The four UK health systems

Learning from each other

Author
Nicholas Timmins

The King's Fund

European Observatory on Health Systems and Policies
a partnership hosted by WHO

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Nicholas Timmins is a senior fellow at The King's Fund. Between 1996 and 2011 he was public policy editor of the *Financial Times*. He has written extensively on public and private health care. He is also a senior fellow at the Institute for Government, and a visiting professor in social policy at the London School of Economics, and in public management at King's College, London. He is a senior associate of the Nuffield Trust and an honorary fellow of the Royal College of Physicians.

Preface

This short paper is built entirely on the work of others. It is a cross between a scream of rage and a call to arms.

Within the boundaries of the United Kingdom there are four health systems that to the untutored eye – to the view from Mars so to speak – look essentially the same. At best, they appear to be minor variations on a theme – certainly not different symphonies, let alone different symphonies written by different composers.

Yet thanks to longstanding historic differences and, more importantly, to the more recent devolution of political power within the United Kingdom, these four systems are diverging in all sorts of ways. The tunes to which they march are becoming noticeably different.

From the point of view of anyone interested in policy – politician, civil servant, policy adviser, academic, member of the public – this should be a unique opportunity to compare, contrast and learn. It is an almost perfect test bed. But that isn't happening. Or, to be fair, very little of it is happening. Where it is happening, there is too little of it.

Something needs to be done to address that – and that is the central argument of this paper, which, in making the case, pejoratively or not, illustrates at least some of the differences that could be explored.

This paper rests entirely on the work of others – Marcus Longley, David Steel, Pat McGregor, Ciarin O'Neill and Sean Boyle, who, along with Jon Cylus, Sherry Merkur, Cristina Hernandez-Quevedo and Sarah Thomson, have variously written and edited papers on the four countries in the European Health Observatory series 'Health Systems in Transition'.

This has been supplemented by a seminar and part of a conference at The King's Fund and by teleconference calls around an early draft of this paper. That work in turn received strong support from Claire Mundle, Policy Officer at The King's Fund, and Anna Dixon, the Fund's Director of Policy.

If there is any merit in what follows, it is all due to them.

In order to produce something that we hoped would engage, it was clear that some broad judgements, or at least some broad observations, would have to be made. It was equally clear that not all the authors would or could agree on

these. So, while this paper is built solely on their work, for which the Fund is immensely grateful, they are not bound in any way by the detail of what follows.

Given the huge cultural and political sensitivities that lie around these issues, I would just also like to point out that while I was born in England and have lived there all my life, I have plenty of Celtic blood. This is not meant to be an Englishman's superior view from his castle. If at any point it reads like that, it is an error of ignorance or interpretation, not of prejudice.

Nicholas Timmins

Introduction

The National Health Service in the United Kingdom should be a policy analyst's dream. Since 1999, devolution to Scotland and Wales, and the restoration of the Northern Ireland Assembly, has seen health policy and the way the NHS is run diverge in the four countries of the United Kingdom.

The divergence in structures and management approaches, and indeed the differences in the way social care relates to health in the four countries, should provide a unique natural laboratory. In theory, by comparison and contrast over time, it should be possible to establish 'what works' in these different approaches, or at least some of 'what works' – even allowing for the fact that the populations of the four countries are not homogeneous in attitudes, characteristics, health behaviours or geography.

In practice, the exercise is plagued with difficulty. Some of the key data needed to compare performance – including data on waiting times – is defined and collected differently in the four countries. Assembling such data over time to allow comparison is a significant undertaking. And there is, of course, a time lag between performance and information being available. Such studies are difficult. They will always be subject to a degree of interpretation, and their findings will sometimes be vigorously disputed. For all of that, these studies are far from impossible, and much more could be done to facilitate them. Indeed that is the central proposition of this paper.

The Health Foundation, for example, in 2009 published a study of comparative clinical and quality indicators across the four countries (Sutherland and Coyle 2009). It showed differences in performance, though the differences were not all in one direction. The latest data it was able to use was from 2006, which predates both some of the policy divergence, and some areas where policy has moved more closely back in line between the countries – for example, the use of waiting time targets.

In 2010, the Nuffield Trust produced a heroic effort comparing performance through activity, again relying on 2006 data as the latest then available (Bevan *et al* 2010). The results, however, were greeted more with denial than acceptance where performance appeared to be poorer. There seemed to be a greater willingness to pick holes in the data, or seek reasons, even excuses, for less good performance rather than confront the fact that there might be a real message here, despite the problems. The Nuffield Trust is currently updating the exercise. Such studies are and will remain controversial – an object lesson in the fact that the conclusions of

attempts at comparative studies across the United Kingdom will never command universal acceptance (McLaren *et al* 2010).

Lack of universal acceptance, however, is not a reason not to conduct these studies. The fact that there are so few is due in large measure to politicians' distinct lack of interest in – indeed at times hostility towards – the idea of encouraging such studies. Their reservations are often reflected in the view of many officials. The reason, one suspects, is that each of the four countries secretly fears that its approach to running the service might not stand up to such comparative scrutiny.

Indeed, the situation is worse than that. Just as in some quarters across all four countries criticism of the NHS can produce powerful emotional responses of denial, even in the face of hard evidence, so questioning from *within* the countries about *comparative* performance between them is too often portrayed as somehow 'disloyal' – a betrayal of Scots or Welsh or Northern Irish identity.

It is almost as if there are four 'truths' around the various versions of the NHS that should not be challenged. Certainly at the political level, there remains a tendency in Scotland and Wales in particular to define their health systems as 'not England'.

