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The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015

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Contents

1. **Introduction** ... 7
   - The Coalition's Inheritance ... 7
   - Overview ... 9
2. **Goals** ... 17
   - Conservative and Liberal Democratic Manifesto Commitments on Health ... 17
   - The Coalition Agreement and Programme for Government ... 21
   - The role of the central state and the Coalition's model for public services ... 24
3. **Policies** ... 27
   - Proposals for health reform following the transition to Government ... 27
   - The enactment of the Health and Social Care Act (2012) ... 28
   - Overview of the Coalition's health reforms ... 30
   - Minimum standards and quality regulation: the Government's response to the Francis Inquiry 36
   - Other policies, strategies and measures ... 38
4. **Resources** ... 41
   - Trends in real public sector expenditure on healthcare ... 41
   - Estimates of the funding gap by 2020 ... 46
   - Trends in total (public and private) expenditure on health ... 47
   - International comparisons ... 48
   - The Coalition's health financing model ... 50
   - Resource allocation funding formula ... 51
5. **Provision** ... 54
   - Inputs, outputs and productivity ... 54
   - Supply, demand and need ... 59
   - The balance of public, private and third sector provision ... 65
6. **Outcomes** ... 69
   - Healthcare access and quality ... 69
   - Life expectancy, the "major killers" and infant mortality ... 78
   - Non-medical determinants ... 96
   - Suicide, mental health and general health ... 99

7.Conclusions, overall evaluation and looking forward ... 105
   - Continuity or change? ... 105
   - Evaluating the impact of the reform programme ... 108
   - Challenges for an incoming Government ... 113

Appendix 1: Supplementary tables – resources ... 116

Appendix 2: supplementary tables - health outcomes ... 124

References ... 148

List of figures

Figure 1: Conservative Party 2010 Manifesto -– commitments on health 19
Figure 2: Liberal Democratic Party 2010 Manifesto -– commitments on health 20
Figure 3: The Coalition Programme for Government – commitments on health................................... 22
Figure 4: Overview of the Coalition healthcare reform programme 35
Figure 5: International comparisons of total (public and private) expenditure on health as a percentage of GDP, 1997 to 2012 49
Figure 6: Out-of-pocket medical spending as a share of final household consumption in Europe, 2012 (or nearest year) 51
Figure 7 Number of full-time equivalent (FTE) qualified nursing, midwifery and health visiting staff, HCHS workforce, May 2010 to July 2014 (England) 54
Figure 8 Number of full-time equivalent (FTE) staff, HCHS workforce, index numbers, May 2010 to July 2014 (England) 55
Figure 9 Finished consultant episodes, outpatient appointments attendances and A&E attendances, 2009 to 2012, indexed 56
Figure 10 Growth of healthcare supply compared with national income, need and demographic pressure, United Kingdom, 1997/98 to 2013/14 60
Figure 11 Growth of healthcare supply compared with national income, need and demographic pressure, United Kingdom 2009/10 to 2013/14 62
Figure 12: Growth of healthcare supply compared with national income, need and demographic pressure, England 2009/10 to 2013/14 63
Figure 13 Growth of healthcare supply compared with need and demographic change, England, 2010-11 to 2014-15 64
Figure 14: Changes in independent sector provision in community and mental health services and hospital care 2010/11-2012/13 67
Figure 15: Waiting times for referral to treatment 73
Figure 16: Percentage waiting 4 hours or less (all) in A&E from arrival to admission, transfer or discharge (quarterly data), 2003-04 to 2014-15 (financial year quarters, up to September 2014), England 74
Figure 17 Overall satisfaction with National Health Service, 1983 to 2013 75
Figure 18 Potential years of life lost (PYLL) from causes considered amenable to healthcare 84
Figure 19: Inequality in life expectancy: the slope index of inequality in life expectancy at birth within English upper-tier local authorities, 2010-12 88
Figure 20: Life expectancy at birth in 32 OECD countries (2012, years) 89
Figure 21: Inequality in mortality from cardiovascular diseases, cancer and respiratory diseases by IMD decile (England, 2012, age standardized under 75 mortality rates per 100,000 population) 91
Figure 22: Infant mortality rate in OECD countries (2012, deaths per 1000 live births)........................ 96
Figure 23: Age-standardized suicide rate per 100,000 males, English regions, 2007-2012.............. 101
Figure 23a: International comparisons of total (public and private) expenditure on health as a percentage of GDP
2012)……………………………………………………………………………………………119
Figure 24: Percentage of admissions where the patient died within 30, 60 and 90 days, covering impatient episodes of care, 1998-99 to 2013-14 140
Figure 25: Percentage of episodes where the patient died within 30, 60 and 90 days, covering impatient episodes of care, 1998-99 to 2013-14 141

