UNIVERSAL HEALTH COVERAGE STUDY SERIES NO. 40

Advancing Universal Health Coverage: What Developing Countries Can Learn from the English Experience?

Please cite this paper as:
Smith, P. 2018. "Advancing Universal Health Coverage: What Developing Countries Can Learn from the English Experience?". Universal Health Coverage Series No. 40, World Bank Group, Washington, DC.

WORLD BANK GROUP

Peter C. Smith

UNIVERSAL HEALTH COVERAGE STUDY SERIES No. 40

Advancing Universal Health Coverage: What Developing Countries Can Learn from the English Experience?

Peter C. Smith

The World Bank, Washington, DC, 2018

ABBREVIATIONS AND ACRONYMS

CCGs	Clinical Commissioning Groups
DRG	Diagnosis-Related Group
EU	European Union
GDP	Gross Domestic Product
GP	General Practitioner
HBP	Health Benefits Package
LMICs	Lower-Middle-Income Countries
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OECD	Organization for Economic Co-operation and Development
PPRS	Pharmaceutical Price Regulation Scheme
RAWP	Resource Allocation Working Party
UHC	Universal Health Care
VHI	Voluntary Health Insurance

TABLE OF CONTENTS

Preface to the second round of the Universal Health Coverage Study Series

All over the world countries are implementing pro-poor reforms to advance universal health coverage. The widespread trend to expand coverage resulted in the inclusion of the "achieving universal health coverage by 2030" target in the Sustainable Development Agenda. Progress is monitored through indicators measuring gains in financial risk protection and in access to quality essential health-care services.

The Universal Health Coverage (UHC) Studies Series was launched in 2013 with the objective of sharing knowledge regarding pro-poor reforms advancing UHC in developing countries. The series is aimed at policy-makers and UHC reform implementers in low- and middle-income countries. The Series recognizes that there are many policy paths to achieve UHC and therefore does not endorse a specific path or model.

The Series consists of country case studies and technical papers. The case studies employ a standardized approach aimed at understanding the tools –policies, instruments and institutions- used to expand health coverage across three dimensions: population, health services and affordability. The approach relies on a protocol involving around 300 questions structured to provide a detailed understanding of how countries are implementing UHC reforms in the following areas:

- **Progressive Universalism**: expanding population coverage while ensuring that the poor and vulnerable are not left behind;
- **Strategic Purchasing**: expanding the statutory benefits package and developing incentives for its effective delivery by health-care providers;
- **Raising revenues** to finance health care in fiscally sustainable ways;
- **Improving the availability and quality of health-care providers**; and,
- **Strengthening accountability** to ensure the fulfillment of promises made between citizens, governments and health institutions.

By 2017, the Series had published 24 country case studies and conducted a systematic literature review on the impact of UHC reforms. In 2018 the Series will publish an additional15 case studies, A book analyzing and comparing the initial 24 country case studies is also available: *Going Universal: How 24 Developing Countries are Implementing UHC Reforms from the Bottom Up*. Links to the Series and the book are included below.

Daniel Cotlear, D. Phil.
Manager and Editor
Universal Health Coverage Study Series

Links:
http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series
http://www.worldbank.org/en/topic/universalhealthcoverage/publication/going-universal-how-24-countries-are-implementing-universal-health-coverage-reforms-from-bottom-up

Acknowledgements

The author would like to thank Daniel Cotlear for his insightful and helpful comments in drafting this report for the World Bank UNICO series of case studies on implementing universal health coverage.

About the Author

Peter C. Smith is Emeritus Professor of Health Policy at Imperial College Business School, London. He is a mathematics graduate from the University of Oxford, and started his academic career in the public health department at the University of Cambridge. He has worked and published in a number of disciplinary settings, including statistics, operational research, and accountancy. However, his main work has been in the economics of health and the broader public services, and he was a previous Director of the Centre for Health Economics at the University of York. Smith has acted in numerous UK governmental advisory capacities, and is currently chair of the National Health Service Advisory Committee on Resource Allocation. He has also advised many overseas governments and international agencies, including the World Health Organization, the International Monetary Fund, the World Bank, the Inter-American Development Bank, the Global Fund, the European Commission, and the Organisation for Economic Co-operation and Development. He continues to conduct research on economic aspects of global health, including participation in the International Decision Support Initiative, funded by the Gates Foundation. Current interests include health system performance assessment, with a particular focus on international comparison; measuring and improving health system productivity; and universal health coverage. He has published widely on these and related topics, including over 150 peer-reviewed journal papers and 12 edited books.

Executive Summary

The United Kingdom has in many respects the archetypal centrally planned, publicly financed health care system in the form of National Health Service (NHS), established in 1948 in a time of great austerity after World War II. It is largely funded from general taxation, and provides wide coverage of most mainstream health services, with little recourse to user charges. It offers strong financial protection against the costs of health care and enjoys high public approval ratings. Its principal shortcomings have been weaknesses in service quality, often in the form of long waiting times, and sometimes relating to clinical quality.

The United Kingdom spends less on health care than most high-income countries. The Organization for Economic Co-operation and Development estimates that, in 2013, health care expenditure accounted for 8.5 percent of GDP, compared to 9.5 percent on average among the EU15. In 2013, public funds accounted for 83.3 percent of all current expenditure on health, compared to the EU15 average of 77 percent. The UK also relies on low numbers of doctors and nurses, employing 2.77 physicians per 1,000 population compared with the EU15 average of 3.27.

This paper concentrates on the experience in England, which accounts for 84 percent of the UK population of 64.6 million. The system of health service coverage adopted in the NHS is very simple. There is no explicit requirement to enroll in an insurance plan. Instead, citizens must register with a general practitioner (GP) of their choice. GPs act as a gatekeeper to nonemergency secondary care and prescription medicines and devices. With the exception of small fees for some prescription medicines (from which many citizens are exempt), patients are not directly charged for access to NHS care.

Throughout most of its history, the NHS model of governance has entailed strong central control by the national ministry, with local administration responsible for detailed local planning and purchasing. The forms of local administration have varied. In the early years of the NHS they were primarily local NHS hospitals, with separate committees for oversight of primary care. Since 1974, local health authorities have assumed the role of oversight of local services, currently covering, on average, populations of 250,000.

In 1991, an “internal market” was created, and for the first time a clear distinction was drawn between purchasers (the local health authorities) and providers. The provider market has gradually diversified to include not-for-profit and private providers (including hospitals) as well as NHS providers. For some services, when referred to a specialist by a GP, patients have the right to select any qualified secondary provider, which will receive the associated NHS payment (the fee “follows the patient”).

The markets for NHS services are highly regulated, and there are a number of specialized national bodies seeking to ensure that they function properly and that NHS finances are well spent. The role of the regulatory bodies, in broad terms, is to set standards; ensure that the required services are universally available and of acceptable quality; address market failures such as lack of information; and ensure that public goods, such as clinical education, public health, and research are adequately funded and of high quality.

There are many lessons to be learned from the UK experience for countries making the transition toward universal health coverage.

1. Political and Economic Context

1. The United Kingdom is a developed country with a parliamentary democracy and high levels of income. It has since 1973 been a member of the European Union (EU), although in a referendum held in June 2016 the UK electorate voted to leave the EU. The UK has been a highly-centralized state, although in recent years there have been increasing trends toward decentralization, with separate parliaments being established for Wales and Scotland.

2. Annual UK gross domestic product (GDP) was estimated to be International $41,459 per capita (purchasing power parity) in 2015.[1] Although it is not part of the Euro currency zone, the country was severely affected by the 2008 global financial crisis. GDP contracted by 6 percent in 2009, and growth has been about 1.5 percent per year since then. Public finances have been especially severely affected. The coalition government elected in 2010 implemented severe constraints on the size of the public sector, which have been retained by the subsequent Conservative government. Although publicly funded health services were to some extent protected from expenditure reductions, the constraints have nevertheless placed severe strains on the ability of those services to meet all expectations.

3. There is considerable income inequality in the UK, which has persisted over an extended period. Since 1979, about 15 percent of the population has been in receipt of relative low income, defined as 60 percent of the median income, before housing costs are taken into account. After housing costs are taken into account, the figure rises to 21 percent. According to the Organisation for Economic Co-operation and Development (OECD) Income Distribution and Poverty Database,[2] the Gini coefficient for income after tax and benefits for the UK was 0.341 in 2011, the highest level of income inequality among the EU15 countries, exceeded only by the United States among high-income countries.

4. The UK has the demographic profile typical of many high-income countries. There is a rapidly growing proportion of older people aged 65+ (17.8 percent of the population in 2015) and a rising dependency ratio. The aging of the population has to some extent been moderated by comparatively high levels of immigration, and parts of the UK such as London are exceptionally ethnically diverse. The epidemiological profile of the country is also typical of high-income countries, with a predominance of noncommunicable diseases. Risk factors are in line with other western European countries, with 20.7 percent of the adult population smoking (compared to an average of 20 percent in the EU15) and average adult consumption of 9.6 liters of alcohol per year (the EU15 average is 9.7 liters). Although there are concerns about measurement comparability, obesity levels in the UK appear to be especially high, with an estimated 25 percent of the total population defined as obese (those with a body mass index of at least 30).

