Health Care Systems in Transition: the Welsh report

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This report was prepared as part of the forthcoming United Kingdom HiT

The European Observatory on Health Systems and Policies is a partnership between the World Health Organization Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

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Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of a health care system and of reform initiatives in progress or under development. The HiTs are a key element of the work of the European Observatory on Health Systems and Policies.

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

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

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides the detailed guidelines and specific questions, definitions and examples needed to compile a HiT. This guidance is intended to be flexible to allow authors to take account of their national context.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health

care 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 WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and data from the World Bank. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

The HiT profiles provide a source of descriptive information on health care systems. They 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 care systems. This series is an ongoing initiative: material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT profiles are most welcome and can be sent to info@obs.euro.who.int. HiTs, HiT summaries and a glossary of terms used in the HiTs are available on the Observatory's website at www.observatory.dk.

This report, prepared as part of the forthcoming Health Care Systems in Transition on the United Kingdom, was written by Marcus Longley (Senior Fellow and Associate Director, Welsh Institute for Health and Social Care). The editor was Nadia Jemiai. The research director was Elias Mossialos. The copy-editor was Jo Woodhead.

Introduction and historical background

Wales is surrounded on three sides by sea and has a land border with England to the east. It covers approximately one twelfth of the land area of the United Kingdom of Great Britain and Northern Ireland, and about a quarter is above 300 m (Statistical Directorate, 1999).

In 2001 the population was 2 903 200, with about two thirds concentrated in the south of the country. Overall population density is currently 140 people per km^2. This is close to the EU average (only half that of the United Kingdom) but the density rises to nearly 500 people per km^2 in the south (twice the United Kingdom average). The largest urban areas are around Cardiff (the capital city), Swansea and Newport, all in the south, with a smaller concentration around Wrexham in the north-east.

The population of Wales changed substantially during the course of the 20th century, rising from 2 million in 1901 to a peak of 2.7 million in 1925. Outward migration caused a sustained fall and it took another 50 years for the population to return to the 1925 level. A small rise in population is predicted, to 3 million by 2011, largely as a result of inward migration.

The age structure is similar to that of the United Kingdom as a whole – for example, 17.3% of the Welsh population is over 65, compared to the United Kingdom average of 15.7%. The proportion aged over 65 is expected to increase to 23% by 2021. About 500 000 people in Wales can speak Welsh, with the highest proportions in the north and west and the lowest (about 2% in Newport) in the south-east. Since the mid-1970s there has been a steady decline in the number of people marrying (currently below 13 per 1000) and the proportion of children born outside marriage has increased to more than 40%.

For centuries Wales has shared many political and legal institutions and structures with England. The courts and policing arrangements are identical to those in England and many other aspects of public life: higher education and schools; healthcare; social welfare policy and transport have been characterized much more by their similarity with those of the much larger neighbour than by their differences. However, for much of the latter half of the 20th century there was an influential pro-devolution or nationalist presence in Welsh public life, culminating with the enactment of the Government of Wales Act in 1999. Supported by a very narrow margin in a referendum, this created a unicameral National Assembly of 60 members elected by proportional representation. It has powers to create only secondary legislation, essentially the detailed implementation of primary legislation, which still requires approval from the United Kingdom's Parliament in London. There have been two elections for the Assembly, resulting in a centre-left (including coalition) government led by the Labour Party. Welsh politics are qualitatively different from those of England in several respects, one of which is the substantial (and probably permanent) majority support for centre-left policies that (as will be shown later) has resulted in significant differences in health policy between Wales and England.

The extent of devolution's effects on Welsh public life remains to be seen but several features are apparent already. One concerns the connection between policy-making and local interests. Before the establishment of the National Assembly, policy-making in Wales was largely the preserve of the Secretary of State for Wales (a member of the United Kingdom Cabinet), junior ministers and the civil service in the Welsh Office. This arrangement provided very little connection between the government and the governed: there were never more than three Ministers at any one time, and for much of this time the Ministers were from a party that attracted only a small number of votes in Wales. Now there is a far more obvious connection between local concerns and interests and the national political discourse.