List of tables

Table 1: Average real annual growth rate of public sector expenditure on health by political administration (United Kingdom unless otherwise stated), 1950/51 to 2014/15 43
Table 2 Growth in real total public expenditure on health, and real public expenditure on health per capita, in England, Wales, Scotland and Northern Ireland 2009/10-2013/14 (2009/10 prices) 44
Table 3 Trends in real public expenditure on health in England 2009-10 to 2014-15 (budgeting framework, within DEL, outturns and plans) 45
Table 4 Total Departmental Expenditure Limits (DEL) – NHS Health, England, 2010/11-2014-15 46
Table 5 Annual average growth rate in per capita health expenditure, real terms, 2000 to 2012 (or nearest year, percentages) 50
Table 6 NHS outputs, inputs and productivity growth 2004/5-2011/12 (summary of estimates by Bojke et al (2014)) 57
Table 7 Percentage of PCT total spending on services by provider type 2010/11-2012/13 66
Table 8 Self-reported unmet need for medical examination where the reason given is *financial cost*, 2012 71
Table 9: Percentage of individuals reporting difficulties in accessing / using healthcare by type of difficulties, EU27, EU15, EU12 and by country; 2011 72
Table 10: Cervical cancer five-year relative survival rate, EU countries, 2007-2012 (or nearest period) 78
Table 11: Life expectancy at birth, England, Wales, Scotland and Northern Ireland 2008/2010-2011/2013 79
Table 12: Life expectancy at birth: by sex and region, 2008-10 to 2011-13 80
Table 13: Local areas with the highest and lowest life expectancy at birth (years), males, UK 2010-12 82
Table 14: Local areas with the highest and lowest life expectancy at birth (years), males, England and Wales, 2011-13 83
Table 15: Life expectancy at age 85, United Kingdom and constituent countries, 1980-1982 to 2011-2013 85
Table 16: Healthy Life Expectancy for males and females at birth by English region (2010-12) 86
Table 17: Life Expectancy (LE) and Healthy Life Expectancy (HLE) at birth (a) by national deciles of area deprivation in England, Slope Index of Inequality (SII) and Range for Life Expectancy (LE) and Healthy Life Expectancy (HLE), males and females, 2009-2011 and 2010-12 87
Table 18: Breast cancer mortality, females, 2011 93
Table 19: Infant mortality rate: routine/manual/other group compared with professional/managerial/intermediate/small employers group (joint registrations, England and Wales) 95
Table 20: Prevalence of obesity among adults in European countries (2012 or nearest available year of data, % of the population aged 15 or above) 98
Table 21: Variations in cigarette smoking by socio-economic classification in Great Britain (2011 and 2012) 99
Table 22: Age-standardised suicide rates for males and females, and age-specific suicide rates, United Kingdom 2007-2012 100
Table 23: GHQ-12 score of 4 or more, England, by subgroup 102

Table 24: Variations in bad and very bad self-reported general health (England and Wales, 2011) .. 104
Table 25: Growth of real and volume public expenditure on health: UK time series (1991/2-2013/14) 116
Table 26: Total real (public and private) expenditure on healthcare in the UK, 1997 to 2012 (2010 prices) 117
Table 27: Public sector expenditure on health in England, Scotland, Wales and Northern Ireland 1998/99-2012/13 119
Table 28: NHS sources of finance, United Kingdom, 1949 to 2011/12, current prices 120
Table 29: NHS patient charges, United Kingdom, 1991/92 to 2011/12 (2009/10 prices) 122
Table 30: Supplementary data on miscellaneous health outcomes 125
Table 31: Patient experience, England, 2002/03 to 2013/14 138
Table 32: Life expectancy in selected countries, males, 2011-2013 142

1. Introduction

This is one of a series of papers examining aspects of the social policy record of the Conservative/Liberal Democrat Coalition in England from 2010-15, with a particular focus on poverty, inequality and the distribution of social and economic outcomes. The papers follow a similar but smaller set covering Labour's record from 1997-2010, published in 2013. They follow the same format as those papers. Starting with a brief assessment of the situation the Coalition inherited from Labour, they move to a description of the Coalition's aims (as discerned from manifestos, the Coalition Agreement and subsequent policy statements) and the policies enacted. They then describe trends in spending on the area under consideration, and provide an account of what was bought and done with the money expended (inputs and outputs). Finally, they turn to outcomes, and a discussion of the relationship between policies, spending and outcomes, so far as this can be discerned.