England is not immune to this. In England political dispute continues not just between but within parties over the application of an element of market principles to the NHS. But among those who are, for example, committed to the values of targets and performance management, or to choice or competition, there is a distinct reluctance to consider whether the differing approaches in the other three countries may on occasion produce better outcomes. In each of the four countries there is defensiveness over difference, and a reluctance to expose performance to the spotlight. This makes discussion of the whole subject sensitive and difficult.

Nonetheless, the marked variations in policy are worth recording and reflecting on, even if it remains difficult to measure comparative performance and even harder to attribute changes in performance to policy differences. That is part of the purpose of this paper.

This paper does not present data, and it makes no attempt to conclude whether one system is performing better than another. What it does try to do is document some of the key policy areas where divergence has occurred, to highlight at least some areas where, consciously or not, policy transfer has in fact taken place across borders, and then to suggest at least some subjects where future research could provide valuable lessons.

Changes since devolution

England has undergone the most dramatic recent transformation in management and systems with the abolition of primary care trusts, strategic health authorities and the NHS executive. These bodies are being replaced by clinical commissioning groups (CCGs), which are heavily GP-led, along with a new national commissioning board, known as NHS England. This will oversee CCGs, authorising them and placing conditions on how they operate while itself commissioning more specialist services, around 35 per cent of the total. The Health and Social Care Act 2012 enshrines competition much more clearly into law in the English NHS, with the introduction of a full economic regulator, known as Monitor. Since April 2013, Monitor not only licenses and regulates NHS foundation trusts, as it has to date but also licenses not-for-profit and private organisations providing NHS-funded care and runs a 'failure regime' aimed at ensuring continuity of essential services. It oversees market rules, polices anti-competitive practices, and works with the Office of Fair Trading on foundation trust mergers and acquisitions. Alongside the board, it also has a significant role to play in setting prices – the so-called tariff – while also having a duty to promote integrated care that is in the taxpayer's and patients' interest.

These changes build on the introduction of more competition, and the re-introduction of choice, in the English system by the 1999–2010 Labour government. Labour in England also created NHS foundation trusts as freer-standing, more self-managed hospital entities. They are subject to the attentions of Monitor, the foundation trust regulator, which oversees their finances and has the power, which it has used on occasion, to replace boards. Quite what to do with those hospitals unable to make it to foundation trust status remains a continuing issue of policy. Part of the response has been to set up the NHS Trust Development Authority, which provides governance and accountability for NHS trusts in England. It is nationally accountable for the outcomes achieved by NHS trusts and is tasked with trying to get the remaining English hospitals to foundation trust status. It must also decide a future for those whose financial viability is such that they will never make it.

The creation of NHS England provides for the first time a statutory division between ministers and the Department of Health on the one hand, and the commissioning and provision side of the NHS on the other. The recent Act also transfers the responsibility for much of public health to local government. In addition, new local authority-based health and wellbeing boards are meant to

provide a common forum for the commissioners of local health care (the CCGs), the commissioners of social care (the local authorities), and the councils' public health responsibilities.

Although presented by the coalition government as a simplifying measure, the English reform has in practice spawned an at times bewildering array of often non-statutory bodies, all of which are expected to have some say and influence. These include clinical senates – advisory bodies to CCGs – and academic health science networks, whose primary aim is to spread innovation and best practice but which, like the clinical senates, may have a part to play in larger-scale hospital reconfigurations. This description has not touched on how research, education and training have been reconfigured. Any attempt to draw an organogram of how the English health system is now meant to operate is a serious challenge.

Scotland, by contrast, has abolished all vestiges of the 'internal market'. NHS trusts no longer exist. Instead, 14 geographically based NHS boards are responsible for both planning and delivering services. Scotland's 32 local authorities provide social care.

On the face of it, this may look very similar to the position in England prior to 1991. In practice, the old pre-1991 'hierarchical' approach – which in England consisted of regional and district health authorities – has been replaced by a strong emphasis on collaboration and partnership, both between NHS bodies and among staff. A fairly sophisticated form of performance management has been introduced, with regular meetings between board chief executives and Scotland's Director General for Health and between chairs and the Scottish Health Minister.

Boards in Scotland have an operating division that runs their acute hospital services. Community and primary care services are overseen by a committee of each board known as a community health partnership. Currently there are 36 of these – more than one in a number of boards – but they share geographical boundaries with local authorities. Seven of these are health and social care partnerships, accountable both to local authorities and to the health board. This is an idea that pre-dates health and wellbeing boards in England, and it has distinct differences. It nonetheless draws on a common desire to link more closely health and social care. Two health boards in Scotland are also currently experimenting with the direct election of a proportion of non-executive directors.

Because there is no purchaser/provider split, Scotland has no formal contracts between providers and commissioners, and no tariff for hospital services.

As a matter of policy, it deliberately makes much less use of what is anyway a much smaller private sector than in England. In 2010, less than 1 per cent of the budget in Scotland was spent in the private sector, against around 5 per cent and

rising in England. There is relatively little cross-border flow of patients from Scotland to England.

Scotland is also distinctive in that, following the 1999 Royal Commission on Long Term Care, it adopted that commission's recommendation for free personal care for the elderly – an approach that England has firmly rejected and Wales has likewise not adopted.

Taking a helicopter view, the position in Wales is now very similar to that in Scotland. Indeed, there are more similarities between Scotland and Wales regarding how the system operates than among any of the other four countries. In Wales, the internal market has disappeared. Seven local health boards now plan and provide hospital and community services and are responsible for primary care, although highly specialist services are commissioned by a national committee answerable to the boards. Although Wales has a smaller population than Scotland – 3 million people against Scotland's 5.2 million – the Welsh boards tend each to be responsible for more people. This has produced concerns in Wales that the boards are too large and too remote. Unlike in Scotland, there is an appreciable flow of patients in north and mid-Wales over the border to England. That creates its own difficulties over cross-border compensation for services. Twenty-two local authorities provide social care. There is, as in Scotland, a strong emphasis on partnership working. Wales, like Scotland, has deliberately limited the involvement of the private sector, which as in Scotland, is small anyway. It has effectively debarred it for clinical services. Given the rural nature of large parts of both Wales and Scotland, the scope for competition is arguably far smaller than in much of England.