5. Life expectancy at birth has risen steadily by 2.8 months every year since 1985. In 2015, it was 82.9 for females, with the exception of Denmark, the lowest among the EU15 (where the average is 83.9). The UK life expectancy of 79.2 for males is slightly higher than the EU15 average of 79.0. Inequalities in health status among income groups, ethnic groups, and geographic regions

[1] World Bank; http://data.worldbank.org/indicator/NY.GDP.PCAP.CD.
[2] http://stats.oecd.org/Index.aspx?DataSetCode=IDD.

have been a long-standing policy concern. A report for the UK government prepared by Sir Michael Marmot highlighted the persistent and systematic differences in health according to social classes, regions, educational level, ethnicity, and income.[3] The report attributed much of the variation in health to variations in "social determinants" such as income levels, unemployment, and housing that lie outside the health system.

6. The National Health Service (NHS) in the United Kingdom is in many respects the archetypal centrally planned, publicly financed health care system. It is largely funded from general taxation, and provides wide coverage of most mainstream health services, with little recourse to user charges. Historically, the UK has spent markedly less than equivalent high-income countries, and the NHS enjoys high public approval ratings. Its principal shortcomings have been weaknesses in service quality, often in the form of long waiting times (which to a great extent have been mitigated in recent years), but also relating to clinical quality, for example, in the form of poor cancer outcomes relative to other high-income countries.[4] This paper concentrates on the experience in England, which accounts for 84 percent of the UK population of 64.6 million. The other UK countries (Scotland, Wales, and Northern Ireland) have similar NHS systems, but with some important organizational variations.

7. This paper does not provide a comprehensive description of the English health system, which is admirably provided elsewhere.[5] Rather, the paper summarizes the implications of the English experience that are relevant for countries contemplating a transition toward universal health coverage.

8. The paper is organized as follows. Section 2 explains how universal health care (UHC) was established, and the form that it takes in England. Section 3 explains how financial resources are mobilized and pooled. Section 4 describes the strategic purchasing function. Section 5 describes how services are supplied. Section 6 outlines governance and accountability arrangements. Finally, section 7 summarizes some of the lessons to be drawn for low- and middle-income countries considering the transition toward UHC.

2. Expanding Population Coverage

9. The NHS was created in July 1948, in the immediate aftermath of World War II, at a time of great austerity for the UK economy due to debt repayments and other consequences of the war. The NHS legislation was largely inspired by a 1942 report entitled *Social Insurance and Allied Services*, by the economist William Beveridge, which proposed a comprehensive set of state-funded welfare protection arrangements, to include pensions and unemployment benefits as well as health services.[6] There is a considerable literature on the origins and history of the NHS which it is impossible to do justice to in this short review.[7]

[3] Strategic Review of Health Inequalities in England 2010.
[4] De Angelis et al. 2014.
[5] Boyle 2011.
[6] Beveridge 1942.
[7] Gorsky 2008.

10. Before the institution of the NHS in 1948, England had a bewildering patchwork of health care institutions that had developed over many decades, described in great detail by Webster (1988). The core elements were:

- ***Voluntary hospitals***, which started to emerge about 1750, and were originally funded by charitable donations. These hospitals were highly variable in size and function, and by 1939 accounted for about 50 percent of acute care and almost all complex or specialist treatment. They struggled to keep pace with improvements in medical science, and had increasingly found it difficult to meet demand while relying only on charitable donations. They had therefore become increasingly reliant on patient fees, which accounted for 59 percent of income in 1939, and voluntary "subscriptions" (rudimentary health insurance arrangements, which yielded income for the hospital, but also led to increased demand for services).
- ***Publicly funded health services,*** which developed from the 1834 Poor Law, and required local governments to provide a range of public services for poor people. Provision was highly variable, and included a range of specialized clinics as well as hospitals. By the 1930s, some municipalities had started to provide general hospital services for the entire population. Copayments could be required from those who could afford them, but they were not in general applied vigorously.
- A system of ***single-handed general practitioners***, funded by a "National Insurance" tax on those employed in the formal sector. Beneficiaries (but not their dependants) were entitled to care within the competence of an ordinary practitioner when necessary, but not specialized care.
- A separate provision of ***mental health services***, based primarily on long-term (often compulsory) institutional care.

11. There was considerable momentum toward reforming this fragmented and uneven system before 1939. However, Webster (1988) concludes that without the major discontinuity of World War II, it would have taken decades, or even been infeasible, to establish the NHS in its eventual form, given the powerful vested interests entrenched in the existing arrangements. However, the emergency caused by the war demonstrated that wholesale changes in institutional arrangements were feasible, for example, in the form of conversion of 290,000 hospital beds as a contingency for civilian casualties. Furthermore, the public mood was such that there was now considerable resistance to the idea that access to health services should be subject to charity and good fortune. The creation of what we now know as UHC was high on the list of public expectations for reconstruction after the war.

12. The system of health service coverage adopted in the NHS is very simple. There is no explicit requirement to enroll in an insurance plan. Instead, citizens must register with a general practitioner (GP) of their choice. Primary care plays an important role in the NHS, and GPs act as a gatekeeper to nonemergency secondary care and prescription medicines and devices. While the GP gatekeeping role is undertaken quite actively, people who are "ordinarily resident" in the UK but not registered with a GP can nonetheless usually secure access to emergency care without incurring charges. With the exception of small fees for some prescription medicines (from which many citizens are exempt), patients are not directly charged for access to NHS care.

13. The aggregate funds made available to the NHS are largely determined by political choices made in the public sector budgetary negotiations. Under the founding NHS legislation, the Secretary of State for Health had a duty to "promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services...."[8] Note that the requirement is to promote the establishment of a comprehensive service, and not necessarily to provide such a service. Later in the Act it requires that services should be provided "to such extent as [the minister] considers necessary to meet all reasonable requirements."[9] This has been interpreted in the courts as permitting the minister and the local health authorities to take account of the limited resources available when making NHS coverage decisions. There have been some changes to the legal duties since 1946; however, the practical effect remains largely unchanged. It means that legal challenges to coverage decisions (such as those relating to expensive drugs) have been rare, and have focused mainly on the procedures used to reach coverage decisions rather than the actual choices made.

14. The funds available to secure these duties are the result of negotiations between the Department of Health (the health ministry) and Her Majesty's Treasury (the finance ministry). Day-to-day planning and management of the health services is devolved to a system of geographically defined health authorities. The precise institutional arrangements for these authorities has been regularly changed by health ministers over the history of the NHS, causing great disruption and very little discernible effect on performance. The current arrangements entail a national body responsible for overall stewardship of the NHS across the country (entitled *NHS England*), and a system of 209 Clinical Commissioning Groups responsible for geographically defined populations of about 250,000. These groups receive a fixed annual budget with which to fulfil their duties, and can be thought of as strategic purchasers of health services at a local level. They are referred to as local health authorities in this paper. The NHS approach toward local strategic purchasing of health services is discussed in more detail in section 4.

15. For the first 25 years of its existence, the amount of local expenditure in the NHS was determined by historical spending patterns, which gave rise to much greater per capita spending levels in London and the south-east than the rest of the country. There was therefore considerable concern about variations in access to services and health status. The Resource Allocation Working Party (RAWP) report in 1976 proposed major reallocations of funding between the English regions in order to rebalance spending and to better secure the objective of ensuring "equal opportunity of access to health care for people at equal [medical] risk"[10] across the whole country. Its proposals were based on a mathematical formula reflecting the demographic and epidemiological characteristics of the regions. The principle of seeking to provide fair funding of all local health authorities remains a central feature of the NHS, described in more detail in section 4. Although intrinsically difficult to measure, attempts are made to monitor equality of access through instruments such as the "NHS Atlas of Variation," also described in greater detail below.

[8] NHS Act 1946, 1.
[9] NHS Act 1946, 1.
[10] Resource Allocation Working Party 1976, 7.

16. About 10.6 percent of the population has some sort of private voluntary health insurance (VHI), often funded by employers.[11] This is one of the lowest rates of VHI coverage in OECD countries. It usually takes the form of duplicate insurance, predominantly for elective surgical treatments. The principal reason for purchasing VHI has been the perception of poor responsiveness offered by the NHS, in the form of long waiting times for treatment, convenience, and poor amenities, rather than poor clinical care. In recent years, NHS waiting times have been the focus of intense policy attention, and have improved markedly. However, the market for VHI remains active.

3. Financial Resources and Pooling

17. The United Kingdom spends less on health care than most high-income countries. The OECD estimates that, in 2013, health care expenditure accounted for 8.5 percent of GDP, compared to 9.5 percent on average among the EU15, among which only Ireland spent less. There was a recognition in the early 2000s that spending levels may have been too low to provide the levels of services expected by voters, and ministers adopted a policy to attain European levels of spending, reflected in a rapid increase in spending until 2008. However, the financial crisis of 2008 abruptly ended that ambition, and spending has remained at about 8.5 percent of GDP since then.

