European Observatory on Health Care Systems

Health Care Systems in Transition

United Kingdom



The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine

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By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.
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Foreword

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

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Norway and Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe 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 care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- 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 the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines

and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Coordination and Development (OECD) health data and the World Bank.

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. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at http://www.observatory.dk.

Acknowledgements

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The current series of the Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems. The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat and the research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof. Administrative support, design and production of the HiTs has been undertaken by a team led by Phyllis Dahl and comprising Myriam Andersen, Sue Gammerman and Anna Maresso. Special thanks are extended to the WHO Regional Office for Europe health for all database from which data on health services were extracted; to the OECD for the data on health services in western Europe, and to the World Bank for the data on health expenditure in central and eastern European (CEE) countries. Thanks are also due to national statistical offices which have provided national data.

Introduction and historical background

Introductory overview

The United Kingdom of Great Britain and Northern Ireland (UK) is made up of four constituent countries, namely: England, Scotland, Wales and Northern Ireland.

Table 1 shows some basic health and population indicators. The population of the United Kingdom has reached nearly 60 million, the majority of which is urban (over 89% in 1995). The dependency ratio[1] has actually fallen from 79.8 (1979) to 70.1 (1995), despite a rising life expectancy at birth from 73.12 (1979) for both men and women to 77.40 in 1997.

Table 1. Health and population indicators

Population	59 008 700
% over 65 years	15.71
Life expectancy at birth	77.40
Infant mortality rate	5.86
Total fertility rate	1.72
Crude birth rate per 1000 population	12.30
Crude death rate per 1000 population	10.67

Source: WHO health for all database.
Note: All figures for 1997.

The leading causes of death in the United Kingdom, shown in Table 2, are diseases of the circulatory system including both cerebrovascular diseases and ischaemic heart disease. Cancer accounts for over 200 deaths per 100 000 population and is followed by diseases of the respiratory system, which account for about 110 deaths per 100 000 population. Of cancer deaths the most common

[1] The dependency ratio is defined as those under 20 years of age and those over 64 years of age in relation to the population aged 20–64 years.

Fig. 1. Map of the United Kingdom[2]

[2] The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

Table 2. Causes of death (deaths per 100 000 population) in the United Kingdom, 1970–1995

	1970	1975	1980	1985	1990	1995
All causes	1 099.2	1 042.2	984.3	917.9	820.8	770.7
Circulatory system diseases	557.6	529.5	483.0	434.9	363.6	317.2
Neoplasm	216.9	217.4	220.3	224.8	220.4	206.5
Respiratory system diseases	160.0	138.7	134.3	97.4	84.3	109.2
External causes	46.7	43.6	41.1	36.1	33.3	28.6
Mental and behavioural disorders	14.8	15.7	17.3	33.7	32.7	25.1
Nervous system diseases	14.8	15.7	17.3	33.7	32.7	25.1
Digestive system diseases	25.5	26.7	28.0	28.2	26.9	27.4
Endocrinal/ metabolic diseases	12.6	12.5	10.9	14.3	14.1	11.7
Genito-urinary system diseases	14.9	14.1	12.8	11.7	9.7	9.0
Infectious/ parasitic diseases	7.3	6.1	4.3	4.1	4.0	4.9
Blood and immune system diseases	3.7	3.2	2.8	3.5	3.2	2.4

Source: OECD health data 1998.

are from lung, breast, colorectal and prostate cancer which together account for about 62 000 deaths each year. The United Kingdom has one of the worst age-standardized mortality rates for breast cancer for women under 65 in western Europe (22.4 deaths per 100 000 compared to 15.1 in Sweden in 1995). Deaths from coronary heart disease dropped by 38% between the early 1970s and late 1990s and from stroke by 54% over the same period. Compared to other European Union (EU) countries, England has one of the worst rates of coronary heart disease. For people aged under 65 years it is two and a half times worse than France (the country with the lowest rate in the EU) amongst men and over four times worse for women.

Politics

The United Kingdom is a constitutional monarchy governed by two houses of representatives (the democratically elected members of parliament (MPs) of the House of Commons and the hereditary and life peers of the House of Lords). Elections take place at least every five years for the House of Commons under a first-past-the-post electoral system based on constituencies. The Prime Minister is the leader of the majority party in the House of Commons (since 1 May 1997 Rt. Hon. Tony Blair, leader of the Labour Party). The Prime Minister appoints the cabinet of ministers.

The issues of devolution, reform of the House of Lords and reform of the voting system for European, national and local elections were put forward as part of the current Labour Government's election manifesto. Reforms have recently been introduced creating a National Assembly in Wales and a Scottish Parliament. The process of devolution to the Northern Ireland Assembly is still under negotiation.

Until May 1999 Scotland and Wales were governed centrally through Westminster. All their 'national' affairs were overseen by the Secretary of State for Scotland and the Scottish Office in Scotland and London, and similarly the Secretary of State for Wales and the Welsh Office in Wales and London. With the establishment of the Scottish Parliament and Welsh Assembly the responsibility for health, education, agriculture and industry will be devolved. Currently the National Health Service (NHS) in Scotland is administered by the Department of Health in the Scottish Office, the NHS in Wales through the Welsh Office and in Northern Ireland there is a joint Department of Health and Social Services which runs the Health and Personal Social Services (HPSS). See Appendix I for details of the main differences in the structure of health care administration in each of the constituent parts of the United Kingdom. The United Kingdom has been a member of the European Union since 1972. Members of the European Parliament (MEPs) were elected on the basis of a proportional system with party lists for the first time in 1999.

In England the system of local government is made up of directly elected representatives of county and city councils (39 and 7 respectively). Northern Ireland is made up of 26 districts. Scotland is made up of 9 regions and three island areas: Orkney, Shetland and the Western Isles. Wales is made up of eight counties. There remain a number of dependent territories: including Bermuda, the Falkland Islands, Gibraltar, Guernsey, Jersey, Isle of Man, Montserrat, and South Georgia. Hong Kong returned to Chinese rule on 1 July 1997.

Economy

GDP grew by 3.12% over the period 1996–1997 (*20*). This follows a period of little growth between 1990 and 1995 when the average change in real GDP was only 1.3% per year. This however was slightly above both the OECD and

Table 3. Average annual percentage change in real GDP in five-year periods

	OECD	western Europe	United Kingdom
1960–1965	5.9	5.6	3.3
1965–1970	5.2	5.0	2.7
1970–1975	4.2	3.8	2.2
1975–1980	3.6	3.5	1.9
1980–1985	2.3	1.9	2.0
1985–1990	3.3	3.5	3.6
1990–1995	1.1	1.0	1.3

Source: OECD health data 1998.
Notes: Figures for OECD and western Europe are arithmetic means for relevant countries and not weighted for population.

western European average (see Table 3). The United Kingdom had a gross public debt of 60.5% GDP in 1997. There is currently debate about whether and when the United Kingdom should participate in European Monetary Union, which began on 1 January 1999.

The total labour force is 49.3% of the population, of which 62.8% work in the service industries, 25% in manufacturing and construction, 9.1% in government employment (includes all NHS employees), 1.9% in energy and only 1.2% in agriculture. Agriculture is intensive and highly mechanized and produces about 60% of food needs. Primary energy production accounts for about 12% of GDP. Services, especially financial services, account for the largest proportion of GDP.

Historical background

Health services

The discussion in this section traces some of the main developments in the UK National Health Service (NHS) over the last fifty years with particular emphasis on those features that remain relevant for understanding the nature of the service today.[3]

The National Health Service (NHS) came into operation in 1948 following the provisions of the *NHS Act* of 1946. This Act was of crucial importance in establishing the post-Second World War pattern of health service finance and provision in the United Kingdom. It introduced the principle of collective responsibility by the state for a comprehensive health service, which was to be available to the entire population free at the point of use. Freedom from user charges was a key feature of this approach which placed heavy emphasis on equality of access.

The political consensus for establishing the NHS was built during the war and was in tune with other welfare state initiatives in areas such as social security, education and housing, which were being developed at this time. However not every group subscribed fully to this consensus. Most notably, the medical profession was initially opposed to some of the proposed features of the newly established NHS. The Royal Colleges – the professional bodies that represent different medical specialties led by consultants (senior specialists) –

[3] Most of the discussion in this report refers to health services in England. The organization and management of the health services in Scotland, Wales and Northern Ireland is similar to the English system, but some important differences apply. Appendix I outlines some of the major differences.

and general practitioners (GPs) were strongly opposed to any loss of professional autonomy. They wanted independence from bureaucratic interference and were especially concerned about proposals that would have placed the health service under local government control. In the event, skilful negotiation by the Minister of Health, Aneurin Bevan, obtained the support of the medical profession for the establishment of a central government-run NHS with a number of concessions to demands for professional autonomy. Thus GPs were allowed to operate as independent contractors within the NHS while hospital specialists, although salaried employees of the NHS, were allowed to retain a large degree of control over their conditions of employment. They were also permitted to retain the right to private practice alongside their NHS work. These conditions of service remain largely unchanged today.

One of the assumptions behind the establishment of the NHS was that there was a "backlog" or "stock" of ill health that would be made good by the new service, after such time demand would level off or fall. In the event, of course, this did not happen and demand in the 1950s outstripped the funding that was made available. One consequence of limited funding was extreme pressure on an under-resourced hospital service. Recognition of this problem led to the 1962 Hospital Plan which proposed major new capital funding over the next ten years and introduced the concept of the district general hospital (DGH). The DGH represented a planned approach to hospital provision whereby a unit of between 600 and 800 beds would cater for all the general medical needs of a population of between 100 000 and 150 000. This pattern of hospital provision has persisted until the present day and is one reason why a number of commentators said that the NHS internal market – introduced by the reforms of 1991 – would be characterized by a series of local monopolies.

Organizational structure

Some of the main elements of the present day organizational structure of the NHS can be traced back to the major changes that were introduced through the *NHS Act* of 1973.

This Act introduced a new hierarchical command and control system. At the apex there was the Ministry of Health headed by the Minister of Health. Below the Ministry there were regional health authorities (RHAs) with broad planning responsibilities. Beneath the RHAs there were 90 area health authorities that were, in turn, divided into districts administered by a district management team. These were all introduced in 1974 under the provisions of the 1973 Act. It was the district that generally had responsibility for the operation of the district general hospital.

This new system had barely been introduced, however, when major problems started to emerge. Some of the most important of these were beyond the control of the health service. For example, the sustained expansion of welfare state expenditures in most advanced industrial countries was interrupted in the mid-1970s as sharp increases in oil prices and worldwide economic recession led to calls to cut back public expenditures. This led to increased pressures on NHS budgets. At the same time, however, it was becoming clear that the new system was cumbersome with its multiple tiers of administration, slow in making decisions and costly to administer. As a result, the Merrison Royal Commission was set up in 1976 to consider the best use and management of resources in the NHS. The Commission reported in 1979 and recommended that, *inter alia*, a single tier of health authorities should be established to take over the functions of areas and districts. Following these recommendations, 192 district health authorities (DHAs) were created in 1982. Despite variations in their number, size and functions, DHAs (now simply referred to as 'health authorities') remain important units in the administration of the NHS today.

Another important development during the 1970s dealt with the equity of resource allocation between different regions of the country. Until the 1970s annual resource allocations were based largely on past allocations with some minor adjustments for particular circumstances. This resulted in some major inequities between different regions. To address this problem a Resource Allocation Working Party (RAWP) was set up in 1975 with the task of developing a formula for allocating resources on a more equitable basis. The Working Party reported in 1976 and recommended a formula for allocating funding between different regions based upon their respective health 'needs'. These needs were measured in terms of the region's population size, age and sex composition, and its levels of morbidity. The RAWP formula was adopted and, although subject to several subsequent modifications, the principle of weighted capitation payments based upon population health needs has remained an important basis for resource allocation within the NHS.

Yet another important development in the history of the NHS occurred in 1979 when the government of Margaret Thatcher was elected with its commitment to a programme of radical economic and social reform. This government saw public expenditure and state involvement as the source of Britain's economic difficulties and embarked upon a major programme of privatization.

Although early policy on privatization in relation to the NHS was restricted mainly to contracting-out of ancillary services (i.e. laundry, catering and cleaning), the government's belief in the superior efficiency of private sector practice led to major changes in management arrangements. An inquiry into the

management of the NHS was set up in 1983 under the chairmanship of Sir Roy Griffiths, a managing director of a chain of supermarkets. Adopting private sector business principles, the Griffiths Inquiry reporting in 1993 recommended a move away from the old-style 'consensus' management towards a system of 'general' management with general managers at the unit, district and regional levels. New boards, responsible for policy and strategic planning on the one hand and operational management on the other, were also established at the centre. This system, based upon local management decision-making and a clear line of accountability from the top to the bottom of the NHS, was designed to replace the previous system, which was based largely on administration within a bureaucratic hierarchy. General management was an important precursor of more dramatic market-based reforms which were to follow.

Despite the Griffiths' reforms and the government's strong belief in the superior efficiency of the private sector, the NHS was not fundamentally affected by major organizational change for most of the 1980s. It is possible that the government was wary about extending its radical programme to a sector which successive opinion polls continued to show enjoyed deep and widespread support. However, following intense debate about inadequate spending on the NHS – which took place towards the end of 1987 – Mrs Thatcher announced an internal review of the NHS under her own chairmanship. This review and its recommendations led to the reforms embodied in the *NHS and Community Care Act 1990* which were implemented on 1 April 1991. These reforms introduced an 'internal' or 'quasi' market to the NHS and represented the greatest change to its organization and management in its entire history.

The internal market separated the responsibility for purchasing (or commissioning) services from the responsibility for providing them. The main purchaser function was assigned to the health authorities (supplemented increasingly by general practice fundholders) while the provision of services was made the responsibility of NHS trusts. Trusts were expected to compete with each other for service contracts from purchasers.

The internal market, albeit with numerous modifications and restrictions, was used as the primary mechanism for the allocation of health care resources throughout much of the 1990s.

With the election of a Labour Government in 1997, however, priorities changed. Their plans for the NHS were set out in the White Paper, *The new NHS: modern, dependable*, published in December 1997. The approach presented in this White Paper and several subsequent documents, including the current NHS Bill, is designed to replace emphasis on market-based processes with far more emphasis on planning, collaboration and partnership-working.

The main features of the 1991 reforms, and the ways in which current proposals indicate that they will be modified, will be analysed extensively in subsequent sections of this report.

Primary care services

Before moving on to consider these recent developments, however, it is worth highlighting another trend which has taken place since the 1980s, namely, the increased emphasis placed upon primary care. Although the United Kingdom has a well-developed system of primary care compared with most other countries, this sector received little attention from policy-makers in comparison with the acute sector until the mid-1980s. The independent contractor status of general practitioners (GPs), established back in 1948, meant that services had developed piecemeal and coordination with hospital-based community health services was poor. Following an extended period of discussion and consultation in the second half of the 1980s, major changes were implemented through the introduction of a new GP contract in 1990. Through this contract, GPs became more accountable to family health service authorities (FHSAs), the primary care counterparts of district health authorities. DHAs and FHSAs were actually merged in 1996. Among other things, GPs were required to produce annual reports, contain pharmaceutical prescriptions within indicative budgets, and meet targets for various health screening and preventative services. At the same time, payments systems were changed to offer incentives for improved performance and to make them more responsive to patients' needs.

Following closely on the heels of this change, GP fundholding was introduced through the *NHS and Community Care Act 1990*. From an early experimental status, primary care-based purchasing became a central element of the NHS during the 1990s. Not only did fundholding expand dramatically in terms of the number of GPs involved but also several variants of the scheme were introduced. Probably the most ambitious of these variants was the total purchasing pilot scheme introduced in 1995. Through this scheme, selected groups of practices were allocated budgets with which they could purchase potentially all of the secondary and community health services received by their patients. While the new Labour Government has abolished GP fundholding – on the grounds of inequity and unacceptably high transaction costs – it has retained an emphasis on the 'primary care-led NHS'. Since April 1999 all GPs have been required to join a primary care group: these are larger area-based groupings of GPs that have responsibilities for commissioning as well as primary care provision. (Primary care groups are discussed further in the sections on *Organizational structure and management* and *Health care reforms.*)

Public health services

Public health medicine has a long history in the United Kingdom. Its origins can be traced back to the middle of the nineteenth century when the main Acts of Parliament concerning public health issues were passed. A total of 17 pieces of legislation were passed between 1848 and 1890, of which six affected the delivery of public health services through administrative and structural changes. It was, however, the *Public Health Act* of 1875 which represented landmark legislation. This consolidated previous legislation, giving a clear account of the powers and responsibilities of local sanitary authorities. It laid the foundations for modern public health (no changes were made for more than 60 years).

Many successes were achieved by the turn of the century including improvements to water supply and sewerage, street cleaning, working and living environments and personal hygiene. The strong legislative framework combined with the growing power and effectiveness of local Medical Officers of Health made a crucial contribution to these improvements.

Having played a significant role in the organization of health services during the Second World War, Medical Officers of Health assumed that the development of a National Health Service would be part of local government with an expansion of services provided by local authorities. However, the strength of political opposition by the British Medical Association, the Royal Colleges and the voluntary hospitals to local government control meant that the role of public health and Medical Officers in the NHS was minimal.

During the reorganization of public health into community medicine and with the establishment of regional, area and district health authorities in 1974, the position of Medical Officer of Health was abolished. It was not until the 1980s that there was renewed discussion about the role of public health doctors. Possibly the most significant document to influence the future direction of public health services was the Acheson Report.

In 1986 the then Secretary of State set up an inquiry team under the chairmanship of the Chief Medical Officer, Sir Donald Acheson, to consider the future of the public health function. Published in 1988, the report identified five main problems: lack of information about the health of the population; lack of emphasis on health promotion and disease prevention; confusion about the roles and responsibilities of public health doctors; confusion about the responsibility for communicable disease control; and lack of information about outcomes on which to make informed choices.

Following the enactment of the *NHS and Community Care Act 1990* a new opportunity for public health arose. The *Health of the Nation* report published in July 1992 aimed to shift the focus from the delivery of clinical services to

health. It encouraged health authorities to take on a more strategic role, namely that of maintaining and improving the health of the local population.

The most recent initiative in the public health area has been the publication of the present government White Paper *Saving Lives: Our Healthier Nation* in July 1999. The White Paper builds on the earlier Green Paper *Our Healthier Nation* and sets out the government's future strategy for public health policy.

The present organization and development of public health services are described in the section on *Primary health care and public health services*.

Organizational structure and management

Organizational structure of the health system

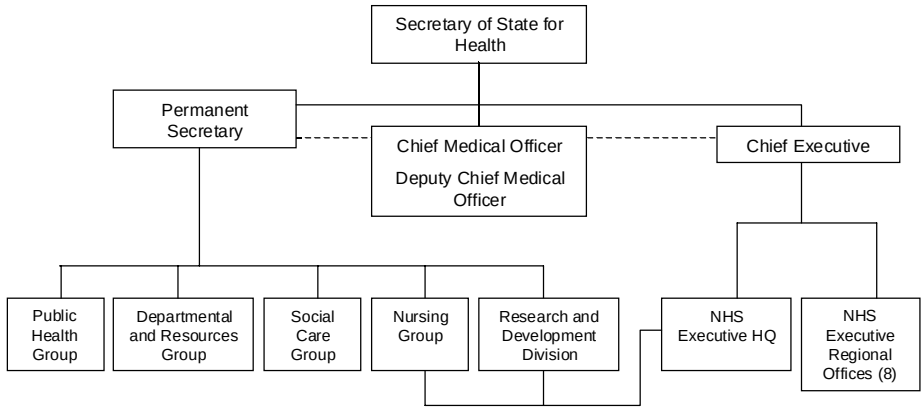
The structure of the UK health system is currently undergoing major organizational change following the election of a Labour Government in May 1997. Their plans for the NHS were set out originally in a White Paper, *The new NHS: modern, dependable*, published in December 1997. The Health Act 1999, which gives a legislative basis to many of the changes set out in the White Paper, received royal assent on 30 June 1999. In addition numerous executive letters and guidance notes setting out the details of the government's plans have been issued. These plans are intended to build on some of the successes of the previous Conservative Government's reform programme but to replace certain important elements of it. In the following account the existing system is described together with the main changes either implemented already, in the process of implementation or planned for the future.[4]

The Department of Health

The Department of Health (DoH) under the direction of the Secretary of State for Health, together with his team of five ministerial colleagues, is responsible for health and personal social services in England. Separate responsibilities are held by the Secretaries of State for Scotland, Wales and Northern Ireland. In England the Department sets overall health policy, including policies on public health and those relating to the health consequences of environmental and food matters. It is also has overall responsibility for the NHS. Fig. 2 indicates the structure of the Department. As the figure shows, it has three main branches.

[4] Most of the discussion in this report refers to health services in England. These account for about 80% of total United Kingdom public expenditure on health and personal social services. The remainder is spent in Scotland (11%), Wales (6%) and Northern Ireland (3%). The organization and management of the health service in these countries is similar to the English system, but some important differences apply. Appendix I outlines some of the major differences.

Fig. 2. Structure of the Department of Health



Departmental Agencies and Non Departmental Public Bodies are not shown

Source: Derived from Department of Health (1998) The Government Expenditure Plans 1998–1999. Departmental Report. Cm 3912. London: The Stationery Office p102.

First, there are a series of groups and divisions with specific area or professional responsibilities, e.g. the Public Health Group, the Social Care Group, the Nursing Group and the Research and Development Division.

Second, there is the office of the Chief Medical Officer (CMO). The CMO is responsible for offering expert medical advice to the whole department.

Third, there is the NHS Executive (NHSE), under the direction of the Chief Executive, which is responsible for leadership and a range of central management functions in relation to the NHS. The NHSE supports ministers in the development of health policies and is responsible for effective management and the cost-effective use of resources in the NHS. As well as its headquarters based in Leeds the NHSE has eight regional offices located around the country. These offices are responsible for the regional implementation of national policies and, with this aim in mind, monitor the performance of health authorities. They occupy an important position in the chain of accountability from the local level to the centre.

A recent innovation, at the ministerial level, was the appointment in 1997, for the first time, of a Minister of State with specific responsibility for public health. The minister has a wide-ranging brief including public health monitoring and strategy; health promotion; notifiable and communicable diseases, including AIDS; family planning; and food safety. At the moment, particular emphasis is being placed upon the need to address health inequalities.

Another innovation of some importance was the establishment of a division within the Department of Health with specific responsibility for leading a programme of research and development geared to policy questions of direct relevance to the NHS. The first director of this division was appointed in 1991 and a strategy designed to make NHS decision-making research-based was launched. Since then, a national research and development programme, together with a series of regional programmes, has played a major role in commissioning and funding research related to the needs of the NHS.

Other ministries

The present Labour Government places considerable emphasis on the co-ordination of policy across ministries (the term 'joined-up government' has been coined). This approach highlights the role of other ministries with responsibilities for health and health-related matters. These include:

- **The Department of Social Security** which has responsibility for social welfare payments (e.g. income support, invalidity and disability benefits);
- **The Department of the Environment, Transport and the Regions** which has responsibility for personal social services administered through local government authorities;
- **The Ministry of Agriculture, Food and Fisheries** which currently has responsibility for food standards (this may change if the *Food Standards Bill* introduced in parliament in June 1999 is passed into law); and
- **The Department for Education and Employment** which funds the training of medical students and other health professionals.

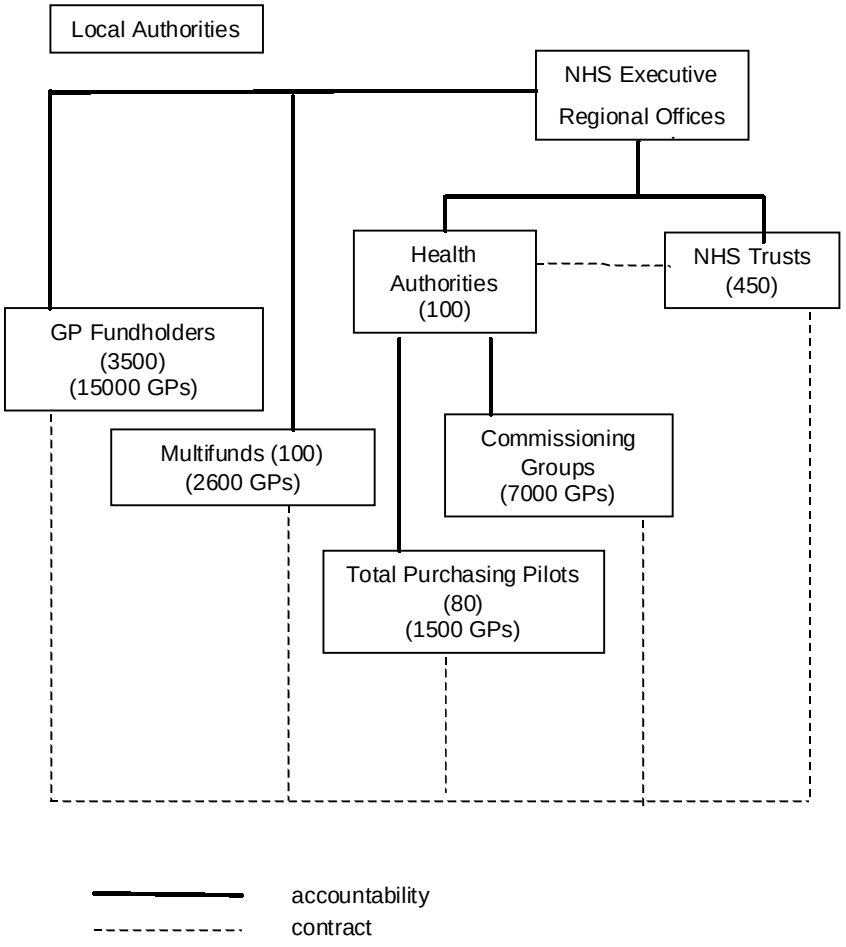
The National Health Service

The organizational structure of the NHS as it existed following the 1991 reforms and prior to the current reform plans is shown in Fig. 3. Within this structure, there are four main organizations; namely, regional health authorities, district health authorities, general practice fundholders (GPFHs) and NHS trusts.

Regional health authorities (RHAs)

At the time of the 1991 reforms, and in the period immediately following them, there were 14 RHAs in England. These regions carried out a range of monitoring and performance management roles on behalf of the NHS Executive. As part of this function, each district health authority (see below) had a contract with the regional office specifying the tasks it was expected to carry out over the next year and it was held to account to the regional office for its actual

Fig. 3. Structure of the 'old' NHS



Source: Derived from Department of Health (1998) The Government Expenditure Plans 1998–1999. Departmental Report. Cm 3912. London: The Stationery Office p103.

performance. NHS trusts were similarly accountable for their performance to regional officers.

