future, reductions in the number of incidents should be the target.

An international review of nine retrospective studies of patient records found that the average incidence of adverse events was 8.9%, with a range from 3.8% to 16.6% (NAO 2005a).

Another key concern relating to patient safety has been the number of health care-associated infections occurring in hospital settings. Following some major issues in the early years of this century, the rate of infections, in particular MRSA and *C. difficile* cases in hospitals, has started to fall: episodes of MRSA in English hospitals fell by 59% (from 1092 to 444 cases) between October–December 2007 and October–December 2009, while episodes of *C. difficile* fell by 51% (from 12 248 to 6009 cases) over the same period (HPA 2010e).

Patient satisfaction

Regular patient surveys are now a feature of the NHS, the CQC and its predecessors having responsibility for regular reporting of patient views. In addition, the Department of Health has carried out an annual survey of patient views of GP services since 2007. However, often questions are quite general and it can be difficult to relate the responses to particular aspects of quality.

In a recent review of NHS performance, The King's Fund reported that overall satisfaction with the NHS has increased since 1993 (based on data from the British Social Attitudes Survey) (Thorlby & Maybin 2010). Between 1997 and 2007, the proportion of people who were quite satisfied or very satisfied increased from 34% to 51%. Moreover, those people in the survey who had recent contact with the NHS tended to be more satisfied. However, these findings are open to interpretation, and Thorlby and Maybin comment:

> … satisfaction can be driven by many factors that are unrelated to health system performance, for example underlying expectations of public services or the way the NHS might have been portrayed in the media.

Patients also seem to be satisfied with the services provided by their GPs. For example, there appear to be high levels of satisfaction in response to a range of questions, including satisfaction with care received and with various modes of access. Nevertheless, there is also significant variation across the country as well as differences in attitude according to age, ethnicity and social class (Boyle, Appleby & Harrison 2010). The King's Fund also reported that younger patients are more negative than older; that patients in poor health or with a disability are more likely to report a negative experience of the NHS; and that patients from black and minority ethnic groups were more likely to report negative experiences of some aspects of care (Thorlby & Maybin 2010).

8.6.3 Summary of quality issues

There is evidence that patients are more satisfied with services now than they were 10 years ago. However, whether this is an indication of improved quality of care is unclear; improved access may be a big factor.

Where there has been a focus on particular process measures, such as access times, undoubtedly there have been improvements. Similarly, implementation of NSFs has led to improvements in the care available, such as significant increases in the proportion of heart attack victims given thrombolysis within 30 minutes of arrival in hospital. But equally, where there was no focus, performance has been poor, for example, hospital infections in the first half of the decade, before reduction targets were set. And, as noted in Chapter 7, some services have been neglected and wide variations remain in the level of provision – and hence probably the quality of care – despite the efforts devoted to defining and implementing national standards. In some areas, such as care for older people in hospital, substantial concerns (e.g. about their nutrition) persist (Nutrition Action Plan Delivery Board 2009).

8.7 The contribution of the health system to health improvement

This section considers the performance of the system in terms of its contribution to improving the health of the population. The new Labour Government in 1997 recognized that improvement in public health requires a combination of specific health policies dealing with cancer and coronary heart disease, action to reduce levels of smoking and deal with communicable diseases, and broader government policies addressing child poverty, unemployment and education. It set out a series of reforms in public health, together with a range of targets; these are discussed in some detail in section 6.1. It also initiated improvements in clinical quality (see section 8.6) with specific mortality targets in mind.

It remains difficult to assess the extent to which current improvements in the health status of the population can be attributed to recent policy innovations; for example, in the case of reductions in the numbers of people smoking often the effects can take many years to appear. Nonetheless, measures of improvements in health status are presented in this section, both in general and relating to specific targets. Before doing so, a brief description of the government's approach to improving the health of the population is provided.

8.7.1 Policy on health improvement

In the 1999 White Paper *Saving Lives: Our Healthier Nation*, the Labour Government spelt out its intentions to improve the health of the whole population and in particular those people who are worst off (Department of Health 1999d). Targets (based on a baseline period of 1995–1997) were set to be achieved by 2010 in four key areas:

- cancer: to reduce the death rate in people aged under 75 years by at least 20%;
- coronary heart disease and stroke: to reduce the death rate in people aged under 75 years by at least 40%;
- accidents: to reduce the death rate by at least 20% and serious injury by at least 10%; and
- mental health: to reduce the death rate from suicide and undetermined injury by at least 20%.

The White Paper claimed that it would be possible to prevent up to 300 000 untimely and unnecessary deaths if these targets were achieved (Department of Health 1999c).

Subsequently, two national health inequality targets were announced in 2001 (Department of Health 2001e) for achievement by 2010:

- for children under one year: to reduce by at least 10% the gap in infant mortality between manual groups and the population as a whole; and
- for health authorities: to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

Health improvement remained a key focus of government policy throughout the first decade of this century, with a series of additional targets introduced relating to smoking prevalence, alcohol abuse, chronic disease management, obesity, screening, teenage pregnancy and psychological well-being and mental health (see section 6.1 for more detailed discussion of public health measures and section 8.6 for some discussion of efforts to improve clinical quality).

The extent to which these targets were achieved is discussed below.

8.7.2 Measuring health improvement: what was achieved?

Before considering performance against the government's own targets for health improvement, recent changes in life expectancy in England are presented.

Life expectancy

As Table 1.3 (Chapter 1) shows, there have been improvements in both male and female life expectancy since 1981.[5] Looking at average annual improvement in life expectancy in the two 10-year periods 1981–1991 and 1991–2001 and the six-year period 2001–2007, Table 8.1 shows an increase in the annual rate of improvement for both men and women. For men this seems to be part of an upward trend over this period; however, for women there was a fall in the average increase in life expectancy in the 10 years to 2001, which has since been reversed.

Table 8.1

Average annual change in life expectancy and healthy life expectancy at birth, England, 1981–2007

	1981–1991	1991–2001	2001–2007
Life expectancy, females (years)	0.19	0.17	0.22
Life expectancy, males (years)	0.23	0.26	0.28
Healthy life expectancy, females (years)	0.19	0.12	0.12
Healthy life expectancy, males (years)	0.16	0.08	0.32

Sources: Analysis based on ONS 2004; ONS 2010c; Smith, Edgar & Groom 2008.

However, looking at healthy life expectancy, there was a decline in the rate of improvement for women up to 2001, and the rate of improvement has remained static since. For males, by comparison, the rate of improvement halved between 1991 and 2001, but since 2001 there has been considerable annual improvement in male healthy life expectancy: 0.32 years per annum.

Although it is difficult to attribute these improvements to any particular aspect of government policy, the changes are in the right direction. The same cannot be said of performance on inequality targets as discussed below.

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[5] Indeed, substantial improvements have occurred throughout the 20th century: in 1901, male life expectancy at birth was 45 years and female was 49 years (Hicks & Allen 1999).

Inequality targets

Table 1.9 (Chapter 1) shows significant differences in life expectancy at birth across social classes. Moreover, although there have tended to be improvements in life expectancy across all social classes since 1972, the gain in life expectancy at birth between 1972–1976 and 2002–2005 for the professional class exceeded that of the unskilled by 1.9 years for men and 2.2 years for women. Also, for women, taking the more recent period between 1987–1991 and 2002–2005, the gap, by social class, in life expectancy gained extends to 2.5 years, whereas for men, the position is reversed with the gain in life expectancy for the unskilled just exceeding that of the professional class.

As section 6.1.5 shows, the government looks like failing on its own inequality targets, with the relative gap in both male and female life expectancy widening since the baseline year (1995–1997), by 2% and 11%, respectively. Similarly, the gap in infant mortality is wider than that recorded at the 1997–1999 baseline year.

These findings were confirmed in a recent NAO report (2010c), which concluded that on current trends the inequality targets would not be met, describing the targets as at first merely aspirational:

> It took until 2006, more than three years from publication of its health inequalities strategy and half way through the lifetime of the PSA target, for the Department to establish health inequalities as a top six NHS priority, alongside a requirement for PCTs to report on action taken. Due to the complex nature of the problem, it also took time to develop an evidence base of the most cost-effective interventions for reducing inequalities in life expectancy, and to provide support to help PCTs implement these interventions.

Performance against four key government targets

Turning now to the government's own specific targets over the period to 2010.

Cancer

The target was to reduce the death rate in people aged under 75 years by at least 20% by 2010. The three-year average mortality rate[6] from cancer for people aged under 75 years fell from 141.2 deaths per 100 000 population in 1995–1997 to 114.0 in 2006–2008, 19.3% below the baseline rate. If this trend continues, the target will be easily met (Department of Health 2009aa).

Table 1.5 (Chapter 1) shows mortality rates in the United Kingdom have been declining for most major disease categories since the early 1970s. For cancer in males of all ages, the rate fell from 281.1 deaths per 100 000 population in

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[6] Unless otherwise stated, these average mortality rates are age-standardized rates using the European Standard Population.

1971 to 220.1 in 2006, a fall of almost 22%.[7] The rate for females of all ages fell from 174.8 deaths per 100 000 population in 1971 to 156.9 in 2006, a fall of just over 10%.

Both one-year and five-year cancer survival rates improved between 2000 and 2007, and particularly since 2003 for some of the more common cancers: colon, rectum, breast and prostate. However, average survival remains well below the European average for a number of cancers, including colon, lung and prostate (Department of Health 2009aa). It is hard, however, to determine how these reductions have come about. The data are not available that would allow separate identification of the contributions of new drugs and treatment, a more specialized workforce and shorter waiting times for treatment.

Coronary heart disease and stroke

The target for heart disease and stroke was to reduce the death rate in people aged under 75 years by at least 40% by 2010. The government announced that it had achieved this target in 2006. The three-year average mortality rate from circulatory diseases for people aged under 75 years fell from 141.0 deaths per 100 000 population in 1995–1997 to 84.2 in 2004–2006, 40.3% below the baseline rate. The rate has continued to fall so that by 2006–2008 it was 74.8 deaths per 100 000 population, an improvement of over 47% from the baseline (Department of Health 2009bb). The Department of Health has attributed this to increases in the use of thrombolysis and angioplasty, and reductions in waiting times for heart surgery. In addition, there has been an increase in the prescription rate for cholesterol-reducing statins, which has more than doubled in a three-year period, and a decline in the proportion of people who smoke (Department of Health 2009cc) (see Table 1.6, Chapter 1).

However, as Table 1.5 (Chapter 1) reveals, this reduction in age-standardized mortality rates reflects an increasing trend that has been observed since 1971. Thus, the age-standardized rate for circulatory diseases for all age groups fell by almost 13%, between 1971 and 1981, by over 24%, between 1981 and 1991, and by almost 30% between 1991 and 2001.

Accidents

The target was to reduce the death rate from accidents by at least 20% and from serious injury by at least 10%. The three-year average mortality rate for accidents for all age groups has increased slightly, from 15.8 deaths per 100 000 population in 1995–1997 to 15.9 in 2006–2008, and hence is well below the

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[7] Between 1993 and 1998, the England and Wales all-age mortality rate fell more slowly, by 18%, than that for people under the age of 75 years, which fell by 25% (National Centre for Health Outcomes Development 2010c).

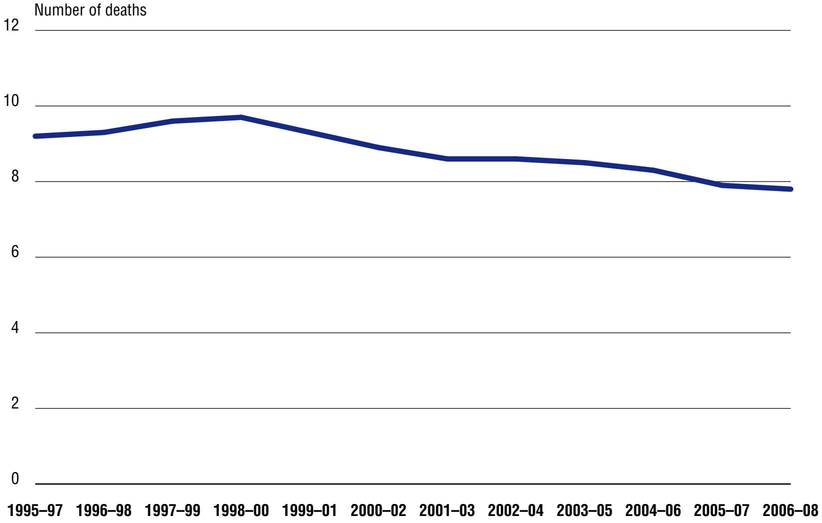
target of 12.6 deaths per 100 000 population by 2009–2011. There has been virtually no change in this rate over the last 11 years and, on this basis, it is highly unlikely that the target will be achieved (Department of Health 2009bb).

Mental health

The target for mental health was to reduce the death rate from suicide and undetermined injury by at least 20%. The three-year average mortality rate[8] for suicide for all age groups has fallen from 9.2 deaths per 100 000 population in 1995–1997 to 7.8 in 2006–2008, 15.2% below the baseline rate. As Fig. 8.4 shows, the rate of deaths increased up to 1998–2000 since when there has been a steady downward trend that appears to have slowed recently; however, even if this downward trend continues, it is unclear that the target of 7.3 deaths will be met by 2009–2011 (Department of Health 2009bb).

Fig. 8.4

Age-standardized three-year average rate of deaths per 100 000 population, all ages, England, 1995–1997 to 2006–2008



Source: Department of Health 2009bb.

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[8] Unless otherwise stated, these average mortality rates are age-standardized rates using the European Standard Population.

A reduction in suicide rates was one of the key standards of the NSF for adult mental health (Department of Health 1999c). It also featured significantly in the NSF for children and young people (Department of Health 2004o), which recognized that:

> In contrast to all other age groups, mortality in this age group did not fall significantly in the second half of the twentieth century. The main causes of mortality in young people are accidents and self-harm, and there has been a record rise in suicides in young men. Morbidity in young people is commonly caused by chronic illness and mental health problems, with the risk of long term adverse consequences.

The NSF for children and young people also pointed out that there was an overall increase of 28.1% in teenage deliberate self-harm between 1985 and 1995, and it linked this to suicides, which were the most frequent cause of death for men and the third most frequent cause of death for women aged 15 to 24 years (Department of Health 2004o). However, suicide rates among young men in England and Wales reached their peak in 1990 in 15–24 year olds and in 1998 in 25–34 year olds and have shown a steady decline since around 1998–2000. The rate for men aged 15–24 years had fallen from its peak of 16.6 per 100 000 in 1990 to 8.5 in 2005, and the rate in men aged 25–34 years had fallen from its peak of 27.8 per 100 000 in 1998 to 15.7 in 2005 (Biddle et al. 2008).

Mortality amenable to health care

Improvements in life expectancy, while welcome, are clearly not just associated with the health care system. However, there is reasonable evidence that some causes of death are likely to be amenable to medical intervention (e.g. breast cancer, pneumonia, abdominal hernia) (Nolte & McKee 2008) and these have formed the basis of several studies that have taken a list of such causes (mortality amenable to health care) and produced comparisons between countries and over time.

International comparisons show that the United Kingdom performs badly on this indicator, ranking 16th out of 19 countries in 2002–2003 (Nolte & McKee 2008). However, as Table 8.2 shows, there has been substantial improvement since 1997–1998, an almost 21% fall in amenable mortality rate, but from a very poor starting point. Many other countries have seen substantial improvement over the same period.

Table 8.2

Comparison of age-standardized death rates from amenable mortality per 100 000 population, 1997–1998 and 2002–2003

Country	Death rates		Change (%)
	1997–1998	2002–2003	
France	75.62	64.79	-14.3
Japan	81.42	71.17	-12.6
Australia	87.95	71.32	-18.9
Spain	84.26	73.83	-12.4
Italy	88.77	74.00	-16.6
Canada	88.88	76.83	-13.6
Norway	98.64	79.79	-19.1
Netherlands	96.89	81.86	-15.5
Sweden	88.44	82.09	-7.2
Greece	97.27	84.31	-13.3
Austria	108.92	84.48	-22.4
Germany	106.18	90.13	-15.1
Finland	116.22	93.34	-19.7
New Zealand	114.54	95.57	-16.6
Denmark	113.01	100.84	-10.8
United Kingdom	129.96	102.81	-20.9
Ireland	134.36	103.42	-23.0
Portugal	128.39	104.31	-18.8
United States	114.74	109.65	-4.4

Source: Nolte & McKee 2008.
Note: Countries are ordered by performance in 2002–2003.

Wheller et al. (2007) found that the amenable mortality rate in England and Wales fell substantially for males, by 46%, and females, by 41%, between 1993 and 2005; over the same period, unavoidable mortality fell by just 9% for males and 5% for females. It is tempting to conclude that this reflects health system improvements. However, as Kamarudeen (2010) points out, there is no study that "explicitly used a health care activity or quality variable in their analyses … (and so) … it is rather difficult to draw definitive conclusions about the relationship between amenable mortality and the health care system."

8.7.3 Summary of health improvement issues

Life expectancy in England has increased since 1997 although this is not all attributable to recent government policy; the extent to which any of it is remains unclear. There is a mixed picture for years of healthy life expectancy, with the trend for men improving while that for women has fallen back.

On the most recent data available, the government looked certain to attain its targets on cancer and on circulatory diseases, although this appears to be merely continuing a trend that was already visible. By comparison, there has been less success in achieving reductions in suicide and none whatsoever in reducing the rates of accidental death.

The White Paper *Saving Lives: Our Healthier Nation* (Department of Health 1999e) had claimed that up to 300 000 lives would be saved, although it never stated a time period. Taking the changes in mortality rates associated with the four targets, there were around 45 000 fewer deaths in 2008 than would have been the case if rates had stayed at their 1995–1997 levels. However, that was never likely to happen: the trends were already strongly downwards.

8.8 Conclusions

The overall conclusion of this assessment of the performance of the English NHS is that it has made substantial progress in some areas, particularly improving access and, to a lesser degree, outcomes. Whether it has become more efficient is unclear – certainly not if the ONS measure of overall productivity is accepted – and in other areas performance has fallen short, particularly health inequalities. Here, despite a vast range of policies, the position has, if anything worsened, even though the health of the population overall has improved.

In some international comparisons, the NHS now scores very well, both in respect of particular services such as mental health and end-of-life care, but also overall performance. Schoen et al. (2009), reporting the results of a 2008 survey, found:

> With the exception of waiting times for specialists and some aspects of patient engagement, the United Kingdom … ranked highly on many aspects of primary care access, coordination, and patient-reported errors. The extensive use of nurses on teams and high rates of diabetics with recommended care likely reflect UK incentives and reporting system reforms focused on primary care.

Other international studies, however, find it trailing behind comparator countries in respect of cancer outcomes (Department of Health 2009aa) and mortality amenable to medical intervention (Nolte & McKee 2008). However, the extent to which that represents failure on the part of the NHS is unclear.

The amount of data available for tracking performance is now much greater, although still far from comprehensive. The regulatory arrangements are now much stronger at organizational level, and the basis for strengthening them at individual professional level has been laid. The knowledge base on operational issues developed by the NHS Institute and others is also much stronger, as is the knowledge base on clinical issues, partly through the work of NICE, partly from professional bodies and partly from international initiatives such as the Cochrane Collaboration.

Hence, the NHS, as a system, is better placed than it was in 1997 to make more effective use of the resources at its disposal; whether it will do so remains to be seen.

Acknowledgment

This chapter was co-written with Anthony Harrison.

9. Conclusions

This report provides a comprehensive view of health service provision in England in the late 20th and early 21st centuries. While its main focus has been on the NHS, there are many areas where the private and voluntary sectors play a significant role, both in the provision of care (publicly funded as well as people who pay out of pocket for care) and through various forms of PMI, which continues to play a role in the English health care system.

This report was written soon after a change in central government that may have far-reaching consequences for the NHS: the election of a Conservative Liberal Democrat coalition in May 2010. How this will play out is difficult to predict, just as it would have been difficult to envisage in 1997 what the NHS would look like after 13 years of Labour rule. As Chapter 7 indicates, although the period between 1997 and 2010 was one of continual reform, there was much that stayed the same. For example, the NHS is largely dependent on tax funding, central government is responsible for ensuring access to health care, and the public sector is the main provider, although the role of the private sector has expanded.