18. The UK places especially heavy reliance on public funds to finance health services. In 2013, they accounted for 83.3 percent of all current expenditure on health, compared to the EU15 average of 77.0 percent. Only the Netherlands relied significantly more heavily on public sources (87.6 percent) (note that, because of its compulsory nature, social health insurance is for these purposes considered public funding). Out-of-pocket expenditure in the UK is correspondingly low (9.5 percent of health expenditure), compared to the EU15 average of 16.7 percent. The small private health insurance market discussed above accounts for only 3.5 percent of total expenditure.

19. The finances available for the NHS are almost entirely determined by the budget set for the health ministry by Parliament and derived from general taxation. By way of illustration, figure 1 summarizes the flow of funds in fiscal year 2013/14, expressed in billions of British pounds (NHS England 2014). In summary, the ministry (the Department of Health) was allocated £112 billion, of which £14.3 billion was spent on internal administration, a variety of regulators, and medical education. Local governments were allocated £2.7 billion to fulfil their public health responsibilities. The remainder (£95 billion) was allocated to NHS England. Of this, £32 billion was retained for purchasing specialized services, primary care, and administration. The remainder (£63 billion) was allocated to the local health authorities (clinical commissioning groups) for purchasing mainstream health services for their local populations.

20. An amendment to the 1946 NHS Act empowered the government to levy charges on NHS prescriptions, and in 1952 the first charges were introduced for prescribed medicines and devices. However, this created considerable political difficulties, and the only significant charge for medical NHS services remains the fee for prescriptions, which is currently £8.40 for each item, up to a maximum of £104 per year for each person.[12] There are widespread exemptions for people who are old, children, on low incomes, or have certain chronic conditions, and in practice fees are not levied

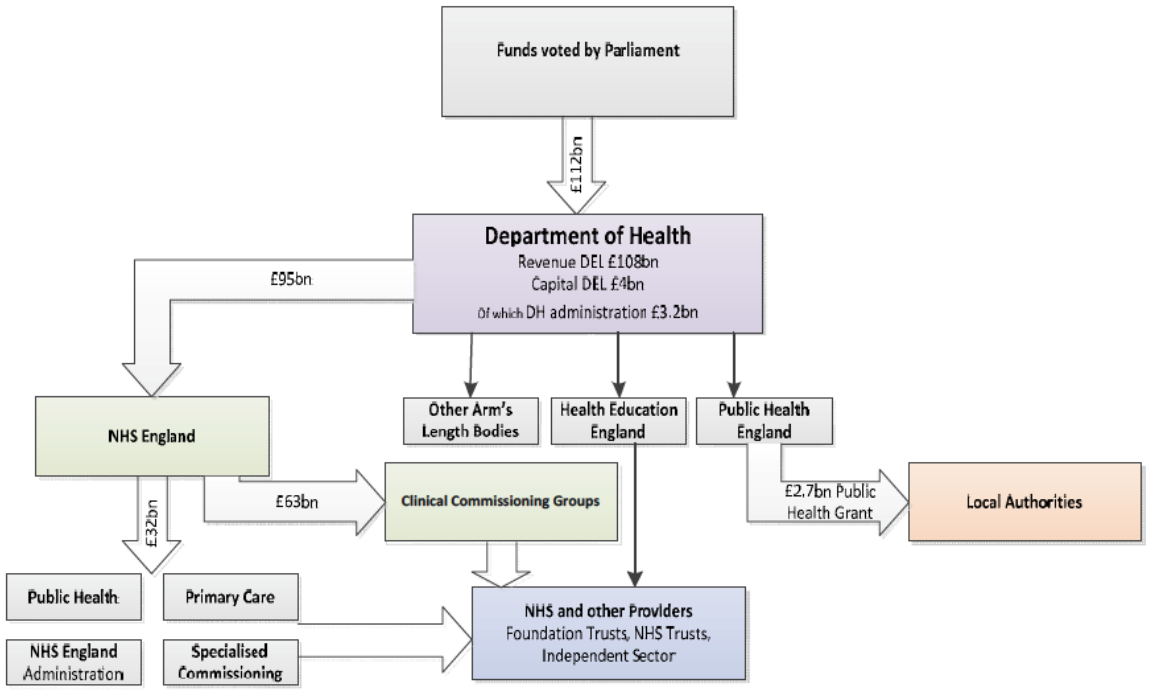
[11] OECD 2015.
[12] Parkin 2016.

for approximately 90 percent of all prescriptions. Prescription charges in total yield about £450 million, approximately 0.4 percent of all NHS expenditure. There are no prescription charges in the rest of the UK outside England.[13]

21. NHS charges for health care services other than prescriptions have never been implemented, and would have to be introduced through primary legislation. Dental care is organized on a different basis, with a scale of NHS charges for examinations and treatment roughly in line with market prices. There are exemptions for those on low incomes.

22. The outcome of these arrangements is that UK citizens enjoy especially strong protection from the immediate financial consequences of ill health. The Commonwealth Fund survey of 11 high-income countries regularly finds that the UK has the lowest proportion of the general population experiencing cost-related problems securing access to care.[14] In 2013, the proportion was 4 percent, compared to a median of 15 percent among the 11 countries surveyed, and 37 percent in the United States. Another noteworthy finding from that survey is the low level of complexity that UK citizens experience in dealing with medical insurance and payment of bills, even compared with social health insurance schemes. This is a significant benefit of single-payer insurance schemes.

Figure 1 Flows of Funds in the English NHS, Fiscal Year 2013/14



Source: Department of Health 2014, 7.

[13] Parkin 2016.
[14] Schoen et al. 2013.

4. Strategic Purchasing

23. Throughout most of its history, the NHS model of governance has entailed strong central control by the national ministry, with local administration responsible for detailed local planning and purchasing. The forms of local administration have varied. In the early years of the NHS they were primarily local NHS hospitals, with separate committees for oversight of primary care. Although local government undertook the public health function, it was not given responsibility for the broader health services, partly as a result of opposition from the medical profession.

24. In 1974, the first local health authorities were created, with an explicit responsibility for a geographically defined population, including public health. The purchasing function of these authorities was largely implicit, as there were few explicit contracts with providers, and there was a general assumption that the health authority would collaborate with and use local NHS providers. The role of authorities was primarily to assess local need, to plan local service provision, and to ensure that budgetary limits were not breached. The authorities remained separate from local government, were not democratically elected, and their prime accountability was to the national ministry.[15] Health authorities were, and continue to be, entirely funded by grants from the national ministry, which are intended to reflect variations in the spending needs of authorities. The funding distribution mechanism is described in more detail later in this section.

25. In 1991, an "internal market" was created, and for the first time a very clear distinction was drawn between purchasers (the local health authorities) and providers. Health authorities were expected to purchase services from the internal market of NHS providers, through explicit contracts. Budgetary discipline remained important, but authorities were—in principle—able to change providers on the basis of criteria such as quality (particularly waiting time) and price. The intention was to expose providers to competitive forces and thereby improve their efficiency and responsiveness. At this stage of reforms, patient choice was not a major feature, and the competition related mainly to contractual choice by the local health authorities.

26. Also in 1991, some general practices opted to become "fundholders." They received a share of the health authority budget with which they were able to purchase certain routine, nonemergency services for their patients. In effect, they became "miniature strategic purchasers" of certain services. The sanctions for overspending (and rewards for underspending) were in general modest for fundholding practices. However, the fundholding experiment resulted in comparative reductions in use of hospital services for routine procedures, and modest reductions in waiting times for patients in fundholding general practices. Fundholding was nevertheless abolished in 1998 on a change of government.

27. The split between purchasers and providers has since remained a feature of the NHS, albeit with periodic changes to the organizational form of the local purchasing authorities. The major development has been the increased diversity of the provider market since 2000 (described in more detail in section 5). In place of the "internal" market of NHS providers, policy makers have encouraged the development of a greater plurality of NHS, not-for-profit and for-profit providers.

[15] Webster 1988, 1996.

This has required increased formality in the contracting process, and the introduction of market regulation, for example, in the form of competition supervision.

28. Since 2000, there has been some effort to increase patient choice of provider, mainly in the nonemergency acute sector. When referred to a specialist by a GP, patients have the right to select any qualified secondary provider, which will receive the associated NHS payment (the fee "follows the patient"). The intention is to improve responsiveness for patients and to stimulate competition and improved performance among providers. To some extent this model of patient choice conflicts with the strategic contracting function of health authorities, as for some services it inhibits their ability to draw up contracts with specific providers and to direct patients toward "preferred" providers.