In 1994, in an effort to reduce management costs, the number of regions was reduced from 14 to 8 and their staffing levels were reduced substantially. At the same time they were converted into regional offices of the NHS Executive. This meant that they lost a good deal of their previous autonomy and that the line management link between the centre and the regions was strengthened.

District health authorities (DHAs)

As was pointed out in the previous section, under the terms of the *NHS and Community Care Act 1990*, responsibility for purchasing or commissioning health services in the NHS was separated from the responsibility for providing them in 1991. This arrangement was dubbed an 'internal' or 'quasi' market. Within this system, the main purchasing function was allocated to district health authorities (DHAs).

DHAs were corporate bodies operating under the general direction of a chairperson, appointed by the Secretary of State, and a board comprising executive and nonexecutive directors. In 1991 there were just under 200 DHAs catering for resident populations of, on average, 250 000 people, although the actual size range extended from 100 000 to 800 000. Each DHA was required to assess the health care needs of its population and, from its weighted capitation-based budget, commission a range of services from providers to meet these needs. Each DHA had a department of public health responsible for carrying out needs assessment. A contract system was introduced to formalize the link between purchasers and providers.

Over time, a series of mergers took place between DHAs with the aim of realizing economies of scale. By 1998 the number of DHAs had fallen to 100, the figure shown in Fig. 3. With the conversion of RHAs to regional offices of the NHS Executive, there is now only one tier of health authority and so DHAs are referred to simply as 'health authorities'.

Family health service authorities (FHSAs)

Within the NHS, there has been a long-standing distinction between primary care (delivered by general practitioners and associated staff) and hospital services. From 1991, DHAs were responsible for hospital services while primary care was the responsibility of family health service authorities (FHSAs). However, as part of the effort to coordinate primary and secondary care effectively, DHAs and FHSAs were merged into single authorities from 1996.

General practice fundholders and other primary care-based purchasers

At the same time as DHAs were allocated a purchasing function in 1991, 294 GP fundholding schemes (GPFHs) were introduced. These were selected GP practices which were allocated budgets with which they could purchase directly a range of diagnostic and elective procedures on behalf of the patients registered with them. (The bulk of services for these patients were still, however, purchased

by the DHA). At the beginning, GP fundholding was very much an experimental scheme, but the number of practices covered by the scheme grew rapidly each year. As Fig. 3 shows, by 1998 there were 3500 GPFHs.

As fundholding grew in scale, and the commitment of the Conservative Government grew towards primary care-based commissioning, several variants of fundholding emerged. Some fundholders sought to economize on management costs by combining into multi-practice consortia: Fig. 3 shows that there were 100 of these 'multi-funds' in 1998.

Even more radically, in 1995, the government approved the establishment of 53 total purchasing pilot sites (TPPs). These were single or multi-practice GP sites, covering populations of between 12 000 and 80 000 people, that were given the opportunity to purchase potentially all of the hospital and community health services for the patients registered with them. With the introduction of a second wave of TPPs in the following year, there were 80 TPP sites nationwide by 1998 (see (*18*) for an account of models of purchasing developed in the United Kingdom over the 1990s).

GP commissioning groups

Despite the formidable growth of GPFHs, multi-funds and TPPs, many GPs remained unhappy with the fundholding experiment. For some there were ideological objections; for others, the practicalities were unattractive. As a result of these reservations, a number of GPs chose to form 'Commissioning Groups'. These were non-fundholding collectives of GPs who worked with their local DHAs in an effort to jointly determine purchasing priorities and strategies. As Fig. 3 shows, approximately 7000 GPs belonged to such groups in 1998 compared with just over 19 000 GPs associated with fundholding models of purchasing.

NHS trusts

Turning to the supply-side of the internal market, providers of services were given greater freedom and autonomy through the creation of NHS trusts. These trusts were within the NHS and run by a board of directors comprising executive and nonexecutive members. Trusts were expected to compete for contracts from DHAs and GPs for the provision of clinical services. By 1998, all acute hospitals, community health service providers and ambulance services had acquired trust status.

Decentralization and regulation in the internal market

The 1991 reforms and subsequent measures were designed to increase efficiency, quality and choice through the creation of decentralized, market-

type mechanisms. They represented a move away from hierarchical, or vertically integrated, forms of organization towards models based on purchaser-provider separation and contractual relationships. The forms of contractual relationships between purchasers and providers are indicated by the dotted lines in Fig. 3. The degree of autonomy offered by these arrangements was, however, strictly limited. As pointed out above, both purchasers and providers were accountable to the regional offices of the NHS Executive, and these offices operated a strong performance management system. In addition, the NHS Executive exerted strong control over DHAs and trusts in terms of planning and service priorities. These issues are discussed more fully in the discussion of regulation below.

The new Labour Government and the new NHS

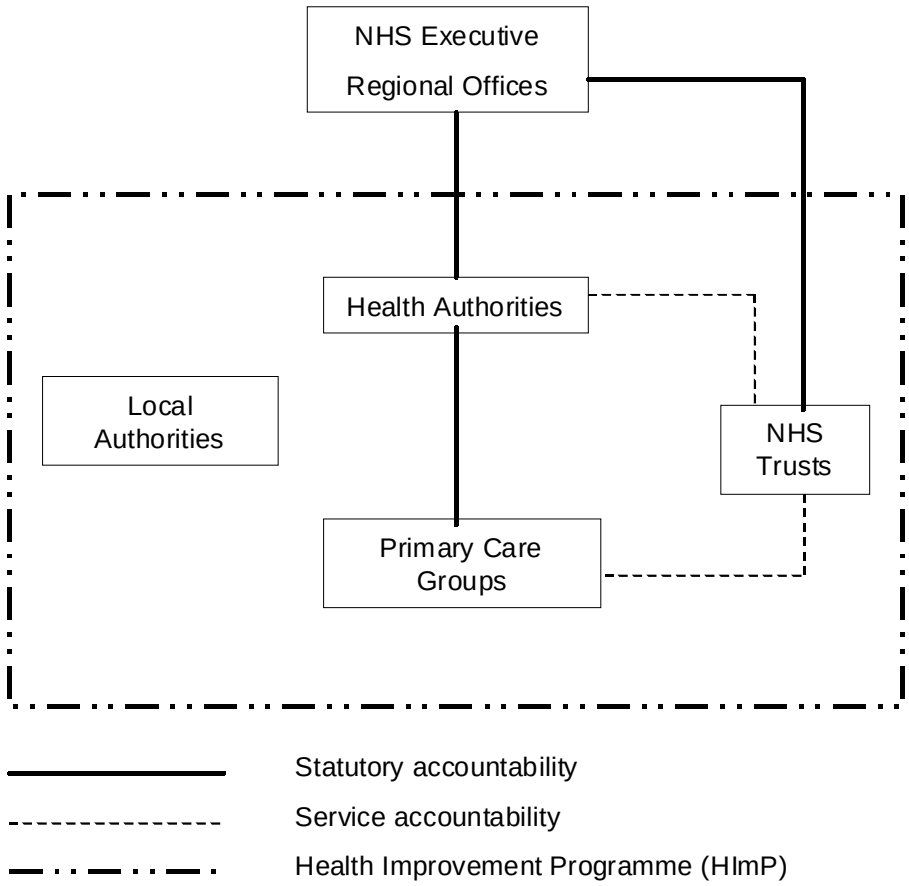
While in opposition, the Labour Party had been sharply critical of the internal market, arguing that it had led to fragmentation, inequality, increased bureaucracy and lack of accountability. On gaining office its first major policy document on the NHS, the White Paper *The new NHS: modern, dependable*, set out Labour's plans for the future of the service. The stated intention is to replace competition within the internal market with a system based upon collaboration and partnership between the different agencies responsible for health and social care. The main organizational features of this approach are depicted in Fig. 4.

A major change is occurring through the abolition of GP fundholding and its variants, and its replacement with primary care groups (PCGs). PCGs are groupings around GP practices in a geographical area to which all GPs – both former fundholders and non-fundholders – belong. These groups have been live since 1 April 1999. They will be far larger than previous primary care-based models, covering populations ranging from 50 000 to 250 000 people. It is envisaged that PCGs will progress through four developmental stages over time, culminating in the formation of primary care trusts (see Fig. 5). The government's plans also envisage a far greater degree of interagency collaboration with PCGs working closely with local government social services departments.

NHS trusts are continuing to be responsible for the provision of services, but their short-term contractual relationships with purchasers are being replaced with longer-term service agreements. More emphasis is being placed on collaborative working between commissioners and providers instead of market-type competition.

With the former regional health authorities becoming regional offices of the NHS Executive, district health authorities are now simply referred to as

Fig. 4. Structure of the 'new' NHS

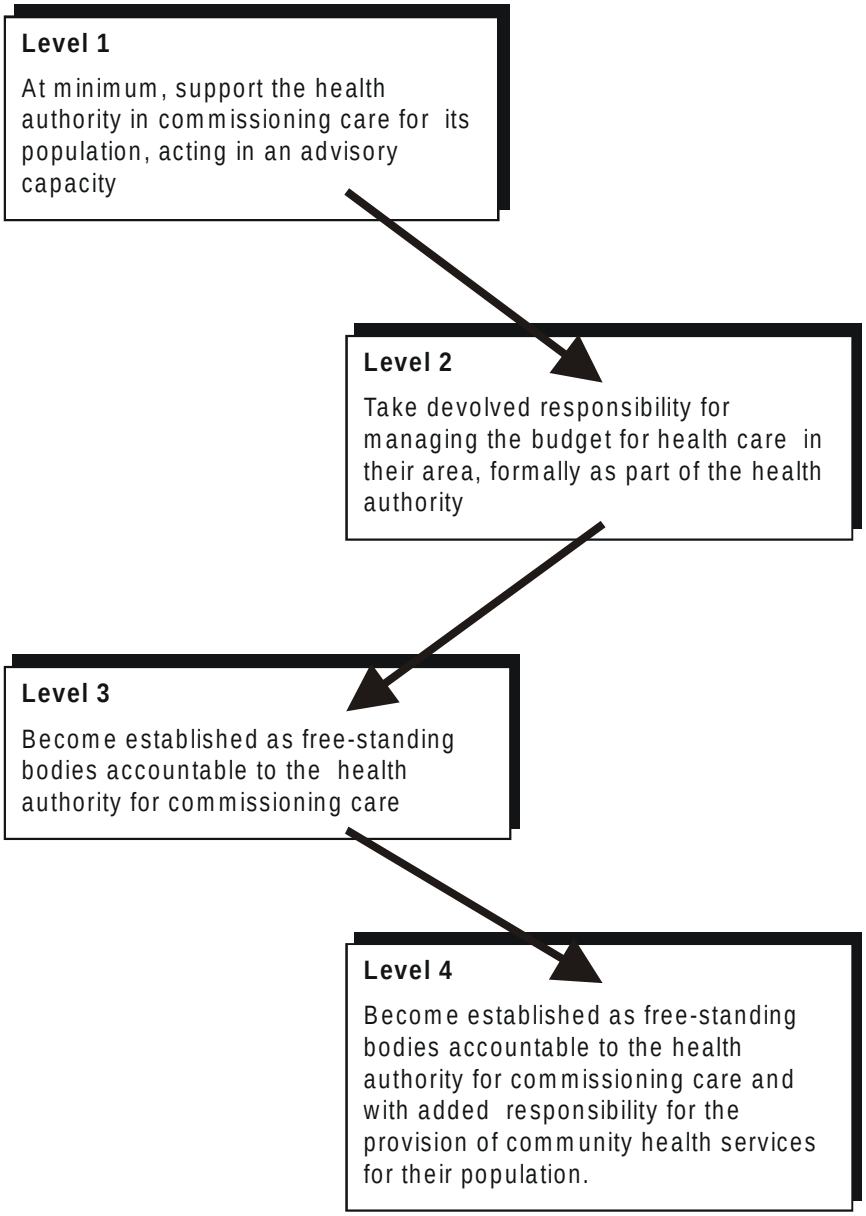


Source: Derived from Department of Health (1998) *The Government Expenditure Plans 1998–1999*. Departmental Report. Cm 3912. London: The Stationery Office p103.

'health authorities'. The functions of health authorities are increasingly shifting towards strategic planning as PCGs assume greater responsibility for commissioning services. The HAs are responsible for drawing up plans for 'health improvement programmes' in their areas in collaboration with PCGs, trusts and local government authorities.

As before, there are lines of accountability from HAs and trusts to the NHS Executive and to its regional offices. In fact, these lines of accountability to the centre appear likely to be rather stronger than they were under the previous government. These considerations are discussed further below.

Fig. 5. The stages of development of primary care groups[5]



Source: Based on Department of Health (1998) *The new NHS: modern and dependable* London: The Stationery Office.

[5] Primary care groups will begin at whatever point on the spectrum is appropriate for them. Most of them are expected to start at level 2 and to progress so that in time all primary care groups will assume fuller responsibilities. Some primary care groups may proceed directly from level 2 to level 4.

Voluntary and consumer groups

There is a plethora of advocacy groups working on behalf of patients in the United Kingdom. Many are disease-based advocacy groups, such as those which promote the interests of people suffering from AIDS, osteoporosis, diabetes, leukaemia, cancer, etc. Others work on behalf of people with mental illness (MIND) and particular patient groups such as the elderly (Age Concern). As well as providing support and information for patients and their families, these groups work to improve the care and services provided by the NHS. In addition, the independent Patients Association works to further the interests of patients in general. Other more formalized mechanisms for public input into the health care system are through community health councils, described in more detail below, and representatives on primary care group boards.

Community health councils

Community health councils (CHCs) were established in 1974. They provide a link between the NHS and the community, separating the management of service provision from the representation of patient and community interests.

There are currently 207 CHCs in England and Wales (16 health councils in Scotland and 4 health and social services councils in Northern Ireland that perform similar functions to CHCs). Each CHC has around 16–30 members; half are local authority nominees; a third are elected by the local voluntary sector; and a sixth appointed by the Secretary of State for Health (or Secretary of State for Wales for Welsh CHCs). CHCs are funded from a national budget held by the NHS Executive, but are independent of the NHS management structure, each other and the Association of CHC for England and Wales (ACHCEW).

Health authorities are required to consult formally with CHCs on substantial variations in service provision, provide information required by the CHC in carrying out its public duties and arrange an annual meeting between the authority and CHC members.

In the light of the current reforms the future of the CHCs is currently under discussion.

Professional bodies

The British Medical Association is both the doctors' professional organization and also an independent trade union protecting the professional and personal interests of its members. Its membership is made up of more than 80% of British doctors. Professional registration and regulation of the medical profession is the responsibility of the General Medical Council. Similar

organizations exist for other professions such as the British Dental Association. There are also several trade unions that represent health care workers. The main unions are UNISON, which represents the interests of people working in the public services and essential industries, and MSF which represents over 60 000 professional, craft, technical, scientific, medical and nursing staff within the NHS.

In addition, each of the medical specialties is governed by a Royal College, which is responsible for the assessment and awarding of qualifications in the specialty and in most cases continuing medical education, the issuing of clinical guidelines and medical auditing.

Private sector

In 1996 there were 25 private medical insurers offering coverage in the United Kingdom. Seven of these were non-profit, provident associations (e.g. BUPA, PPP Healthcare, WPA); the remaining 18 may be described as "commercial insurers", although some of them are mutual societies owned by their members (e.g. Norwich Union).

Although the commercial insurers include five relatively long-established companies who entered the market before 1988, the majority of them entered during the late 1980s and early 1990s. With the increased competition from these new entrants, the provident associations have experienced a reduction in their market share in recent years (see Table 4).

On the supply-side, there are approximately 230 independent medical/surgical hospitals in the United Kingdom. Five main groups (General Healthcare Group Ltd, Nuffield Trust Ltd, BUPA Hospitals Ltd, Community Hospitals Group and PPP Columbia Healthcare Ltd) dominate the market. These five groups account for just over 60% of hospitals and a combined share of approximately 65% of total private beds.

Table 4. Market shares (%) of private insurance companies by subscription income

Company	Year			
	1985	1990	1995	1996
BUPA	59	50	44	42
PPP	25	29	27	27
WPA	7	7	5	5
Other providents	2	3	4	4
Commercials	7	11	20	22
Total subscription income (£m)	521	1 105	1 757	1 923

Source: Laing and Buisson (1997) *Laing's Healthcare Market Review 1997–1998*, Laing and Buisson, London.

Planning, regulation and management

Planning

The NHS can be characterized as a publicly owned and financed health system within which there are strong lines of vertical accountability. Over the 1990s some of the central command and control features have been loosened as responsibility for decision-making has been partly devolved to local organizations and agencies. Within this context, planning takes a number of different forms and is undertaken by several different agencies.

Expenditure planning

Total expenditure on the NHS is still tightly controlled from the centre. Expenditure planning, for both capital and recurrent expenditure, takes place as part of the government's general public expenditure planning process, through which the level of funding to be made available to the NHS for the following year is determined. The Department of Health determines the allocation of this funding to regions, and regions determine district allocations (see the sections on *Health care finance and expenditure* and *Financial resource allocation* for further discussion of NHS finance, expenditure and resource allocation).

Service planning

Although there is no detailed national plan for service planning purposes, each year the Department of Health issues an executive letter setting out the priorities and planning guidance for the NHS. The guidance for 1998–1999, for example, set out the government's general aims for the coming year, identified specific pressures which it expected the NHS to manage, and identified areas for development.

The aims covered improving the public's health, a commitment to fairness in the health service, developing the quality of services and promoting partnership and collaboration. Pressures to be managed included the provision of prompt and effective emergency care, the maintenance of guarantees and standards for maximum waiting times, and ensuring financial stability. Specific areas identified for development were: the provision of comprehensive mental health services, the development of a leading role for primary care, improving clinical and cost effectiveness, giving greater voice and influence to users, meeting the needs for continuing health care and developing NHS organizations as good employers.

The new Labour Government and planning guidance

In a departure from previous practice, the new government produced national guidance on the priorities for a three-year period – 1999/2000–2001/2002 – in

September 1998 under the heading *Modernising Health and Social Services.* This document is wider in scope than previous guidance. It sets out a new direction for the health service based upon tackling the root causes of ill health, breaking down barriers between service providers and placing greater emphasis on the quality of services.

The guidance identifies priority areas where the NHS is expected to take a lead responsibility and other areas where it is expected to share lead responsibility with local government social services departments.

In the case of NHS lead responsibility, the service is expected:

- to reduce waiting lists and waiting times in line with quantitative targets;
- to undertake specific measures to develop primary and community services in order to address inequality, improve quality and convenience for patients, and increase efficiency;
- to meet targets for reducing deaths from heart disease by providing high quality, cost-effective and responsive services for the prevention and treatment of coronary heart disease;
- to improve the quality, effectiveness and speed of access to cancer services in the areas of prevention, screening and palliative care.

Areas where the NHS and local government social service departments are expected to take lead responsibility and work together are:

- reducing health inequalities by improving the health of the worst-off in society at a faster rate than the rest of the population (this will include strategies to reduce unwanted teenage pregnancies, ensure fair access to services for black and ethnic minority groups, reducing smoking, increasing childhood immunization rates and reducing drug dependency);
- improving the mental health of the population, and improving the treatment and care of those with mental health problems, through the provision of a comprehensive set of high quality, effective and responsive services;
- ensuring the provision of services which help adults achieve and sustain maximum independence in their lives through, *inter alia*, reducing avoidable admissions to hospitals, developing preventative services and respite care, and providing additional support to informal carers.

Alongside these plans, the government is developing a national framework for assessing performance in the NHS. This will cover six dimensions of performance, namely: health improvement, fair access, effective delivery of appropriate health care, efficiency, patient/user experience, and health outcomes. It is intended that this framework will underpin accountability agreements between regional offices and health authorities, and between health authorities and primary care groups.

Planning and public health

Setting priorities for the achievement of specific health improvement targets in relation to particular diseases and disabilities has its origins in a major public health planning exercise undertaken by the previous Conservative Government. The *Health of the Nation* strategy, launched in 1992, identified five priority areas for reducing mortality and morbidity – namely, heart disease and stroke; cancers; mental illness; sexual health; and accidents – and set 25 quantified targets for achieving reductions in rates of mortality and morbidity over given timescales. This was the first time that such a strategic planning approach had been adopted in the United Kingdom.

The present government published its own plans for public health in a Green Paper, *Our Healthier Nation*, in February 1998 which was followed by a White Paper, *Saving Lives: Our Healthier Nation*, in July 1999. This expresses a commitment to setting goals for improving population health with more emphasis placed upon the social and environmental determinants of health and in particular the need to reduce health inequalities. Among other things this will involve taking into account the effects of poverty, unemployment, poor housing and environmental pollution. This strategy is intended to replace the *Health of the Nation* strategy and includes revised targets for the four key areas of cancer, coronary heart disease and stroke, accidents and mental health.

Planning by health authorities

The national priorities and planning guidance issued by the NHS Executive sets the context within which health authorities are expected to develop their own plans. Until recently, these were presented in the form of health strategy and purchasing plans, often extending over planning periods of up to five years ahead. Under the government's new approach they are now formulated in terms of service and financial frameworks. These plans are normally prepared by the planning, finance and public health departments of each HA and need to be approved by the HA board comprising chair, chief executive and other executive and nonexecutive members. Although these plans usually pay a good deal of attention to local needs, strong accountability to the NHS Executive means that strong emphasis tends to be placed upon the achievement of national priorities. These priorities figure prominently in the assessments carried out by regional offices as part of their performance management function.

New responsibilities placed upon health authorities, as part of the new Labour Government's plans, involve drawing up health improvement programmes (HImPs) for their areas. These programmes are expected to bring together a range of health and social care agencies, together with other organizations, e.g. voluntary organizations and private sector firms, in the production of plans for improving the health of local people. HImPs are seen as a vehicle

for formulating a local response to national priorities and targets, and of determining local priorities for action. In addition, some areas of extreme deprivation have been designated health action zones (HAZs). These will receive special assistance for the development of plans aimed at raising health standards among deprived groups.

Planning and NHS trusts

During the 1990s, NHS trusts have been required to produce business plans. These set out their expectations in terms of income and expenditure and have been an important component of the capital planning process. Under the internal market arrangements, trusts wishing to undertake major capital investments have been required to obtain support – in the form of statements of purchasing intentions – from those HAs who intend to purchase services from them. GP fundholders and other primary care-based purchasers have also been required to produce annual purchasing plans.

Regulation

In common with most health care systems, the UK system has long been subject to a variety of regulatory policies. In this section, some of the long-established forms of regulation are discussed briefly. However, most of the discussion concentrates on new approaches to regulation developed in the 1990s as a part of managing the evolving internal market, and to the systems of regulation being developed by the present government as part of its new approach to the NHS.

Regulation of professional standards

One of the most important areas of regulation applies to the standards expected of clinical professionals. By and large, this function has traditionally been performed through a system of professional self-regulation. Thus the General Medical Council regulates the education, training and professional standards of doctors while the UK Central Council of Nursing and Midwifery performs a similar function for its members. At the present time, however, a number of well-publicized instances of the failure of professional self-regulation to prevent serious professional malpractice have led to official proposals and plans for greater external regulation.

Medical workforce planning

The Medical Workforce Standing Advisory Committee advises the Secretary of State on developments relating to the overall supply of and demand for doctors in the United Kingdom. Following the recommendations contained in its 1995 report, the system of workforce planning has been recently overhauled.

An advisory group on medical (and dental) education, training and staffing has been created – chaired by the Chief Medical Officer – which is responsible for developing a national strategic policy.

Local medical advisory groups have been set up to advise regional officers on medical staffing aspects of NHS trusts. These groups are designed to ensure that individual trust policies are consistent with national standards and objectives. Trusts are required to include information on medical staffing strategies in their business plans and, although medical staff are now employed directly by trusts, the trusts are nonetheless expected to act in accordance with national objectives.

Regulation of hospital standards

NHS hospitals are not subject to formal regulation through systems of accreditation, as in some countries, although nongovernmental organizations such as the King's Fund in London have offered an accreditation service which a number of NHS and private hospitals have taken up. However, official regulation does apply in the cases of mental health institutions, which are subject to official inspections, and residential care and nursing homes, in which nursing and safety standards are regulated.

Regulation of the pharmaceutical industry

Another area where there has been long-standing regulation – both on clinical and financial grounds – is in relation to the pharmaceutical industry. All new products are subject to rigorous testing on safety grounds before they can be licensed for use. Moreover, the profits that pharmaceutical firms make through their sales to the NHS are regulated through the Pharmaceutical Price Regulation Scheme (PPRS). This is a nonstatutory scheme negotiated between the Department of Health and the Association of the British Pharmaceutical Industry, which has been in operation since 1957. The scheme operates at the level of a company's total business with the NHS rather than in relation to individual products.

A company's return on capital is calculated by assessing profits minus allowable costs. A 1996 report to parliament argued that the PPRS has a number of strengths. It claimed the PPRS promotes reasonable prices; contributes to a strong industry capable of successful investment in research and development; provides continuity and stability; encourages innovation; and is administratively simple. Nonetheless the report also claimed that PPRS has a number of disadvantages such as a lack of transparency, a tendency to encourage inefficiency and to undermine cost containment policies, and to act as a barrier to price competition.

The most recent five-year PPRS agreement expired in 1998 and the government is currently seeking to replace it with a statutory system.

Regulation of the internal market

Notwithstanding these long-established regulatory mechanisms, it is the new pressures posed by the introduction of the internal market in 1991 and by the subsequent plans for the replacement of the internal market, which have attracted most attention in relation to regulatory policy.

The 1991 reforms placed heavy emphasis on the need to introduce competition into the NHS as a spur for improved performance. The government's expectations of competition were stated unequivocally:

> *... a funding system in which successful hospitals can flourish ... will encourage local initiative and greater competition. All of this in turn will ensure a better deal for the public, improving the choice and quality of services offered and the efficiency with which these services are delivered.* (*3*)

Thus competition between providers for contracts from purchasers was expected to widen choice, improve quality and increase efficiency. From the outset, however, there were a number of experts who questioned the theoretical and empirical case for expecting competition to have these effects in the health care market. In particular, fears were expressed about an overemphasis on efficiency to the detriment of quality and equity. The government's response to these concerns was to develop a system of what became known as 'managed competition'. In essence, this involved using competition, or contestability, as an incentive for increased efficiency, but regulating the market so that excessive competition did not jeopardize other objectives.