9.1 The present English health care system

The synopsis in Chapter 7 of the series of reforms since 1997 paints a rather mixed picture of progress. Perhaps the single most significant factor between 1997 and 2010 has been the large increase in public expenditure on health care. Although total expenditure on health care has risen steadily since 1948 when the NHS was established, real expenditure on the NHS soared in recent years, almost doubling since 1999–2000. Expenditure on health care per capita in cash terms (including private spending) increased from £231 in 1980 to £1168 in 2000, and by 2008 was £1852. Of this, the proportion that came from public funds fluctuated from 89% in 1980 to 79% in 2000, and back to 83% in 2008 (see Table 3.1, Chapter 3).

Expansion of the NHS workforce has been a key focus of government policy since 2000 (see Chapter 5). There are over 50 000 more doctors, including 10 000 more GPs, and almost 100 000 more nurses and midwives. However, NHS productivity has not increased over this period. According to the most recent measure, which includes an element for quality improvements, although NHS output increased rapidly between 1997 and 2008, at over 4.5% per annum, the increase in inputs was even greater, at almost 4.75% per annum (see Chapter 8). Much of the increased expenditure was taken up by extra spending on inputs; input costs rose by over 25% in the four years alone between 2001 and 2005. This general finding accords with what Appleby argued in 2006, that nearly 40% of the then £4.5 billion cash increase for HCHS would be absorbed by pay rises, and that higher prices and increases in costs associated with NICE recommendations, clinical negligence and increased costs for capital would absorb a further 32% (Appleby 2006). So although there has been a seismic shift in NHS spending, the evidence suggests that the NHS has failed to achieve value for money.

However, Chapter 8 outlined the substantial progress that the NHS has made in some areas, particularly improving access to elective care. Waiting time targets have been a key government focus for some time but much more substantial improvements were achieved during the Labour Party's period of office. Nevertheless, the failure to improve overall productivity is an issue that may come back to bite, particularly looking to the future at a time when the NHS will be expected to deliver £20 billion of efficiency savings (see below). In addition, although reduction in health inequalities was a key target for Labour Governments, the position has worsened despite a vast range of policies introduced to meet that target, even though the health of the population overall has improved.

9.2 What does the future hold?

The White Paper published in July 2010 by the new Conservative Liberal Democrat Coalition Government signals major changes to the NHS. These include a fundamental change to the structure of health care commissioning, with the abolition of PCTs and their replacement by a system of GP consortia that will commission and contract for services; the abolition of the regional tier of NHS governance (SHAs), with part of this role perhaps being taken by a new independent NHS Commissioning Board; and a reiteration of Labour's intention that all NHS trusts would become independent FTs (see Chapter 7). However, the eventual impact of all this is difficult to assess and a great deal of the detail remains to be worked out.

The new government has also announced its intention of abolishing a number of arm's-length bodies, with the transfer of some functions to existing organizations or into the Department of Health itself. Included among these are the NPSA, the HPA and the Audit Commission. While it looks like the three key regulators – CQC, NICE and Monitor – will be retained, it remains to be seen how their roles may change. For example, the government has announced that Monitor will become an economic regulator of the market for health care services, taking on responsibility for PbR and the maintenance, where appropriate, of competition. In addition, it is already clear that the new government intends to restrict NHS expenditure compared with previous regimes. This is almost certain to have an impact on the delivery of NHS services. According to many commentators, the recent Spending Review plans for the NHS (October 2010) amount to a *de facto* cut in NHS spending in real terms (Hunter 2010). The Department of Health has stated that there will be a 0.4% increase in real terms over four years, or an average of 0.1% per annum; in other words an insignificant increase. Moreover, the Department of Health (2010hh) stated recently that:

> To meet the rising costs of health care and increasing demand on its services, the NHS will release up to £20 billion of annual efficiency savings over the next four years, all of which will be reinvested …

This requirement that NHS organizations make large-scale efficiency savings seems already to be having an impact on health care, with various reports of cuts in services emerging as 2010 draws to a close. The key question is whether an NHS that found improvements in productivity so difficult to deliver at a time of record increases in expenditure will find it any easier as spending, at best, stands still. What is at least clear is that the financial framework that the NHS faces in the next five years will be very different from that of the last 10 years.

9.3 Envoi

In 2008, an independent report on recent NHS system reforms (Audit Commission and Healthcare Commission 2008) pointed to three key factors that affected the overall performance of the NHS: first, there was continual structural change that acted as a drag on the system; second, the mechanisms developed for commissioning health care were not effective; and third, the information was still not there to enable good system management at all levels. If this is a fair diagnosis of the problem, then it is reasonable to ask what the new government will learn from past experience. Its instinct to introduce yet more major structural change may not be the right one.

10. Appendices

10.1 References

Acheson D (1988). *Public health in England: the report of the Committee of Inquiry into the Future Development of the Public Health Function.* London, Her Majesty's Stationery Office (Cm 289).

Acheson D (1998). *Independent inquiry into inequalities in health*. London, The Stationery Office (http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm, accessed 3 January 2011).

Alberti G (2007). *Emergency care ten years on: reforming emergency care*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074234.pdf, accessed 12 January 2011).

All Party Parliamentary Group for Muscular Dystrophy (2009). *Access to specialist neuromuscular care: the Walton report*. London, All Party Parliamentary Group for Muscular Dystrophy (http://www.muscular-dystrophy.org/assets/0000/9943/Walton_report.pdf, accessed 12 January 2011).

All Party Parliamentary Group for Parkinson's Disease (2009). *Please mind the gap: Parkinson's disease services today*. London, All Party Parliamentary Group for Parkinson's Disease (http://www.parkinsons.org.uk/PDF/APPG_Report_Please_Mind_the_Gap.pdf, accessed 12 January 2011).

Andrews G, Hammond R (2004). Small business complementary medicine: a profile of British therapists and their pathways to practice. *Primary Health Care Research and Development,* 5:40–51.

Appleby J (2006). *Where's the money going?* London, The King's Fund (http://www.kingsfund.org.uk/publications/briefings/wheres_the_money.html, accessed 3 January 2011).

Appleby J et al. (in press). *Explaining variations in primary care trusts' spending on cancer services*. London, The King's Fund.

Appleby L (2007). *Mental health ten years on: progress on mental health care reform*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074241, accessed 12 January 2011).

Appleby L et al. (2001). *Safety first: five-year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058243.pdf, accessed 12 January 2011).

Association of British Insurers (2008). *Are you buying private medical insurance? 2008*. London, Association of British Insurers http://www.abi.org.uk/Publications/ABI_Publications_Are_you_buying_Private_Medical_Insurance_984.aspx, accessed 12 January 2011).

Association of the British Pharmaceutical Industry (2006). *Parallel trade in medicines*. London, Association of the British Pharmaceutical Industry (http://www.abpi.org.uk/publications/briefing/parallel, accessed 12 January 2011).

Association of the British Pharmaceutical Industry (2009a). *Facts & statistics from the pharmaceutical industry: pharmaceuticals and the UK economy*. London, Association of the British Pharmaceutical Industry (http://www.abpi.org.uk/statistics/section.asp?sect=2#29, accessed 12 January 2011).

Association of the British Pharmaceutical Industry (2009b). *Facts & statistics from the pharmaceutical industry: a global industry*. London, Association of the British Pharmaceutical Industry (http://www.abpi.org.uk/statistics/section.asp?sect=1#2, accessed 10 January 2011).

Atkinson T (2005). *Atkinson review: final report – measurement of government output and productivity for the national accounts*. New York, NY, Palgrave Macmillan (http://www.statistics.gov.uk/about/data/methodology/specific/PublicSector/Atkinson/downloads/Atkinson_Report_Full.pdf, accessed 12 January 2011).

Audit Commission (2002a). *Procurement and supply. Acute hospital portfolio. Review of national findings*. London, Audit Commission (http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/Procurement_Supply.pdf, accessed 12 January 2011).

Audit Commission (2002b). *General practice in England*. London, Audit Commission (http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/genprac.pdf, accessed 12 January 2011).

Audit Commission (2004). *Support for carers of older people*. London, Audit Commission (http://www.auditcommission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/OlderPeople_5_Report.pdf, accessed 12 January 2011).

Audit Commission (2006). *Payment by results assurance framework – pilot results and recommendations*. London, Audit Commission (http://www.audit-commission.gov.uk/health/audit/paymentbyresults/assuranceframework/workprogramme200710/Pages/assuranceframeworkpilot.aspx, accessed 12 January 2011).

Audit Commission (2008). *Improving medium-term financial planning – a practical guide for primary care trusts*. London, Audit Commission (http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/IPCTMTFP.pdf, accessed 12 January 2011).

Audit Commission (2009). *More for less: are productivity and efficiency improving in the NHS?* London, Audit Commission (http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20091111moreforless.pdf, accessed 12 January 2011).

Audit Commission (2010). *Under pressure – tackling the financial challenge for councils of an ageing population*. London, Audit Commission (http://www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/20100218-underpressure-nationalstudy.pdf, accessed 12 January 2011).

Audit Commission and Healthcare Commission (2008). *Is the treatment working? Progress with the NHS system reform programme*. London, Audit Commission (http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/IstheTreatmentWorking.pdf, accessed 12 January 2011).

Baldwin R, Cave M (1999). *Understanding regulation: theory, strategy, and practice*. Oxford, Oxford University Press.

Ball J, Pike G (2005). *Nurses in the independent sector 2005*. London, Royal College of Nursing (http://www.rcn.org.uk/__data/assets/pdf_file/0011/78689/003019.pdf, accessed 12 January 2011).

Barber ND et al. (2009). Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. *Quality and Safety in Health Care,* 18:341–346.

Barnes D et al. (2009). *A profile of children's health services, child and adolescent mental health services and maternity services in England 2007/8*. Durham, Durham University (http://www.childrensmapping.org.uk/reports/archive/CH_CAMHS_MS_ATLAS_200708.pdf, accessed 12 January 2011).

Barnes D et al. (2010). *A profile of children's health services, child and adolescent mental health services and maternity services in England 2008/9*. Durham, University of Durham (http://www.childrensmapping.org.uk/results/publications/CH_CAMHS_MS_Atlas_200809.pdf, accessed 12 January 2011).

Beveridge W (1942). *Social insurance and allied services*. London, Her Majesty's Stationery Office.

Bhui K et al. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review. *British Journal of Psychiatry*, 182:05–116.

Biddle L et al. (2008). Suicide rates in young men in England and Wales in the 21st century: time trend study. *BMJ,* 336:539.

Black D et al. (1980). *Inequalities in health: report of a research working group*. London, Department of Health and Social Security (http://www.sochealth.co.uk/Black/black.htm, accessed 3 January 2011).

Blackburn P (2007). *Health & care cover – UK market report 2007*. London, Laing & Buisson.

Blackburn P (2009). *Health & care cover – UK market report 2009*. London, Laing & Buisson.

Blofeld J et al. (2003). *Independent inquiry into the death of David Bennett*. Cambridge, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (http://www.blackmentalhealth.org.uk/index.php?option=com_content&task=view&id=365&Itemid=63, accessed 10 January 2011).

Bloor K, Maynard A, Freemantle N (2004). Variation in activity rates of consultant surgeons and the influence of reward structures in the English NHS. *Journal of Health Services Research and Policy*, 9:76–84.

Bolling K et al. (2007). *Infant feeding survey 2005*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/ifs06/2005%20Infant%20Feeding%20Survey%20%28final%20version%29.pdf, accessed 12 January 2011).

Boyle S (2005a). Payment by results in England. *Euro Observer*, 7:12–16.

Boyle (2005b). *What foundation trusts mean for the NHS*. London, LSE Health and Social Care (Discussion Paper 18) (http://www.lse.ac.uk/collections/PSSRU/pdf/DP18_2005.pdf, accessed 12 January 2011).

Boyle S (2007). Payment by results in England. *Eurohealth*, 13:12–16.

Boyle S, Hamblin R (1997). *The health economy of London*. London, The King's Fund.

Boyle S, Harrison A (2000). PFI in health: the story so far. In: Kelly G, Robinson P, eds. *A healthy partnership: the future of public private partnerships in the health service*. London, Institute of Public Policy Research.

Boyle S, Smaje C (1992). *Acute health services in London, an analysis*. London, The King's Fund.

Boyle S, Appleby J, Harrison A (2010). *A rapid view of access to care*. London, The King's Fund (http://www.kingsfund.org.uk/current_projects/gp_inquiry/dimensions_of_care/access_to_care.html, accessed 3 January 2011).

Breakwell C et al. (2007). Trends and geographical variations in alcohol-related deaths in the United Kingdom, 1991–2004. *Health Statistics Quarterly*, 33:6–24.

British Dental Association (2010). *About the BDA*. London, British Dental Association (http://www.bda.org/about-the-bda/index.aspx, accessed 15 January 2011).

British Homeopathic Society (2009). *NHS referrals to homeopathy*. London, British Homeopathic Society (http://www.britishhomeopathic.org/media_centre/facts_about_homeopathy/nhs_referrals.html, accessed 3 January 2011).

Burge P et al. (2005). *London patient choice project evaluation: a model of patients' choices of hospital from stated and revealed preference choice data*. London, RAND Corporation, The King's Fund, and City University.

Byrne D, Ruane S (2007). *The case for hospital reconfiguration: not proven a response to the IPPR's the future hospital*. London, Keep Our NHS Public (http://www.nhscampaign.org.uk/uploads///documents/Reconfiguration%20Not%20Proven.pdf, accessed 12 January 2011).

Byrne G et al. (2007). A survey of NHS Direct callers' use of health services and the interventions they received. *Primary Health Care Research and Development*, 8:91–100.

Carers UK (2009). *National carers strategy care partnership managers*. London, Carers UK (http://www.carersuk.org/Professionals/ResourcesandBriefings/Policybriefings/main_content/CarePartnershipManagersNov09.pdf, accessed 12 January 2011).

Care Services Improvement Partnership (2009). *Combined mapping framework*. London, Care Services Improvement Partnership (http://www.mhcombinedmap.org/Reports.aspx, accessed 3 January 2011).

Carr-Hill R et al. (1994). *A formula for distributing NHS revenues based on small area use of hospital beds*. York, University of York (http://www.york.ac.uk/inst/che/pdf/op22.pdf, accessed 12 January 2011).

Carter D (2006). *Review of commissioning arrangements for specialised services May 2006 – an independent review requested by the Department of Health*. London, Department of Health (http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Commissioningspecialisedservices/DH_4135174, accessed 10 January 2011).

Center for Integrative Medicine of the University of Maryland School of Medicine (2010). *The Cochrane Collaboration Complementary Medicine Field's operational definition of CAM*. Balimore, MD, University of Maryland School of Medicine, the Center for Integrative Medicine (http://www.compmed.umm.edu/Camdef.asp, accessed 10 January 2011).

Clinical Standards Department Royal College of Physicians of London (2010). *National sentinel stroke audit: organisational audit 2009 – Report for England, Wales and Northern Ireland*. London, Royal College of Physicians (http://old.rcplondon.ac.uk/media/Press-releases/Documents/Stroke-Organisational-Audit-2009.pdf, accessed 12 January 2011).

Coleman P, Irons R, Nicholl J (2001). Will alternative immediate care services reduce demands for non-urgent treatment at accident and emergency? *Emergency Medicine Journal*, 18:482–487.

Colin-Thomé D (2007). *Keeping it personal–clinical case for change: report by David Colin-Thomé, National Director for Primary Care*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065094, accessed 10 January 2011).

Community Health Partnerships (2010). *Community health partnerships – about us*. London, Community Health Partnerships (http://www.communityhealthpartnerships.co.uk/index.php?ob=1&id=5, accessed 10 January 2011).

Competition Commission (1994). *Private medical services: a report on agreements and practices relating to charges for the supply of private medical services by NHS consultants*. London, Competition Commission (Cm 2452) (http://www.competition-commission.org.uk/rep_pub/reports/1994/348privmedicallhtm#full, accessed 10 January 2011).

Connecting for Health (2008). *NHS data model and dictionary*. London, Connecting for Health (http://www.datadictionary.nhs.uk/web_site_content/navigation/main_menu.asp, accessed 12 January 2011).

Cook T (2007). *The history of the carers movement*. London, Carers UK.

Cooper Z et al. (2009). Equity, waiting times, and NHS reforms: retrospective study. *BMJ,* 339:b3264.

Coulter A, Maistre N, Henderson L (2005). Patients' experience of choosing where to undergo surgical treatment: evaluation of London Patient Choice Scheme. Oxford, Picker Institute Europe.

Counter Fraud and Security Management Service (2001). *Countering fraud in the NHS*. London, Counter Fraud and Security Management Service (http://www.nhsbsa.nhs.uk/CounterFraud/Documents/countering_fraud_nhs.pdf, accessed 12 January 2011).

CQC (2009a). *Periodic review 2009/10*. London, Care Quality Commission (http://www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/periodicreview2009/10.cfm, accessed 10 January 2011).

CQC (2009b). *Regulator publishes closed mortality outlier alerts for the first time*. London, Care Quality Commission (http://www.cqc.org.uk/newsandevents/pressreleases.cfm?cit_id=35262&FAArea1=customWidgets.content_view_1&usecache=false, accessed 10 January 2011).

CQC (2010a). *National NHS patient survey programme: survey of adult inpatients 2009*. London, Care Quality Commission (http://www.cqc.org.uk/_db/_documents/20100505_IP09_Historical_comparisons_tables_v3.doc, accessed 10 January 2011).

CQC (2010b). *The state of health care and adult social care in England: key themes and quality of services in 2009*. London, Care Quality Commission (http://www.cqc.org.uk/_db/_documents/CQC_Complete_2009_18.pdf, accessed 12 January 2011).

Darzi A (2007). *NHS next stage review interim report*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079087.pdf, accessed 12 January 2011).

Dawson D et al. (2005). *The effects on waiting times of expanding provider choice: evidence from a policy experiment*. York, Centre for Health Economics, University of York (http://www.york.ac.uk/inst/che/pdf/rp1.pdf, accessed 12 January 2011).

Dawson D et al. (2007). The effects of expanding patient choice of provider on waiting times: evidence from a policy experiment. *Health Economics*, 16:113–128.

Department for Work and Pensions (2009). *Carer's allowance May 2009*. London, Department for Work and Pensions (http://www.direct.gov.uk/en/MoneyTaxAndBenefits/BenefitsTaxCreditsAndOtherSupport/Caringforsomeone/DG_10018705, accessed 12 January 2011).

Department for Work and Pensions (2010a). *Households below average income: an analysis of the income distribution 1994/95–2008/09*. London, Department for Work and Pensions (http://statistics.dwp.gov.uk/asd/hbai/hbai_2009/pdf_files/full_hbai10.pdf, accessed 12 January 2011).

Department for Work and Pensions (2010b). *Department for Work and Pensions statistical tabulations*. London, Department for Work and Pensions (http://83.244.183.180/100pc/tabtool.html, accessed 3 January 2011).

Department of Communities and Local Government (2008). *Creating strong, safe and prosperous communities statutory guidance*. London, Department of Communities and Local Government (http://www.communities.gov.uk/documents/localgovernment/pdf/885397.pdf, accessed 12 January 2011).

Department of Communities and Local Government (2009a). *Household estimates and projections: United Kingdom 1961–2031*. London, Department of Communities and Local Government (http://www.communities.gov.uk/documents/housing/xls/table401.xls, accessed 10 January 2011).

Department of Communities and Local Government (2009b). *Household estimates and projections by household type: United Kingdom 1961–2031*. London, Department of Communities and Local Government (http://www.communities.gov.uk/documents/housing/xls/402.xls, accessed 10 January 2011).

Department of Health (1989). *Caring for people: community care in the next decade and beyond*. London, Her Majesty's Stationery Office.

Department of Health (1990). *The care programme approach for people with a mental illness referred to the specialist psychiatric services*. London, Department of Health (Circular HC(90)23/LASSL(90)11).

Department of Health (1991). *The patient's charter*. London, Department of Health.

Department of Health (1994a). *1994 capital investment manual*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4119896, accessed 10 January 2011).