29. Note that the enhancement of patient choice necessarily required changes to the methods of provider payment. Before the change many contracts were in the form of a "block contract" for a wide range of services, irrespective of demand (although of course there were often payment contingencies in place to accommodate unexpectedly high or low demand). Patient choice required adoption of a system of diagnosis-related group (DRG) payments for specific treatments, known in England as health care resource groups. In this way, the money associated with a specific treatment could "follow the patient" to the chosen provider. Note that such payment mechanisms are likely to be a prerequisite for implementation of most types of explicit health benefit packages, to ensure that payment is restricted to specified treatments only.

30. The NHS nevertheless does not have a formal benefits package, to which all citizens are entitled. As explained by Mason (2005), legislation defines broad categories of health care service that can be provided by the NHS, according to medical need. However, the statutes define a person's need as a "reasonable requirement," circumscribed by the right of local health authorities to take into account NHS financial capacity. In practice this means that patients have few entitlements to specific services. The NHS Constitution sets out a patient's broad entitlements including "… the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences."[16] However, although certain principles and quality criteria are set out, it includes few explicit treatment entitlements, with the exception of drugs mandated by the National Institute for Health and Care Excellence (NICE), as described in the following paragraph. Instead, the NHS Constitution states that "you have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you."[17]

31. NICE was created in 1998 to inform national and local decision making about treatment coverage, and makes an important contribution to the evidence base underlying NHS purchasing. It uses explicit criteria and a formal deliberative process to assess health technologies, and has become highly influential, especially for the assessment of new drugs. It uses a variety of criteria in coming to its judgements, although the clearly dominant influence on decisions is cost-effectiveness.[18] One aspect of NICE guidance is mandated by statute. If NICE produces a

[16] Department of Health 2015, 6.
[17] Department of Health 2015, 7.
[18] Dakin et al. 2015.

technology appraisal that says that a new medicine should be made available to NHS patients who meet particular criteria, then local health authorities are under a statutory duty to ensure that the technology is made available to all relevant patients within three months. This process forms the basis for what is in effect an English "essential medicines list."

32. The local health authorities responsible for purchasing NHS services are currently known as Clinical Commissioning Groups (CCGs), and are responsible for geographically defined populations of about 250,000 people. They are given fixed budgets with which to purchase routine health services. The NHS has, since the original RAWP report in 1974, used an increasingly sophisticated set of formulas to allocate funds to CCGs (and their predecessor organizations), with the intention of securing equal access to services for equal clinical need.[19] These formulas are based on extensive econometric analysis, and redistribute funds on the basis of characteristics such as the demography and socioeconomic deprivation of the area, and the local costs of inputs such as wages. The net effect of these adjustments in 2015 was that the most deprived areas of the country receive over 50 percent more funding per capita than the least deprived areas.

33. In principle, the budget allocated to localities should reflect the costs of providing a stated benefits package. In practice, because no such package is explicitly defined, the funding formula estimates the expected expenditure in a locality if it adopts average spending across England, given the locality's demographic, health, social, and economic circumstances. A major policy concern is therefore the extent to which the current formulas (which are based on an empirical analysis of previous spending patterns) do not reflect "unmet" medical needs that the NHS has historically failed to satisfy. Of course, by the same token, the empirical analysis may also reflect some aspects of unwarranted expenditure, in the form of inefficient care or inappropriate treatments.

34. Local health authorities are subject to many performance criteria, including attainment in clinical outcomes, waiting times, and measures of public health. However, their overriding imperative (and statutory duty) is to "ensure expenditure in a financial year does not exceed the allocated budget."[20] Therefore, if clinical needs exceed those assumed in the budget (or if there is local inefficiency), there will often be strong pressure on the health authority to limit access to certain treatments, a freedom they can to some extent exercise given the statutory framework for the NHS described above. The NHS relies on central command (NHS England) to enforce spending limits, and the jobs of chief executives and other senior managers are at risk if they fail to constrain spending. In the extreme, the management of local health authorities can be brought under the central control of NHS England. These arrangements have been largely successful in keeping aggregate NHS spending within national budgets, although there can be over- and underspending among individual health authorities.

35. The local discretion on funding decisions has led to a phenomenon known as the NHS "postcode lottery," a term adopted by the media and politicians when referring to geographic variations in coverage decisions among local health authorities. Examples include variations in

[19] Smith 2008.
[20] Department of Health 2012a, 12.

drugs made available (even when approved by NICE)[21] and variations in clinical thresholds for treatments such as hip replacement and cataract surgery.[22]

36. There is considerable evidence that clinical variation is widespread, as documented in some detail in the NHS Atlas of Variation in Healthcare.[23] Some of these clinical variations can be attributed to differences in local policies. However, there is also variation in professional practice. Moreover, for some conditions variation can to some extent be explained by access barriers, such as travel time, ethnicity, language and other cultural factors, although evidence is rarely conclusive.[24] In some disease areas, efforts have been made to address variations through the promulgation of clinical guidelines. However, these are advisory and have variable levels of effectiveness, and Chalkidou and Smith (2017) conclude that there is likely to be considerable unwarranted, and therefore inefficient, variation in clinical practice in the NHS.

37. Thus, there is an apparent policy desire, through the creation and development of NICE, to create a consistently and comprehensively specified health benefits package. However, in practice the English NHS does not have an explicitly specified basket of treatments. This is readily observed through the wide geographic variations in both the availability of and eligibility criteria for many services. Chalkidou and Smith (2017) nevertheless conclude that, although the English NHS does not explicitly specify a health benefits package, it is in some respects establishing an "intelligent" package, based on instruments such as an essential medicines list, NICE clinical guidelines, its provider payment mechanisms, and performance reporting. These instruments shape the packages of care provided, while giving room for maneuver that acknowledges gaps in evidence and variations in the availability of local resources.

5. Supply of Health Care

38. Every citizen must be registered with a general practitioner and, except in emergencies, cannot secure access to secondary NHS care without a referral by the GP to a specialist. Patients have the right to register with the GP of their choice, and practices cannot discriminate among patients. The gatekeeping role, and the restraint exercised by GPs in making referrals, has made an important contribution toward containing NHS costs. About 85 percent of general practices are independent contractors—in effect small private businesses. Most of these are subject to a national GP contract negotiated between the Department of Health and the doctors' union (the British Medical Association). The contract specifies detailed terms and conditions for GP remuneration, including capitation payments per patient, additional payments for extra services, and a bonus scheme for securing higher-quality primary care, which accounts on average for about 25 percent of practice income. About a third of GPs are salaried, employed by NHS England, but their employment conditions are effectively similar to those of the independent contractor GPs.

39. Local health authorities and NHS England purchase community, secondary and tertiary care from a mixed market of public, private and not-for-profit sector providers. Traditionally, hospitals

[21] Sheldon et al. 2004.
[22] Coronini-Cronberg et al. 2012.
[23] Public Health England 2015.
[24] Dixon-Woods et al. 2006.

were public sector NHS organizations, with boards appointed by the national minister. However, from 2000 an increasing number have been converted into not-for-profit "Foundation Trusts," once they satisfy certain financial management and clinical quality criteria. Unlike traditional NHS hospitals, Foundation Trusts are not directly accountable to the health minister. All hospitals are regulated by an independent financial regulator currently known as NHS Improvement.

40. From 2000, there was also a major policy effort to increase provider capacity by encouraging the entry of private sector providers of secondary care, especially for nonemergency surgical treatments. The objectives were to increase competitive pressures, expand patient choice, and reduce waiting times by creating extra capacity. An example was the introduction of privately owned "independent treatment centers," intended to provide routine diagnostic and surgical procedures for day-case and short-stay NHS patients. In practice, private sector provision accounts for less than 10 percent of all NHS activity, and it has proved especially difficult to encourage a great deal of private entry into the hospital market, even with substantial financial incentives. This is possibly because of the large investment costs required and considerable political uncertainty concerning the long-term business prospects for NHS-funded activity in the private sector. Other important categories of providers include mental health services and community services. These NHS-funded services have been opened up to competition by many health authorities, and in contrast to the hospital sector there is a significant presence of non-NHS providers.

41. The markets for NHS services are highly regulated, and there are a number of specialized national bodies seeking to ensure that they function properly and that NHS finances are well spent. These are described in more detail in section 6 below. The role of the regulatory bodies, in broad terms, is to set standards, to ensure that the required services are universally available, and of acceptable quality, to address market failures such as lack of information, and to ensure that public goods, such as clinical education, public health, and research are adequately funded and of high quality.

42. The UK has a strong pharmaceutical industry that wishes to secure high prices for its products in order to remain profitable and fund future research, and it has argued that low prices may eventually lead to weakening of the UK pharmaceutical industry. [25] Pharmaceutical procurement by the NHS is mainly effected through a voluntary agreement with the bulk of the pharmaceutical industry known as the Pharmaceutical Price Regulation Scheme (PPRS).[26] This is a noncontractual voluntary scheme agreed between the UK Government and the pharmaceutical industry. The scheme covers the pricing of the majority of NHS branded medicines and runs for five years. The most recent agreement was put in place on January 1, 2014. Over 90 percent of branded medicines are covered by the scheme. Medicines not covered are subject to pricing at 15 percent below the NHS list price. The stated objectives of the PPRS are "to strike a balance through promoting the common interests of patients, the NHS, the industry and the taxpayer."[27] The PPRS effectively seeks to protect the UK taxpayer while encouraging the development of new medicines that offer benefits for patients and the industry. The core instrument in the 2014 agreement is an arrangement to place a limit on the aggregate growth rate in NHS expenditure on branded medicines.