All the papers focus on UK policy where policy is not devolved (for example taxes and benefits) and English policy where it is, although in some cases some spending, outcomes and international comparisons cannot be disaggregated below the UK level. In the case of devolved policy areas, key points of similarity and difference between England and the other UK nations are highlighted, but a full four country comparison is beyond the scope of the study.

The current paper provides an evaluation of the Coalition's record on health over the period 2010-2015. The paper follows on from an earlier research report (Vizard and Obolenskaya 2013) which evaluated Labour's record on health 1997-2010 using a similar conceptual framework. Like our overview paper (Lupton et al 2015), this health paper is in many ways an interim assessment. Many of the major health reforms introduced by the Coalition were only put into place in 2013, and, in some cases, are still being rolled out. Independent evaluation evidence remains patchy and current health data typically dates to no later than 2012/2013. This evaluation of the Coalition's record on health will therefore require updating when data for the second half of the administration, together with further independent evaluation evidence, becomes available. Whilst we examine overall UK trends and comment on trends in Wales, Scotland and Ireland in some cases, health is a devolved policy area and the focus is on developments in England.

The Coalition's Inheritance

The Coalition inherited an overall framework for the protection of the right to health in the UK that provides an essential continuity with arrangements dating back to the post-war welfare state settlement. The NHS remained an outlier internationally in that it remained a general tax funded model (albeit with a growing role of national insurance), free at point of delivery, with access based on need not ability to pay. Alternative financing models, such as a social insurance model and a hypothecated tax model, were considered but not implemented under Labour; and patient charges remained limited in their scope. Private expenditure on health remained low by international standards. Challenges to the protection of the right to health that arise in some countries and contexts - such as high out-of-pocket payments, catastrophic health expenditure and private insurance gaps - continued to be avoided in the UK.

Our companion paper (Vizard and Obolenskaya (2013) provides a detailed evaluation of Labour's record on health over the period 1997-2010. The central conclusion is that period was a

positive one for the NHS in a number of important respects. In 1997, the public were highly dissatisfied with the NHS, with long waiting lists, pressure for more expenditure on healthcare and demand for private medical insurance going up. Funding for the NHS increased considerably. Substantial returns on this investment were achieved and were reflected in measures of healthcare quantity, quality and satisfaction. By the end of period, waiting lists and waiting times were down, demand for private medical insurance was down, and satisfaction with the NHS was running at more than 70%. The "big picture" for this period is one of massive supply expansion, the elimination of capacity constraints, improvements in a range of quality indicators and a remarkable increase in overall satisfaction with the NHS. Overall, the Coalition could be said to have inherited an NHS that was better than it had ever been.

The Coalition inherited the legacy of major healthcare reform programme undertaken over the period 1997-2010. The future of the NHS had been central to the 1997 General Election and modernising the NHS through a major public services reform programme was one of Labour's key election pledges. The public services reform programme that was implemented was wide ranging and included a number of different strategies including the introduction of a framework of inspection and regulation; measures to extend democratic participation and accountability (for example, the introduction of the NHS Constitution); emphasis on decentralisation (with the creation of autonomous foundation trusts in 2004); commissioning (with the retention of the purchaser / provider split which Labour itself inherited in 1997, and the introduction of practice based GP commissioning); as well as measures to promote competition and choice (for example, the creation of autonomous foundation trusts and the use of private treatment centres and measures to extend patient choice of hospital).

Substandard healthcare and variations in quality - highlighted by Labour as key issues in the run up to the 1997 General Election - remained key challenges in 2010. Indeed, the systems for regulation and inspection that Labour established themselves helped to generate a growing body of empirical evidence on variations and sub-standard care. The Public Inquiry into the Mid-Staffordshire NHS Foundation Trust (2013) highlighted variations in standardised hospital mortality rates and sub-standard care. The Inquiry raised the spectre of supervisory and regulatory failure, as well as management failure, in the failure to detect variations in sub-standard care and mortality variations and made far-reaching recommendations on the need for enforcing minimum standards and for enhanced systems for monitoring, regulation and inspection. The Coalition Government inherited responsibility for responding to the legacy of Mid-Staffordshire and the Francis Inquiry - and in 2015, the nature and adequacy of this response remains at the top of the healthcare agenda.