Northern Ireland has always been distinct from the other three countries in that health and social care are, at least in theory, jointly commissioned. In theory too, Northern Ireland retains a purchaser/provider split. Care is now commissioned by the Health and Social Care Board, advised by five local commissioning groups. There are five geographically based health and social care trusts responsible for providing secondary, tertiary and social care while also managing the GPs' contract for primary care. Despite the commissioning arrangements, the political and managerial emphasis is on consultation and co-operation. Given also that the current arrangements are relatively new, there are questions about how far the purchaser/provider split operates in practice (O'Neill *et al* 2012). In addition, Northern Ireland's small population (1.8 million), its very small private sector, and its relative isolation from the rest of the United Kingdom, along with limited cross-border flows of patients either way with the Irish Republic, mean that there is relatively little opportunity for competition. Patient exchanges with the south are problematic due to the Irish Republic's essentially insurance-based health care system, with more co-payment, as opposed to the tax-funded approach in the north.

England has retained a decided appetite for structural re-organisation to the point where 'organisation, re-organisation and re-disorganisation' might almost be dubbed the English NHS 'disease'.

To provide the briefest of summaries for England: since 1990 GP fundholding has been invented, been dispensed with, been partially recreated and then transformed into CCGs. Regions have been abolished, partly re-invented, and scrapped again. Health authorities have gone up and down in number and role before being done away with entirely, while GP commissioning has evolved through primary care groups, primary care trusts (whose numbers themselves changed radically over the years) and on to CCGs. All that had occurred before the invention of foundation trusts and their regulator Monitor, along with new health and social care inspectorates that have themselves been created and re-organised three times in a decade.

Against that, the broad shape of the structures in Scotland has remained largely unchanged since 2004 – indeed its local authority structure has remained unchanged since 1996. There are one or two important qualifiers such as the creation, outlined above, of health and social care partnerships in some areas, and the experiment with elected board members.

Wales, on this measure, is mid-way between Scotland and England. Post-devolution structures were relatively stable until 2009 when 22 local health boards were shrunk to 7, with separate hospital trusts abolished and managed by boards that are responsible for both hospital and community services. All four political parties in Wales now publicly state that they wish to avoid any further major re-organisations of this superstructure.

Northern Ireland, where the picture is complicated by the suspension of the assembly between 2002 and 2007, is currently going through the re-organisation outlined above.

Meanwhile, choice remains an issue in all four countries, though the word, of course, covers more than one concept (Peckham *et al* 2011). There is choice of treatment – where clinicians put the options before patients and patients receive information, or seek it out themselves, and then make a choice between them. And there is choice of provider, where only in England is it being used as a policy tool to help drive competition. This does not mean that patients in the other three countries may not choose, for whatever reason, to be treated somewhere other than their local hospital, even though in those countries there are no formal contracts of the type found in England and no 'tariff' for care. Such choice between providers is not actively promoted, however, as it is, at least up to a point, in England.

Finance

At a macro level, the framework for NHS funding is set by the Westminster government. The Treasury agrees the overall NHS settlement for England. Thereafter amounts for the other three countries are determined according to the 'Barnett formula'.

This has historically produced higher spending per head in Scotland, Wales and Northern Ireland, along with a persistent if intermittent debate over how far that higher spend is justified. In recent years, the gap that the formula produces between England's spending per head and that in the other countries has in fact been narrowing.

Moreover, health is now a devolved responsibility, so Wales, Scotland and Northern Ireland can make their own decisions over how much they actually spend on the NHS.

For England, the settlement for 2014/15 is technically one of real terms growth – an increase of 0.1 per cent per year. In practice, £2 billion a year by 2014 will be transferred to local authority social care spending, which, viewed solely from the NHS's perspective, will produce a reduction in real terms expenditure. The hope is that the transfer of cash to social care may reduce pressure on the NHS by reducing unnecessary admission to hospitals and enabling the swift discharge of patients who no longer need to be there. However, social services spending in England is under severe pressure, and local government's own contribution to social care is on average falling, as councils face an overall reduction of 27 per cent in the central government grant between 2010 and 2014.

While NHS funding in England is at best at a standstill in real terms, the complex position in Northern Ireland has produced a 2.2 per cent reduction in NHS spending by 2014/15. This arose from the Northern Ireland Assembly's decision not to introduce water charges, which were due to raise revenue.

Audit Scotland has calculated that spending north of the border will fall by 4.2 per cent in real terms by 2014/15 (Feeley 2012).

The biggest divergence has come in Wales, where the Audit Office calculates spending will be 10 per cent lower in real terms by 2014/15 (Thomas 2012a). Wales faces not only the largest reduction in NHS spending in its history, but by far the largest reduction among the four UK countries. That reduction also comes alongside the judgement of the House of Commons Health Select Committee that it could not find evidence of any country in the world that had managed to hold health care spending flat in real terms for four years, let alone cut it (Commons Health Select Committee 2010).

Against that, social services spending in Wales has been reduced much less severely than in England. Between 2009/10 and 2012/13 spending on social services in Wales fell by only 3.8 per cent, compared to almost 12 per cent in England, according to the Institute for Fiscal Studies (Institute for Fiscal Studies 2012). That may or may not be a sensible approach compared to England's protection of the NHS at, so to speak, the expense of the social services expenditure. It is not, however, perceived in Wales to have made the task of its local NHS any easier. While spending pressures are mounting in Scotland, England and Northern Ireland, with more hospitals and health organisations starting to report deficits or achieving year-end balance only thanks to various forms of brokerage in the system, the strains are also already becoming evident in Wales. The Wales Audit Office warned recently that the cycle of Welsh NHS bodies over-spending does not appear to have been broken and there is 'no let up in the financial pressures for the foreseeable future' (Thomas 2012b). Waiting times, meanwhile, are starting to rise.