[25] Towse 1995.
[26] Department of Health 2013.
[27] Department of Health 2013, 9.

43. There is evidence that the NHS has to some extent been able to use its monopoly purchasing power to secure relative low prices for pharmaceuticals.[28] NICE has been important in securing comparable assessment of technologies in different therapeutic areas, and in assessing new therapies. However, there is some evidence that NICE may have been too generous in the informal cost-per-quality-adjusted-life-year threshold it has applied to new technologies.[29] Furthermore, the UK government introduced a "cancer drugs fund" to pay for high-cost cancer drugs that would not normally have secured approval from NICE on cost-effectiveness grounds.[30] Similarly, the cost-effectiveness threshold has been relaxed for certain "end-of-life" treatments.[31]

44. The NHS directly employs about 1.2 million people in England, making it one of the largest employers in the world. It also indirectly employs many others in non-NHS organizations that deliver NHS services. Approximately 1 million are employed in hospital services, of which 104,000 are doctors and 307,000 are qualified nurses. In primary care, there are about 34,000 full-time-equivalent GPs, organized into 7,700 practices. Compared to other EU countries, the UK relies on low numbers of doctors and nurses. In aggregate, the UK employs 2.77 physicians per 1,000 population compared with the EU15 average of 3.27. Only Ireland has a lower rate. There are eight professional self-regulatory bodies in England, including the General Medical Council and the Nursing and Midwifery Council, which seek to assure continuing professional competence to practice.

45. In general, the wages of UK doctors and nurses are high by international standards, and the presence of the NHS as a dominant employer does not appear to have significantly moderated rates of reimbursement.[32] As in many European countries, there have been shortages of certain clinical professionals, which have been addressed through a substantial increase in training places for doctors in the 2000s, and migration of professionals from Europe and beyond. NHS doctors are allowed to have private patients outside their contracted NHS hours, and this "dual practice" is a significant source of income for some hospital specialities, especially in the London area.

46. Given the model of UHC adopted in the UK, a particular concern relates to the supply and quality of general practitioners. In a report that describes general practice as in "crisis," the King's Fund found that the workload of GPs is increasing rapidly, while resources are largely static.[33] The proportion of medical trainees choosing to enter GP specialty training is declining, and five years after qualifying, only 1 in 10 new GP trainees plan to be working full time in general practice. GPs are also retiring earlier and in greater numbers, without compensating supply from elsewhere.

47. One approach toward easing workforce supply issues is to encourage a more multidisciplinary approach toward roles traditionally undertaken solely by doctors. Many general practices have experimented with professional skill mix, for example, by employing nurses to undertake routine tests and interventions. A Primary Care Workforce Commission (2015) has examined the scope for increased flexibility in the primary care workforce, and identified the potential for much greater utilization of nurses, pharmacists, physician associates, and health care

[28] Department of Health 2012b.
[29] Claxton et al. 2015.
[30] Chamberlain and Hollingworth 2014.
[31] Collins and Latimer 2013.
[32] OECD 2015.
[33] Baird et al. 2016.

assistants in collaboration with GPs. However, the Commission noted the general lack of evidence on the effectiveness and cost-effectiveness of changing ways of working, and identified many areas where more research is needed.

48. Public health is an important function in the English health system, with the objectives of improving health, protecting against health threats, and reducing inequalities. Within the NHS, public health has historically struggled to compete for resources with mainstream health services. Partly as a consequence, local provision of public health services was in 2013 transferred from the NHS local health authorities to local governments. The intention was that local governments should appoint public health specialists to lead the new functions. At the time of writing it is too early to pass judgement on how successful the transfer has been, but it is noteworthy that the central grants-in-aid to local governments to support the public health function have been severely cut in the first years of implementation.

49. The NHS does not cover the finance of most long-term care or social care. These are mainly funded by local government or privately by individuals and their families, and provided by a mixed market of public, not-for-profit and for-profit organizations. The level of coverage by local governments is variable, but is means-tested and generally restricted to those with low wealth and income, in sharp distinction to the universality of health services. This institutional distinction between health and social care has given rise to serious problems of care coordination and perverse incentives. Examples include:

- In 2016, the use of over 60,000 hospital bed days per month arose from delayed discharges from hospital that were attributable specifically to failures in social care.
- Approximately 20 percent of emergency admissions to NHS hospitals are associated with conditions that could in principle be prevented with adequate primary and social care.
- NHS accident and emergency centers are experiencing sharply increasing levels of demand that can to some extent be attributed to failures in primary and social care.

50. The most fundamental challenge is caused by the two different funding streams available for health and social care, and the separate institutions responsible for the stewardship of those streams. To contain expenditure and improve population health, local health authorities (CCGs) have a natural interest in minimizing unnecessary use of health services, for example, in the form of avoidable admissions to hospital for people with multiple chronic conditions. Social care has an important role to play in promoting that objective, by forestalling emergencies that require admission to hospital, and facilitating timely discharge of inpatients when they become medically fit. However, CCGs have limited control over social care policies, particularly when a great deal of care is purchased privately. More generally, there is a perception that the separate institutional arrangements for health and social care inhibit the necessary integration of care for people with complex chronic needs. In the worst cases, local health authorities and local governments may try to shift costs onto each other. There are now experiments underway in Manchester and other cities to pool budgets and authority under a single city-wide local authority in an attempt to remedy this weakness.

6. Governance and Accountability

51. Many of the governance arrangements have been described in the preceding sections. The prime responsibility for overseeing the health system and ensuring that the necessary NHS services are provided rests with the Department of Health, led by the minister (Secretary of State for Health), who is accountable to the national Parliament. In practice, the prime role of the ministry is to set policy and ensure relevant institutions are in place to carry out that policy. The details of the institutional arrangements in place have been regularly changed by ministers, with little discernible impact on performance and often causing great disruption. However, the broad structure has remained unchanged for the last 40 years.

52. Operational responsibility for the NHS is delegated by the minister to NHS England, the objectives and budget for which are set out in an annual "mandate." In 2016, for example, the five objectives were:

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities
2. To help create the safest, highest-quality health and care service
3. To balance the NHS budget and improve efficiency and productivity
4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives
5. To maintain and improve performance against core standards.

53. While these objectives are defined at a high level of generality, they are supported by more detailed criteria and metrics. The Board of NHS England is held to account by the minister against these detailed indicators of performance.[34]

54. The local health authorities (currently CCGs) are accountable to NHS England, and receive detailed annual operational guidance. Their performance is assessed against an annual reporting process known as the CCG Improvement and Assessment Framework. This has four broad domains of performance: health improvement, health services, financial sustainability, and leadership. These domains are supported by detailed metrics.

55. To ensure the system works as intended, there are numerous regulatory and advisory bodies specific to the health system, many of which apply to the private health care sector as well as the NHS. Among the most important are:

- A clinical quality inspectorate, known as the Care Quality Commission, responsible for supervision and inspection of clinical quality and safety
- A financial inspectorate, known as NHS Improvement, responsible for assuring financial sustainability of NHS organizations and proper functioning of NHS markets
- The National Institute for Health and Clinical Excellence, responsible for promulgating best clinical practice and treatment guidelines

[34] NHS England 2015.

- The Medicines and Healthcare Products Regulatory Agency, responsible for assessing the effectiveness and safety of products
- Public Health England, responsible for monitoring public health and health inequalities, and promulgating best public health practice
- Health Education England, responsible for workforce planning and development
- The Professional Standards Authority, responsible for ensuring that the self-regulation of the health care professions functions satisfactorily
- The National Institute of Health Research, responsible for maximizing the quality and impact of NHS research
- NHS Digital, responsible for providing information, data, and IT systems for the NHS.

56. Most of the regulators are responsible to the Secretary of State. However, some (such as the Professional Standards Authority) are directly responsible to Parliament. This baroque map of regulation has developed piecemeal over the decades, with change often prompted by crises or scandals in some part of the health system. There are therefore cases of gaps and overlaps in regulation, with the functions of certain regulators being misaligned with others. Moreover, there are sometimes potential conflicts of interest in the goals set for an individual regulator. For example, NHS Improvement is in principle responsible for assuring financial viability of NHS hospitals, but also for ensuring there are adequate competitive forces, which may endanger the finances of some hospitals. It is nevertheless the case that each of these regulators addresses an important issue relevant to the proper functioning of any health system. In addition to these health-specific regulators, there is an important role for economy-wide bodies such as the National Audit Office (reporting on the use of public funds) and the Competition and Markets Authority (seeking to ensure markets work well for consumers and providers), both of which are accountable to parliament.