Department of Health (1994b). *Health and personal social services statistics for England,* 1994 edn. London, Department of Health.

Department of Health (1996). *Complaints – listening acting improving: guidance on implementation of the NHS complaints procedure*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006264, accessed 10 January 2011).

Department of Health (1997). *The new NHS: modern, dependable*. London, Department of Health (http://www.archive.official-documents.co.uk/document/doh/newnhs/contents.htm, accessed 3 January 2011).

Department of Health (1998a). *Information for health – an information strategy for the modern NHS 1998–2005: a national strategy for local implementation*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007832, accessed 10 January 2011).

Department of Health (1998b). *Partnership in action (new opportunities for joint working between health and social services)*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008919, accessed 10 January 2011).

Department of Health (1998c). *Modernising social services: promoting independence, improving protection, raising standards* London, Department of Health (Cm 4169) (http://www.archive.official-documents.co.uk/document/cm41/4169/4169.htm, accessed 3 January 2011).

Department of Health (1998d). *A first class service: quality in the new NHS*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902, accessed 10 January 2011).

Department of Health (1999a). *Doubly disabled: equality for disabled people in the new NHS – access to services*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006828, accessed 10 January 2011).

Department of Health (1999b). *Caring about carers: a national strategy for carers*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4049323.pdf, accessed 12 January 2011).

Department of Health (1999c). *National service framework for mental health: modern standards and service models*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077209.pdf, (accessed 29 January 2011).

Department of Health (1999d). *The NHS performance assessment framework*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4057184.pdf, accessed 12 January 2011).

Department of Health (1999e). *Saving lives: our healthier nation*. London, Department of Health (http://www.archive.official-documents.co.uk/document/cm43/4386/4386.htm, accessed 3 January 2011).

Department of Health (2000a). *The NHS plan: a plan for investment, a plan for reform*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf, accessed 12 January 2011).

Department of Health (2000b). *An organisation with a memory: report of an expert group on learning from adverse events in the NHS*. Norwich, The Stationery Office (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4065083, accessed 10 January 2011).

Department of Health (2000c). *For the benefit of patients: a concordat with the private and voluntary health care provider sector*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006892, accessed 10 January 2011).

Department of Health (2000d). *Shaping the future NHS: long term planning for hospitals and related services. Consultation document on the findings of the national beds inquiry – supporting analysis*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009640, accessed 10 January 2011).

Department of Health (2000e). *Comprehensive critical care: a review of adult critical care services*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082872.pdf, accessed 12 January 2011).

Department of Health (2000f). *Measures to control the price of generic medicines sold to community pharmacies and dispensing doctors*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4117461.pdf, accessed 12 January 2011).

Department of Health (2000g). *Hospital activity statistics – day care attendances*. Only available electronically: Department of Health (http://www.performance.doh.gov.uk/hospitalactivity/data_requests/day_care_attendances.htm, accessed 3 January 2011).

Department of Health (2000h). *The NHS cancer plan: a plan for investment, a plan for reform*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014513.pdf, accessed 12 January 2011).

Department of Health (2000i). *National service framework for coronary heart disease*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4057526.pdf, accessed 12 January 2011).

Department of Health (2001a). *Your guide to the NHS: getting the most from your National Health Service*. London, Department of Health (http://www.nnuh.nhs.uk/docs%5Cleaflets%5C36.pdf, accessed 15 February 2011).

Department of Health (2001b). *Shifting the balance of power within the NHS: securing delivery*. London, Department of Health (http://www.nnuh.nhs.uk/docs%5Cleaflets%5C36.pdf, accessed 15 February 2011).

Department of Health (2001c). *The NHS plan: proposal for a new approach to the consultant contract*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002985, accessed 10 January 2011).

Department of Health (2001d). *The report of the Chief Medical Officer's project to strengthen the public health function*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4062359.pdf, accessed 12 January 2011).

Department of Health (2001e). *Health Secretary announces new plans to improve health in poorest areas*. London, Department of Health (Press release 2001/0108, 28 February (http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4014292, accessed 10 January 2011).

Department of Health (2001f). *Reforming emergency care*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058836.pdf, accessed 12 January 2011).

Department of Health (2001g). *Ambulance services, England: 2000–01*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4022143.pdf, accessed 12 January 2011).

Department of Health (2001h). *National service framework for older people*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066, accessed 10 January 2011).

Department of Health (2001i). *Intermediate care*. London, Department of Health (HSC 2001/01: LAC (2001) (http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003694, accessed 10 January 2011).

Department of Health (2001j). *Mental health & learning disability: hospital beds & places in residential & nursing care homes for people with mental illness*. London, Department of Health (http://www.performance.doh.gov.uk/HPSSS/TBL_B23.htm, accessed 3 January 2011).

Department of Health (2001k). *Government response to the House of Lords Select Committee on Science and Technology's report on complementary and alternative medicine*. London, Department of Health (Cm 5124) (http://www.archive.official-documents.co.uk/document/cm51/5124/5124.htm, accessed 3 January 2011).

Department of Health (2001l). *The expert patient: a new approach to chronic disease management for the 21st century*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018578.pdf, accessed 12 January 2011).

Department of Health (2001m). *National service framework for diabetes*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058938.pdf, accessed 12 January 2011).

Department of Health (2002a). *Growing capacity: independent sector diagnosis and treatment centres*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005842, accessed 10 January 2011).

Department of Health (2002b). *Reforming NHS financial flows – introducing payment by results*. London, Department of Health (http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4016901, accessed 10 January 2011).

Department of Health (2002c). *Delivering the NHS plan – next steps on investment, next steps on reform*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118524.pdf, accessed 12 January 2011).

Department of Health (2002d). *HR in the NHS plan – more staff working differently*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009112, accessed 10 January 2011).

Department of Health (2002e). *NHS dentistry: options for change*. London, Department of Health (http://www.nao.org.uk/publications/0405/reforming_nhs_dentistry.aspx, accessed 3 January 2011).

Department of Health (2002f). *National service framework for older people: supporting implementation – intermediate care: moving forward*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006996, accessed 10 January 2011).

Department of Health (2002g). *Community care statistics 2002: supported residents (adults), England*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4023643.pdf, accessed 12 January 2011).

Department of Health (2003a). *Building on the best – choice, responsiveness and equity in the NHS*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4075292, accessed 10 January 2011).

Department of Health (2003b). *Choice of hospital: guidance for PCTs, NHS trusts and SHAs on offering patients choice of where they are treated*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006060, accessed 10 January 2011).

Department of Health (2003c). *National Health Service Act 1977: The Primary Care Trust Executive Committees (Membership) Directions 2003*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4083011, accessed 10 January 2011).

Department of Health (2003d). *Keeping the NHS local – a new direction of travel*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4085947.pdf, accessed 12 January 2011).

Department of Health (2003e). *Sold on health: public service productivity panel progress report*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4117472, accessed 10 January 2011).

Department of Health (2003f). *Public health in England*. London, Department of Health (http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/Archive/CMOtopicsarchive/Browsable/DH_4102835, accessed 10 January 2011).

Department of Health *(*2003g). *Tackling health inequalities – a programme for action*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019362.pdf, accessed 12 January 2011).

Department of Health (2003h). *Community care statistics 2003: supported residents (adults), England*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4080972.pdf, accessed 12 January 2011).

Department of Health (2003i). *Direct payments guidance – community care, services for carers and children's services (direct payments) guidance England 2003*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4069262.pdf, accessed 12 January 2011).

Department of Health (2003j). *Fair access to care services – guidance on eligibility criteria for adult social care*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019641.pdf, accessed 12 January 2011).

Department of Health (2003k). *Fairer charging policies for home care and other non-residential social services – guidance for councils with social services responsibilities*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4117931.pdf, accessed 12 January 2011).

Department of Health (2004a). *Reconfiguring the Department of Health's arm's-length bodies*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086081, accessed 10 January 2011).

Department of Health (2004b). *Making partnership work for patients, carers and service users: a strategic agreement between the Department of Health, the NHS and the voluntary and community sector*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089515, accessed 10 January 2011).

Department of Health (2004c). *Guidance to support implementation of the National Health Service (Complaints) Regulations 2004*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4088156, accessed 10 January 2011).

Department of Health (2004d). *Independent Complaints Advocacy Service (ICAS). The first year of ICAS: 1 September 2003 – 31 August 2004*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103327, accessed 10 January 2011).

Department of Health (2004e). *NHS dentistry: delivering change – report by the Chief Dental Officer (England) July 2004*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4085912, accessed 10 January 2011).

Department of Health (2004f). *Practice based commissioning – promoting clinical engagement*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4098564, accessed 10 January 2011).

Department of Health (2004g). *Agenda for change – final agreement*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4095943, accessed 10 January 2011).

Department of Health (2004h). *Global sum allocation formula*. London, Department of Health (http://www.york.ac.uk/inst/che/pdf/rp35.pdf, accessed 12 January 2011).

Department of Health (2004i). *The NHS improvement plan – putting people at the heart of public services*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084476, accessed 10 January 2011).

Department of Health (2004j). *Mobile magnetic resonance imaging (MRI scanning service)*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_4090305, accessed 10 January 2011).

Department of Health (2004k). *Medical schools: delivering the doctors of the future*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4075403, accessed 10 January 2011).

Department of Health (2004l). *National standards, local action: health and social care standards and planning framework 2005/06–2007/08*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086058.pdf, accessed 12 January 2011).

Department of Health (2004m). *Choosing health – making healthy choices easier*. London, Department of Health (http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550?IdcService=GET_FILE&dID=2344&Rendition=Web, accessed 12 January 2011).

Department of Health (2004n). *NHS funded nursing care: November 2003 census of residents of care homes receiving nursing care in England*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082241.xls, accessed 10 January 2011).

Department of Health (2004o). *National service framework for children, younger people, and maternity services: executive summary*. London, Department of Health (http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Children/DH_4089111 or http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Children/NationalServiceFrameworkdocuments/index.htm, accessed 3 January 2011).

Department of Health (2004p). *Practice based commissioning: engaging practices in commissioning*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4090359.pdf, accessed 12 January 2011).

Department of Health (2004q). *Standards for better health*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4132991.pdf, accessed 12 January 2011).

Department of Health (2004r). *National service framework for renal services*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4070359, accessed 10 January 2011).

Department of Health (2005a). *NHS redress: statement of policy*. Leeds, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4123281, accessed 10 January 2011).

Department of Health (2005b). *Commissioning a patient-led NHS*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116716, accessed 10 January 2011).

Department of Health (2005c). *Creating a patient-led NHS – delivering the NHS improvement plan*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4106506, accessed 10 January 2011).

Department of Health (2005d). *Implementing the new community pharmacy contractual framework information for primary care trusts*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4109256, accessed 10 January 2011).

Department of Health (2005e). *Treatment centres: delivering faster, quality care and choice for NHS Patients*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100523, accessed 10 January 2011).

Department of Health (2005f). *New long-term arrangements for reimbursement of generic medicines Scheme: M*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4114256.pdf, accessed 12 January 2011).

Department of Health (2005g). *Independence, well-being and choice: our vision for the future of social care for adults in England*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4106478.pdf, accessed 12 January 2011).

Department of Health (2005h). *Delivering race equality in mental health care, an action plan for reform inside and outside services*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773, accessed 10 January 2011).

Department of Health (2005i). *Choosing better oral health: an oral health plan for England*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4123253.pdf, accessed 12 January 2011).

Department of Health (2005j). *The national service framework for long-term conditions*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4105369.pdf, accessed 12 January 2011).

Department of Health (2005k). *Supporting people with long term conditions. An NHS and social care model to support local innovation and integration*. Leeds, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122574.pdf, accessed 12 January 2011).

Department of Health (2005l). *FOI request DE00000176152*. London, Department of Health.

Department of Health (2005m). *Taking healthcare to the patient: transforming NHS ambulance services*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4114270.pdf, accessed 12 January 2011).

Department of Health (2006a). *Cross-border emergency treatment: agreement between England, Scotland, Wales and Northern Ireland*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139150, accessed 10 January 2011).

Department of Health (2006b). *EU enlargement and overseas visitors' rights to primary care treatment in the UK*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_064150, accessed 10 January 2011).

Department of Health (2006c).*Our health, our care, our say: a new direction for community services*. London, Department of Health (http://www.official-documents.gov.uk/document/cm67/6737/6737.pdf, accessed 12 January 2011).

Department of Health (2006d). *Safety first: a report for patients, clinicians and healthcare managers*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062848, accessed 10 January 2011).

Department of Health (2006e). *A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137040, accessed 10 January 2011).

Department of Health (2006f). *Departmental report 2006*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_4134613, accessed 10 January 2011).

Department of Health (2006g). *Government response to the Health Committee's report on NHS Charges*. London, Department of Health (Cm 6922) (http://www.official-documents.gov.uk/document/cm69/6922/6922.pdf, accessed 12 January 2011).

Department of Health (2006h). *Primary care trust model standing orders, reservation and delegation of powers and standing financial instructions – August 2006*. Electronic publication: Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139133, accessed 10 January 2011).

Department of Health (2006i). *Best research for best health: a new national health research strategy*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127127, accessed 10 January 2011).

Department of Health (2006j). *Direct payments for people with mental health problems: a guide to action*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4131064.pdf, accessed 12 January 2011).

Department of Health (2006k). *Action on stigma: promoting mental health, ending discrimination at work*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139567, accessed 10 January 2011).

Department of Health (2006l). *Our health, our care, our say: making it happen*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4140065.pdf, accessed 12 January 2011).

Department of Health (2007a). *The DH guide: a guide to what we do and how we do it*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_083463.pdf, accessed 12 January 2011).

Department of Health (2007b). *The future regulation of health and adult social care in England: response to consultation*. London, Department of Health (http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_078227, accessed 10 January 2011).

Department of Health (2007c). *Choice matters 2007–08: putting patients in control*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076331, accessed 10 January 2011).

Department of Health (2007d). *Making experiences count – the proposed new arrangements for handling health and social care complaints*: *detailed policy background*. London, Department of Health (http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_075652, accessed 10 January 2011).

Department of Health (2007e). *Getting ready for LINks – planning your local involvement network*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077266, accessed 10 January 2011).

Department of Health (2007f). *Promoting equality: response from Department of Health to the Disability Rights Commission report, "Equal Treatment: Closing the Gap"*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072955, accessed 10 January 2011).

Department of Health (2007g). *Single equality scheme 2007–2010*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075463, accessed 10 January 2011).

Department of Health (2007h). *10 steps to your SES: a guide to developing a single equality scheme*. London, Department of Health (http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Browsable/DH_066006, accessed 10 January 2011).

Department of Health (2007i). *Departmental report 2007*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_074767, accessed 10 January 2011).

Department of Health (2007j). *Eligibility for free hospital treatment under the NHS*. London, Department of Health (http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/Browsable/DH_074373, accessed 10 January 2011).

Department of Health (2007k). *National Health Service Act 2006, The Primary Care Trust (Executive Committees and Standing Financial Instructions) Directions 2007*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Directionsfromthesecretaryofstate/DH_078673, accessed 10 January 2011).

Department of Health (2007l). *Guidance on joint strategic needs assessment*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097, accessed 10 January 2011).

Department of Health (2007m). *Rebuilding the NHS – a new generation of healthcare facilities*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075176, accessed 10 January 2011).

Department of Health (2007n). *Guidance on preparation of local IM&T plans for 2008/09*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081102, accessed 10 January 2011).

Department of Health (2007o). *FOI releases to requests made from 1 January to 31 December 2006*. London, Department of Health (http://www.dh.gov.uk/en/FreedomOfInformation/Freedomofinformationpublicationschemefeedback/FOIreleases/DH_065334, accessed 10 January 2011).

Department of Health (2007p). *Delegated limits for capital investment*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080864, accessed 10 January 2011).

Department of Health (2007q). *Maternity matters: choice, access and continuity of care in a safe service*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074199.pdf, accessed 12 January 2011).

Department of Health (2007r). *The operating framework for the NHS in England 2008/09.* London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081271.pdf, accessed 12 January 2011).

Department of Health (2007s). *Improving access to psychological therapies: commissioner-led pathfinder specification*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074600.pdf, accessed 12 January 2011).

Department of Health (2007t). *Commissioning framework for health and well-being*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_072605.pdf, accessed 12 January 2011).

Department of Health (2007u). *World class commissioning: vision*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_080952.pdf, accessed 12 January 2011).

Department of Health (2008a). *Choice at referral – supporting information for 2008/09.* London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083586, accessed 10 January 2011).

Department of Health (2008b). *Departmental report 2008*. London, The Stationery Office (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_084908, accessed 10 January 2011).

Department of Health (2008c). *Prescription charge increases remain below rate of inflation*. London, Department of Health (http://webarchive.nationalarchives.gov.uk/20080313140813/http://dh.gov.uk/en/News/Recentstories/DH_083365, accessed 10 January 2011).

Department of Health (2008d). *A quick guide to help with health costs including charges and optical voucher values. Effective from 1 April 2008*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083845.pdf, accessed 10 January 2011).

Department of Health (2008e). *Report of the Advisory Committee on Resource Allocation*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091484, accessed 10 January 2011).

Department of Health (2008f). *Resource allocation: weighted capitation formula,* 6th edn. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091849, accessed 10 January 2011).

Department of Health (2008g). *Guidance on the standard NHS contract for acute hospital services*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091451, accessed 10 January 2011).

Department of Health (2008h). *The operating framework for 2009/10 for the NHS in England*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091446.pdf, accessed 12 January 2011).

Department of Health (2008i). *Pharmacy in England: building on strengths – delivering the future.* London, Department of Health (Cm 7341) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083815, accessed 10 January 2011).

Department of Health (2008j). *Guidance on the routine collection of patient reported outcome measures (PROMs)*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092647, accessed 10 January 2011).

Department of Health (2008k). *Department of Health strategic framework*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085928, accessed 10 January 2011).

Department of Health (2008l). *Operational plans 2008/09–2010/11*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542, accessed 10 January 2011).

Department of Health (2008m). *A high quality workforce: NHS next stage review*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840, accessed 10 January 2011).

Department of Health (2008n). *New hospital schemes*. London, Department of Health (http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/Privatefinanceinitiative/Newhospitalschemes/index.htm, accessed 3 January 2011).

Department of Health (2008o). *High quality care for all: NHS next stage review final report*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf, accessed 12 January 2011).

Department of Health (2008p). *Health inequalities: progress and next steps*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085312.pdf, accessed 12 January 2011).

Department of Health (2008q). *Health inequality target monitoring – infant mortality*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081306.pdf, accessed 12 January 2011).

Department of Health (2008r). *Health inequality target monitoring – life expectancy at birth*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081305.pdf, accessed 12 January 2011).

Department of Health (2008s). *Hospital activity statistics – beds open overnight*. London, Department of Health (http://www.performance.doh.gov.uk/hospitalactivity/data_requests/beds_open_overnight.htm, accessed 3 January 2011).

Department of Health (2008t). *Survival rates publication on NHS Choices*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086107.pdf, accessed 12 January 2011).

Department of Health (2008u). *NHS next stage review: our vision for primary and community care*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085947.pdf, accessed 12 January 2011).

Department of Health (2008v). *Transforming social care*. London, Department of Health (LAC (DH) (2008) 1) (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082139.pdf, accessed 12 January 2011).

Department of Health (2008w). *Carers grant 2008–2011 guidance*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081666.pdf, accessed 12 January 2011).

Department of Health (2008x). *End of life care strategy: promoting high quality care for all adults at the end of life*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086345.pdf, accessed 12 January 2011).

Department of Health (2008y). *Improving access to psychological therapies implementation plan: national guidelines for regional delivery*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083168.pdf, accessed 12 January 2011).

Department of Health (2008z). *Government response to the Health Select Committee report on dental services*. London, Department of Health (Cm7470) (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_088997.pdf, accessed 12 January 2011).

Department of Health (2008aa). *Report to ministers from the Department of Health Steering Group on the statutory regulation of practitioners of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systems practised in the UK*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086358.pdf, accessed 12 January 2011).

Department of Health (2008bb). *Framework for managing choice, cooperation and competition*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_084856.pdf, accessed 12 January 2011).

Department of Health (2008cc). *Cancer reform strategy: maintaining momentum, building for the future – first annual report*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091268.pdf, accessed 12 January 2011).