Improving broader health outcomes and tackling health inequalities also remained key challenges in 2010. A number of outcomes improved at population level during Labour's period in power. For example, there was a notable fall in circulatory disease mortality and there was a considerable decline in the overall cancer mortality rate with important reductions for some specific cancers (e.g. male lung cancer). However, the UK's position on international health outcomes league tables also remained disappointing, with the UK lagged behind the best performers and comparator countries for a range of outcomes in 2010. Whilst smoking prevalence declined, progress in addressing lifestyle, behavioural and risk factors such as obesity was also limited. The task Labour set to reduce health inequalities had yielded mixed results against the targets that were set. The narrowing of the social class gap in infant mortality was an important achievement. However, deep

and entrenched inequalities in outcomes remained in 2010 and targets for reducing both absolute and relative gaps were missed against a number of indicators (Vizard and Obolenskaya (2013: 94-133).

Furthermore, the 2010 General Election represented a seismic break-point for health services in terms of the UK's economic and fiscal climate. The unprecedented period of expenditure growth on health under Labour was mainly undertaken during a period of sustained economic growth. With the onset of the downturn and recession which spiralled into a full blown crisis in many European countries after Autumn 2008, the question of fiscal sustainability moved to the top of the political agenda. The Coalition's analysis of its own inheritance was that the increases in real public expenditure under Labour had generated a considerable structural deficit in the UK and characterised its inheritance as "one of the most challenging fiscal positions in the world" (HM Treasury 2010a). The Coalition Agreement set out plans for cutting the structural deficit within one Parliament financed mainly by public expenditure cuts rather than taxation (Conservatives and Liberal Democrats (2010) and the election was followed by the announcement of a major programme of fiscal consolidation and deficit recession. According to the IFS, the reductions in public expenditure spending amounted to the "longest, deepest sustained period of cuts to public services spending at least since World War II" (Chote 2010).

The prospect of real resource freezes together with adverse demographic pressures raised the possibility of the growth in real resources lagging behind demographic pressure in the current Parliament and beyond. Prior to the 2010 General Election, in 2009, David Nicholson, then Chief Executive of the NHS (and subsequently Chief Executive of NHS England) had warned that services would need to make unprecedented efficiency savings of £15bn to 20bn over period 2011-2014/15 as resources were squeezed (the so called "Nicholson challenge") (Nuffield Trust 2012: 11). The Coalition inherited this challenge. The extent to which efficiency savings and / or broader productivity gains in the NHS can compensate for the on-going squeeze on real resources has been a critical question during the Coalition's period in power and remains high up on the public policy agenda in the run up to the 2015 General Election.

Overview

The paper summarises, brings together and assesses the available evidence on goals (section 2); policies (3); resources (section 4); provision (supply) (section 5); and outcomes (section 6). The concluding section (section 7) draws together the findings, provides an overall evaluation and sets out the challenges facing an incoming Government in 2015.

Section 2 examines the Coalition's aims and goals as discerned from individual Manifesto commitments, the Coalition Agreement and Programme for Government, and subsequent policy statements. In the Coalition Agreement, the Conservatives and Liberal Democrats promised to increase public expenditure on health in every year of the Parliament. The Programme for Government repeated this commitment and pledged to maintain an NHS that is free at the point of use, and based on need, not ability to pay. Other commitments included a promise to end "top-down re-organisations of the NHS that have got in the way of patient care"; plans to 'free' the NHS from 'political micro-management'; to reduce administration costs; to "enable" GP commissioning; to introduce an independent NHS Board; and to increase democratic participation and accountability.

The Coalition argued in its Programme for Government that Conservative thinking on markets, competition and choice, combined with the Liberal Democrat's emphasis on advancing democracy,

would create a “radical vision’ for the NHS; and that the shared plans that had emerged from the process of negotiation and coalition-formation were “more radical and comprehensive than our individual manifestos.” Plans for health were set out in the context of a broader “big ideas” on decentralization and a changed role for the central state in public services. Plans for restructuring public services were taken forward in the Coalition’s “Open Public Services” White Paper. This set out the Coalition’s new public service model focusing on the role of the central state in as a guarantor of minimum standards, outcomes and quality (with a range of providers involved in provision). This broader thinking, we argue, provides the essential context of the Coalition’s heath reforms.

