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Issue Brief

International Innovations in Health Care: Quality Improvements in the United Kingdom

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ABSTRACT: Starting in 1997, the United Kingdom has introduced a series of interdependent legislative and regulatory reforms to improve access, treatment, and administration in the National Health Service (NHS)—attracting worldwide attention in the process. The NHS quality agenda involves a centrally coordinated program, defined quality targets, public reporting, enhanced incentives for stakeholders, improved information technology, and increased financial support. These efforts so far seem to be improving care in a country that suffered from a long list of serious health care problems.

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Introduction

The United Kingdom has implemented one of the world's largest initiatives to improve the quality of health care.¹ Quality of health care was a cornerstone of the New Labour Party's election campaign in 1997. Since then, the government has introduced a series of interdependent legislative and regulatory reforms to improve access, treatment, and administration in the National Health Service (NHS). Their scope and purposeful design have attracted attention from around the world, including the United States.²

About the National Health Service

The NHS was established in 1948 to provide health care services without regard to an individual's ability to pay. The NHS is now the largest organization in Europe,³ employing 1.2 million individuals⁴ and serving 60 million people.⁵ On any given day, nearly 1 million patients visit their family doctor, 33,000 get treated in emergency rooms, and 25,000 undergo an operation.⁶ It serves all the residents of England, Wales, Scotland, and

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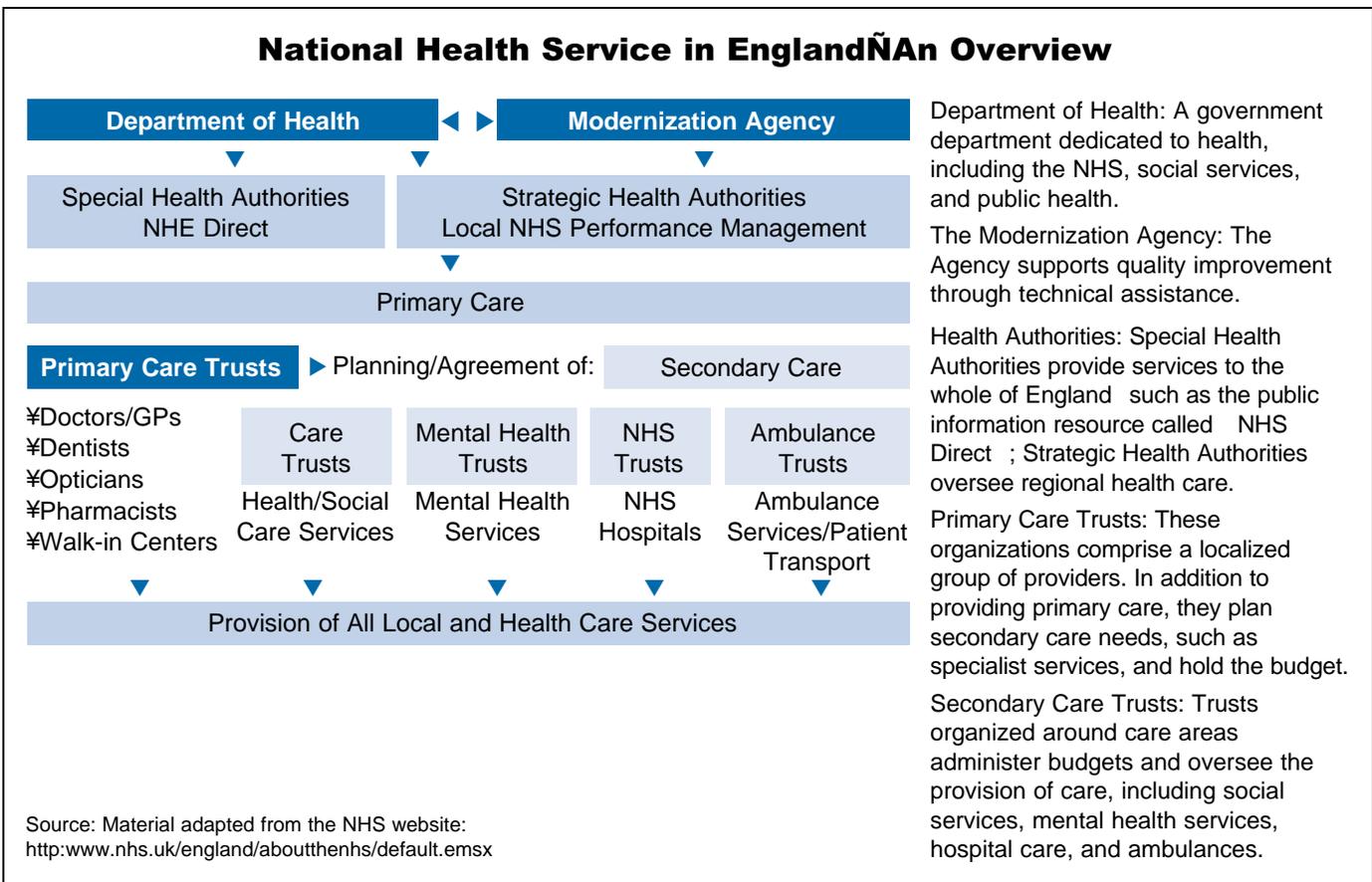
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Northern Ireland,⁷ although its organizational structure and administration differ slightly in each country. These differences partly reflect the asymmetric government patterns of “devolution”—a series of policies that give greater responsibility to the individual country governments, rather than to the UK Parliament.⁸ Health legislation is determined by Parliament at Westminster and in Scotland and by the Assemblies in Wales and Northern Ireland.⁹