Department of Health (2008dd). *GP extended opening hours results for July 2008*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089690.xls, accessed 10 January 2011).

Department of Health (2009a). *The European Commission's proposals for a directive on the application of patients' rights in cross-border healthcare – UK Government's response to consultation*. London, Department of Health (http://collections.europarchive.org/tna/20100509080731/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098387.pdf, accessed 12 January 2011).

Department of Health (2009b). *Department of Health single equality scheme 2009–2012*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100963.pdf, accessed 12 January 2011).

Department of Health (2009c). *Departmental report 2009*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100819.pdf, accessed 12 January 2011).

Department of Health (2009d). *Extension of the list of medical conditions giving exemption from NHS prescription charges: guidance for doctors*. London, Department of Health (http://www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Reviewofprescriptioncharges/index.htm, accessed 3 January 2011).

Department of Health (2009e). *Developing the Quality and Outcomes Framework: proposals for a new, independent process – consultation response and analysis*. Leeds, Department of Health (http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_096423, accessed 10 January 2011).

Department of Health (2009f). *Transforming community services: enabling new patterns of provision*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197, accessed 10 January 2011).

Department of Health (2009g). *Quality reporting in 2008–09 annual reports and accounts: a consultation for NHS foundation trusts and NHS organisations in East of England*. London, Monitor (http://www.monitor-nhsft.gov.uk/sites/default/files/090219%20quality%20reporting%20consultation%20v1%208%20JR%20(with%20gateway).pdf, accessed 12 January 2011).

Department of Health (2009h). *The operating framework for the NHS in England 2010/11*. London, Department of Health (http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/links/operatingframework2010–2011.pdf, accessed 12 January 2011).

Department of Health (2009i). *Freedom of information publication scheme – guide to information*. London, Department of Health (http://www.dh.gov.uk/en/FreedomOfInformation/Freedomofinformationpublicationschemefeedback/Classesofinformation/index.htm, accessed 3 January 2011).

Department of Health (2009j). *Average daily number of available beds, by sector, England, 1987–88 to 2008–09*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_106171.xls, accessed 10 January 2011).

Department of Health (2009k). *Necessity – not nicety: a new commercial operating model for the NHS and Department of Health*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098874.pdf, accessed 12 January 2011).

Department of Health (2009l). *Imaging and radiodiagnostics*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalActivityStatistics/DH_077487, accessed 10 January 2011).

Department of Health (2009m). *Beds open overnight – average daily number of available and occupied beds by sector, strategic health authorities in England, 2008–09*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_107064.xls, accessed 1 March 2011).

Department of Health (2009n). *Integrated care pilots: an introductory guide*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106206.pdf, accessed 12 January 2011).

Department of Health (2009o). *NHS celebrates success and progress in A&E*. London, Department of Health (Press release 15 May 2009) (http://www.dh.gov.uk/en/MediaCentre/Pressreleasesarchive/DH_099259, accessed 10 January 2011).

Department of Health (2009p). *The pharmaceutical price regulation scheme 2009*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098498.pdf, accessed 12 January 2011).

Department of Health (2009q). *The pharmaceutical price regulation scheme: tenth report to parliament*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_113578.pdf, accessed 12 January 2011).

Department of Health (2009r). *Guidance on direct payments for community care, services for carers and children's services, England 2009*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104895.pdf, accessed 12 January 2011).

Department of Health (2009s). *Shaping the future of care together*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102732.pdf, accessed 12 January 2011).

Department of Health (2009t). *End of life care strategy: quality markers and measures for end of life care*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101684.pdf, accessed 12 January 2011).

Department of Health (2009u). *Living well with dementia: a national dementia strategy*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058, accessed 10 January 2011).

Department of Health (2009v). *World class commissioning: improving dental access, quality and oral health*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093828.pdf, accessed 12 January 2011).

Department of Health (2009w). *A joint consultation on the report to ministers from the DH Steering Group on the statutory regulation of practitioners of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systems practised in the UK*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103566.pdf, accessed 12 January 2011).

Department of Health (2009x). *Clinical commissioning: our vision for practice-based commissioning*. Leeds, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108672.pdf, accessed 12 January 2011).

Department of Health (2009y). *NHS 2010–2015: from good to great. Preventative, people-centred, productive*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_109887.pdf, accessed 12 January 2011).

Department of Health (2009z). *GP extended opening hours results for July 2009*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_104001.xls, accessed 10 January 2011).

Department of Health (2009aa). *Cancer reform strategy: achieving local implementation – second annual report*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_109597.pdf, accessed 12 January 2011).

Department of Health (2009bb). *Mortality target monitoring – update to include data for 2008*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106971.pdf, accessed 12 January 2011).

Department of Health (2009cc). *The coronary heart disease national service framework: building on excellence, maintaining progress – progress report for 2008*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096556.pdf, accessed 12 January 2011).

Department of Health (2010a). *Equity and excellence: liberating the NHS*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf, accessed 12 January 2011).

Department of Health (2010b). *Ministers and department leaders*. London, Department of Health (http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/index.htm, accessed 3 January 2011).

Department of Health (2010c). *Structure charts: Department of Health*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_120567.pdf, accessed 12 January 2011).

Department of Health (2010d). *Department of Health's public bodies 2009*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111364.pdf, accessed 12 January 2011).

Department of Health (2010e). *The NHS Constitution, the NHS belongs to us all*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf, accessed 12 January 2011).

Department of Health (2010f). *The Handbook to the NHS Constitution*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113644.pdf, accessed 12 January 2011).

Department of Health (2010g). *Cross-border healthcare and patient mobility: revised advice on handling requests from patients for treatment in countries of the European Economic Area*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115252.pdf, accessed 12 January 2011).

Department of Health (2010h). *Estimated England level gross expenditure by programme budget*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_general/@dh/@en/documents/digitalasset/dh_118577.pdf, accessed 12 January 2011).

Department of Health (2010i). *Charging for residential accommodation guide (CRAG) – in support of the National Assistance (Assessment of Resources) Regulations 1992 (S.I. 1992/2977)*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115533.pdf, accessed 12 January 2011).

Department of Health (2010j). *The standard NHS contracts for acute hospital, mental health, community and ambulance services and supporting guidance*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203, accessed 1 March 2011).

Department of Health (2010k). *Payment by results guidance for 2010–11*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf, accessed 12 January 2011).

Department of Health (2010l). *2010–11 National tariff information*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_115898.xls, accessed 10 January 2011).

Department of Health (2010m). *Code of conduct for payment by results*. Leeds, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112379.pdf, accessed 12 January 2011).

Department of Health (2010n). *PCT procurement guide for health services*. London, Department of Health (http://www.ccpanel.org.uk/content/PCT-procurement-guide-for-health-services.pdf, accessed 12 January 2011).

Department of Health (2010o). *Revision to the operating framework for the NHS in England 2010/11*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116860.pdf, accessed 12 January 2011).

Department of Health (2010p). *Average daily number of available beds, by sector, England, 1987–88 to 2009–10*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_117058.xls, accessed 10 January 2011).

Department of Health (2010q). *A&E attendances*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AccidentandEmergency/DH_077485, accessed 10 January 2011).

Department of Health (2010r). *Independent sector treatment centres contract information*. London, Department of Health (http://www.dh.gov.uk/en/Healthcare/Primarycare/Treatmentcentres/DH_115042, accessed 10 January 2011).

Department of Health (2010s). *Beds open overnight, England, 2009/10*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_083781, accessed 10 January 2011).

Department of Health (2010t). *Hospital mortality rates*. London, Department of Health (http://www.dh.gov.uk/en/MediaCentre/Statementsarchive/DH_114591, accessed 10 January 2011).

Department of Health (2010u). *NHS referral to treatment (RTT) waiting times statistics for England – 2009 annual report*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_112663.pdf, accessed 12 January 2011).

Department of Health (2010v). *18 weeks referral to treatment statistics – RTT time series*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/18WeeksReferraltoTreatmentstatistics/index.htm, accessed 3 January 2011).

Department of Health (2010w). *Critical care beds*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_077451, accessed 10 January 2011).

Department of Health (2010x). *Archive: emergency admissions through accident and emergency*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086345.pdf, accessed 30 January 2011).

Department of Health (2010y). *Archive: total time spent in accident and emergency*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AccidentandEmergency/DH_087978, accessed 30 January 2011).

Department of Health (2010z). *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care – guidance on eligibility criteria for adult social care England 2010*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113155.pdf, accessed 12 January 2011).

Department of Health (2010aa). *Building the national care service*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_114923.pdf, accessed 12 January 2011).

Department of Health (2010bb). *Average daily number of available and occupied residential beds, NHS organisations in England, 2009/10*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_117060.xls, accessed 10 January 2011).

Department of Health (2010cc). *Steele implementation programme – becoming a Steele pilot*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112294.pdf, accessed 12 January 2011).

Department of Health (2010dd). *Liberating the NHS: report of the arm's-length bodies review*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118053.pdf, accessed 12 January 2011).

Department of Health (2010ee). *Inpatient and outpatient waiting times statistics*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_117904.xls, accessed 10 January 2011).

Department of Health (2010ff). *Imaging and radiodiagnostics*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalActivityStatistics/DH_077487, accessed 25 February 2011).

Department of Health (2010gg). *Payment by results. Step-by-step guide: calculating the 2010/11 national tariff*. Leeds, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112963.pdf, accessed 12 January 2011).

Department of Health (2010hh). *Department of Health – spending review 2010*. London, Department of Health. (http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_120676, accessed 24 January 2011).

Department of Health and Department for Children, Schools and Families (2009). *Healthy lives, brighter futures – the strategy for children and young people's health*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_094397.pdf, accessed 12 January 2011).

Department of Health and Department for Education and Skills (2004). *National service framework for children, young people and maternity services – maternity standard*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4090523.pdf, accessed 12 January 2011).

Department of Health and Independent Healthcare Association (2000). *For the benefit of patients: a concordat with the private and voluntary health care provider sector*. London, Department of Health. (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076781.pdf, accessed 12 January 2011).

Department of Health and Ministry of Defence (2005). *Delivering our armed forces' healthcare needs: a concordat between the UK Departments of Health and the Ministry of Defence*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126590, accessed 10 January 2011).

Department of Health and Social Security (1980). *Hospital services: the future of hospital provision*. London, Her Majesty's Stationery Office.

Department of Health and Social Security Resource Allocation Working Party (1976). *Sharing resources for health in England*. London, Her Majesty's Stationery Office (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121873, accessed 10 January 2011).

Department of Health and Welsh Office (1995). *A policy framework for commissioning cancer services: a report by the expert advisory group on cancer to the Chief Medical Officers of England and Wales (Calman–Hine report)*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014366.pdf, accessed 12 January 2011).

Devlin NJ, Appleby J (2010). *Getting the most out of PROMs: putting health outcomes at the heart of NHS decision-making*. London, The King's Fund (http://www.kingsfund.org.uk/publications/proms.html, accessed 3 January 2011).

Disability Rights Commission (2006). *Equal treatment: closing the gap – a formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems*. Stratford, Disability Rights Commission (http://www.leeds.ac.uk/disability-studies/archiveuk/DRC/Health%20FI%20main.pdf, accessed 12 January 2011).

Dixon A et al. (2007). Is the British National Health Service equitable? The evidence on socioeconomic differences in utilization. *Journal of Health Services Research and Policy*, 12:104–109.

Dixon A et al. (2010). *Patient choice: how patients choose and how providers respond*. London, The King's Fund (http://www.kingsfund.org.uk/publications/patient_choice.html, accessed 3 January 2011).

Donaldson L (2007). *Dirty hands … the human cost – 2006 Annual Report of the Chief Medical Officer on the state of public health*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076846.pdf, accessed 12 January 2011).

Dyke G (1998). *The new NHS Charter – a different approach*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005210, accessed 10 January 2011).

Eurobarometer (2007). *Health and long-term care in the European Union, Special Eurobarometer 283 EB67.3*. Brussels, European Commission (http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf, accessed 12 January 2011).

European Commission (2008). *Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare*. Brussels, Commission of the European Communities (COM(2008) 414 final, 2008/0142(COD)) (http://ec.europa.eu/health-eu/doc/com2008414_en.pdf, accessed 12 January 2011).

European Court of Human Rights (2004). *Chamber Judgment H.L. v. The United Kingdom – Application No.45508/99*. Strasbourg, European Court of Human Rights (http://www.echr.coe.int/Eng/Press/2004/Oct/ChamberjudgmentHLvtheUK051004.htm, accessed 3 January 2011).

European Parliament and Council (2003). *Directive 2002/92/EC of the European Parliament and of the Council of 9 December 2002 on insurance mediation*. Brussels, Official Journal of the European Communities (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:009:0003:0010:EN:PDF, accessed 3 January 2011).

Eurostat (2007). *Europe in figures: Eurostat yearbook 2006–07*. Luxembourg, European Commission (http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-CD-06-001/EN/KS-CD-06-001-EN.PDF, accessed 10 January 2011).

Extending Professional Regulation Working Group (2009). *Extending professional and occupational regulation – the report of the Working Group on Extending Professional Regulation*. London, Department of Health. (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102818.pdf, accessed 12 January 2011).

Faculty of Occupational Medicine of the Royal College of Physicians (2006). *Provision of occupational health services to small and medium sized enterprises (SMEs)*. London, Faculty of Occupational Medicine (http://www.facoccmed.ac.uk/library/docs/pp_smes.pdf, accessed 12 January 2011).

Farrington-Douglas J, Brooks R (2007). *The future hospital: the progressive case for change*. London, Institute for Public Policy Research (http://www.ippr.org.uk/publicationsandreports/publication.asp?id=518, accessed 30 January 2011).

Francis R (2010). *Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009,* Vol. 1. London, The Stationery Office (Francis Report) (http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf, accessed 12 January 2011).

Freeney M et al. (1999). *Working in partnership to implement Section 21 of the Disability Discrimination Act 1995 across the National Health Service*. London, NHS Executive (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007773, accessed 10 January 2011).

Gabbay J (1992). The health of the nation. *BMJ*, 305:129–130.

Gaffney D et al. (1999a). PFI in the NHS: is there an economic case. *BMJ*, 319:116–119.

Gaffney D et al. (1999b). NHS capital expenditure and the private finance initiative: expansion or contraction? *BMJ*, 319:48–51.

Gaynor M, Moreno-Serra R, Propper C (2010). *Death by market power: reform, competition and patient outcomes in the National Health Service*. Bristol, Centre for Market and Public Organisation (Working paper 10/242) (http://www.bristol.ac.uk/cmpo/publications/papers/2010/wp242.pdf, accessed 12 January 2011).

GDC (2005). *Standards for dental professionals*. London, General Dental Council (http://www.gdc-uk.org/Newsandpublications/Publications/Publications/StandardsforDentalProfessionals[1].pdf, accessed 12 January 2011).

GDC (2006). *Continuing professional development (CPD) for dentists*. London, General Dental Council (http://www.gdc-uk.org/Newsandpublications/Publications/Publications/CPDfordentists2010[1].pdf, accessed 12 January 2011).

GDC (2008a). *General Dental Council annual report 2007.* London, General Dental Council (http://www.gdc-uk.org/Newsandpublications/Publications/Publications/AnnualReport2007FINAL1[1].pdf, accessed 12 January 2011).

GDC (2008b). *The first five years,* 3rd edn (interim). London, General Dental Council (http://www.gdc-uk.org/Dentalprofessionals/Education/Documents/TheFirstFiveYears.pdf, accessed 12 January 2011).

GMC (2003). *Tomorrow's doctors*. London, General Medical Council (http://www.gmc-uk.org/static/documents/content/TomorrowsDoctors_2003.pdf, accessed 12 January 2011).

GMC (2006). *Good medical practice*. London, General Medical Council (http://www.gmc-uk.org/static/documents/content/GMP_0910.pdf, accessed 12 January 2011).

GMC (2009). *FAQs about undergraduate education*. London, General Medical Council. Electronic publication only (http://www.gmc-uk.org/education/undergraduate/undergraduate_faqs.asp, accessed 12 January 2011).

GMC (2010). *Bodies awarding UK medical degrees*. London, General Medical Council. Electronic publication only (http://www.gmc-uk.org/education/undergraduate/awarding_bodies.asp, accessed 12 January 2011).

General Osteopathic Council (2010). *Surveys & statistics*. London, General Osteopathic Council (http://www.osteopathy.org.uk/resources/surveys-statistics/, accessed 10 January 2011).

General Practitioners Committee (2004). *The new GMS contract explained – focus on patient registration*. London, British Medical Association (http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFfocuspatientreg0404/$FILE/Focuspatientreg0404.pdf, accessed 12 January 2011).

Gilmore I (2010). *Prescription charges review: implementing exemption from prescription charges for people with long term conditions*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_116367.pdf, accessed 12 January 2011).

Glendinning C et al. (2008a). *Evaluation of the individual budgets pilot programme: summary report*. York, Individual Budgets Evaluation Network (http://www.lse.ac.uk/collections/PSSRU/pdf/IBSENSummaryReport.pdf, accessed 30 January 2011).

Glendinning C et al. (2008b). *Evaluation of the individual budgets pilot programme: final report*. York, Social Policy Research Unit, University of York (http://www.york.ac.uk/inst/spru/pubs/pdf/IBSEN.pdf, accessed 12 January 2011).

Goddard E (2008). *General household survey 2006: smoking and drinking among adults, 2006*. Newport: Office for National Statistics (http://www.vhscotland.org.uk/library/misc/Smokinganddrinkingamongadults2006.pdf, accessed 12 January 2011).

Gray S, Sandberg E (2006). *The specialist public health workforce in the UK – 2005 survey.* London, Faculty of Public Health (http://www.teespublichealth.nhs.uk/Download/Public/1012/DOCUMENT/3686/FPH%20Report%20Specialist%20Public%20Health%20Workforce%20in%20the%20UK.pdf, accessed 12 January 2011).

Green S, Miles R (2009). *Access to cardiac care in the UK: a report on invasive procedures in cardiac conditions – recent trends, variations in access & future need*. London, Oxford Healthcare Associates (http://www.bcs.com/documents/Access_to_Cardiac_Care_in_the_UK_-_Full_Version_FINAL_1_07_09.pdf, accessed 12 January 2011).

Griffiths R (1983). *NHS management inquiry report*. London, Department of Health and Social Security (Griffiths Report).

Hancock R et al. (2007). *Paying for long-term care for older people in the UK: modelling the costs and distributional effects of a range of options*. Canterbury, Personal Social Services Research Unit (Discussion Paper 2336/2) (http://www.pssru.ac.uk/pdf/dp2336_2.pdf, accessed 12 January 2011).

Harrison A, Appleby J (2005). *The war on waiting for hospital treatment – what has Labour achieved and what challenges remain?* London, The King's Fund (http://www.kingsfund.org.uk/publications/the_war_on.html, accessed 3 January 2011).

Harrison A, Appleby J (2009). Reducing waiting times for hospital treatment: lessons from the English NHS. *Journal of Health Services Research and Policy*, 14:168–173.

Harrison A, Prentice S (1996). *Acute futures*. London, The King's Fund.

Hassell K, Seston L, Eden M (2006). *Pharmacy workforce census 2005: main findings*. London, Royal Pharmaceutical Society of Great Britain (http://www.rpsgb.org.uk/pdfs/census05.pdf, accessed 12 January 2011).

Hayes G (2009). *Independent review of NHS and social care IT*. London, EHealth Insider (http://www.e-health-insider.com/img/document_library0282/NHS_and_Social_Care_IT_Review%5B1%5D.pdf, accessed 12 January 2011).

Haynes J (2010). *Expenditure on healthcare in the UK*. London, Office for National Statistics (http://www.statistics.gov.uk/articles/nojournal/Expenditure-on-Healthcare-in-the-UK.pdf, accessed 12 January 2011).

Hazeldine M et al. (2010). Follow-up survey of general practitioners' perceptions of UK allergy services. *Primary Care Respiratory Journal,* 19:84–86.

Health and Safety Commission & Health and Safety Executive (2000). *Securing health together – a long-term occupational health strategy for England, Scotland and Wales*. Sheffield, Health and Safety Executive (http://www.hse.gov.uk/sh2/sh2strategy.pdf, accessed 12 January 2011).