Early examples of market regulation appeared in the guise of 'core' services that each health authority was expected to purchase from its local provider to ensure that access to key services was maintained for their local population. Beyond this, the whole raft of purchasing and planning priorities, described in the preceding section, was used to regulate the purchasing activities of health authorities, albeit in the form of 'guidance' (backed up by management sanctions) rather than through prescribed rules of behaviour.

But probably the most explicit use of regulation occurred in relation to restrictions on provider behaviour. From the beginning, it was made clear that NHS trusts would have limited freedom over their financial affairs. Thus trusts could not behave as profit-seeking firms; rather, they were required to make a 6% return on their capital assets and to break even. Pricing policy was also regulated. They were expected to price their services on the basis of average costs and could not, except in exceptional circumstances, engage in marginal cost pricing or cross-subsidization.

The most vivid statement of regulatory policy towards providers was contained in the guidance document published by the NHSE in 1994, *The*

operation of the internal market: local freedoms, national responsibilities. This set out criteria for the NHS Executive to use when carrying out activities such as: approving mergers and joint ventures between providers; managing provider restructuring and closures; and in preventing collusion (with the possible adverse consequences of higher prices, lower quality and barriers to entry) while encouraging collaboration which is in the interests of patients.

The significance of *The operation of the internal market: local freedoms, national responsibilities* is that it makes explicit the need to manage or regulate the market, while claiming that the internal market was never intended to meet all of the aims of the NHS on its own. This signalled a move away from dependence on competition and a greater reliance on planning and regulation. This is a trend that has continued with added emphasis by the new Labour Government.

The new NHS and its regulatory framework

A prominent feature of the present government's approach to regulation in the NHS is a strong emphasis on measuring and improving quality standards. To achieve this aim a number of new agencies are being set up. These include a National Institute of Clinical Excellence (NICE) and a Commission for Health Improvement (ChIMP).

The NICE will be responsible for assessing evidence on the clinical and cost-effectiveness of existing and new treatments and for producing clear guidance for clinicians. At the outset it is expected that the Institute will carry out 30–50 appraisals per year which will be used as the basis for clinical guidelines. This approach will be bolstered by the specification of national service frameworks that will spell out how services should be best organized to cater for patients in different service areas. To ensure that good quality services are actually delivered, the government intends to establish a Commission for Health Improvement. This is designed to provide independent scrutiny of local services and will intervene when local action fails to address deficiencies. (A full statement of the government's plans in these areas is contained in *A First Class Service: Quality in the new NHS* published by the Department of Health in 1998).

One of the first outputs from the government's new approach to regulation through performance assessment was the publication of clinical indicators and high-level performance indicators in June 1999. Through its new performance assessment framework, the quality and efficiency of services are measured in terms of six main areas; namely, improvements in people's health, fair access to services, the delivery of effective care, efficiency, the experiences of patients and their carers and health outcomes. The June 1999 publication reports on the

performance of each NHS trust in terms of six main clinical indicators and also on health authority performance. The clinical indicators include such measures as deaths in hospital within 30 days of surgery, deaths in hospital within 30 days of emergency admission with hip fracture for patients aged 65 and over and rates of emergency re-admission to hospital within 28 days of discharge. The indicators used to measure health authorities include size of inpatient waiting list per 1000 head of population and five-year survival rates for breast and cervical cancer.

Other aspects of planning and regulation to be carried out as part of the government's plans for the new NHS – such as health improvement programmes – have been outlined in earlier sections and are reviewed again at the end of this report.

Health care finance and expenditure

Main system of finance and coverage

The main system of health finance and coverage in the United Kingdom is less complex than in most other countries. The NHS is financed mainly through central government general taxation together with an element of national insurance (NI) contributions. As shown in Table 5, in 1996/1997 93.7% of gross spending on the NHS in England was met from these two sources: 81.5% from the Consolidated Fund, that is, general taxation, and 12.2% from national insurance contributions. (Despite the separation of tax and NI payments for national income accounting purposes, NI contributions are nowadays tantamount to an income tax and eligibility for NHS services is not dependent on their payment). The remainder of NHS finance (6.3%) was raised through user charges (2.1%) – mainly charges for pharmaceutical prescriptions and dental charges; from repayments of NHS trust interest bearing debt (3.0%); and from other miscellaneous sources (1.2%) such as health authority capital repayments.

Raising finance through general taxation means that there is a broad funding base, covering all forms of income, capital and expenditure taxation. Because the NHS finance component is not separately identified at the collection stage, it is not possible to specify the degree of progressivity in the payments system. However, to the extent that the overall tax system is broadly progressive, so the NHS finance system may be described as broadly progressive. Collection through general taxation also means that the costs of collection are kept low because funding destined for the NHS is collected as part of the general inland revenue, 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 low. Until recently (1998), an annual Public Expenditure Survey (PES) was undertaken to determine the levels of funding for public expenditure programmes, including the NHS. Through this process,

Table 5. NHS sources of finance (% unless otherwise shown), 1988/1989–1996/1997

Financial Year	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992	1992/ 1993	1993/ 1994	1994/ 1995	1995/ 1996	1996/ 1997
Total funding (£m)	**19 317**	**21 088**	**23 632**	**26 954**	**29 856**	**31 275**	**33 266**	**34 878**	**36 330**
Total Public	**95.2**	**94.1**	**94.5**	**94.7**	**95.0**	**94.7**	**94.5**	**94.3**	**93.7**
Consolidated fund expenditure	80.1	77.5	78.8	80.7	81.8	82.0	82.4	82.1	81.5
NHS element of NI contributions	15.1	16.6	15.7	14.0	13.2	12.7	12.1	12.2	12.2
Total from other sources	**4.8**	**5.9**	**5.6**	**5.6**	**5.2**	**5.4**	**5.6**	**5.8**	**6.3**
Charges	3.1	4.5	4.5	4.1	3.7	3.1	2.4	2.3	2.1
Capital funds from NHS Trusts	–	–	–	–	–	1.2	2.2	2.5	3.0
Miscellaneous	1.7	1.4	1.1	1.1	1.5	1.1	1.0	1.0	1.2

Source: Department of Health (1998) *The Government Expenditure Plans 1998–1999*. Departmental Report. Cm 3912. London: The Stationery Office.

ministers from spending departments submitted expenditure bids for the next financial year to the Treasury, and Treasury Ministers, through a process of consultation and negotiation, determined the amounts to be allocated to each spending department as part of the total public expenditure planning total. This system led to effective control of public expenditure on health care. Indeed, according to some commentators, it led to excessively effective control with insufficient spending on the NHS. In 1997 the government launched a Comprehensive Spending Review of all government departments' spending. Following the outcome of this review, expenditure plans were announced for a three-year period.

In addition to general tax-based funding, there was an estimated £7474 million of private expenditure on health care in the United Kingdom in 1996 (*20*) – 14.6% of total spending on health care in that year. Fewer than 11% of the population had some form of private medical insurance. In addition, there were substantial amounts of private spending out-of-pocket. This took the form of payments for private medical care, payments for long-term care and co-payments for pharmaceuticals, dental and ophthalmic services. (There is a fuller discussion of private expenditure on health and social care in later sections of this report).

Eligibility for NHS care

All persons normally resident in the United Kingdom are eligible for services through the NHS. The statute specifying the scope of the NHS is the *National*

Health Service Act 1977. This Act requires the Secretary of State to promote a comprehensive health service designed to secure improvement in the physical and mental health of the population and to develop services for the prevention, diagnosis and treatment of illness. Under section one of the 1977 Act, all hospital and specialist services are to be provided free-of-charge, unless the law expressly permits charges to be made. Charges can be levied on insurance companies for treating patients following road accidents and inpatients who leave hospital during the day to do paid work (typically long-stay patients) may also be charged. Charges may also be made for drugs, optical and dental services. Following an amendment to the 1977 Act by section seven of the *Health and Medicines Act 1988*, overseas visitors are also liable to charges for services at a rate to be determined by health authorities on behalf of the Secretary of State. (Emergency medical treatment is available without charge to residents of other EU countries under reciprocal agreements).

Health care benefits and rationing

Unlike those countries in which the range of health care benefits covered under private or social health insurance plans is defined explicitly, the NHS does not specify an explicit list of services to be provided. At a general level, the 1977 Act imposes a number of responsibilities on the Secretary of State in relation to the provision of hospital and community health services. For example, there is a strict duty to provide for regular medical examinations for state school pupils. However, for the most part, there is a large degree of discretion about the range of services that are actually provided. Thus the Secretary of State is required to provide services 'to such extent as he considers necessary to meet all reasonable requirements'. These wide discretionary powers are relevant to the rationing debates that have taken place in the United Kingdom in recent years. These are discussed below.

The responsibility for making available general medical practitioner (GP), dental, ophthalmic and pharmaceutical services lies with health authorities rather than the Secretary of State. Their duty is to arrange that practitioners in their area provide an acceptable level of service for the resident population. Once again, however, what constitutes an acceptable level of service remains vague. In the case of GPs, for example, their national contract states that they are obliged to provide patients registered with them 'all necessary and appropriate personal medical services of the type usually provided by general medical practitioners'.

The Patient's Charter

In an attempt to be more specific about patient rights and expectations in relation to the NHS, the Conservative Government introduced a Patient's Charter in 1991. This Charter – which was part of a wider initiative based on a Citizen's Charter – set out a number of NHS rights together with charter standards which the NHS was expected to meet (see Box 1). These are not, however, enforceable through the legal system. Subsequent published reports have provided information on comparative hospital performance in terms of Patient's Charter standards.

The Labour Government came to office with a commitment to review the Patient's Charter and to produce a new one. The Government asked Greg Dyke, with a group of advisors, to review the Patient's Charter and his report, *The New NHS Charter: A Different Approach* was published by the Department of Health in 1998. Although Mr Dyke emphasized the importance of local rather than national charters, no decisions have yet been taken about the final form of the new approach.

Waiting lists

The Government elected in 1997 had made a specific commitment to reduce the number of people waiting for NHS treatment. Prior to the election, extensive public consultation had revealed waiting times to be a major source of public concern with the NHS.

The specific commitments were:

(i) no one should have to wait for more than 18 months for a hospital inpatient admission, and

(ii) to reduce total numbers of people waiting by 100 000 below the 1 May 1997 figure by the time of the next election.

However, following a substantial increase in the numbers waiting during the first year of government, a subsequent pledge was made to reduce the total number of people waiting to the 1 May 1997 level by 1 April 1999.

Figures for the total number of people waiting for hospital admissions are given in Table 6. These figures show that after rising until March 1998, the total number of people waiting has subsequently fallen. The government would like to achieve a position where no one is waiting for more than 12 months, but – although the numbers in this category are falling – there are now more people waiting between 12 and 18 months than when the government came to office.

Box 1 The Patient's Charter: Rights and Standards

Rights

- To receive health care on the basis of clinical need, regardless of ability to pay;
- To be registered with a GP;
- To receive emergency medical care at any time, through your GP or the emergency ambulance service and hospital accident and emergency departments;
- To be referred to a consultant, acceptable to you, when your GP thinks it necessary and to be referred for a second opinion if you and your GP agree this is desirable;
- To be given a clear explanation of any treatment proposed, including any risks and any alternatives, before you decide whether you will agree to the treatment;
- To have access to your health records, and to know that those working for the NHS will, by law, keep their contents confidential;
- To choose whether or not you wish to take part in medical research or medical student training;
- To be given detailed information on local health services, including quality standards and maximum waiting times. You will be able to get this information from your Health Authority, GP or Community Health Council;
- To be guaranteed admission for virtually all treatments by a specific date no later than two years from the day when your consultant places you on a waiting list. Most patients will be admitted before this date. Currently, 90 per cent are admitted within a year;
- To have any complaint about NHS services – whoever provides them – investigated, and to receive a full and prompt written reply from the chief executive of your Health Authority or general manager of your hospital. If you are still unhappy, you will be able to take up the case with the Health Services Commissioner.

Standards

- Respect for privacy, dignity and religious and cultural beliefs;
- Arrangements to ensure everyone, including people with special needs, can use the services;
- Information to relatives and friends about the progress of your treatment, subject, of course, to your wishes;
- An emergency ambulance should arrive within 14 minutes in an urban area, or 19 minutes in a rural area;
- When attending an accident and emergency department, you will be seen immediately and your need for treatment assessed;
- When you go to an outpatient clinic, you will be given a specific appointment time and will be seen within 30 minutes of it;
- Your operation should not be cancelled on the day you are due to arrive in hospital. If, exceptionally, your operation has to be postponed twice you will be admitted to hospital within one month of the second cancelled operation;
- A named qualified nurse, midwife or health visitor responsible for your nursing or midwifery care;
- A decision should be made about any continuing health or social care needs you may have, before you are discharged from hospital.

Source: Department of Health (1995) *NHS: the patient's charter: a charter for England* HMSO, London.

Table 6. Total number of people waiting for hospital admissions in England, 1997–1999 (thousands)

	March 1997	June 1997	March 1998	December 1998	February 1999
Total	1 158	1 190	1 298	1 174	1 120
< 12 months	1 127	1 143	1 230	1 118	1 068
12–18 months	31.1	46.3	68.0	56.0	51.8

Source: Department of Health, 1999.

The number of people waiting for outpatient appointments is not included in the above figures. Figures collected on those still waiting over 13 weeks for a first outpatient appointment have shown an increase on the inherited position.

Pharmaceuticals

In the case of pharmaceuticals, the scope of NHS benefits is more explicit than in other areas. In 1985, a Selected List Scheme was introduced restricting the range of medicines that are available through NHS prescriptions. Schedule 10 to the National Health Service (General Medical Services) Regulations 1992 lists drugs which may not be prescribed on the NHS by general practitioners; Schedule 11 to the same regulations lists drugs which may only be prescribed to the specified types of patient or for the specified condition(s). In addition, the Department of Health seeks to influence prescribing behaviour through the periodic distribution of leaflets containing cost comparison charts for alternative pharmaceutical products within particular therapeutic groups. There is also a British National Formulary (BNF) which is prepared by The Royal Pharmaceutical Society of Great Britain and the British Medical Association. This is mailed free to all doctors on a regular basis.

Government policy in relation to prescribing in the NHS is currently in the process of change. Under the previous Conservative Government, services to be provided under the NHS (including pharmaceuticals) were left to local decision-making. The new Labour Government has a far stronger preference for national standards. As part of this approach, the newly-established National Institute for Clinical Excellence (NICE) issues guidance to local decision-makers about services of proven effectiveness and recommended for adoption by the NHS. In its first judgement NICE recommended that the newly licensed anti-flu drug Relenza should not be generally prescribed by the NHS because of lack of evidence regarding its efficacy in relation to high-risk elderly people.

Priority setting by health authorities

Following the implementation of the *NHS and Community Care Act* in April 1991, health authorities acquired major new responsibilities as purchasers or commissioners of health care. They assumed responsibility for assessing the health care needs of their populations and commissioning a mix of services which best met these needs. As before, however, the NHS remained a cash-limited service and so this task needed to be carried out within the constraint of fixed budgets. This meant that a series of choices needed to be made about which services were commissioned, in what quantities and for whom. The assignment of explicit responsibility for these decisions to health authorities was one of the main reasons for the heightened awareness about rationing in the NHS during the 1990s.

Over this period there have been a number of high profile debates centering on the decisions of particular health authorities that have decided to restrict the range of services to be made available to their resident populations or decided not to fund particular services for particular individuals. Probably the most widely-publicised case is that of the so-called 'Child B' (Jaymee Bowen) which occurred in March 1995. The father of the child took Cambridge and Huntingdon District Health Authority to court for refusing to fund further chemotherapy and a second bone transplant for his daughter, who was suffering from leukaemia, on the grounds that the clinical prognosis was extremely poor. In fact the court found in favour of the health authority. The child actually received the treatment in the private sector, funded by a private donation, but sadly died subsequently.

Faced with the need to make difficult choices over decisions of this type, a number of approaches to priority setting have been developed. For its part, the central government has encouraged health authorities to involve the general public in decisions about rationing and priority setting. This stance was subsequently supported by the all-party House of Commons Select Committee on Health in its report on priority setting (1995). At the local level, numerous methods for eliciting the public's views have been used including population surveys, public meetings, focus groups and, latterly, citizens' juries.

Other initiatives have involved health authorities in elaborate exercises where expert and public inputs have been drawn upon to assist managers in determining priorities in relation to future spending. Methods of economic evaluation developed by health economists have also been drawn upon.

Despite all these initiatives, however, a major study of priority setting, as carried out by health authorities, found that outright exclusion of services was rare and, where it did occur, was confined to peripheral services such as tattoo removals, cosmetic surgery and homeopathy. For the most part, health authorities

sought to avoid major controversies by providing at least some services, and relying on traditional NHS approaches of waiting lists and rationing by clinicians in the case of major service categories. In a recent review of rationing approaches, Hunter (*12*) has dubbed this approach 'muddling through elegantly'.

Complementary sources of finance

The NHS dominates health care provision in the United Kingdom and, as Table 7 shows, it is financed overwhelmingly through general taxation. There are, however, some complementary sources of health finance. Table 7 shows that the NHS itself derives about 2% of its income from user charges. In addition, there are private, out-of-pocket payments for nonprescription medicines and also payments for private health care which may be funded out of pocket or through private health insurance.

Table 7 indicates the relative shares of total health expenditure accounted for by mainstream taxation and complementary sources of finance for selected years over the period 1975–1995. As the table shows the share of total health expenditure accounted for by private payments rose from 3.1% in 1975 to 6.7% in 1990. Most of this growth was attributable to a rising share of payments from private insurance. During the 1990s, however, this share has remained almost constant and the overall share of private expenditure has fallen slightly. Trends in private insurance are considered in more detail in the next two sections.

Table 7. Main sources of finance (as % of total expenditure on health care), 1975–1995

Source of finance	1975	1980	1985	1990	1994	1995
Public						
Taxes	89.0	89.0	86.0	79.0	82.0	84.0
Other public	7.9	7.3	8.2	14.3	11.6	9.8
Private						
Out-of-pocket	2.2	2.5	3.3	3.4	2.9	2.7
Private insurance	0.9	1.2	2.5	3.3	3.5	3.5

Source: Derived from OECD health data 1998 and Department of Health (1998) *The Government Expenditure Plans 1998–1999*. Departmental Report. Cm 3912. London: The Stationery Office.

Out-of-pocket payments

In the NHS hospital sector, small amounts of income come from charges for "amenity" beds which generally have more privacy than normal ward beds. But the main areas where charges are levied is the family health services in relation to pharmaceutical, dental and ophthalmic services.

Pharmaceuticals

Prescription charges were first introduced back in 1952, as the demand for services outstripped the expectations of the original architects of the NHS, and, apart from the period 1965–1968, have been in existence ever since. These charges have risen steeply over time. For example, the real charge (i.e. price adjusted for general inflation) rose by nearly 300% over the period 1971–1993. In 1998 the prescription charge amounted to £5.80 per item (about 57% of the average total prescription cost). There are, however, widespread exemptions from charges for children under the age of 16, elderly people, those on low incomes, for people with specific chronic conditions and for specified uses, e.g. contraceptive pills. By 1995/1996, 84% of prescriptions were dispensed to people claiming exemptions.

Despite the existence of widespread exemptions, changes in prescription charges can have a noticeable impact both on government revenues and on the number of prescriptions dispensed. For example, it has been estimated by a group of leading academic researchers that the increase in prescription charges from £3.75 to £4.25 per item in 1993 resulted in the generation of £17.3 million in extra revenue for the government. It also resulted in a reduction of 2.3 million in the number of prescriptions dispensed compared with the number that would have been dispensed if charges had not risen.

From 1953 to 1969, pharmaceutical prescriptions were the largest source of NHS income from charges. Since 1969, however, they have been exceeded by dental charges: for example in 1998/1999, income from prescription charges for England was £341 million whereas income from dental charges amounted to £420 million.

Dental services

Within the NHS, general dental services are provided by independent dentists under agreements made with local health authorities. There is currently a considerable amount of co-payment with individuals paying 80% of the cost of their treatment up to a maximum charge set at £348 in 1999/2000. NHS charges are not levied on certain patient groups, mainly children, those on low incomes and pregnant or nursing mothers. In 1998/1999 the average full cost of a course of NHS dental treatment was approximately £34.

Many dentists offer services both to NHS patients and to private patients. In recent years disputes between dentists and the government over the fees offered for NHS work have led to some dentists withdrawing entirely from NHS work, and to others reducing the amount they undertake. Faced with difficulties in obtaining treatment under the NHS, patients in many areas have become private patients. This involves bearing the full costs of dental treatment. As a result private dental insurance has expanded rapidly in recent years. For

example, Denplan Ltd (which was acquired by the major medical insurer, PPP, in 1994) currently funds about £60 million of private dentistry per year for 500 000 patients out of an estimated total private dental market of £500 million per year.

Ophthalmic services

During the 1980s there was general deregulation of ophthalmic services. From April 1989, free NHS eye tests have been restricted to certain priority groups; namely, children, students under 19 years of age and in full-time education, adults on low income and people who have, or are predisposed to, certain eye diseases. Entitlement to free NHS sight tests was reinstated to all aged 60 and over from April 1999. All other groups must seek private eye tests. Prices are usually in the range £16–£18. Most spectacles are now provided on a commercial basis by opticians, although NHS vouchers are provided to help certain priority groups, mainly children and those on low incomes, meet the cost of spectacles. Just fewer than four million vouchers were issued in 1996/1997 in England.

Social care

Within British health and social care policy, there has been a long-standing distinction between health care provided by the NHS, which is overwhelmingly free at the point of use, and social care provided through local government, which is means-tested. For much of the post-war period, however, this distinction was masked as local authorities often failed to levy charges for domiciliary social care and a large amount of long-term nursing care was provided free-of-charge by the NHS.

A change in this situation started to occur in the 1980s as government policy encouraged the private provision of nursing and residential care at the expense of NHS and local authority provided care. To begin with, the financial implications of the withdrawal of free NHS care were obscured because the social security system funded the newly provided private care. However, following the implementation of the care in the community component of the *NHS and Community Care Act* in 1993, this situation changed.

Under the new arrangements, all individuals who require social care are subject to a needs assessment carried out by a case manager from their local authority social services department. On the basis of this assessment, an appropriate package of care – which may involve domiciliary or residential care – is identified. The individual is also assessed in terms of their income, and (in the case of residential care) in terms of the value of their assets, in order to determine what level of payment they will be required to bear privately.

At the present time, anyone with assets in excess of £10 000 is required to make a contribution towards the costs of nursing home or residential care.

Anyone with assets in excess of £16 000 is required to meet the costs in full. For the purposes of this calculation, a person's equity holding in their home is included as part of their assets and must be drawn upon to meet the costs of social care.

This process has led to considerable complaint from those people, and their families and heirs, who have been expected to meet their long-term care costs in this way. Claims have been made that an implicit social contract between the government and elderly people has been broken. As a result, there has been much debate on the subject and numerous proposals have been made for reform of the system. In the light of these concerns, the Labour Government set up a Royal Commission on Long Term Care in 1997. The Commission published its report, *With Respect to Old Age: Long Term Care – Rights and Responsibilities*, in March 1999. Its main recommendation was that the costs of care should be split between living costs, housing costs and personal care. Personal care should be available after an assessment, according to need and paid for from general taxation: the rest should be subject to a co-payment according to means. At the time of writing the government is considering its response to the Committee's recommendations.

Voluntary (private) health insurance*

Private medical insurance takes two main forms: employment-based, company insurance (which represents 59% of the total) and individual insurance (which accounts for 31%). The remaining 10% is made up of voluntary employee-paid groups whereby professional associations or trades unions act as umbrella organizations, but employees meet the costs of premiums themselves. It is also worth noting that in just under one third of company schemes employees meet all or part of the premium costs.

Table 8 shows how the size of the private insurance market – as measured by the percentage of the population covered – has grown over the last 30 years. For most of the early period, coverage grew slowly so that by the end of the 1970s it represented about 5% of the population. During the 1980s, however, the sector expanded dramatically, primarily as the result of the growth of employment-based schemes. Coverage peaked in 1990 when 11.5% of the population were covered. Since then, the sector has stagnated, probably as a result of the combined effects of economic recession and a substantial increase in the real price of insurance premiums. These grew at an average rate of nearly 5% per year between 1991 and 1996. By 1996, private insurers provided coverage for 6.4 million people; this represented about 10.8% of the population.

* The material in this section draws extensively on Laing and Buisson (*14*).

Table 8. Persons covered by private health insurance, 1970–1996 (selected years)

Year	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995	1996
% of the population	3.6	4.1	6.4	8.9	11.5	11.3	11.2	10.5	10.5	10.6	10.8

Source: Laing and Buisson (1997) *Laing's Healthcare Market Review 1997–1998*, Laing and Buisson, London.

Note: Figures for 1970–80 are for the three main provident insurers, BUPA, PPP and WPA. Figures for 1985 onwards are from the Laing and Buisson annual survey of private health insurers. These tend to indicate that overall rates of coverage are about 1 percentage point higher than the provident totals for the overlapping period 1985 to 1993.

Examination of the socioeconomic status of those people with private insurance coverage indicates that it is heavily skewed towards higher socioeconomic groups (see Table 9). Apart from major variations between socioeconomic groups, Table 9 also shows how private coverage drops sharply for 'employers and managers' and 'intermediate and junior nonmanual' groups in the 65 years and older age group, as their employment-based coverage ceases. This pattern of coverage has remained largely unchanged over the last ten years. There has been little growth among lower socioeconomic groups or in the 65 and over age group, despite the introduction in 1991 of tax relief on medical insurance premiums for people over 60 years of age This policy was subsequently withdrawn in 1997.

Private health insurance is used mainly to cover the costs of acute health care. In 1996 the total value of independent sector acute work was approximately £2.4 billion.

The prospects for future growth in private medical insurance in the United Kingdom are uncertain. On the one hand, waiting times for elective procedures in the United Kingdom are lengthy by the standards of comparable countries. This might be expected to increase the demand for private insurance coverage.

Table 9. Private medical insurees, by age and socioeconomic group (%), 1995

Socioeconomic group	Age			
	16–44	45–64	65+	All ages
Professional	20	23	21	22
Employers and managers	23	26	14	23
Intermediate and junior nonmanual	9	12	6	9
Skilled manual and own account nonprofessional	5	5	1	4
Semi-skilled manual and personal services	3	3	1	2
Unskilled manual	2	2	–	1
All persons covered by private medical insurance	10	12	5	10

Source: Laing and Buisson (1997) *Laing's Healthcare Market Review 1997–1998*, Laing and Buisson, London.