The NHS provides a full range of health care services, including emergency, ambulatory, hospital, rehabilitative, mental, ophthalmologic, dental, and home care, as well as inpatient and outpatient drugs. The system, funded by a mixture of taxation and national insurance contributions, is generally free at the point of care, and there are few cost-sharing practices (e.g., copayments).¹⁰ The NHS accounts for 88 percent of health expenditures. There is also a private health care market,

made up of private organizations and providers from the NHS who practice privately after hours. The private market is funded through insurance policies and some out of pocket spending.¹¹ Approximately 12 percent of the population is covered by private insurance.¹²

The NHS has experienced several structural and financial reforms since its inception. Key elements of the financing structure today include an increasing emphasis on patient choice and a move to case-mix reimbursement of hospitals.¹³ Key elements of the delivery structure today include an emphasis on local decision-making. General practitioners are organized into groups called Primary Care Trusts that hold the budget for primary and secondary care planning. Hospitals and providers of secondary care (e.g., consultants) are organized into trusts that contract with the Primary Care Trusts. The basic structure of the NHS in England today is shown below.¹⁴



Quality in the NHS

The government's "quality agenda" is a 10-year plan for improvement, announced in 1997¹⁵ and rolled out in waves with ongoing revisions. It includes legislative and regulatory actions, new programs and organizations, structural changes, modification of financing mechanisms, and evaluation efforts. The reforms are not uniform in all four countries, but in general the agenda emphasizes detailed targets for achievement, performance feedback, and public reporting. Efforts have been supported by a significant increase in funding, much of which draws on tax increases. UK health spending will grow from 6.8 percent of gross domestic product in 1997 to 9.4 percent in 2007–08.¹⁶

Current efforts to improve quality were motivated in part by a crisis of confidence in the NHS. Concerns stemmed from visibly rundown buildings, inadequate equipment, and relatively few available doctors,¹⁷ which resulted in underprovision of care and long waiting lists. UK health outcomes, such as cancer survival rates, were also notably lower than their European and American counterparts.¹⁸ Concerns about quality were heightened by a series of public incidents, the most famous of which was the Bristol Infirmary tragedy, in which 29 children died and four were left brain damaged because of doctors' negligence.¹⁹ The problem with quality apparently stemmed, in part, from low levels of funding.²⁰ In 2000, per capita total health spending was \$1,813 in the United Kingdom, compared with \$2,387 in France and \$4,540 in the United States.²¹ Poor stewardship and financing mechanisms apparently also affected the quality of care.²²

Although it is difficult to assess the quality agenda this early, several assessments suggest that key "building blocks" are in place and successes in key areas are apparent.²³ Waiting times have decreased, for example. The number of patients waiting 12 months or longer for admission to a hospital fell by more than 50 percent during