Two further points broadly relating to finance are worth noting – prescription charges and the private finance initiative. Wales, Scotland and Northern Ireland have all abolished prescription charges – Wales in 2007, Northern Ireland in 2010 and Scotland in 2011. Although 90 per cent of prescriptions are dispensed free of charge in England, the charge per item for those who do pay is now £7.65. Recommendations in England, first from the Commons Health Select Committee, and then from a government-appointed review to try to simplify the country's complex exemptions regime, have disappeared into the long grass.

Scotland and Northern Ireland both chose to go ahead with the abolition of prescription charges (which had been reduced in the preceding years) despite it being clear in both cases that overall health spending was coming under severe pressure. In Northern Ireland, abolition went ahead despite advice from the civil service not to proceed. Scotland and Wales have also abolished car park fees at hospitals where existing contracts, such as those under the private finance initiative, do not prevent that.

There have also been differences in the extent to which the four countries have embraced the private finance initiative as a means of renewing the hospital stock. England leads by a mile in terms of numbers of projects built, both numerically and proportionately. Some have proved enormously expensive, with the Department of Health having to take over a significant part of their cost for hospitals in south-east London as part of a major reconfiguration of services there.

There is always a natural reluctance to write off recently built stock when services are reshaped. The long-term nature of private finance initiative contracts,

however, and the severe financial penalties for exiting them, mean that in England the private finance initiative is likely to influence some decisions about the reconfiguration of services.

Politics

Devolution has undoubtedly changed the politics of health care, most notably in Scotland and Wales. Northern Ireland experienced less of an impact as suspension of its Assembly ended only in 2007.

In England, the health service remains a deeply political issue – the fierce and indeed continuing debate over the Health and Social Care Act 2012 has been a vivid reminder of that (Timmins 2012).

But health plays a far bigger role in Scotland, Wales and Northern Ireland because it is by far the largest element of the devolved administrations' budgets.

Under the devolution settlement, some large items of expenditure, notably social security, defence and debt interest, but also some smaller ones such as overseas aid, are matters purely for the UK government and UK parliament. In other words, the devolved administrations directly control only some parts of public expenditure.

As a result, health, which the devolved administrations do control, accounts for a significant percentage of their budgets – approaching 40 per cent of the Scottish government's budget and more than 40 per cent of spending by the Welsh Assembly. In Northern Ireland, where the budget also embraces spending on social care, it is more than 42 per cent of total expenditure. By contrast, in England health accounts for only around 30 per cent of all departmental expenditure – although that percentage is rising as spending on other programmes (for example, education, the environment, local government, social security, transport and much else) is being heavily cut as part of the coalition's drive to eliminate the deficit.

Health is thus a central issue for members of the Scottish Parliament, the Welsh Assembly, the Northern Ireland Assembly and for local councillors. But it also remains an important issue for Scots, Welsh and Northern Irish MPs. As a result it receives even more political scrutiny and debate in the devolved administrations than it does in England.

In England, health can become embroiled in council elections. But nationally it becomes an election issue roughly once every four years – presumably now once every five years given that fixed-term parliaments have been established for Westminster. In Scotland, Wales and Northern Ireland, however, assembly

elections do not follow the same pattern as those for Westminster, so health becomes an electoral issue every two to three years – in other words, more or less permanently.

In England, because of the gap between elections, there is a strong political perception that it is possible to do unpopular but perhaps necessary things to the NHS and indeed to social care early in a parliament because there will be time for political controversy to die back before the next election. That luxury, if a luxury it is, is no longer available for the devolved administrations.

In addition, because the devolved countries are smaller, debates on the NHS make an even less clear-cut distinction between national and local than in England. What is local more easily becomes national. This makes health appear to be even more 'politicised' in the three smaller countries of the United Kingdom.

The impression is that this increased democratisation, or 'politicisation', in Scotland and Wales has made hospital closures and reconfigurations harder, not easier.

In England they are difficult enough. Under Labour, a deliberate attempt was made to make such decisions more technocratic, and arguably more evidence-based, by creating an Independent Reconfiguration Panel. Local authority overview and scrutiny committees – England's only attempt under Labour to provide more democratic oversight over the health service – can refer contested changes of service to the panel, which then makes recommendations to the Health Secretary. The panel, by and large, has supported the case for change, though sometimes with some amendments and conditions. Almost without exception, the Health Secretary has accepted those recommendations, being able to rely on – or, if you like, enjoy the cover provided by – an 'independent' and 'expert' view. This arrangement has survived the new NHS legislation in England.

This attempt to take some of the politics out of the NHS in England around configurations has, at least in theory, gone a large step further with the Health and Social Care Act 2012. It has set up a statutory commissioning board, independent of ministers, which will operate to a mandate. Health ministers in England now have a duty to 'promote autonomy' for the various NHS bodies and regulators, although in the course of the passage of the Act that duty became subject to some qualification, including the requirement on the Health Secretary to continue to promote a comprehensive health service. How far, in practice, ministers will be able to distance themselves from day-to-day involvement in the management of the service, or how far successive health ministers will wish to do that, remains an open question – one of the many intriguing questions around how the most recent set of English reforms will operate in practice.

Up until the Health and Social Care Act of 2012, it might have been possible to make a case that coalition government in the devolved nations of Scotland and Wales, and power-sharing in Northern Ireland has produced more consistency of purpose in terms of the high-level managerial approach to how the NHS is run.