Another difference relates to the extent to which Wales is developing a distinctive approach to public policy, some of which is described below. A Concordat agreed in December 1999 guides relations between the National Assembly and the United Kingdom's Government (National Assembly for Wales, 1999b). These have not been problematical, largely because both Whitehall and Cardiff have had Labour (or Labour-led) administrations since Devolution. This may have encouraged both parties to avoid difficult issues such as the level of overall resources or comparative public sector performance. It is difficult to predict how this will change if the political balance shifts.

Organizational structure and management

A simplified organizational structure, which began in April 2003, is shown in Fig. 1. There are several points of note.

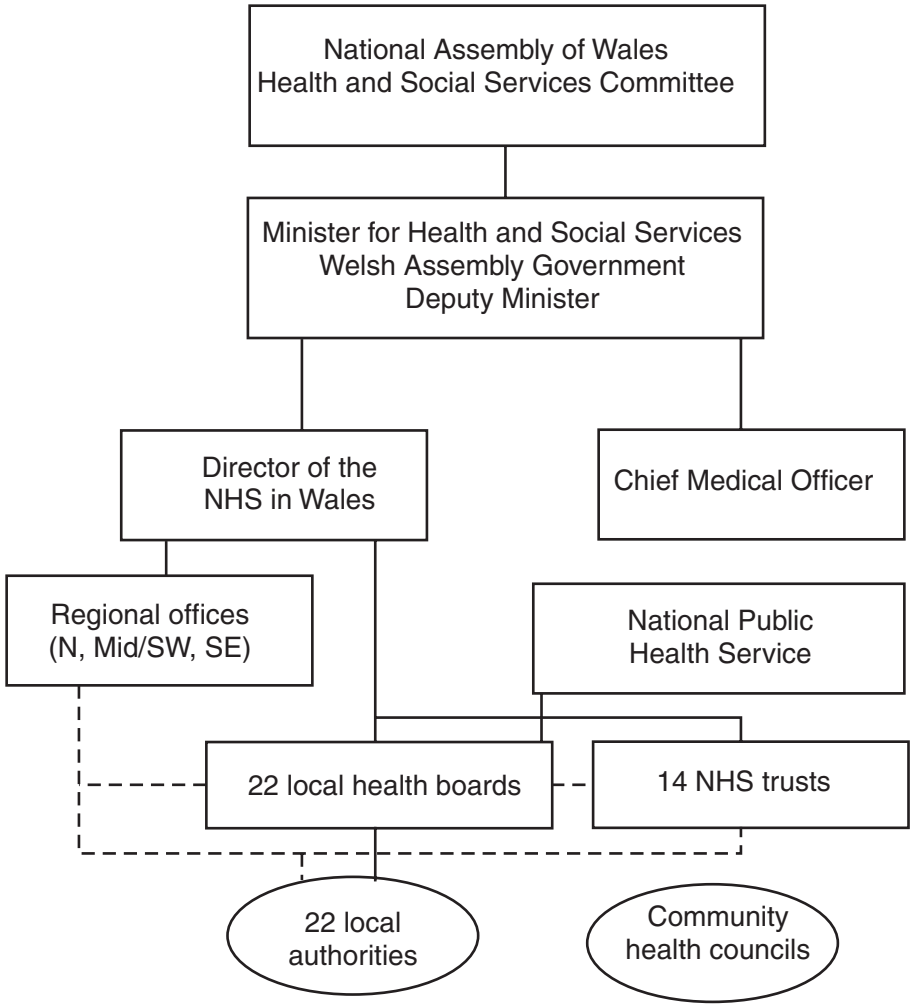
Health and social care

The minister and the relevant Committee of Assembly Members are responsible for Health and Social Services. In addition, the director of the NHS also has responsibilities for social services policy. The desire to align policy (and service delivery) between health and social care at all levels is an important thread running throughout policy in Wales. At the local level, it is manifest in the local health boards (LHBs), which include several representatives (elected councillors and directors) of the coterminous local authority.