2002–03, and is expected to be eliminated by 2005.²⁴ In a recent study, 86 percent of hospital executives in the UK felt that waiting times had improved in the past two years.²⁵ However, the public has yet to perceive the impact,²⁶ and important problems remain. A fifth of UK residents still wait more than six months to get admitted to a hospital,²⁷ the number of doctors has not reached the level that experts believe is needed,²⁸ and there is still geographic variation in care.²⁹ Ongoing challenges for the quality agenda include improved data monitoring and greater support for the primary care doctors who have been charged with increasing quality efforts.³⁰

Key Initiatives of the Quality Agenda

National Institute for Clinical Excellence

Historically, the NHS has had geographic variations in care. Providers have differing abilities to keep up with new treatments and technologies, and the level of regional funding varies. In response, the government established the National Institute for Clinical Excellence (NICE) in 1999.³¹ NICE develops guidelines with respect to pharmaceuticals and technologies, treatments, and surgeries in England and Wales.³² While its primary purpose is to reduce variations in care by providing standardized best practices, the organization also aims to:

- Prioritize treatments and make more efficient use of fixed financial resources;³³
- Prevent unproven practices from becoming the norm;³⁴
- Motivate innovation by disseminating new treatments more quickly.³⁵

NICE is the first national body in the world to provide guidelines across this range of care.³⁶ Unlike other guideline organizations, NICE considers clinical evidence and cost effectiveness, as well as the clinical priorities of the NHS.³⁷ NICE receives input from NHS staff, the academic community, industry, other experts, and the public.³⁸ Providers are expected to take the guidelines into

account in decisions. In the area of pharmaceuticals and technologies, health authorities and primary care trusts must provide funding to support doctors who wish to follow the guidelines.

However, NICE guidelines do not override individual doctor choices or negate responsibility for making appropriate care decisions for individual patients.³⁹

The World Health Organization has called NICE a leader in guideline development and dissemination.⁴⁰ NICE has increased acceptance of the idea of guidelines, even if there is disagreement about specific recommendations.⁴¹ NICE's strengths include relative transparency in its development process. There are many opportunities for input, and the organization's Web site makes meeting minutes, committee member information, and supporting documents publicly available.⁴² NICE also accommodates feedback.⁴³ For example, after criticism of its public responsiveness, NICE introduced the Citizens Council to ensure that the values underpinning the guidelines "resonate broadly with the public."⁴⁴

Other aspects of NICE have received mixed reviews and stimulated debate:

- There are differing opinions about NICE's impact on the quality of care, health outcomes, and the allocation of resources.⁴⁵ One reason is that doctors follow the guidelines to differing degrees. NICE recently recommended that doctor contracts assess guideline utilization,⁴⁶ added a staff member responsible for guideline uptake, and revised the Web site to assist doctors in charge of local quality efforts.⁴⁷
- Some are concerned that a national guideline organization could ration care,⁴⁸ but NICE denies this.⁴⁹ Others counter that all care is rationed in the sense that health services are prioritized because funds are limited, adding that they would prefer care be prioritized on clinical reasoning rather than on price.⁵⁰
- Some are concerned that national guidelines slow the pace of scientific discovery because

NICE requires extensive experimental evidence before approving a new drug or technology.⁵¹

Others suggest that NICE will help disseminate new technologies more quickly and therefore motivate scientific discovery.⁵²

- Some argue that the process is subject to manipulation of advocacy groups and industry,⁵³ while others maintain that the perspectives are balanced.⁵⁴

The New General Practitioner Contract

General practitioners (GPs) play a central role in both clinical care and the administration of the NHS.⁵⁵ Almost everyone in the UK is registered with a GP who serves as a primary care provider and gatekeeper to hospital care and other secondary services. GPs are independent contractors within the NHS, but the vast majority operate with a nationally recognized contract.⁵⁶ In the past, GPs were paid according to the number of people on their register. They were required to be available 24 hours a day ("out of hours"), and they received few financial rewards for the quality of care they provided.⁵⁷