57. Since the early 1980s, the NHS has sought to make better use of information for performance reporting and accountability.[35] However, ambitious policy initiatives have often not been sustained, and the NHS has not always used its dominant role in health services to secure greater transparency and performance improvement through the use of information. A particularly high-profile initiative was the set of "performance ratings" prepared for all NHS organizations (providers and purchasers) in the 2000s, under which each organization was ranked annually on a four-point scale (zero to three stars) according to a series of about 40 performance indicators. These indicators reflected the national targets set for the health ministry by the national government, which were dominated at that time by a concern with patient waiting times.

58. The most striking innovation associated with performance ratings was the introduction of strong managerial incentives dependent on the level of attainment, which some commentators characterize as a regime of "targets and terror."[36] The jobs of senior executives of poorly performing organizations came under severe threat, and the performance indicators (especially the key targets) became a prime focus of managerial attention. The performance rating regime appeared to secure some major benefits, in particular sharp reductions in the wait for nonemergency inpatient surgery.[37] However, there were also concerns that it was leading to neglect of unmeasured outputs, such as clinical quality, and in 2008 it was radically reformed and its managerial implications considerably

[35] Smith 2005.
[36] Hood and Bevan 2005.
[37] Propper et al. 2010.

softened. However, a reformed set of rankings remains in place for providers as an important focus for managerial attention. More generally, a broad set of performance indicators is available with which to assess the performance of most aspects of the NHS. The indicators used in 2016–17 are summarized in the Annex.[38]

59. The response to performance measurement among NHS managers has been mixed. Many criticize the approach because of some of the apparently arbitrary ways in which the ratings are calculated, and their sensitivity to small data fluctuations.[39] However, some have acknowledged that the system gives managers a clear operational focus, and a real lever with which to affect organizational behavior and clinical practice. Reaction among health care professionals has been less ambiguous, with a widespread view that they distort clinical priorities and undermine professional autonomy.[40] This is hardly surprising, as one of the aims of the national and local targets was precisely to challenge traditional clinical behavior, and to direct more attention to issues such as waiting times that had not always been a high priority.

60. Thus, although vast in size, the NHS is a highly-centralized organization, subject directly or indirectly to a detailed "command and control" system of accountability to the national ministry. NHS England receives detailed guidance on priorities from the ministry, and in turn passes on its priorities to the local health authorities (CCGs). Regulators are given carefully circumscribed remits, and many (such as NICE and the Care Quality Commission) create a national template to which all providers must conform. To some extent this uniformity is intentional, and any departure may receive adverse media references, for example, in the form of criticizing the "postcode lottery."

61. Policy making therefore occurs predominantly in national government, influenced by the government's broader priorities, pressure from parliament and the electorate in general, and lobbying by the many interest groups that seek to influence priorities. As a national institution, the NHS often plays an especially prominent role in national political debate and elections, and receives exceptionally high levels of media coverage. There are also a number of highly regarded think tanks that contribute important commentaries on the NHS and offer forums for debating new policies. The high prominence of the NHS in national debate makes the role of Secretary of State for Health especially challenging.

62. Of the regulators, NICE has a particularly difficult task to resolve the pressures from a variety of stakeholders, including drug companies, patient groups, the health care professions, the government, and taxpayers. It has adopted a carefully crafted set of formal procedures to deliberate on the coverage decisions it must make. These include a particularly interesting approach toward members of the public, in the shape of its "Citizens' Council," which offers views on the overarching moral and ethical issues that NICE has to take account of when producing guidance. That is, it shapes the values that underlie NICE coverage decisions.[41]

63. A serious weakness in the NHS is nevertheless the scope for recognizing local preferences when organizing and delivering NHS services. Since 2003 local government has been given the

[38] Department of Health 2016.
[39] Barker et al. 2004.
[40] Mannion et al. 2005.
[41] Littlejohns and Rawlins 2009.

power to scrutinize and report on local NHS services, and in 2013 it was given responsibility for public health services. Furthermore, elected local government representatives have often been appointed to the boards of local NHS organizations. However, in general the role of formal local democracy in the NHS has been very limited. There have periodically been efforts to offer some forums for a local "voice" in the NHS (currently in the form of a patient "watchdog" known as Healthwatch, with local bases in larger towns and cities). However, these organizations have limited resources, and their effectiveness is open to question.

7. Lessons from the English Experience

64. The English NHS is the archetypal centrally planned health system, and therefore its decades of experience offer important lessons for all health systems seeking to move toward UHC. This section draws some of the more important conclusions from the thumbnail sketch of the health system outlined above.

1. A simple and effective method of offering financial protection to the entire population

65. Without question, the NHS offers exceptional levels of financial protection. There are no major financial impediments to securing health care, although other potential geographic and cultural barriers do sometimes occur. No annual enrolment is necessary, and even the small number of people who do not register with a GP are effectively protected from the immediate financial consequences of ill health. The system obviates the bureaucracy, costs, and anxiety associated with enrolment, billing, and reimbursement required in many insurance-based systems. While there is some evidence that the easy access to care may induce unnecessary treatment (moral hazard), it has been moderated by the gatekeeper system (see below).

2. The health benefits package needs clearer definition

66. The NHS was established at a time when the range of effective clinical treatments was limited, and no serious effort was made to directly circumscribe the freedom of doctors to offer treatments they considered appropriate. The principal rationing devices were the constraints on resources made available to the NHS, and the consequent waiting times and other limits to access for nonemergency care. As medical technology developed, demand for treatments increased, leading to increased political pressure for growth in NHS expenditure. In broad terms, increases in national prosperity allowed the NHS to grow without having to impose significant explicit limits to the treatments made available. The establishment of NICE was an acknowledgement that some limits should be placed on access to care (most obviously expensive drug therapies) and on product prices. However, the NHS benefits package remains largely implicit.

67. This approach is infeasible for most lower-middle-income countries (LMICs), which are confronted by a huge range of treatments, many of which are clearly unaffordable for inclusion in a health benefits package (HBP). It is therefore impossible for lower-income countries to emulate the implicit and organic approach toward the HBP historically adopted in England. For such countries, the development of an explicit HBP that defines entitlements and limitations to treatment

is a clear priority for any system of UHC. The alternative is arbitrary exclusions, and access to care only for those who shout loudest (or even offer informal payments). England itself is now confronted by serious limitations to the availability of NHS funds, and is finding the absence of a formal HBP a major handicap. It is, however, politically very difficult for NHS leaders to propose limitations to treatments or user charges, given the history of the NHS. The lesson for LMICs is to embed the formal creation and maintenance of an HBP into the governance of the health system at an early stage of the transition toward UHC.

3. Avoid arbitrary reorganizations

68. A striking feature of the English NHS is the frequent administrative reorganization to which it has been subjected, with little measurable benefit for patients or taxpayers. These changes have been mainly in the strategic purchasing role (health authorities), and have imposed immense costs on the system, as new working arrangements are put in place and staff assume new roles. The lesson for countries considering the transition toward UHC is clearly first to take advantage of any good structures currently in place (such as properly functioning local government). Where this is not the case, and new entities such as health authorities or insurance offices must be established, it is important to establish mechanisms to ensure that they are properly held to account, while having the autonomy to respond to local circumstances. A further requirement (not least so that it can attract high-caliber staff) is to maximize the prospect that any new entities have a good prospect of longevity.

4. The gatekeeping role of primary care may be helpful

69. From its inception, the English NHS took advantage of its existing network of family doctors to create a gatekeeping system based in primary care. Citizens were asked to register with a GP of their choice, and could secure access to nonemergency secondary care only with a referral from a GP. This approach seeks to coordinate the care for an individual by offering a "medical home," and to minimize the risk of unnecessary treatment. It probably makes a marked contribution to the low spending on health services in the UK relative to other high-income countries. The effectiveness of gatekeeping is highly reliant on the quality of GPs, and their judgement as to when specialist referral is appropriate. Evidence suggests that—even within England—the quality of GPs is highly variable, and it is becoming increasingly difficult to recruit GPs in certain parts of the country. Therefore, while GP gatekeeping is an important potential policy tool for implementing UHC, its relevance in an LMIC is likely to depend on the current interests and caliber of the medical workforce.

5. Assure alignment of the health system with other public services

70. The distinction between health and social care in the English NHS is particularly dysfunctional. The two sectors are the responsibility of different organizations, with separate budgets, so the incentive to shift costs from one to the other is always present. Furthermore, there is a risk that the two sectors do not consider broader objectives for the individual in their care—health services may have little regard for an individual's future social needs, while social care services may not adequately consider the need to prevent or defer future health care needs. For the individual, social care is means tested while NHS care is free whatever an individual's

circumstances, leading to a potential for excess use of health services. In sum, it is necessary to consider the broader context within which UHC must function to ensure that an efficient outcome is achieved.

