

Déposé le 25 mars 2015

No. : CSSS-027

Secrétaire [Signature]

Health Systems in Transition

Vol. 13 No. 1 2011

United Kingdom (England)

Health system review

Seán Boyle

Anna Maresso (Editor) and Elias Mossialos (Editor in chief) were responsible for this HiT profile

Editorial Board

Editor in chief

Elias Mossialos, London School of Economics and Political Science, United Kingdom

Series editors

Reinhard Busse, Berlin University of Technology, Germany

Josep Figueras, European Observatory on Health Systems and Policies

Martin McKee, London School of Hygiene & Tropical Medicine, United Kingdom

Richard Saltman, Emory University, United States

Editorial team

Sara Allin, University of Toronto, Canada

Matthew Gaskins, Berlin University of Technology, Germany

Cristina Hernández-Quevedo, European Observatory on Health Systems and Policies

Anna Maresso, European Observatory on Health Systems and Policies

David McDaid, European Observatory on Health Systems and Policies

Sherry Merkur, European Observatory on Health Systems and Policies

Philipa Mladovsky, European Observatory on Health Systems and Policies

Bernd Rechel, European Observatory on Health Systems and Policies

Erica Richardson, European Observatory on Health Systems and Policies

Sarah Thomson, European Observatory on Health Systems and Policies

Ewout van Ginneken, Berlin University of Technology, Germany

International advisory board

Tit Albreht, Institute of Public Health, Slovenia

Carlos Alvarez-Dardet Díaz, University of Alicante, Spain

Rifat Atun, Global Fund, Switzerland

Johan Calltorp, Nordic School of Public Health, Sweden

Armin Fidler, The World Bank

Colleen Flood, University of Toronto, Canada

Péter Gaál, Semmelweis University, Hungary

Unto Häkkinen, Centre for Health Economics at Stakes, Finland

William Hsiao, Harvard University, United States

Alan Krasnik, University of Copenhagen, Denmark

Joseph Kutzin, World Health Organization Regional Office for Europe

Soonman Kwon, Seoul National University, Republic of Korea

John Lavis, McMaster University, Canada

Vivien Lin, La Trobe University, Australia

Greg Marchildon, University of Regina, Canada

Alan Maynard, University of York, United Kingdom

Nata Menabde, World Health Organization Regional Office for Europe

Ellen Nolte, Rand Corporation, United Kingdom

Charles Normand, University of Dublin, Ireland

Robin Osborn, The Commonwealth Fund, United States

Dominique Polton, National Health Insurance Fund for Salaried Staff (CNAMTS), France

Sophia Schlette, Health Policy Monitor, Germany

Igor Sheiman, Higher School of Economics, Russian Federation

Peter C. Smith, Imperial College, United Kingdom

Wynand P.M.M. van de Ven, Erasmus University, The Netherlands

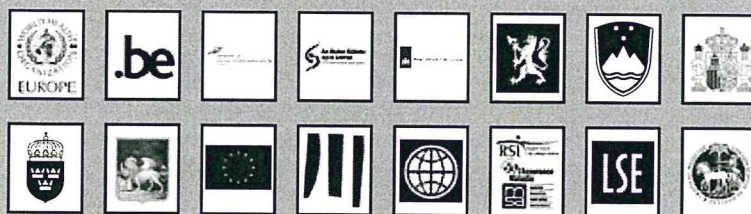
Witold Zatonski, Marie Skłodowska-Curie Memorial Cancer Centre, Poland

Health Systems in Transition

Seán Boyle, *LSE Health and Social Care, London School
of Economics and Political Science*

United Kingdom (England):

Health System Review
2011



The European Observatory on Health Systems and Policies is a partnership between the World Health Organization Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