Moreover, the long-term growth in income levels might also be expected to fuel the demand for private health care, given the relatively tight constraints on NHS funding resulting from government attempts to control the growth of public spending. Set against these factors is the fact that there has been no growth in private insurance during the 1990s, while the unfavourable short-term prospects for the economy do not seem likely to encourage additional consumer expenditures in this area at the moment. Public opinion polls do not suggest that people view private care as 'better' than NHS care (as in the case of, for example, private education), but do see it as 'quicker'. On a political level, the present Labour Government is less supportive of the private health care sector compared with the previous Conservative Government.

Health care expenditure

Table 10 shows total expenditure on health care in the United Kingdom, for selected years, as recorded in the WHO health for all database. It includes expenditure in current and constant prices; per capita expenditure in US dollars purchasing power parities at current prices; health expenditure as a share of GDP; and public expenditure as a share of total expenditure. As would be expected, all of the expenditure series display a general upward trend.

Health care expenditure as a share of GDP rose quite rapidly between 1970 and 1975; thereafter, in the wake of worldwide recession and restrictions on public spending which occurred in the mid-1970s, it grew far more slowly

Table 10. Trends in health care expenditure in the United Kingdom, 1970–1997

Year	Value in current prices (million £)	Value in constant prices (1990) (million £)	Value in current prices per capita (US $PPP)	Share of GDP (%)	Public as share of total expenditure on health care (%)
1970	2 323	16 882	144	4.5	87.0
1975	5 784	24 488	271	5.5	91.1
1980	13 019	26 960	444	5.6	89.4
1985	20 859	30 143	669	5.9	85.8
1990	32 998	32 998	955	6.0	84.1
1991	37 202	34 395	1 021	6.5	83.7
1992	41 409	35 266	1 151	6.9	84.5
1993	43 372	34 887	1 165	6.9	84.8
1994	46 053	36 143	1 213	6.9	84.1
1995	48 469	37 169	1 234	6.9	84.4
1996	51 093	38 358	1 317	6.9	84.5
1997	52 300	–	1 347	6.7	84.5

Source: WHO health for all database (*23*); OECD health data 1998 (*20*).

over the second half of the 1970s and throughout the 1980s. There was, once again, a marked increase in this share from 6% to 6.9% between 1990 and 1992, but since then it has stayed constant for the remainder of the 1990s.

Public expenditure on health as a proportion of total expenditure fell from 91.1% to 84.1% between 1975 and 1990. Thereafter, however, the public share has remained fairly constant in the light of stagnation of the private health finance market during the 1990s.

Some further analysis of public expenditure on health care is presented in Table 11.

Because public expenditure on the NHS dominates expenditure on health in the United Kingdom, and because this public expenditure is subject to tight cash limits, levels of spending on the NHS are the subject of intense political debate. Over the last 20 years, particular attention has focused on the hospital sector as, according to many commentators, annual increases in funding have not been sufficient to meet increases in demand. Table 11 indicates the nature of this claim. It shows, for example, that over the period 1981/1982 to 1989/1990 annual increases in real expenditure on hospital and community health services

Table 11. Growth in NHS expenditure (% change on previous year), 1980/1981–1996/1997

Year	NHS (total)	Hospital and community health	Family health services
1980/1981	9.8	11.5	4.9
1981/1982	1.5	0.6	4.5
1982/1983	2.0	0.6	4.5
1983/1984	1.2	0..5	2.4
1984/1985	2.0	0.7	4.8
1985/1986	0.2	0.0	0.4
1986/1987	4.3	4.5	4.0
1987/1988	5.0	4.9	5.3
1988/1989	4.1	4.1	5.8
1989/1990	-0.4	0.1	-2.6
1990/1991	3.8	3.8	2.7
1991/1992	7.3	7.1	7.2
1992/1993	5.7	5.7	6.2
1993/1994	1.4	1.0	2.8
1994/1995	3.0	2.9	4.9
1995/1996	2.9	2.9	2.2
1996/1997	0.9	0.1	3.7

Source: J. Dixon and A. Harrison (1997) Funding the NHS. A little local difficulty. BMJ 314:216–219, Table 1, p. 218.

Note: Figures are for current spending on the NHS and record real growth rates i.e. cash increases adjusted for general price inflation.

(i.e. cash increases adjusted for general inflation) amounted to an average rate of about 1.7%. In fact, if cash increases were adjusted by the rate of price inflation in the NHS hospital sector, the average annual rate of increase in expenditure was less than 1%. These figures contrast with unofficial estimates which suggest that the NHS requires annual increases in spending of around 3% per year to keep abreast of rising demands resulting from an ageing population, the introduction of new medical technologies and rising public expectations. According to many commentators, it was the build-up of funding pressures during the 1980s (and the political debate surrounding these pressures) that prompted the Prime Minister at the time, Margaret Thatcher, to instigate the inquiry which led to the 1991 reforms.

Annual funding settlements for the NHS in general, and the hospital service in particular, were considerably more generous in the period immediately preceding and following the implementation of the 1991 reforms, but started to tighten up again in 1993/1994. In July 1998, following a far-reaching, comprehensive spending review, the new Secretary of State for Health, Frank Dobson, announced a three-year expenditure plan for the NHS with annual increases in real growth over the period 1999/2000–2001/2002 planned to average 4.7% per year. Despite the generally favourable response accorded to this announcement, the winter pressures on the hospital service in 1998/1999 once again led to headlines announcing an 'NHS in crisis'.

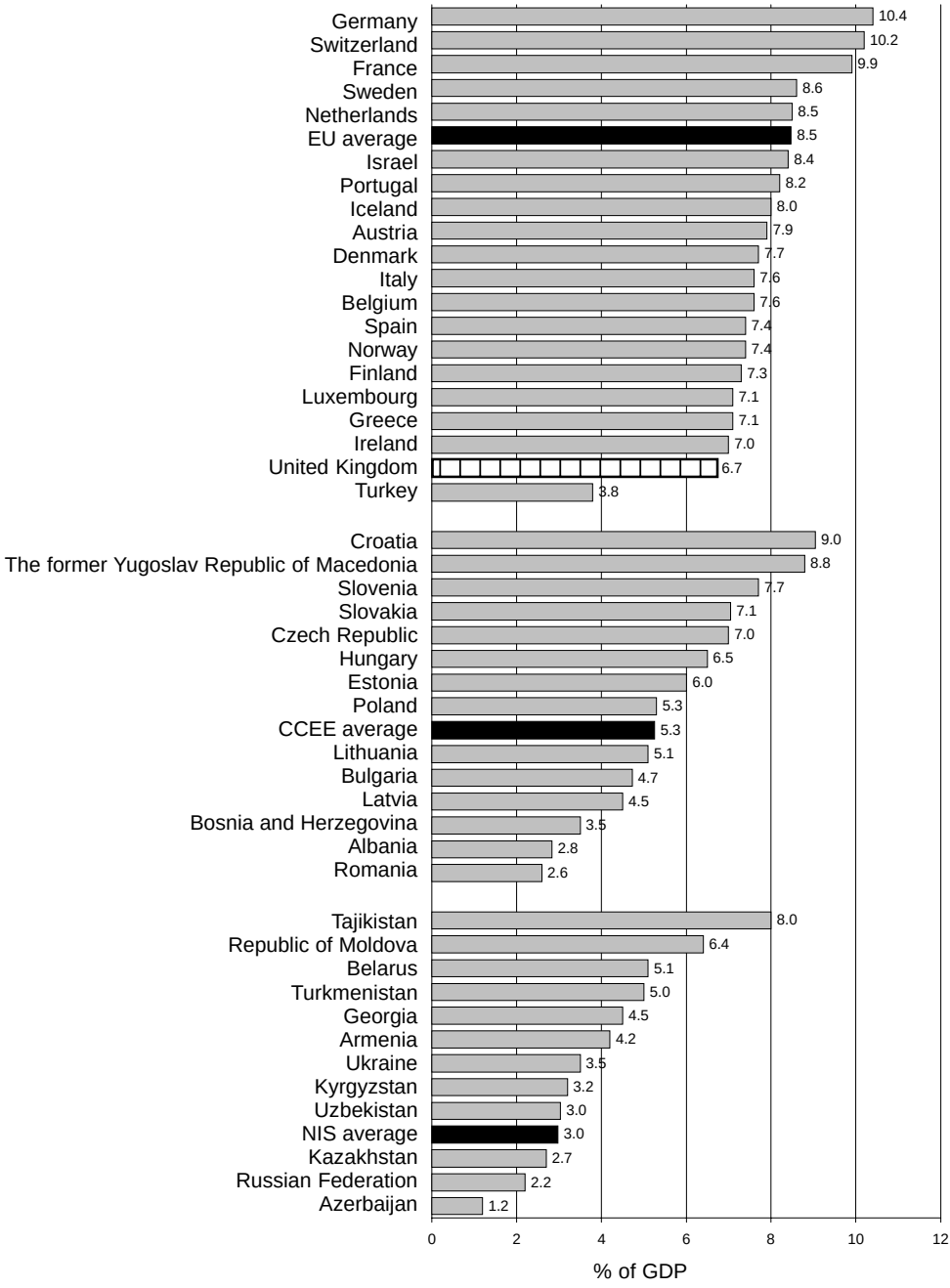
During debates about the adequacy of NHS expenditure, reference is often made to the smaller proportion of GDP devoted to health expenditure in the United Kingdom compared with most other similar countries. As Fig. 6 shows, total expenditure on health as a proportion of GDP, at 6.7% in the United Kingdom, is indeed lower than the western European average of 8.5%. On this measure, the United Kingdom ranks 20 out of 21 countries.

Comparative data on public expenditure as a proportion of total expenditure on health for the WHO European countries is given in Fig. 7. This indicates that the UK proportion of 85% is among the highest in western Europe. This highlights the fact that it is the low level of private expenditure on health which produces the low overall ratio of health spending-to-GDP in the United Kingdom.

Fig. 8 shows the trends in health care expenditure as a percentage of GDP over the period 1970–1995 for selected countries. It shows that the UK percentage has grown over time, but that it has remained below that of the other countries included in the figure.

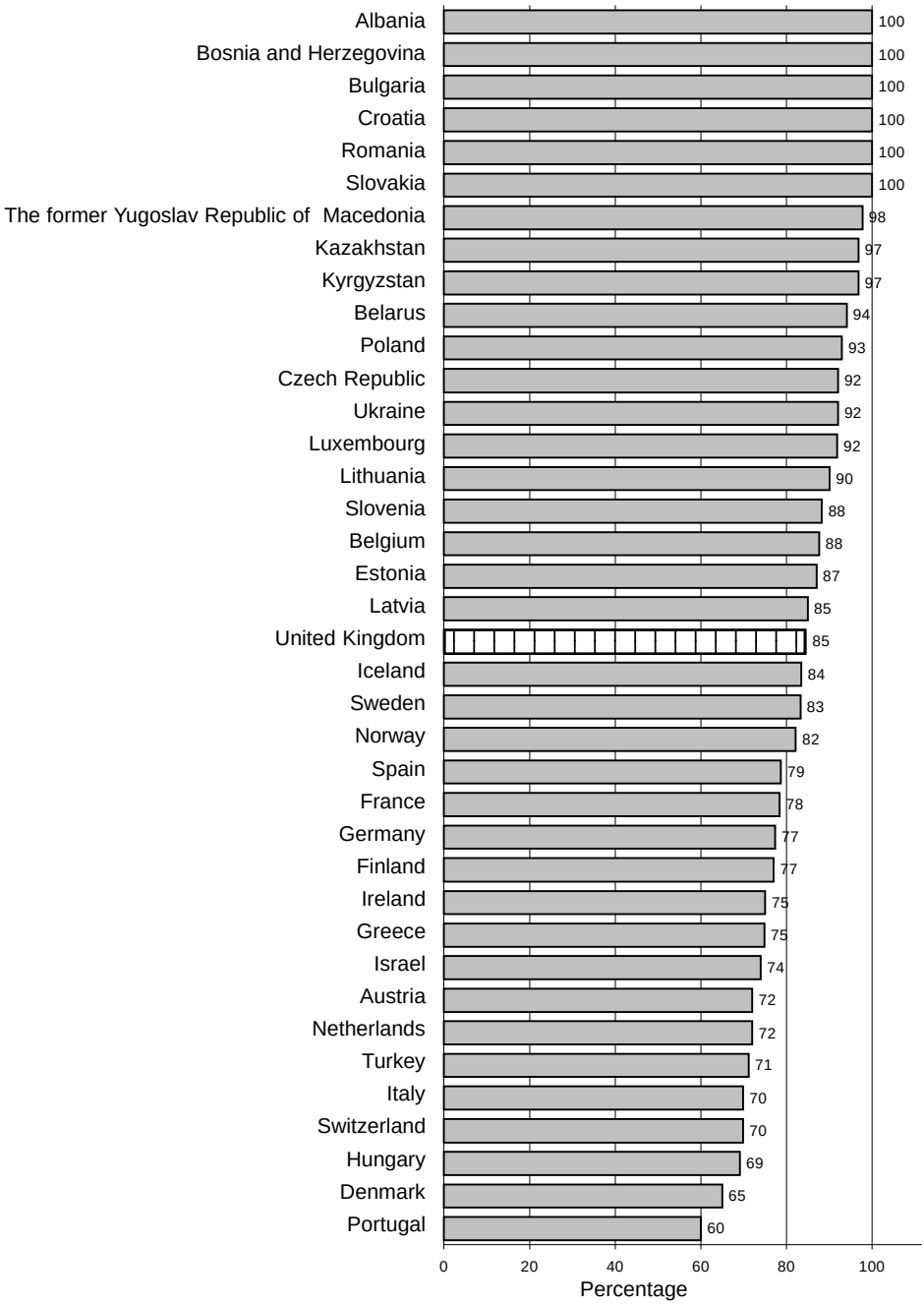
Some idea of the actual spending levels on health in different countries is provided in Fig. 9. This indicates health care expenditure per head in US dollars

Fig. 6. Total expenditure on health care as % of GDP in the WHO European Region, 1997 or latest available year



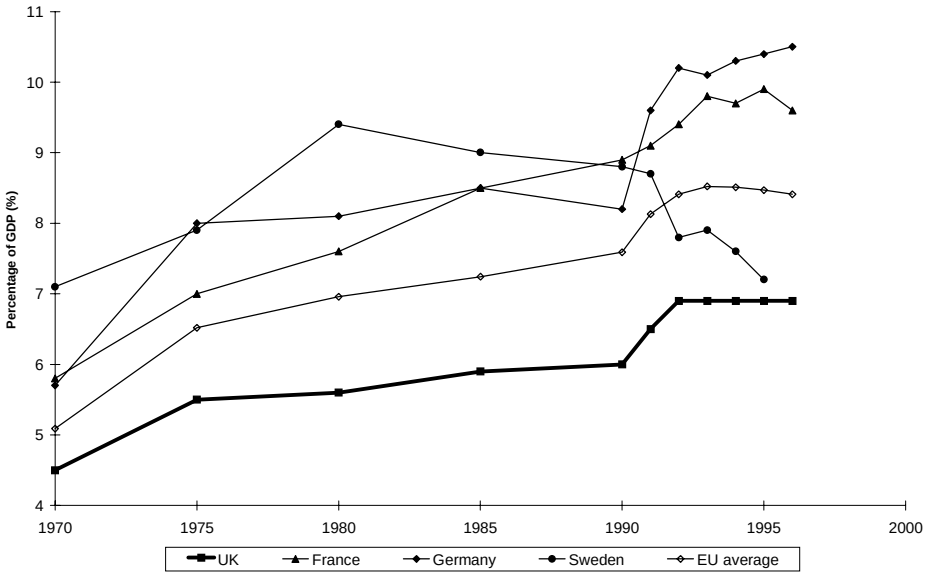
Source: WHO Regional Office for Europe health for all database (*23*).

Fig. 7. Public (government) health care expenditure as % of total health care expenditure in the WHO European Region, 1997 or latest available year



Source: WHO Regional Office for Europe health for all database (*23*).

Fig. 8. Trends in total expenditure on health care as % of GDP in the United Kingdom and selected countries, 1970–1996



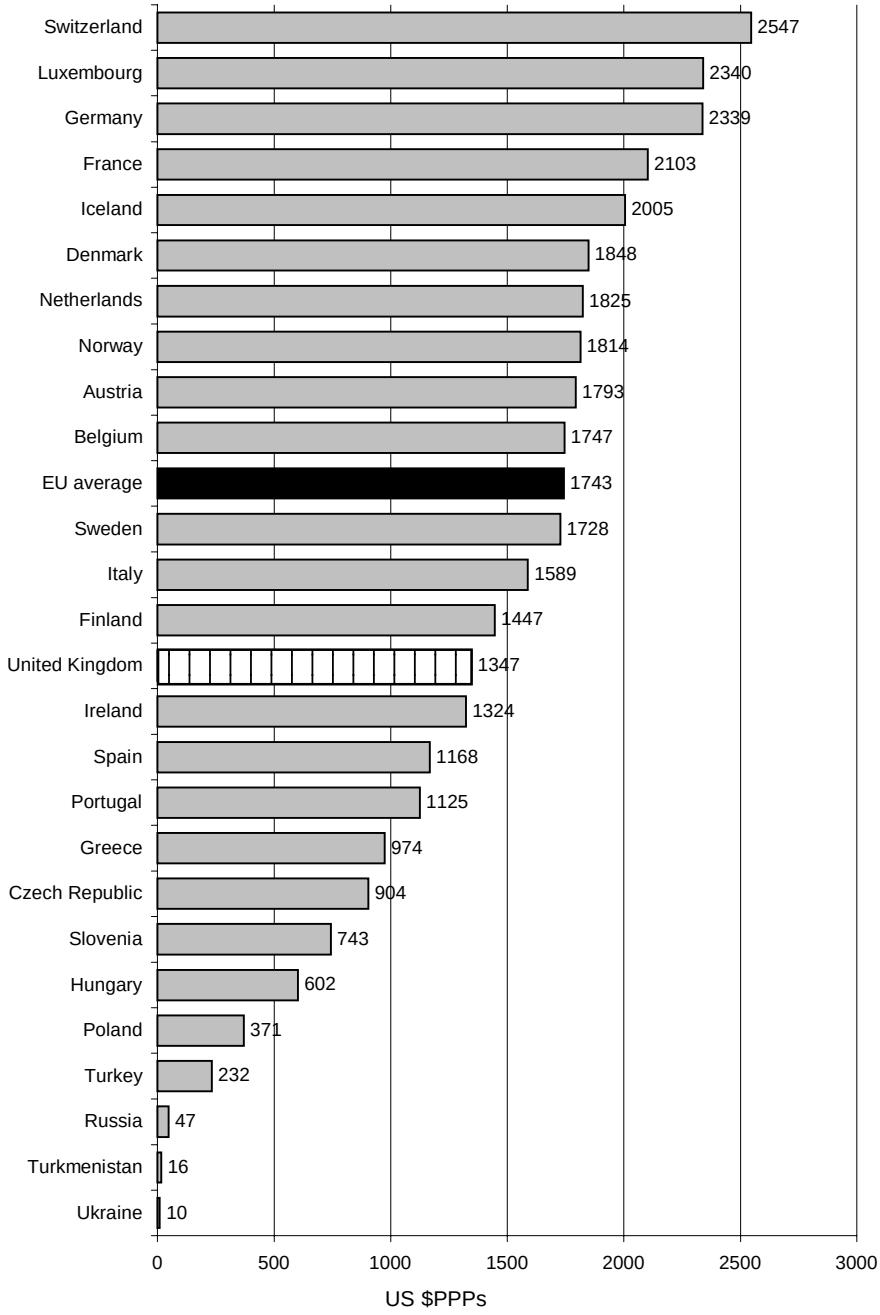
Source: WHO Regional Office for Europe health for all database (*23*).

at purchasing power parities. It shows that the UK level of expenditure, at US $1347, is substantially below that of Germany (US $2339), France (US $2103) and the EU average (US $1743), but is only marginally less than Italy (US $1589), Sweden (US $1728) and Finland (US $1447).

Structure of health care expenditures

Table 12 shows some of the main categories of spending on health in the United Kingdom, as a proportion of total expenditure, over the period 1970–1997. It shows how spending on inpatient care represented over 50% of expenditure in 1980 but had fallen to 42% by 1995. Spending on pharmaceuticals displays a long-term upward trend and had reached 17.3% of total expenditure by 1997. The other noticeable trend has been the long-run decline of public investment as a percentage of the total investment, and a more modest decline in total investment since 1990.

Fig. 9. Total expenditure on health care in US $PPP per capita in the WHO European Region, 1997 or latest available year



Source: WHO Regional Office for Europe health for all database (*23*).

Table 12. Health care expenditure by categories in the United Kingdom (as % of total expenditure on health care), 1970–1997

Year	Inpatient care	Pharmaceuticals	Total investment	Public investment
1970	–	12.5	6.9	6.6
1975	–	11.2	6.8	6.3
1980	53.5	12.8	5.5	4.7
1985	–	14.1	6.1	4.8
1990	43.9	13.8	6.7	5.1
1991	44.6	14.0	6.1	4.4
1992	43.3	14.5	5.7	3.9
1993	42.8	15.3	4.9	2.3
1994	42.2	15.3	5.0	1.0
1995	42.2	15.9	–	0.7
1996	–	16.5	–	–
1997	–	17.3	–	–

Source: OECD health data 1998 (*20*).

Health care delivery system

Primary health care and public health services

Primary health care services

The United Kingdom has a highly developed system of generalist, primary care delivered by general medical practitioners (GPs) and associated staff (e.g. practice nurses and community nurses) as part of the NHS.

General practitioners (GPs)

Over 99% of the population are registered with GPs who provide 24-hour access and a range of preventative, diagnostic and curative primary care services (those not registered with GPs tend to be homeless people and those in temporary accommodation). Approximately 90% of patient contacts with the NHS are with GPs. Patients may select a GP of their choice, although choice is restricted within geographical areas. The incidence of patients changing their GP – other than for reasons of changed residential location – is low. Most people have a long-standing relationship with their GP.

Patient referral to hospital specialists is made by GPs. This GP 'gatekeeping' role is an important element of the NHS. Unlike many other countries, NHS patients do not have direct access to specialists other than in special circumstances, e.g. attendance at hospital accident and emergency departments. Recent reforms have aimed to offer patients more choice concerning referrals to hospital, but there is little evidence to suggest that this has resulted in, for example, more active choice of specialists.

On 1 October 1998 there were 27 392 general practitioners practising in 8994 practices in England. This produces an average practice size of around three GPs. The average practice size has increased over time with over 63% of practices currently comprising four or more doctors. Less than 10% of practices

are currently single-handed, compared with 50% in 1952. The average patient list size per general practitioner on 1 October 1998 was 1866. The average list size has fallen by 7% over the last ten years. The average GP carries out 10 000 consultations per year. The number of consultations per GP has risen over the last ten years at about the same rate as list sizes have fallen.

Since the establishment of the NHS in 1948, GPs have been self-employed professionals who provide services to the NHS under contract. This independent contractor status gives GPs considerable autonomy. The terms and conditions of the GPs' contract with the NHS are negotiated nationally between the doctors' representatives and the government. The latest version of this contract (1990) introduced some major changes. It was designed to increase patient choice by requiring practices to provide more information about their services; to make their terms of service more explicit; and to relate payments more closely to performance. (These performance-related payments are discussed more fully in the section *Payment of health care professionals.*)

A central Medical Practices Committee has the responsibility for reviewing and controlling the spread of GP practices around the country. Any new practice can set up in an area that is designated 'open' by the Committee; in contrast, new practices can only be set up in exceptional circumstances in areas which are considered to be over-doctored and therefore designated 'restricted'.

Practice nurses, health visitors and community nurses

Various other health professionals are involved in the provision of primary health care services: namely, practice nurses, district nurses, midwives and health visitors.

Practice nurses are generally registered general nurses who are employed by GPs to work within practices. They undertake a wide variety of tasks including chronic disease management, health promotion activities, immunizations and health assessments of elderly people. The number of practice nurses employed by GPs has increased by almost fourfold over the last ten years so that by October 1998 there were 10 358 full-time equivalents working in the NHS.

In addition, there are community-nursing staff who are formally employed by community hospital trusts, although they are often attached to, and work with GPs and other primary care professionals. These include district nurses, midwives, health visitors, chiropodists and various therapists (e.g. physiotherapists, occupational therapists).

District nurses are registered general nurses who provide skilled nursing care for patients in their own homes. There are about 10 000 district nurses in England.

Midwives are registered general nurses who have undertaken further training focused on women's health during pregnancy and childbirth. Working in the community, they provide services to pregnant women and have responsibility for mother and child for 28 days following delivery. There are around 5000 midwives in England.

Health visitors are registered general nurses who have undertaken a course of further training. They concentrate on visiting families with babies and very young children in their own homes. They offer advice and are generally concerned with the prevention of ill health and health promotion. There are approximately 12 600 health visitors in England.

In recent years, increasing emphasis has been placed upon the creation of primary care teams, comprising GPs and associated nursing staff. While these have worked effectively in some areas, problems of joint working and the split management responsibility between GPs and community trusts have inhibited their performance in many places.

Private primary care

There is very little privately financed primary care in the United Kingdom. Successive user opinion polls have revealed a high level of satisfaction with NHS GP services and so there is little scope for private practice to address perceived failings of the NHS, such as lengthy waiting times for elective surgery in the hospital sector. A recent innovation has seen the appearance of private primary care centres located at certain London mainline railway stations, offering immediate consultations for a standard fee of £35. These are designed to address the needs of busy working people who experience difficulty making normal GP appointments but are, so far, on a very small scale.

Pharmaceutical services

Pharmaceutical services are provided mainly by community pharmacists, who supply drugs and appliances prescribed by GPs. In 1997/1998 there were 10 503 contracting pharmacies, a number that has remained fairly constant over the last ten years. The number of prescriptions dispensed, on the other hand, has grown by 38% over the last ten years, amounting to 505.8 million prescriptions in 1997/1998. Rising expenditure on pharmaceuticals is a major policy concern of the government. Expenditure is now within a cash-limited budget.