As of April 2004, GPs in all four countries work under a new contract that rewards them for quality. The contract uses a pay-for-performance system in which GPs can increase their salary by fulfilling a set of predefined quality objectives.⁵⁸ This effort to use quality incentives is believed to be the world's largest.⁵⁹ The new contract is also designed to improve GP morale, recruitment, and retention (especially in underserved regions) by allowing for greater flexibility in the hours that GPs work and the services they provide and by simplifying payments.⁶⁰ GPs will be able to opt out of providing "out of hours" services and some alternative services, although there is a financial cost to that decision.⁶¹ This voluntary program focuses on reward for good practice rather than punishment for poor performance.⁶²

Under the quality incentives component of the contract, called the "Quality and Outcomes

Framework,”⁶³ GPs can earn up to 1,050 “points” for achieving fixed goals in four areas: clinical care (such as diabetes care and hypertension), organization (such as record-keeping), patient experience, and additional services (including maternity services).⁶⁴ The measures were chosen because they address illnesses or conditions that are widespread or have a high burden of disease and have clearly defined criteria for measurement.⁶⁵ The points translate to financial rewards for GPs.⁶⁶ An average group practice’s annual gross earnings could potentially increase approximately \$230,000. Because there are three doctors in the average practice, this translates to approximately \$76,000 for the individual doctor’s gross earnings.⁶⁷ GPs also are given initial funds to prepare for raising quality standards in their practice, which they may spend on upgrading infrastructure or adding staff or information technology, for example.⁶⁸ The project is funded with a 33 percent increase in the primary medical service budget between 2003–04 and 2005–06.⁶⁹

Many experts hope that this system will affect quality of care and ultimately health outcomes in the UK.⁷⁰ The incentive program has several strengths. For example, the contract includes clear, cost-effective targets in a range of clinical and practical areas that address process as well as outcomes. The scoring allows doctors flexibility in choosing targets they wish to focus on, and they encourage teamwork because the targets are based on a group practice.⁷¹ Some also suggest that there may be a “spillover” of high quality care that reaches beyond the program’s objectives.⁷² However, there is no conclusive evidence about the effect of financial incentives in general,⁷³ and this project is seen as an important trial of the idea.

Unintended negative outcomes are possible. There is concern that doctors will cheat the system. While the program has a formal review,⁷⁴ some forms of cheating (like misrepresenting data in a patient’s file) are difficult to discover.⁷⁵ NICE

aims to improve its point system, recognizing that the current profile does not adequately address some areas, like mental health.⁷⁶ There is concern that some doctors will not treat a patient as a whole person if they focus on specific targets. This problem may not occur with such a wide range of targets, but it will be monitored.⁷⁷

National Program for Information Technology

Until recently, providers’ use of computers and the Internet was inconsistent. Different local IT systems made it difficult for providers to share information.⁷⁸ Responding to recommendations by key consultants,⁷⁹ the NHS in England has developed the National Programme for Information Technology (NPfIT).⁸⁰ NPfIT aims to facilitate secure communication among all providers and patients, provide timely information to support treatment decisions, give patients access to their personal health care information, streamline processes of care, improve training and education for providers, and support data analysis with much greater access to current data. Ultimately, the NPfIT will connect 30,000 GPs to nearly 300 hospitals.⁸¹

Although the NHS’s IT program has many interlocking pieces, the 2002 NPfIT targets four core elements:⁸²

- Improving the infrastructure, including hardware and software, as well as establishing a New National Network (N3) to provide secure broadband connectivity for all providers. The goal is not only to provide e-mail communications, but also to provide sufficient bandwidth for universal access to information-rich resources, including the National electronic Library for Health. The goal is also to ensure the foundation for future developments and to encourage innovation in areas like telemedicine, where doctors can diagnose and treat patients remotely.
- Enhancing electronic records within the NHS Care Records Service. Basic features have been

rolled out in 2004, and more advanced features are expected to be available for all by 2008. Detailed information about particular episodes of care will be held in electronic records at the local level, while a lifelong summary of important information (such as summaries of major episodes of care or surgeries and allergies) is held in a central “spine.” The goal is to support both clinician decisions and patient self-management.