In Scotland, even ahead of devolution formally taking effect, policy consistently moved away from the internal market approach and has remained on that trajectory through Lab/Lib minority governments, an SNP-minority government and more recently an SNP-majority government. The picture is slightly less clear-cut in Wales. But in the decade since devolution the outcome there has also been integration of planning and management rather than the use of market-like mechanisms, and there has been a stability to that approach.

Any argument that this is a product of coalition has, however, been seriously undermined by the experience in England of the Health and Social Care Act. In England, the existence of a coalition – and the trade-offs made within it – resulted in the abolition of both strategic health authorities and primary care trusts, along with the transfer of much of public health to local government. The original approach from Andrew Lansley, the former Health Secretary, would almost certainly have seen public health stay where it was, with the number of primary care trusts and strategic health authorities being significantly reduced before, in all likelihood over a number of years, 'withering on the vine' in the face of clinical commissioning and the drive to turn all hospitals into foundation trusts (Timmins 2012).

Rather than being the product of coalition, the very different direction of travel taken in Scotland and Wales is more the result of those nations' political appetites. The political centre of gravity is more to the left, and for the foreseeable future it is likely that Scotland and Wales will continue to have centre-left governments, whether single-party or in coalition. The difference is thus one of ideology rather than coalition. It is also notable that the public sector as a whole plays a larger part in the economy of the devolved nations than it does in England. That gives the public sector, and the NHS and social care in particular, a larger political voice.

That rather more centre-left view of the world has informed the co-operative, partnership approach to health service management in the devolved nations. Scotland specifically embraces a philosophy of 'mutuality' between the Scottish people and the NHS. Internally it has a highly developed approach to partnership working between the trade unions and management. The partnership's remit stretches well beyond terms and conditions to broader issues such as quality and the design of services. Wales has a weaker version of the same approach, as indeed, technically, does England, though it feels weakest by far in England.

An independent review of this approach in Scotland has been praised as 'arguably one of the biggest examples of industrial democracy to be found anywhere in the world – and they have made it work' (Bacon and Samuel 2012). However, the direct links between its existence and improvement in care and performance are neither clear nor easy to make.

Part of this agreement in the face of the spending squeeze is a non-compulsory redundancy approach. The same has applied in Wales. While clearly comforting for staff, it is not clear how this contributes to the reshaping of services and the greater integration of care that is accepted as a policy goal across all four countries. Indeed, among some managers in Wales and Scotland the view is held privately that this provision, along with heavy limitations on the use of the private sector as a catalyst for change, acts as a barrier to reconfiguring services (non-attributable conversations 2013).

More local democracy – more 'politicisation' – may also have played a part in the decisions on prescription and car park charges in the devolved versions of the NHS. Both decisions are understandably popular. Some, however, will tend to see such changes as pandering to populism, particularly at a time of severe spending constraints, rather than addressing far more fundamental questions such as raising the quality of care, improving outcomes and dealing with striking differences in performance within each country.

Lessons and opportunities

While for reasons already discussed, there is often a reluctance to acknowledge learning from each other, this has clearly taken place on occasion, albeit indirectly. But it is equally clear that there are many more opportunities to be seized. What follows is a far-from-comprehensive list of both lessons learnt, or partially learnt, along with some of the opportunities that are going begging.

Markets and personal care

One of the most dramatic differences between the countries is in the use of market-like mechanisms in the management of the NHS, which England continues to embrace and indeed is extending. By contrast, politicians from Scotland, Wales and Northern Ireland would, in the main, argue they have learnt, from the English experience, not to adopt such an approach. Equally, many English politicians would argue that they have been proved broadly right in their resistance to the idea of free personal care by Scotland's experience of it. Costs for this have risen inexorably – in cash terms more than doubling in seven years from £219 million to £450 million – with the development of local waiting lists for access to it (Scottish Government 2012).

Targets and public service agreements

In terms of day-to-day management of the NHS, however, one of the most obvious examples of lessons learnt is over the use of targets. Initially, Wales rejected, and Scotland was at best lukewarm about, the target-driven approach to waiting times that the English NHS adopted, ahead of the re-introduction of choice and competition. Targets have their problems. They can distort clinical priorities, at least for a time. They have on occasion produced truly perverse outcomes – for example, ambulances queuing for hours outside accident and emergency (A&E) departments to delay the 'four-hour' clock starting in the department.

But there is no doubt that 'targets and terror', as the approach was originally dubbed by Gwyn Bevan and Christopher Hood, worked in England by focusing management effort on reducing waiting times as a key priority (Bevan and Hood 2006; Propper *et al* 2007). In England they duly fell, sharply and steadily. By 2005, even despite the difficulty of directly comparing waiting times *between* the countries, it was clear that waiting times *within* countries were coming down faster in England than in Scotland, Wales or Northern Ireland. The devolved administrations decide to follow suit, either adopting such targets,

or strengthening the political will behind them. In each case waiting times fell – although none of the devolved administrations adopted quite the draconian approach taken in England where a chief executive's job could, literally, depend on hitting the target if it was repeatedly missed. The 2010 coalition government in England, having first given the impression that it was abandoning waiting time targets, has now reaffirmed them, although they appear to be subject to less direct and aggressive performance management from the centre than was the case in the past. At the time of writing waiting times in England were holding up well, at least on the national measures, although this may change with the effects of the spending squeeze.

Northern Ireland also followed the broader English approach under Labour of detailed public service agreements for government more generally, not just for the health and social service department. There this approach has brought the same gains (such as clarity over what is expected to be achieved by the use of public money) and the same problems as in England. Some of the targets are very general in nature, many depend on action by more than one department, and attribution of success and failure is not easy. The Department of Health, Social Services and Public Safety performed poorly compared with other departments when the public service agreements were reviewed in 2011. But it is not clear that any penalties were incurred, or indeed that much action followed, as a result of that poor performance.