Current government plans are also designed to extend the role of community pharmacists and to make better use of their skills. To this end, a series of pilot projects have been launched, such as those involving extended advice from pharmacists for patients with medication-related problems. The *NHS (Primary Care) Act 1997* also gives health authorities more flexibility in providing additional

pharmaceutical services. The Department of Health will be publishing a strategy for community pharmacy in the near future.

Dental services

Dental services are provided as part of the NHS by independent general dental practitioners who have service agreements with their local health authorities. The number of dentists on health authority lists grew by 14.4% in the ten years 1988/1989–1998/1999, so that by 1998/1999 there were 17 245 dentists listed. However, the number of adult courses of NHS dental treatment rose by just under 9% over the same period, resulting in a slight fall in the number of courses of treatment per dentist. Over this period, courses of private dental treatment, provided, for the most part, by the same independent practitioners, have expanded considerably. In some areas, patients find it difficult to obtain NHS-funded treatment and have switched to private treatment. The section on *Complementary sources of finance* reports how about £500 million per year is currently spent on private dental treatments.

The government's own plans in relation to dental services have concentrated on reducing inequalities in dental health status and overcoming difficulties with access to NHS treatment.

Reform of primary care

Over the last ten years, an increasing amount of policy emphasis has been placed upon the primary care sector within the NHS. This process gained real momentum following the publication of a White Paper, *Promoting Better Health*, in 1987. This White Paper contained a number of measures designed to make general practice more responsive to market forces. It was followed by the new 1990 contract and the various organizational reforms, involving GP fundholding and its variants, which have been discussed already in the section on *Organizational structure and management*.

Another significant event in the development of primary care occurred with the publication of the NHS executive letter, *Developing NHS Purchasing and GP Fundholding*, in October 1994. The subtitle of this document was *Towards a primary care-led NHS*. Much of the change resulting from the strategy set out in the executive letter has concentrated on primary care-based purchasing, but there has also been considerable emphasis on extending and improving primary care provision. As a result, many new services have grown up in primary care settings (e.g. a large expansion in primary care counselling services), while other services have been transferred from secondary care to primary care settings (e.g. specialist outpatient clinics held on primary care premises). The *NHS (Primary Care) Act 1997* also set up a number of pilot projects around the

country with the aim of expanding further the form and scope of primary care provision.

The new government's current reforms discussed in the section on *Organizational structure and management* look set to continue this emphasis on a primary care-led NHS. In April 1999, 481 primary care groups were established involving all general practices within an area. These are designed both to improve the quality of primary care provision and to enable GPs and other primary care professionals to influence the nature of secondary care services provided for their patients.

Fig. 10 provides some comparative data on the number of outpatient contacts per person per year in the WHO European Region. It suggests that at 5.9 consultations per person in 1996, the United Kingdom has an average consultation rate amongst the countries of western Europe. The average number of patient contacts of those western European countries shown in Fig. 10 is 5.7.

Public health services

Responsibility for the promotion and maintenance of public health in the United Kingdom is shared by a number of different levels within the Department of Health and the NHS.

Central government

The current government was the first to appoint a minister with responsibility for public health. The Minister has a broad remit covering several government departments as well as specific responsibilities in relation to policies on, for example, tobacco and food safety. At the present time, a major responsibility for the minister is to lead the development and implementation of the health strategy set out in *Saving Lives: Our Healthier Nation.*

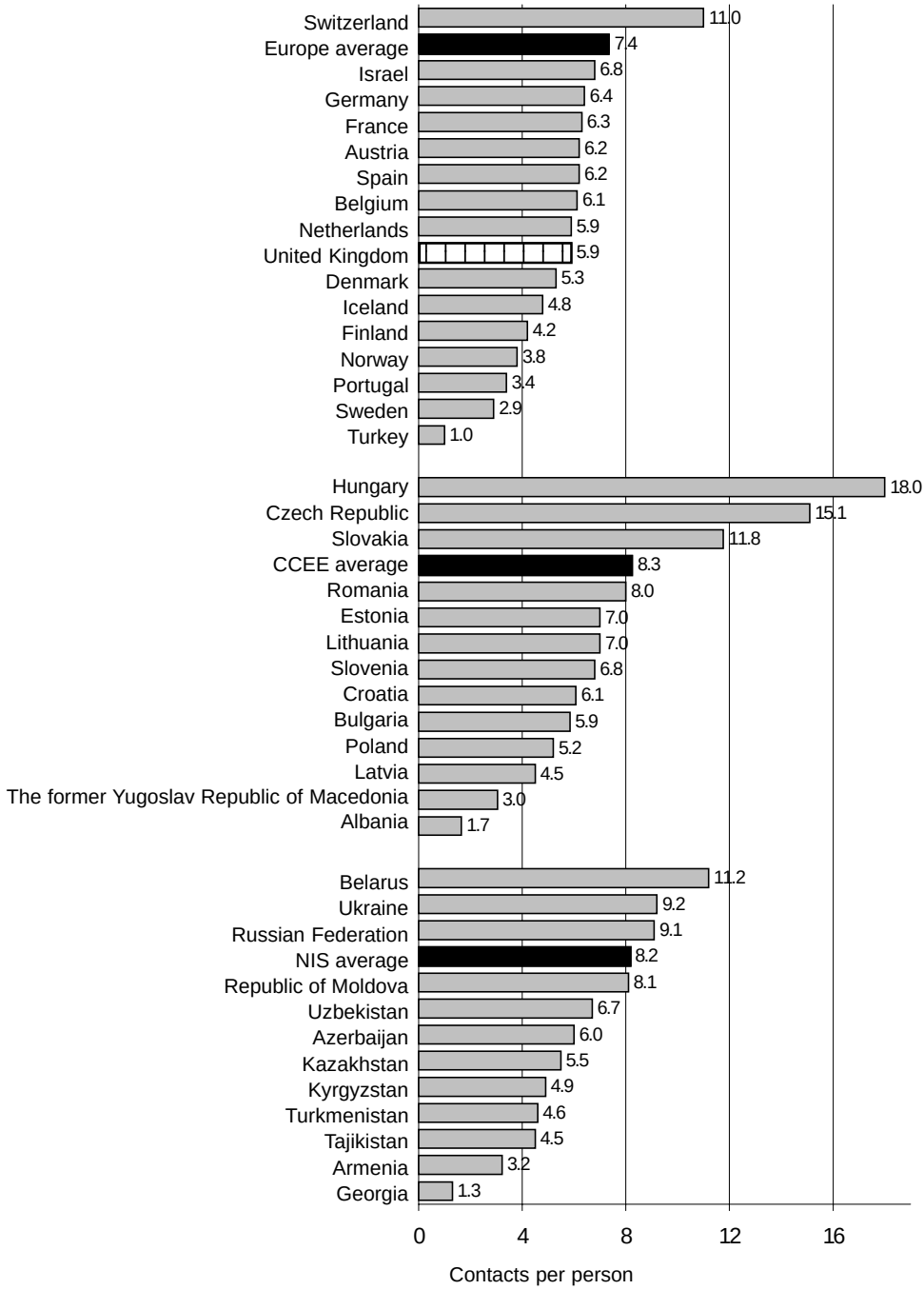
Also at the central government level, the Chief Medical Officer – within the Department of Health – provides independent medical advice on public health matters across the whole department. The Annual Report of the Chief Medical Officer reports on the state of public health in England and identifies areas for improvement.

Health authorities

Health authorities have major responsibilities for pursuing population-based, public health strategies within a framework set out by the Department of Health.

Each HA has a department of public health under a medically-trained director who is an executive member of the board. The director of public health is

Fig. 10. Outpatient contacts per person per year in the WHO European Region, 1998 or latest available year



Source: WHO Regional Office for Europe health for all database (*23*).

required to produce an annual report which documents the state of the local population's health and strategies for improving it. Within the department a consultant in public health medicine will have specific responsibility for the control of communicable diseases. During the 1990s, departments of public health have played an increasingly important role in developing local health strategies and carrying out health needs assessments as a basis for the HAs' purchasing strategy. Most HAs have a health promotion department, often as part of the department of public health.

General practitioners

GPs have traditionally responded to individual patient demands and have not been prominent in population-based health programmes. However, the 1990 contract sought to increase the role of GPs and other primary health care professionals in the area of public health by offering a range of financial incentives for achieving immunization and disease-screening targets. Systems of performance-related payments were subsequently introduced for health promotion and chronic disease programmes. These programmes involve registration, data collection and the provision of advice. They include maintaining registers of patients with hypertension, coronary heart disease and stroke; maintaining registers of patients' smoking habits; monitoring diet and physical activity; carrying out annual health checks on people over 75 years of age; and carrying out cervical and breast cancer screening.

Despite the expansion of public health activities in primary care settings, concerns persist about the ability of GPs to carry out effective public health functions. This potential limitation is of particular importance given the increasing power being devolved to GPs for the allocation resources as part of the move towards a primary care-led NHS.

New approaches to public health

The 1992 White Paper, *The Health of the Nation*, provided a national public health strategy for England for the first time. It set priorities and quantified targets for mortality reductions in five key areas: heart disease and strokes, cancers, mental illness, sexual health, and accidents. Although it represented a considerable step forward, the *Health of the Nation* approach was widely criticized for placing too much emphasis on individual behaviours as an explanation of poor health, and for disregarding important social determinants of poor health, particularly inequality and poverty.

The Government's approach to public health was set out in the Green Paper *Our Healthier Nation*, published in February 1998. Following wide public consultation, the new health strategy was published in the White Paper *Saving Lives: Our Healthier Nation* in July 1999.

The government's declared aim is to find "a third way between the old extremes of individual victim blaming, on the one hand, and nanny-state social engineering, on the other". An important feature of the new approach is an emphasis on improving the health of the worse-off in society and narrowing health gaps. Partnership working between central government, local health authorities, local government, voluntary organizations and the business sector is also a key feature of the new approach. This approach will be taken forward through the health improvement programmes (HimPs) to be developed by all health authorities in collaboration with their local partners. In addition, 26 specially designated health action zones (HAZs) – located in areas of particular social and economic deprivation – have been targeted for particular action. These HAZs receive central funding and are designed to improve health by wide-ranging policies involving the participation of local partners in, *inter alia*, health, housing and employment.

Comparative country performance in terms of one specific public health indicator – that is, the levels of immunization against measles – is shown in Fig. 11. This suggests that the United Kingdom level of immunization – at 91% – places it slightly above the mid-point in the distribution for western European countries in the WHO European Region. Since 1995, parental concerns about MMR (measles/mumps/rubella) vaccine have led to a fall in uptake and the latest Department of Health published figure (1998/1999) shows that rates have fallen to 88.3% at the age of two years. Immunization rates against other diseases such as diphtheria, tetanus, pertussis and poliomyelitis are similarly high in the United Kingdom at or around 93%. Immunizations are the responsibility of GPs, who receive target payments for attaining certain levels of immunization amongst patients on their list.

The responsibility for communicable disease control lies with the department of public health within each health authority. Most have a consultant responsible for the control of communicable disease who would take action in the event of an outbreak, such as meningitis or E coli.

Secondary and tertiary care

The NHS hospital system is a hierarchical one comprising three tiers. The middle tier comprises district general hospitals.

District general hospitals

The district general hospital (DGH) is the bedrock of the system. They were originally introduced in the 1960s in order to provide a comprehensive range

Fig. 11. Levels of immunization for measles in the WHO European Region, 1997 or latest available year

Source: WHO Regional Office for Europe health for all database (*23*).

of services to populations of between 150 000 and 200 000 people. Despite a number of changes in organization, the model of the DGH remains the basis of NHS hospital provision today.

DGHs are wide in terms of the scope of services they provide – in 1991/1992, for example, there were over 200 hospitals carrying out work in 300 or more of the 500 'health-related groups' used to classify clinical activity. The central idea underlying the DGH is that there are benefits in terms of both superior quality and lower costs from providing a number of different services from the same site. There were, however, considerable variations in their scale of activity: the largest carried out over 100 000 episodes of care per year, while the smallest performed only about 10 000.

Because the DGH system was developed as a planned system, the distribution of hospitals is such that access to services is generally good throughout the country. This does not mean, however, that there are no variations in access. The pre-1948 distribution of hospitals left a highly unequal legacy between different regions in terms of the quality and quantity of provision. Parts of this legacy persist today, such as the heavy concentration of teaching hospitals in London.

There is also a substantial backlog of maintenance and repair work necessary in order to bring parts of the system up to acceptable standards. As part of the programme to improve the quality of the capital stock within the NHS, both the previous government and the present one are committed to the Private Finance Initiative (PFI). This is a partnership programme designed to encourage private investment in the public sector. At the start of 1998, there were 15 projects planned with a total capital value of £1.2 billion. Ten further schemes were announced in April 1998 taking the total capital value to £2.3 billion.

Clinical activity within a typical DGH is organized in terms of specialty departments comprising teams of consultants (i.e. senior specialists) and their teams of junior doctors (similar organizational arrangements exist in tertiary hospitals). Specialists and their juniors are responsible for conducting out-patient clinics at the DGH, where they see patients referred to them by GPs, and for providing inpatient treatments. Doctors and nurses working in the NHS hospitals are employed on a salaried basis. (Details of the payments systems for doctors and nurses are discussed in the section on *Financial resource allocation.*)

Regional and supra-regional specialties

Above the DGH in the hierarchy, there are tertiary level hospitals offering highly specialized services in addition to secondary care. These services

typically include neurosurgery, heart and liver transplants, renal services and certain cancer treatments. They are often offered by teaching hospitals and may operate at the regional level or the supra-regional level. Patients are normally referred to these hospitals by their specialist colleagues at the district level, when it becomes clear that highly specialized treatment is necessary.

Small-scale community hospitals

At the other end of the spectrum there are small-scale community hospitals. These may have up to 200 beds, but typically have up to 50 beds, some of which are available for GPs to manage their patients directly. Facilities offered vary from hospital to hospital but they will often have a range of diagnostic facilities, operating theatres, minor injuries units and, sometimes, day-hospital facilities.

Community hospitals have had a rather chequered history in recent years. The general move towards concentrating services on larger sites, for reasons of cost and quality, has led to a reduction in their number. Between 1980 and 1990, the number of hospitals with less than 50 beds fell from around 600 to just over 400. However, the emphasis placed upon treatment in primary and community settings during the 1990s has led to renewed support for smaller, community-based hospitals. Some of those GPs with control over their budgets, such as the total purchasing pilot sites, have sought to develop their community hospitals as an alternative to expensive and unnecessary, acute hospital care – particularly in the case of elderly people.

Hospital closures

Government policy over the years has led to the closure of many hospitals and to a reduction in the number of hospital beds. In 1993, for example, there were less than 2000 hospitals of all types compared with around 3000 in 1960. In the period 1990–1994, there were 245 hospital closures in England. This has led to a steady reduction in the number of hospital beds. In the last ten years, for example, around just over 10 000 beds have been closed each year in England.

There are several reasons for this downsizing. Much of it has been associated with the closure of long-stay psychiatric hospitals as policy for people suffering from mental illness has shifted towards care in the community. At the same time, the movement towards day surgery rather than inpatient care has reduced the number of beds needed for a given level of clinical activity. A similar reduction in demand for hospital beds has occurred because of the ability – with new drugs and other technologies – to treat people in their own homes instead of as inpatients. New technologies also enable shorter lengths of stay

and, therefore, greater productivity per bed. Thus between 1991 and 1997, the number of general and acute episodes of care rose from 7.5 million to 9.6 million despite the substantial reduction in the number of beds.

Despite these trends, however, the current government believes that the downsizing process may have gone too far. Ministers are currently speaking of an excessive run-down in hospital capacity and the resultant insufficient level of spare capacity to deal with peaks in demand, such as those resulting from winter outbreaks of influenza. In this connection, the low level of bed provision in the United Kingdom, by international standards, has been highlighted by a number of experts (see below).

In recent years there has also been a trend towards hospital mergers in the belief that combining units offers economies of scale and scope. For example, 22 mergers (54 trusts into 27) took place on 1 April 1999. This trend continues despite some research evidence which queries whether larger hospitals really do yield economies of scale.

On the issue of bed numbers, the difficulties that many hospitals faced coping with the rises in emergency admissions during the winter of 1998/1999 led the current Secretary of State for Health, Frank Dobson, to announce the National Beds Inquiry. He expressed the belief that this trend had progressed too far and that there was now insufficient spare capacity in the system to deal with emergency situations. The National Beds Inquiry has been set up within the Department of Health to review assumptions about growth in the volume of general and acute health services and their implications for health services and hospital bed numbers looking 10 to 20 years ahead.

Hospital management

There have been a number of developments in the organization and management of DGHs over recent years. Under the 1991 reforms, hospitals became NHS trusts; that is, not-for-profit organizations within the NHS but outside the control of the district health authority. Each trust was expected to generate income through service contracts with purchasers and had to meet centrally specified financial objectives such as making a 6% return on its capital assets.

In many hospitals, this new financial regime led to new management systems combining clinical and financial governance. As a result, clinical activity within a hospital is now typically organized in terms of ‘clinical directorates’. Each directorate is headed by a clinical director, assisted by a nurse manager and a business manager, and is responsible for its own clinical and financial management. The hospital medical director who works alongside the chief executive usually undertakes the overall management of clinical directorates.

Despite its commitment to abolish the internal market, the present government has announced no plans radically to change trust status. Trusts appear likely to remain independent organizations within the NHS. However, the emphasis on competition for service contracts has been replaced by a requirement to work collaboratively with health authorities and other trusts in the design and implementation of health improvement programmes. The previous emphasis on financial performance is being replaced. Instead a greater emphasis is being placed on the quality of care and health outcomes within a new system of clinical governance.

Private hospitals and clinics

There are about 230 independent medical/surgical hospitals in the United Kingdom (mid-1998) with operating theatres registered to take inpatients according to Independent Healthcare Association (IHA) figures. The market is dominated by five main hospital chains: General Healthcare Group Ltd (of which BMI Healthcare is a subsidiary), Nuffield Nursing Homes Trust Ltd (who operate Nuffield Hospitals), BUPA Hospitals Ltd, Community Hospitals Group PLC. and PPP Columbia Healthcare Ltd. These alone own 61% of all independent hospitals and have a combined share of 65% of the total number of private beds in independent hospitals (see Table 13).

A number of independent hospitals opened in the early 1990s (see Table 14). Many of the more recent hospitals to have been built are on NHS sites. Since the decision by the Labour Government to proceed with a number of PFI projects it is likely that most of the independent hospitals built in future will not be fully equipped hospitals on independent sites but part of NHS hospital developments.

It is noticeable that there has been some vertical integration between the insurance function and hospital ownership in United Kingdom private health care market, with both PPP and BUPA heading up the league tables of private hospital ownership and private health insurance (see Table 4).

One way for the major hospital groups to strengthen their market position has been through acquisitions and mergers. However the number of mergers and acquisitions has not accelerated in the 1990s due in part to the findings of a report on private health care by the Monopolies and Mergers Commission, which stated that further mergers and integration would be against the public interest. Instead since 1996, two of the main insurers have established networks of preferred providers.

The first network of this kind was launched by BUPA in May 1996 which included 150 hospitals (the majority of which are operated by the main chains

Table 13. Independent medical/ surgical hospitals and beds in the United Kingdom for the largest 12 hospital operators mid-1998

Operator	No. of hospitals	No. of beds	Share of beds %
BMI Healthcare	40	2 241	20.7
BUPA Health Services	36	1 861	17.1
Nuffield Hospitals	38	1 547	14.3
Community Hospitals Group PLC	22	829	7.6
PPP	4	560	5.2
St Martin's Hospitals Ltd	3	214	2.0
British Pregnancy Advisory Service	8	205	1.9
King Edward VII Hospital Group	2	194	1.8
Aspen Healthcare Ltd	2	127	1.2
Abbey Hospitals Ltd	5	105	1.0
Hospital Management Trust	2	64	0.6
Marie Stopes International Ltd	3	61	0.6
All other	64	2 844	26.2
Total	229	10 852	100

Source: Laing and Buisson (1998) *Laing's Healthcare Market Review 1998–1999*, Laing and Buisson, London

Table 14. Independent acute medical/surgical hospitals in the United Kingdom, 1986–1998

Year	Total	Net change
1986	200	0
1987	199	-1
1988	202	+3
1989	205	+3
1990	211	+6
1991	216	+5
1992	219	+3
1993	221	+2
1994	224	+3
1995	227	+3
1996	224	-3
1997	227	+3
1998	229	+2

Source: Laing's Healthcare Market Review 1998–1999, Laing and Buisson, London 1998.

of hospital operators). PPP Healthcare followed in February 1997 with its own network. This is expected to have 170 hospitals, including NHS hospitals with private patient units. These networks constitute a major change in the private hospital sector in recent years and could have significant implications for smaller non-affiliated hospitals. The take-up of this 'restricted' insurance policy has been high and as these two companies dominate the insurance market, those providers excluded from the networks could see a significant reduction in admissions. This shift, taken together with the strong incentives offered to

private specialists and consultants to encourage them to refer their patients to a preferred provider, could result in independent hospital closures. By mid-1998, 4000 of the 20 000 privately practising consultants had signed up to the BUPA partnership which may account for as much as 50% of all private work.

Table 15 indicates the estimated number of operations and procedures carried out in independent hospitals in 1992/1993. It shows that abortions were the commonest procedure (13.2%). Excluding abortions, most clinical activity was for elective surgery covering such procedures as cataract removals, hernia

Table 15. Estimated number of operations and procedures carried out in independent hospitals, inpatients and day cases

Main operation or procedure	Residents of England and Wales			Total no.	%
	1981	**1986**	**1992/1993**	**1992/1993**	**1992/1993**
All known excluding abortion operations	206 920	381 605	557 451	572 104	84.3
– All endoscopic examination	11 012	31 535	58 928	59 963	8.8
– Other orthopaedic	16 537	35 353	57 134	58 227	8.6
– Other ear nose and throat	12 811	24 789	31 784	31 880	4.7
– Other gynaecological	6 629	11 071	31 069	31 492	4.6
– Other skin subcutaneous	8 972	24 478	28 706	28 768	4.2
– Dental extraction	7 344	14 504	21 587	21 655	3.2
– Abdominal hernia repair	9 435	15 664	16 444	16 604	2.4
– All hysterectomy	9 211	13 843	16 146	16 216	2.4
– Lens operations	3 935	8 491	15 356	15 875	2.3
– Ligation or stripping varicose veins	7 429	10 505	13 428	13 428	2.0
– Arthroplasty	6 328	10 080	12 637	12 787	1.9
– Tonsillectomy and adenoidectomy	9 229	12 115	13 092	13 031	1.9
– Dilation and curettage	11 973	20 915	12 350	12 420	1.8
– Plastic surgery	3 825	4 539	11 100	11 279	1.7
– Major intra-abdominal	6 117	10 198	11 107	11 191	1.6
– Other eye operations	3 086	6 125	8 896	9 902	1.5
– Prostatectomy	2 803	4 585	9 756	9 802	1.4
– Haemorrhoidectomy and other anal and peranal surgery	5 483	6 562	8 595	8 715	1.3
– All other heart operations	234	2 902	6 379	7 604	1.1
– Coronary artery bypass graft	374	929	3 809	6 463	1.0
– Vasectomy	2 546	4 912	4 393	4 396	0.6
– Circumcision	2 490	3 605	3 342	3 342	0.5
– Appendicectomy	1 694	2 350	1 947	1 947	0.3
– Division ligation occlusion of oviducts	4 035	2 819	1 827	1 925	0.3
– All other operations and procedures	36 496	64 446	82 878	84 935	12.5
– No operation or procedure	16 930	34 290	74 712	78 257	11.5
Abortions	66 027	68 956	81 476	89 809	13.2
Not known	2 805	11 106	16 423	16 789	2.5
Total	275 752	461 666	655 350	678 703	100

Source: T. Williams and J. Nicholl (1994) Patient Characteristics and clinical caseload of short-stay independent hospitals in England and Wales, 1992–1993, BMJ 308:1699–1701.

repairs, hip replacements and stripping of varicose veins. Comparisons with 1986 data do indicate, however, that there has been a substantial growth in rather more complex procedures, such as coronary artery bypass grafts and other heart operations, in recent years.

In addition to the large amount of acute health care, a small amount of private health care was provided in NHS hospitals. For the most part, private acute services are supplementary to NHS provision – offering shorter waiting times for procedures that are available through the NHS. In some cases, however, private provision has effectively replaced NHS provision because its scale is insufficient to meet user needs, e.g. termination of pregnancies.

Numbers of hospital beds: some comparative data

As Fig. 12 shows, the United Kingdom had approximately 4.5 hospital beds per 1000 population in the mid-1990s. This is one of the lowest levels in western Europe and contrasts markedly with countries such as Norway (13.5), France (10.5) and Germany (10.2).

Fig. 13 provides some comparative data on hospital beds per 1000 population for selected countries over the period 1983–1995. It shows how all countries have been reducing their bed numbers over time, but that the rate of decline in the United Kingdom has been greater than in both France and Germany.