- Providing electronic prescription processes. The plan will allow providers to write and send prescriptions electronically to local pharmacies for patient pickup. Electronic prescriptions will allow improved efficiencies in the process with a goal of increasing convenience, reducing prescription errors, and creating a long-term record that ties into the patient’s electronic record.
- Creating an Electronic Booking Service. GPs will be able to book appointments in hospitals and other secondary care facilities, which will reduce waiting lists by replacing a cumbersome manual process. The goal is to improve patient satisfaction, as well as provide a more efficient access point to care.

The NPfIT may become the world’s largest IT program.⁸³ Unlike past NHS efforts, the current strategy emphasizes a comprehensive national program with national standards for compatibility and central management of implementation.⁸⁴ The plan emphasizes centralized procurement from a small list of top firms to gain cost efficiencies,⁸⁵ both in the initial financial outlay and in ongoing contracts with strict quality checks.⁸⁶ NPfIT has been supported with significant financial increases, including a \$4.14 billion increase for 2003–06.⁸⁷

Many believe that the NPfIT could enable the NHS to surpass other countries on total health care quality.⁸⁸ Key strengths of the program include its strong political and financial support, as well as ongoing input from key stakeholders. NPfIT also has created a “Gateway” review process to review projects during the process and rein in unnecessary

efforts.⁸⁹ In addition, NPfIT has responded to criticism that doctors are not sufficiently involved in the process by adding a joint general director to focus on frontline staff needs⁹⁰ and creating new training efforts.⁹¹

Some observers remain skeptical and are concerned that:

- Government efforts of this scale will repeat past errors, such as overly ambitious design and tight timelines.⁹²
- The Gateway process will not prevent unnecessary spending.
- The program has not sufficiently accounted for the fundamental cultural shift required to ensure that doctors and other care providers use IT.⁹³
- The system does not alter the way care is delivered and will miss opportunities to improve care.⁹⁴
- The procurement system will limit competitive growth in the UK IT business⁹⁵ or GP choice in service providers.⁹⁶

Moving forward, several independent bodies, including the National Audit Office (NAO), will assess the NPfIT’s success.⁹⁷

Additional Efforts

National Service Frameworks

The National Service Frameworks (NSFs) are a series of long-term strategies for quality improvements targeted to priority health areas and populations.⁹⁸ The rolling program of NSFs began in 1998 and now includes Cancer, Children’s Services, Coronary Heart Disease, Diabetes, Mental Health, Older People, and Pediatric Intensive Care. In addition, NSFs are planned for Long Term Conditions (with a focus on neurological conditions) and Renal Care. Using inputs from experts and the public, each NSF 1) provides a set of national standards and key interventions pertaining to each topic or population, 2) defines relevant service delivery models, 3) establishes resources and strategies to support implementation, and 4) sets milestones to track progress. Although NSFs do

not carry the weight of statutes,⁹⁹ the effect of NSFs is to provide a set of priorities and matched solutions that become the foundation for quality improvements enacted through organizations that include the Modernization Agency. Further, evidence suggests NSFs have been successful in areas like cancer and cardiovascular care.¹⁰⁰ Future challenges include identifying factors that support or inhibit NSF implementation.¹⁰¹

Commission for Healthcare Audit and Inspection

The Commission for Healthcare Audit and Inspection (CHAI) is an independent regulatory body within the NHS.¹⁰² Its overriding purpose is to monitor progress in quality improvement, including movement toward key targets (such as those in the NSFs) and implementation of NICE guidelines. Among its key tasks, CHAI performs audits of each hospital, publishes the star ratings (see Public Reporting section below), investigates individual service failures, and produces reports for Parliament on the state of the NHS.¹⁰³ Research indicates that CHAI¹⁰⁴ has been successful in raising awareness of quality initiatives and improving performance.¹⁰⁵ Criticisms include the number and range of potentially conflicting responsibilities (such as setting standards and enforcing them), its relationship to other auditing systems, and potential negative impacts on morale.¹⁰⁶