Regional offices

The Regional offices have geographical responsibility for the different health economies of Wales – North, Mid and South West, South East. These areas are self-sufficient for the great majority of health care provision. Formally, their role is to ensure the implementation of Assembly policy; to support improved joint working at local levels between LHBs, local authorities (LAs) and trusts; and to monitor the development of local health, social care and wellbeing strategies. The regional offices had no direct equivalent before April 2003, and therefore are still defining (or having defined) their detailed roles.

Fig. 1. Organizational structure of the NHS



Local health boards

LHBs are in many respects the linchpins of the whole structure. There are 22, corresponding to the 22 local authorities, whose responsibilities include needs assessment, commissioning of specialist care from NHS trusts and the management of primary care. Their boards consist of local general practitioners (GPs), dentists, pharmacists and optometrists; a nurse and representative of other

health care professions; members of the local authority; representatives of the voluntary sector; representatives of patients and carers; as well as executive directors. They are charged with forging a close relationship with their local authority and to draw on the expertise of the National Public Health Service. They developed from local health groups that until April 2003 covered the same geographical areas, but were constituted as sub-groups of the Health Authority. The principal difference between LHBs and their predecessors is that the former now have direct accountability (including financial) to the Welsh Assembly Government.

Certain features of the composition of LHBs make their role difficult. The first concerns their size: LHBs are required to be coterminous with LAs therefore most are relatively small, with some serving populations of as few as 60 000. This has resulted in the allocation of relatively few staff and other resources to perform their various functions. Secondly, not all the LHBs are coterminous with their providers of specialist care: the trusts. Indeed in some cases, such as the five LHBs covering the old county of Gwent in south-east Wales, as many as five LHBs relate to one trust. This in turn reduces their individual leverage on the trust.

NHS trusts

Trusts in Wales are constituted in much the same way as their English equivalents. Perhaps the greatest difference is that each trust, with minor exceptions, provides both acute hospital and community services (including mental health) to the local population.

Community health councils

Although abolished in England, community health councils (CHCs) have been retained in Wales. Their role is to provide lay input into the planning and provision of local health services (including primary care) and they retain certain statutory rights to be consulted for major changes. The size and resources of each CHC vary considerably and in some parts of Wales they operate on a consortium basis, sharing resources.

Planning, regulation and management

Factors affecting people's health

The home page of the National Assembly's Health of Wales Information Service (online) proudly proclaims, "Our aim is to promote the health and well being of everyone living in Wales and provide effective and efficient health services (…). The policies of the Welsh Assembly Government aim to promote health and develop a health service, not an illness service" (their emphasis). This is perhaps the most important difference between pre- and post-devolution policy in Wales – a persistent determination to focus much more on the promotion of health and therefore (by implication) to give slightly less priority to issues relating solely to the provision of services. It has been a difficult balance to maintain, especially when service issues such as growing waiting times dominate the headlines.

Almost since inception the National Assembly has sought to capitalize on its breadth of responsibilities to tackle the root causes of ill-health. In *Better health better Wales* (NAfW, 1999a) these were identified as including poverty, social exclusion, lack of equal opportunities, and the need for sustainable development. The document went on to outline the collective responsibility to tackle those causes in the various policy areas of the Assembly: economic development, agriculture, training and education, transport and environment, culture, arts and sport, housing, as well as health and social services.

The latest manifestation of this drive towards a "joined-up" policy for promoting health is *Well-being in Wales* (WAG, 2002b). This also emphasizes the need to improve health and reduce inequalities through partnerships between the various parts of the statutory and non-statutory sectors, local communities and individuals. Specifically, it provides a framework for health impact assessment and serves as the platform for local health, social care and wellbeing strategies.

These strategies are to be produced by every LHB in conjunction with other local agencies, especially the local authorities. Initially covering a three-year period (subsequently 5 years), they will be subject to public consultation. The guidance (WAG, 2003b) describes the key features of a local strategy that, "addresses full range of issues affecting health and wellbeing … puts action to improve health and reduce inequalities as an equal priority to effective and efficient health services … [provides] the basis for the commissioning strategy for NHS services and local authority health related services".