Private beds

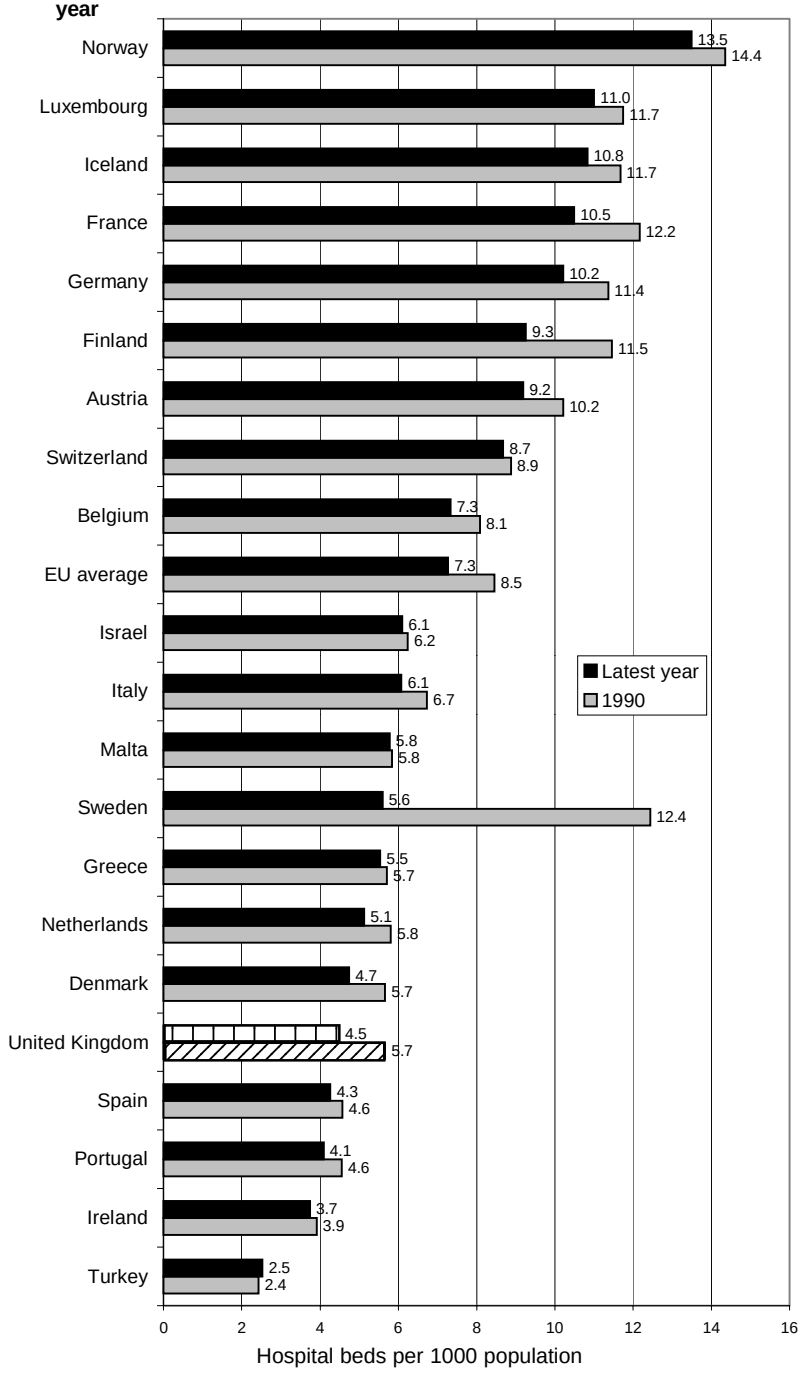
British for-profit companies dominate ownership of private hospital beds in the private and independent sector (over 50% of the total). For-profit companies own 65% of beds in the private sector. This figure is up from 41% in 1979. Charitable and religious groups own a significant proportion (34% of the total number of beds).

The total numbers of beds in the independent sector has seen a decline since 1995 when the total number peaked at 11 681. By 1998 there were 10 852 beds, representing a reduction of 829 beds or 7.1%. This follows similar trends in the NHS as a result of the shift towards day surgery and outpatient treatment for a number of complaints.

NHS amenity beds and private patient units

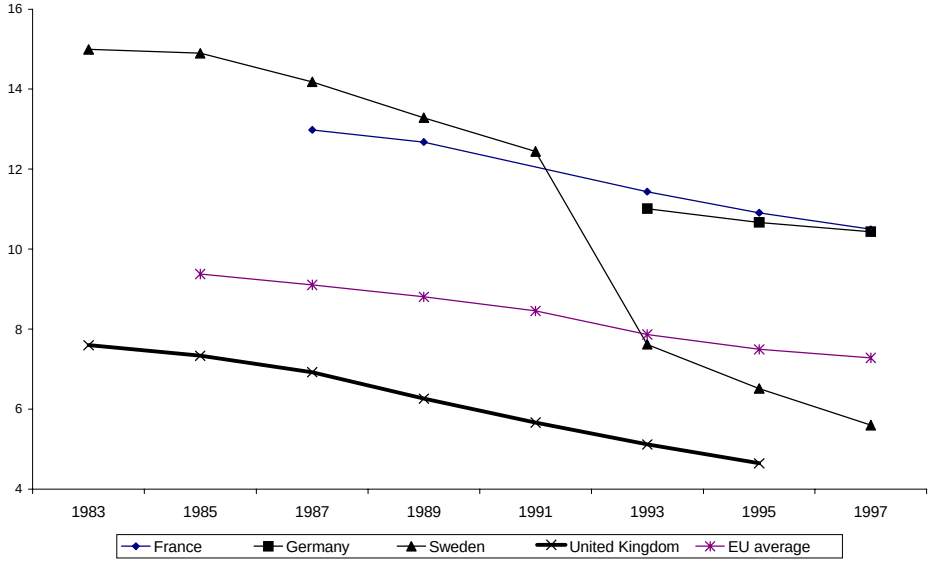
There are 3000 authorized amenity beds in the United Kingdom NHS, of which the majority (about 1600) are on ordinary NHS wards. Amenity beds refer to beds that are available for the treatment of NHS patients for an extra charge usually in a private room.

Fig. 12. Hospital beds per 1000 population in western Europe, 1990 and latest available year



Source: WHO Regional Office for Europe health for all database (*23*).

Fig. 13. Number of hospital beds per 1000 population in the United Kingdom and selected countries, 1983–1995



Source: WHO Regional Office for Europe health for all database (*23*)

Table 16. Inpatient facilities utilization and performance in the United Kingdom, 1970–1996

Year	Hospitals beds per 1000 population	Admissions per 100 population	Average length of stay in days
1970	–	10.9	25.7
1975	–	11.6	22.9
1980	7.9	12.17	19.1
1985	7.1	13.45	15.8
1990	5.7	14.46	15.6
1991	5.4	14.81	14.1
1992	5.1	14.94	12.4
1993	4.8	15.20	10.0
1994	4.6	15.32	10.0
1995	4.5	15.86	9.9
1996	–	23.10	9.8

Source: WHO Regional Office for Europe health for all database (*23*).

NHS trusts can offer services and accomodation to private patients in what are known as NHS pay beds. Consultants are authorized to use a certain number of NHS bed days for private patients in a given year. Another NHS/private partnership is the use of dedicated private patient units, which are either entire

wards or wings in NHS hospitals that are dedicated to private patients. In mid-1998 there were 78 units of this sort with nearly 1400 beds.

Utilization and performance of hospitals

Table 16 presents some data on the utilization of inpatient facilities in the United Kingdom over the period 1970–1997. As well as the reduction in the number of beds per 1000 head of population, it shows how average lengths of stay have fallen from over 25 days in 1970 to less than 10 days in 1996. (It should be borne in mind, however, that much of the large fall between 1970 and 1985 resulted from the closure of long-stay institutions. Since then the fall has continued but at a slower rate).

Table 17 provides the same utilization data as that presented in Table 16 for countries in the WHO European Region for 1996 (or the latest year available). Comparing these kind of data across countries is hazardous because of the different categories of inpatient care included in national definitions. However, the data do suggest that that admission rates and lengths of stay in the United Kingdom are towards the lower end of the distribution among western European countries.

Social care

Social care in Britain is usually defined as long-term care in residential or nursing homes for people with mental illness, people with learning difficulties and elderly people, together with a range of domiciliary services provided for people in their own homes. Responsibility for making sure that these services are provided is shared between local government, social services departments and the NHS. This joint responsibility has led to long-standing problems of poor coordination that current policy reforms are seeking to overcome (see below).

In common with many other countries, UK policy over the last 30 years has favoured 'care in the community' as an alternative to long-stay institutional care for people with mental illness or learning difficulties. As a result, nearly 100 000 people have been discharged into the community between the 1960s and 1980s. Throughout this period, however, there have been concerns that rates of discharge have exceeded the rate at which alternative services are being provided in the community. In recent years, some highly publicized – but also highly atypical – cases of violence involving discharged mental health patients have led to a reconsideration of some aspects of this policy.

Table 17. Inpatient utilization and performance in the WHO European Region, 1997 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Austria	9.2[a]	25.1[a]	10.5[a]	75.1[a]
Belgium	7.3[a]	20.0[a]	11.3[a]	81.4[b]
Denmark	4.7[a]	19.8[b]	7.3[a]	79.1[b]
Finland	9.3[b]	26.7	11.0	74.0
France	10.5[a]	22.8[b]	11.2[a]	75.0
Germany	10.2	–	14.3[a]	79.8[a]
Greece	5.5[a]	15.0[b]	8.2[a]	–
Iceland	10.8[e]	28.0[c]	16.8[e]	70.3[h]
Ireland	3.7[a]	15.1[a]	7.5[a]	82.3[a]
Israel	6.1	19.0	13.0	93.0
Italy	6.1[a]	17.5[a]	9.4[a]	77.4[a]
Luxembourg	11.0[c]	19.4[c]	15.3[a]	74.3[c]
Malta	5.8[a]	–	–	–
Netherlands	5.1	9.8	13.8	64.4
Norway	13.5[c]	15.3[a]	9.9[a]	81.1[a]
Portugal	4.1	11.8	9.3	70.1
Spain	4.3[a]	10.0[a]	11.0[a]	73.9[c]
Sweden	5.6[a]	18.0[a]	7.5[a]	81.9[a]
Switzerland	8.7[f]	15.0[c]	24.5[h]	77.7[c]
Turkey	2.5	6.9	6.1	57.7
United Kingdom	4.5[b]	23.1[a]	9.8[a]	76.2[i]
CCEE				
Albania	3.0	7.7	7.9	–
Bosnia and Herzegovina	4.5[f]	8.9[f]	13.3[f]	70.9[f]
Bulgaria	10.3	17.5[a]	12.9	64.1[a]
Croatia	6.0	14.9	12.9	89.3
Czech Republic	8.8	20.2	12.3	71.8
Estonia	7.4	18.3	10.9	71.4
Hungary	8.3	23.7	11.0	74.4[a]
Latvia	9.7	21.7	12.9	–
Lithuania	9.8	21.8	12.9	–
Poland	6.2[a]	11.6[b]	10.4	–
Romania	7.4	20.9	10.0	–
Slovakia	8.3	19.9	12.1	78.5
Slovenia	5.7	16.2	10.0	77.7
The former Yugoslav Republic of Macedonia	5.2	10.0	13.4	63.9
NIS				
Armenia	6.8	6.7	13.9	36.1
Azerbaijan	9.6	5.8	17.5	–
Belarus	12.4	26.1	15.5	88.7[c]
Georgia	4.5	4.3	10.5	26.8[c]
Kazakhstan	8.4	15.1	16.5	80.8
Kyrgyzstan	8.3	17.5	14.5	83.6
Republic of Moldova	11.3	18.7	18.0	80.0
Russian Federation	11.4	20.6	16.6	87.7
Tajikistan	7.0	11.0	15.0	59.9
Turkmenistan	7.1	13.0	13.4	72.1
Ukraine	9.4	19.1	16.2	85.2
Uzbekistan	6.4	15.8	13.8	–

Source: WHO Regional Office for Europe health for all database.
Note: [a] 1996, [b] 1995, [c] 1994, [d] 1993, [e] 1992, [f] 1991, [g] 1990, [h] 1989, [i] 1986.

Informal carers look after those who are sick, disabled, vulnerable or frail. Britain has an estimated 5.7 million carers and one in six households – 17% – contains a carer. Of the estimated 5.7 million carers, 1.7 devote at least 20 hours a week to caring. Of those, 855 000 care for 50 hours or more. Most caring is based on close personal relationships.

Another key feature of government policy in the 1980s and early 1990s was the encouragement of the private long-term care sector. This was part of the general preference of the government of that time for private provision over public sector provision, wherever feasible. For example, in the case of long-term care places for elderly people, between 1980 and 1994 the number of places in private residential homes rose from just under 36 000 to over 164 000. The number of places in local authority residential homes fell from approximately 114 000 to under 69 000.

As was pointed out in the section on *Complementary sources of finance*, much of this growth in private sector residential care was fuelled by publicly-funded, social security payments. This was, of course, at variance with the thrust of 'care in the community' which favoured care at home rather than institutional care. In 1986 Sir Roy Griffiths, a policy adviser of the Prime Minister Margaret Thatcher, was invited to examine the issue. His report, published in 1988, formed the basis of the community component of the *NHS and Community Care Act 1990* and its main elements were implemented in April 1993. The Griffiths proposals continue to form the basis of community care policy in the United Kingdom today.

Under this policy, local government social service departments are responsible for identifying needs, setting priorities and developing plans. At the individual level, case managers assess individuals and make sure that appropriate packages of care are provided. These packages will typically involve both domiciliary care and residential care sometimes publicly, but increasingly privately, provided. Between 1992 and 1995, for example, the proportion of home-care contact hours provided by independent contractors rose from 2% to 29%.

To overcome the perverse incentives for residential care presented through the social security system prior to 1993, central government transferred monies from social security to local authorities to be spent on care packages. In some cases, this is used to fund residential care where the case manager deems it necessary and the patient is eligible for public funding. However, particularly in the case of elderly people, private funding is becoming increasingly necessary. At the present time, anyone with assets of £16 000 or more (including their equity holding in their home) is not eligible for assistance through public funding. As was pointed out in the section on *Complementary sources of finance*, this requirement has led to widespread concern about elderly people having to

sell their homes to fund long-term care and was the subject of a recent investigation by a Royal Commission which reported in early 1999.

Other current policy developments in relation to social care allow the NHS and all health-related aspects of local government – not just social services – to delegate commissioning and providing functions to one another and pool budgets. These powers are designed to enable organizations to work together in the best interests of users and look more carefully at the mix of professionals providing services. Additionally, changes are being made to existing legislation governing transfers of money from the NHS to local government. The NHS can already transfer money to local authorities for a limited range of mainly social service functions. This power has been expanded and a new reciprocal power introduced for local authorities to transfer funds to the NHS where such a transfer will better meet the objectives of the local authority. All these new powers will be available from April 2000.

Ensuring adequate quality standards in social care, especially in the case of residential care, has been a long-standing concern. With the provision of care (for often vulnerable people) distributed among thousands of different sites, this is clearly a complex task. Periodic media reports have highlighted some worrying cases of poor standards and sometimes patient abuse. Legislation during the 1990s has sought to strengthen mechanisms for monitoring and ensuring satisfactory service standards. At the national level, the Social Services Inspectorate within the Department of Health plays an important role in the national monitoring and in-depth study of particular aspects of community care. At the local level, health authorities have been responsible for the inspection of nursing homes, and local authorities for residential homes. However, under the government's current proposals (included in the White Paper *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards* (*4*)), independent agencies with across-the-board responsibilities will undertake the inspection of nursing homes, residential homes and domiciliary care providers.

Human resources and training

Training

Doctors

The education and training of doctors in the United Kingdom covers three related stages:

(i) undergraduate medical education

(ii) postgraduate medical education

(iii) continuing medical education.

In England, students receive a five-year (or in some cases six-year) undergraduate education and training in medicine at one of 19 medical schools. These are part of the university system and are funded by the Higher Education Funding Council.

The number of students entering medical schools in the United Kingdom grew steadily from 4311 in 1990 to 5091 in 1998. There are currently plans to expand the number of places for medical students by about 1000 places per annum by 2005. In England there will be expansion at some of the existing 19 medical schools and at least three new centres of medical education. There are currently four medical schools in Scotland, one in Wales and one in Northern Ireland.

On completion of their undergraduate training, students enter a pre-registration year during which they have provisional registration with the General Medical Council (GMC) that allows them to practice in hospitals and primary care as pre-registration house officers under supervision. The pre-registration year is the final part of basic medical training and is overseen by the medical school.

After successfully completing one year's training as a house officer, a doctor is eligible to apply for full registration with the GMC. Inclusion on the GMC's medical register is necessary to work in the NHS as a doctor and enables doctors to, for example, prescribe drugs and complete medical certificates.

The subsequent career progression of a hospital doctor would generally follow the path of:

- Senior house officer (minimum three to five years but often longer) undergoing general professional and basic specialist training;
- Specialist registrar (four to five years) undergoing specialist training;
- Consultant specialist in the specialty of choice. This is the career grade and doctors should expect to reach this point in their mid-thirties.

Doctors entering general practice follow a different path. After their pre-registration year as a house officer, (and possibly some experience as a senior house officer), they must undertake three years of vocational training with at least two years in hospital SHO posts and one year as a GP registrar. As a GP registrar, they work and train in general practice with a recognized GP trainer. Upon successful completion of this period they will receive a certificate which enables them to work in general practice, including as a GP principle.

Doctors who have completed their formal medical training should continue to learn and develop through the concepts of continual professional development. This is central to 'lifelong learning' and underpins the key principle of clinical governance. Under this system doctors take responsibility for the maintenance and development of professional skills which will improve services available to NHS patients. This is designed to keep doctors up-to-date with developments in their own area of practice.

Nurses

In order to work as a qualified nurse in the United Kingdom, an individual has to be registered with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and registration has to be renewed every three years. In March 1998 there were 637 449 qualified nurses, midwives and health visitors registered with the UKCC. This represents the pool from which nursing staff are drawn, although not all nurses on the register are currently working in the United Kingdom.

The vast majority of nurses are employed by the NHS. In 1995, there were 305 160 whole time equivalents (wte) employed by the service. This compared with 57 775 (wte) employed by independent hospitals and nursing homes. In addition, there were also 10 478 (wte) working as GP practice nurses. When expressed in terms of the total number of individuals working as nurses, either full- or part-time, these figures amount to over half a million. With 90% of nurses being female, nursing represents the largest source of professional employment for women in the United Kingdom.

The number of nurses employed directly by the NHS has remained fairly static since the late 1980s, whereas the number working in the independent sector has grown threefold and the number working as GP practice nurses by fourfold.

Nursing retention and turnover was a major problem during the 1980s. Each year approximately one in ten nurses left the workforce and two thirds of these never returned. The reduction in alternative employment opportunities associated with economic recession in the late 1980s and early 1990s relieved some of the pressure, but wastage and vacancy rates have once again risen in the late 1990s. Currently, nursing shortages are seen as a major problem. The scale of this shortage is estimated at between 8000 and 12 000 nurses. In an attempt to address this problem, the Secretary of State for Health has recently announced a new salary structure for nurses with a significant increase in the starting salary. A campaign has also been launched to persuade those who have left nursing to return to the profession.

The system of nurse education and training in the United Kingdom was transformed by the implementation of a new policy in 1988. This was based

largely upon the UKCC's recommendations for the reform of nursing education. The new approach represents a full-scale reorientation of nurse education, away from on-the-job training to full-time study in colleges of further and higher education. Under this system, students are counted as supernumerary to service staffing requirements while acquiring on-the-job experience and their applied work is designed to be closely linked to course-based learning.

In July 1999, the Secretary of State for Health launched a new strategy, *Making a Difference for Nurses, Midwives and Health Visitors.* The new strategy is designed to increase the supply of nurses, midwives and health visitors by improving their career prospects. It will allow training to be spread over more than three years by incorporating 'take-a-break' periods, introduce new pathways into nursing via national vocational qualifications, and create new posts of nurse consultants who will take on senior roles while devoting at least half of their time to direct patient care for example.

Professions Allied to Medicine (PAMs)

The Council for Professions Supplementary to Medicine is responsible for registering practitioners, approving-training courses and carrying out disciplinary functions for the following professions: art, music and drama therapy, chiropody/podiatry, dietetics, medical laboratory scientific officers, occupational therapy, orthoptics, orthotics and prosthetics, physiotherapy, radiography, speech and language therapy, paramedics and clinical scientists.

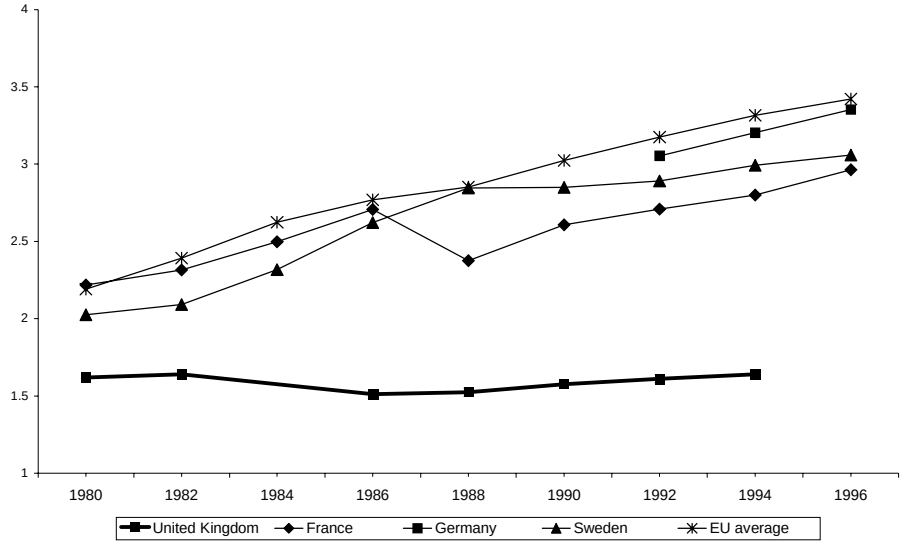
At September 1998 there were 103 540 scientific, therapeutic and technical staff, 14% of the total NHS Hospital and Community Health Services staff. This group includes a wide range of areas of work, the main components of which were 14 550 (14%) physiotherapy staff, 12 080 (12%) occupational therapy staff and 11 290 (11%) radiography staff.

A greater focus on rehabilitation is increasing demand for physiotherapy and occupational therapy services. Investment in PAMs training continues to increase and the professions remain a popular choice with students. In the last five years, the number of training places of occupational therapists has grown by 41% and for physiotherapists by 45%. Ways of widening access into these professions and encouraging applications from those employed in the NHS who wish to pursue a professional career are being considered.

Dentists

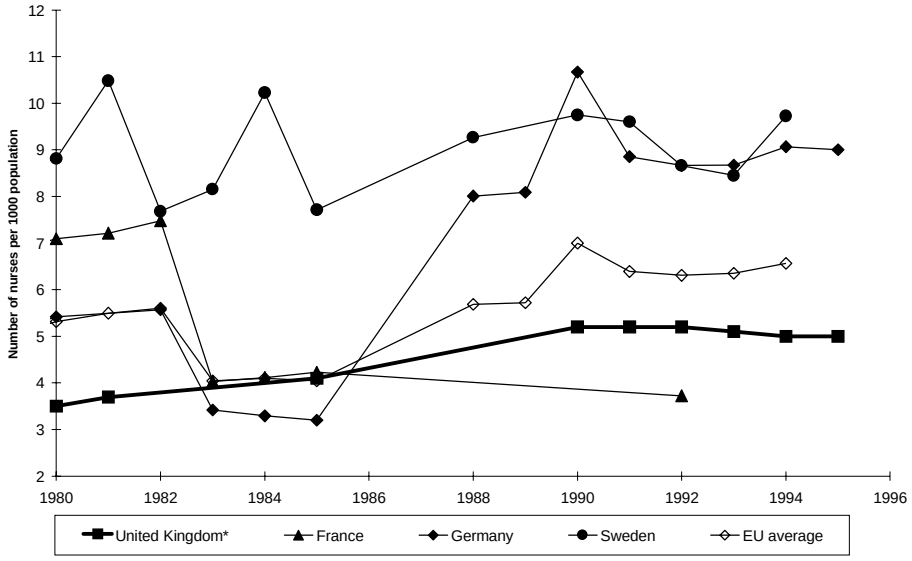
Dentists are required to complete five years' dental school training before practising as a dentist. However those wanting to go into general practice must also do a period of vocational training. There are a number of areas of dental specialty for which further training is required, e.g. oral surgery, orthodontics, restorative dentistry, dental public health, paediatric dentistry and others. The

Fig.14. Number of doctors per 1000 population in the United Kingdom and selected countries, 1980–1996



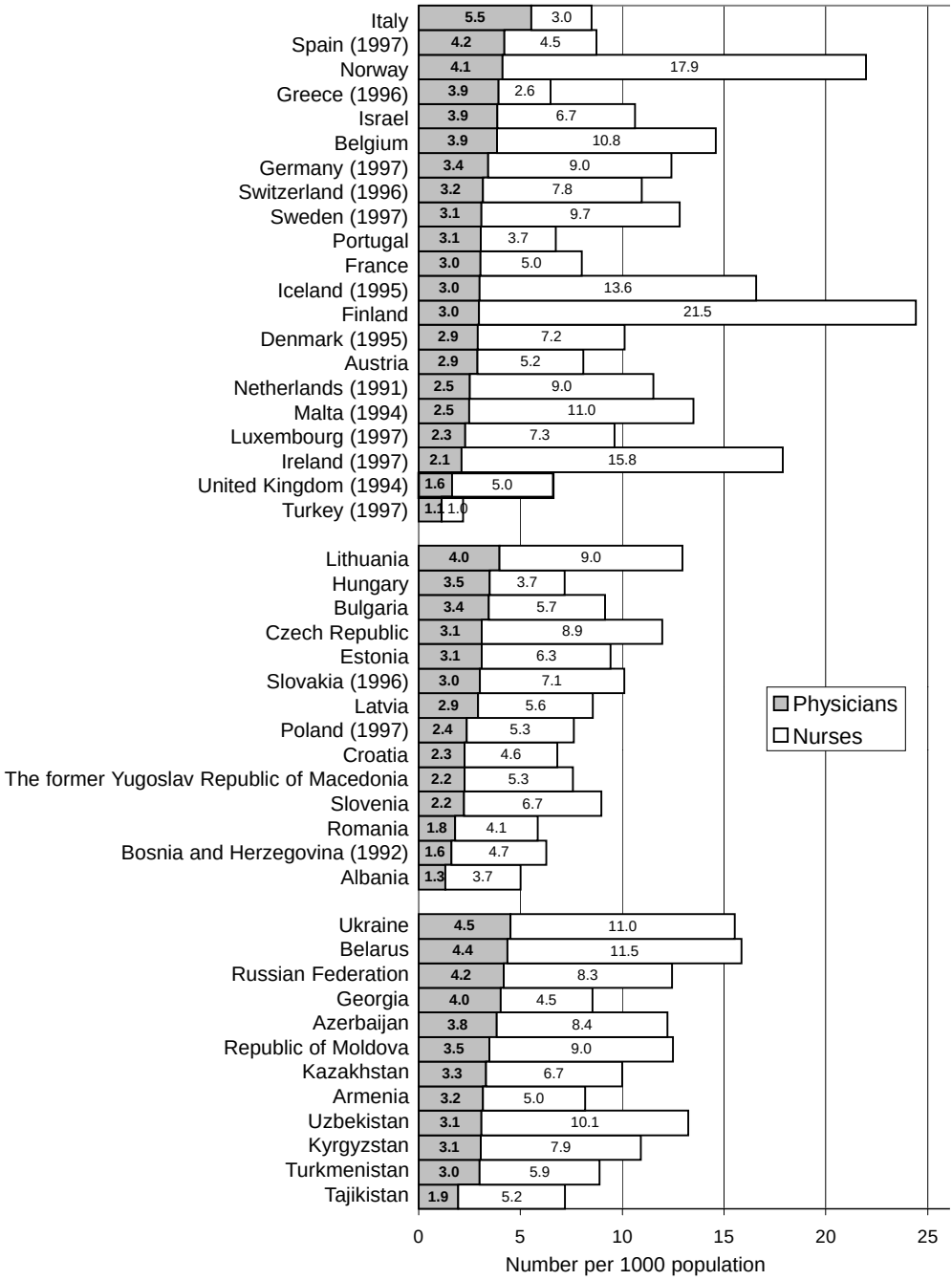
Source: WHO Regional Office for Europe health for all database (*23*).