Health and Safety Executive (2000a). *Occupational Health Advisory Committee report and recommendations on improving access to occupational health support*. Sheffield, Health and Safety Executive (http://www.hse.gov.uk/aboutus/meetings/iacs/ohac/access.htm, accessed 3 January 2011).

Health and Safety Executive (2000b). *The Employment Medical Advisory Service and you*. Sheffield, Health and Safety Executive (http://www.luton.gov.uk/media%20library/pdf/environment%20&%20regeneration/environmental%20&%20consumer%20services/health%20&%20safety/emas.pdf, accessed 12 January 2011).

Healthcare Commission (2007). *Investigation into outbreaks of* Clostridium difficile *at Maidstone and Tunbridge Wells NHS Trust*. London, Healthcare Commission (http://webarchive.nationalarchives.gov.uk/20100611090857/http://www.cqc.org.uk/_db/_documents/Maidstone_and_Tunbridge_Wells_investigation_report_Oct_2007.pdf, accessed 12 January 2011).

Healthcare Commission (2008a). *Towards better births: a review of maternity services in England*. London, Healthcare Commission (http://www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf, accessed 12 January 2011).

Healthcare Commission (2008b). *State of healthcare, 2008*. London, Healthcare Commission (http://www.cqc.org.uk/_db/_documents/State_of_Healthcare_2008.pdf, accessed 12 January 2011).

Healthcare Commission (2008c). *Not just a matter of time: a review of urgent and emergency care services in England*. London, Healthcare Commission (http://www.wehct.nhs.uk/hcc-report.pdf, accessed 12 January 2011).

Hellowell M, Pollock A (2009). The private financing of NHS hospitals: politics, policy and practice. *Economic Affairs*, 29:13–19.

Help the Hospices (2006). *Volunteer value – a pilot survey in UK hospices*. London, Help the Hospices (http://www.helpthehospices.org.uk/our-services/publications/publications-catalogue/, accessed 14 January 2011).

Help the Hospices (2009). *Hospice and Palliative Care Directory – United Kingdom and Ireland 2009–2010*. London, Help the Hospices.

Hicks J, Allen G (1999). *A century of change: trends in UK statistics since 1900*. London, House of Commons Library (Research Paper 99/111) (http://www.parliament.uk/documents/commons/lib/research/rp99/rp99–111.pdf, accessed 12 January 2011).

HM Government (2005). *The Kerr/Haslam Inquiry*. London, The Stationery Office (Cm 6640) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4115349, accessed 14 January 2011).

HM Government (2007). *Putting people first – a shared vision and commitment to the transformation of adult social care*. London, HM Government (http://www.dhcarenetworks.org.uk/_library/Resources/ALC/OtherOrganisation/Putting_People_First.pdf, accessed 30 January 2011).

HM Government (2008). *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085338.pdf, accessed 12 January 2011).

HM Revenue and Customs (2007). *Departmental autumn performance report 2007*. London, HM Revenue and Customs (Cm 7251) (http://www.hmrc.gov.uk/about/autumn-report-2007.pdf, accessed 12 January 2011).

HM Revenue and Customs (2010). *Measuring tax gaps 2010*. London, HM Revenue and Customs (http://www.hmrc.gov.uk/stats/measuring-tax-gaps-2010.htm.pdf, accessed 12 January 2011).

HM Treasury (2002). *Budget 2002 – the strength to make long-term decisions: investing in an enterprising, fairer Britain*. London, The Stationery Office (http://webarchive.nationalarchives.gov.uk/20100407010852/http://www.hm-treasury.gov.uk/d/Budget_2002.pdf, accessed 12 January 2011).

HM Treasury (2003). *The Green Book: appraisal and evaluation in central government*. London, The Stationery Office (http://www.hm-treasury.gov.uk/d/green_book_complete.pdf, accessed 30 January 2011).

HM Treasury (2004). *Building a cooperative assurance relationship between internal audit, departmental gateway coordinators and centres of excellence*. London, The Stationery Office (http://www.hm-treasury.gov.uk/d/ocg_audit_190105.pdf, accessed 12 January 2011).

HM Treasury (2007). *Meeting the aspirations of the British people: 2007 pre-budget report and comprehensive spending review, October 2007*. London, The Stationery Office (http://www.hm-treasury.gov.uk/d/pbr_csr07_completereport_1546.pdf, accessed 12 January 2011).

HM Treasury (2008). *Budget 2008: stability and opportunity: building a strong, sustainable future*. London, The Stationery Office (http://www.hm-treasury.gov.uk/media/9/9/bud08_completereport.pdf, accessed 12 January 2011).

HM Treasury (2009a). *Budget 2009: building Britain's future*. London, HM Treasury (http://www.hm-treasury.gov.uk/d/Budget2009/bud09_completereport_2591.pdf, accessed 12 January 2011).

HM Treasury (2009b). *2009 Value for money update*. London, HM Treasury (http://webarchive.nationalarchives.gov.uk/20100407010852/http://www.hm-treasury.gov.uk/d/vfm_2009update_pu787_230409.pdf, accessed 12 January 2011).

HM Treasury (2010). *Budget 2010*. London, The Stationery Office (http://www.hm-treasury.gov.uk/d/junebudget_complete.pdf, accessed 12 January 2011).

Hole A et al. (2008). *Fairness in primary care procurement measures of under-doctoredness: sensitivity analysis and trends*. York, Centre for Health Economics, University of York (Research Paper 35) (http://www.york.ac.uk/inst/che/pdf/rp35.pdf, accessed 12 January 2011).

Home Office (2009). *Control of immigration: statistics, United Kingdom 2008*. London, Home Office (http://rds.homeoffice.gov.uk/rds/pdfs09/hosb1409.pdf, accessed 12 January 2011).

Home Office (2010). *Applications received for asylum in the United Kingdom, Q1 2009 to May 2010*. London, Home Office (http://rds.homeoffice.gov.uk/rds/pdfs10/asylum-may2010.xls, accessed 14 January 2011).

Home Office UK Border Agency (2010). *Government-approved shortage occupation list for tier 2 of the points based system 29 April 2010*. London, Home Office (http://www.ukba.homeoffice.gov.uk/sitecontent/documents/workingintheuk/shortageoccupationlist.pdf, accessed 12 January 2011).

House of Commons (2009a). Written answers to questions. *Hansard* 28 January 2009, column 624W. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090128/text/90128w0027.htm, accessed 5 January 2011).

House of Commons (2009b). Written answers to questions. *Hansard* 9 February 2009, column 1768W. London, The Stationery Office. (http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090209/text/90209w0055.htm, accessed 5 January 2011).

House of Commons (2009c). Written answers to questions. *Hansard* 9 March 2009, column 125W. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090309/text/90309w0027.htm#column_124W, accessed 5 January 2011).

House of Commons (2010a). Written answers to questions. *Hansard* 26 July 2010, column 743W. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm100726/text/100726w0006.htm, accessed 5 January 2011).

House of Commons (2010b). Written answers to questions. *Hansard* 2 March 2010, column 1094W. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200910/cmhansrd/cm100302/text/100302w0023.htm, accessed 5 January 2011).

House of Commons Library (2002). *The National Insurance Contributions Bill: Bill 130 of 2001–02*. London, House of Commons Library (Research Paper 02/32, 8 May 2002) (http://www.parliament.uk/documents/commons/lib/research/rp2002/rp02-032.pdf, accessed 12 January 2011).

House of Commons Public Accounts Committee (2009). *The national programme for IT in the NHS: progress since 2006*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200809/cmselect/cmpubacc/153/153.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (1998). *Minutes of evidence: examination of witnesses (Questions 661–679)*, 6 May 1998. London, The Stationery Office. (http://www.publications.parliament.uk/pa/cm199798/cmselect/cmhealth/586/8050602.htm, accessed 12 January 2011).

House of Commons Select Committee on Health (2002). *The role of the private sector in the NHS*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200102/cmselect/cmhealth/308/30802.htm, accessed 3 January 2011).

House of Commons Select Committee on Health (2003). *Public expenditure on health and personal social services 2002*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200102/cmselect/cmhealth/1210/1210m01.htm, accessed 3 January 2011).

House of Commons Select Committee on Health (2004a). *Public expenditure on health and personal social services 2003*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200203/cmselect/cmhealth/1108/1108m01.htm, accessed 3 January 2011).

House of Commons Select Committee on Health (2004b). *Public expenditure on health and personal social services 2004*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/1113/111301.htm, accessed 3 January 2011).

House of Commons Select Committee on Health (2004c). *Palliative care,* Vol. 1. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/454/454.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2005). *NHS continuing care,* Vol. 1. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/399/399i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2006a). *NHS charges,* Vol 1. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/815/815-i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2006b). *Public expenditure on health and personal social services 2005*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/736/736.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2006c). *Changes to primary care trusts*. London, The Stationery Office (HC 646) (http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/646/646.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2006d). *Independent sector treatment centres*. London, The Stationery Office (HC 934–1) (http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2006e). *Public expenditure on health and personal social services 2006*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/1692-i/1692-i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2007a). *Public expenditure on health and personal social services 2007.* London, The Stationery Office (HC 26–1) (http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/26/26i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2007b). *Patient and public involvement in the NHS,* Vol. 1. London, The Stationery Office (HC 278–1) (http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/278/278i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2007c). *The electronic patient record*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/422/422.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2007d). *Workforce planning*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2008a). *Dental services,* Vol. 1. London, The Stationery Office (HC 289–1) (http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/289i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2008b). *Public expenditure on health and personal social services 2008*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/1190/1190.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2009a). *Health inequalities,* Vol. 1. London, The Stationery Office (HC 286–1) (http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/286.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2009b). *Patient safety,* Vol. 1. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/151i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2010a). *Public expenditure on health and personal social services 2009*. London, The Stationery Office (http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/269/269i.pdf, accessed 12 January 2011).

House of Commons Select Committee on Health (2010b). *Social care,* Vol. 1. London, The Stationery Office (HC 22–1) (http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/22/22.pdf, accessed 12 January 2011).

House of Commons Work and Pensions Committee (2008). *Valuing and supporting carers*. London, The Stationery Office (HC 485–1) (http://www.publications.parliament.uk/pa/cm200708/cmselect/cmworpen/485/485i.pdf, accessed 12 January 2011).

House of Lords Committee on Science and Technology (2000). *Sixth report session 1999–00: complementary and alternative medicine*. London, The Stationery Office (http://www.publications.parliament.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm, accessed 3 January 2011).

HPA (2007). *Testing times: HIV and other sexually transmitted infections in the United Kingdom: 2007.* London, Health Protection Agency (http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1203496897276, accessed 14 January 2011).

HPA (2009). *HIV in the United Kingdom: 2009 report*. London, Health Protection Agency (http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1259151891830, accessed 14 January 2011).

HPA (2010a). *Epidemiological data*. London, Health Protection Agency (http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1191942172799?p=1191942172799, accessed 14 January 2011).

HPA (2010b). *Health protection report,* Vol. 4(21). London, Health Protection Agency (http://www.hpa.org.uk/hpr/archives/2010/hpr2110.pdf, accessed 12 January 2011).

HPA (2010c). *Health protection report,* Vol. 4(40). London, Health Protection Agency (http://www.hpa.org.uk/hpr/archives/2010/hpr4010.pdf, accessed 12 January 2011).

HPA (2010d). *About the HPA*. London, Health Protection Agency (http://www.hpa.org.uk/AboutTheHPA/, accessed 14 January 2011).

HPA (2010e). *Quarterly epidemiological commentary: mandatory MRSA bacteraemia &* Clostridium difficile *infection (October 2007 to December 2009)*. London, Health Protection Agency (http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1267551242367, accessed 14 January 2011).

Humphries R, Forder J, Fernandez J-L (2010). *Securing good care for more people: options for reform*. London, The King's Fund (http://www.kingsfund.org.uk/publications/securing_good_care.html, accessed 3 January 2011).

Hunter D (2010). The impact of the spending review on health and social care. *BMJ*, 341:c6022.

Hunter D, Marks L, Smith K (2007). *The public health system in England: a scoping study*. Durham, Centre for Public Policy and Health (http://www.sdo.nihr.ac.uk/files/project/150-final-report.pdf, accessed 30 January 2011).

IFF Research Ltd (2007). *Third sector market mapping: research report prepared for Department of Health*. London, IFF Research (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065411, accessed 14 January 2011).

Imison C, Buchan J, Xavier S (2009). *NHS workforce planning: limitations and possibilities*. London, The King's Fund (http://www.kingsfund.org.uk/publications/nhs_workforce.html, accessed 3 January 2011).

Information Centre (2005a). *Ambulance services, England 2004–05*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/ambulanceserv05/AmbulanceServices170605_PDF.pdf, accessed 12 January 2011).

Information Centre (2005b). *Community care statistics 2004: home care services for adults, England*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/commcare05/CommunityCareStatistics260505_PDF.pdf, accessed 12 January 2011).

Information Centre (2005c). *Community care statistics 2004–05: referrals, assessments and packages of care for adults, England: national summary*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/commcare05adultengsum/CommunityCareStatistics161205_PDF.pdf, accessed 12 January 2011).

Information Centre (2006a). *NHS dental activity and workforce report, England: 31 March 2006*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/dwfactivity/NHSDentalActivityWorkforce230806_PDF.pdf, accessed 12 January 2011).

Information Centre (2006b). *Community care statistics 2005–06: referrals, assessments and packages of care for adults, England: national summary*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/ccs0506/CommunityCareStatistics151206_PDF.pdf, accessed 12 January 2011).

Information Centre (2007a). *NHS immunisation statistics, England 2006–07*. London, Information Centre (http://www.ic.nhs.uk/webfiles/publications/immstats2005to2006/Final%202006–07%20Immunisation%20Bulletin%20%28with%20copyright%29.pdf, accessed 12 January 2011).

Information Centre (2007b). *General ophthalmic services: activity statistics for England and Wales year ending 31 March 2007*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/gosactivity/General%20Ophthalmic%20Services%20Activity%20year%20end%20March%202007.pdf, accessed 12 January 2011).

Information Centre (2007c). *Staff in the NHS 1996–2006 overview*. Leeds, Information Centre (http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1996--2006-overview, accessed 14 January 2011).

Information Centre (2007d). *Ambulance services England 2006–07*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/ambulanceserv06/Final%20Ambulance%20Services%202006–07.pdf, accessed 12 January 2011).

Information Centre (2008a). *Statistics on obesity, physical activity and diet: England, January 2008*. London, Information Centre (http://www.ic.nhs.uk/webfiles/publications/opan08/OPAD%20Jan%202008%20final%20v6%20with%20links%20and%20buttons.pdf, accessed 12 January 2011).

Information Centre (2008b). *GP patient survey (hospital choice) national report 2007/08 (England)*. London, Information Centre (http://www.ic.nhs.uk/webfiles/publications/gppatientsurvey2008/GP%20Patient%20Survey%20Hospital%20Choice%20National%20Report%202007%2008.pdf, accessed 12 January 2011).

Information Centre (2008c). *GP patient survey (access) national report 2007/08 (England)*. London, Information Centre (http://www.ic.nhs.uk/webfiles/publications/gppatientsurvey2008/GP%20Patient%20Survey%20Access%20National%20Report%202007%2008.pdf, accessed 12 January 2011).

Information Centre (2008d). *Prescriptions dispensed in the community – statistics for 1997 to 2007: England*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/PCA%20publication/Final%20version%20210708.pdf, accessed 12 January 2011).

Information Centre (2008e). *NHS hospital and community health services: medical and dental staff, England 1997–2007*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/nhsstaff2007/med%20and%20den/Revised%20Medical%20and%20Dental%20bull%2097–07.pdf, accessed 12 January 2011).

Information Centre (2008f). *Community care statistics 2008: supported residents (adults), England*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/commcareSR12007/2008%20SR1%20PSA%20Revised%202009.pdf, accessed 12 January 2011).

Information Centre (2009a). *Health survey for England – 2008 trend tables*. Leeds, Information Centre (http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england--2008-trend-tables, accessed 14 January 2011).

Information Centre (2009b). *NHS immunisation statistics, England 2008–09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/immunisationstats0809/NHS_Immunisation_Statistics_England_2008_09_Bulletin.pdf, accessed 12 January 2011).

Information Centre (2009c). *Cervical screening programme, England 2008–09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/cervscreen0809/Cervical_%20Screening_Programme_Report_2008_09_%28revised%29.pdf, accessed 12 January 2011).

Information Centre (2009d). *NHS maternity statistics, 2008–09*. Leeds, Information Centre (http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/maternity/nhs-maternity-statistics-2008–09, accessed 14 January 2011).

Information Centre (2009e). *Quality and outcomes framework achievement data 2008/09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/QOF/2008–09/QOF%20Achievement%20and%20Prevalence%20Bulletin%202008–09.pdf, accessed 12 January 2011).

Information Centre (2009f). *General pharmaceutical services in England and Wales 1999–2000 to 2008–09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/Primary%20Care/Pharmacies/pharmserv9909/General%20Pharmaceutical_Services_in_England_1999_2000_to_2008_09.pdf, accessed 12 January 2011).

Information Centre (2009g). *NHS hospital and community health services: medical and dental staff, England 1998–2008*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/nhsstaff2008/medandden/Medical%20and%20Dental%20bulletin%201998–2008.pdf, accessed 12 January 2011).

Information Centre (2009h). *NHS hospital and community health services: non-medical staff, England 1998–2008*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/nhsstaff2008/nonmed/Non%20Medical%20Bulletin%2008%20print%20edition.pdf, accessed 12 January 2011).

Information Centre (2009i). *General and personal medical services detailed results, England 30 September 2008*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/nhsstaff2008/gp/Detailed%20Stats%20Sept%202008.pdf, accessed 12 January 2011).

Information Centre (2009j). *Ambulance services, England 2008–09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/Audits%20and%20Performance/Ambulance/Ambulance%20Services%2C%20England%202008_09%20Bulletin.pdf, accessed 12 January 2011).

Information Centre (2009k). *Hospital prescribing, 2008: England*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/Primary%20Care/Prescriptions/hospre08/Hospital_prescribing_2008_report2.pdf, accessed 12 January 2011).

Information Centre (2009l). *Prescriptions dispensed in the community statistics for 1998 to 2008: England*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/presdisp98–08/Prescriptions_Dispensed_in_the_Community_1998_2008_England_2.pdf, accessed 12 January 2011).

Information Centre (2009m). *In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment: 1998–99 to 2008–09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/mental%20health/mental%20health%20act/inpatientdetmha0809/KP90_October_2009.pdf, accessed 12 January 2011).

Information Centre (2009n). *Dental earnings and expenses, England and Wales, 2007/08*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/dentalearnexp0708/Dental_Earnings_and_Expenses_England_and_Wales_2007_08.pdf, accessed 12 January 2011).

Information Centre (2009o). *NHS dental statistics for England: 2008/09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/Primary%20Care/Dentistry/dentalstats0809/NHS_Dental_Statistics_for_England_2008_09_Report.pdf, accessed 12 January 2011).

Information Centre (2009p). *National lung cancer audit 2009*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/Services/NCASP/audits%20and%20reports/NHS%20IC%20Lung%20Cancer%20AUDIT%202009%20FINAL.pdf, accessed 12 January 2011).

Information Centre (2010a). *Cervical screening programme, England 2009–10*. London, Information Centre (http://www.ic.nhs.uk/webfiles/publications/008_Screening/cervscreen0910/Final_Report_v2_20Oct2010.pdf, accessed 12 January 2011).

Information Centre (2010b). *Breast screening programme, England 2008–09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/breast_screening/Breast_Screening_Programme_Report_2008_09.pdf, accessed 12 January 2011).

Information Centre (2010c). *Data on written complaints in the NHS 2009–10*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/complaints/complaints200910/Data_on_written_complaints_in_the_NHS_2009_to_10.Report.pdf, accessed 12 January 2011).

Information Centre (2010d). *Prescriptions dispensed in the community – statistics for 1999 to 2009: England*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/prescriptionsdispensed/Prescriptions_Dispensed_1999_2009%20.pdf, accessed 12 January 2011).