Modernization Agency

The Modernization Agency is a central organization that provides technical assistance for improving quality to other organizations within the NHS, centered on the NSFs.¹⁰⁷ It focuses on four key areas: improving access, increasing local support, raising standards of care, and capturing and sharing knowledge.¹⁰⁸ Specific efforts include a national program to ensure patients are prepared for surgery, which reduces unnecessary cancellations.¹⁰⁹ These and other programs have helped the Modernization Agency to have an impact on key

quality measures, including waiting times. The Modernization Agency recently published a 10-point guide to lessons it has learned across the range of projects, including the important role of ambulatory care, management of admissions and discharges, support for patients with chronic conditions, and reducing waiting lists.¹¹⁰ The major criticism of the Modernization Agency has been excessive bureaucracy and size,¹¹¹ and in 2005, it will be replaced with a more streamlined organization that is expected to fulfill a similar role.¹¹²

National Patient Safety Agency

Some 850,000 medical errors occur each year in the UK, half of which are preventable.¹¹³ The National Patient Safety Agency (NPSA) addresses medical errors by learning systematically from existing problems.¹¹⁴ The NPSA 1) monitors national trends through an anonymous error tracking system called the National Reporting and Learning System (NRLS); 2) compares these data with information from other sources; 3) promotes research in target areas; 4) identifies root causes of the problems; and 5) creates solutions, including training and guidelines.¹¹⁵ To encourage reporting, the NPSA focuses on the system, rather than blaming individual providers.¹¹⁶ Although the NRLS was launched in February 2004, its pilot efforts and first data analyses have identified several recommendations for protocol changes, including a recommendation to prevent unnecessary fatal bleeding or a heart attack in spinal cord patients.¹¹⁷ Despite some problems in the pilot programs,¹¹⁸ many experts report positively on initial successes in the full program, and are hopeful about more changes in the future.¹¹⁹ Future challenges include overcoming provider fears about reporting, and thus exposing themselves to criticism and legal claims in an environment that is increasingly litigation focused.¹²⁰ A rise in litigation against doctors has heightened these fears.¹²¹

Public Reporting

The United Kingdom has two public reporting initiatives. The goal is to make comparison information about hospitals and doctors available to patients, administrators, and providers in order to motivate quality improvements, strengthen accountability, and support consumer choice.

- The performance ratings program (“star ratings”) is a government effort.¹²² It assesses hospitals on the basis of government targets, staff and patient experiences, and management.¹²³ Three stars result in financial rewards and administrative freedoms, while zero stars result in required changes and possible executive replacement.¹²⁴ The system has successfully highlighted the role of targets, inspection, and accountability,¹²⁵ and has been linked to performance improvements.¹²⁶
- “Dr. Foster” is a private enterprise that publishes performance data about doctors, hospitals, and other care centers in the form of service guides.¹²⁷ In general, Dr. Foster targets the public more than the star ratings program does,¹²⁸ and may communicate more clearly.¹²⁹

There are some concerns that neither providers nor the public use information from these organizations.¹³⁰ Star ratings also have been controversial because they fluctuate from year-to-year, and thus seem unreliable. There have been criticisms of the chosen indicators¹³¹ and claims that the process of combining indicators to create star ratings is not statistically valid or sufficiently transparent, for example.¹³²

Revalidation and Appraisal

- Revalidation is an accreditation and licensure process that doctors will participate in every five years, starting in 2005. The goal is to ensure that doctors not only have initial qualifications, but also “remain up to date and fit to practice.”¹³³ The process goes beyond continuing medical education because it includes monitoring of practice.
- Appraisal is an annual procedure that has been in place since 2001.¹³⁴ It requires doctors to

reflect on their practice and discuss plans for professional development and quality.¹³⁵ The confidential process is not punitive,¹³⁶ and it is overseen by the relevant local organization.¹³⁷

Both processes rely on standards outlined by an independent regulatory agency,¹³⁸ and the information collected during the annual appraisals becomes the basis for revalidation.¹³⁹ Initial efforts have been viewed favorably,¹⁴⁰ but some have concerns that the processes will demoralize doctors, especially if punitive aspects of revalidation become linked to appraisal.¹⁴¹

Conclusions

The quality agenda in the NHS is the most comprehensive quality improvement effort in the world. It involves a centrally coordinated program, characterized by clear priorities; defined quality objectives and targets; public reporting; enhanced incentives for stakeholders; improved information technology; and overall increases in financial support. To date, the efforts seem to be improving care in a country that suffered from deep health care problems, including waiting lists, deteriorating facilities, low physician-to-patient ratios, and underprovision of care. Countries around the world are watching the UK for further developments. Because the U.S. also faces quality challenges,¹⁴² many have focused on international comparisons. Despite differences in their systems, the UK’s experience might suggest ways to improve health care in the United States.¹⁴³