Contents

Preface	vii
Acknowledgements	ix
List of abbreviations	xi
List of tables and figures	xv
Abstract	xix
Executive summary	xxi
1. Introduction	1
1.1 Geography and sociodemography	1
1.2 Economic context	4
1.3 Political context	6
1.4 Health status	8
2. Organizational structure	21
2.1 Overview of the health care system	21
2.2 Historical background	25
2.3 Organizational overview	28
2.4 Decentralization and centralization	42
2.5 Patient empowerment	44
3. Financing	69
3.1 Expenditure on health care	71
3.2 Population coverage and the basis for entitlement	78
3.3 Sources of funds	83
3.4 Pooling and allocation of funds	103
3.5 Purchasing and purchaser-provider relations	109
3.6 Payment mechanisms	114

4. Regulation and planning	131
4.1 Regulation	131
4.2 Planning, health information management and health-related research	148
5. Physical and human resources	167
5.1 Physical resources	167
5.2 Human resources	194
6. Provision of services	209
6.1 Public health	209
6.2 Patient pathways	224
6.3 Primary care	224
6.4 Secondary and tertiary care	234
6.5 Emergency care	247
6.6 Pharmaceutical care	260
6.7 Intermediate care and rehabilitation	271
6.8 Long-term care	276
6.9 Services for informal or unpaid carers	289
6.10 Palliative care	297
6.11 Mental health	305
6.12 Dental care	327
6.13 Complementary and alternative medicine	337
7. Principal health care reforms	345
7.1 National policy framework	347
7.2 Reform of services	368
7.3 Conclusions	373
8. Assessment of the health system	377
8.1 Government objectives	377
8.2 Access	379
8.3 Equity	384
8.4 Allocative efficiency	388
8.5 Technical efficiency	395
8.6 Quality of care	402
8.7 The contribution of the health system to health improvement	408
8.8 Conclusions	416

9. Conclusions	419
9.1 The present English health care system	419
9.2 What does the future hold?	420
9.3 Envoi	422
10. Appendices	423
10.1 References	423
10.2 Useful web sites	475
10.3 Principal legislation	477
10.4 HiT methodology and production process	480
10.5 The review process	482
10.6 About the author	483

Preface

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

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

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

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

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

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

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

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

8.2 Access

8.2.1 Policy on access

Nearly all health services in England are free at the point of delivery and have been so since the foundation of the NHS. The main exceptions are prescription drugs and some optical and dental services; however, the impact of charges for these has been mitigated by various forms of exemption and controls over their level (see section 3.3.3). Nevertheless, some people, particularly those just above the exemption limit, are deterred from consulting a GP, from taking up a prescription if they do or from using it in line with the recommended frequency or dosage (House of Commons Select Committee on Health 2006a). The government acknowledged this and went on to change the rules governing the low income exemption and also to extend the exemption from charges to cancer patients, covering drugs administered in community settings. However, it never responded systematically to the core criticism made in a report from the House of Commons Select Committee on Health (2006a) that there was no underlying logic to the current system of exemptions.

Nevertheless, in 1997, the main obstacle to easy access was not charges but delay. By 1998, waiting lists for hospital treatment were at a record level and long waiting times were still common, although the longest waits – over two years – had been eliminated by measures taken by the previous government. Delays were also common when patients wanted to see a GP or went to an A&E department. The new government had pledged to reduce waiting lists in its manifesto but it went on, in the *NHS Plan* and subsequent policy statements, to set new targets for waiting times covering hospital inpatient treatment, A&E departments and GP consultations. A number of policies were introduced to ensure they were met: the effectiveness of these measures is assessed in the second part of this section.

Even where services are free at the point of delivery, users may nevertheless incur costs, principally those related to transport, to gain access to them. Reducing these costs was never a government priority, but section 8.2.3 briefly sets out developments in this area.