Information Centre (2010e). *NHS staff earnings estimates June 2010: based on payments to staff in the NHS in England from January to March 2010*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/workforce/staff_earnings/NHS_Staff_Earnings_January_March_2010_Bulletin.pdf, accessed 12 January 2011).

Information Centre (2010f). *Dental earnings and expenses, England and Wales, 2008/09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/dentalearnexp0809/Dental_Earnings_Expenses_England_Wales_2008–09.Report.pdf, accessed 12 January 2011).

Information Centre (2010g). *Hospital estates and facilities statistics 2009/10*. London, Information Centre (http://www.hefs.ic.nhs.uk/ReportFilterConfirm.asp?FilterOpen=&Year=2009%2F2010&Level=T&Section=T01&SHA=&Org_Type=&Foundation=&Site_Type=&PFI=&getReport=Get+Report, accessed 14 January 2011).

Information Centre (2010h). *Hospital estates and facilities statistics 2008/09*. London, Information Centre (http://www.hefs.ic.nhs.uk/ReportFilterTop.asp, accessed 12 January 2011).

Information Centre (2010i). *NHS hospital and community health services: medical and dental staff, England 1999–2009*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/Medical_Dental_Bulletin_1999_2009.pdf, accessed 12 January 2011).

Information Centre (2010j). *NHS hospital and community health services: medical and dental workforce census, England: 30 September 2009 – detailed results*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/Medical_Dental_Staff_2009_Detailed_Results.pdf, accessed 12 January 2011).

Information Centre (2010k). *NHS dental statistics for England: 2009/10*. London, Information Centre (http://www.ic.nhs.uk/webfiles/publications/Primary%20Care/Dentistry/dentalstats0910/NHS_Dental_Statistics_England_200910.Report.pdf, accessed 12 January 2011).

Information Centre (2010l). *NHS hospital and community health services: non-medical staff, England 1999–2009*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/Non_Medical_Bulletin_1999_2009.pdf, accessed 12 January 2011).

Information Centre (2010m). *General and personal medical services, England 1999–2009*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/General_Practice_Bulletin_1999_2009.pdf, accessed 12 January 2011).

Information Centre (2010n). *General and personal medical services detailed results, England 30 September 2009*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/General_Practice_Staff_2009_Detailed_Results.pdf, accessed 12 January 2011).

Information Centre (2010o). *Accident and emergency attendances in England (experimental statistics) 2008–09*. Leeds, Information Centre (http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1271, accessed 14 January 2011).

Information Centre (2010p). *NHS hospital and community health services non medical workforce census – England: 30 September 2009, detailed results*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/Non_Medical_Staff_2009_Detailed_Results.pdf, accessed 12 January 2011).

Information Centre (2010q). *Community care statistics 2008–09: social services activity report, England*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/Social%20Care/socialcarepubs280410/Community%20Care%20Statistics%20Social%20Services%20Activity%20Report%20England%20-%202008–09%20FINAL2.pdf, accessed 12 January 2011).

Information Centre (2010r). *Personal social services staff of social services departments at 30 September 2009, England*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/Social%20Care/socialcarepubs280410/Personal%20Social%20Services%20Staff%20of%20Social%20Services%20Departments%20-%20England%20at%2030%20September%202009%20FINAL2.pdf, accessed 12 January 2011).

Information Centre (2010s). *Personal social services expenditure and unit costs England, 2008–09*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/PSS%20staff%202008–09/Final%20-%20Personal%20Social%20Service%20Expenditure%20and%20Unit%20Cost%2C%20England%20-%202008–09_v2_29–04–10.pdf, accessed 12 January 2011).

Information Centre (2010t). *HESonline: Headline figures*. Leeds, Information Centre (http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=193, accessed 30 January 2011).

Information Centre (2010u). *National diabetes audit executive summary 2008–2009*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/Services/NCASP/audits%20and%20reports/National_Diabetes_Audit_Executive_Summary_2008_2009.pdf, accessed 12 January 2011).

Information Centre (2010v). *Quality and outcomes framework: online GP practice results database – QOF 2009/10 results*. Leeds, Information Centre (http://www.qof.ic.nhs.uk/, accessed 14 January 2011).

Information Centre (2010w). *NHS staff 1999–2009 (non-medical)*. Leeds, Information Centre (http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/Non_Medical_Bulletin_1999_2009.Tables.xls, accessed 14 January 2011).

Information Commissioner's Office (2007). *Freedom of information: two years on, February 2007*. Wilmslow, Information Commissioner's Office (http://www.ico.gov.uk/upload/documents/library/corporate/research_and_reports/foi_two_years_on_findings.pdf, accessed 12 January 2011).

Intercollegiate Group on Trauma Standards (2009). *Regional trauma systems: interim guidance for commissioners*. London, Royal College of Surgeons of England (http://www.rcseng.ac.uk/service_delivery/documents/Regional_trauma_systems%202009.pdf, accessed 12 January 2011).

Intermediate Care National Evaluation Team (2006). *A national evaluation of the costs and outcomes of intermediate care for older people*. Birmingham, Health Services Management Centre of the University of Birmingham and the Leicester Nuffield Research Unit of the University of Leicester (http://www.hsmc.bham.ac.uk/research/pdfs/Int_Care_Exec.pdf, accessed 12 January 2011).

Jobbins C et al. (2007). *Best practice guidance: specification for adult medium-secure services*. London, Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078744, accessed 14 January 2011).

Kafetz A, Bedford Z, eds. (2009). *The Doctor Foster hospital guide 2009: how safe is your hospital*? London, Doctor Foster Intelligence (http://www.drfosterhealth.co.uk/docs/hospital-guide-2009.pdf, accessed 12 January 2011).

Kamarudeen S (2010). *Amenable mortality as an indicator of healthcare quality – a literature review*. Newport, Office for National Statistics (http://www.statistics.gov.uk/articles/nojournal/Amenable-Mortality.pdf, accessed 12 January 2011).

Keen J (2008). *Does anyone care about fairness in adult social care?* York, Joseph Rowntree Foundation (http://www.jrf.org.uk/sites/files/jrf/2292.pdf, accessed 12 January 2011).

Kennedy I (2001). *The report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995: Learning from Bristol*. London, The Stationery Office (http://www.bristol-inquiry.org.uk/final_report/the_report.pdf, accessed 12 January 2011).

King D, Mossialos E (2005). The determinants of private medical insurance prevalence in England, 1997–2000. *Health Services Research*, 40:195–212.

Klein R (2006). *The new politics of the NHS, from creation to reinvention*. Abingdon, Radcliffe Publishing.

Laing & Buisson (2007). *Laing's healthcare market review 2007–2008*. London, Laing & Buisson.

Laing & Buisson (2008). *Health care cover: UK market report 2008*. London, Laing & Buisson.

Laing & Buisson (2009). *Laing's healthcare market review 2009–2010*. London, Laing & Buisson.

Lee R, Glover G (2008). *2007 adult mental health services workbook*. Stockton-on-Tees, Mental Health Observatory Brief (Issue 5, July 2008) (http://www.nepho.org.uk/uploads/doc332_1_brief005.pdf, accessed 30 January 2011).

Lewis G, ed. (2007). *The confidential enquiry into maternal and child health. Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2003–2005. The seventh report of the confidential enquiries into maternal deaths in the United Kingdom*. London, CEMACH (http://www.cemach.org.uk/getattachment/26dae364-1fc9-4a29-a6cb-afb3f251f8f7/Saving-Mothers%20-Lives-2003-2005-(Full-report).aspx, accessed 30 January 2011).

Lilford R, Pronovost P (2010). Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. *BMJ,* 340:c2016.

Lister J (2008). *The NHS after 60: for patients or profits?* London, Middlesex University Press.

Lowy A, Kohler B, Nicholl J (1994). Attendance at accident and emergency departments: unnecessary or inappropriate? *Journal of Public Health Medicine,* 16:134–140.

McGraw C, Drennan V (2004). Older people and medication management: from compliance to concordance. *Reviews in Clinical Gerontology*, 14:145–153.

Maher J, Green H (2002). *Carers 2000*. London, The Stationery Office (http://www.statistics.gov.uk/downloads/theme_health/carers2000.pdf, accessed 12 January 2011).

Manheimer E, Berman B (2008). Cochrane complementary medicine field. *About The Cochrane Collaboration (Fields)*, Issue 2: CE000052 (http://www.mrw.interscience.wiley.com/cochrane/clabout/articles/CE000052/frame.html, accessed 3 January 2011).

Mannion R et al. (2010). *Changing management cultures and organisational performance in the NHS. Produced for the National Institute for Health Research Service Delivery and Organisation Programme*. Norwich, The Stationery Office (http://www.sdo.nihr.ac.uk/files/project/94-final-report.pdf, accessed 30 January 2011).

Marie Curie Palliative Care Institute Liverpool and Clinical Standards Department of the Royal College of Physicians (2009). *National care of the dying audit – hospitals (NCDAH) round 2 generic report 2008/09.* Liverpool, Marie Curie Palliative Care Institute Liverpool (http://www.liv.ac.uk/mcpcil/pdfs/Generic_NCDAH_2nd_Round_Final_Report%5B1%5D.pdf, accessed 12 January 2011).

Marks L (1993). *Seamless care or patchwork quilt? Discharging patients from acute hospital care*. London, The King's Fund.

Marmot M (2010). *Strategic review of health inequalities in England post-2010: fair society healthy lives. The Marmot review*. London, The Marmot Review (http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf, accessed 12 January 2011).

Martin S, Rice N, Smith P C (2008). *The link between health care spending and health outcomes for the new English Primary Care Trusts*. York, Centre for Health Economics (Research Paper 42) (http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHE%20Research%20Paper%2042.pdf, accessed 12 January 2011).

Matheson J, Babb P (2002). *Social Trends*, No. 32. London, The Stationery Office (http://www.statistics.gov.uk/downloads/theme_social/Social_Trends32/Social_Trends32.pdf, accessed 12 January 2011).

Matheson J, Summerfield C, eds. (2000). *Social Trends*, No. 31, 2001 edn: Ch. 8 Social protection. London, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_social/social_trends31/ST31(final).pdf, accessed 12 January 2011).

Matthews S (2004). *Committee of inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale*. London, The Stationery Office (Cm 6315) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4088995, accessed 14 January 2011).

Maynard A, Bloor K (2003). Do those who pay the piper call the tune? *Health Policy Matters*, Issue 8. York, University of York (http://www.york.ac.uk/media/healthsciences/documents/research/hpm8final.pdf, accessed 29 January 2011).

Mental Health Strategies (2010). *2009/10 national survey of investment in adult mental health services*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_117695.pdf, accessed 12 January 2011).

MHRA (2003). *The Homeopathic Registration Scheme: guidance for manufacturers and suppliers*. London, Medicines and Healthcare products Regulatory Agency (http://www.mhra.gov.uk/home/groups/comms-ic/documents/publication/con007550.pdf, accessed 12 January 2011).

MHRA (2005). *The Blue Guide: advertising and promotion of medicines in the UK*. London, Medicines and Healthcare products Regulatory Agency (http://www.mhra.gov.uk/Howweregulate/Medicines/Advertisingofmedicines/index.htm, accessed 3 January 2011).

MHRA (2006). *The Homeopathic National Rules Scheme: brief guidance for manufacturers and suppliers*. London, Medicines and Healthcare products Regulatory Agency (http://www.mhra.gov.uk/home/groups/l-unit1/documents/websiteresources/con2024923.pdf, accessed 12 January 2011).

MHRA (2007). *Traditional Herbal Medicines Registration Scheme: guidance for retailers, wholesalers, importers and manufacturers in the requirements of the THMRS*. London, Medicines and Healthcare products Regulatory Agency (http://www.mhra.gov.uk/home/groups/pl-p/documents/websiteresources/con2030651.pdf, accessed 12 January 2011).

MHRA (2008). *MHRA annual report and accounts 2007/08*. London, Medicines and Healthcare products Regulatory Agency (http://www.mhra.gov.uk/home/groups/comms-ic/documents/publication/CON020819.pdf, accessed 12 January 2011).

Migration Advisory Committee (2010). *Skilled, shortage, sensible: third review of the recommended shortage occupation lists for the UK and Scotland: Spring 2010*. London, Migration Advisory Committee (http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/third-review-lists/0310/mac-3rd-review-10?view=Binary, accessed 14 January 2011).

Mills SY (2001). Regulation in complementary and alternative medicine. *BMJ*, 322:158–160.

Ministry of Health (1962). *Hospital Plan for England and Wales*. London, Her Majesty's Stationery Office (Cmnd 1604).

Mintel (2009). *Complementary Medicines UK – December 2009*. London, Mintel (http://reports.mintel.com/sinatra/reports/display/id=394670#about, accessed 29 January 2011).

Modernising Medical Careers (2009). *A reference guide for postgraduate specialty training in the UK – The Gold Guide,* 3rd edn. London, UK Medical Education Strategy Group (http://www.mmc.nhs.uk/pdf/Gold%20Guide%20--2009.pdf, accessed 12 January 2011).

Monitor (2008a). *Identifying risk, taking action: Monitor's approach to service performance in NHS foundation trusts*. London, Monitor (http://www.monitor-nhsft.gov.uk/sites/default/files/publications/Identifying_risk_taking_action_08.pdf, accessed 12 January 2011).

Monitor (2008b). *Compliance framework 2010–11*. London, Monitor (http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-frame-0, accessed 14 January 2011).

Monitor (2008c). *NHS foundation trusts review and consolidated accounts 2007–08*. London, The Stationery Office (http://www.monitor-nhsft.gov.uk/sites/default/files/publications/Monitor_Consolidated_Review_07–08_0.pdf, accessed 12 January 2011).

Monitor (2009a). *NHS foundation trusts: consolidated accounts 2008–09*. London, Monitor (http://www.monitor-nhsft.gov.uk/sites/default/files/NHS%20Foundation%20Trusts%20-%20Consolidated%20Accounts%202008%2009.pdf, accessed 12 January 2011).

Monitor (2009b). *Prudential borrowing code (PBC) for NHS foundation trusts 1 April 2009*. London, Monitor (http://www.monitor-nhsft.gov.uk/sites/default/files/Prudential%20Borrowing%20Code%20April%202009_0.pdf, accessed 12 January 2011).

Monitor (2010). *NHS foundation trust directory*. London, Monitor (http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory, accessed 14 January 2011).

Mossialos E, Thomson S (2002). Voluntary health insurance in the European Union. In: Mossialos E et al., eds. *Funding health care: options for Europe*, Buckingham: Open University Press.

Mossialos E, Allin S, Thomson S (2007). *Health systems in transition: template for analysis*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

NAO (2001). *Handling clinical negligence claims in England*. London, National Audit Office (http://www.nao.org.uk/publications/nao_reports/00–01/0001403.pdf, accessed 12 January 2011).

NAO (2002). *The management of surplus property by trusts in the NHS in England*. London, NAO (http://www.nao.org.uk/publications/0102/the_management_of_surplus_prop.aspx, accessed 3 January 2011).

NAO (2004). *Reforming NHS dentistry: ensuring effective management of risks*. London, National Audit Office (http://www.nao.org.uk/publications/nao_reports/04–05/040525.pdf, accessed 12 January 2011).

NAO (2005a). *A safer place for patients: learning to improve patient safety*. London, National Audit Office (http://www.nao.org.uk/publications/nao_reports/05–06/0506456es.pdf, accessed 12 January 2011).

NAO (2005b). *Innovation in the NHS: local improvement finance trusts*. London, National Audit Office (http://www.nao.org.uk/publications/0506/local_improvement_finance_trus.aspx, accessed 3 January 2011).

NAO (2005c). *Tackling cancer: improving the patient journey*. London, National Audit Office (http://www.nao.org.uk/publications/0405/tackling_cancer.aspx, accessed 3 January 2011).

NAO (2006). *The provision of out-of-hours care in England*. London, National Audit Office (http://www.nao.org.uk/publications/0506/out-of-hours_care_in_england.aspx, accessed 3 January 2011).

NAO (2007a). *Survey of NHS consultants – May 2006*. London, National Audit Office (http://www.nao.org.uk/publications/0607/pay_modernisation_a_new_contr.aspx, accessed 3 January 2011).

NAO (2007b). *Pay modernisation: a new contract for NHS consultants in England*. London, National Audit Office (http://www.nao.org.uk/publications/0607/pay_modernisation_a_new_contr.aspx, accessed 3 January 2011).

NAO (2007c). *Improving the PFI tendering process*. London, National Audit Office (http://www.nao.org.uk/publications/0607/improving_pfi_tendering.aspx, accessed 3 January 2011).

NAO (2007d). *Caring for vulnerable babies: the reorganisation of neonatal services in England*. London, National Audit Office (http://www.nao.org.uk/publications/0708/caring_for_vulnerable_babies.aspx, accessed 3 January 2011).

NAO (2008a). *NHS pay modernisation: new contracts for general practice services in England*. London, National Audit Office (http://www.nao.org.uk/publications/0708/new_contracts_for_general_prac.aspx, accessed 3 January 2011).

NAO (2008b). *Financial reporting and financial management: general report of the Comptroller and Auditor General 2007.* London, National Audit Office (http://www.nao.org.uk/publications/0708/general_report.aspx, accessed 3 January 2011).

NAO (2008c). *The national programme for IT in the NHS: progress since 2006*. London, National Audit Office (http://www.nao.org.uk/publications/0708/the_national_programme_for_it.aspx, accessed 3 January 2011).

NAO (2008d). *NHS (England) summarised accounts 2007–2008*. London, National Audit Office (http://www.nao.org.uk/publications/0809/nhs_summarised_accounts_07–08.aspx, accessed 3 January 2011).

NAO (2008e). *End of life care*. London, National Audit Office (http://www.nao.org.uk/publications/0708/end_of_life_care.aspx, accessed 3 January 2011).

NAO (2009a). *Supporting carers to care*. London, National Audit Office (http://www.nao.org.uk/publications/0809/supporting_carers_to_care.aspx, accessed 3 January 2011).

NAO (2009b). *Services for people with rheumatoid arthritis*. London, National Audit Office (http://www.nao.org.uk/publications/0809/services_for_people_with_rheum.aspx, accessed 3 January 2011).

NAO (2009c). *NHS pay modernisation in England: agenda for change*. London, National Audit Office (http://www.nao.org.uk/publications/0809/nhs_pay_modernisation.aspx, accessed 3 January 2011).

NAO (2010a). *Major trauma care in England*. London, National Audit Office (http://www.nao.org.uk/publications/0910/major_trauma_care.aspx, accessed 3 January 2011).

NAO (2010b). *Improving dementia services in England – an interim report.* London, National Audit Office (HC82) (http://www.nao.org.uk/publications/0910/improving_dementia_services.aspx, accessed 3 January 2011).

NAO (2010c). *Tackling inequalities in life expectancy in areas with the worst health and deprivation*. London, National Audit Office (http://www.nao.org.uk/publications/1011/health_inequalities.aspx, accessed 3 January 2011).

National Archives (2009). *The national digital archive of datasets: health departments*. Richmond, National Archives (http://www.ndad.nationalarchives.gov.uk/AH/21/detail.html, accessed 3 January 2011).

National Association of Citizens Advice Bureaux (2001). *Unhealthy charges*. London, National Association of Citizens Advice Bureaux (http://www.citizensadvice.org.uk/index/campaigns/social_policy/evidence_reports/er_healthcomcare/unhealthy-charges, accessed 14 January 2011).

National Center for Complementary and Alternative Medicine (2007). *CAM basics*. Bethesda, MD, US National Institutes of Health, National Center for Complementary and Alternative Medicine (http://nccam.nih.gov/health/whatiscam/D347.pdf, accessed 12 January 2011).

National Centre for Health Outcomes Development (2010a). *Clinical and health outcomes database: stroke*. London, National Centre for Health Outcomes Development (http://www.nchod.nhs.uk/NCHOD/compendium.nsf/($All)/56FF93CCEF4331D3802577FB002D7039/$File/10B_230ISR3BP_09_V1_D.xls?OpenElement#'10B_230ISR3BP_09_V1'!A1543), accessed 25 February 2011).