Data and transparency

Scotland has a long and honourable tradition of clinical audit that over the years, both before and after devolution, has helped inform the approach of the other countries. Like the English NHS, which declared quality to be the 'organising principle' of the service following the Darzi review of 2008 (Department of Health 2008), Scotland has put heavy emphasis on improving the quality of the service. In both cases that has been done in part in the belief that this will improve productivity and efficiency by eliminating error, repetition and waste. Wales too has moved to make quality more central. It would be difficult to decide who learnt what from whom in this area. But the parallel emphasis on quality is notable, even if hanging on to this as the central concept may prove challenging as the money gets tighter. Comparing the somewhat differing approaches may well offer lessons.

Furthermore, particularly in the wake of the recent Francis report into care at the Mid Staffordshire NHS Foundation Trust (Francis 2013), England appears to be poised to publish far more data on clinical quality, performance and patient experience. How this 'transparency' agenda plays out will provide lessons for all four countries.

Health technology assessment

After England established in 1999 the National Institute for Clinical Excellence (now known as the National Institute for Health and Care Excellence, or NICE), Scotland set up the Scottish Medicines Consortium in 2001. It has a narrower remit than NICE, concentrating on advising which medicines the Scottish NHS should and should not adopt, as opposed to broader health technology assessment. Since its foundation, NICE's remit has expanded enormously to include guidelines on best practice, such as the best organisation of services, as well as more recently a similar role in social care and public health.

Over the years, the Scottish Medicines Consortium and NICE have reached conclusions that are remarkably – and reassuringly – similar on the provision of medicines. In the early years, the fact the Scottish Medicines Consortium reached its conclusions more quickly than NICE clearly contributed to a speeding up of NICE's own decision-making processes. In a move that arguably undermines NICE's role, the decision of the English coalition government to create a cancer drugs fund has put pressure on Scottish Health Ministers over the availability of some newer cancer drugs in Scotland.

NICE's recommendations are, broadly speaking, followed in Wales and Northern Ireland.

Inspection and regulation

In 2003, the Scottish Medicines Consortium became part of Quality Improvement Scotland while retaining its own identity within that. Quality Improvement Scotland brought together in one organisation the consortium, the pre-existing production of guidelines for the Scottish NHS, and other elements of the Scottish system that at least in part mirror England's Healthcare Commission (the then NHS inspectorate), the National Patient Safety Agency, and the Modernisation Agency (now the NHS Institute for Innovation and Improvement). Since 2011, Quality Improvement Scotland has been renamed Health Improvement Scotland, adding inspection of private sector clinical facilities to its role. Inspection of services in Scotland is heavily clinically led through peer review, with significant patient input.

Wales has a Healthcare Inspectorate covering both the public and private sectors, while Northern Ireland relies on a Regulation and Quality Improvement Authority.

In England, inspection has morphed its way through various bodies into the Care Quality Commission, which is now, in the wake of the Francis report (Francis 2013), again rethinking its approach to inspection and regulation.

Given the longstanding struggle over *how* to inspect hospital services effectively, the opportunities to learn at least something from differing approaches are obvious.

Public health

All four countries face very similar challenges over public health – rising obesity, excess alcohol consumption, a proportion of their population who still smoke to name but three – even if the scale of these challenges varies by country.

On both smoking and alcohol there has been a regulatory response, but not a consistent one in either time or degree across the four countries. Scotland pioneered a smoking ban in public places. The other three countries followed suit shortly afterwards. However, differences in the legislative timetables, and the gaps between legislation and implementation, hide the degree of controversy over this, and the extent to which the Scottish debate and experience clearly had an influence elsewhere. Scotland implemented its ban in 2006. Wales and Northern Ireland followed shortly afterwards, and England, after considerable controversy within the Labour government, followed suit in 2007.

Scotland has legislated for a minimum price for alcohol, although at the time of writing it remains subject to legal challenge and has yet to be implemented. England has outlawed the sale of alcohol at below the cost and tax price and has repeatedly considered the idea of a minimum price for alcohol but, as yet, has not implemented it.

Workforce and size

There are clearly issues around size, from which Scotland, Wales and Northern Ireland could potentially learn from each other. Indeed England might be able to glean something in terms of manageable regions or areas.

There are workforce problems in all four countries, but size appears to exacerbate them particularly in Northern Ireland and Wales. In the area of medical staffing, for example, these two countries appear to be especially vulnerable to the loss of key specialists given that each has relatively little alternative provision. England is displaying a growing tendency to concentrate more specialist services in more specialist hospitals, for a mix of training, medical roster and quality of service reasons. That may well have a knock-on effect for smaller Welsh district general hospitals outside Cardiff and Swansea as doctors in training, and indeed those seeking consultant posts, gravitate towards hospitals that are perceived to provide a higher quality of service. There are already, for example, difficulties in recruiting sufficient paediatricians to staff the existing hospitals in Wales.

Some things may be easier to do in smaller countries; some harder. An understanding of the reasons for this would be helpful.

There are also broader questions that Scott Greer and Alan Trench have raised about the longer-term tensions that could emerge over, for example, policy for communicable disease control, as well as other changes that could affect the various countries' ability to recruit and retain professional workforces as pay and broader terms and conditions start to diverge between the four. The recent agreement on a new contract for GPs in Wales and in Scotland, and the evident tensions over a somewhat different new GP contract in England, is an example of that. If terms and conditions start to diverge significantly, the result could be unintended professional flows from one country to another. The same potentially applies to education and training, where it is entirely possible that the redesign of health care will produce new roles in one country or another that have no strict equivalent in the others (Greer and Trench 2010).