Fig.15. Number of nurses per 1000 population in the United Kingdom and selected countries, 1980–1995



Source: WHO Regional Office for Europe health for all database (*23*).

Fig. 16. Number of physicians and nurses per 1000 population in the WHO European Region, 1998 or latest available year



Source: WHO Regional Office for Europe health for all database (*23*).

majority of whom work as consultants in hospitals (with the exception of public health dentists who work for health authorities). Those who wish to work as hospital dentists pursue a progression through hospital training grades (i.e. house officer, senior house officer, etc.) similar to that of doctors. There are a number of auxiliary positions including, dental hygienist, dental therapist, dental technician and oral health educator.

Human resources

The main employer of doctors in the United Kingdom is the NHS. Table 18 shows that in 1996 there were 102 610 doctors employed by the NHS or, in the case of GPs, holding contracts with it. This total comprised 19 940 UK-trained hospital consultants (together with 3740 consultants from overseas) and 27 490 UK-trained GP principals (together with 5700 trained overseas).

Fig. 15 presents some comparative WHO data on the number of nurses per 1000 population for the United Kingdom and selected countries over the period 1970–1995. These data suggest that the UK ratio of nurses-to-population grew over the period 1980–1990 but has, thereafter, remained fairly static. The ratio is currently below that found in Germany and Sweden, and the EU average, but above that found in France (in 1992). The UK figure also appears to be far more stable over time than those for other countries.

Fig. 16 provides comparative data on the number of doctors and nurses per 1000 population in the WHO European Region for 1998 (or the latest year available). It shows that the doctor-to-population ratio is the second lowest in western Europe. According to the 1998 NHS Executive census of the hospital workforce there were 1.21 hospital doctors of all grades per 1000 population in England. This figure does not include the number of GPs in the United Kingdom.

The low international ranking of the UK nurse-to-population ratio is not quite so evident, but the United Kingdom is still in the lowest one third in western Europe.

Table 19 presents some data on the number of health care personnel in relation to the population, in the United Kingdom, over the period 1980–1996 (or the latest year available). It shows how the numbers of active physicians per 1000 population rose slightly over the period; how the number of active dentists and pharmacists per 1000 population remained constant; and how the number of certified nurses rose from 3.5 per 1000 to 5.2 per 1000 between 1980 and 1990, remained constant and then fell slightly between 1990 and 1995, but then fell to 4.5 per 1000 population in 1996.

Table 18. Number of doctors at 30 September each year in the United Kingdom, 1991 and 1996

	1991	1996	Growth rate, % pa
All United Kingdom qualified doctors			
Hospital consultants	16 770	19 940	3.5
Unrestricted principals[1]	26 230	27 490	0.9
Junior doctors[2]	21 820	23 740	1.7
Other Hospital and Community Health Service doctors[3]	5 530	4 880	-2.5
Other General Medical Service doctors[4]	2 330	2 180	-1.3
Subtotal	72 6701	78 230	1.5
Doctors qualified overseas or in other countries of the European Economic Area			
Hospital consultants	2 810	3 740	5.9
Unrestricted principals	5 400	5 700	1.1
Junior doctors	8 110	10 610	5.5
Other Hospital and Community Health Service doctors	2 640	3 790	7.5
Other General Medical Service doctors	480	540	2.3
Subtotal	19 450	24 390	4.6
All doctors[5]			
Hospital consultants	19 580	23 680	3.9
Unrestricted principals	31 630	33 190	1.0
Junior doctors	29 930	34 360	2.8
Other Hospital and Community Health Service doctors	8 170	8 660	1.2
Other General Medical Service doctors	2 810	2 730	-0.6
Total[6]	92 120	102 610	2.2

Source: Department of Health (1997) *Planning the Medical Workforce: Medical Workforce Standing Advisory Committee Report*

Notes:

[1] Unrestricted principals (at 1 October) in the General Medical Service.

[2] Junior doctor refers to hospital staff training grades (higher specialist trainees, senior house officers and pre-registration house officers).

[3] "Other Hospital and Community Health Service doctors" includes staff grade, associate specialist and community health service doctors but no hospital practitioners and clinical assistants because the majority of these are GPs.

[4] "Other General Medical Service doctors" includes general practice trainees in the practice-based part of their training together with restricted principals, assistants and associates in Scotland.

[5] "All doctors" is the total number of doctors irrespective of where they qualified.

[6] All numbers rounded to nearest ten. Some of the total may not match the sum of relevant column due to rounding.

Table 19. Health care personnel in the United Kingdom (per 1000 population), 1980–1996

	1980	1985	1990	1991	1992	1993	1994	1995	1996
Active physicians	1.3	1.4	1.5	1.5	1.5	1.5	1.6	–	–
Active dentists	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Certified nurses	3.5	4.1	5.2	5.2	5.2	5.1	5.0	5.0	4.5
Active pharmacists	–	–	0.6	0.6	0.6	0.6	–	–	–

Source: OECD health data 1998 (*20*).

Pharmaceuticals and health care technology assessment

Pharmaceuticals

The level of consumption of pharmaceuticals in the United Kingdom is relatively modest by international standards. In 1996/1997 just under 500 million prescriptions were dispensed through the NHS in England (nearly 600 million in the United Kingdom) – this amounted to approximately ten prescriptions per person in England (usually higher for the United Kingdom). This level of prescribing is between 30% and 80% lower than the corresponding figures reported in other western European countries such as France, Germany and Italy. The rate of drug consumption is, however, increasing in the United Kingdom. Between 1986/1987 and 1996/1997, the number of prescriptions dispensed increased by around 40% in England.

The use of cost sharing in the case of pharmaceuticals is discussed in the section on *Complementary sources of finance*. This discussion showed that prescription charges have risen substantially over time but that, because of widespread exemptions, only around 14% of prescriptions are presently subject to charges. This means that the majority of the drugs bill for NHS prescriptions – which rose by over 70% in real terms in the ten-year period to 1996/1997 – is met by central government funding.

In 1993 there were approximately 1500 pharmaceuticals eligible for prescription through the NHS. Since 1985 however, there has been a Limited List (or negative list) which excludes some products from NHS prescribing on the grounds of poor therapeutic value or excessive cost.

In recent years, the government has launched several initiatives designed to control the growth of pharmaceutical costs and to encourage cost-effective prescribing. At the beginning of the 1990s, a system of indicative prescribing budgets was introduced for GPs. These were used by independent medical

advisers at the local level in order to influence high prescribers. In addition, prescribing budgets were included within GP fundholding budgets and thereby gave fundholders an incentive to manage their prescribing more efficiently. From April 1999, as part of the nationwide primary care groups scheme, prescribing budgets for all GPs will be merged with hospital and community health service budgets and cash limited.

The United Kingdom has a strong research-based pharmaceutical industry that makes a significant contribution to export performance. The profits of the industry have been regulated since 1957 through the nonstatutory Pharmaceutical Price Regulation Scheme (PPRS). The aim of this scheme has been to balance the needs of the NHS with the needs of a research-based industry. A new PPRS has been negotiated between the UK Health Departments and the pharmaceutical industry. The Health Act 1999 gives powers to impose statutory price and profit controls on those companies that elect not to sign up to the voluntary scheme. It is also expected that the newly-established National Institute for Clinical Excellence will play a leading role in making recommendations about the cost-effective use of pharmaceuticals in the NHS.

In the meantime the National Prescribing Centre and the Prescribing Support Unit have continued to provide support to medical and pharmaceutical advisers through information bulletins and other means.

Health technology assessment

There is a national health technology assessment (HTA) programme that is funded as part of the NHS Research and Development Programme. This was established in 1993 and aims:

> *to ensure that high quality research information on the costs, effectiveness and broader impact of health technologies is produced in the most efficient way for those who use, manage and work in the NHS.*

Since its inception the programme has allocated over £39 million to around 180 research projects. Examples of areas where work has been commissioned include screening for postnatal depression, management strategies for chronic fatigue syndrome, diagnostic tests for glaucoma, telemedicine and patient satisfaction. The HTA programme will support the National Institute for Clinical Excellence (NICE), which will play a significant role in directing research and disseminating results. NICE will also be informed by a "horizon scanning" unit at the University of Birmingham. This unit will be responsible for identifying new technologies likely to affect the NHS, with a view to encouraging their evaluation and the production of evidence on their clinical and cost-effectiveness.

Financial resource allocation

Third-party budget setting and resource allocation

The NHS budget

The budget for the NHS is set annually as part of the overall public expenditure planning process. As was described in the section *Main system of finance and coverage*, until recently ministers from spending departments submitted expenditure bids for the next financial year to the Treasury. Following a process of consultation and negotiation, Treasury Ministers determined the spending totals for each department. While this was an extremely effective method of short-term expenditure control, the arrangement has been criticized because it inhibits longer-term expenditure planning. Last year, for the first time, spending totals for the following three years were announced. This decision followed the results of a wide-ranging, comprehensive spending review which looked at numerous aspects of public expenditure and its planning.

Once the overall budget has been announced, the Department of Health determines the breakdown of the allocation between the two main health sectors: namely, 'hospital and community health services' and 'family health services'. The former, as the name implies, covers acute and community hospital services, while the latter covers primary care. (Note: the Department of Health allocations relate to England; separate allocations take place in Scotland, Wales and Northern Ireland. Also it is worth noting that several current policy initiatives are blurring the distinction between budgets for secondary and primary care, through the development of integrated budgets.)

Hospital and community health service budgets

Following the determination of the total budget for hospital and community health services, the allocation to regional health authorities is made. The current

weighted capitation approach to regional allocations dates from the 1976 Resource Allocation Working Group (RAWP) report. This Group produced a formula for allocating budgets to regions based upon their population size, their composition in terms of age and gender, their levels of morbidity (using standard mortality ratios as a proxy) and unavoidable geographical differences in the costs of providing services.

The original RAWP formula indicated substantial discrepancies between regions in terms of the distance of their actual allocations from their target allocations (based upon the formula). In particular, the regions surrounding London were shown to be substantially "over-funded" while those in the North were "under-funded". Over the period 1977–1985, the RAWP formula was used to reduce variations around target levels of spending and to produce a greater degree of interregional equity.

By 1985 the government decided that discrepancies around regional targets had been largely eradicated and the RAWP formula required some fine tuning. Accordingly, a review of the formula was commissioned. As a result of this review, adjustments were made that mainly had the effect of reducing the importance attached to differences in the needs-based element, that is the standardized mortality ratios.

In 1990, in anticipation of the introduction of the internal market, the RAWP formula was replaced by an alternative weighted capitation formula although the principles of the RAWP formula were retained. Yet another review, carried out by a team from the University of York, reported in 1994. Their work – based upon the most sophisticated econometric modelling undertaken to date – differed from earlier approaches by incorporating a wider range of health status and social factors in the needs-based element. Thus health status measures included the incidence of limiting long-standing illness and low birth-weight babies, while social factors included unemployment rates and the numbers of lone elderly households. While not all of the recommendations of the York group were accepted by the government, their work forms the main basis of the current system for allocating funds to regions.

Allocations from regional health authorities to district health authorities have been based on a variety of approaches. Most regions use a variant of the national allocation formula but tend to adjust it in the light of historic allocations and local circumstances. During the 1990s the task of subregional allocations has been made more complicated by the emergence of a plurality of purchasers. This has required allocations to be made not only to district health authorities but also to GP fundholders and total purchasing pilot sites. While there has been general agreement about the desirability of basing all of these allocations on weighted capitation formulae, reliable formulae for application in the case

of small populations are not generally available. As such most allocations have relied heavily on historic patterns of costs and activity.

Family health service budgets

Although the principle of weighted capitation funding is well established in relation to hospital and community health services, no such approach has been developed in relation to allocations between the family health services responsible for funding primary care in different parts of the country. As a result there are substantial variations in expenditure per head between family health service areas. Moreover these variations do not seem to reflect needs-based, hospital and community health service variations.

In the future, the formation of primary care groups can be expected to lead to greater consistency in the funding of primary care as formulae are developed for budgetary allocations. In the short term, however, it is expected that most PCGs will have funds allocated to them by health authorities on the basis of patterns of activity and cost.

Fig. 17 illustrates the flow of funds within the United Kingdom health system as at 1 April 1999. However, as the new system of organization and funding is further implemented, this model will change. For example, it is anticipated that PCGs may develop into primary care trusts in future and directly employ health personnel.

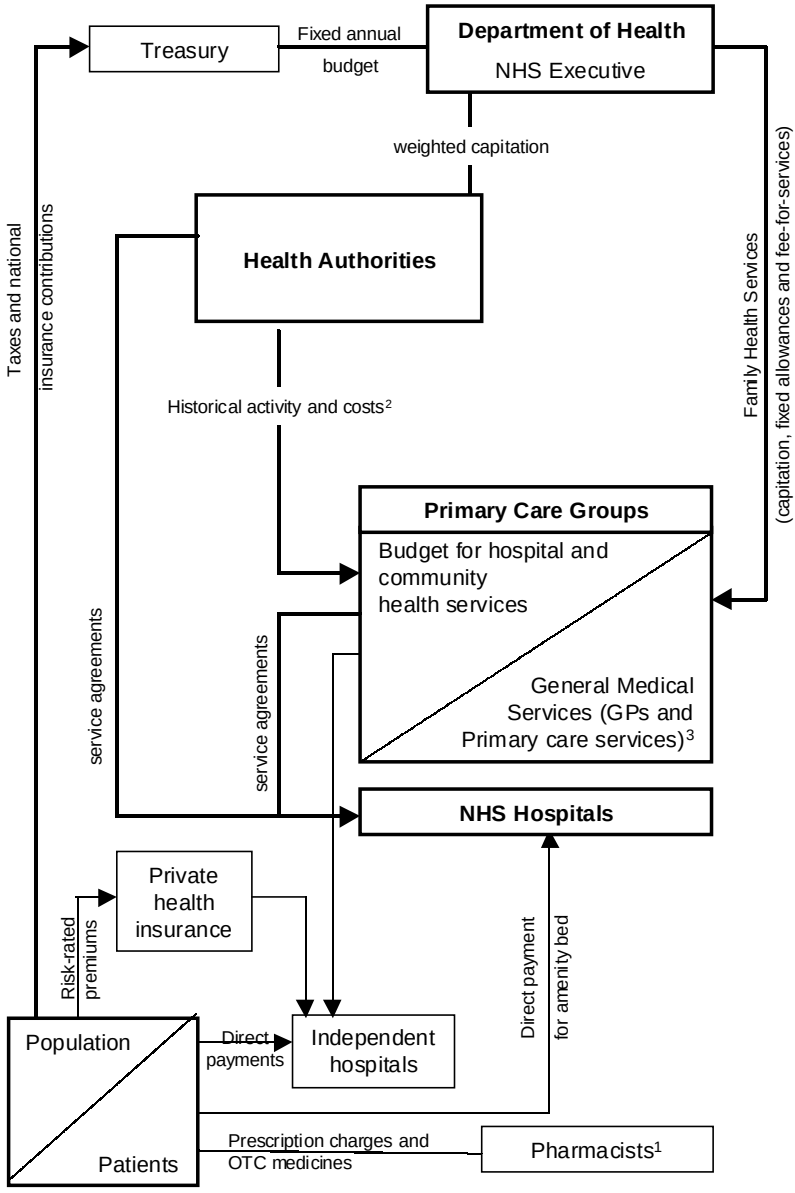
Payment of hospitals

The methods used for paying hospitals are currently under reform. In this section we describe the major move to a contracting system which took place in the 1990s – a move that is currently being revised.

Under the provisions of the 1991 reforms a contracting system was introduced through which funds were transferred from purchasers (i.e. district health authorities and GP fundholders) to hospitals and other providers. Contracts specify what services are to be provided and the terms on which they are to be supplied. Initially, there were three types of contract: namely, block contracts, cost-and-volume contracts and cost-per-case contracts.

Block contracts specified access by DHA residents to a range of services in return for a defined sum of money. Such contracts often included some form of indicative workload agreement. The lack of information for more detailed contracting was seen as justifying block contracts which gave hospitals a guaranteed sum of money in return for a broad service agreement. They were seen primarily as a mechanism for establishing a new system of hospital financing.

Fig. 17. Financing flow chart



[1] Pharmacists are reimbursed by the Prescription Pricing Authority, a special Health Authority of the Department of Health. See section on *Payment of health care professionals*.
[2] It is not yet entirely clear on what basis PCGs will be allocated funds by the health authorities. It is anticipated that it will initially be on the basis of historical activity and costs, however there are plans to develop local allocation formulas.
[3] Most NHS hospitals have some facilities for patients to pay a supplementary charge for superior facilities known as 'amenity beds'.

Cost-and-volume contracts specified that a provider would supply a given number of treatments or cases at an agreed price. They allowed service specifications to be made more specific than was generally the case with block contracts. Greater emphasis was placed upon services defined in terms of 'outputs' (i.e. patients treated) rather than in terms of 'inputs' (i.e. facilities provided). If the number of cases exceeded the cost-and-volume agreement, extra cases were often paid for on a cost-per-case basis.

Cost-per-case contracts were defined at the level of the individual patient. Thus activity and expenditure were linked explicitly. Because they involved a considerable level of transaction costs, health authorities have tended to use cost-per-case contracts as a residual category in order to fund treatments that fall outside their block and cost-and-volume contracts. These have covered referrals of patients to hospitals with whom the health authority does not have a prospective contract, so-called 'extra contractual referrals'. Many services bought by GP fundholders have also been based on cost-per-case contracts.

The initial expectation of this contracting system was that, as it became more refined, there would be a movement from block contracts to cost-and-volume and/or cost-per-case contracts. In practice however, a new form of contract emerged which has been described as a 'sophisticated block' contract. These typically involve a purchaser paying a hospital an agreed contract sum for access to a defined range of services or facilities. However, indicative patient activity targets or thresholds with 'floors' and 'ceilings' will also be included in the contract together with agreed mechanisms for further action if actual activity falls outside the specified range between the floor and the ceiling. This action could include additional work on data validation or further negotiation.

A survey of district health authorities for the year 1994/1995 indicated that 69% of their main contracts with acute hospitals were in the form of sophisticated block contracts, 25% were cost-and-volume and 5% cost-per-case.

The actual sums of money agreed in these contracts have been based on a variety of approaches. Historic evidence on the sums of money necessary to fund a defined level of activity played a large part in the specification of early block contracts. Over time, considerable effort has been devoted to refining hospital costing practices so that contract prices can reflect the costs of particular episodes of treatment more accurately. As part of this effort the NHS Case Mix Office has been developing a series of 'health related groups' – these are a UK equivalent of US diagnosis-related groups (DRGs). At the same time, the development of a market-based system meant that the negotiating skill and power of particular purchasers and providers also played a part in determining the sums of money received by hospitals.

In terms of the analytical categories used to classify hospital payments systems in international studies, the NHS contract system can be described as a mix involving global budgets with elements of cost-per-case payments. In some of the more sophisticated arrangements there have also been payments related to length of stay.

The contracting system introduced in 1991 was part of a wider move on the part of the government of that time to move from a system based on hierarchies to one based on contractual relationships. It represented a major cultural shift for the NHS and meant that considerable amounts of management time have been devoted to the annual tasks of writing, executing and monitoring contracts. The present government believes that management costs associated with the contracting process have not been justified and is in the process of replacing it with a system based on longer-term service agreements. This approach will retain the distinction between commissioners (purchasers) and providers but will aim to reduce transaction costs by using three-year agreements. It is also aimed at shifting the focus from an emphasis on cost and activity levels to one based on the quality of care. The new performance assessment framework, discussed previously, is part of this shift in emphasis.

Payment of health care professionals

Doctors

Separate payments systems apply in the case of general practitioners and hospital doctors.

General practitioners (GPs)

General practitioners contract with the NHS to provide general medical services. The terms of this contract are negotiated nationally between the General Medical Services Committee – the GPs representation within the British Medical Association – and the Department of Health. The actual payment system set out in the national contract is a mix of fixed allowances, capitation fees and fees for a number of specific services.

GPs are independent self-employed contractors to the NHS who provide general medical services (GMS). The arrangement is a statutory one, and the terms of service (TOS) and the fees and allowances payable are determined by Secretary of State following consultations with the profession's representatives – the General Practitioners Committee (GPC) – the GPs representation within the British Medical Association.

The GP remuneration system

GPs are paid by the NHS as independent, self-employed professionals under a "cost plus" principle. The payments they receive cover both their expenses (the "cost") in providing GMS and a net income for doing so (the "plus"). This level of income is reviewed annually by the Doctors' and Dentists' Review Body (DDRB) who then make recommendations for decision by the Government.

GPs do not, therefore, receive a salary but are paid through a system of payments designed to deliver a certain level of gross income for the average GP. The basic elements of the current payment system are:

Capitation fees – annual fees payable for each patient registered on their list amounting to just over half of gross income from fees and allowances. They provide an incentive for GPs to provide high quality services, thereby attracting and retaining patients.

Allowances – are the next largest single element of gross income from fees and allowances for the average GP. They include basic practice allowance, paid in recognition of the basic or standing costs incurred in setting up and maintaining a practice.

Health promotion payments – comprise payments for running health promotion and chronic disease management programmes, and for achieving target levels of coverage for childhood immunizations and cytology screening.

Item of service payments – paid every time a GP provides certain services, contraception services being an example. These payments are, by definition, workload sensitive.

Therefore for individual GPs the amount of income they derive from fees and allowances will depend on the number of registered patients on their list, whether or not they qualify for specific fees and allowances, the number, and level of activities undertaken and the performance achieved.

The introduction of GP fundholding, and subsequent variants such as total purchasing, did not affect the ways in which GPs received their personal incomes. Fundholding budgets were for the purchase of hospital and community services and could not be used to supplement GP incomes. The financial incentives offered by this scheme were in the form of control over budgets to be spent on patient care and not in the form of personal financial incentives.

Personal Medical Services (PMS) pilots

From 1 April 1998, under the provisions of the NHS (Primary Care) Act 1997, a series of pilot sites were established which gave health authorities the power to contract directly with GPs on a local basis for the provision of services. They provide an alternative to the national GP contract, giving primary care professionals the opportunity to test different concepts for delivering GMS.

These changes offer the opportunity for exploring potentially radical changes to the payments system for GPs. They not only permit local specification of contracts, including payments levels, but also allow for the pooling of budgets for purchasing hospital services and for GPs to be employed on a salaried basis.

Primary Care Groups (PCGs) and Primary Care Trusts (PCTs)

As pointed out earlier, all GPs were assigned to primary care groups in April 1999 and some will join primary care trusts in April 2000. Membership of PCGs and PCTs does not however affect the independent contractor status of GPs who remain self-employed.

Hospital doctors

Unlike GPs hospital doctors are directly employed by the NHS on a salaried basis. Their actual salary scales are determined by the government each year taking into account the recommendations of the Review Body on Doctors' and Dentists' Remuneration. In addition to their NHS earnings, full-time NHS consultants (i.e. senior specialists) are permitted to earn up to 10% of their gross income from private practice. Those consultants who opt for maximum part-time contracts are permitted to engage in private practice without restriction on their earnings by giving up payment for one NHS session per week.

There has been extensive debate in the United Kingdom on the possible perverse incentives offered to NHS consultants by the combination of private and NHS earnings. In particular it has been claimed that private earnings might reduce both the time available for and commitment to NHS work. However, despite the frequency of these claims, there is little hard evidence on the subject.

In addition to their basic payments, selected hospital consultants receive merit awards, which are allocated by a peer review process. These merit awards fall into different categories and can represent sizeable additions to basic NHS salaries. The merit award system has come under some criticism recently for being too heavily based on research performance and for being too little concerned with medical performance. As a result the whole system is currently under review.

Doctors are paid fee-for-service for private consultations and activity either directly by the patient who may then be reimbursed by a private insurance company if he/she is a policyholder, or by the private hospital/clinic at which the services are provided.

Private activity of doctors

It has been estimated that there are 17 100 consultants providing private specialist services in the United Kingdom (1992). Full-time doctors in the NHS

are allowed to practice privately. However, they are limited to earning 10% of their gross income from this source. Those NHS doctors on maximum part-time contracts are allowed to practice privately without restriction. In return they have to give up one eleventh of their NHS salary.

There is very little private activity in primary care. Only 3% of GP consultations are estimated to be in the private sector according to self-reporting in the General Household Survey. There are about 200 exclusively private GPs in the United Kingdom mostly concentrated in London practices. The main reasons for the lack of development in this area are that GPs are not allowed under their contract to see patients on their NHS list privately or to issue NHS prescriptions and there are currently few insurance products to cover primary care services. A growth in this area may occur depending on the success of walk-in clinics (see *Private primary care* in the section on *Primary health care and public services*). Other possibilities being experimented with are the siting of general practices on private hospital sites and the provision of company-paid private GP services.

Dentists

On 31 March 1997, there were 19 209 dentists in the NHS General Dental Service. These dentists undertake work for the NHS but may also undertake private work. They are paid for their NHS work on the basis of a gross fee per item of service. This fee is meant to cover their personal income and associated costs. Fee relativities between different services are designed to reflect the time taken and the direct costs involved.

The Doctors' and Dentists' Pay Review Body is responsible for collecting evidence and for making recommendations to the government each year for adjustments to fee schedules. In recent years there have been moves to influence the mix of services offered (e.g. more preventative work, more emphasis on services for children) through adjustments to fee relativities.

Because of dissatisfaction with NHS fee levels many dentists are increasing the amount of private work that they undertake. The British Dental Association claims that on average just over 14% of a dentist's income came from private work in 1994/1995 and that this share is increasing over time at the expense of NHS work.