Section 3 examines the policies that have been implemented by the Coalition. The period 2010-15 has been an extremely policy intensive one. The enactment of the Health and Social Care Act (2012) brought a series of far-reaching health reforms in England that have been implemented simultaneously within a short time frame. In addition, there have been a number of other important policy developments.

The Health and Social Care Act (2012) introduced major reforms which have transformed the policy landscape for health services in England. The overall framework for political responsibility and accountability for the NHS has been changed. Reforms emphasising decentralization, competition and outcomes have been simultaneously implemented and have resulted in new arrangements for health services commissioning, management and provision. The new decentralized organisational structure includes an independent NHS Board; the abolition of strategic health authorities and the existing Primary Care Trusts; GP-led clinical commissioning groups (CCGs); and all hospitals becoming autonomous foundation trusts. On competition, the Act applied an “any qualified provider” rule to commissioning, intended to promote competitive tendering between public, private and third sector providers. In the absence of further reforms, it is widely anticipated that this rule will result in a considerable expansion of the provision of publicly financed health services by non-NHS providers over time. Monitor was given new responsibilities as an economic regulator and to combat anti-competitive behaviour. The Act puts explicit emphasis on “outcomes”. This emphasis is reflected in the new policy landscape in the new NHS Outcomes and Public Health Outcomes Frameworks. On health inequalities, the Act established new statutory duties on the part of the Secretary of State, the NHS Commissioning Board (NHS England) and local commissioning groups to reduce health inequalities. On public health, local authorities and new Health and Wellbeing Boards being were given new responsibilities and powers to secure public health outcomes for their local populations. These arrangements were put forward as building on the Coalition’s decentralization and localization agenda, as well as the objective of increasing democratic participation and accountability.

A considerable number of additional policies, strategies and measures in health have been introduced since the Coalition came to power. The Government has moved to strengthen minimum standards, inspection and quality regulation in its response to the recommendations of the Mid-Staffordshire Public Inquiry (2013). The Government accepted the vast majority of the recommendations set out in the Public Inquiry. A review of hospitals with higher than expected mortality ratios, led by Sir Bruce Keogh, subsequently led to 11 trusts being put into special measures by Monitor / the NHS Trust Development Authority. New fundamental standards were introduced in 2015 and there have been policies and strategies on dignity and respect and patient safety. The Care

Quality Commission (CQC) has introduced a new inspection model. The National Institute for Health and Care Excellence (NICE) issued guidelines on “safe” nursing levels in hospitals.

In other policy areas, the Quality, Innovation, Productivity and Prevention Initiative (QIPP) was introduced in 2010. This was in response to estimates that the NHS needed to make £20bn in efficiency savings between 2011 and 2014/15. Measures adopted included wage restraint policies, cuts to administration budgets and cost savings on drugs and procurement. Comprehensive Spending Reviews transferred part of the NHS budget to local authorities and pooled budgeting for integrated health and local authority social care services. There were also new powers for the Health Secretary to close local hospital services and healthcare charges for arriving migrants and foreign nationals from outside the EU. In late 2014, a mental health strategy paper promised the introduction of waiting time standards from 2015. Plans for minimum alcohol pricing in England were dropped in 2012 but a ban on below cost selling was introduced in 2014. Plans to move ahead with a ban on smoking in cars where children are present were announced in December 2014.

Section 4 examines trends in resources over the period 2010-2015. We find that whilst the Coalition has ‘protected’ health relative to other expenditure areas, the level of recent growth in health spending has been exceptionally low by historical standards. Average annual growth rates have lagged behind the rates that are deemed necessary to maintain and extend NHS care in response to increasing need and demand.

Across the UK as a whole, spending on health grew from £116.9bn in 2009/10 to £120.0bn in 2013/14 (in 2009/10 prices), a real terms increase of 2.7 per cent. Cuts of 0.1% and 1.1% in the first two years were followed by real increases of 1.5% and 2.4% in the subsequent two years. Real growth in public expenditure on health in the UK averaged 0.7 per cent a year over this period. This figure is exceptionally low by historical standards, and compares to average annual growth of 4.0% over the period 1950/1-2009/10. Looking at the figures for England separately (based on the budgeting framework rather than the expenditure on services framework and bringing in budget plans for 2014/15), real growth in expenditure on the NHS over the period 2009/10-2014/15 is estimated as 4.2%. The real average annual growth rate was 0.8 per cent (that is, a small but nevertheless positive figure). Year on year growth was negative in 2009/10-2010/11 but positive for each year 2011/12-2014/15 (which is important, given the pledge in the Coalition Programme for real year on year increases in each year of the Parliament).