Addendum

NOTES

Milestones in the Quality Agenda: 1997–2004

1997

- New Labour wins General Election
 - Chancellor announces additional 1.2bn for NHS
 - Government white paper, *The New NHS—Modern, Dependable*, outlines major components of the Quality Agenda, including National Institute for Clinical Excellence (NICE)
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1998

- Consultation papers published:
A National Framework for Assessing Performance
A First Class Service—Quality in the New NHS
Information for Health
 - Rolling program of National Service Frameworks (NSFs) begins
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1999

- Publication of first set of clinical and high-performance indicators
 - White paper published: *Saving Lives: Our Healthier Nation*
 - Consultation document published: *Patient and Public Involvement in the New NHS*
 - NICE established
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2000

- Royal College of GPs and the BMA publishes *Revalidation for Clinical General Practice and Good Medical Practice for General Practitioners*
 - Published Report *An Organisation with a Memory* recommends new approach to patient safety
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2001

- *Building a Safer NHS for Patients* published
 - National Patient Safety Agency (NPSA) announced
 - Report published: *Learning from Bristol—the Report of the Public Inquiry into Children’s Heart Surgery at the Bristol Royal Infirmary 1984–1995*
 - First set of Acute Trust Performance ratings published
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2002

- Chancellor announces 40bn increase for NHS funds over 5 years
 - White papers published:
Delivering the NHS Plan
Delivering 21st-Century IT Support for the NHS
 - Commission for Healthcare Audit and Inspection (CHAI) announced
-

2003

- NHS star ratings published
 - Commission for Health Improvement (CHI) publishes evaluation *Getting Better? A Report on the NHS*
-

2004

- National Reporting and Learning System (NRLS) launched
 - New general practitioner (GP) contract put in place
 - White paper published: *The NHS Improvement Plan: Putting People at the Heart of Public Services*
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Material through 2003 adapted from: Sheila Leatherman and Kim Sutherland. 2003. *The Quest for Quality in the NHS: A Mid-term Evaluation of the 10-Year Quality Agenda*. The Nuffield Trust. London: TSO.

- ¹ In a central document (*The New NHS—Modern, Dependable*), the Department of Health defined quality as: “doing the right things, at the right time, for the right people, and doing them right-first time...measured in terms of prompt access, good relationships and efficient administration.” As quoted by Leatherman, Sheila and Kim Sutherland. 2003. *The Quest for Quality in the NHS: A Mid-term Evaluation of the 10-Year Quality Agenda*. The Nuffield Trust. London: TSO.
- ² Abramson, John. September 18, 2004. “Information is the Best Medicine.” *The New York Times*. A2: 15. See also: Schoenbaum, Stephen C. et al. “Obtaining Greater Value From Health Care: The Roles of the U.S. Government.” *Health Affairs*. 22(6): 183. See also: Moffit, Robert E. et al. July 9, 2001. “Perspectives on the European Health Care Systems: Some Lessons for America.” The Heritage Foundation. Heritage Lectures: No.711.
- ³ Retrieved from the NHS website: <http://www.nhs.uk/england/aboutTheNHS/default.cmsx>.
- ⁴ Doran, James. April 18, 2002. “Swollen NHS Will Be the Size of a Small Country.” *The Times*.
- ⁵ Population statistics retrieved from: <http://www.statistics.gov.uk/>.
- ⁶ Department of Health. 2000. *The NHS Plan—A Plan for Investment, A Plan for Reform*. London: TSO.
- ⁷ According to the Foreign & Commonwealth Office: “Eligibility for free NHS treatment is based on residence in the UK, National Insurance contributions, or payment of UK taxes, not on nationality.” Further information can be found at: <http://www.fco.gov.uk/servlet/Front?pagename=OpenMarket/Xcelerate/ShowPage&c=Page&cid=1013618138355>.
- ⁸ A more detailed discussion of devolution can be found at: <http://www.state.gov/r/pa/ei/bgn/3846.htm>; at: <http://www.dca.gov.uk/>; and at: <http://www.parliament.uk/commons/lib/research/rp2003/rp03084.pdf>.
- ⁹ Commonwealth Fund. October 2004. “The British Health Care System.” Briefing Sheet.