National Centre for Health Outcomes Development (2010b). *Clinical and health outcomes database: fractured femur*. London, National Centre for Health Outcomes Development (http://www.nchod.nhs.uk/NCHOD/compendium.nsf/($All)/A6018CD3CBCEF3FD802577FB002D7032/$File/32C_213ISR2AP_09_V1_D.xls?OpenElement, accessed 25 February 2011).

National Centre for Health Outcomes Development (2010c). *Clinical and Health Outcomes Database: mortality from all cancers*. London, National Centre for Health Outcomes Development (http://www.nchod.nhs.uk/NCHOD/compendium.nsf/($All)/7A3DD806F9A301E4802577FB002D6E34/$File/11B_075SMT0074_08_V1_D.xls?OpenElement, accessed 21 January 2011).

National Council for Hospice and Specialist Palliative Care Services (2000). *The palliative care survey 1999*. London, National Council for Hospice and Specialist Palliative Care Services (http://www.ncpc.org.uk/download/publications/archive/The_PC_Survey_1999.pdf, accessed 12 January 2011).

National Council for Hospice and Specialist Palliative Care Services (2002). *Definitions of supportive and palliative care*. London, National Council for Hospice and Specialist Palliative Care Services (http://www.ncpc.org.uk/download/publications/archive/Briefing_Bulletin_11.pdf, accessed 12 January 2011).

National Council for Hospice and Specialist Palliative Care Services (2004). *The House of Commons Health Committee Inquiry into Palliative Care: submission of evidence*. London, National Council for Hospice and Specialist Palliative Care Services (http://www.ncpc.org.uk/download/publications/archive/The_House_of_Commons_Inquiry.pdf, accessed 12 January 2011).

National Council for Palliative Care (2006). *End of life care strategy: the National Council for Palliative Care submission*. London, National Council for Palliative Care (http://www.ncpc.org.uk/download/publications/NCPC_EoLC_Submission.pdf, accessed 12 January 2011).

National Council for Palliative Care (2007). *Minimum data sets – project update including 2005/06 data*. London, National Council for Palliative Care (http://www.ncpc.org.uk/download/publications/archive/MDS_Project_Update_0506.pdf, accessed 12 January 2011).

National Institute for Mental Health in England (2004). *2004–09, a strategic plan to tackle stigma and discrimination on mental health grounds: from here to equality*. Leeds, National Institute for Mental Health in England (http://kc.csip.org.uk/viewdocument.php?action=viewdox&pid=0&doc=37176&grp=475, accessed 14 January 2011).

National Prescribing Centre (2004). *Glossary of prescribing terms March – 2004*. Liverpool: National Prescribing Centre (http://www.npc.co.uk/npc_publications/resources/glossary_prescribing_terms.pdf, accessed 12 January 2011).

National Research Ethics Service (2009). *National Research Ethics Service year in review 2008–09*. London, National Research Ethics Service (http://www.nres.npsa.nhs.uk/, accessed 14 January 2011).

National Screening Committee (1998). *First report of the National Screening Committee*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_084456.pdf, accessed 12 January 2011).

National Screening Committee (2010). *Programme appraisal criteria*. London, Department of Health (http://www.screening.nhs.uk/criteria, accessed 14 January 2011).

National Social Inclusion Programme (2009). *Vision and progress: social inclusion and mental health*. London, National Social Inclusion Programme (http://www.socialinclusion.org.uk/publications/NSIP_Vision_and_Progress.pdf, accessed 12 January 2011).

National Specialised Commissioning Group (2008). *Annual report 2007/08*. London, National Specialised Commissioning Group (http://www.ncg.nhs.uk/documents/ar_nscg_annual_report_2007–08.pdf, accessed 12 January 2011).

National Specialised Commissioning Group (2010). *Specialised services national definitions set*. London, National Specialised Commissioning Group (http://www.specialisedservices.nhs.uk/info/specialised-services-national-definitions, accessed 14 January 2011).

NCEPOD (2007). *Trauma: who cares? A report of the National Confidential Enquiry into Patient Outcome and Death*. London, National Confidential Enquiry into Patient Outcome and Death (http://www.ncepod.org.uk/2007report2/Downloads/SIP_summary.pdf, accessed 12 January 2011).

NHS Appointments Commission (2003). *Governing the NHS: a guide for NHS boards*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082637.pdf, accessed 12 January 2011).

NHS Choices (2009). *NHS walk-in centres*. London, NHS Choices (http://www.nhs.uk/aboutnhsservices/walkincentres/Pages/Walk-incentresSummary.aspx, accessed 3 January 2011).

NHS Choices (2010). *Emergency and urgent care services*. London, NHS Choices (http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/AE.aspx, accessed 3 January 2011).

NHS Confederation (2010). *Where next for health and social care integration?* London, NHS Confederation (Discussion paper 8) (http://www.nhsconfed.org/Publications/Documents/health_social_careintegration180610.pdf, accessed 12 January 2011).

NHS Connecting for Health (2007). *The national programme for IT implementation guide,* version 5 July 2007. Leeds, NHS Connecting for Health (http://www.connectingforhealth.nhs.uk/systemsandservices/implementation/docs/national_programme_implementation_guide.pdf, accessed 12 January 2011).

NHS Connecting for Health (2009a). *Electronic prescribing in hospitals – challenges and lessons learned*. Leeds, NHS Connecting for Health (http://www.connectingforhealth.nhs.uk/systemsandservices/eprescribing/challenges/Final_report.pdf, accessed 12 January 2011).?searchterm=hospital+prescribing, accessed 14 January 2011).

NHS Connecting for Health (2009b). *N3 Factsheet*. Leeds, NHS Connecting for Health (http://www.connectingforhealth.nhs.uk/systemsandservices/n3/factsheet, accessed 14 January 2011).

NHS Connecting for Health (2010). *Latest deployment statistics and information*. London, NHS Connecting for Health (http://www.connectingforhealth.nhs.uk/newsroom/statistics/deployment/index_html/?searchterm=choose%20and%20book, accessed 14 January 2011).

NHS Dental Services (2008). *NHS dental services quarterly vital signs reports*. London, NHS Dental Services (http://www.nhsbsa.nhs.uk/Documents/Quarterly_Vital_Signs_England.pdf, accessed 12 January 2011).

NHS Direct (2010). *Facts and figures about NHS Direct*. London, NHS Direct (http://www.nhsdirect.nhs.uk/article.aspx?name=FactsAndFiguresAboutNHSDirect, accessed 14 January 2011).

NHS East Midlands, NHS London and NHS North West SHAs (2009). *A framework for the performance management of high security hospitals*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086483.pdf, accessed 12 January 2011).

NHS Employers (2005). *Investing in general practice – revisions to the GMS contract for 2006–07 in England, stage 1*. London, NHS Employers (http://www.nhsemployers.org/SiteCollectionDocuments/briefing_revisions_gms_stage1_cd_130209.pdf, accessed 12 January 2011).

NHS Employers (2008). *Annual review 2007/08*. London, NHS Employers (http://www.nhsemployers.org/aboutus/aboutus-3652.cfm, accessed 14 January 2011).

NHS Employers (2010). *Minimum practice income guarantee*. London, NHS Employers (http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/GMSfinance/Pages/MPIG.aspx, accessed 3 January 2011).

NHS Employers and General Practitioners Committee of the British Medical Association (2005). *Revisions to the GMS contract 2006–07: delivering investment in general practice*. London, NHS Employers (http://www.nhsemployers.org/SiteCollectionDocuments/Revisions_to_the_GMS_contract_-_full_CD_120209.pdf, accessed 12 January 2011).

NHS Employers and General Practitioners Committee of the British Medical Association (2007). *Review of the general medical services global sum formula*. London, NHS Employers and British Medical Association (http://www.nhsemployers.org/SiteCollectionDocuments/frg_report_final_cd_090207.pdf, accessed 12 January 2011).

NHS Employers and General Practitioners Committee of the British Medical Association (2009). *Quality and outcomes framework guidance for GMS contract 2009/10 – delivering investment in general practice*. London, NHS Employers and British Medical Association (http://www.nhsemployers.org/Aboutus/Publications/Documents/QOF_Guidance_2009_final.pdf, accessed 12 January 2011).

NHS End of Life Care Programme (2006). *NHS end of life care programme progress report, March 2006*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4133325.pdf, accessed 12 January 2011).

NHS Forms Orderline (2009). *Help with health costs: effective from 1 April 2008*. Oldham, 3M Security Printing and Systems (http://www.nhsbsa.nhs.uk/HealthCosts/Documents/HealthCosts/HC11.pdf, accessed 12 January 2011).

NHS Institute for Innovation and Improvement (2009). *High impact actions for nursing and midwifery*. London, NHS Institute for Innovation and Improvement (http://www.institute.nhs.uk/building_capability/general/aims/, accessed 14 January 2011).

NHS Modernisation Agency (2004). *10 High impact changes for service improvement and delivery: a guide for NHS leaders*. London, Department of Health (http://www.ogc.gov.uk/documents/Health_High_Impact_Changes.pdf, accessed 12 January 2011).

NHS PASA (2002). *Modernising NHS supply*. Chester, NHS Purchasing and Supply Agency.

NHSLA (2010a). *The National Health Service Litigation Authority report and accounts 2010*. London, NHS Litigation Authority (http://www.nhsla.com/NR/rdonlyres/3F5DFA84–2463–468B-890C-42C0FC16D4D6/0/NHSLAAnnualReportandAccounts2010.pdf, accessed 12 January 2011).

NHSLA (2010b). *The NHS Litigation Authority factsheet 2: financial information*. London, NHS Litigation Authority (http://www.nhsla.com/NR/rdonlyres/465D7ABD-239F-4273-A01E-C0CED557453D/0/NHSLAFactsheet2financialinformation200910.doc, accessed 14 January 2011).

NHSLA (2010c). *The NHS Litigation Authority factsheet 3: information on claims*. London, NHS Litigation Authority (http://www.nhsla.com/NR/rdonlyres/C1B3F310-E13D-4C71-B248-C5384438E603/0/NHSLAFactsheet30910.doc, accessed 14 January 2011).

NICE (2004a). *Improving supportive and palliative care for adults with cancer – the manual*. London, National Institute for Clinical Excellence (http://www.nice.org.uk/nicemedia/pdf/csgspmanual.pdf, accessed 12 January 2011).

NICE (2004b). *Guidance on cancer services – improving supportive and palliative care for adults with cancer: the manual*. London, National Institute for Clinical Excellence (http://www.nice.org.uk/nicemedia/pdf/csgspmanual.pdf, accessed 12 January 2011).

NICE (2008). *NICE and the NHS*. London, National Institute for Health and Clinical Excellence (http://www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice_and_the_nhs.jsp, accessed 25 February 2011).

NICE (2009). *Depression: the treatment and management of depression in adults*. London, National Institute for Health and Clinical Excellence (http://www.nice.org.uk/nicemedia/pdf/Depression_Update_FULL_GUIDELINE.pdf, accessed 12 January 2011).

NICE (2010). *Technology appraisal recommendation summary*. London, National Institute for Health and Clinical Excellence (http://www.nice.org.uk/newsroom/nicestatistics/TADecisionsRecommendationSummary.jsp, accessed 14 January 2011).

NICE and SCIE (2006). *Dementia: supporting people with dementia and their carers in health and social care*. London, National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (http://www.nice.org.uk/nicemedia/pdf/CG042NICEGuideline.pdf, accessed 12 January 2011).

Nicholl J, Beeby N, Williams B (1989). Role of the private sector in elective surgery in England and Wales, 1986. *BMJ,* 298:243–247.

NIHR (2007). *Best research for Best Health Implementation Plan 5.6 (previously 6.7) (established): NIHR research centres*. London, National Institute for Health Research (http://www.nihr.ac.uk/files/pdfs/Implementation%20Plan%205.6%20Research%20Centres.%20Final%20August%202007%20(PDF).pdf, accessed 12 January 2011).

NIHR (2008). *Transforming health research: summary of progress since 2006*. London, National Institute for Health Research (http://www.nihr.ac.uk/files/pdfs/NHIR%20leaflet.pdf, accessed 12 January 2011).

NIHR (2009a). *Best Research for Best Health Implementation Plan 5.1: NIHR clinical research network*. London, National Institute for Health Research (http://www.nihr.ac.uk/files/pdfs/Implementation%20Plan%205.1%20NIHR%20Clinical%20Research%20Network.%20Final%20July%202009%20-%20edited%20Jan%202010%20(PDF).pdf, accessed 12 January 2011).

NIHR (2009b). *Best Research for Best Health Implementation Plan 5.8 (established): NIHR collaborations for leadership in applied health research and care (CLAHRCs)*. London, National Institute for Health Research (http://www.nihr.ac.uk/files/pdfs/Implementation%20Plan%205.8%20CLAHRCs.%20Final%20January%202009%20(PDF).pdf, accessed 12 January 2011).

NIHR Health Technology Assessment programme (2009). *NIHR Health Technology Assessment programme annual report 2008*. Southampton, National Institute for Health Research Health Technology Assessment (http://www.hta.ac.uk/publicationspdfs/Annualreports/HTAannualreport08web.pdf, accessed 12 January 2011).

Nocon A, Baldwin S (1998). *Trends in rehabilitation policy: a review of the literature*. London, The King's Fund.

Nolte E, McKee M (2008). Measuring the health of nations: updating an earlier analysis. *Health Affairs,* 27:58–71.

NPSA (2007). *National Clinical Assessment Service Handbook,* 4th edn. London, National Patient Safety Agency (http://www.ncas.npsa.nhs.uk/, accessed 14 January 2011).

NPSA (2009). *Patient safety incident reports in the NHS: reporting and learning system quarterly data summary – England,* Issue 11, February 2009. London, National Patient Safety Agency (http://www.npsa.nhs.uk/nrls/patient-safety-incident-data/quarterly-data-reports/, accessed 14 January 2011).

NPSA (2010a). *Patient safety incident reports in the NHS: national reporting and learning system quarterly data summary – England,* Issue 14, November 2009. London, National Patient Safety Agency (http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=65329, accessed 14 January 2011).

NPSA (2010b). *Rapid response report: reducing harm from omitted and delayed medicines in hospital*. London, National Patient Safety Agency (http://www.nrls.npsa.nhs.uk/resources/?EntryId45=66720, accessed 14 January 2011).

Nursing and Midwifery Council (2008). *Statistical analysis of the Register 1 April 2007 to 31 March 2008*. London, Nursing and Midwifery Council (http://www.nmc-uk.org/Documents/Statistical%20analysis%20of%20the%20register/NMC-Statistical-analysis-of-the-register-2007-2008.pdf, accessed 14 January 2011).

Nutrition Action Plan Delivery Board (2009). *Nutrition Action Plan Delivery Board: end of year progress report*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113150.pdf, accessed 12 January 2011).

OECD (2000). *A system of health accounts.* Paris, Organisation for Economic Co-operation and Development (http://www.oecd.org/dataoecd/41/4/1841456.pdf, accessed 12 January 2011).

OECD (2009). *OECD factbook 2009: economic, environmental and social statistics*. Paris, Organisation for Economic Co-operation and Development (http://oberon.sourceoecd.org/vl=1252287/cl=19/nw=1/rpsv/factbook2009/07/02/04/index.htm, accessed 3 January 2011).

OECD (2010a). *Health data 2010*. Paris, Organisation for Economic Co-operation and Development (http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html, accessed 3 January 2011).

OECD (2010b). *OECD factbook 2010: economic, environmental and social statistics*. Paris, Organisation for Economic Co-operation and Development (http://www.oecd-ilibrary.org/economics/oecd-factbook-2010_factbook-2010-en, accessed 14 January 2011).

Office of Fair Trading (1996). *Health insurance: a report by the Office of Fair Trading*. London, Office of Fair Trading (http://www.oft.gov.uk/shared_oft/reports/financial_products/oft168.pdf, accessed 12 January 2011).

Office of Fair Trading (1998). *Health insurance: a second report by the Office of Fair Trading*. London, Office of Fair Trading (http://www.oft.gov.uk/shared_oft/reports/financial_products/oft230.pdf, accessed 12 January 2011).

Office of Fair Trading (2003). *The private dentistry market in the UK*. London, Office of Fair Trading (http://www.oft.gov.uk/shared_oft/reports/consumer_protection/oft630.pdf, accessed 12 January 2011).

Office of Fair Trading (2007). *The Pharmaceutical Price Regulation Scheme: an OFT market study*. London, Office of Fair Trading (http://www.oft.gov.uk/shared_oft/reports/comp_policy/oft885.pdf, accessed 12 January 2011).

O'Leary L et al. (2010). Fertility and partnership status in the last two decades. *Population Trends*, 140:5–36.

Oliver A (2005). The English National Health Service: 1979–2005. *Health Economics*, 14(Suppl 1): S75–S99.

Oliver A, Mossialos E (2005). European health system reforms: looking backward to see forward? *Journal of Health Politics, Policy and Law*, 30:7–28.

ONS (1997). *Population Trends 90*. London, Office for National Statistics.

ONS (2000). *Adult dental health survey: oral health in the United Kingdom 1998*. London, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_health/DHBulletinNew.pdf, accessed 12 January 2011).

ONS (2003a). *KS06 ethnic group: census 2001, key statistics for local authorities*. London, Office for National Statistics (http://www.statistics.gov.uk/statbase/ssdataset.asp?vlnk=6561&More=Y, accessed 14 January 2011).

ONS (2003b). *KS07 religion: census 2001, key statistics for local authorities*. London, Office for National Statistics (http://www.statistics.gov.uk/statbase/ssdataset.asp?vlnk=6563&More=Y, accessed 14 January 2011).

ONS (2004). *Healthy life expectancy at birth and at 65 in Great Britain and England, 1981–2001*. London, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_health/HealthExp198101.xls, accessed 14 January 2011).

ONS (2007). *Variations persist in life expectancy by social class, 2002–2005 data released*. London, Office for National Statistics (http://www.statistics.gov.uk/pdfdir/le1007.pdf, accessed 12 January 2011).

ONS (2008a). *Expenditure on health care in the UK*. London, Office for National Statistics (http://www.statistics.gov.uk/articles/nojournal/ExpenditureonHealth08.pdf, accessed 12 January 2011).

ONS (2008b). *Internet access 2008: households and individuals*. London, Office for National Statistics (http://www.statistics.gov.uk/pdfdir/iahi0808.pdf, accessed 12 January 2011).

ONS (2009a). *Population trends, winter 2009*. Newport, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_population/Pop-trends-winter09.pdf, accessed 12 January 2011).

ONS (2009b). *Birth statistics 2008*. Newport, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_population/FM1–37/FM1_37_2008.pdf, accessed 12 January 2011).

ONS (2009c). *General household survey 2007.* Newport, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_compendia/GHS07/GeneralHouseholdSurvey2007.pdf, accessed 12 January 2011).

ONS (2009d). *Annual business inquiry (ABI).* Newport, Office for National Statistics (http://www.statistics.gov.uk/abi/2007-archive/default.asp, accessed 12 January 2011).

ONS (2009e). *Mortality statistics: deaths registered in 2008*. Newport, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_health/DR2008/DR_08.pdf, accessed 12 January 2011).

ONS (2010a). *Population estimates for UK, England and Wales, Scotland and Northern Ireland – current datasets*. Newport, Office for National Statistics (http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106, accessed 14 January 2011).

ONS (2010b). *Economic and labour market review,* Vol. 4(8). Basingstoke, Palgrave Macmillan (http://www.statistics.gov.uk/elmr/08_10/downloads/ELMR_Aug10.pdf, accessed 12 January 2011).

ONS (2010c). *Mortality monitoring bulletin*. Newport, Office for National Statistics (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_121003.pdf, accessed 12 January 2011).

ONS (2010d). *Mortality statistics: deaths registered in 2009.* Newport, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_health/dr2009/dr-09.pdf, accessed 12 January 2011).

ONS (2010e). *English health geography*. Newport, Office for National Statistics (http://www.statistics.gov.uk/geography/england_health.asp, accessed 12 January 2011).

ONS (2010f). *Internet access 2010: households and individuals*. Newport, Office for National Statistics (http://www.statistics.gov.uk/pdfdir/iahi0810.pdf, accessed 12 January 2011).

ONS (2010g). *General lifestyle survey 2008*. Newport, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_compendia/GLF08/GeneraLifestyleSurvey2008.pdf, accessed 12 January 2011).