6. Do not underestimate the managerial capacity needed to make UHC work

71. The NHS is a major part of the UK economy, with a highly complex and specialized range of services. Considerable managerial capacity to coordinate and control those services is needed in order to maximize their effectiveness. In addition to the obvious needs in hospitals and other provider organizations, managerial skills are needed in the purchaser organizations (NHS England and the CCGs) and the many regulators, especially the clinical quality and financial inspectorates. Compared to other developed health systems (in particular, the United States), the NHS has a low administrative burden, especially in arranging billing and reimbursement for services. However, the increasing reliance of the NHS on a market for health services means that national and local purchasers of services must have the necessary procurement skills, and that appropriate regulatory mechanisms are in place to assure that the system is functioning properly. It is likely that the system of over 200 local health authorities in England has spread managerial skills too thinly, and that a smaller number of CCGs would be able to concentrate managerial expertise more effectively. Those designing UHC systems should consider the managerial burden of their plans, and whether the system can provide the necessary skills.

7. Information is a key resource

72. The English NHS should in principle have a major advantage over other types of health system in respect of information standardization, availability, and comparison. The single-payer system should also in principle permit ready development of an electronic health record, available to all providers of NHS services. In practice, the NHS has not always exploited these advantages fully, and information policy has been subject to frequent change in line with changes in governments and ministers. While periodic efforts have been made to improve the availability, and use of performance information, there has been widespread skepticism about the quality of such data, and a reluctance to use them to effect system improvement. Furthermore, an ambitious scheme to create a universal electronic health record ran into serious implementation difficulties.[42] The creation of the NHS information center (NHS Digital), which seeks to coordinate and maximize the impact of information resources, is an indication of a current policy commitment to improving the effectiveness of information creation and use.

73. Information is a key resource in any health system, but it is often difficult for decision makers to assign priority to improving its coverage and quality. Information is a classic "public good" that can only be provided optimally if a central authority of some sort coordinates. It is of course possible to argue that a voluntary agreement among the constituent parts of the health system may be able to serve that purpose (for example, between the separate provinces in a federal system). However, it is more likely that the role must be assumed by the national government or a properly constituted national agency with an agreed remit. The NHS experience suggests that the latter is likely to be a more enduring and reliable approach than reliance on ministries to coordinate information resources.

[42] Comptroller and Auditor General 2011.

8. How can local accountability and involvement be assured?

74. The discussion above has highlighted the highly-centralized nature of the English NHS, and the difficulty of securing meaningful local involvement in decision making. It noted, on the one hand, the desire the provide nationally "uniform" levels of UHC, and on the other hand, the need to secure local involvement in important decisions, such as closures of hospitals and other changes to the nature and location of services. Without some sort of local accountability, there is a risk that decision making may appear illegitimate, and it may become difficult to implement needed changes. While the situation will be different in every health system, the tension between the need for some central oversight of UHC and the need to assure local legitimacy will always be present, and requires the explicit attention of UHC designers.

9. Is the workforce aligned with the expectations of UHC?

75. The ability of a health system to implement any form of UHC is crucially dependent on the nature of the workforce available to deliver the chosen services. The UK is fortunate in being a high-income country, with the resources available to train, recruit, and retain large numbers of health care professionals. However, even with that advantage, the English NHS has difficulties recruiting some types of professionals, such as emergency specialists, anesthetists, and general practitioners, and there are some parts of the country where recruitment is especially problematic. Such problems are of course greatly amplified, to a different order of magnitude, in many LMICs. In principle, as effectively a monopoly employer of many professionals, the NHS should be able to tailor employment policies to the needs of the NHS. However, it does not appear to have used that capacity to any great effect. For example, when hospitals were given the opportunity to become Foundation Trusts, they assumed the freedom to depart from national employment contracts. However, few have used that power.

76. The English NHS has experimented with a range of policy initiatives to improve workforce supply, but has relied mainly on remuneration. A recent dispute between employers and junior doctors suggests that many other factors enter professionals' considerations, in particular, working conditions (such as weekend working). Another area that would benefit from more creative policy making in almost all health systems is a more flexible approach to skill mix, for example, greater use of professionals other than doctors for some aspects of health care. To this end, the NHS is undertaking some experiments in primary care, but these are at an early stage. In many LMICs, these considerations are likely to assume a high priority when seeking to enhance UHC, requiring fundamental decisions about whether to treat human resource constraints as fixed, or to implement policies designed to relax the constraints.

10. Where does public health fit in?

77. There is a recognition that the health of the population will be a major determinant of the future demands on the health system, and its financial sustainability. Many commentators therefore argue that attention to risk factors such as nutrition, smoking, and alcohol is an important function, with benefits both for the population and for the NHS. However, the public health function has rarely been given a high profile in the NHS, and has struggled to secure resources when competing with the more immediate demands for curative services. This is one of the reasons for recently

transferring responsibility for local public health services from the NHS to local government. It remains to be seen whether this will secure a higher priority for public health, but it is in line with practice in some other high-income countries, such as the Netherlands. The political difficulty of reconciling the longer-term perspective of public health with the immediate concerns of curative services is a feature of all health systems, and is likely to be an important consideration in any design of UHC.

Annex 1: Outcomes and Indicators in the NHS Outcomes Framework for 2016–17[43]

Domain 1: Preventing people from dying prematurely

Overarching indicators

1a Potential years of life lost (PYLL) from causes considered amenable to healthcare

1b Life expectancy at 75

1c Neonatal mortality and stillbirths

Improvement areas

Reducing premature mortality from the major causes of death

1.1 Under 75 mortality rate from cardiovascular disease

1.2 Under 75 mortality rate from respiratory disease

1.3 Under 75 mortality rate from liver disease

1.4 Under 75 mortality rate from cancer

- i One- year survival from all cancers
- ii Five-year survival from all cancers
- iii One- year survival from breast, lung and colorectal cancer
- iv Five-year survival from breast, lung and colorectal cancer
- v One-year survival from cancers diagnosed at stage 1&2
- vi Five-year survival from cancers diagnosed at stage 1&2

1.5 Reducing premature mortality in people with mental illness

- i Excess under 75 mortality rate in adults with serious mental illness
- ii Excess under 75 mortality rate in adults with common mental illness
- iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services

1.6 Reducing mortality in children

- i Infant mortality
- ii Five-year survival from all cancers in children

1.7 Reducing premature death in people with a learning disability

- Excess under 60 mortality rate in adults with a learning disability

Domain 2: Enhancing quality of life for people with long-term conditions

Overarching indicators

2 Health-related quality of life for people with long-term conditions

Improvement areas

2.1 Ensuring people feel supported to manage their condition

- Proportion of people feeling supported to manage their condition

2.2 Improving functional ability in people with long-term conditions

- Employment of people with long-term conditions

2.3 Reducing time spent in hospital by people with long-term conditions

- i Unplanned hospitalization for chronic ambulatory care sensitive conditions
- ii Unplanned hospitalization for asthma, diabetes and epilepsy in under 19s

2.4 Enhancing quality of life for carers

[43] Department of Health 2016.

Health-related quality of life for carers

2.5 Enhancing quality of life for people with mental illness

i Employment of people with mental illness

ii Health-related quality of life for people with mental illness

2.6 Enhancing quality of life for people with dementia

i Estimated diagnosis rate for people with dementia

ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life

2.7 Improving quality of life for people with multiple long-term conditions

Health-related quality of life for people with three or more long-term conditions (ASCOF 1A**)

Domain 3: Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission

3b Emergency readmissions within 30 days of discharge from hospital

Improvement areas

3.1 Improving outcomes from planned treatments

Total health gain as assessed by patients for elective procedures

i Physical health-related procedures

ii Psychological therapies

iii Recovery in quality of life for patients with mental illness

3.2 Preventing lower respiratory tract infections (LRTI) in children from becoming serious

Emergency admissions for children with LRTI

3.3 Improving recovery from injuries and trauma

Survival from major trauma

3.4 Improving recovery from stroke

Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

3.5 Improving recovery from fragility fractures

Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at

i 30 days

ii 120 days

3.6 Helping older people to recover their independence after illness or injury

i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service

ii Proportion offered rehabilitation following discharge from acute or community hospital

3.7 Improving dental health

i Decaying teeth (PHOF 4.02**)

ii Tooth extractions in secondary care for children under 10

Domain 4: Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care

i GP services

ii GP Out-of-hours services
iii NHS dental services
4b Patient experience of hospital care
4c Friends and family test
4d Patient experience characterized as poor or worse
i. Primary care
ii. Hospital care
Improvement areas
4.1 Improving people's experience of outpatient care
Patient experience of outpatient services
4.2 Improving hospitals' responsiveness to personal needs
Responsiveness to in-patients' personal needs
4.3 Improving people's experience of accident and emergency services
Patient experience of A&E services
4.4 Improving access to primary care services
i GP services
ii NHS dental services
4.5 Improving women and their families' experience of maternity services
Women's experience of maternity services
4.6 Improving the experience of care for people at the end of their lives
Bereaved carers' views on the quality of care in the last 3 months of life
4.7 Improving experience of healthcare for people with mental illness
Patient experience of community mental health services
4.8 Improving children and young people's experience of healthcare
Children and young people's experience of inpatient services
4.9 Improving people's experience of integrated care
People's experience of integrated care

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm
Overarching indicators
5a Deaths attributable to problems in healthcare
5b Severe harm attributable to problems in healthcare
Improvement areas
5.1 Reducing the incidence of avoidable harm
Deaths from venous thromboembolism (VTE) related events
5.2 Incidence of healthcare associated infection (HCAI)
i MRSA
ii C. difficile
5.3 Proportion of patients with category 2, 3 and 4 pressure ulcers
5.4 Hip fractures from falls during hospital care
5.5 Improving the safety of maternity services
Admission of full-term babies to neonatal care
5.6 Improving the culture of safety reporting
Patient safety incidents reported

References

Baird, B., A. Charles, M. Honeyman, D. Maguire, and P. Das. 2016. *The King's Fund*. London: King's Fund.