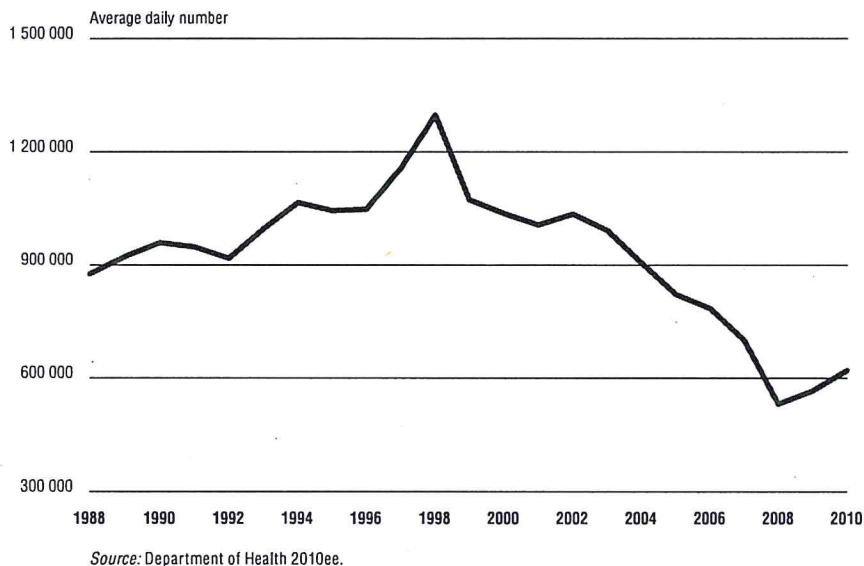
8.2.2 Reducing waiting times

The new Labour Government had made an election pledge to reduce the numbers waiting for hospital treatment by 100 000. This reduction was achieved by March 2000 and further reductions followed. By 2008, the number waiting

was as low as it had been in the 1970s when there was considerably less activity. However, there has been an increase since 2008 so that it now stands at over 620 000 (Fig. 8.1).

Fig. 8.1

Total inpatient waiting list, March 1988 to March 2010

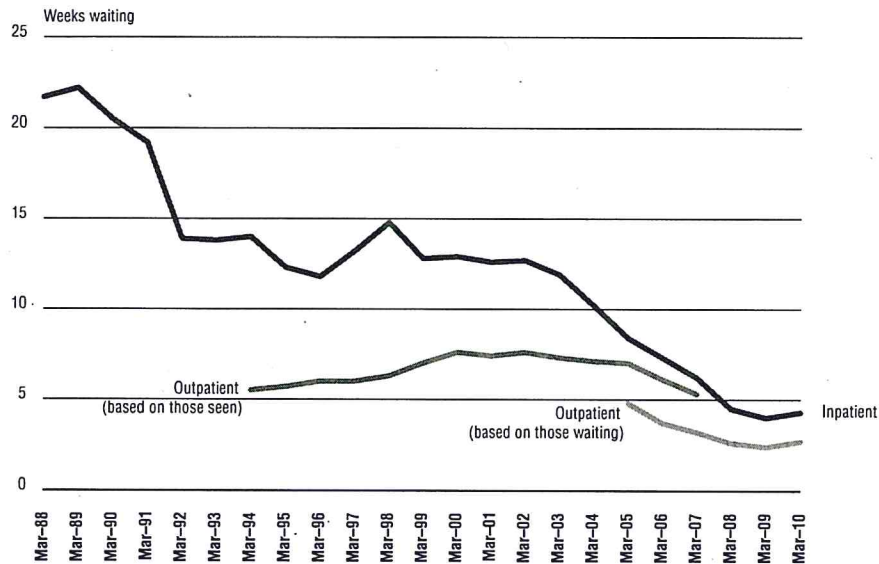


The government went on in the *NHS Plan* to set targets for initial consultation and treatment, involving a halving of the maximum waiting time for outpatient appointments from over 6 months to 3 months and a reduction from 18 to 6 months for the maximum waiting times for treatment. As Fig. 8.2 shows, the median wait for inpatient treatment has fallen considerably since March 2002, from 12.7 weeks to 4.3 weeks in March 2010; outpatient waits have also fallen over the same period.