Integrated care

Better integration of care is high on the agenda in all four countries, though there is often no common definition of what integrated care means. Is it merely better integration between primary and secondary care? Or does it mean between either or both of those and community care? Does it mean all three elements along with social care? Or better integration of physical and mental care? And does achieving better integration require new organisations, or merely new governance arrangements – or new ways to challenge professional and behavioural boundaries, or new funding mechanisms? If so, which ones?

In all four countries, the bulk of GPs remain independent contractors while the responsibility for the oversight of primary care lies in different places in the different countries. Simply allocating oversight of primary care to a single managerial body, as in Scotland, Wales and Northern Ireland, does not yet appear to make it appreciably easier to integrate primary and secondary care. Scotland has a policy allowing boards to increase their own provision of GP premises, allowing larger, purpose-built surgeries that could also accommodate community services (a narrow but nonetheless useful form of integration). Capital for that development, however, is now decidedly limited.

A forthcoming paper to be published by The King's Fund looks at integrated care in Scotland, Wales and Northern Ireland more closely (The King's Fund, forthcoming). Preliminary analysis suggests that Scotland appears to have made more progress, perhaps in part due to its relative organisational stability over the past decade and the commitment of successive ministers and leaders in both the NHS and local authorities.

An impact on emergency bed use and on delayed transfers can be demonstrated, as can lower than projected use of care homes, with managed clinical networks playing a part in this. Even so, health boards have struggled to bring about any significant shift of resources from hospitals to the community, hence the introduction of the new health and social care partnerships in a bid to tackle that.

Northern Ireland, despite common funding of health and social care, has some local examples of innovation. But there is little systematic evidence of measurable improvements for the population as a whole from what, purely on the face of it, is the most integrated funding system in the United Kingdom. Paradoxically, it may have made social care more subservient to health care.

Wales is still at an early stage, but there is evidence that emergency admissions and re-admissions for conditions such as chronic obstructive pulmonary disease and diabetes have declined significantly, though from a poor base and for a range of reasons (The King's Fund, forthcoming).

However, the comparisons are not helped by having different data sources and differing availability of evidence in the three countries.

One interesting question is whether the new arrangements in England will make integration of health and social care any easier. In England, GPs should now have a powerful voice in commissioning. They will also, however, have a more direct interest in the commissioning of social care, and be more answerable to local authorities for their health provision, through the health and well-being boards. At the same time, CCGs might, at least in theory, have an interest in improving their poorest performing practices, even though the contract for general practice will be held by NHS England.

Whatever the answers to these questions – and despite the differences in managerial approaches – there is clearly much that could be learnt by the countries from their differing efforts to achieve what is now widely accepted to be a key policy goal across all four countries.

Prescription and car park charges

The differing approaches to prescription and car park charges, though relatively narrow issues, are notable. In England both appear on the political agenda from time to time. Indeed, just ahead of the 2010 election, Labour announced plans to phase out most hospital car park charges in England over three years – a measure promptly scrapped by the Conservative/Liberal Democrat coalition.

Under Labour in England, the rate of increase in prescription charges was constrained. But there has been no willingness to move towards abolition as

there was in Scotland, Wales and Northern Ireland. Labour in England argued, as does the coalition, that the money raised (some £450 million in England, or very roughly 0.5 per cent of the budget) should not be lost.

The argument around prescription charges is that while almost 90 per cent of prescription items in England are still dispensed free, the charge deters people whose earnings are only just above the qualification level from getting treatment.

In practice, when Wales abolished prescription charges there was less of a surge in prescriptions than might have been expected. Overall, there was a roughly 1.5 per cent increase in Wales over and above the rise that anyway occurred in the north-east of England, whose population in socio-economic terms is broadly similar (Cohen *et al* 2010). As health service budgets tighten, it will be interesting to see if free prescriptions survive in the devolved administrations, or whether charges will return – as they did nationally when the then Labour administration abolished them in 1965 but reinstated them three years later due to economic difficulties.

Harder to discern is whether a rise in prescribing following the abolition of charges is a reflection of unmet need finally being met, or merely the result of people claiming something that is now free. An attempt to answer that question has been made in Wales (Groves *et al* 2010). But the availability of linked records in Northern Ireland offers a richer opportunity to explore that issue. Given that it is possible that increased charges for prescriptions may come back on to the English agenda – or the restoration of charges in the devolved administrations – a clearer answer to the question of how far charges are a barrier to necessary care would be valuable.

Hospital reconfiguration

All four countries face controversial hospital reconfigurations. England now has an unsustainable provider regime for dealing with the most extreme examples of clinically or financially failing trusts. That issue is likely to become larger if the current desire to move more care out of hospital is realised. There can be powerful cases for re-organising services on clinical grounds that are not driven by finance, even if financial savings may follow. For example, the reshaping of London's A&E stroke service into just eight centres.

Northern Ireland has undertaken a recent review of its health and social care services (the Compton report). The review pointed out that if the pattern of hospital services mirrored that in England, then Northern Ireland would have just four acute hospitals rather than eleven (Compton 2011). Scotland and Wales both face significant changes to the number of hospitals they have, and what precisely those hospitals should be doing. How the countries attempt to build support for

changes to the shape of hospital services, and how far they are able to reconfigure them may well offer learning opportunities.

As outlined above, England in recent years has attempted to ensure that decisions about reconfigurations are more technocratic and less subject to emotion and political lobbying. However, one key counterpoint to this has been the development of an accelerated special administration, or 'failure' regime – the unsustainable provider regime – for those NHS trusts that have hit apparently insuperable financial problems.

This arrangement, legislated for by Labour, has recently been used for the first time in south-east London. One of its effects, however, is to bring the final decision very clearly back to the Health Secretary's desk. He or she has to accept, reject or modify the special administrator's recommendation.