Barker, R., M. Pearce, and M. Irving. 2004. "Star Wars, NHS style." *British Medical Journal* 329: 107–109.

Beveridge, W. 1942. *Social insurance and allied services.* London: Her Majesty's Stationery Office.

Boyle, S. 2011. "United Kingdom (England): Health system review." *Health Systems in Transition* 13 (1): 1–486.

Chalkidou, K., and P. Smith. 2017. "Should countries set an explicit health benefits package? The case of the English National Health Service." *Value in Health* 20 (1): 60–66.

Chamberlain, C., and W. Hollingworth. 2014. "Where is the evidence for the existence of the Cancer Drugs Fund?" *BMJ* 349: g5901.

Claxton, K., S. Martin, M. Soares, N. Rice, E. Spackman, S. Hinde, N. Devlin, P. C. Smith, and M. Sculpher. 2015. "Methods for the estimation of the National Institute for Health and Care Excellence cost-effectiveness threshold." *Health Technology Assessment* 19 (14): 1–502.

Collins, M., and N. Latimer. 2013. "NICE's end of life decision making scheme: impact on population health." *BMJ* 346.

Comptroller and Auditor General. 2011. *Department of Health: The National Programme for IT in the NHS: an update on the delivery of detailed care records systems, Session 2010–2012, HC 888*. London: National Audit Office.

Coronini-Cronberg, S., H. Lee, A. Darzi, and P. Smith. 2012. "Evaluation of clinical threshold policies for cataract surgery among English commissioners." *Journal of Health Services Research & Policy* 17 (4): 241–247.

Dakin, H., N. Devlin, Y. Feng, N. Rice, P. O'Neill, and D. Parkin. 2015. "The Influence of Cost-Effectiveness and Other Factors on Nice Decisions." *Health Economics* 24 (10): 1256–1271.

De Angelis, R., M. Sant, M. P. Coleman, S. Francisci, P. Baili, D. Pierannunzio, A. Trama, O. Visser, H. Brenner, E. Ardanaz, M. Bielska-Lasota, G. Engholm, A. Nennecke, S. Siesling, F. Berrino, and R. Capocaccia. 2014. "Cancer survival in Europe 1999–2007 by country and age: results of EUROCARE-5—a population-based study." *The Lancet Oncology* 15 (1): 23–34.

Department of Health. 2012a. *The functions of Clinical Commissioning Groups*. London: Department of Health.

———. 2012b. *The Pharmaceutical Price Regulation Scheme. Eleventh Report to Parliament*. London: Department of Health.

———. 2013. *The pharmaceutical price regulation scheme 2014*. London: Department of Health.

———. 2014. *Department of Health, Annual Reports and Accounts 2013–14*. London: House of Commons.

———. 2015. *The NHS Constitution: the NHS belongs to us all*. London: Department of Health.

———. 2016. *NHS Outcomes Framework 2016 to 2017 at-a-glance*. London: Department of Health.

Dixon-Woods, M., D. Cavers, S. Agarwal, E. Annandale, A. Arthur, J. Harvey, R. Hsu, S. Katbamna, R. Olsen, L. Smith, R. Riley, and A. J. Sutton. 2006. "Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups." *BMC Medical Research Methodology* 6 (1): 35.

Gorsky, M. 2008. "The British National Health Service 1948–2008: A Review of the Historiography." *Social History of Medicine* 21 (3): 437–460.

Hood, C., and G. Bevan. 2005. *Governance by Targets and Terror: Synecdoche, Gaming and Audit*. Oxford: All Souls College.

Littlejohns, P., and M. Rawlins, eds. 2009. *Patients, the Public and Priorities in Healthcare*. London: CRC Press.

Mannion, R., H. Davies, and M. Marshall. 2005) "Impact of star performance ratings in English acute hospital trusts." *Journal of Health Services Research and Policy* 10 (1): 18–24.

Mason, A. 2005. "Does the English NHS have a 'Health Benefit Basket'?" *The European Journal of Health Economics* 6 (1): 18–23.

NHS Act 1946. http://www.legislation.gov.uk/ukpga/Geo6/9-10/81/enacted.

———. 2014. *NHS England. Annual Report and Accounts 2013–14*. Leeds: NHS England.

———. 2015. *NHS England. Annual Report and Accounts 2014–15*. Leeds: NHS England.

OECD (Organisation for Economic Co-operation and Development). 2015. *Health at a Glance*. Paris: Organisation for Economic Co-operation and Development.

Parkin, E. 2016. *The prescription charge and other NHS charges. House of Commons Library Briefing Paper Number 07227*. London: House of Commons Library.

Primary Care Workforce Commission. 2015. *The future of primary care. Creating teams for tomorrow*. London: Primary Care Workforce Commission.

Propper, C., M. Sutton, C. Whitnall, and F. Windmeijer. 2010. "Incentives and targets in hospital care: Evidence from a natural experiment." *Journal of Public Economics* 94 (3–4): 318–335.

Public Health England. 2015. *NHS Atlas of Variation in Healthcare – 2015*. London: Public Health England.

Resource Allocation Working Party. 1976. *Sharing resources for health in England*. London: Department of Health and Social Security.

Schoen, C., R. Osborn, D. Squires, and M. M. Doty. 2013. "Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries." *Health Affairs* 32 (12): 2205–2215.

Sheldon, T. A., N. Cullum, D. Dawson, A. Lankshear, K. Lowson, I. Watt, P. West, D. Wright, and J. Wright. 2004. “What’s the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients’ notes, and interviews.” *BMJ* 329 (7473): 999.

Smith, P. 2005. “Performance measurement in health care: history, challenges and prospects.” *Public Money and Management* 25 (4): 213–220.

———. 2008. “Resource allocation and purchasing in the health sector: the English experience.” *Bulletin of the World Health Organization* 86 (11): 884–888.

Strategic Review of Health Inequalities in England. 2010. *Fair Society, Healthy Lives*. London: Government of the United Kingdom.

Towse, A., ed. 1995. *Industrial Policy and the Pharmaceutical Industry*. London: Office of Health Economics.

Webster, C. 1988. *The Health Services since the War. Vol. I: Problems of health care: the National Health Service before 1957*. London: Her Majesty’s Stationery Office.

———. 1996. *The Health Services since the War, Vol. II: Government and Health Care: The National Health Service 1958–1979*. London: Her Majesty’s Stationery Office.

The Universal Health Coverage (UHC) Studies Series was launched in 2013 to develop and share knowledge regarding pro-poor reforms seeking to advance UHC in developing countries. The Series recognizes that there are many policy alternatives to achieve UHC and therefore does not endorse a specific path or model.

The Series consists of country case studies and technical papers. The case studies employ a standardized approach aimed at understanding the tools –policies, instruments and institutions-used to expand health coverage across three dimensions: population, health services and affordability. The approach relies on a protocol involving around 300 questions structured to portray how countries are implementing UHC reforms in the following areas:

- **Progressive Universalism:** expanding coverage while ensuring that the poor and vulnerable are not left behind
- **Strategic Purchasing:** expanding the statutory benefits package and developing incentives for its effective delivery by health-care providers
- **Raising revenues** to finance health care in fiscally sustainable ways
- **Improving the availability and quality of health-care providers**
- **Strengthening accountability** to ensure the fulfillment of promises made between citizens, governments and health institutions

---

By 2017, the Series had published 24 country case studies and a book analyzing and comparing the initial 24 case studies. In 2018 the Series will publish 15 additional case studies. Links to the country case studies and the book are included below.

COUNTRY CASE STUDIES:
http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series

GOING UNIVERSAL (BOOK):
http://www.worldbank.org/en/topic/universalhealthcoverage/publication/going-universal-how-24-countries-are-implementing-universal-health-coverage-reforms-from-bottom-up

The Universal Health Coverage Study Series aims to provide UHC policy makers and implementers with knowledge about available and tested tools—policies, instruments and institutions—to expand health coverage in ways that are pro-poor, quality enhancing, provide financial risk protection and are fiscally sustainable.

WORLD BANK GROUP