However, these targets were superseded when, in 2004, the government announced its intention to introduce an 18-week referral-to-treatment target for all conditions treated by a consultant, to be achieved by the end of 2008. This was an “end-to-end” target covering all stages of the care pathway: similar targets had already been set for cancer in the *NHS Cancer Plan*: an “end-to-end” target of 62 days and a 31-day target from diagnosis to treatment (Department of Health 2000h). The 18-week target covered all delays, including those waiting for diagnosis.

Fig. 8.2

Median waiting times for inpatients and outpatients, 1988–2010



Sources: Department of Health 2010e; House of Commons Select Committee on Health 2010a.

Notes: Between March 1994 and March 2007, outpatients waits were recorded based on the waits of people actually seen in that quarter (in March 2007, collection of data in this form was dropped); between March 2005 and March 2010 outpatient waits were collected based on how long people on the waiting list had been waiting at the end of the quarter.

As Fig. 6.6 (Chapter 6) shows, performance for England as a whole improved significantly against this target so that 97.8% of non-admitted patients (i.e. those found after consultation and/or investigation not to need treatment) were dealt with within 18 weeks by February 2010, as were 92% of admitted patients. By December 2009, the median wait for admitted patients was 7.7 weeks; the median wait for non-admitted patients was 4.2 weeks (Department of Health 2010u).

Waiting in A&E departments

The *NHS Plan* set a four-hour maximum wait target for all patients seeking care in A&E departments. This was subsequently modified to allow a small proportion of patients (e.g. those where diagnosis was difficult), to remain longer before being treated. As a result, acute hospital A&E departments were expected to process 98% of patients attending A&E within four hours. Since 2005–2006, over 97% has been achieved although the target of 98% has continued to prove elusive. In 2008–2009, average compliance for England as a whole was 97.2% with little variation between regions; in only one region was 98% achieved while the worst region still managed to achieve 96.6% (see Fig. 6.11, Chapter 6).

Waiting in general practice

The *NHS Plan* stated that patients would be able to see a primary care professional within 24 hours and a GP within 48 hours. This target has not yet been fully met. The GP Patient Survey 2008–2009 found that 89% of patients were able to see a GP within 48 hours and 81% could book an appointment more than two days ahead. Around 83% of patients said they were satisfied with GP opening hours (Boyle, Appleby & Harrison 2010).

It is not possible to provide a full account of how these reductions were achieved but it is clear that as far as waiting for hospital treatment was concerned, the increase in NHS budgets allowed a substantial increase in the number of operations and diagnostic tests carried out (Harrison & Appleby 2009). Between 1998–1999 and 2008–2009, the total number of elective procedures carried out in hospitals rose from 5.4 million to 7 million, with growth in some specific procedures much greater: cataracts 73%, hip replacement 47% and percutaneous transluminal coronary angioplasty 227% (Information Centre 2010t). From 1998–1999 to 2009–2010, the number of MRI scans quadrupled from just over 0.5 million to almost 2 million and CT scans almost trebled from 1.25 million to 3.72 million (Department of Health 2010ff).

Active performance management by the Department of Health and its regional arms combined with the targets – a regime that came to be known as “targets and terror” (Propper et al. 2007) – was also important. It ensured that every senior NHS manager or clinician was aware that the targets had to be met. In addition, extensive programmes of technical support, initially from the Modernisation Agency and subsequently the NHS Institute for Innovation and Improvement, assisted hospitals to increase their capacity to treat patients and to redesign their care pathways so as to reduce unnecessary delays.

The targets for GP access were also supported by an increase in resources. The number of GPs, particularly in areas that had insufficient doctors, was increased substantially: in Chapter 6, Fig. 6.1 shows the increase in the number of GPs and Fig. 6.2 shows the reduction in list size. By 2009, 50 new GP-led health centres were open and there were 65 new practices in areas that previously did not have enough doctors. In addition, financial incentives were offered to GPs to open for longer hours. By July 2009, more than 77% of practices had agreed to open longer at evenings or weekends, compared with 38% in the year before (Department of Health 2008dd, 2009z).

Ease of access was also promoted through a programme of walk-in centres in main streets or at transport hubs for those, particularly those in work, who might find conventional opening hours inconvenient. There are now over 90 of

these. The government also increased the number of places at which people could access some primary care services by extending the role of community pharmacists. The number of medicines available over the counter or under the control of a pharmacist was increased – most notably this included simvastatin – and the new pharmacy contract introduced in 2005 opened the way for local purchasers to commission additional services, such as smoking cessation advice or treatment of minor ailments from community pharmacists over and above the pharmacists' dispensing role (Department of Health 2005d). The government also made it easier for new entrants to enter the market, particularly if they were prepared to open more than 100 hours a week or were located in out-of-town shopping centres. There are now 450 100-hour pharmacies and 46 pharmacies in out-of-town shopping centres (Information Centre 2009f).

NHS Direct was established in 1998 to enable patients to access telephone advice at any time of day. The usage of this service is high, with over 5 million calls per year and some 42 million Internet contacts, particularly among the more affluent (NHS Direct 2010). This is discussed further in section 2.5.2. The initial hope was that availability of telephone advice would reduce the load on GP services; however, it appears to have generated new demand. Most callers are referred on to other parts of the NHS, and while a majority of these do require active treatment, about one quarter do not (Byrne et al. 2007).

8.2.3 Other obstacles

Transport costs

In principle, the NHS offers free transport services to hospital facilities for patients with severe medical problems, and some financial support is available for those able to travel but with low incomes. However, many patients were not aware of the support available (National Association of Citizens Advice Bureaux 2001) and the application process for repayment of travel costs was cumbersome. Subsequently, the government issued a revised scheme in 2008 and extended it to include patients travelling as a result of a GP or dentist referral. The House of Commons Select Committee on Health also found that parking charges at hospitals presented a problem for users requiring frequent visits for treatment (House of Commons Select Committee on Health 2006a). The government announced in December 2009 that it intended to tackle this issue but no proposals were made before the general election in May 2010.

Physical access

As noted in Chapter 7, the White Paper, *Our Health, Our Care, Our Say* (Department of Health 2006c), proposed a number of initiatives designed to promote the transfer of some services from hospital sites to other settings such as GP premises or new specially built health centres, and the expansion of the numbers of GPs and pharmacists with special interests capable of providing specialist advice. In 2008, a commitment was made that a new health centre (or polyclinic) should be established in each PCT area to provide a base for the transfer of hospital services.

Despite these measures a report by the Audit Commission (2009) found no evidence to show that PCTs had been successful in moving care out of hospitals and, as Fig. 6.9 and Fig. 6.5 (Chapter 6) show, use of hospitals continued to rise: between 1996–1997 and 2008–2009 by almost 40% in the case of emergency admissions; and between 1998–1999 and 2008–2009 by almost 30% for elective admissions. Calls to ambulances and A&E attendances have also increased over a similar period (see sections 6.4 and 6.5).

8.2.4 Summary of access issues

Waiting times for most NHS hospital and primary care services have been substantially reduced since the late 1990s. However, for some services based outside hospital, such as physiotherapy, waiting times can be very long as these were not included in the 18-week target. Some people are still not able to see their GP quickly and conveniently and some users are still deterred from using services by cost or other obstacles, although the proportion of the population affected is small and lower than in other comparable countries (Schoen et al. 2009).

8.3 Equity

Equity in health systems can be measured in a number of ways: equity in how the resources used in the health sector are raised; and geographical equity, and equity for different societal classifications (e.g. by social class, ethnicity, age and gender), in terms of both equal access to health care for individuals at equal risk and equal health outcomes. Equity in the sense of equal access to care for individuals at equal risk has been a consistent aim of government policy, as is discussed below; less clear is the extent to which it has been achieved.