Community pharmacists

Community pharmacists submit NHS prescriptions to the Pharmaceutical Pricing Authority (PPA), a special health authority established by the Department of

Health. They are paid by way of a flat fee, about 95 pence per item for most prescriptions they dispense. In addition, pharmacies that dispense more than 1600 items a month are eligible for a professional allowance worth around £17 000 a year. Pharmacies dispensing between 1100 and 1600 prescriptions a month receive a proportionately lower professional allowance. Pharmacies that do not get the full (or any) professional allowance qualify for subsidies under the Essential Small Pharmacies Scheme.

Pharmacies are reimbursed the average net acquisition cost of the drugs they dispense.

Price lists are submitted by the manufacturers to the PPA each year and form the basis for reimbursement. Any revenue received directly by the pharmacist for prescription charges is deducted from the amount to be reimbursed. Any drugs that are covered by the drug tariff list, drawn up by the Department of Health, should be dispensed as generics as they will only be reimbursed to the pharmacist at the level stated in the drug tariff list.

Nurses, midwives and professions allied to medicine

A separate review body makes recommendations to the government for annual increases in the salaries of nurses, midwives and professions allied to medicine (including occupational therapists, radiographers, physiotherapists, etc.).

Prior to 1988, the career structure for nurses and health visitors had remained basically unaltered since the creation of the NHS. Whatever its original merits, the system had failed to adapt to the considerable changes within nursing that had taken place over a 40-year period. A particular concern was that it failed to offer a career structure that rewarded clinical skills and responsibilities. As a result many nurses found that the only way for them to progress up the career ladder was to leave direct patient care completely.

To address this problem a new clinical grading structure was introduced in 1988 that was designed to reward nursing skills and responsibilities. This structure comprised nine scales and extended from scale A, covering nursing auxiliaries and support workers, to scale I covering managers of units with overall responsibility for clinical care together with responsibilities for budgetary, staffing and planning matters.

It was hoped that this system would help overcome the perennial problems associated with nursing recruitment and retention. While the principle of offering a clear ladder for career progression has been generally welcomed, problems of recruitment and retention have persisted.

New proposals for modernizing the NHS pay system as a whole are set out in the document *Agenda for Change-Modernising NHS Pay* published by the Government on 15 February 1999.

For nurses, midwives and health visitors a new career structure is proposed to replace the existing clinical grades. It is designed to provide better career progression and fairer rewards for developing new skills, taking on extended roles and team-working. There will be three broad flexible ranges – registered nurses, a higher range of nurse experts and clinical managers and above that nurse consultants and a fourth for nursing auxiliaries and other clinical support workers. There will be a clear minimum pay threshold for each of these set nationally. For PAMs the proposals are expected to support better career development and give a clear basis for valuing these skilled staff fairly. These changes are dependent on reaching agreement with the Trade Unions and professional organizations.

In February 1999 the Secretary of State for Health announced substantial increases in the starting pay for newly-qualified nurses with the aim of attracting more entrants to the professions.

Health care reforms

Aims and objectives

The period 1989–1999 has been one of unprecedented change for the NHS. First there were the radical market-based reforms introduced by the Conservative Government through the *NHS and Community Care Act* in 1991. These led to numerous changes in the period up to 1998. Then, following the election of a Labour Government in 1997, a new policy direction was announced. At the present time these policy changes are in the process of being implemented. In the following account, the determinants and objectives that led to the round of reforms introduced by the previous Conservative Government are discussed. Then discussion moves on to the current reforms being introduced by the Labour Government.

The Conservative Government's reform programme was set out in the White Paper, *Working for Patients*, which was published in January 1989. This proposed a radical reform programme that was subsequently embodied in the *NHS and Community Care Act 1990*. It was this act which led to the introduction of an internal or quasi-market in the NHS. A combination of factors appears to have influenced the timing and direction of this change.

The immediate cause was the funding crisis of the winter of 1987 which prompted the Prime Minister, Margaret Thatcher, to set up a high-profile ministerial review of the NHS, which she herself chaired. The early deliberations of the group were believed to have centred on alternative ways of NHS funding: ways that would avoid the constant funding crises to which the NHS was prone. However it soon became clear that the existing method of central tax-based funding was particularly effective at containing the growth in health expenditure. For this reason the United Kingdom, unlike many other countries was not subject to serious cost escalation. Recognition of this fact made ministers reluctant to interfere with funding mechanisms. As a result attention shifted to the way services were organized, managed and delivered.

Within this new focus, a wider set of considerations became relevant. Throughout the 1980s a constant theme of government microeconomic policy had been a belief in the superior efficiency of the private sector. A central component of this belief was that the competitive environment, within which private sector firms operate, provides the necessary incentive structure for achieving greater efficiency. This had been the stated rationale for previous privatization schemes. As such there was an established commitment to a system of organization that could – with suitable modification – be applied to the NHS. The result was the introduction of an internal market into the NHS, with the claim that competition between providers would increase efficiency, offer wider choice and improve the quality of services.

Thereafter a number of other factors came into play. It soon became clear that the wider, social objectives of health care required the market to be quite closely regulated, so a system of managed or regulated competition developed. This trend was reinforced on the political level as the unpopularity of a strongly market-based approach among the general public and many health care professionals led successive ministers to distance themselves from aggressively pro-market stances. At the same time, the unexpected rate of growth and expansion of GP fundholding led ministers to attach increasing importance to primary care-based models of purchasing and to an eventual emphasis on a 'primary care-led NHS'.

Throughout the 1990s, while in opposition, the Labour Party was sharply critical of the Conservative Government's market-based approach. The alleged inequity of the system, particularly the unequal treatment received by patients of fundholding and non-fundholding GPs and the heavy transaction costs of running a market system, were particular sources of criticism. For these reasons the Labour Party was committed to the abolition of the internal market. These pledges have started to be put into practice since the election of a Labour Government in May 1997,

As mentioned above, the Labour Government's main criticisms of the internal market reforms are that they led to fragmented services, carried heavy transaction costs and were inequitable. There has also been criticism of the overemphasis on costs in the contracting system, and a belief that the quality of health care has been neglected. At the same time, however, there seems to have been an acceptance of the merits of the primary care focus of the previous reform programme and a desire to retain this emphasis in a way that avoids the perceived unfairness and fragmentation caused by GP fundholding.

The Labour Government's own plans for the reform of the NHS were set out in the White paper, *The new NHS: modern, dependable*, published in

December 1997. This set out a ten-year agenda that aims to replace competition and the internal market with a new-style system based on partnership working and collaboration. Since then, there has been a steady stream of NHS executive letters and guidance providing more details about implementation. At the time of writing, the Health Act 1999 is going through parliament containing details of those changes that require legislative approval.

The main elements of the new approach are:

- Maintenance of the separation of responsibilities for commissioning and providing but the replacement of annual contracts with three-year service agreements;
- The abolition of GP fundholding and the formation of area-based primary care groups (PCGs) to which all GPs in an area will belong. 400 to 500 of these groups, formed since April 1999, will cater for average populations of 100 000 patients (see the section on *Organizational structure of the health system*);
- The maintenance of health authorities (HAs) but with the intention that their activities should become increasingly strategic as PCGs assume the responsibility for commissioning services. A major responsibility for health authorities will be to take the lead on the development of health improvement plans (HimPs) in collaboration with other local agencies in their area;
- Maintenance of NHS trusts but with an obligation for them to work collaboratively with DHAs, PCGs and other providers;
- Far greater emphasis on the quality of care and health outcomes with the establishment of new methods of clinical governance. These include the establishment of the National Institute for Clinical Excellence for determining and disseminating information on best clinical practice; the development of national service frameworks setting out recommended patterns of care in specific disease, disability and client areas; and the formation of a Commission for Health Improvement to monitor and improve standards at the local level;
- A far higher priority attached to reductions in inequality and deprivation. The commitment to this objective can be seen in the new approach to public health and the formation of 26 health action zones (HAZs). This latter initiative is focused on areas of particular deprivation and is designed to encourage collaborative working between the NHS, local government, local industry and voluntary organizations in order to improve the health of deprived populations.

Reforms and legislation

This section provides a chronological account of the main policy measures affecting the NHS that have been introduced over the period 1989 to 1999. Each measure is described only briefly as they have all been discussed more fully elsewhere in the report.

1989 Publication of the White Paper, *Working for Patients*, which set out the Conservative Government's plans for radical reforms of the NHS through the development of an internal market.

1990 The introduction of a new national contract for GPs aimed at improving performance and making the profession more accountable. The contract was introduced in the face of fierce opposition from the profession.

1991 The start of the implementation of the NHS internal market reforms following the embodiment of the proposals contained in *Working for Patients* in the *NHS and Community Care Act 1990*.

The *Health of the Nation* Green Paper published setting out a public health strategy based on setting quantified targets and measuring performance against these targets.

A research and development strategy for the NHS was launched with the aim of contributing towards evidence-based practice and policy.

Publication of the Patient's Charter setting out for the first time the rights of patients and the standards of service they could expect from the NHS.

1992 A White paper on the *Health of the Nation* published confirming the approach outlined in the previous year's Green Paper.

An additional 1400 doctors joined the GP fundholding scheme, bringing the total to over 3000 GPs caring for 6.7 million patients or 14% of the population.

1993 The start of the delayed implementation of the community care component of the *NHS and Community Care Act 1990*.

1994 An executive letter was distributed by the NHS Executive, entitled *Developing NHS Purchasing and GP Fundholding*, which set out an agenda for greater emphasis to be placed upon fundholding and extended versions of it (such as total purchasing) as part of the development of a 'primary care-led NHS'.

Guidelines on regulation of the internal market were issued by the NHS Executive entitled *The operation of the internal market: local freedoms, national responsibilities*.

1995 The *Health Authorities Act* led to closer integration of primary and secondary care through the creation of approximately 100 merged district health authorities and family health service authorities.

1996 Regional health authorities were replaced by regional offices of the NHS Executive.

A report *Primary care: the future*, published by the NHS Executive, setting out the results of an extensive consultation exercise on the future of primary care in the NHS. Following this publication, a White Paper *Choice and opportunity: primary care, the future*, was published setting out new models of primary care that the government intended to pilot, including practice-based contracts and salaried GPs.

1997 The *NHS (Primary Care) Act* was passed giving the go-ahead for the introduction of pilot schemes covering GP personal medical services.

A new Labour Government was elected committed to the abolition of the internal market.

The Labour Government sets out its plans for a reformed NHS in a White Paper *The new NHS: modern, dependable***.** This describes an approach in which markets and competition will be replaced by collaboration and joint working.

1998 A consultation paper *Our Healthier Nation* was published, setting out the government's intended approach to public health. It placed considerable emphasis on improving the health of the worse-off in society and to reducing health inequalities.

A document *A First Class Service: Quality in the new NHS* was published setting out the government's plans for improving quality and clinical governance. This involved the establishment of the National Institute for Clinical Excellence and the Commission for Health Improvement.

A White Paper *Designed to Care – Renewing the National Health Service in Scotland* was published setting out the reforms of the organization of the NHS in Scotland which will take place under the Scottish Parliament. This involved the establishment of primary care trusts under which mental health services, local health care cooperatives and community hospitals would operate.

A White Paper *NHS in Wales: Putting Patients First* was published in January setting out the arrangements for the organization of the NHS in Wales under the responsibility of the Welsh Assembly. This involved the establishment of local health groups (equivalent to PCGs in England).

1999 Primary care groups went "live" on 1 April 1999.

Report of the Royal Commission on Long Term Care for the Elderly, *With Respect to Old Age: Long Term Care – Rights and Responsibilities*, was published.

The White Paper, *Saving Lives: Our Healthier Nation*, setting out the government's strategy on public health, was published.

A document *Fit for the Future – A New Approach* was published in March 1999 which set out the Government's proposals for the future of the health and personal social services in Northern Ireland.

Reform implementation

As the preceding account has demonstrated reform of the NHS in the United Kingdom during the 1990s has involved some radical changes of direction.

The 1991 reforms

The reforms introduced by the Conservative Government in 1991 were part of a wider policy aimed at introducing a greater element of market discipline into the public sector where it was felt that such discipline had been lacking. The result of which, it was claimed, was inefficient bureaucracy and services that were not sufficiently responsive to user needs.

The introduction of market-based approaches to the public sector was controversial and attracted a good deal of opposition. This was especially true of the NHS. From the outset, health care professionals (i.e. doctors, nurses and other professions allied to medicine) and the general public were generally seen as opposed to the direction of change. Most support came from NHS managers who experienced an increase in power *vis-à-vis* doctors.

Despite this opposition, however, the government pressed ahead with its plans. The late 1980s and early 1990s was a period when strongly held conviction-led policies were pursued at the expense of a more consensual approach. Certainly this resulted in the implementation of major change, albeit sometimes at the cost of morale in different parts of the service.

Over time however, possibly as a result of the continuing electoral unpopularity of some of the more radical changes, the government softened its stance. The emphasis on competition and the internal market was reduced as a system of regulated or managed competition was developed. The term 'purchasing'

was increasingly replaced by the term 'commissioning' as attempts were made to move away from models based on spot purchasing to those on a more strategic, planned approach.

GP fundholding

The implementation process of GP fundholding is of particular interest. When fundholding was first introduced, it was an experimental scheme restricted to 303 practices. Even among the architects of the reforms it was widely seen as a 'sideshow' and not part of the main agenda. At the outset the scheme was strongly opposed by the British Medical Association. Over the ensuing seven years, however, the scheme expanded dramatically in scale and scope. By 1998 there were over 3500 fundholding practices covering 15 000 GPs. The BMA had long since withdrawn its opposition as increasing numbers of its members joined the scheme.

A number of factors can be identified as contributing to the unexpected growth of fundholding. Firstly the experience of the early fundholders showed that they were able to improve the services received by their patients. Holding budgets gave them small but effective levers for improving services at the primary–secondary care interface. Others noted these advantages and sought to share them by joining the scheme. At the same time there is no doubt that the government's growing support for fundholding led them to offer a range of inducements (e.g. support for computer systems) that were not available to non-fundholders. Some GPs, although not attracted to fundholding *per se*, felt that by not becoming fundholders they would be seen as laggards and behind the times; such a perception, it was feared, could lead to the loss of patients. As a result they became reluctant fundholders. Taken together these factors contributed to the accelerated growth of fundholding.

Not all GPs, however, joined the bandwagon. Many continued to harbour deep-seated ideological objections to fundholding on the grounds that it was inequitable and led to the rationing of services. These GPs sometimes formed non-fundholding commissioning groups. These have been important in the thinking leading to proposals for primary care groups.

Policy evaluation

Another area where there was a marked change of stance in the government's position was the evaluation of policy changes. In 1991 the government set itself firmly against evaluation of the reforms. It denied the need for an official programme of monitoring and evaluation and expressed the view that calling

on outside academics or others to perform this role would be a sign of weakness. The consequence of this stance was that there was little firm evidence on the successes and failures of the largest reform to be undertaken in the history of the NHS.

Gradually, however, this governmental stance shifted as it became apparent that it lacked good evidence of performance of the NHS. This hampered its political agenda as well as the scope for finessing policy on the basis of evidence. It was also totally inconsistent with the launch of the NHS R&D programme that was postulated on the need to base action on evidence. As a consequence of these various pressures, programmes of official evaluation started to be funded. This process has developed so far that it is now virtually impossible for a new policy initiative to be announced without an accompanying commitment being made to its evaluation. (In passing, it should be noted that this pro-evaluation stance is posing its own problems. Ministers and civil servants frequently look for definitive answers from research in complex areas of social change that cannot be provided.)

The most up-to-date review of the evidence relating to the performance of the internal market reforms is contained in the King's Fund publication *Learning from the NHS Internal Market: a Review of the Evidence* (*15*). Material drawn from this source is presented in the conclusions of this report.

Current reforms

The change of government in 1997 led to a change of direction in health policy in the United Kingdom. A system based upon competition within the internal market is in the process of being replaced by one based upon partnership and collaboration. Although certain key elements of the 1991 reforms are being retained, e.g. the separation of responsibility for commissioning health services from the responsibility for providing them, the present government's expectation is that health authorities, trusts and other agencies will operate in partnership to bring about improvements in health services. The production of a health improvement programme by each health authority – in collaboration with other local agencies – is one vehicle for achieving this objective.

Another feature of the new government's approach has been to place greater emphasis on the quality of care and health outcomes. To this end it has established a National Institute for Clinical Excellence (NICE), charged with the task of assembling evidence on best clinical practice and disseminating it throughout the NHS, and a Commission for Health Improvement (CHImP) to ensure that performance at the local level meets expectations. A number of

commentators have pointed out that these agencies represent something of a return to a command and control approach following the devolution of the internal market period.

Yet another important feature of the present government's approach is the importance it attaches to addressing social deprivation and to bringing about a reduction in health inequalities. One aspect of this policy has been the designation of 26 health action zones (HAZs). These are specifically designated areas of deprivation that are receiving central government funding – and certain new freedoms and flexibility – in order to bring about health improvements in their areas. Each HAZ is expected to pursue a seven-year programme, in the first instance. Partnership working between health authorities, trusts, primary care groups, local authorities, the voluntary sector and private industry is a key feature of the HAZ approach. It is far too early to comment on the success of the HAZ experiments (the first eleven HAZs were set up only in April 1998, with another fifteen following later in the year) although the programme is the subject of a Department of Health-funded independent national evaluation.

A final feature of the new government's approach worthy of mention is the abolition of GP fundholding and its replacement with primary care groups (PCGs). While in opposition the government was opposed to GP fundholding on the grounds that it created inequitable services between the patients of fundholding GPs and those of non-fundholding GPs, and that it imposed heavy transaction costs through the proliferation of small-scale contracts. As a result, it has sought to retain the primary care-based focus of provision and commissioning on a comprehensive basis by creating 481 PCGs. These were set up on 1 April 1999 and in contrast to fundholding, which was optional, all GPs have been required to join a PCG. Each PCG is managed by a board with GP, other primary care and health authority representation. They cover populations ranging from 46 000 to 257 000 patients. The government recognizes that individual PCGs are presently at different stages in their readiness to assume new functions and has therefore designated four stages for PCG development. These range from level one (where the PCG acts as an advisory committee to the health authority) to level four (where it becomes a free-standing body accountable to the health authority for commissioning care and with the added responsibility for the provision of community health services).

Conclusions

The UK National Health Service was established over 50 years ago. At the time it was designed to provide comprehensive and universal access to health care on the basis of need rather than ability to pay. For this reason the overwhelming majority of services were provided free at the point of use. It was also decided to fund health care from general taxation rather than adopt the social insurance system used by a number of other European countries. These features remain an important part of the present NHS. Despite, the growth of user charges in some areas (e.g. pharmaceuticals, dental and ophthalmic services, long-term care for elderly people), most primary and secondary health care is still provided free at the point of use. Successive public opinion polls indicate that this system continues to command widespread public support and results show a strong attachment to the NHS as a national institution. Furthermore, despite frequent funding 'crises' resulting from tight finance limits set by successive governments, there has been no serious attempt to move away from a system of general tax-based funding.

However despite this continuity, there have been many management and organizational changes affecting the way in which services are delivered. The most radical of these was introduced in 1991 when the Conservative Government of the day, under the leadership of Margaret Thatcher, introduced an internal market. These changes have been described earlier in this report. However, it is worth reiterating that they represented a fundamental attempt to change the culture of the NHS by introducing private sector and market-style mechanisms into a large, public sector bureaucracy. (The earlier Griffiths' general management reforms of 1984 started this process but the reforms of 1991 represented a more widespread and radical programme).

Evidence on the performance of the internal market, in terms of the criteria of efficiency, equity, choice and responsiveness, and accountability, has recently been reviewed by Le Grand *et al* (1998) (*15*). They suggest that much of the evidence is inconclusive.

On efficiency it is possible to point to increases in the Department of Health's cost-weighted index of activity over the early period of the reforms. This increase is more likely to have arisen through increases in funding than as a consequence of the reforms themselves. And yet there were substantial increases in management and transaction costs, although attributing these to the reforms themselves is problematic.

The main research finding on equity relates to the two-tier system associated with GP fundholding (GPFH). This feature in particular was heavily criticized by the present Labour Government when they were in opposition.

There is little research evidence to suggest that trust status improved the quality of care or that patient choice increased. However GP fundholders did succeed in bringing about a number of improvements in the quality of services, albeit on a small scale. They seemed to be more successful than health authority purchasers in obtaining responsiveness from providers.

Regarding accountability, the reforms were associated with a quite marked increase in central control and upward accountability. These imposed substantial management costs in addition to costs associated with the functioning of the internal market.

Overall, Le Grand *et al* (*15*) conclude that it is perhaps remarkable that such a radical programme of reform should produce so few marked changes on the key criteria of performance. One possible explanation they put forward is that the internal market was not really put to the test; that is, its functioning was hampered because the incentives were too weak and the constraints too strong.

On the other hand, the 1991 reforms did bring about some marked changes in culture and organization. The involvement of GPs in decision-making and an emphasis on devolved purchasing or commissioning is one such change. The general belief in the desirability of the purchaser–provider split is another one. Emphasis on the need for services to be both clinically effective and cost-effective – within an environment of accountability – was also strengthened through the 1991 reforms.

Indeed it is these elements that have been retained in the reform programme currently being implemented by the Labour Government elected in 1997. Despite their opposition to the internal market whilst in opposition, separation of commissioning and providing roles, emphasis on primary care-based devolved decision-making, and a continued quest for improvements in clinical and cost effectiveness all remain important features of their approach. However, in contrast to the previous Conservative Government, they attach more importance to collaborative working and partnership as mechanisms for achieving

their objectives, rather than competition. Greater emphasis on the elimination of health inequalities and on health outcomes are also key features of the present government's approach.

An ambitious new agenda for developing the NHS in collaboration with other agencies has been set out. It remains to be seen how successful these partnerships will be in achieving the fundamental objectives of greater efficiency, more equity, better quality, stronger responsiveness and clearer accountability.

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Appendix I

The section on *Organizational structure and management* sets out the structure and organization of the NHS in England. Some of the main differences between this system and those applying in Scotland, Wales and Northern Ireland are set out below. A number of these arrangements are in the process of changing following the establishment of the Scottish Parliament and the Welsh Assembly.

Scotland

The Department of Health of the Scottish Office is responsible for health policy and the administration of the NHS in Scotland. The government's Chief Medical Officer for Scotland heads the Public Health Policy Unit and is the Secretary of State's chief medical adviser. The Chief Executive (CE) of the NHS in Scotland leads the central management of the service and is accountable to ministers for the efficiency and performance of the service. The CE heads the Management Executive which oversees the work of the 15 area health boards (i.e. the counterparts of English health authorities). As in England, the health boards are responsible for the planning and commissioning of health services for their resident populations and the trusts are responsible for the provision of services.

The NHS in Scotland employs approximately 132 000 staff, including 63 000 nurses, midwives and health visitors and 8500 doctors. In addition, there are more than 7000 family practitioners, including doctors, dentists, opticians and community pharmacists.

The White Paper *Designed to Care –Renewing the National Health Service in Scotland* sets out the government's reform proposals for the NHS in Scotland. While there are broad similarities of emphasis with those adopted in England, there is no provision for the creation of levels one to three of primary care groups. Instead provision was made for the creation of primary care trusts. The

implementation of the White Paper *Designed to Care* has resulted in a number of trust mergers and the establishment of primary care trusts. There are now 28 new NHS trusts of which 13 are primary care trusts.

The recently elected Scottish Parliament will also have major new responsibilities for health. The White Paper describes these in the following terms:

> *It will be for the Scottish Parliament to decide the details of its relationship with health bodies, including funding arrangements. Devolution provides an opportunity to build on the strengths of the NHS in Scotland, as well as on the Scottish tradition of community responsibility for those needing care.*

At present it is too soon to comment on exactly how these new arrangements will work.

Wales

The Director of the Welsh Office Health Department is accountable to the Secretary of State for the management and performance of the NHS in Wales. The Director, under the Permanent Secretary, is the Secretary of State's principal policy adviser on the NHS.

The Welsh Office Health Department comprises five divisions: namely, Health Financial Management, Health Services and Management, Health Strategy, Primary and Community Health and the Public Health Division.

In Wales, there are no counterparts to the English regional offices of the NHS Executive. The five Welsh health authorities are directly accountable to the Director of the Health Department.

The White Paper *NHS in Wales: Putting Patients First*, published in January 1998, sets out the government's plans for reform. As in Scotland, there are broad similarities with the English plans although a major difference is that local health groups based on local authority areas – instead of primary care groups – will assume responsibility for commissioning services. These groups will, however, also have a strong primary care representation and it is expected that eventually indicative budgets will be extended to individual GP practices.

Since 1999, the newly-elected Welsh Assembly holds responsibility for health functions previously exercised by the Secretary of State. The Assembly has powers to:

- draw up strategic policies for health and health services and to allocate resources;

- configure the NHS in Wales in a way that is consistent with its broader objectives;
- hold NHS organizations to account for their performance;
- promote the provision of particular services in Wales.

Northern Ireland

Northern Ireland has a joint Department of Health and Social Services which covers the range of business covered by the Department of Health and the Department of Social Security in England. The Department is headed by the Permanent Secretary and comprises a number of core groups. These are the Resources and Social Security Group, Health and Social Policy Group, Health and Social Services Executive, and five professional groups.

There are four health and social services boards (HSSBs) that are directly accountable to the Department of Health and Social Services. As the names of these boards imply, a major difference between them and the rest of the United Kingdom is that they are responsible for both health *and* social services. It is widely believed that this makes the coordination between health and social care services less problematic in Northern Ireland than in the rest of the United Kingdom.

A document published in March 1999, *Fit for the Future – A New Approach* sets out the Government's proposals for the future of the health and personal social services in Northern Ireland.

Resource distribution

The NHS in England accounts for about 80% of total UK expenditure although spending per head of population is lower in England than in the other three countries. In 1995–1996, Scotland received 25% more funding per capita than England, and Wales and Northern Ireland received 18% and 5% more respectively. Differences in need do not seem to account for these differences, nor do they seem to be associated with better health outcomes in the higher spending countries.

Abbreviations

BMA	British Medical Association
CHImP	Commission for Health Improvement
CMO	Chief Medical Officer
DGH	District General Hospital
DHA	District Health Authority
DoH	Department of Health
GP	General practitioner
GPFH	General practice fundholding
HA	Health Authority
HAZ	Health Action Zone
HImP	Health Improvement Programme
HPSS	Health and Personal Social Services
LA	Local Authority
NHSE	National Health Services Executive
NICE	National Institute for Clinical Excellence
PCG	Primary Care Group
PCT	Primary Care Trust
PPRS	Pharmaceutical Price Regulation Scheme
RHA	Regional Health Authority
TPP	Total Purchasing Pilot
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting