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United Kingdom (Wales)

Health system review

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Preface

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

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

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

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

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

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

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

HiTs and HiT summaries are available on the Observatory's web site (<http://www.healthobservatory.eu>).

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The Health Systems in Transition (HiT) profile on Wales was co-produced by the European Observatory on Health Systems and Policies and The King's Fund, which is a member of the National Lead Institutions network working with the Observatory on country monitoring.

The National Lead Institutions network is made up of national counterparts that are highly regarded at national and international level and have particular strengths in the area of health systems, health services, public health and health management research. They draw on their own extensive networks in the health field and their track record of successful collaboration with the Observatory to develop and update the HiTs.

The King's Fund is an independent charity working to improve health and health care in England, with the vision that the best possible health care is available to all. The King's Fund contributes to achieving this vision in two ways: by working to improve the way health care, and related social care, in England is organized, funded and delivered, and by supporting individuals, teams and organizations to improve health and health care.

This profile was written by Marcus Longley (Professor and Director, Welsh Institute for Health and Social Care, University of Glamorgan), Neil Riley (Public Health Wales) and Paul Davies (Welsh Institute for Health and Social Care, University of Glamorgan). It was edited by Cristina Hernández-Quevedo of the Observatory's team at the London School of Economics and Political Science. Sarah Thomson was the Research Director for this profile, which is based on the 2004 HiT on Wales written by Marcus Longley and edited by Nadia Jemai.

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Thanks are also extended to the WHO Regional Office for Europe, for their European Health for All database from which data on health and health services were extracted; to the European Commission for Eurostat data on European Union (EU) Member States; to the OECD for the data on health services in western Europe; and to the World Bank for the data on health expenditure. Thanks are also due to national statistical offices that provided data. The HiT reflects data available in 2012, unless otherwise indicated.

The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. The Observatory team working on HiTs is led by Josep Figueras, Director, Elias Mossialos, Martin McKee, Reinhard Busse and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Gabriele Pastorino. The production and copy-editing process of this HiT was coordinated by Jonathan North, with the support of Caroline White, Jane Ward (copy-editing), Steve Still (design and layout) and Sophie Richmond (proofreading).

List of abbreviations

Abbreviations	
EU	European Union
GVA	Gross value added
GP	General practitioner
IT	Information technology
IMF	International Monetary Fund
LHB	Local health board
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
OECD	Organisation for Economic Co-operation and Development
PHW	Public Health Wales
WHSSC	Welsh Health Specialised Services Committee

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Abstract

Wales is situated to the west of England, with a population of approximately 3 million (5% of the total for the United Kingdom), and a land mass of just over 20 000 km². For several decades, Wales had a health system largely administered through the United Kingdom Government's Welsh Office, but responsibility for most aspects of health policy was devolved to Wales in a process beginning in 1999. Since then, differences between the policy approach and framework in England and Wales have widened. The internal market introduced in the United Kingdom National Health Service (NHS) has been abandoned in Wales, and seven local health boards (LHBs; supported by three specialist NHS trusts) now plan and provide all health services for their resident populations. Wales currently has more than 120 hospitals as part of an overall estate valued at £2.3 billion. Total spending on health services increased in the first decade of the 21st century, but Wales now faces a period of financial retrenchment greater than in other parts of the United Kingdom as a result of the Welsh Government's decision not to afford the same degree of protection to health spending as that granted elsewhere. The health system in Wales continues to face some structural weaknesses that have proved resistant to reform for some time. However, there has been substantial improvement in service quality and outcomes since the end of the 1990s, in large part facilitated by substantial real growth in health spending. Life expectancy has continued to increase, but health inequalities have proved stubbornly resistant to improvement.

Executive summary

Introduction

Wales is situated to the west of England, with a population of approximately 3 million (5% of the total for the United Kingdom), and a land mass of just over 20 000 km². The bulk of the population is concentrated in the post-industrial south of the country and along the northern coastal strip. Overall, it is comparatively economically disadvantaged, with gross value added (GVA) per head at only 74% of the United Kingdom average. In 1999 and subsequently, legislative and executive responsibility for several areas of public policy (including health) was devolved to a new National Assembly based in the Welsh capital, Cardiff, and additional law-making powers have been devolved more recently. The country is bilingual (English and Welsh). Health status has improved in recent years, following the patterns of other developed nations, but health inequalities remain high across Wales.

Organization and governance

For several decades, Wales had a health system largely administered through the United Kingdom Government's Welsh Office. Far greater responsibility for most aspects of health policy was devolved to Wales in a process beginning in 1999. Since then, differences between the policy approach and framework in England and that in Wales have widened. The internal market introduced in the United Kingdom NHS in the 1990s created a separation between purchasers and providers. This system has been abandoned in Wales. In 2009, seven LHBs were created, responsible for all aspects of planning and providing health services in their geographical areas. The boards of these bodies, together with those of the three remaining NHS trusts (for ambulance services, specialized cancer care and public health), are appointed by and accountable to the Minister for Health and Social Services. There is no formal competition between providers. Patients' views are reflected through the internal mechanisms of LHBs or

statutory community health councils rather than through choice of provider. LHBs operate within a policy framework determined by the Welsh Government and plan services accordingly. Because of the country's small size and the absence of an organizational level between the local and national, political involvement in local decision-making is sometimes strong. Responsibility for social services lies with 22 local authorities, which are required to work in partnership with the NHS and the third (non-profit-making) sector. Separate regulatory bodies for health and social care work with the Wales Audit Office and others to report independently on service performance.

Financing

Total spending on health services increased in the first decade of the 21st century, but Wales now faces a period of financial retrenchment greater than in other parts of the United Kingdom as a result of the Welsh Government's decision not to afford the same degree of protection to health spending as that granted elsewhere. The overall budget Wales receives from the United Kingdom Government is based on its share of the total United Kingdom population; how that "block grant" is used is determined by the National Assembly. Budgets are allocated to LHBs (three of which have allocations in excess of £1 billion a year). General practitioners (GPs) and other private contractors are remunerated in ways very similar to that elsewhere in the United Kingdom. Limited use is made of formal mechanisms to pool funding between NHS and other public bodies. There is relatively limited private financing of health care, and the NHS makes very little use of the private sector. In 2004, the government announced the abolition of prescription charges and more recently it has abolished charges for parking on hospital premises (except where existing contractual arrangements make this difficult).

Physical and human resources

Wales currently has more than 120 hospitals as part of an overall estate valued at £2.3 billion. There is a substantial backlog of maintenance, reflecting the age of premises, and a perceived overreliance on hospital care. The NHS currently has approximately 72 000 directly employed full-time equivalent staff, reflecting an increase of almost a quarter in the first decade of the 21st century. These

staff members are mostly regulated on a United Kingdom basis, with education and contractual terms also generally following a United Kingdom model, with some Wales variation.

Provision of services

Public health is the shared responsibility of all NHS bodies and more widely permeates all Welsh Government departments, which share a commitment to assess the health impact of policy developments. Leadership is provided by the NHS Trust Public Health Wales (PHW), which operates both nationally and through its staff located in each LHB. Primary care is mainly provided by independent contractors, as in the rest of the United Kingdom. Specialized ambulatory care is developing rapidly in Wales, as the NHS responds to an historical model generally perceived to be overdependent on hospitalization. Emergency care is currently located in district general hospitals, but this may change significantly during 2012–2014 as LHBs propose radical restructuring of hospital services. Pharmaceutical care is led by a network of community pharmacies, on which the government is relying for some of the extension of access to services, a current priority. Intermediate care is another priority area, and considerable work has focused on supporting self-care and managing long-term conditions more effectively in the community. Informal carers provide the vast majority of care for people living at home, and their entitlement to their own assessment of needs is enshrined in law. Palliative care receives less public funding in Wales than in England, but third sector providers remain the mainstay of such provision. Mental health care is another priority area, with clear action focused on the provision of services and attempts to reduce stigma. Dental care in Wales now relies heavily on private provision, as parts of the country struggle to recruit NHS general dental practitioners.

Principal health care reforms

Responsibility for health policy has been fully devolved to Wales since 1999. In the first ten years of devolution, organizational change focused on aligning the boundaries of the NHS and local government and on other initiatives designed to foster joint working on a public health agenda. In 2009, the remaining vestiges of the internal market were removed with the creation of LHBs. Wales has developed many distinctive policy initiatives. Some have attracted considerable popular attention (the abolition of prescription charges).

Others were more subtle and possibly more far reaching, such as the statutory commitment to sustainable development across all government policy areas. Public services in Wales now face significant resources pressures, particularly the NHS. Government has made implementation a priority, amid concerns that progress in implementing policy has been too slow in many areas of Wales's public services.

Assessment of the health system

The health system in Wales continues to face structural weaknesses that have proved resistant to reform for some time. However, there has been substantial improvement in service quality and outcomes since the end of the 1990s, in large part facilitated by substantial real growth in health spending. The financial climate has now changed significantly, and in the short term Wales faces perhaps the severest reduction in expenditure it has seen since the foundation of the NHS, worse than that in other parts of the United Kingdom. Life expectancy has continued to increase, but health inequalities have proved stubbornly resistant to improvement.

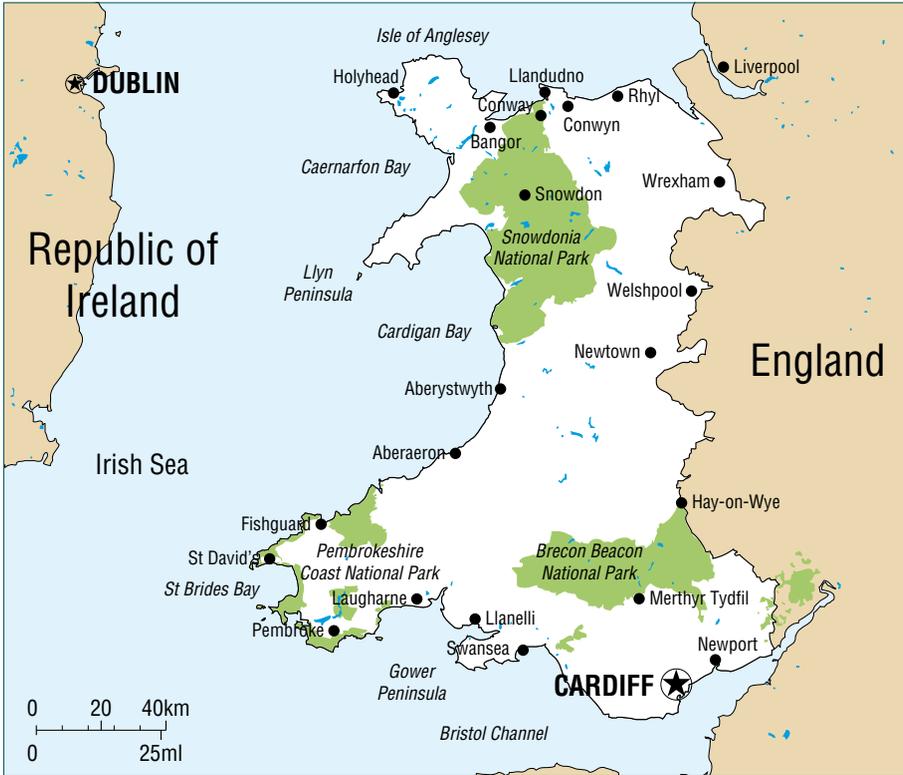
1. Introduction

Wales is situated to the west of England, with a population of approximately 3 million (5% of the total for the United Kingdom). The bulk of the population is concentrated in the post-industrial south of the country and along the northern coastal strip. Overall, it is comparatively economically disadvantaged, with GVA per head at only 74% of the United Kingdom average. In 1999 and subsequently, legislative and executive responsibility for several areas of public policy (including health) was devolved to a new National Assembly based in the Welsh capital, Cardiff, and additional law-making powers have been devolved more recently. The country is bilingual (English and Welsh). Health status has improved in recent years, following the patterns of other developed nations, but health inequalities remain high across Wales.

1.1 Geography and sociodemography

Wales is located to the west of England, with whom it has a land border (Fig. 1.1). It is just over 20 000 km² (8% of the United Kingdom), 250 km from north to south and 200 km from east to west at its longest and widest points. Flat coastal plains in the south give way to a series of valleys (the heart of the coal- and iron-producing areas of the 19th and 20th centuries, but now largely deindustrialized), hills and then the mountains of central and north Wales. The country hosts three national parks and five areas of outstanding natural beauty, which cover a quarter of the land mass.

Fig. 1.1
Map of Wales



Source: Author's own compilation.

In 2010, the population of Wales was estimated to be 3 006 430 and is projected to increase to 3 348 000 by 2033, with a distinct ageing of the population profile (a 90% increase in the numbers aged 80 years and over) (Table 1.1).

Table 1.1
Population projections for Wales (000s), to 2033

Year	Under 16 years	Working age	Pension age (years)		All ages
			<80	80+	
2013	551	1 829	505	164	3 048
2023	602	1 902	502	213	3 220
2033	591	1 953	502	302	3 348

Source: Office for National Statistics (2011b).

Between mid-2001 and mid-2008, Wales experienced net inward migration from the rest of the United Kingdom totalling almost 62 000 people (almost 8900 per year).

1.2 Economic context

Although 80% of the land is dedicated to agriculture, this sector of the economy contributes only 0.2% of the country's GVA. The largest sectors of the economy measured by GVA are public administration, defence, education and health (27.4% of GVA, higher than the United Kingdom figure of 20.3%), production (19.5%, compared with a United Kingdom figure of 13.7%), and wholesale, retail, transport, hotels and food (18.3%, compared with a United Kingdom figure of 19.0%). Overall, Wales is the region of the United Kingdom with the lowest GVA per head (which measures economic output), with a value of 74 in 2010 compared with the index value of 100 for the United Kingdom. In April 2012, 5.5% of the working population in Wales were in receipt of unemployment benefit (against a United Kingdom rate of 4.9%) out of a total workforce of 1 440 250 (this includes both the employed and unemployed) (Welsh Government, 2012d).

1.3 Political context

Wales was united with England by two Acts of Parliament passed in 1536 and 1542, and the constitutional position of Wales changed little (beyond the creation of a post in the Cabinet of the United Kingdom Government in the 1960s) until a referendum in 1997 paved the way for the Government of Wales Act and the formal devolution of certain powers in 1999 to a newly created National Assembly of Wales. These powers included most aspects of domestic governance, including health, local government, transportation, economic and other planning. The responsibilities of the National Assembly are funded almost entirely by the United Kingdom Parliament through a sum of money based on the Welsh population share of the corresponding English expenditure, to be spent in Wales as determined by the Assembly. There are 60 elected representatives, known as assembly members, comprising constituency (40) and regional (20) members, the latter allocated according to a formula that aims to ensure that the overall balance of the Assembly broadly reflects the number of votes cast for different parties. In addition, Wales is represented in the United Kingdom Parliament by 40 members.

A subsequent Government of Wales Act (2006) extended the powers of the Assembly to seek from the United Kingdom Parliament legislative competence within 20 specified fields (including health and health services). This competence would be granted for specific topics within the specific fields, a procedure now (following a referendum in 2011) replaced with a more simple approach, which allows the Assembly to legislate within its 20 fields without prior approval of the United Kingdom Parliament. The first bills under this procedure are now in preparation. There are up to 14 Welsh ministers who form the Cabinet and are accountable to the Assembly.

The post-devolution governments in Wales have all been dominated by the left-leaning Labour Party, either acting alone or in coalition with the centrist Liberals or the nationalist party, Plaid Cymru. Given the electoral geography of Wales, it is likely that future governments will also be centre-left. The Welsh Labour Party has followed quite different policies from its English counterpart, especially in health, and it rejects all notions of quasi-markets and competition in public services. There is a determined attempt to get public services to work in partnership, using to the full the potential that comes from the fact that some public agencies, whether separately or as clusters, have common boundaries. Mechanisms established to facilitate this include local service boards, led by local authorities, which bring together local agencies in partnership to tackle issues that need a common approach (such as difficulties in discharging people from hospitals to social services and tackling domestic violence).

Wales has 22 local authority areas, each having a single elected local authority responsible for the full range of local government powers. They vary widely in size, from Cardiff (341 000), Rhondda Cynon Taf (234 000) and Swansea (233 000), to Anglesey (69 000), Blaenau Gwent (68 000) and Merthyr Tydfil (56 000).

1.4 Health status

There is a well-developed network of outlets for information and intelligence relating to health status of the population. Government statistics (in Wales as elsewhere in the United Kingdom) are subject to a rigorous policy of accountability, transparency and quality assurance relating to the publication of data. These mechanisms mean that data can be used with confidence.

Wales has a health profile that is very similar to post-industrial nations and regions across western Europe. Life expectancy at birth was 77.6 years for males and 81.8 years for females in 2008–2010 (Office for National Statistics, 2011a), an increase of 0.5 years over the figure for 2007–2009 for men and an increase of 0.3 years for women. Life expectancy at birth for males and females is lower in Wales than in England and higher than in Scotland and Northern Ireland. Overall life expectancy in Wales has risen since 1991–1993 by 4.4 years for males and 3.0 years for females.

In 2010, the main cause of death was circulatory diseases, with 10 341 deaths (33% of all deaths) (Table 1.2). This was followed by 8476 deaths from all cancers (27%). Much smaller numbers of people died from respiratory disease (4340), digestive diseases (1632), mental disorders (1332) and external causes (1160). Since the 1960s, there has been an almost constant decline in deaths from heart disease. Since 2005, there has been a recorded decline of over 25% in the rate of deaths from circulatory diseases for men under the age of 75 years (Welsh Government, 2012a). The rate of cancer deaths has remained constant.

Table 1.2

Trends in demographic indicators, selected years

	1980	1990	1995	2000	2005	2010
Total population (thousands)	2 815.8	2 861.5	2 888.5	2 906.9	2 950.1	3 006.4
Population, female (thousands)	1 448.5	1 476.8	1 488.4	1 498.8	1 513.3	1 535.5
Population aged 0–16 years (thousands)	684.6	620.4	637.5	628.2	605.5	586.0
Population aged 65 and over for men and 60 and over for women (thousands)	518.9	568.5	577.9	581.0	607.5	661.0
Population aged 85+ (thousands)	29.5	43.2	52.4	58.2	63.0	76.5
Population growth through natural change (thousands) ^a	na	na	-1.3	-1.9	1.9	4.6
Population density (per km ²) ^a	na	na	na	140	142	145
Fertility rate (total births per woman)	na	1.91	1.77	1.68	1.81	1.98
Live births by year ^{a, b}	na	na	na	31 304	32 593	35 952
Deaths by year ^a	na	33 963	35 306	33 501	32 162	31 197

Sources: Office for National Statistics (2011c); ^a Welsh Government (2012j).

Notes: ^b Based on difference between live births and deaths for 12 months from the mid-year point of the year shown and the next (e.g. 1995 is 1995–1996 etc.); na: Not available.

1.4.1 Health behaviours

In 2011, 23% of Welsh adults were smokers; 43% of Welsh adults drank above recommended limits at least once the previous week; 67% of Welsh adults did not eat five portions of fruit and vegetables the previous day, and 71% of Welsh adults were not physically active on five or more days the previous week (Welsh Government, 2012l).

The International Health Behaviour in School-aged Children survey shows that 2% of 11-year-old girls and 5% of 11-year-old boys in Wales reported drinking alcohol on a weekly basis in 2009–2010. Around 14% of 13-year-olds (approximately one in seven girls and boys) and 32% (one in three overall) of 15-year-olds reported drinking any alcoholic drink weekly, a decline of 8 percentage points since the previous survey in 2005–2006. However, Wales remains in a group of countries internationally with the highest rates of teenage alcohol use, including being drunk on more than two occasions (Currie et al., 2012).

While people are living longer and living in good health for longer, health gain is not distributed equally across the country. There are substantial geographical variations in all types of life expectancy, and emerging evidence suggests that inequality gaps between the most and least deprived parts of the country increased in the first decade of the 21st century (Public Health Wales Observatory, 2011). This has been recognized as a major issue for the Welsh Government, and direct action to reduce these inequalities is a component of the government strategic plan *Programme for Government* (Welsh Government, 2011c).

Life expectancy has increased more slowly in the most deprived areas compared with the least deprived. In 2008–2010, life expectancy figures at local authority level in Wales differed by 5.4 years for males and 4.2 years for females, with the highest in Ceredigion and the lowest in Merthyr Tydfil (males) and Blaenau Gwent (females). Taking the country as a whole, the difference between the best and worst communities is 9.2 years for males and 7.1 years for females (Public Health Wales Observatory, 2011). This difference between the highest and lowest life expectancy by local authority is smaller than in 2007–2009, but higher than in the early 1990s.

National inequalities are particularly wide in healthy life expectancy, which for males ranges from 57.1 in Blaenau Gwent to 68.2 years in Monmouthshire, a difference of around 11 years (10 years for females). Overall, the gap between the most and least deprived communities is 18.9 years for males and 17.8 years

for females. People in the least deprived areas experience a substantially higher proportion of their life expectancy in good health (87% in males) than those in the most deprived areas (75% in males). While females can expect to live 4.4 years longer than males, females are also estimated to spend only around two years longer than males in good health or free from limiting long-term illness or disability (Public Health Wales Observatory, 2011).

Mortality rates in Wales for the main causes of death have fallen, but the inequality gap has widened over time, with the exception of mortality from respiratory disease in males. The largest inequality gaps are in alcohol-related mortality. Rates are three and a half times as high in the most deprived areas as in the least deprived areas for males, and more than twice as high for females. Inequality gaps are particularly wide for mortality from all causes for people younger than 75 years, and for mortality from respiratory disease and smoking. For these causes, rates in the most deprived areas are more than twice those in the least deprived areas. Alcohol-related and alcohol-attributable mortality rates in Wales have risen. However, there is no clear trend in the inequality gap over time. Smoking-attributable mortality rates in Wales have fallen, although the inequality gap has widened slightly. The inequality gap is more pronounced in females than males. Locally, trends in inequality gaps in types of life expectancy and mortality vary substantially. Inequalities have widened in some local authorities and LHBs but narrowed or stayed the same in others. The gap within an area that has largely similar levels of deprivation, such as Blaenau Gwent, is smaller than the gap within an area that has greater variation in deprivation levels, such as Swansea.

It is only recently, through the work of Eurostat and WHO, that Wales has been able to compare its health metrics with other health systems. The European Commission-funded I2SARE project (I2SARE, 2012) has helped to provide further understanding, but there remain issues over the robustness of comparative data. In general terms, Welsh trends mirror those of the United Kingdom in European comparisons, with relatively lower rates of mortality from circulatory disease for men than the European average and higher rates of deaths from cancers for women compared with Europe. This is an area of work that will require further investigation in coming years (Eurostat, 2011).

One area of concern may be in Welsh performance in entering a post-industrial economy. Recent work by the Glasgow Centre for Population Health has focused on comparing deindustrialized areas across Europe (Walsh et al., 2010a). Findings show that the area described as South Wales and Valleys, as in the west of Scotland, does not appear to have the same rates of health gain as similar parts of western and central Europe (Walsh et al., 2010b).

2. Organization and governance

For several decades, Wales had a health system largely administered through the Welsh Office of the United Kingdom Government. Far greater responsibility for most aspects of health policy was devolved to Wales in a process beginning in 1999. Since then, differences between the policy approach and framework in England and Wales have widened. The internal market introduced in the United Kingdom NHS in the 1990s created a separation between purchasers and providers. This system has been abandoned in Wales. In 2009, seven LHBs were created, responsible for all aspects of planning and providing health services in their geographical areas. The boards of these bodies, together with those of the three remaining NHS trusts (for ambulance services, specialized cancer care and public health), are appointed by and accountable to the Minister for Health and Social Services. There is no formal competition between providers. Patients' views are reflected through the internal mechanisms of LHBs or statutory community health councils rather than through choice of provider. LHBs operate within a policy framework determined by the Welsh Government and plan services accordingly. Because of the country's small size and the absence of an organizational level between local and national, political involvement in local decision-making is sometimes strong. Responsibility for social services lies with 22 local authorities, which are required to work in partnership with the NHS and the third (non-profit-making) sector. Separate regulatory bodies for health and social care work with the Wales Audit Office and others to report independently on service performance.

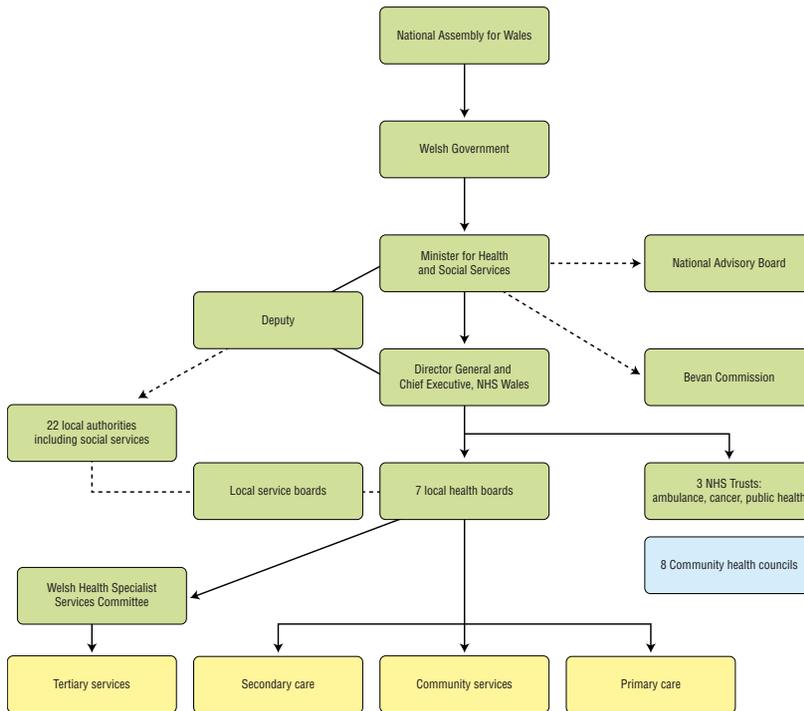
2.1 Overview of the health system

Health services in Wales are financed almost entirely out of general taxation and are, therefore, largely free at the point of use. The Welsh Government establishes a national framework for health policy and the Minister for Health

and Social Services has direct control over the NHS. However, the 22 elected local authorities decide how services are delivered. Health services are planned and provided by seven LHBs, which are directly accountable to the Minister, and three NHS trusts (for public health, ambulance services, cancer services). Fig. 2.1 shows the main actors in the health system.

Fig. 2.1

Overview of the Welsh health system



2.2 Historical background

Post-devolution health policy has been dominated by the desire to reduce and eventually eliminate the role of the internal market in health care, which the newly devolved administration inherited. So, during the first decade of the 21st century, successive governments in Wales abolished general practice fundholding, and initially experimented with creating a different form of health service commissioning. The latter was organized through 22 LHBs, established in 2004, and involved entering into agreements with NHS trusts

for community and secondary care services, but on the basis of collaboration rather than market operations. In addition the LHBs managed the local primary care system and worked with other local agencies to improve health and reduce health inequalities, building on the fact that they shared the same populations as the 22 local authorities, who organized such services as housing, environmental health, leisure services and social services.

In 2009, this structure was replaced by a simplified model that no longer had any separation into health service providers and commissioners. Instead, seven larger LHBs were created, differing from their predecessors in that they were now responsible for the planning and delivery of all health services within their geographical boundaries, including hospital, community and primary care.

2.3 Organization

Responsibility for most aspects of health policy is devolved to the National Assembly for Wales and exercised by the Welsh Government, including the Minister for Health and Social Services. The Minister has direct control over the NHS in Wales, including the allocation of budgets to different bodies and appointment of boards, but her/his influence over social services is more indirect, setting the overall legislative and policy framework but relying on elected local authorities to decide how services are delivered. Policy is coordinated across the Welsh Government at the national level. Local bodies are encouraged to work together locally, and LHBs and local authorities have joint statutory responsibilities, for example in relation to planning.

The post-2009 health system structure unifies the planning and delivery functions of primary, secondary and tertiary care on a geographical basis, in seven LHBs. Each of these has a board appointed by, and directly accountable to, the Minister for Health and Social Services. In addition, there are three NHS trusts: the Welsh Ambulance Services, PHW for public health, and Velindre NHS Trust for specialist cancer services. Specialist care is commissioned by the Welsh Health Specialised Services Committee (WHSSC), which is accountable to the seven LHBs. Other bodies exist to support particular functions best discharged at a national level, such as the National Leadership and Innovation Agency for Healthcare, which is hosted by some of the LHBs and trusts. Public and patient input is the statutory responsibility of eight community health councils, the successors of bodies originally established in 1974.

The Minister is supported by the Department for Health, Social Services and Children, the Director General of which is also the Chief Executive of the NHS in Wales. The Deputy Minister takes the lead on policy matters relating to social services and social care, whose delivery remain largely a responsibility of local government.

The Minister is a member of the Welsh Government Cabinet and liaises with colleagues across government. She/he receives a wide range of advisory input, which informs and supports decision-making. This includes the Ministerial Advisory Group. In addition, there are seven statutory committees and other committees, such as the Health Protection Committee and National Joint Professional Advisory Committee, through which the Minister receives “specialist” professional health advice. The Minister has also re-established the Bevan Commission, an independent group of experts whose role is to advise on NHS reforms in Wales and related matters (Bevan Commission, 2011).

Eight community health councils (for the most part sharing the same boundaries as the LHBs) provide a statutory input on behalf of patients and the public, and local county voluntary councils coordinate the work of the third (non-profit-making) sector. Most of the United Kingdom’s professional organizations representing particular staff groups (doctors, nurses, etc.) have a Welsh structure within their organizations, providing a voice on behalf of their members in Wales. The private sector is a small part of the total, and government policy since devolution has marginalized this sector, with a clear intention to limit the proportion of NHS spend going to private providers.

2.4 Decentralization and centralization

The Welsh Government formulates policy at the macro level, but there is currently a strong policy drive to ensure that LHBs lead and take responsibility for the implementation of policy locally. The balance between national and local in Wales has often been somewhat ambiguous, with successive ministers taking different views on the level of involvement they wish to exercise locally, and NHS bodies being cautious that their local decisions might be overruled by ministers. The small size of the country, with consequently few managerial levels between local and national, and the sometimes close influence of assembly members on matters affecting their constituency, further complicates the national–local relationship. Currently, ministers argue that the new LHBs – some of the largest health care organizations in the United Kingdom – are well enough resourced to take more responsibility for key decisions.

2.5 Planning

The structure of the NHS in Wales – the absence of market mechanisms and the existence of all-purpose bodies with responsibility for the health needs of all local residents – makes planning vitally important. It has a further importance in that the Welsh Government is looking for significant changes in the health sector over coming years in a period when resources are severely constrained. This means that there needs to be a carefully managed programme of change including, for example, a greater emphasis on quality and a review of how and where all major services are delivered.

Services are not planned at national level. The Welsh Government sets the framework through national policy and strategy documents. The major strategic documents are *Our Healthy Future* (Welsh Government, 2009b), *Together for Health* (Welsh Government, 2011f) and *Sustainable Social Services in Wales* (Welsh Government, 2011e). In addition, the Welsh Government sets out annual requirements in relation to NHS performance. The Welsh Government is currently trying to reduce the planning burden on local government and the NHS through simplification of central requirements.

The responsibility for local planning lies with the LHBs. They plan all services for their own resident population and work together through the WHSSC to make available national and highly specialized services for the whole of Wales. Those services include, for example, ambulance services and highly specialized cancer and mental health services. Each LHB prepares a five-year forward plan and is expected to review this on an annual basis. Their approach should bring together service, financial, infrastructure and workforce planning within a single framework. Planning should be based on a full assessment of the health needs of their local population. Improving health and meeting health needs cannot be achieved just through the activities of the NHS and so planning involves other bodies, such as local government, nongovernmental organizations and specialist providers.

To rebalance health services and develop more services closer to home, primary and community care is being planned through locality networks, made up of clusters of GP practices working in partnership with other providers such as pharmacists.

NHS organizations in Wales are expected to deliver a robust response and ensure business continuity in the event of emergencies. Specific emergency planning and business continuity duties are placed on NHS organizations in the Civil Contingencies Act 2004. In addition, the Welsh Government issues

detailed guidance to the NHS covering emergency planning and business continuity. To support implementation, there is a specific Civil Contingencies Wales Healthcare Standard that requires NHS organizations to:

- be prepared to meet the health needs and impact on services arising from any major incident or emergency, which will involve working in cooperation with other organizations locally;
- have in place documented response plans that are resilient against assessed risks and coordinated with those of response partners, including arrangements to warn and inform the public;
- have business continuity management arrangements that are aligned with the British Standard BS25999, which is the accepted Business Continuity Standard used widely by organizations to demonstrate that they have adequate business resilience arrangements in place; and
- ensure that staff are appropriately trained and equipped for their role within emergency response and business continuity arrangements and that a programme is in place to exercise and test response plans.

2.6 Intersectorality

The need for intersectoral working to achieve health gains is accepted by government and implemented through a number of documents including *Our Healthy Future* (Welsh Government, 2009b). The potential for achieving “Health in all” policies has yet to be fully explored, but mechanisms are being developed to strengthen cross-government working, and the possible role for a Public Health Act is under consideration. There is strong support for health impact assessment, with cross-sectoral collaboration, working with agencies such as the Sport Council and the Countryside Council for Wales. Cardiff and Swansea are WHO Healthy Cities, and both follow the principles of intersectorality advocated by the Healthy Cities movement.

2.7 Health information management

2.7.1 Information systems

Non-clinical, secondary care management information is collected mostly around activity and waiting times and is used by its many and varied customers to inform policy; cost, plan and develop services; manage performance; monitor quality of care; benchmark against other organizations; and publish as national statistics. It also indirectly informs the resource allocation process.

Historically, quality aspects of care have been indirectly monitored through measures such as length of hospital stay, readmission rates and so on, but there is a move to develop “outcome” measures to better reflect any real benefits to patients. LHBs are required to collect patient-level datasets that describe various aspects of activity and submit these to NHS Wales Informatics Service. The Service processes and stores these data, monitors and reports on quality, and then disseminates information in various forms and through a range of media. LHBs also provide clinical data sets covering particular specialities, conditions or procedures to other, more clinical organizations, for clinical audit purposes. Unlike secondary care data, primary care data is mostly related to the financial payment system of GPs through the Quality and Outcomes Framework (see also section 5.3).

2.7.2 Health technology assessment

Wales has an All Wales Medicines Strategy Group that is responsible for assessing selected new medicines on behalf of the NHS in Wales that have not been assessed by the National Institute for Health and Clinical Excellence (NICE). There are no other formal mechanisms for health technology assessment at the national level.

2.8 Regulation

Regulatory functions in Wales are discharged by a mix of United Kingdom and Wales bodies. Table 2.1 summarizes the position, looking at the three principal regulatory functions of standard setting, monitoring and enforcement.

Table 2.1
Discharge of regulatory functions in Wales

Function	Regulatory institutions	Regulatory activities
Standard setting	Welsh Government	The Welsh Government has issued <i>Doing Well, Doing Better: Standards for Health Services in Wales</i> (Welsh Government, 2010a), which came into force on 1 April 2010; this provides a consistent framework that enables health services to look across the range of their services in an integrated way to ensure that all that they do is of the highest quality
	NICE	Clinical elements of the <i>Standards</i> are underpinned by NICE guidance
	Health professional bodies, e.g. the General Medical Council, the Health Professionals Council, Nursing and Midwifery Council	Clinical elements of the <i>Standards</i> are underpinned by standards issued by health professional bodies
Monitoring in Wales	Healthcare Inspectorate Wales	Core role is to review and inspect NHS and independent health care organizations in Wales to provide independent assurance for patients, the public, the Welsh Government and health care providers that services are safe and good quality
	Wales Audit Office	Mission is to promote improvement so that people in Wales benefit from accountable, well-managed public services that offer the best possible value for money
Other monitoring bodies in England and Wales	Healthcare Quality Improvement Partnership	Established in April 2008 to promote quality in health care and in particular to increase the impact that clinical audit has on health care quality in England and Wales
	NHS Commissioning Board Authority	Responsible for a National Reporting and Learning System for the reporting of patient safety incidents; the Board utilizes patient safety incident data to analyse risk, drive learning and improve patient safety
	Health Research Authority	Hosts a National Research Ethics Service that protects the rights, safety, dignity and well-being of research participants
Enforcement	Healthcare Inspectorate Wales	Seeks to identify and support improvements in services and the actions required to achieve this; it will undertake special reviews and investigations where there appears to be systematic failures in delivering health care services
	Wales Audit Office	Audits the accounts of public bodies and examines whether services are being delivered efficiently and effectively; most information is published in audit reports on individual public bodies as well as reports on specific value-for-money studies and topical issues. If necessary, it will publish a "Report in the Public Interest"
	Health care professional bodies, e.g. General Medical Council	Individual health care professional bodies maintain a register of practising health professionals; if a health professional does not meet the standards set by the health professional body, they can take action to protect patients from harm, which, if necessary, might include removing the health professional from the register and removing their right to practise

2.9 Patient empowerment

2.9.1 Patient information

The Healthcare Standards document *Doing Well, Doing Better* (Welsh Government, 2010a), set clear requirements for what the NHS should achieve, and its performance against those standards is monitored by Healthcare Inspectorate Wales. The specific requirements regarding patient information and consent are covered in Standards 9 and 18.

Standard 9: Patient Information and Consent. Organizations and services recognize and address the needs of patients, service users and their carers by:

- providing timely and accessible information on their condition, care, medication, treatment and support arrangements;
- providing opportunities to discuss and agree options;
- treating their information confidentially;
- obtaining informed consent, in line with best practice guidance; and
- assessing and caring for them in line with the Mental Capacity Act 2005 when appropriate.

Standard 18: Communicating Effectively. Organizations and services comply with legislation and guidance to ensure effective, accessible, appropriate and timely communication and information sharing:

- internally and externally;
- with patients, service users, carers and staff using a range of media and formats;
- about patients, service users and their carers;
- on the full range and locations of services they provide; and
- addressing all language and communication needs.

The Welsh language has parity with English in the conduct of much public business, and the NHS has statutory responsibilities in this respect. A new Welsh language strategy for health and social services is currently being developed.

2.9.2 Patient choice

The NHS provides care that is generally free at the point of delivery. Although patients in Wales (as elsewhere in the United Kingdom) are free to register with a GP of their choice, Wales places much less emphasis on choice as a means to drive service change and improvement than does England, and patients are expected to discuss their individual requirements with their clinical team, who

will then seek to help them to access the service that is best suited to their needs. Patients are not generally, for example, provided with a range of choices when accessing elective secondary care. People can seek private medical care, which they can pay for either through private health insurance arrangements or directly to the provider.

2.9.3 Patient rights

Patients in Wales have a series of entitlements that are embodied in a variety of legislation and policy. These range from entitlement to free prescriptions and certain assessments in primary care through to the right to access specialist care following referral. A commitment to develop a Charter for Patients' Rights and legislation on NHS redress was provided by *One Wales* (an agreement between the Labour and Plaid Cymru groups in the National Assembly in 2007) but the government has yet to issue a single formal statement of such rights. The main guidance on public engagement approaches are the *Signposts* documents (Office for Public Management, 2001, 2003) as well as specific guidance on how NHS bodies should handle public engagement and consultation around service changes (see section 6.1).

2.9.4 Complaints procedures

From 1 April 2011, new arrangements were introduced into Wales to support the complaints and redress arrangements in the NHS. The arrangements are described in *Putting Things Right: Raising a Concern about the NHS from 1 April 2011* (Welsh Government, 2011d). Information leaflets designed for children and adults are available and set out the steps necessary to raise a concern or make a complaint about their care or treatment. All health organizations in Wales have arrangements in place to receive, review and act on concerns raised. There is also a process to alert the Welsh Government about serious incidents or concerns. Evidence is used as part of the performance monitoring of the health organizations, for example in organizational dashboards and through inspection by Healthcare Inspectorate Wales.

2.9.5 Public participation

Eight community health councils represent the views of local people on their health services and support individual patients who are unhappy with the care they have received. The councils have statutory powers to be consulted on

major service change and also the power to inspect NHS premises (including those of primary care contractors) and those of agencies providing services for the NHS.

There is a commitment to ensuring transparency and sharing of information with the public. This is a fundamental principle in *Together for Health* (Welsh Government, 2011f). This document sets out the vision for the NHS in Wales and is a partner document to the *Programme for Government* (Welsh Government, 2011c), which sets out the broader work programme for the Welsh Government's five-year term of office.

The Welsh Government is also committed to ensuring that the patient's voice is evident in all audit and inspection tools it develops to support NHS organizations in meeting their responsibilities.

Fundamentals of Care Audit tool. This is a web-based tool for ward/unit staff to use to identify performance in key areas of care. It was created in 2008 and use nationally in NHS Wales began in 2009. It has the facility to create action plans for staff to use locally where performance needs improvement. It gathers evidence from the ward/unit staff and patients. As this is an audit tool, it currently gathers data at specific points in time. The annual audit reports of individual organization and the data collated for the whole of NHS Wales will be made accessible to the public via the Welsh Government's web site.

Specific tools of Healthcare Inspectorate Wales as part of its inspection regime. As part of the government's response to the report of the Older People's Commissioner, dignity spot checks are undertaken. All of the tools used for this type of activity include a facility to gain the users' views. All reports from inspections are available to the public via the Inspectorate's web site.

National Survey for Wales. At a national population level, a new National Survey for Wales was launched in 2012. The survey includes a range of questions about primary and hospital care and asks explicitly about whether the individual was treated with dignity and respect in all aspects of their interaction with the NHS. It is proposed that 13 000 people will be interviewed face to face annually and the results made public.

A national approach to measuring patient experience. This is being developed to ensure that the Welsh Government obtains feedback from health service users to use in shaping policy and service delivery. This approach will complement the National Survey for Wales as well as local approaches to measuring satisfaction and experience as part of an overall framework.

2.9.6 Patients and cross-border health care

Welsh residents receive treatment elsewhere in the United Kingdom depending on their circumstances but seldom travel outside the United Kingdom for treatment. Welsh patients can receive free treatment in some other parts of Europe under arrangements linked to EU treaties and other agreements, and patients from Europe can do the same in Wales. The framework for this is the

same across Wales. Patients from abroad not covered by the EU agreements receiving treatment in Wales will be charged in accordance with the relevant Welsh regulations, and Welsh patients abroad not covered by the treaty or by reciprocal agreements agreed by the United Kingdom need to make their own private arrangements to meet the costs.

3. Financing

Total spending on health services increased in the first decade of the 21st century, but Wales now faces a period of financial retrenchment greater than in other parts of the United Kingdom as a result of the Welsh Government's decision not to afford the same degree of protection to health spending as that granted elsewhere. The overall budget Wales receives from the United Kingdom Government is based on its share of the total United Kingdom population; how that "block grant" is used is determined by the National Assembly. Budgets are allocated to LHBs (three of which have allocations in excess of £1 billion a year). GPs and other private contractors are remunerated in ways very similar to those elsewhere in the United Kingdom. Limited use is made of formal mechanisms to pool funding between NHS and other public bodies. There is relatively limited private financing of health care, and the NHS makes very little use of the private sector. In 2004, the Welsh Government announced the abolition of prescription charges, and more recently it has abolished charges for parking on hospital premises (except where existing contractual arrangements make this difficult).

3.1 Health expenditure

The Welsh Government is funded through a block grant of £15.12 billion (2010–2011) from the United Kingdom Government to cover all devolved services. This includes health, which accounts for around 40% of the budget (£6.3 billion, both revenue at £5.9 billion and capital at £0.4 billion). There is no available information that shows the total expenditure on health in Wales, i.e. NHS (state and privately funded) and direct private expenditure in the private health care market. However, given the comprehensive nature of public financing and provision through the NHS, this sum from the block grant

makes up the vast majority of the total spending on health. Table 3.1 shows total spending on health per capita since 2005 and compares it with that in the United Kingdom.

Table 3.1

Total health expenditure per capita, Wales and UK, selected years

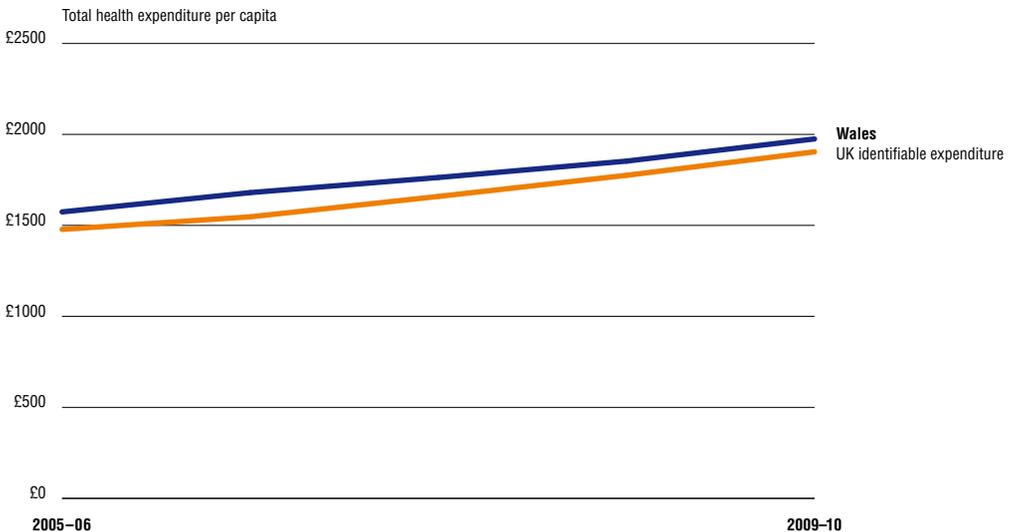
	Expenditure per capita (£)				
	2005-06	2006-07	2007-08	2008-09	2009-10
Wales	1 574	1 680	1 763	1 853	1 975
United Kingdom identifiable expenditure	1 478	1 547	1 659	1 775	1 904

Source: Wales Audit Office (2012).

Fig. 3.1 shows the significant increases in health spending from 2005 to 2010; the health expenditure in Wales is higher than the average for the United Kingdom, at 103.7 in 2010 compared with the United Kingdom at 100 (this, however, is a fall from 106.9 in 2005); and the level of expenditure in Wales has grown at a slightly slower rate compared with the United Kingdom, which mainly reflects the impact of the Barnett Formula (see below) in deriving the per capita share of the United Kingdom budget for the Wales block grant.

Fig. 3.1

Trend in health expenditure per head



Source: Wales Audit Office (2012).

Hence, the amount spent on health has grown significantly since the end of the 1990s, as a result of the United Kingdom Government's political commitment to increase the level of spending as a percentage of gross domestic product to the average for European nations. Consequently, the level of expenditure on health in Wales since 2000–2001 has seen a real increase to 2009–2010 of 56%, at £5.7 billion, equivalent to 5.1% per annum. The additional investment has been used to modernize staff structures, including new contracts for staff; for additional capacity to improve patient access for both elective and emergency care; for the introduction of new drugs, including for human immunodeficiency virus infection and cancer care; for eliminating user charges for all prescription drugs; and for meeting the increased costs of continuing care.

Table 3.2 shows expenditure by health programme using the data for 2010–2011.

Table 3.2

NHS expenditure by programme budget in Wales, 2010–2011

	£ (millions)	% of total
Infectious disease	80.7	1.5
Cancers and tumours	347.1	6.5
Disorders of blood	45.5	0.8
Endocrine, nutritional and metabolic, including diabetes	178.0	3.3
Mental health disorders	636.7	11.9
Problems of learning disability	119.7	2.2
Neurological	171.3	3.2
Problems of vision	119.2	2.2
Problems of hearing	26.6	0.5
Problems of circulation	464.4	8.7
Problems of the respiratory system	349.3	6.5
Dental problems	188.3	3.5
Problems of the gastrointestinal system	304.5	5.7
Problems of the skin	106.2	2.0
Problems of the musculoskeletal system (excluding trauma)	334.9	6.3
Problems from trauma and injuries (including burns)	377.1	7.0
Problems of genitourinary system	258.2	4.8
Maternity and reproductive health	192.0	3.6
Conditions of neonates	43.3	0.8
Poisoning	61.9	1.2
Healthy individuals	142.6	2.7
Social care needs	44.1	0.8
Other	763.3	14.3
Total	5 354.9	100.0

Detailed in Table 3.3 is the latest analysis of the expenditure for the NHS in Wales using 2010–2011 data, showing the main expenditure by service input.

Table 3.3

NHS expenditure for services in Wales, 2010–2011

	£ (millions)	% of total
Staff: hospital and community	2 886.7	48.5
Clinical supplies	989.0	16.6
General supplies	291.4	4.9
Primary care	820.2	13.8
Continuing care	339.9	5.7
Other providers	78.3	1.3
Establishment/premises	248.4	4.2
Depreciation	258.2	4.3
Other	44.0	0.7
Total	5 956.1	100.0

Source: Welsh Government (2012h).

3.2 Sources of revenue

Detailed in Table 3.4 are the main sources of NHS revenue income. It can be seen that over 96% of income comes from government sources, with only relatively small sums from other sources. The majority of out-of-pocket expenses are for user charges for dental treatment (see below).

Table 3.4

Sources of NHS income in Wales, 2010–2011

	£ (millions)	% of total
Government	5729.9	96.18
Other bodies	81.3	1.36
Out of pocket	27.6	0.46
Private patients	8.7	0.15
Charity	13.5	0.23
Other	96.5	1.62
Total	5 957.5	100.00

Source: Welsh Government (2012h).

3.3 Overview of the statutory financing system

3.3.1 Coverage

All patients in Wales can access the NHS for their care, which is generally free at the point of delivery. Further, all residents of the United Kingdom have access to NHS services in Wales. This is not the case for “overseas visitors”. Primary care providers (GPs, dentists, opticians and pharmacists) need to establish if a patient seeking treatment meets the definition of “ordinarily resident” as defined in Welsh Health Circular No. 32 (National Assembly of Wales, 1999); if not, the patient is deemed an overseas visitor. When an overseas visitor requests non-emergency medical treatment or treatment that is not immediately necessary, it is for the primary care provider to decide whether to accept that person as an NHS patient or as a private patient. Free treatment is provided when a service is considered to be immediately required because of an accident or emergency, independently of nationality or residence. Visitors from the European Economic Area Member States carrying EC Health Care Form 128 must also be treated free of charge under EU obligations. If patients are not ordinarily resident in the United Kingdom, charges may also be applicable regarding provision of secondary care by NHS services. The National Health Service (Charges to Overseas Visitors) Regulations 1989 place a legal obligation on LHBs and trusts in Wales to establish if people for whom they are providing NHS hospital services are not ordinarily resident in the United Kingdom.

The NHS does not specify an explicit list of services to be provided. At a general level, the United Kingdom 1977 Act imposes a number of responsibilities on the Secretary of State in relation to the provision of hospital and community health services. The responsibility for making available GP, dental, ophthalmic and pharmaceutical services in Wales lies with LHBs and the community health councils (see section 5.2).

The NHS in Wales aims to provide all effective interventions for its patients. Judgements on “effectiveness” are made by LHBs and trusts in accordance with NICE and other guidance and may lead to restricted programmes of treatment (e.g. for in vitro fertilization) or to the denial of treatment where the patient’s clinical condition makes treatment suboptimal. One challenging area for this universal and comprehensive approach has been general dental care, where a shortage of dentists willing to provide NHS services has resulted in some communities having no local NHS service.

While most NHS treatments are free at the point of use, some services require further payment from the patient. These payments are established in the NHS Wales Health Form HC12W (Welsh Government, 2009a), including the differing exceptions for certain group of patients.

3.3.2 Collection

The Welsh Government's source of funds is through the block grant. This is a single sum of money transferred to Wales by the United Kingdom Government. Its size is determined by the United Kingdom Government through the periodic comprehensive spending reviews, which are approved by the United Kingdom Parliament. The United Kingdom Government decides how much to allocate to the public expenditure budgets of the individual spending departments, with the corresponding funding earmarked for the Welsh Government ultimately derived using the Barnett Formula.

The formula works by applying an equivalent share for Wales of the “extra” funding given to each Whitehall department in the Spending Review (for those areas in which the Assembly has responsibility). These shares are called “consequentials”. The Barnett Formula attributes the share for Wales based on the per capita proportion of the Welsh population, with the current Barnett share for Wales being approximately 1/17 or 5.8%. The application of the Barnett Formula remains a politically controversial issue, with the Welsh Government arguing that the per capita share funding method does not reflect the proper health needs of the Welsh population and, in fact, has steadily reduced the historical share of the overall funding for Wales by some £380 million per annum.

Following receipt of the block grant from the United Kingdom Government, the Welsh Government allocates funds between the areas for which it has responsibility, although the budget has to be approved by the National Assembly. The determination of the share for the NHS is based on the Welsh Government's assessment of priorities, with the strongly held view that the NHS will continue to provide a comprehensive health service to all the people of Wales, paid out of public funds and remaining free at the point of access.

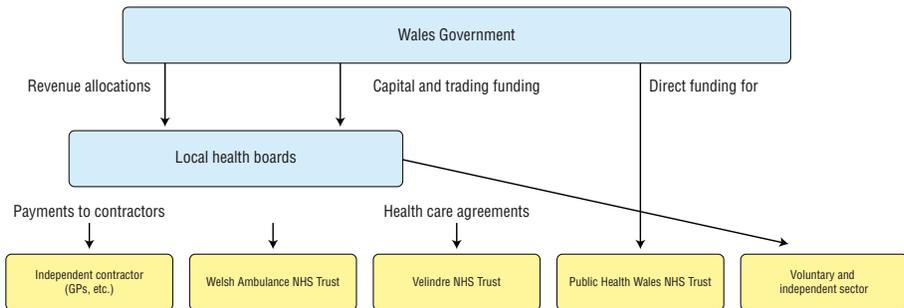
3.3.3 Pooling of funds and financial flows

In support of the new organizational structures introduced in 2009, a new financial system was put in place (Fig. 3.2) with funding flows reflecting the overall responsibility of the seven LHBs and the three specialist provider trusts. There are also cross-border financial flows between LHBs, reflecting the facts that people cross LHB boundaries to receive services and provision of specialist

or tertiary services may occur under particular collaborative arrangements. Finally, patients may move between Wales and England if they require either emergency or elective care across the border.

Fig. 3.2

How funds flow to the NHS organizations



In line with the new structure, a new financial regime was introduced that reflected the role and responsibility of the new bodies, taking into account the following principles:

- the basis for operational delivery would be through a planning and collaborative, rather than a market approach;
- there would be clarity on who is responsible for funding and delivering care;
- there would be progress in providing fair allocations that address health inequalities;
- there would be a complete and unified allocation for each LHB;
- there would be a national planning/funding body for specialist services (WHSSC) managed by the LHBs; and
- there would be an environment that drives LHBs to challenge inefficiency in current service provision, with an emphasis on prevention and community-based services.

Fundamental to the financial flows regime adopted by the new Welsh NHS is the capitation-based funding mechanism that minimizes interorganizational transactions while providing clarity of accountability for patient care, service delivery and resources. Capitation-based funding would allow progress to be made in ensuring that resources are made available based on the needs of

the population served. This was reflected in the application of the Townsend Formula, which assesses how the available resources at NHS Wales level should be shared out fairly, recognizing the health needs of their population. The distribution of funding to the LHBs is largely based on historical patterns of funding. The Townsend Formula was used in the past to determine target allocations for each health board the pace of change from the current distribution of funding to the target allocations is now dependent on the availability of funding and the policy of ministers. The allocation of revenue funds to the seven LHBs for the health care of their resident population is shown in Fig. 3.2.

Separate funding streams are provided to meet the capital financing requirements, which are controlled at an all-Wales level with funding passed to the relevant LHB based on the priorities of the Wales Government. In addition, separate funding is provided to the relevant LHB to reflect teaching and research responsibilities.

The Welsh Government sets out its policy priorities for the NHS annually, alongside the approved revenue and capital allocations. All NHS organizations are required to prepare individual operational plans by the start of the new financial year that demonstrate how the Welsh Government's requirements will be met within the funding available. The government, through the responsible Minister, holds to account the LHBs and the chief executives of the ten statutory NHS bodies for their overall (including financial) performance.

LHBs are responsible for planning and securing health care for their resident population:

- managing and funding treatment of their residents through their own services;
- paying for the treatment of their residents by other LHBs and trusts;
- funding the WHSSC to plan and commission specialist services for their residents;
- securing primary care services via independent contractor services;
- providing health care services in response to the needs of other commissioners (WHSSC/other Welsh LHBs/English primary care trusts); and
- managing cross-border funding flows.

LHBs and trusts delegate budgetary responsibility in line with organizational structures, with emphasis on clinical leadership. Individual budget holders are responsible for delivering high-quality safe patient services, monitoring

expected patient activity levels, achieving government objectives and delivering the required financial savings, thus ensuring that spending does not exceed their delegated budgets.

The Welsh Risk Pool is a mutual organization funded by all trusts and LHBs in Wales with the main functions of reimbursement of losses, management of claims, encouraging good risk-management practice and assessing risk-management performance.

3.4 Out-of-pocket payments

Most NHS treatments are free at the point of use, although there can be charges for some services, such as dental treatment, sight tests, glasses and contact lenses. Patients are exempt from these charges if they are on a low income and can be reimbursed for the necessary costs of travel to and from hospital for NHS treatment under the care of a hospital consultant.

NHS prescriptions

From 1 April 2007, the NHS prescription charge was abolished for people in Wales, with all patients registered with a Welsh GP and who get their prescriptions from a Welsh pharmacist being entitled to free prescriptions. Similarly, Welsh patients living in Wales but registered with a GP practice in England have been able to apply to their LHB for an entitlement card. Cardholders are able to get their prescription dispensed for free providing they take it to a Welsh pharmacy to get it dispensed. Along with free prescriptions, charges for wigs and appliances have been abolished, while patients who receive these services from an English NHS trust should have their costs met by their LHB.

NHS dental treatment

From 1 April 2009, there are three standard charges for NHS dental treatment, depending on the treatment the patient needs:

- examination, diagnosis and preventive care; urgent and out-of-hours care: £12.00;
- all necessary treatment covered by the £12.00 charge plus additional treatment such as fillings, root canal treatments or extractions: £39.00; and
- all necessary treatment covered by the £12.00 and £39.00 charges plus more complex procedures such as crowns, dentures or bridges: £177.00.

Sight tests

The out-of-pocket costs regarding sight tests are:

- NHS sight test: £20.26
- NHS sight test at home: £55.93
- hospital eye department test: free.

Free sight tests are available under the NHS for certain eligible groups, such as young people in full-time education, those older than 60 years, those at risk of glaucoma or a close relative of a patient with glaucoma, diabetics, those severely sight impaired or with a need for complex lenses, and those with income support or any other type of income allowance or tax credit exemption.

NHS optical vouchers

Vouchers towards the cost of glasses or contact lenses are also provided for young people in full-time education, those who need complex lenses and those getting income support or any other type of income allowance or tax credit exemption (NHS Wales Health Form HC12W (Welsh Government, 2009a) includes a list of vouchers provided).

NHS travel costs

It is possible to get help with the necessary cost of travel to receive NHS treatment under the care of a consultant or if the patient has a low income, being on income support or any other type of income allowance or tax credit exemption, and is referred by a doctor or dentist.

3.5 Voluntary health insurance

The contribution of voluntary health insurance (measured by premiums) to total health care expenditure is smaller than that relative to public expenditure, accounting for just 2.9% in the United Kingdom in 2008 (Boyle, 2011). Given that the proportion of the population covered by voluntary health insurance and self-insured medical expenses schemes in Wales is slightly lower than in the United Kingdom as whole (around 8.5% in Wales versus 12% in the United Kingdom in 2006) (Laing & Buisson, 2011), it is likely that the actual contribution of voluntary health insurance to total health care expenditure in Wales is lower.

3.6 Payment mechanisms

3.6.1 Paying for health services

The new Welsh NHS has adopted a capitation-based funding mechanism, which minimizes interorganizational transactions while providing clarity of accountability for patient care, service delivery and resources (see section 3.3). As illustrated in Fig. 3.2, funding is distributed from NHS Wales to the LHBs, who are responsible for planning and securing health care for their resident population. LHBs are responsible for managing and funding treatment of their residents through their own services.

3.6.2 Paying health workers

This section considers the contractual arrangements for payments to health workers in the NHS in Wales, making reference to places where there are differences with the United Kingdom arrangements.

GPs

The GP contract is a United Kingdom national agreement and was negotiated between the British Medical Association and NHS employers (with representation from the devolved nations) and introduced in April 2004. GP practices receive their funding through several major streams, although the main ones are the Global Sum (the amount of money a practice is allocated towards primary care, determined by the size of its practice population and adjusted for age and sex of the patients), performance-related payments through the Quality and Outcomes Framework and payment for provision of additional (“enhanced”) services.

Specialists

Specialists (known as consultants) are the most senior doctors in the NHS system. The amended Consultants’ Contract for Wales introduced in 2003 was agreed in partnership between the Welsh Government, the British Medical Association Cymru Wales and NHS Wales. The main features are:

- a 37.5 hour working week comprising ten sessions (normally split into seven direct clinical and three support sessions), compared with 40 hours per week in England;
- a strong emphasis on annual job plans and appraisal with accountability for standards of care, management of resources, levels of activity and clinical outcomes;

- permission for consultants to undertake private practice but on no account is it to interfere with NHS duties and patients; and
- salaries broadly comparable with the rest of the United Kingdom, being made up of basic pay plus commitment and clinical excellence awards.

Junior hospital doctors

The contracts for junior doctors are negotiated on a national United Kingdom basis with representation from each of the devolved administrations. The main focus has been on ensuring that their hours of work do not exceed the European Working Time Directive and that their training is suitable for making them fit for purpose as consultants or GPs.

Nurses, midwives and other NHS staff

The salaries of most nonmedical staff groups in the NHS are negotiated on the basis of a pay structure, often referred to as *Agenda for Change*, which was introduced in late 2004. Nurses, midwives and health visitors form the largest group in the NHS workforce and are generally salaried employees working either for the LHB or an NHS trust. GP practice nurses may be paid according to the same pay structure but this is a decision for the GP practice employing them. The new NHS pay system remains a national framework.

Dentists providing general dental services

The majority of dentists are independent self-employed practitioners who are at liberty to choose whether they contract a proportion of their time to provide NHS treatment on behalf of LHBs. As a consequence, they may provide only NHS care, work totally outside the NHS or, as is commonly the case, provide a mixture of NHS and private dental care. For NHS services, the new general dental services contract was introduced in England and Wales on 1 April 2006. The main changes brought in included:

- three standard charges for patients receiving NHS treatment (see section 3.4);
- patients are no longer registered with a particular dentist, but dentists may keep a list of patients for whom they provide regular treatment; and
- a new way of calculating dental activity so that NHS dentists in England and Wales are paid according to how many units of dental activity they do in a year.

Community pharmacists

Community pharmacists provide services as independent practitioners with a contract with the NHS. In 2005, a new community pharmacist contract was developed following negotiation between the Pharmaceutical Services Negotiating Committee, the Department of Health and the NHS Confederation (Pharmaceutical Services Negotiating Committee, 2012). Under the new national contract, which took effect in 2005, most community pharmacies provide services on the basis of three levels of service: essential, advanced and local enhanced.

4. Physical and human resources

Wales currently has more than 120 hospitals as part of an overall estate valued at £2.3 billion. There is a substantial backlog of maintenance, reflecting the age of premises and a perceived overreliance on hospital care. The NHS currently has approximately 72 000 directly employed full-time equivalent staff, reflecting an increase of almost a quarter in the first decade of the 21st century. These staff members are mostly regulated on a United Kingdom basis, with education and contractual terms also generally following a United Kingdom model, with some Wales variation.

4.1 Physical resources

The current NHS land and property portfolio covers a total land area of approximately 750 ha. The value of the estate is assessed at £2.3 billion and includes over 100 hospitals, over 200 health centres and clinics, around 50 mental health units, around 90 ambulance stations, over 150 miscellaneous properties in the form of offices, storage and distribution warehouses, and over 14 radiomast sites. Backlog maintenance costs are currently in excess of £400 million. This reflects the fact that over 50% of the estate is pre-1975, 20% pre-dates 1948 and only 20% was built since 1995.

The allocation of capital to the NHS is managed by the Welsh Government via an All Wales Capital Programme, which was established in March 2007. The plan has been revised since then to take account of changing policy and needs. The Welsh Government capital allocation for investment in the NHS is £329 million (about 5.5% of the NHS revenue allocation of £5.9 billion). There are no other sources of capital available.

The All Wales Capital Programme has focused on providing fit-for-purpose buildings in the right places rather than investing in backlog maintenance on estate, which will never be fit for purpose and may be sited in the wrong place.

The All Wales Capital Programme targets capital investment to support delivery of one or more of the following high-level service objectives:

- services that are accessible to patients and carers (right services in the right places);
- radically redesigned services;
- decentralization of routine work/centralization of complex work;
- new models in primary care and adaptation of existing primary care estate to do more locally;
- investment in communication technology and diagnostic capability needed to enable new clinical models; and
- improvement of the ongoing efficiency of estate (backlog maintenance), sustainable development, energy efficiency, climate change adaptation.

In the context of the above, the NHS capital allocation is prioritized each year across the following broad requirements:

- upgrading and modernization of secondary care facilities
- modernization of mental health services
- upgrading and modernization of community and primary care facilities
- investment in diagnostic equipment and technology
- replacement of ambulances
- replacement information technology (IT) and communication technology.

Before capital is released to the NHS, every scheme has to go through a thorough business case process that will include identification of explicit deliverable outcomes and evidence of arrangements for delivery of projects.

4.2 Human resources

4.2.1 Health workforce trends

The NHS is Wales's largest employer, with a payroll at the end of September 2011 of almost 72 000 full-time equivalent staff, excluding contactors such as GPs and dentists. This has increased by 24.7% since 2001, although there are signs of a more recent reduction in the total numbers (Table 4.1). In the largest group, nursing and related professions, significant changes have taken place in the types of staff employed (Table 4.2). The number of GPs has increased somewhat less quickly; there were 501 practices and 1816 GPs in 2004, and 488 practices and 1940 GPs in 2009, an increase of 6.8% in GP numbers over those five years (NHS Information Centre, 2011).

Table 4.1

Directly employed staff in NHS Wales, 2001 and 2011

Staff group	2001	2011	% change in the last	
			10 years	1 year
Medical and dental	3 907	5 813	+48.8	+2.8
Nursing, midwifery and health visiting	24 751	27 999	+13.1	-0.6
Administration and estates	12 326	15 230	+23.6	-1.8
of which:				
managers	1 339	2 092	+56.2	-10.7
scientific, therapeutic and technical	7 605	11 450	+50.6	-0.3
health care assistants and other support	7 781	9 711	+24.8	-3.4
ambulance	1 103	1 458	+32.2	+2.1
other	121	157	+29.7	-0.9
Total	57 595	71 817	+24.7	-0.9

Source: Welsh Government (2012k).

Table 4.2

Nurses, midwives, health visitors and health care assistants in NHS Wales, 2001 and 2011

Grade	2001	2011	% change in the last	
			10 years	1 year
Qualified staff	18 088	21 733	+20.2	-0.4
of which:				
managers	236	563	+138.7	+0.2
nurse consultants	0	28	na	+30.2
registered midwives	1 130	1 165	+3.1	-2.6
health visitors	629	739	+17.5	-0.8
district nurses	886	823	-7.1	+2.1
other first-level nurses	13 535	17 890	+32.2	-0.6
other second-level nurses	1 269	118	-90.7	-13.5
Unqualified staff	6 662	6 266	-6.0	-1.3
Health care assistants and support staff	7 781	9 711	+24.8	-3.4

Source: Welsh Government (2012k).

Note: na: Not available.

4.2.2 Professional mobility of health workers

Recruitment of key staff, particularly doctors and nurses, from abroad has fluctuated over recent years, mainly in response to changes in immigration rules. Historically, the NHS throughout the United Kingdom has relied on doctors from Commonwealth countries, and Wales has followed this trend. There have also been periods of intensive recruitment of nurses from the Philippines. Such recruitment is now very restricted.

Most professional groups also move within the United Kingdom. So far, this has not presented significant problems, with flows usually balancing each other and supported by nationally determined terms and conditions of employment. This may change in the future, if the United Kingdom Government pursues its avowed intent to decentralize the determination of employment conditions.

5. Provision of services

Public health is the shared responsibility of all NHS bodies and also more widely permeates all Welsh Government departments, which share a commitment to assess the health impact of policy developments. Leadership is provided by the NHS Trust PHW, which operates both nationally and through its staff located in each LHB. Primary care is mainly provided by independent contractors, as in the rest of the United Kingdom. Specialized ambulatory care is developing rapidly in Wales, as the NHS responds to an historical model generally perceived to be overdependent on hospitalization. Emergency care is currently located in district general hospitals, but this may change significantly during 2012–2014 as LHBs propose radical restructuring of hospital services. Pharmaceutical care is led by a network of community pharmacies, on which the government is relying for some of the extension of access to services, a current priority. Intermediate care is another priority area, and considerable work has focused on supporting self-care and managing long-term conditions more effectively in the community. Informal carers provide the vast majority of care for people living at home, and their entitlement to their own assessment of needs is enshrined in law. Palliative care receives less public funding in Wales than in England, but third sector providers remain the mainstay of such provision. Mental health care is another priority area, with clear action focused on the provision of services and attempts to reduce stigma. Dental care in Wales now relies heavily on private provision, as parts of the country struggle to recruit NHS general dental practitioners.

5.1 Public health

Improving and protecting the health of the population is a key duty of the Welsh Government. It is included as an aspiration in the Welsh Government's operational strategy *Programme for Government* (Welsh Government, 2011c).

Responsibility for the planning and delivery of public health is shared between a number of government departments, NHS organizations and local authorities, whose actions are coordinated using a variety of statutory and hierarchical relationships.

The main policy instrument for public health in Wales is *Our Healthy Future* (Welsh Government, 2009b). This sets out the ambition for work in Wales to improve and protect the health of the population. Complementing *Our Healthy Future*, there is also an approach to reducing inequality and inequity across the country, which is known as *Fairer Health Outcomes for All* (Welsh Government, 2011b).

The principal lead for public health is the Chief Medical Officer for Wales. This position is part of the Department for Health, Social Services and Children and the incumbent is responsible to the First Minister for Wales as the senior adviser on health matters. The Chief Medical Officer leads the Public Health Directorate in the Department, which is tasked with the planning and articulation of strategy on public health. This directorate works with other government departments to pursue “Health in all” policy ambitions through a range of tools. It is also the sponsoring body of actions conducted outside government, bearing on a wide range of health-promoting initiatives, and has performance-management relationships with key delivery organizations such as LHBs.

The PHW NHS Trust was created as part of the health system reforms of 2008–2009 through the amalgamation of the National Public Health Service, Wales Centre for Health and a number of subsidiary functions; this followed a review of public health services in 2006. PHW provides expertise in the area of specialist public health at national and local levels. At a national level, this includes the national screening programmes, Wales Communicable Disease Centre, Smoking Cessation Service and the Pharmaceutical Public Health Team. In each LHB, PHW provides staff to support health improvement and protection initiatives and the work of the LHB director of public health. The director is a joint appointment between the LHB, PHW and, in some cases, the local authority. The role of the director of public health in an LHB is to act as pivot for public health action within a defined geographical area.

Local authorities in Wales have responsibility for environmental public health, including maintaining food hygiene regulations and air quality control. Staff of these local authority units work closely with colleagues in PHW and the Welsh Government in the performance of their work.

5.2 Patient pathways

A typical patient pathway varies from the pathway in England as described in section 6.1 in Boyle (2011) mainly in the extent of provider choice available to patients (see section 2.9.2).

5.3 Primary/ambulatory care

Primary care provides health care outside of the hospital setting and plays a gatekeeping role: access to more specialized, often hospital-based, acute health care services usually requires a referral. A range of health care professionals and organizations provide primary care, some as part of the general practice system (e.g. GPs, practice nurses, therapists) but some with a distinct role of their own. The latter includes NHS Direct Wales, which runs a telephone and web-based helpline to provide a 24/7 nurse-led advice and health information service. It acts as a first point of call for many people and where necessary routes them to the most appropriate resource to deal with their health concerns. Responsibility for the coordination and delivery of primary care services rests with LHBs, which must ensure that the appropriate range of services is available to their populations.

In 2011, there were 2022 GPs working in 483 GP practices, of whom 43% were women. Most GPs are in a contractual relationship with a LHB although some work within practices as salaried GPs and others are training in general practice. Single-handed GP practices are run by 13% of GPs, although they may employ a salaried GP or a GP trainee. There are also practice nurses working in GP practices. The list size – the number of residents cared for by an individual GP – has fallen in Wales by 6% between 2001 and 2011, from 1665 to 1564 (6.5 GPs per 10 000 registered patients) (Welsh Government, 2012e).

GPs work in their own premises or in ones provided by the health service; the premises are usually called surgeries. Under the General Medical Services Contract, GPs need to ensure that services are provided within their core hours (Monday to Friday between 08.00 and 18.30 except Good Friday, Christmas Day and Bank Holidays). An “out-of-hours” service (18.30 to 08.00 on weekdays and all day at weekends and public holidays) ensures that individuals with urgent primary care needs can receive attention and that other patients accessing the service are given appropriate advice and information. The out-of-hours service has three core elements: call handling, telephone assessment and triage, and

face-to-face consultations at home or at primary care treatment centres. During 2011–2012, the out-of-hours service was used by approximately 575 000 people in Wales, 18% of the population.

Other key staff involved in the delivery of primary care include practice nurses, district nurses, midwives, health visitors and other health care professionals such as physiotherapists, chiropodists and occupational therapists. Other health care professionals working within GP practices may include occupational therapists, physiotherapists and chiropodists (see Table 4.2). Dentists, ophthalmic medical practitioners, optometrists and community pharmacists also deliver primary care services on behalf of the NHS.

5.4 Specialized ambulatory care/inpatient care

The 74 NHS hospitals in Wales provide the following services:

- 13 hospitals have major accident and emergency units (approximately two per LHB area), and a wide variety of acute medical and surgical specialties; two hospitals (Swansea and Cardiff) also provide specialist tertiary services for the south of Wales;
- 15 hospitals have minor accident and emergency units or minor injuries units; and
- 46 community hospitals, with the highest numbers in rural areas in north, central and west Wales, have a mixture of rehabilitation, step-down and GP beds; Powys LHB in central Wales only has 10 community hospitals in its area and receives acute services from neighbouring LHBs in Wales and across the border in England.

There are a small number of private, profit-making hospitals and charitable institutions providing hospital care.

Parts of north and central Wales also receive secondary care services from cross-border hospitals in England (e.g. in Chester, Shrewsbury, Hereford and Bristol). In addition, people in those areas also use highly specialized hospitals in England, such as the Walton Centre NHS Foundation (Neurosurgery) and Alder Hey Children's NHS Foundation Trust in Liverpool. In south Wales, the size of the population supports highly specialized services provided in Wales. Hospitals in Cardiff and Swansea provide specialized orthopaedics (spine), cardiac, neurosciences and plastics services, and Cardiff has a dedicated children's hospital. Specialized cancer services in south and central Wales

are provided by Velindre Trust. North Wales has a cancer centre for local radiotherapy and chemotherapy and only very rare cancers require services across the border.

The integrated LHBs are responsible for the coordination and integration of primary and secondary services in their area. For LHBs that require specialist services from over the border with England, commissioning contracts still apply. This mainly relates to Betsi Cadwaladar LHB in north Wales and Powys LHB in central Wales.

The Welsh NHS structure has resulted in greater integration of services between primary and secondary care. Part of the Welsh Government's strategic direction is to enhance this integration through the movement of services out of secondary care into local primary and community services. The main area of recent focus has been the development of community services for the management of chronic conditions. This was supported by central investment and project management. Recent evaluation has shown a reduction in both emergency admissions and readmissions for these conditions.

Further work in this area is being taken forward through the establishment of primary care and community locality groups across each LHB. They will be responsible for assessing local need and deciding on what additional services can and should be provided locally to support patients to live well at home.

A move to short-stay surgery, in particular outpatient and day-case surgery, has been a key efficiency and productivity target since the early 2000s. Fifty procedures from the British Association of Day Surgery have been highlighted and targeted for focus across Wales. On an all-Wales basis, 77.5% of these procedures have been delivered either for outpatients or on a day-case basis in 2011, a significant improvement from the previous year's performance.

In addition to strengthening integration, three other challenges have attracted considerable attention recently and will do so for some time.

The need to increase capacity to meet growing demand and access targets within a tight financial environment. There is a need for a continued focus on the delivery of efficiency and productivity within an environment of service redesign, spreading clinically effective models across Wales to ensure that all areas in Wales deliver high-quality safe services that address the needs of their local population.

Trauma and orthopaedic demand. Activity to increase capacity to meet demand has not been sufficient and has resulted in delays in access times across a number of areas in Wales. Additional money, allocated by a National Orthopaedic Group and regional plans, is on track to deliver the required access targets by the end of March 2012.

Understanding and managing demand. Working with primary care through the review of referrals (elective and unplanned care), LHBs are trying to gain a greater understanding of demand and how best to meet the changing requirements. A possible solution is to review and redesign the current delivery model of outpatient departments.

The quality and dignity of service delivery is prioritized, together with timeliness (access). Two particular areas of focus are zero tolerance for pressure ulcers and hospital-acquired infections. These areas are closely monitored and supported by an all-Wales quality campaign called *1000 Lives Plus*, which began in 2008 and champions quality improvement. In addition, clinical quality is assessed through national and local audits.

Healthcare Inspectorate Wales is the independent inspectorate and regulator of all health care in Wales. The primary focus of the Healthcare Inspectorate Wales is on:

- making a significant contribution to improving the safety and quality of health care services in Wales;
- improving citizens' experience of health care in Wales, whether as a patient, service user, carer, relative or employee;
- strengthening the voice of patients and the public in the way health services are reviewed; and
- ensuring that timely, useful, accessible and relevant information about the safety and quality of health care in Wales is made available to all.

From May 2012, a five-year Quality and Delivery Framework for Wales will capture the outcomes of delivery through an agreed set of indicators based on the six quality domains. This will allow the government to demonstrate the effectiveness of NHS Wales for the health of the citizens of Wales.

5.5 Emergency care

Emergency or unscheduled care is defined as any event that is unplanned or unscheduled where an individual is seeking attention from a health or social care professional. This includes emergency department provision and various assessment facilities such as medical assessment units or clinical decision units.

As at September 2012, emergency services are provided through 13 district general hospitals with a major emergency department, 15 minor injury units within acute hospitals, and 25 minor injury units provided within community hospitals.

Ambulance services in Wales are provided by a single ambulance trust, the Welsh Ambulance Services NHS Trust. This provides accident and emergency services, pre-hospital emergency treatment and care, urgent patient transfer, response to major incidents and non-emergency patient transport services. The Trust has its headquarters in St Asaph, North Wales, with seven other regional headquarters, control and call centres. The Trust operates from 88 ambulance stations, has one fleet workshop and two regional training facilities.

Emergency care is also accessed via a wide range of other service provision.

All primary care services, both in and out of hours. Services are provided by GP practices, dental practices, community pharmacies and local optometrists.

NHS Direct Wales. This is a nurse-led telephone advice and information service and a dedicated dental helpline for a number of LHBs.

Mental health care services. Crisis resolution/home treatment services offer a rapid response for adults who are experiencing a mental health crisis; the response comprises assessment and, where appropriate, support and treatment for a brief period as an alternative to hospital admission.

Urgent social care providers. Within local authorities, social services have a major role in protecting the most vulnerable people in the community. They provide care and support to children and young people, older people, and people with mental health problems, learning disabilities, physical disabilities and sensory impairments.

The Welsh Government sets national targets for its emergency care services and a summary of the current standards are set out below.

Emergency departments. Of new patients, 95% should spend no longer than four hours in the department from arrival until admission, transfer or discharge; 99% should spend no longer than eight hours until admission, discharge or transfer.

Ambulance response times. A monthly all-Wales average performance of 65% of first responses to category A (immediately life-threatening) calls arriving within eight minutes. A monthly minimum performance of 60% of first responses to category A calls arriving within eight minutes in each unitary authority area.

Handover of patients from an ambulance to an emergency department. No patient should spend longer than 15 minutes in being handed over from an emergency ambulance to a major emergency department.

5.6 Pharmaceutical care

Pharmaceuticals are a major component of expenditure on health care in Wales. Patients treated under the NHS are entitled to receive prescription medicines with the cost of those medicines met by the NHS (some medicines are specifically excluded from this arrangement by virtue of being included in a negative list of medicines not for prescribing on the NHS). On 1 April 2007, NHS prescription charges were abolished for people in Wales. All patients registered with a Welsh GP and who get their prescriptions from a Welsh pharmacist are entitled to free prescriptions. Welsh patients registered with an English GP are provided with an entitlement card by the NHS Shared Services Centre that enables them to receive free prescriptions provided these are from a pharmacy in Wales.

There were 72.2 million NHS prescriptions dispensed in Wales in 2011 compared with 46.0 million in 2001, an increase in average items per head of population from 15.8 to 24.0 (52%). The majority of these prescriptions were written by GPs in Wales, although a proportion originated from other sources in Wales or the rest of the United Kingdom (e.g. GPs in England or NHS hospitals).

In the same period, total net ingredient cost in 2011 was £587.8 million compared with £443.8 million in 2001, an increase of 32%. Average net ingredient cost decreased from £9.64 per prescription item in 2001 to £8.14 per prescription item in 2011 (Welsh Government, 2012i). This reduction can be attributed to the introduction of revised pricing arrangements for generic medicines introduced in 2005 and reductions to the price of branded medicines required by the Pharmaceutical Price Regulatory Scheme.

Since 2004, health professionals other than doctors or dentists have been able to prescribe medicines if they have been trained and accredited to do so. What medicines can be prescribed will depend on the accreditation of the prescriber. Supplementary prescribers can only prescribe in partnership with a doctor or dentist. All supplementary prescribers may prescribe for any medical condition provided they are acting in accordance with an agreed individual patient's clinical management plan. The doctor, or dentist, is responsible for the diagnosis and setting the parameters of the clinical management plan.

The following professionals can practise as supplementary prescribers providing they have qualified and registered to do so:

- registered nurses, registered midwives
- registered specialist community public health nurses

- registered pharmacists
- registered chiropractors and podiatrists
- registered physiotherapists
- registered radiographers, diagnostic or therapeutic
- registered optometrists.

Nurses, pharmacists and optometrists may prescribe as independent prescribers for any medical condition within their area of competence. District nurses and health visitors are also able to prescribe independently from a limited formulary known as the *Nurse Prescribers Formulary for Community Practitioners*. The extension of prescribing rights to other groups of health care professionals will continue.

The All Wales Medicines Strategy Group leads on the development of optimal prescribing practice in Wales. It advises government on prescribing issues, works closely with prescribers across the country and also reviews the merits of medicines not scrutinized by NICE.

Since the mid-1980s, regulations have required that any community pharmacy wishing to dispense NHS prescriptions must pass a local needs test. Therefore, the choice of whether to open and where to locate an NHS dispensing pharmacy is not simply a commercial decision left to the discretion of the pharmacy owner. In rural areas where patients have difficulties in accessing a pharmacy, GPs can dispense prescribed medicines if the LHB has decided they can do so.

There were 708 community pharmacies in Wales on 31 March 2011, 453 of which were part of pharmacy chains owning six or more premises. The remaining community pharmacies were independent. The number and proportion of independent pharmacies in Wales fell for the fifth consecutive year in 2010–2011 (Welsh Government, 2012e); in this period, 15 community pharmacies in Wales were in receipt of support from the Essential Small Pharmacy Scheme. The Scheme provides financial assistance to pharmacies that are not economically viable because of their location but are considered vital to the provision of pharmaceutical services to the local community.

In recent years, the number of community pharmacies in Wales providing additional pharmaceutical services (i.e. services other than dispensing NHS prescriptions) has significantly increased and Welsh Government policy is indicative of a continued focus on additional services.

5.7 Intermediate and long-term care

5.7.1 Chronic conditions management

The Welsh Chronic Conditions Management Model and Framework, developed in 2007, sets out a proactive approach to the management of chronic conditions, based upon early assessment, diagnosis and appropriate treatment within the community. Findings from the Chronic Conditions Management programme of work have shown that there is clear evidence from LHBs of improvement in community-based service provision, the establishment of cluster-based primary care and the formation of integrated teams working across health and social care that has contributed to improvements across a range of associated outcomes in patient care.

Implementation of the Chronic Conditions Management programme of work between 2008 and 2011 has supported mainstream change in community service delivery and the introduction of the core model of care coordination, integrated teams, GP clusters and locality working, as well as transferring appropriate services from secondary care settings into settings based on local community or primary care services. Further work is being undertaken to speed up and embed improvements more consistently across LHBs, focusing on high-risk and vulnerable groups and developing individual care plans for people with chronic conditions to improve the treatment, care and outcomes for patients with long-term conditions.

5.7.2 Social care

Each local authority has a statutory responsibility for providing or arranging the provision of a range of residential and community-based social services to meet the needs of its resident population. It has a duty to assess the long-term care needs of individuals considered in need of such care, and to meet those needs as appropriate. Local authorities assess need through the Unified Assessment Process and in line with locally agreed eligibility criteria for services. This process should be multidisciplinary, taking into account a person's long-term health and social care needs. Where individuals meet those criteria, they will be provided with community-based or residential services to meet their needs as appropriate. While authorities will provide some services themselves, the vast majority of services are run by the private and independent sector. Where individuals do not meet an authority's eligibility criteria for services they are free to arrange services if they wish on a private basis.

Where an individual is provided with a social service through their local authority, authorities have a statutory duty to charge for residential care provided or arranged. Where an individual receives community-based services, authorities have the discretion to charge for these up to a maximum amount. An individual's contribution towards their care costs is based on their financial ability to pay or whether they are deemed eligible to financial support from their local authority.

Local authorities and LHBs are required to work together as part of the multidisciplinary assessment of individuals requiring long-term health and social care. The provision and delivery of long-term care is commissioned in a joint working approach by both sectors.

Residential care is provided in a variety of settings; for older people, this includes personal care, nursing care and elderly mentally infirm care. Settings for younger adults include provisions for individuals with physical and learning disabilities plus provisions for mental health needs. All care homes must be registered with the Care and Social Services Inspectorate Wales. Care homes range from small units housing several people to larger homes providing a mix of care provisions and facilities. The vast majority of care homes are provided by the private and independent sector.

Most recently published data confirmed that, in March 2011, 65 499 adults were in receipt of a community-based service provided or commissioned by their local authority. Most are in receipt of home care services or equipment to aid their daily living. In recent years, there has been a significant increase in the number of people receiving direct payments that enable them to have greater choice and control over the services they receive.

In March 2011, 83% of those in need of some form of long-term care and support received such services as a community-based service and 17% were in long-term residential care. Of those in residential care, around a third were in receipt of some NHS care. These figures have remained consistent over recent years (Welsh Government, 2011a).

The Welsh Government's policy aim is to ensure that individuals remain living in their own homes and as independently as possible with support where and when required. Its policy document *Strategy for Social Services in Wales: Fulfilled Lives, Supportive Communities* (Welsh Government, 2007) sets out its long-term key aims. A second paper, *Sustainable Social Services in Wales* (Welsh Government, 2011e), sets out the Welsh Government's priorities for action through a programme of policy and legislation.

Challenges facing the provision and delivery of social care include long-term financial constraints coupled with an increase in demand as a result of an ageing population, which, in turn, leads to increases in the number of individuals entering care settings with more complex care needs.

In April 2011, the Welsh Government introduced more consistency into charging by local authorities as it implemented the Social Care Charges (Wales) Measure for non-residential care services. Among the changes made was the introduction of a weekly maximum charge of £50 and a review process for service users who were unhappy with their notified level of charges.

The Welsh Government is taking forward its agenda to review and reform the current system in place for funding and paying for social care. This is being undertaken in line with the recommendations of the Dilnot Report (Commission on Funding of Care and Support, 2011) and recommendations on the current system in England.

5.8 Services for informal carers

Carers in Wales have the right to a professional assessment of their needs, which will then be met by social services and the NHS if they exceed the agreed thresholds for need. Third sector organizations are also major providers of such support. The extent of informal care provided in Wales is not known, although estimates suggest that perhaps 95% of all care provided in the community comes from unpaid (“informal”) carers (Llewellyn et al., 2010).

5.9 Palliative care

Palliative care services are organized on a LHB basis, with all providers working as part of a wider specialist clinical team. Each LHB has palliative care clinical medical and nursing leads who work to achieve service integration across 52 teams. The clinical leads represent their LHB on the All Wales Palliative Clinical Implementation Group. An agreed funding formula supports both statutory and voluntary sector organizations. The funding formula compensates voluntary sector hospices for core service provision. Care settings include acute and community hospitals, hospice inpatient and day-care units and hospice-at-home services. An End of Life Alliance Group includes all relevant services. Peer learning has been developed between specialist palliative care teams and cardiac and renal services.

The voluntary sector continues to support and develop service provision above the level agreed within the funding formula. While clinical services are funded, volunteers are well established and engaged at all levels of service in the voluntary sector and more recently within NHS teams. A training programme is provided before volunteers commence.

A specific target for end of life care requires LHBs within the Annual Quality Framework to demonstrate “increase in the number of patients who receive care in their preferred place of care as agreed in their dynamic end of life plan”.

A dedicated palliative care module has been developed as part of the computerized cancer patients’ clinical record system. The module is designed to hold consistent registration details for all diagnoses, not just cancer, and also to record the first clinical assessment after referral. It is linked to voluntary and statutory sector providers to improve communication by enabling important clinical details to be available across providers. Secure computers and associated connections have been provided to all voluntary sector and NHS specialist palliative care providers, with training and support to clinicians, thus making important clinical information available at all times. The system is capable of providing Wales-wide reports on activity and levels of clinical intervention, including referral and discharge details, response times and patient-reported outcomes.

A national patient satisfaction survey commenced during July 2009, “iWantGreatCare” (iWGC, 2009), is a straightforward system to capture the patient’s view of the care they experienced from their local specialist palliative care teams. The simple forms are offered to all patients referred to specialist palliative care. Anonymized returned forms are independently analysed to provide monthly reports to the specialist palliative care teams. A national survey allows evaluation of our palliative care services as a nation and offers both patients and carers/families the opportunity to give feedback on the effectiveness of service provision in a consistent format across Wales. Feedback enables teams to benchmark themselves against the all-Wales average. Feedback is then monitored by the Palliative Care Implementation Board to provide a mechanism for Wales-wide positive feedback and for lessons to be learnt by service providers.

Future work includes the introduction during 2012 of a peer-reviewed process for palliative care providers. The Palliative Care Planning Group set the direction of future services with the Sugar Report (All Wales Palliative Care Planning Group, 2008b). The Palliative Care Implementation Board was

established to oversee recommendations within the Sugar Report (All Wales Palliative Care Planning Group, 2008a; Wales Palliative Care Implementation Board, 2011).

5.10 Mental health care

The seven LHBs and 22 local authorities plan and deliver a range of mental health services for their local populations and also work with third sector organizations to ensure this service continues. Mental health provision has increasingly moved from institutional settings towards an emphasis on local delivery within community mental health teams, including assertive outreach and crisis intervention and home treatment for adults and older people, and through Children and Adolescents Mental Health Services for children and young people. Community-based mental health services are now well developed and embedded across Wales so that they are generally delivered as close as is practically possible to people's homes. Wales is increasingly moving towards locating mental health services on general hospital sites.