In theory, this sounds little different to deciding upon a recommendation from the Independent Reconfiguration Panel. In practice, certainly in the one example to date, it feels very different, chiefly because the issue affected four large hospitals across the whole of south-east London – ie, a very large service change which had knock-on effects to adjacent hospitals. Compared to decisions on recommendations from the Independent Reconfiguration Panel, this felt much more like a ministerial decision – or appeared much more transparently like one. The expectation is that the special administration regime will have to be used in other parts of England.

Highly controversial though it has been on its first outing, the unsustainable provider regime does nonetheless have the advantage of bringing longstanding issues to a head regarding the viability of services, in terms of both quality and finance.

More locally in England, the local authority overview and scrutiny committees remain. But proposals for changes to services will also be discussed in the new health and wellbeing boards, which bring together the interests of local authorities and the CCGs. Again it remains to be seen whether closer involvement of local authorities in commissioning will make change of service easier or harder.

Management and bureaucracy

There are concerns in all four countries about bureaucracy – using the word less to cover actual management costs than the number of bodies involved in health care. Audit Scotland, for example, in 2011 criticised the 'cluttered institutional landscape', and complex governance and accountability arrangements for community health partnerships, which are now being re-organised into health

and social care partnerships. There are questions in Northern Ireland over whether the current re-organisation has in fact reduced the size and function of the 'quango state' involved in health. In Wales there is concern that the new local health boards may be too large and remote.

While one justification for the major restructuring of the English NHS was to cut management costs, the reforms have in fact spawned a plethora of new or nascent bodies, not all of them statutory. Aside from NHS England with its extensive responsibilities for commissioning specialist services, approving CCGs and holding the primary care contracts, there is the NHS Trust Development Authority, tasked with steering remaining trusts towards foundation trust status. In addition to the 211 CCGs, there are also clinical senates, academic health science networks, local education and training boards to provide the new arrangements for education and training, health and wellbeing boards, and assorted re-cast clinical networks, to name but a few. Perhaps presciently, Mike Farrar, chief executive of the NHS Confederation recently warned of the dangers of a 'tsunami' of bureaucracy (NHS Confederation 2012). He has led a review of the bureaucratic and regulatory burden on the English NHS with the aim of reducing that by one-third. Some of its recommendations are clearly specific to England (Farrar 2013). But the part of its remit relating to information and data collection may well also have lessons for the other three countries.

Some of these studies may be more fruitful if the comparison is between Scotland and Wales, or between Wales and parts of England. For example, there have been studies that have chosen to compare Wales solely to north-east England where the socio-demographic characteristics of the populations, and the geography, are more comparable than between Wales and England as a whole. Both the Nuffield Trust's 2010 assessment of performance and funding in the four countries and the Wanless review of health and social care in Wales in 2003 did that (Connolly *et al* 2010; Wanless 2003).

These are just a few of the more obvious areas where the countries could learn from each other. There are plenty of others, not least Scotland's greater and earlier success in getting an electronic and shared summary care record in place, despite England investing vastly greater sums in its National Programme for IT, otherwise known as Connecting for Health. Equally, Scotland and England have both created clinical networks – non-statutory networks of clinicians in particular diseases or medical specialisms – as a means of both raising the quality of service and re-organising how and where they are delivered, sometimes on a 'hub-and-spoke' approach. There is plainly potential for clinical networks in the different countries to learn from differing approaches to the same core idea.

Conclusion

As the outline above makes clear, it is not that there is no cross-country learning and indeed more of it will take place. Public Health England and Public Health Wales, for example, are planning a joint study on the effectiveness of public health policies not just in Wales and England but in smaller jurisdictions more similar to Wales, including Scotland, New Zealand and British Columbia.

But the most striking conclusion that remains after any attempt, however shallow, to compare the NHS across the four countries of the United Kingdom is that there is a huge opportunity going to waste.

After all, the four countries are facing essentially the same issues. All face severe financial pressure, although it is more pronounced in some countries than others. Spending is set to be at best flat in real terms until at least 2014 – with NHS spending already declining in real terms in Wales, Scotland and Northern Ireland. There is the distinct possibility that money will get even tighter in the immediately succeeding years as the UK government seeks to eliminate the deficit.

All four countries face similar pressures from technological advance, from an ageing society, from obesity and other public health issues. Equally, there is a broad consensus in the policy and managerial community across the four countries that more care needs to be moved out of hospital and into community settings, including into primary care and patients' own homes. That implies a significant reconfiguration of hospital services, though the extent to which that implies complete closure of hospitals – always a controversial issue – looks likely to vary between countries.

The difficulty of assembling timely and genuinely comparable data means, however, that it is remarkably hard to say which country is doing better, or getting better value for money compared to the others.

Even where differences are longstanding – such as Northern Ireland's approach to combining the management of health and social care – there is a shortage of studies to demonstrate whether managing the two together has produced better or worse results.

In the interests of transparency and value for money, the governments of the four countries really should swallow their fear and pride and take steps to make the data comparable.

A whole systems comparison between the four countries may be an over-ambitious agenda. But more comparable data would allow a better answer over time to a whole range of key issues around the organisation of clinical care, mechanisms for change, the means for achieving more integrated care and much else.

It is impossible not to echo the conclusion of a Welsh Audit Office report in June 2012: that the four health departments are charged with securing value for public money. And that the four health services offer a natural starting point to better understand the factors that affect value and the impact of diverging health policies and systems on performance.

To bring this about, ministers and their health departments need to agree the specific indicators that would provide the most insight, establish the data needed to make comparisons and identify how to collect and collate that data cost-effectively.

This is a call to arms that should be answered. In the meantime academics, their funders and others should do whatever is possible with what is available. And they should do so without fear of the answers. It is a public duty.

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