Local strategies are to be included within the context of national health gain targets (WAG, 2004b). These set a total of 13 high level targets to be achieved by 2012 in five areas: coronary heart disease, cancer, mental health, the health of older people and the health of children. For each there are targets for both "health outcome" and "health inequalities". For example, the two cancer targets are:

Health outcome: to reduce cancer EASR (European Age Standardized Rate) mortality for those aged below 75 by 20% by 2012 (excluding non-melanoma skin cancer).

Health inequalities: to improve cancer mortality in all groups and at the same time to aim for a more rapid improvement in the most deprived groups.

Overarching health services strategy

The key document which describes the overall approach to developing NHS services in Wales was published in 2001, *Improving health in Wales: a plan for the NHS and its partners* (NAfW, 2001). This addresses each of the main areas of health and social care policy.

For primary care it outlines a programme of gradual reform, maintaining the central role of GPs but expanding the roles of others. There is a desire to provide services under a 'single roof' wherever possible, and a call for experimentation in areas such as salaried GPs and nurse prescribing. For the future, the more recent negotiations over the fundamental changes to GPs' (also dentists' and pharmacists') contracts may have a significant impact on this strategic overview.

For secondary care a more revolutionary view is described or, at least, hinted at. The year before *Improving health in Wales* was launched, there had been a much less well-noticed publication, *Access and excellence: acute health services in Wales* (NHS Wales, 2000). This was the result of an Assembly-commissioned expert study of the current state of secondary (and tertiary) care in Wales, and the direction in which it should develop. It described a series of long-term pressures on acute hospital provision, common to the rest of the United Kingdom(and elsewhere). These were set in the particular context of Wales, where history and rurality had combined to bequeath a pattern of acute care heavily reliant upon a relatively large number of small general hospitals, several serving a population of fewer than 100 000 people. Despite the conclusion that, "this report is essentially optimistic" (NHS Wales, 2000, 56) it calls for a radically new vision for acute care, based on "new ways of planning and developing services; a new, more responsive model of hospital care; a new approach to

capital; and the prospect of major investment in the infrastructure to support patient care". In summary: centralization and hospital closure facilitated by substantial increases in capital investment.

Much of this reappears in more muted, jargon-camouflaged terms in *Improving health in Wales*. This describes the population base for secondary care as being 500 000+ people, based on "natural health economies" and a "differentiated model of hospital services". This would be built upon clinical networks, a separation of elective and emergency work and greatly expanded intermediate care. It talks explicitly of the trade-offs between access and affordability, a particularly sensitive issue for the Assembly Members representing rural Wales.

Public involvement is another major theme within *Improving health in Wales*. It announces the decision to retain CHCs and a host of small initiatives, such as local patient advocacy and support schemes (a Welsh version of England's PALS), the use of expert patients and the development of Internet sites.

In other areas there is greater similarity with England. Clinical governance and National Service Frameworks are to be key bulwarks in the improvement of the quality of care, and the full opportunities for joint working afforded by the 1999 Health Act are to be realized.

The most recent development in overarching service policy was inaugurated by the Wanless report (Wanless, 2003). The British Chancellor asked Derek Wanless, a former banker, to look at NHS funding. The Welsh Assembly Government also commissioned him, "to examine how resources [for health and social care in Wales] should be translated into reform and improved performance" (Wanless, 2003, 1). The report makes several recommendations, including:

- more attention to preventing ill-health and promoting good health;
- radical re-design of health and social care, to ensure the delivery of national standards and genuinely "seamless" provision;
- "re-balancing" of the elements of health care – especially primary, secondary and intermediate, emergency and elective;
- more effective means of involving the public, particularly in the context of the difficult issues arising from the above;
- greater financial discipline within the NHS, especially an end to the practice of under-writing deficits;
- improved incentives, sanctions and "collaborative accountability";
- improved workforce planning, development and utilization;
- better information systems;

- whole systems estates strategies.
- new money explicitly to be linked to improved results.

The Assembly Government takes this report very seriously; it remains to be seen to what extent the NHS and government are able to rise to its major challenges.