Multidisciplinary community mental health teams work across LHBs and local authorities and include therapists, medical staff, social work staff and nonmedical staff. Specialist training programmes are available to ensure teams have appropriate skill mixes. The National Leadership and Innovation Agency for Healthcare, working with the Welsh Government, NHS Wales and education providers, aims to create and retain a workforce with the skills that are needed to meet the demands of modern day health care through workforce planning, commissioning, education and training. Local authorities, together with higher education colleges, ensure the availability of the social care workforce and the availability of approved mental health professionals to exercise duties under the Mental Health Act 1983.

The development of mental health services in the period 2001–2011 has been informed by the adult mental health strategy *Equity, Empowerment, Effectiveness, Efficiency* (National Assembly for Wales, 2001) and the associated National Service Framework (NSF) *Raising the Standard: The Adult Mental Health National Service Framework* (2002, updated 2005) (Welsh Government, 2005). Requirements for dementia care were included in the older person's NSF and in a recently published document, *National Dementia Vision for Wales* (Alzheimer's Society and Welsh Government, 2011). In addition, the

Children's NSF and the Children and Adolescents Mental Health Services Strategy *Everybody's Business* (Child and Adolescent Mental Health Services, 2001) have provided direction for children and younger people's services.

A key driver for the development of mental health care is the additional statutory requirements contained within the Mental Health (Wales) Measure 2010 (a Measure is a piece of law made by the National Assembly for Wales and has similar effect to an Act of Parliament). The Measure will make a number of important changes to the current legislative arrangements in respect to the assessment and treatment of people with mental health problems in Wales. The Measure will also expand primary care mental health services and the duties relating to the provision of statutory advocacy.

A new Mental Health Strategy for Wales is now in development to replace the strategies highlighted above and to address the recommendations of the Wales Audit Office report. A draft of the Mental Health Strategy for Wales is intended to be produced for consultation by spring 2012 and will cover the whole life-course: services for children, adolescents and older people. The principles of the new Mental Health Strategy for Wales will include:

- embedding the Mental Health (Wales) Measure 2010 and other relevant legislation;
- consolidating existing policy;
- addressing mental health and well-being as well as mental illness;
- challenging stigma and discrimination; and
- focusing on the individual's care within a recovery approach.

The Welsh Government undertakes work on an interdepartmental basis and in collaboration with NHS Wales, local authorities and the third sector to ensure that the needs of specific vulnerable groups are met by general mental health services. These include all priority groups within the latest equality legislation. Statutory bodies are expected to plan and deliver services to meet the needs of these groups.

A new All Wales Veterans' Health and Wellbeing Services has been established. The Social Services Action Plan for Wales and the Welsh Review of Secure Services address the needs of people detained under the Mental Health Act and of offenders.

A new national programme to tackle stigma and discrimination surrounding mental health problems, *Time to Change Wales*, was launched in 2011 (Mind Cymru, Hafal & Gofal, 2012). Three leading mental health charities, Gofal, Hafal and Mind Cymru, have joined forces to lead the campaign, which is funded by the Big Lottery Fund Cymru, Comic Relief and the Welsh Government. One of the key principles of the new mental health strategy being developed will include the challenging of stigma and discrimination.

The Wales Audit Office published a follow-up review of the implementation of the Adult Mental Health NSF strategy in July 2011. *Adult Mental Health Services: A Follow-up Report* (Wales Audit Office, 2011) highlighted that “since 2005 there have been important improvements in adult mental health services in many parts of Wales, though progress has been variable and some service gaps and inequalities remain”.

5.11 Dental care

LHBs are responsible for the provision of NHS dental services and must ensure that NHS dentistry is available to anyone wishing to access services. Individuals have the right under the NHS to all treatment clinically necessary to keep teeth, gums and mouth healthy, including dentures. Dental services in Wales are provided in three settings.

Secondary and tertiary dental services in acute hospitals (and some single-specialty hospitals). These provide specialist advice (e.g. in oral and maxillofacial surgery, orthodontics, restorative dentistry and paediatric dentistry) and treatment for more difficult and complex problems. Patients are usually referred by general dental practitioners or GPs.

Community dental services. These provide care in community settings (community clinics, patient’s own home, nursing homes) for patients who would find it difficult to use general dental practices (e.g. young children with learning difficulties, some older people, people with severe physical disabilities or mental health issues). They also provide screening of schoolchildren for dental decay and deliver oral health promotion.

General dental services. These provide a range of services in local community settings to meet most dental health needs.

Since 2006, contracts are negotiated locally between each individual dental practice and the LHB, which commissions an annual level of service. General dental services are provided by both the NHS and the independent sector. Often general dental practitioners provide both NHS and private care from the same premises. Although an individual could receive a mix of NHS and private treatment, patients should receive all appropriate treatment under the NHS.

Private dental care is usually paid for either through private insurance plans or through out-of-pocket payments. Prices for private treatment are not regulated but are determined by the supplier. Data on the size of the private market are not readily available. Most practices provide both NHS and private care.

In the 24 months to 31 March 2012, 1.7 million patients were recorded as accessing Welsh NHS dental treatment (Welsh Government, 2012b). This amounts to 55.7% of the population: 65.6% of the child (under 18 years) and 53.2% of the adult population. In addition, the community dental service had contact with 182 000 patients across Wales in 2010–2011. Feedback from NHS service and independent patient questionnaires shows a high level of satisfaction with the provision of NHS dental services.

The latest workforce data at 31 March 2012 showed there were 1360 dentists with NHS activity recorded. This compares with 1349 at 31 March 2011 and 1087 at 31 March 2006. There has been additional investment in dental undergraduate training in Wales. The number of vocational training/dental foundation 1 posts funded by the Welsh Government has increased from 55 in 2003 to 74 from 2012 (Welsh Government, 2012e). Following graduation, dentists must complete vocational training prior to being permitted to work unsupervised in the NHS. The Welsh Government funds training places to accommodate dental students who graduate from Cardiff Dental School.

Access to dental care has improved significantly in recent years, although difficulties remain in some areas. The Welsh Government's *Programme for Government* (2011c) includes, as a key action, improving access to dentists where there are localized problems.

The Welsh Government is also examining possible changes to the dental contract's current system of remuneration, with the aim of building in greater equity for patients and contractors while ensuring that improvements are made around quality and prevention. Two new models of care are currently being piloted in eight practices, which are expected to run for two years from 1 April 2011.

The Welsh Government has recently reviewed the provision of orthodontic treatment in Wales with the aim of developing more effective and efficient commissioning of services, including the facilitation of strategic, detailed operational management and modernization of services.

There is a widening gap between the oral health of children from the most deprived and the least deprived families in Wales. Under the *Eradicating Child Poverty in Wales: Measuring Success* strategy (Welsh Government, 2006),

the dental targets set are that by 2020 the dental health of 5- and 12-year-old children in the most deprived fifth of the population will improve to that presently found in the middle fifth.

In the absence of fluoridation of water supplies in Wales, there is a need to get more teeth in contact with fluoride using alternative methods. The *Designed to Smile* oral health improvement programme sets out to achieve this by targeting young children in areas of greatest need and building on the foundation of the fissure sealant programme, which has run since 2001–2002 (Welsh Government, 2012c). *Designed to Smile* is delivered by the community dental service, which has significant experience in oral health promotion. Their additional role in this initiative focuses on the delivery of fluoride supplementation programmes and improving care for children with tooth decay. *Designed to Smile* is more than simply teaching children how to brush their teeth. The scheme also delivers direct clinical interventions that have been shown to prevent decay – effectively a fluoride delivery programme.

The Welsh Government is currently consulting on a draft National Oral Health Plan, which will aim to address the key challenges set out above.

6. Principal health care reforms

Responsibility for health policy has been fully devolved to Wales since 1999. In the first ten years of devolution, organizational change focused on aligning the boundaries of the NHS and local government and other initiatives designed to foster joint working on a public health agenda. In 2009, the remaining vestiges of the internal market were removed with the creation of LHBs. Wales has developed many distinctive policy initiatives. Some have attracted considerable popular attention (the abolition of prescription charges). Others were more subtle and possibly more far reaching, such as the statutory commitment to sustainable development across all government policy areas. Public services in Wales now face significant resources pressures, particularly the NHS. The Welsh Government has made policy implementation a priority, amid concerns that progress in implementing policy has been too slow in many areas of Wales's public services.

6.1 Analysis of recent reforms

Much of the first decade of post-devolution health policy was dominated by a greater emphasis on public health, and by an attempt to improve the performance of current health care structures. In 2004, health bodies were reconfigured to align NHS and local government boundaries, but the purchaser–provider split in health care remained. In 2009, the remaining organizational vestiges of the internal market were removed with the creation of seven LHBs. LHBs are responsible for planning and providing all services in their geographical area. The only exceptions to this, specialist cancer services, ambulance and public health, are now provided by three NHS trusts.

This restructuring was based on the following principles:

- maintaining consistently high standards of care
- putting patients and patient safety above all else

- all services being given equal prominence
- open and transparent governance
- compliance with the highest standards of probity
- valuing staff.

It was claimed that the reorganization would simplify structures, reduce wasteful transactions between separate bodies, facilitate strategic shifts between different parts of the NHS (particularly from the hospital to primary/community care) and continue to support partnership between different public services and the third sector.

However, there were concerns that the new bodies might be too big/remote from the communities they serve and from local government (the one-to-one NHS to local authority relationship was replaced by one NHS body relating to several local government bodies) and captured by the dominant secondary care interests. To counteract these risks, stakeholder boards were established in each LHB. No comprehensive evaluation has yet been carried out to assess the success of the new structures.

In addition to this structural reform, Wales developed distinctive policy approaches. The abolition of prescription charges announced in 2004 and the abolition of car parking charges at all hospitals (or the freezing of charges where existing contractual obligations with private car park operators prevented abolition) received substantial public attention and demonstrated the potential for health policy to make symbolic statements about the political values of the devolved government.

The current health improvement strategy is *Our Healthy Future* (Welsh Government, 2009b). It addresses six themes: good health and well-being through the life-course, reducing inequalities in health, healthy sustainable communities, prevention and early intervention, health and well-being as a shared goal, and strengthening the evidence. *Health Challenge Wales* is the flagship approach to health improvement (Welsh Government, 2012f). Health gain targets have been set for 2012 for five priority areas: coronary heart disease, cancer, mental health, the health of older people and the health of children. The current strategy for reducing inequalities is *Fairer Health Outcomes for All* (Welsh Government, 2011b).

More recently, government policy has been set out in a *Programme for Government* (Welsh Government, 2011c). The key NHS strategy document, a five-year vision for the NHS in Wales, is *Together for Health* (Welsh Government, 2011f). Factors identified in the document as driving the need for reform include:

- a growing number of older people in the population
- inequalities in health
- increasing numbers of people with chronic conditions
- medical staffing pressures
- some specialist services being spread too thinly.

The main commitments in *Together for Health* are:

- service modernization, including more care provided closer to home and specialist “centres of excellence”;
- addressing health inequalities;
- better IT systems and an information strategy ensuring improved care for patients;
- improving quality of care;
- workforce development;
- instigating a “compact with the public”; and
- a changed financial regime.

The main social service policy document is *Sustainable Social Services in Wales* (Welsh Government, 2011e), which sets out the framework for strengthening social services in the next decade and beyond, and sets out priorities for action on the basis of the following nine principles:

- a strong voice for clients and real control over services received
- supporting each other
- safety
- respect
- recovery and restoration of full functioning
- helping people adjust to altered circumstances
- stability
- simplicity
- professionalism.

The White Paper *Sustainable Social Services in Wales: A Framework for Action* was published in February 2011 and set out the future direction for renewing and reforming social services in Wales (Welsh Government, 2011e). This built on the extensive engagement work of the Independent Commission on Social Services in 2009–2010, chaired by Geoffrey Pearson (Independent Commission on Social Services in Wales, 2010). This reform programme will ensure that social services are delivered more effectively and simply, and in an integrated way both between regions and local councils and particularly with the NHS.

The Social Services bill will provide the legislative framework required to deliver this ambitious programme. This primary legislation will provide, for the first time, a coherent legal framework for social services based on principles enunciated in Wales. The bill will be introduced for scrutiny by the National Assembly in January 2013 and is expected to receive Royal Assent by December 2013. A full implementation programme, including where needed regulations and guidance, will then follow.

The key strategy in out-of-hospital care is *Setting the Direction* (Welsh Government, 2010b), which stated the following key underlying principles for improvement:

- universal population registration and open access to effectively organized services within the community;
- first contact with general physicians that deal with undifferentiated problems supported by an integral community team;
- localized primary care teamworking serving discrete populations;
- focus on prevention, early intervention and improving public health not just treatment;
- coordinated care where generalists work closely with specialists, and wider support in the community to prevent ill health, reduce dependency and effectively treat illness;
- provision of a highly skilled and integrated workforce;
- health and social care working together across the entire patient journey, thus ensuring that services are accessible and easily navigated;
- robust information and communication systems to support effective decision-making and public engagement; and
- active involvement of citizens and their carers in decisions about their care and well-being.

The NHS is now embarking on a controversial set of proposals for reconfiguring elements of acute hospital provision. There is substantial local suspicion about aspects of these proposals. Many vocal groups have developed to oppose the changes, and they remain unconvinced about the case for change advanced by their LHB, suspecting that alternatives have not been adequately explored and fearing that the desire to reduce cost may be the prime driver for the proposed changes.

Informing Healthcare (Welsh Government, 2003) is a strategy to ensure the timely and free flow of information to support health and health care, as well as to develop the role of the patient as a member of the team. It identifies five development areas: care process improvement, workforce development, patient and public empowerment, electronic health records and better use of information. In addition, it ensures that infrastructure is developed and that the NHS is fully prepared for the implications of major investment in modernization. The organization Informing Healthcare is taking this forward (NHS Wales Informatics Service, 2012).

The *Signposts* documents (Office for Public Management, 2001, 2003) are the main guidance on public engagement approaches. In addition, there is specific guidance on how NHS bodies should handle public engagement and consultation around service changes.

6.2 Future developments

The focus of the Welsh Government is now on implementing the various changes set out in policy. There is a general recognition that the NHS in Wales – in common with many other public services – is not always able to implement the changes required by policy at sufficient pace. This problem now has added urgency, given the impending pressures on public finances, which has hit the NHS harder than other sectors.

7. Assessment of the health system

The health system in Wales continues to face structural weaknesses that have proved resistant to reform for some time. But there has been substantial improvement in service quality and outcomes since the end of the 1990s, in large part facilitated by substantial real growth in health spending. The financial climate has now changed significantly, and in the short term Wales faces perhaps the severest reduction in expenditure it has seen since the foundation of the NHS, worse than in other parts of the United Kingdom. Life expectancy has continued to increase, but health inequalities have proved stubbornly resistant to improvement.

7.1 Stated objectives of the health system

In May 2011, the Bevan Commission (2011) – in a generally well-received report – summarized the challenges facing the NHS in Wales as follows:

- improving quality by reducing variation in practice;
- improving efficiency and productivity by reducing waste, harm and variation;
- encouraging innovation, especially by re-engineering care pathways to improve access to services;
- improving the coordination of policy across government departments;
- using information to promote transparency and trust and drive improvement;
- improving partnerships with citizens, patients, staff, other public services and suppliers; and
- providing courageous leadership.

These are echoed in the current five-year plan for NHS Wales (Welsh Government, 2011f), which prioritizes:

- service modernization, including more care provided closer to home and specialist “centres of excellence”;
- addressing health inequalities;
- better IT systems and an information strategy to ensure improved care for patients;
- improving quality of care;
- workforce development;
- instigating a “compact with the public”; and
- a changed financial regime.