Pauffley A (2004). *Committee of Inquiry – independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling.* London, The Stationery Office (Cm 6298) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4088996, accessed 14 January 2011).

Pemberton J et al. (2003). Issues and trends in computerisation within UK primary health care. *Logistics Information Management*, 16:181–190.

Peñaloza M-C et al. (2010). *UK Centre for the Measurement of Government Activity – public service output, inputs and productivity: healthcare*. Newport: Office For National Statistics (http://www.statistics.gov.uk/articles/nojournal/healthcare-productivity-2010.pdf, accessed 12 January 2011).

Pharmaceutical Services Negotiating Committee (2009). *The negotiation of the pharmacy contract.* Aylesbury, Pharmaceutical Services Negotiating Committee.

Pharmaceutical Services Negotiating Committee (2010a). *National contract funding.* Aylesbury, Pharmaceutical Services Negotiating Committee (http://www.psnc.org.uk/pages/national_contract_funding.html, accessed 3 January 2011).

Pharmaceutical Services Negotiating Committee (2010b). *NHS pharmacy contract: indicative income tables*. Aylesbury, Pharmaceutical Services Negotiating Committee (http://www.psnc.org.uk/data/files/funding_and_drug_tariff/contract_funding/income_tables_april_2010_updated.pdf, accessed 12 January 2011).

Phelps MG et al. (2010). *UK Centre for the Measurement of Government Activity: total public service output, inputs and productivity*. Newport: Office For National Statistics (http://www.statistics.gov.uk/articles/nojournal/tpsopjuly2010.pdf, accessed 12 January 2011).

Philp I (2004). *Better health in old age*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4093215.pdf, accessed 12 January 2011).

Pickard L et al. (2000). Relying on informal care in the new century? Informal care for elderly people in England to 2031. *Ageing and Society*, 20:745–772.

Postgraduate Medical Education and Training Board (2008). *The state of postgraduate medical education and training 2008 – a changing landscape*. London, Postgraduate Medical Education and Training Board (http://www.gmc-uk.org/State_of_PMET_20081117.pdf_30377402.pdf, accessed 12 January 2011).

Propper C, Croxton B, Shearer A (2000). *Waiting times for hospital admissions: the impact of GP fundholding*. Bristol: Centre for Market and Public Organisation (Working paper series No. 00/20) (http://www.bristol.ac.uk/cmpo/publications/papers/2000/wp20.pdf, accessed 12 January 2011).

Propper C et al. (2007). *Did 'targets and terror' reduce English waiting times for elective hospital care?* Bristol, The Centre for Market and Public Organisation (Working Paper No. 07/179) (http://www.bristol.ac.uk/cmpo/publications/papers/2007/wp179.pdf, accessed 12 January 2011).

Purdy S, Griffin T (2008). Reducing hospital admissions. *BMJ,* 336:4–5.

Quinn M et al. (2001). *Studies on Medical and Population Subjects*, No. 66: c*ancer trends in England and Wales 1950–1999*. London, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_health/cancertrends_5099.pdf, accessed 12 January 2011).

Raleigh V et al. (2008). Inpatient mental healthcare in England and Wales: patterns in NHS and independent healthcare providers. *Journal of Royal Society of Medicine*, 101:544–551.

Ramesh R (2010). London NHS facing winter crisis. *Guardian,* 14 October 2010 (http://www.guardian.co.uk/society/2010/oct/14/nhs-london-hospitals-winter-crisis?INTCMP=SRCH, accessed 24 February 2011).

RCN (2010). *Pay rates 2010/11*. London, Royal College of Nursing (http://www.rcn.org.uk/support/pay_and_conditions/pay_rates_2010–2011, accessed 14 January 2011).

Research for Patient Benefit Working Party (2004). *Research for Patient Benefit Working Party – final report*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082675.pdf, accessed 14 January 2011).

Richards M (2008). *Improving access to medicines for NHS patients*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089952.pdf, accessed 12 January 2011).

Richardson A, Mmata C (2007). *NHS maternity statistics, England: 2005–06*. London, Information Centre (http://www.ic.nhs.uk/webfiles/publications/maternity0506/NHSMaternityStatsEngland200506_fullpublication%20V3.pdf, accessed 12 January 2011).

Rivett G (1998). *From cradle to grave: fifty years of the NHS*. London, The King's Fund.

Robertson A et al. (2010). Implementation and adoption of nationwide electronic health records in secondary care in England: qualitative analysis of interim results from a prospective national evaluation. *BMJ*, 341:c4564.

Rogers A et al. (2007). *The national evaluation of the pilot phase of the expert patient programme final report*. Manchester, National Primary Care Research and Development Centre (http://www.npcrdc.ac.uk/Publications/National_Evaluation_of_EPP_Report_2006.pdf, accessed 12 January 2011).

Royal College of Physicians (2008). *National audit of services for people with multiple sclerosis*. London, Royal College of Physicians (http://www.rcplondon.ac.uk/sites/default/files/ms-audit-2008-full-report.pdf, accessed 12 January 2011).

Royal College of Physicians (2009). *National audit of the organisation of services for falls and bone health of older people*. London, Royal College of Physicians (http://www.bgs.org.uk/pdf_cms/pubs/National%20Audit_Organisation%20of%20Falls%20Services.pdf, accessed 12 January 2011).

Royal Commission on Long Term Care (1999). *With respect to old age: long term care – rights and responsibilities. A report by The Royal Commission on Long Term Care*. London, The Stationery Office (http://www.archive.official-documents.co.uk/document/cm41/4192/4192.htm, accessed 3 January 2011).

Salisbury D, Ramsey M, Noakes K (2010). *Immunisation against infectious disease*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_124456.pdf, accessed 23 February 2011).

Schoen C et al. (2009). In chronic condition: experiences of patients with complex health care needs, in eight countries, 2008. *Health Affairs*, 28:w1–w16 (http://content.healthaffairs.org/content/28/1/w1.full.pdf+html, accessed 24 February 2011).

Secretary of State for Health (1992). *The health of the nation: a strategy for health in England*. London, Her Majesty's Stationery Office (Cm 1986).

Secretary of State for Health (1998). *Our healthier nation: a contract for health*. London, The Stationery Office (Cm 3852) (http://www.archive.official-documents.co.uk/document/doh/ohnation/title.htm, accessed 3 January 2011).

Secretary of State for Health (1999a). *Saving lives: our healthier nation*. London, The Stationery Office (Cm 4386) (http://www.archive.official-documents.co.uk/document/cm43/4386/4386.htm, accessed 3 January 2011).

Secretary of State for Health (1999b). *Reducing health inequalities: an action report*. London, The Stationery Office.

Secretary of State for Health (2007). *Trust, assurance and safety – the regulation of health professionals in the 21st century*. London, The Stationery Office (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946, accessed 14 January 2011).

Secretary of State for Health (2009). *The government's response to the Health Select Committee report on health inequalities*. London, The Stationery Office (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099782.pdf, accessed 12 January 2011).

Self A, Zealey Z (2008). *Social trends 38*. London, Office for National Statistics (http://www.statistics.gov.uk/downloads/theme_social/Social_Trends38/Social_Trends_38.pdf, accessed 12 January 2011).

Seston L, Hassell K (2009). *Pharmacy workforce census 2008: main findings*. London, Royal Pharmaceutical Society of Great Britain (http://www.rpsgb.org/pdfs/census08.pdf, accessed 12 January 2011).

Smallwood C (2005). *The role of complementary and alternative medicine in the NHS: an investigation into the potential contribution of mainstream complementary therapies to healthcare in the UK*. London, Freshminds (http://www.getwelluk.com/uploadedFiles/Publications/SmallwoodReport.pdf, accessed 31 January 2011).

Smith J (2004). *The Shipman Inquiry. Fifth report safeguarding patients: lessons from the past – proposals for the future*. London, The Stationery Office (Cm 6394–1) (http://www.the-shipman-inquiry.org.uk/fifthreport.asp, accessed 12 January 2011).

Smith J et al. (2004). *A review of the effectiveness of primary care-led commissioning and its place in the NHS*. London, The Health Foundation (http://www.health.org.uk/public/cms/75/76/313/518/A%20review%20of%20the%20effectiveness%20%20of%20primary%20care%20led%20commissioning%20and%20its%20place%20in%20the%20NHS%20reportpdf.pdf?realName=3firzu.pdf, accessed 12 January 2011).

Smith M, Edgar G, Groom G (2008). Health expectancies in the United Kingdom, 2004–06. *Health Statistics Quarterly,* 40:77–80.

Social and Market Strategic Research (2008). *Report on the findings of the Information Commissioner's Office annual track 2008: organisations*. Wilmslow, Information Commissioner's Office (http://www.ico.gov.uk/upload/documents/library/corporate/research_and_reports/ico_annual_tracking_orgs_final_report2008.pdf, accessed 12 January 2011).

Standing Commission on Carers (2009). *Report of the Standing Commission on Carers 2007 to 2009: carers at the heart of 21st century families and communities – work in progress*. London, Department of Health (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_107481.pdf, accessed 12 January 2011).

Steele J et al. (2009). *NHS dental services in England: an independent review led by Professor Jimmy Steele*. London, Department of Health (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf, accessed 12 January 2011).

Stevens R (1966). *Medical practice in modern England: the impact of specialization and state medicine*. New Haven, CT, Yale University Press.

Sutton M et al. (2002). *Allocation of resources to English areas: individual and small area determinants of morbidity and use of healthcare resources. Report to the Department of Health*. Edinburgh: Information and Statistics Division (http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_4137767, accessed 14 January 2011).

Thomas K, Coleman P (2004). Use of complementary or alternative medicine in a general population in Great Britain. Results from the National Omnibus survey. *Journal of Public Health,* 26:152–157.

Thomas K, Nicholl J, Coleman P (2001). Use and expenditure on complementary medicine in England: a population based survey. *Complementary Therapies in Medicine,* 9:2–11.

Thorlby R, Maybin J, eds. (2010). *A high-performing NHS? A review of progress 1997–2010*. London, The King's Fund (http://www.kingsfund.org.uk/publications/a_highperforming_nh.html, accessed 3 January 2011).

Townsend I (2003). *The burden of taxation*. London, House of Commons Library (http://www.parliament.uk/documents/commons/lib/research/rp2003/rp03–074.pdf, accessed 12 January 2011).

UK Clinical Research Collaboration (2006). *UK health research analysis*. London, UKCRC (http://www.ukcrc.org/PDF/UKCRC_Health_Research_Analysis_May_06.pdf, accessed 12 January 2011).

UK Foundation Programme Office (2007). *The rough guide to the foundation programme,* 2nd edn, July 2007. London, The Stationery Office (http://www.foundationprogramme.nhs.uk/pages/medical-students/key-documents, accessed 14 January 2011).

University of Texas at Austin (2010). *Perry-Castañeda Library map collection* (http://www.lib.utexas.edu/maps/united_kingdom.html, accessed 3 January 2011).

Wagstaff A et al. (1999). Equity in the finance of health care: some further international comparisons. *Journal of Health Economics*, 18:263–290.

Walley T (1998). Prescription charges: change overdue? *BMJ,* 317:487–488.

Wanless D (2002). *Securing our future health: taking a long-term view (final report)*. London, HM Treasury (http://www.hm-treasury.gov.uk/consult_wanless_final.htm, accessed 3 January 2011).

Wanless D (2006). *Securing good care for older people: taking a long-term view.* London, The King's Fund (http://www.kingsfund.org.uk/publications/securing_good.html, accessed 3 January 2011).

Wanless D et al. (2007). *Our future health secured? A review of NHS funding and performance*. London, The King's Fund (http://www.kingsfund.org.uk/publications/our_future.html, accessed 3 January 2011).

Webster C (2002). *The National Health Service: a political history*. Oxford, Oxford University Press.

Westlake S, Cooper N (2008). Cancer incidence and mortality: trends in the United Kingdom and constituent countries, 1993 to 2004. *Health Statistics Quarterly,* 38:33–46.

Wheller L et al. (2007). Trends in avoidable mortality in England and Wales, 1993–2005. *Health Statistics Quarterly,* 34:6–26.

WHO Regional Office for Europe (2009). European Health for All database (HFA-DB) [online/offline database as updated August 2009]. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/hfadb, accessed 14 January 2011).

Wilson M (2009). *Delivering race equality in mental health care: a review*. London, Department of Health (http://www.nmholu.org.uk/silo/files/delivering-race-equality-in-mental-health-care-a-review.pdf, accessed 17 February 2011).

Winslow C (1920). The untilled fields of public health. *Science*, 51:23–33 (http://www.sciencemag.org/content/vol51/issue1306/index.dtl#articles, accessed 28 February 2011).

10.2 Useful web sites

Association of the British Pharmaceutical Industry:
www.abpi.org.uk

British Medical Association:
www.bma.org.uk

Care Quality Commission:
www.cqc.org.uk

Department of Health:
www.dh.gov.uk

European Medicines Agency:
www.emea.europa.eu

General Dental Council:
www.gdc-uk.org

General Medical Council:
www.gmc-uk.org

General Pharmaceutical Council:
www.pharmacyregulation.org

General Social Care Council:
www.gscc.org.uk

Health Protection Agency:
www.hpa.org.uk

Health Professions Council:
www.hpc-uk.org

Local Government Association:
http://www.lga.gov.uk

Medicines and Health Products Regulatory Agency:
www.mhra.gov.uk

National Audit Office:
www.nao.org.uk

National Institute for Health and Clinical Excellence (NICE):
www.nice.org.uk

National Institute for Mental Health in England:
www.nimh.nih.gov

Nursing and Midwifery Council:
www.nmc-uk.org

Office for Fair Trading:
www.oft.gov.uk

Office of National Statistics:
www.statistics.gov.uk

Organisation for Economic Co-operation and Development:
www.oecd.org

Royal College of General Practitioners:
www.rcgp.org.uk

Royal College of Nurses:
www.rcn.org.uk

Royal College of Surgeons of England:
www.rcseng.ac.uk

Royal Pharmaceutical Society of Great Britain:
www.rpharms.com

UK Government information (Directgov):
www.direct.gov.uk

UK Parliament:
http://www.parliament.uk/

World Health Organization (WHO):
www.who.int

World Trade Organization (WTO):
www.wto.org

10.3 Principal legislation

Audit Commission Act 1998

Care Standards Act 2000

Carers (Equal Opportunities) Act 2004

Carers (Recognition and Services) Act 1995

Carers and Disabled Children Act 2000

Community Care (Delayed Discharges etc.) Act 2003

Community Care (Direct Payments) Act 1996

Data Protection Act 1998

Disability Discrimination Act 1995

Disability Discrimination Act 2005

Disability Rights Commission Act 1999

Domestic Violence Crime and Victims Act 2004

Employment Act 2002

Equality Act 2006

Food Standards Act 1999

Freedom of Information Act 2000

Health Act 1999

Health Act 2009

Health and Social Care Act 2001

Health and Social Care Act 2008

Health and Social Care (Community and Health Standards) Act 2003

Health Protection Agency Act 2004

Health Services Act 1980

Human Rights Act 1998

Human Tissue Act 2004

Local Authority Social Services Act 1970

Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Local Government and Public Involvement in Health Act 2007

Local Government Finance Act 1982

Medical Act 1983

Medicines Act 1968

Mental Capacity Act 2005

Mental Health Act 1959

Mental Health Act 1983

Mental Health Act 2007

National Audit Act 1983

National Health Service (Charges to Overseas Visitors) Regulations 1989

National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 1991

National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 1994

National Health Service (Charges to Overseas Visitors) Amendment Regulations 2000

National Health Service (Charges to Overseas Visitors) Amendment (No. 2) Regulations 2000

National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004

National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2006

National Health Service (Complaints) Regulations 2004

National Health Service (Complaints) Amendment Regulations 2006

National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004

National Health Service (Pharmaceutical Services) Regulations 2005

National Health Service (Reimbursement of the Cost of EEA Treatment) Regulations 2010

National Health Service (Primary Care) Act 1997

National Health Service (Quality Accounts) Regulations 2010

National Health Service Act 1946

National Health Service Act 1977

National Health Service Act 2006

National Health Service and Community Care Act 1990

National Health Service Reorganisation Act 1973

NHS Redress Act 2006

Personal Care at Home Act 2010

Race Relations (Amendment) Act 2000

Work and Families Act 2006

10.4 HiT methodology and production process

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. The profiles are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile HiTs. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010.

Authors draw on multiple data sources for the compilation of HiT profiles, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 33 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT profile consists of 10 chapters.

1 Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.

2 Organizational structure: provides an overview of how the health system in the country is organized and outlines the main actors and their decision-making powers; discusses the historical background for the system; and describes the level of patient empowerment in the areas of information, rights, choice, complaints procedures, safety and involvement.

3 Financing: provides information on the level of expenditure, who is covered, what benefits are covered, the sources of health care finance, how resources are pooled and allocated, the main areas of expenditure, and how providers are paid.

4 Regulation and planning: addresses the process of policy development, establishing goals and priorities; deals with questions about relationships between institutional actors, with specific emphasis on their role in regulation and what aspects are subject to regulation; and describes the process of HTA and research and development.

5 Physical and human resources: deals with the planning and distribution of infrastructure and capital stock; the context in which IT systems operate; and human resource input into the health system, including information on registration, training, trends and career paths.

6 Provision of services: concentrates on patient flows, organization and delivery of services, addressing public health, primary and secondary health care, emergency and day care, rehabilitation, pharmaceutical care, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health care for specific populations.

7 Principal health care reforms: reviews reforms, policies and organizational changes that have had a substantial impact on health care.

8 Assessment of the health system: provides an assessment based on the stated objectives of the health system, the distribution of costs and benefits across the population, efficiency of resource allocation, technical efficiency in health care production, quality of care, and contribution of health care to health improvement.

9 Conclusions: highlights the lessons learned from health system changes; summarizes remaining challenges and future prospects.

10 Appendices: includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following:

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the profile is finalized that focus on copy editing and proof reading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely to ensure that all stages of the process are as effective as possible and that the HiTs meet the series standard and can support both national decision-making and comparisons across countries.

10.5 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. The HiT is then sent for review to two independent academic experts and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

10.6 About the author

Seán Boyle is Senior Research Fellow at the Personal and Social Services Research Unit (PSSRU), LSE Health and Social Care, at the London School of Economics and Political Science. He has researched and written extensively on a range of policy issues concerning the finance and provision of health care in the United Kingdom, including the economic evaluation of the use and allocation of resources, public–private partnerships (particularly the private finance initiative), modelling elective and emergency health care, and performance measurement. His current main interest is developing collaborative techniques for the strategic modelling of whole systems. Seán is also a health planning and policy consultant with experience of working at senior level with public and private sector managers, civil servants and politicians (both local and national), and a detailed knowledge of the public policy environment. He was public expenditure advisor to the Select Committee on Health of the House of Commons between 1993 and 2008 and contributed to special inquiries on resource allocation in the NHS, on public–private partnerships, and on foundation hospitals.

The Health Systems in Transition profiles

A series of the European Observatory on Health Systems and Policies

The Health Systems in Transition (HiT) country profiles provide an analytical description of each health care system and of reform initiatives in progress or under development. They aim to provide relevant comparative information to support policy-makers and analysts in the development of health systems and reforms in the countries of the WHO European Region and beyond. The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the financing, organization and delivery of health services;
- to describe accurately the process, content and implementation of health reform programmes;
- to highlight common challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in countries of the WHO European Region.

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All HiT country profiles are available as PDF files at www.healthobservatory.eu, where you can also join our listserve for monthly updates of the activities of the European Observatory on Health Systems and Policies, including new HiTs, books in our co-published series with Open University Press, Policy briefs, Policy Summaries, the *EuroObserver* newsletter and the *Eurohealth* journal.

If you would like to order a paper copy of a HiT, please write to:

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Uzbekistan (2001[g], 2007[g])

Key

All HiTs are available in English.
When noted, they are also available in other languages:

[a] Albanian
[b] Bulgarian
[c] French
[d] Georgian
[e] German
[f] Romanian
[g] Russian
[h] Spanish
[i] Turkish
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[k] Polish
[l] Tajik

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HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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