Children and young people

This is another arena intended for joint working between the NHS, local government and others (WAG 2004a). In this instance, the lead forum is the Framework Partnership for children and young people in the local authority/LHB area. Each is charged with developing a plan for their area against seven core aims: "a flying start in life" for 0–3 years; a comprehensive range of education, training and learning opportunities; the best possible health; play, leisure, sporting and cultural activities; respect for race and cultural identity; a safe home and community; children and young people not disadvantaged by poverty.

Older people

The strategy for older people in Wales (WAG 2003a) recognizes the joint responsibility of parts of the Welsh Assembly Government and various local agencies. This is to be supported by a National Service Framework for older people and the appointment of a commissioner for older people in Wales who will promote their rights and welfare.

Regulation

Wales has worked closely with the Commission for Health Improvement and has been subject to the same work employed in England to increase standards. However, a more detached structure is being created for the future with three principal arms located within the Government (although separated from the NHS Department) – Health Inspectorate Wales, the Care Standards Inspectorate Wales and the Social Services Inspectorate Wales.

Patient and public involvement

Improving health in Wales (NafW, 2001) specifically mentioned the importance of patient and public involvement. The retention of CHCs was one measure

of the policy differences between Wales and England. Others have been the eschewing of a series of measures (promulgated in England) that give patients automatic access to services elsewhere if particular waiting-times are breached, and a greater emphasis on the involvement of local government as an important voice of its local community. The Assembly Government has issued guidance on how best to involve public and patients (OPM/WAG, 2001, 2003).

Free prescriptions

One of the Labour Party's manifesto pledges in the 2003 Assembly Election was to abolish prescription charges in Wales. This followed an earlier decision to freeze prescription charges and to provide free prescriptions for everyone under the age of 25. This policy has greater popular significance in Wales than either its financial impact or potential for health gain might suggest. Already, approximately 90% of prescriptions are dispensed free of charge and there is little evidence to quantify the adverse health impact of prescription charges. It is seen as something of a symbol of the difference between Wales and England – what the First Minister, Rhodri Morgan, referred to before the election as the "clear red water" between old and new Labour. It is planned to abolish all prescription charges by the next Assembly election in 2007.

Financial resource allocation

The Westminster (United Kingdom) Parliament allocates almost all of the National Assembly's resources, largely on the basis of the Barnet formula.[1] Within Wales, the Assembly allocated £3.8 billion to the NHS in 2003/2004. The use to which this money is put, and accountability for it, is set out in each LHB and trust's service and financial framework (SaFF).

The formula governing the allocation of NHS money between the LHBs has been the subject of prolonged controversy. To simplify, people in rural Wales long have argued that the costs of rurality and isolation are not adequately addressed by the current arrangements. On the other hand those in some areas of the south Wales valleys, a European Objective 1 area containing some of the most deprived wards in the United Kingdom, argue that their poor health does not attract sufficient extra funding. The Assembly's Health and Social Services Committee joined the debate in 2000 and, as a result, the government commissioned a team led by Professor Peter Townsend to review the allocation arrangements. *Targeting poor health* (WANSG, 2001), was published in 2001 and suggested a new formula that would, predictably, create winners and losers – for example, North Wales might lose up to 5% of its allocation for hospital and community services.

This issue awaits a final resolution although the government claims that the abolition of prescription charges, and the creation of an Inequalities Fund, will help to ensure that money goes where it is most needed.

In the meantime, Wanless (2003) identified substantial problems with the management of the allocated resources. He pointed out that although health spending has risen since 1998/1999, both in absolute terms and as a percentage of total Assembly spending, in every year but one since 1994/1995 NHS organizations have reported deficits over £10 million. The accumulated deficit since the advent of the Assembly now stands at £70 million, and rising.

[1] Since the end of the 1970s, the overall resource allocation to Wales from the United Kingdom government has been substantially based on a formula named after the then Chief Secretary to the Treasury, Joel Barnett. It compares Welsh (and Scottish) expenditure programmes to those in England so as to allocate to Wales the same proportional increase (or decrease) as England receives.

Physical and human resources

Estates

Wales has major problems with the state of its health premises. The backlog maintenance figure in 2001 was estimated to be £400 million (Auditor General for Wales, 2001), with only half of the estate held by Trusts being assessed as fully or reasonably fit for its purpose. Although there is now a plan for future development (NHS Wales, 2002) the scale of the task is enormous, especially given the need for additional investment if the service is to move from its current pattern of hospital provision to one that better meets public and professional aspirations in the future.

Information and communication technology (ICT)

Wanless (2003) was particularly critical of the state of ICT in Welsh trusts. The government also (WAG, 2002a) recognizes the problems. Professionals experience delays in obtaining paper-based results, there is poor access to evidence in the workplace, time is wasted by hand-writing patients' notes and there is frustration at the unavailability of notes produced by others. For patients, there may be wasted journeys because records have been mislaid and incorrect treatment due to misidentification or misdiagnosis. As with estates there is a strategic plan, but concern that lack of resources may delay its achievement.

Human resources

The NHS in Wales is the country's largest employer with a total of 81 000 staff and a further 10 000 employed in primary care (Wanless, 2003). There have been substantial increases in the numbers of staff in recent years. Between 1997 and 2002 nursing, midwifery and health visiting staff increased by 9%; medical

and dental staff by 18%; administrative and estates staff by 20%; and scientific, therapeutic and technical staff by 21% (Statistical Directorate, 2003b).

However, substantial problems remain. For example, vacancy rates (Statistical Directorate 2002) and the use of locums are high and Wales experiences the same problems as other parts of the United Kingdom in recruiting to shortage professions. Workforce planning is an area that will receive particular attention.

Process: provision of services

In most respects, Welsh health service provision at clinical and directorate levels is very similar to that of the rest of the United Kingdom. In what is perhaps the most politically highly charged area, however, the provision of services in Wales contrasts sharply (and unfavourably) with England.

Waiting times for inpatient, day case and outpatient care in Wales are substantially longer than those in England and, until very recently, were still lengthening.

There is much speculation about the reasons for this relatively poor performance. In addition to a variety of local factors, there is probably one important overarching issue – the fact that, until recently, waiting times do not appear to have had quite the same degree of urgency in performance management in Wales as they have had in England. This may be due in part to the Assembly Government's emphasis that it is at least as interested in health as it is in providing efficient health services. This, together with the persisting inability to resolve the financial problems afflicting significant parts of the NHS in Wales, may have tended to absolve managers of the absolute imperative of reducing waiting times.

Table 1. Waiting times in thousands

Waiting time	March 2000	March 2001	March 2002	March 2004	January 2004
Outpatients >6 months	38	46	69	70	78
Inpatients/day cases >1 year	11	9	10	12	11
Inpatients/day cases >18 months	4	4	4	5	4

Conclusions

In most aspects of service delivery and the local organization of services, health care in Wales remains very similar to that elsewhere in the United Kingdom. Many policy challenges are shared – the state of premises and ICT, workforce issues, the tension between public expectations and performance, the difficulties of resource allocation and so on.

Some significant differences are starting to become apparent in the policy arena, however. First, in Wales there is considerable emphasis on the health service's role in promoting health and reducing health inequality, and perhaps somewhat less on its efficiency and performance as an ill-health service. Second, and closely linked with this, is the continuing thrust towards encouraging NHS and local government departments in Wales to work more closely together. Yet, so far, there is comparatively little evidence of change in practice. Neither of these is different in kind from England, but the qualitative differences of emphasis are substantial.

Third, the performance management regime in Wales has so far been unable to deal effectively with two major challenges – the eradication of recurring financial deficits, and waiting times that are not falling at the same rate as elsewhere. To date, performance management in Wales has been characterized more by consensus and tolerance of problems, than by rigour and achievement.

Finally, and perhaps underpinning each of the above, the commitment to consensual and cooperative politics and policy and rejection of individualism and quasi-market approaches. In part this is a function of the proportional representational system in Assembly elections; in part it reflects the prevailing political philosophy in a country that still appears to share a strong sense of communitarian identity. If England were to return a centre-right government, these contrasts between the two countries might become even more pronounced. It remains to be seen whether the Richard Commission's (Richard, 2004) recently published recommendations, gradually to confer on Wales the ability to create primary legislation, will be implemented and whether they might reduce this potential problem.

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Key

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[b] Georgian
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