- ¹⁰ Light, Donald. January 2003. "United Health Care: Lessons from the British Experience." *American Journal of Public Health*. 93(1): 27.
- ¹¹ Approximately 20 percent of all private operations are paid for out of pocket. See: Feachem, Richard G A, et al. January 19, 2002. "Getting More for their Dollar: A Comparison of the NHS with California's Kaiser Permanente." *British Medical Journal*. 324(7530): 135.
- ¹² Calculations based on information from Laing & Buisson: <http://www.laingbuisson.co.uk/PMI.htm>.
- ¹³ Commonwealth Fund. October 2004. "The British Health Care System." Briefing Sheet.
- ¹⁴ The description and chart are adapted from the NHS website: <http://www.nhs.uk/england/aboutTheNHS/default.cmsx>.
- ¹⁵ Many of the reform developments are announced through government white papers and consultation documents. These are outlined in an Addendum and footnoted throughout the text. The first major paper is: Department of Health. 1997. *The New NHS—Modern, Dependable*. London: TSO.
- ¹⁶ Stevens, Simon. May/June 2004. "Reform Strategies for the English NHS." *Health Affairs*. 23(3): 37.
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- ¹⁸ Evans, BT and C. Pritchard. September 2000. "Cancer Survival Rates and GDP Expenditure on Health: A Comparison of England and Wales and the USA, Denmark, Netherlands, France, Germany, Italy, Spain and Switzerland in the 1990s." *Public Health*. 114(5): 336.
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- ²⁰ Wanless, Derek. April 2002. *Securing Our Future Health: Taking a Longterm View*. London: Her Majesty's Treasury.
- ²¹ Organization for Economic Cooperation and Development. 2003. *OECD Health Data 2003*, 2nd ed. Paris: OECD.
- ²² Enthoven, Alain C. May/June 2000. "In Pursuit of an Improving National Health Service." *Health Affairs*. 19(3): 102.
- ²³ Department of Health (DOH). 2003. *The NHS Plan—A Progress Report: The Modernization Board's Annual Report*, available at: www.doh.gov.uk/modernisation/boardreport. Also see: Leatherman, Sheila and Kim Sutherland. 2003. *The Quest for Quality in the NHS: A Midterm Evaluation of the 10-Year Quality Agenda*. The Nuffield Trust. London: TSO.
- ²⁴ As shown in: Leatherman, Sheila and Kim Sutherland. 2003. *The Quest for Quality in the NHS: A Mid-term Evaluation of the 10-Year Quality Agenda*. The Nuffield Trust. London: TSO. Original data source: Commissionerbased data from the Department of Health: www.doh.gov.uk/waitingtimes.
- ²⁵ Note that only 9 to 29 percent of executives in other countries with waiting list problems felt that waiting times had decreased. See: Blendon, Robert J. et al. May/June 2004. "Confronting Competing Demands to Improve Quality: A FiveCountry Hospital Survey." *Health Affairs*. 23(3): 119.
- ²⁶ Commission for Health Improvement (CHI). 2003. *Getting Better? A Report on the NHS*. London: Commission for Health Improvement. Retrieved from: http://www.chi.nhs.uk/eng/about/publications/getting_better/index.shtml.
- ²⁷ Smith, Richard. November 29, 2003. "Is the NHS Getting Better or Worse? We Need Better Data to Answer the Question." *BMJ*. 327: 1239.
- ²⁸ Smith, Richard. November 29, 2003. "Is the NHS Getting Better or Worse? We Need Better Data to Answer the Question." *BMJ*. 327: 1239.
- ²⁹ Leatherman, Sheila and Kim Sutherland. 2003. *The Quest for Quality in the NHS: A Mid-term Evaluation of the 10-Year Quality Agenda*. The Nuffield Trust. London: TSO
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- ³¹ NICE was announced in *The New NHS—Modern, Dependable*. For further information see: National Organization for Clinical Excellence. *A Guide to NICE*. May 21, 2004. Retrieved from: www.nice.org.uk.

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