7.2 Financial protection and equity in financing

The health system is predominantly publicly financed through general taxes, and access to a comprehensive range of health services is free at the point of use for the whole population. Dental care incurs user charges, but these are capped per treatment. As a result, the Welsh health system provides strong financial protection. However, the financial pressures on the health system in the near future threaten the achievement of these objectives. LHBs are having to identify significant cuts in expenditure, and staff numbers are starting to fall. This has given added impetus to attempts to effect structural change in service provision as the only way to sustain access and improve quality without spending more.

7.3 User experience and equity of access to health care

Resource allocation between Wales’s various health bodies follows a formula-based approach that seeks to promote equity of access by matching resources to health needs. However, the allocation of funds from the United Kingdom Government to Wales is becoming increasingly contentious, as the effects of the formula used results in increasing pressure on Wales’s allocation. It is now widely perceived in Wales as being outdated and it is under review.

Wales faces similar problems to the rest of the United Kingdom in ensuring that access to good quality services – particularly in primary care – matches need. There have been sustained attempts to supplement provision in the more

deprived neighbourhoods through the selective deployment of LHB-employed doctors and other staff to areas of greatest need. These initiatives have gone in parallel with the use of EU and other funds to boost local economic and other development.

Responsibility for monitoring and improving the user experience of health services is shared between LHBs and trusts and the community health councils, with input from inspectorates and others. Hitherto, the emphasis has been on local measurement, albeit against national standards and inspection. In the future, the Welsh Government is interested in introducing a greater element of transparency (and, therefore, of contestability), partly in response to concerns over issues such as dignity and respect for older people receiving inpatient care. A lack of national data has made the monitoring of improvement difficult in cases such as this.

7.4 Health outcomes, health services outcomes and quality of care

Although data on health care outcomes and service quality are generally not very plentiful or reliable, and there is some confusion across the statistical sources, there is little doubt that performance has improved since the end of the 1990s in several key respects. This is seen, for example, in the improvement in risk-adjusted data for mortality following admission to hospital for most major conditions, and in the substantial reduction in waiting times for elective surgery. In large part, this is attributable to substantial increases in expenditure on health and on associated inputs; for example, overall staff numbers increased by about a quarter in the first decade of the 21st century, and there has been a substantial capital investment programme. It also results, in part, from special policy interventions such as the 1000 Lives (2012) campaign, which engaged large numbers of clinicians across Wales in a variety of simple measures to improve quality and thereby reduce unnecessary mortality (the original aim was to demonstrate that the campaign saved 1000 lives in a year across all the hospitals).

Elements of service provision have been redesigned to follow evidence of what is the best configuration. One example is stroke services, which were sharply criticized in Wales by an audit conducted by the Royal College of Physicians. As a result, services have been remodelled, and progress continues in achieving audit targets for specific crucial elements of performance within the care process. Death rates from stroke have now started to fall.

LHBs are now embarking on an ambitious programme of service reconfiguration. This addresses the need both to improve provision in the community – service planning and delivery clusters are being developed, supported by communication hubs and integrated health and social care services – and to rationalize elements of acute hospital provision. The latter has proved controversial, with some local communities – particularly in rural areas of Wales – fearful and suspicious of proposals to transfer elements of provision to hospitals some distance from those communities.

7.5 Health system efficiency

There is general agreement that health provision in Wales is weakened by an overreliance on hospital care (e.g. hospitalization rates in Wales appear higher than those in comparable areas of England). This is caused by a combination of factors, such as inadequate community services, poorly coordinated discharge/transfer arrangements and a culture that equates hospital provision with high-quality care (and this, in part, explains local people's suspicion about service changes). This reliance also probably fuels elements of relative underperformance, although the available data on this are controversial. Public health improvements have been substantial, but current funding levels will not be sufficient to meet projected demand for health care in future as the numbers of people with chronic conditions increases. In part, this appears to be because many patients – particularly those with long-term conditions – are not given sufficient support to enable them to manage their own care.

7.6 Transparency and accountability

Wales has rejected the quasi-market approach to effecting change that has dominated policy in England for some time, and there is very little political support for overt competition between providers. But Wales has been less clear about enunciating its alternative set of metrics and levers for change. The dominant philosophy appears to rely on a combination of exhortation to do better plus performance management of the LHBs by the Welsh Government. There has been a sustained effort to encourage clinicians to take the lead in making substantial service change, with some success. More recently, the government has committed itself to a policy of greater transparency in performance data, based on the assumption that a combination of professional pride and political pressure will force poor performers to do better. Whether this will be sufficient

to make change on the scale generally recognized to be necessary remains uncertain, but there is a widespread acceptance that developing new policies is not a substitute for making change happen.

8. Conclusions

The health system in Wales is still very similar to those in the rest of the United Kingdom, with many of the original features of the NHS still present: universal registration with a GP, comprehensive care available to all mainly free at the point of use, and resources allocated within the system according to need. It also faces many of the same challenges, including long-term rising demand and the need to effect a strategic shift from hospital to community services. However, where England has explored the use of quasi-market and other mechanisms to address these challenges, Wales has remained consistent in its belief that common direction of provision within a unified system is the best approach to effect change while ensuring maximum equity of provision. These differences are set to become more pronounced over the coming years, as policy in England increasingly diverges from that in Wales. The relatively recently acquired legislative competence of the National Assembly of Wales, and the political differences between the governing parties in Cardiff and London, are likely to fuel this growing divergence.

In the next few years, health policy in Wales will be powerfully shaped by significant financial challenges. The decision of the government to allow real health expenditure to decline faster than that in the rest of the United Kingdom – if maintained – will place LHBs and others under relentless pressure and may arouse political controversy.

There is concern in Wales that the health care system is not financially sustainable in the longer term unless additional funds can be found to meet rising demands and unless this demand can be controlled. Public health measures will have an important part to play in this, as will strategic shifts in provision, but progress to date has been relatively modest, and much remains to be achieved.

9. Appendices

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9.2 Summary of key Welsh health policies

General policy background

Programme for Government

Programme for Government sets out the administration's agenda around 12 chapters (<http://wales.gov.uk/about/programmeforgov/?lang=en>).

1. Growth and sustainable jobs
2. Public service in Wales
3. Education

4. 21st-century health care
5. Supporting people
6. Welsh homes
7. Safer communities for all
8. Equality
9. Tackling poverty
10. Rural communities
11. Environment and sustainability
12. The culture and heritage of Wales.

Sustainable development

The government has a legal commitment to sustainable development and has to produce a scheme demonstrating how it will discharge this responsibility. The current scheme is *One Wales: One Planet* (<http://wales.gov.uk/topics/sustainabledevelopment/publications/onewalesoneplanet/?;jsessionid=2RJyPVINLbV4FfTDJw5TDQc22LJ5G41G0ftBMvyT5cTgb93kq2cT!-1747186160?lang=en>)

Bilingual Wales

The Welsh Government is committed to a bilingual policy, and NHS bodies have their own Welsh language schemes. A new Welsh language scheme for Health and Social Services is currently under development (<http://wales.gov.uk/about/cabinet/cabinetstatements/2011/strategicwelshlanguage/?lang=en>).

Overall health and social services programmes

Improving health and well-being

The current health improvement strategy is *Our Healthy Future* (<http://wales.gov.uk/topics/health/ocmo/healthy/?lang=en>). It addresses six themes.

1. Good health and well-being through the life-course
2. Reducing inequalities in health
3. Healthy sustainable communities
4. Prevention and early intervention
5. Health and well-being is a shared goal
6. Strengthening the evidence.

Health Challenge Wales is the flagship approach to health improvement (<http://wales.gov.uk/hcws/site/healthchallenge/?lang=en>).

The Chief Medical Officer's reports give an annual account of issues and progress (<http://wales.gov.uk/topics/health/ocmo/publications/annual/?lang=en>).

A number of health gain targets have been set for 2012 for five priority areas: coronary heart disease, cancer, mental health, the health of older people and the health of children (<http://wales.gov.uk/topics/health/research/research/gain/targets/health-gain/?lang=en>).

There are a large number of individual initiatives on preventing poor health and promoting good health including for:

- pregnancy and early years
- food and physical activity
- health at work
- health promotion for schools
- healthy sustainable communities
- sexual health and well-being
- smoking
- cancer awareness.

Details on these can be accessed at:

<http://wales.gov.uk/topics/health/improvement/?lang=en>

Tackling health inequalities

The current strategy for reducing inequalities is *Fairer Health Outcomes for All* (<http://wales.gov.uk/topics/health/publications/health/reports/fairer/?lang=en>)

NHS strategies

The key document is *Together for Health*, which is the five-year vision for the NHS in Wales (<http://wales.gov.uk/topics/health/publications/health/reports/together/?lang=en>). Factors driving the need for reform include:

- a rising elderly population
- inequalities in health
- increasing numbers of patients with chronic conditions
- medical staffing pressures
- some specialist services being spread too thinly.

The main commitments in *Together for Health* are:

- service modernization, including more care provided closer to home and specialist “centres of excellence”;
- addressing health inequalities;
- better IT systems and an information strategy ensuring improved care for patients;
- improving quality of care;
- workforce development;
- instigating a “compact with the public”; and
- a changed financial regime.

Social services

The main document is *Sustainable Social Services in Wales*, which sets out the framework for social services in the next decade and beyond (<http://wales.gov.uk/topics/health/publications/socialcare/guidance1/services/?lang=en>). It sets out priorities for action on the basis of the following nine principles:

- a strong voice and real control
- supporting each other
- safety
- respect
- recovery and restoration
- adjusting to new circumstances
- stability
- simplicity
- professionalism.

Specific service areas

Each year, an annual requirements document is issued to the NHS setting out requirements for the following financial year. That for 2011–2012 specifies requirements in relation to the following areas, and for each summarizes current policy aims and identifies the key documents (<http://wales.gov.uk/topics/health/publications/health/ministerialletters/framework/?lang=en>).

NB: some of these documents may only be accessed from within the NHS in Wales; the authors can provide a link or copy if there are problems in accessing documents.

Elective care, access 2009. This addressed the need to achieve maximum waiting times for elective care by December 2009.

Primary and community care. The key strategy is *Setting the Direction*, which stated the following key underlying principles for improvement:

- universal population registration and open access to effectively organized services within the community;
- first contact with general physicians, who deal with undifferentiated problems supported by an integral community team;
- localized primary care teamworking serving discrete populations;
- focus on prevention, early intervention and improving public health not just treatment;
- coordinated care where generalists work closely with specialists and wider support in the community to prevent ill health, reduce dependency and effectively treat illness;
- a highly skilled and integrated workforce;
- health and social care working together across the entire patient journey, ensuring that services are accessible and easily navigated;
- robust information and communication systems to support effective decision-making and public engagement; and
- active involvement of citizens and their carers in decisions about their care and well-being.

Unscheduled care (emergency services). The DECS (delivering emergency care services) project will create modern integrated unscheduled care services.

Chronic conditions management. This involves action to implement the Chronic Conditions Model and Framework.

Mental health services. NB, there is an NSF.

Child and adolescent mental health services

Healthcare-associated infections

Cancer services

Coronary heart disease services. NB, there is an NSF.

Stroke services. NB, this is also covered in the Older People's NSF.

Renal services. NB, there is an NSF.

Sexual health services

Civil contingencies

Diabetes. NB, there is an NSF.

Maternal and children and young people. NB, there is an NSF.

Older people. NB, there is an NSF.

Palliative care services. *A Strategic Direction for Palliative Care* was published in 2003 and is on the web.

Critical care services. Critical care standards are in place.

Diagnostic services. A diagnostic and imaging strategy was issued in 2004 (<http://wales.gov.uk/topics/health/professionals/scientific/diagnostic-services/?lang=en>). Since then the work has been taken forward as a managed programme, under two programme boards, one each for imaging and pathology. Documents on *The Future Delivery of Pathology Services* and *A National Pathology Framework* were issued in 2008 and are available at: <http://wales.gov.uk/topics/health/publications/health/ministerialletters/letter00508/?lang=en>

Therapy services. A strategy (2006) is in place covering the therapy professions: art, drama and music therapies, dietetics, occupational therapy, orthotics, orthotics, physiotherapy, podiatry, prosthetics and speech and language therapy (http://www.wales.nhs.uk/documents/A_Therapy_Strategy_for_Wale1.pdf).

The six NSFs are available at: <http://www.wales.nhs.uk/sites3/home.cfm?OrgID=334>.

Support programmes

Acute services

Following the issue of *Designed for Life*, the three NHS regions (north, mid and west, and south-east) prepared acute services reconfiguration plans. These were contested in some areas and work has continued on refining them.

Workforce

There is a core workforce strategy, *Designed to Work* (<http://www.wales.nhs.uk/sites3/page.cfm?orgid=433&pid=23250>).

Information and information systems

Informing Healthcare is a strategy to ensure the timely and free flow of information to support health and health care, as well as developing the role of the patient as a member of the team. It identifies five development areas: care process improvement, workforce development, patient and public empowerment, electronic health records, and better use of information. In addition, it undertakes to ensure that infrastructure is developed and that the NHS is fully prepared for the implications of major investment in modernization (<http://www.wales.nhs.uk/IHC/documents/ihc-strategy-e.pdf>). The organization Informing Healthcare (<http://www.wales.nhs.uk/IHC/home.cfm>) is taking this forward.

Patient, client, carer and public support and engagement

The *Signposts* documents (Office for Public Management, 2001, 2003) are the main guidance to the NHS.

There is guidance on major service changes (2008) that will need updating when the new NHS bodies begin work (<http://www.wales.nhs.uk/documents/EH-ML-016-08.pdf>).

One Wales includes a commitment to develop a Charter for Patients Rights and legislation on NHS redress.

Wales will not adopt England's NHS Constitution.

Quality and regulation

Wales has its own health care standards (2005) (<http://www.wales.nhs.uk/sites3/page.cfm?orgid=465&pid=8970>). These have been updated in 2010 as *Doing Well, Doing Better* (<http://www.hiw.org.uk/Documents/477/Doing%20well%2C%20doing%20Better-e.pdf>). These standards are monitored by Health Inspectorate Wales (<http://www.hiw.org.uk/>).

Information on the Healthcare Quality Improvement Plan ([http://www.wales.nhs.uk/documents/WHC\(2006\)073.pdf](http://www.wales.nhs.uk/documents/WHC(2006)073.pdf)) was included in the papers for the first meeting of the Bevan Commission.

Modernization, learning, leadership and management development

The lead agency is the National Leadership and Innovation Agency for Healthcare, which has five main programmes covering workforce, leadership, improvement, partnership and quality (<http://www.wales.nhs.uk/sites3/home.cfm?OrgID=484>).

Research and development

Strengthening research and development is the role of a division in the government known as WORD (<http://wales.gov.uk/topics/health/research/word/?lang=en>).

Performance monitoring and improvement

Performance monitoring and improvement, as stated above, is managed through the Annual Operating Framework. Currently there is a process of developing “intelligent and clinically focused targets”.

9.3 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory’s research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at:

<http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010>.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office

for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border health care.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers are paid.
4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health services for specific populations.
6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.

7. Assessment of the health system: provides an assessment based on the stated objectives of the health system, financial protection and equity in financing; user experience and equity of access to health care; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with each other to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

9.4 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. It is then sent for review to two independent academic experts, and their comments and amendments are incorporated into the text, and modifications are made

accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

9.5 About the authors

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