Real annual average expenditure growth has therefore been positive but exceptionally low. Furthermore, the average annual growth of real expenditure on health has been low when compared to the rates deemed necessary just to keep up with need and demand. An estimated minimum 1.2 - 1.5 per cent annual increase in real funding is estimated as necessary just to keep pace with demographic pressures. The extent of the gap between real expenditure growth on the one hand, and need and demand pressures on the other, depends on a complex range of factors, including non-demographic pressures, technological change and offsetting productivity increases. However, it is notable that real average annual growth rates over the Parliament have lagged behind these rates. Forecasts paint a bleak picture regarding a growing funding gap within the NHS during the next five years. As analysed by the Nuffield Trust, Monitor and in the NHS’s Five-year Forward View, this gap could reach £30bn by 2020/21 unless offset by funding increases and / or compensating productivity gains.

Looking at the UK's expenditure on health relative to other European countries, there are some signs of slippage over the period 2009-2012. OECD data suggests that the ratio of total (public and private) expenditure on healthcare in the UK was 0.7 percentage points in 2009 and 0.8 percentage points in 2012. However, data on change in the annual average growth rate in real total (public and private) health expenditure per capita in EU countries over the period 2009-2012 suggests a bigger cut in the UK than in countries such as France, Germany and the Netherlands.

Section 5 examines healthcare provision (or supply). We comment on trends in healthcare inputs and outputs and productivity; the relationship between volume expenditure growth and simple indicators of need and demand; and the balance between public, private and other provision.

On inputs, outputs and productivity, updated ONS data for the current period is not available at the time of writing. Independent analysis (Bojke et al 2014) suggests positive year on year increases in all three of these measures up to 2010/11-2011/12. However, comparing rates of growth to average year on year figures going back to 2004/5-2005/06, growth of inputs in 2010/11-2011/12 was considerably less than average, and growth of outputs less than average. The combination of these trends resulted in positive overall productivity gains in 2010/11 and 2011/12. Evidence against the target of £20 billion in efficiency savings over the Parliament and of the costs associated with the healthcare reform programme is reviewed. A number of recent analyses suggests that some current policy levers (eg pay freezes) may be non-sustainable in the medium term and highlight the need for 'genuine transformational change' (Appelby et al 2014; NHS 2014).

On supply, demand and need, we find that growth of supply, as measured by volume expenditure, lagged behind simple measures of growth in need and demand. In the UK as a whole, growth in volume expenditure on health between 2009/10 and 2013/14 was less than the modest increase in GDP and lagged behind simple measures of demographic pressure, including 10.5 and 9.0 per cent increases respectively in the population aged over 65 and over 85. There was no growth in real expenditure per capita over this period (that is, in expenditure adjusted for general inflation) whilst volume growth per capita (adjusted for NHS specification inflation) was just negative.

On the balance between public, private and other provision, a medium term trend towards the provision of healthcare by non-NHS is found to pre-date the Coalition. In the current period, analysis of PCT expenditure on services by provider type undertaken by Nuffield Trust suggests an increasing share of expenditure on non-NHS providers in the community services was relatively high and increasing over the period 2010/11 and 2012/13, whilst share in the hospital services context remained low (Lafond et al 2014). However, these analyses pre-date the major health reforms implemented in 2013 (including the introduction of the "any qualified provider" rule highlighted above). Data on subsequent trends is limited and the picture is mixed.

Section 6 reviews the available empirical evidence on outcomes. We begin by examining healthcare outcomes (the outcomes of the healthcare system itself) and then move on to look at population health outcomes (such as life expectancy and mortality), nonmedical determinants (such as obesity and smoking) and suicide, mental health and general health.

In the current period, the UK remained a good performer in terms of equitable access to healthcare when compared to other European countries. For example, in terms of unmet need for health (medical examination) due to financial costs, the UK performed best out of 31 European countries with available data.

Nevertheless, we find that there has been adverse movement against a number of indicators of healthcare access and quality suggesting current pressure on the health system. These include indicators of waiting times for hospital treatment, A&E waiting times and the proportion of patients receiving definitive treatment within 62 days of an urgent GP referral. Overall public satisfaction with the NHS, measured by the annual British Social Attitudes Survey fell from a high of 70 per cent in 2010 to 60 per cent in 2013. Trends in patient experience data are more mixed. While the overall score for patient experience within acute hospitals has continued to increase, there have been adverse movements in patient experience of mental health services.

On life expectancy and mortality, health inequalities remain deeply entrenched. For example, latest data for 2010-12 suggests a gap of nine years in average life expectancy between men living in the poorest and most prosperous areas and more than six years for women. The gap for “healthy” life expectancy is wider still at 18 years for men and 19 years for women. Whilst trends in overall mortality from circulatory diseases and cancer have continued to decline in the most recent period, inequalities in these rates by index of multiple deprivation remain stark. Social class inequalities in infant mortality appear to have continued to narrow, in line with the trend towards the end of Labour’s period in power (1997-2010) reported in (Vizard and Obolenskaya 2013). The UK’s ranking on international legal tables in relation to a number of key outcomes remained disappointing.

Non-medical determinants such as obesity, physical exercise, diet, smoking and alcohol consumption remained a major challenge in the most recent period. Adult obesity rates increased between 2009 and 2012, although early signs of progress amongst the youngest children reported in our companion paper (Vizard and Obolenskaya 2013) continued. There was little evidence of an “Olympic effect” on physical activity, whilst on dietary factors, mean portions of fruit and vegetables amongst by adults declined between 2007 and 2011, over the period of the downturn and crisis. Overall smoking prevalence in England continued to decline but in Great Britain social class gaps widened.

The economic crisis and downturn coincided with an increase in prevalence of suicide and risk of poor mental health. Whilst suicide rates are difficult to interpret and are subject to fluctuation, the most recent data on age specific suicide rates raises the spectre of stalling of progress in the period since the financial crisis and downturn amongst middle aged men after 2007. Based on Health Survey for England data, overall risk of poor mental health increased over the period 2008-2012. Prevalence of poor mental health risk remained greatest amongst men and women with the lowest quintile of equivalised household income.

Section 7 concludes by drawing together the findings, provides an overall evaluation and setting out the challenges facing an incoming Government in 2015. In making an overall assessment of the Coalition’s record, we find that at the end of the period 2010-2015, the NHS remains free at the point delivery, based on need not ability to pay. No major changes were made by the Coalition to its financing model and the NHS continues to be funded through general taxation and National Insurance contributions. Challenges elsewhere to the ‘right to health’ – such as high out-of-pocket payments and healthcare depending on ability to afford private insurance – continue to be avoided in the UK. The private healthcare sector – beyond services commissioned by the public sector – is limited. Private spending on healthcare remains low as a proportion of GDP and expenditure on private medical insurance has remained stable.

We also argue that there have been important continuities between the Coalition's health reforms and those undertaken by Labour. The previous Government's programme included decentralisation policies (such as the creation of autonomous foundation trusts), commissioning based on a purchaser-provider split, and practice based GP commissioning. Competition and 'patient choice' policies extended the use of private treatment centres to provide NHS services. There was an emphasis on achieving greater democratic participation and accountability.

Nevertheless, a number of factors suggesting a break with the past and a significant and entrenched new policy landscape for health services in England are widely cited. There has been a major shift in commissioning, management and delivery models. Specific changes that are cited as pointing to a discontinuity with previous arrangements include the extent of the shift towards a decentralized organisational structure; the likely magnitude of the shift towards private provision of publicly financed healthcare services in the future; the possibility of hospital trusts retaining 49% private patient revenue; the introduction of a trust failure regime; the central role of competition brought about by the "any qualified provider" rule; emphasis on anti-competitive behaviour; and the potential application of international competition rules.

Furthermore, whereas reforms under Labour were introduced incrementally against the backdrop of unprecedented growth in resources, major health reforms have been implemented under the Coalition in an extremely short time period against a backdrop of a real resources squeeze. The speed and scale of the reforms as well as their compulsory (rather than opt in) nature has resulted in considerable controversy, costs and organisational upheaval, as well as creating a myriad of new and untested bodies and systems. Multiple reforms have been implemented simultaneously.

Perhaps the most notable break with the pre-2010 period, though, relates to the magnitude of the financial squeeze and adverse movements against to headline indicators such as waiting times and satisfaction with the NHS. The Coalition committed to 'cut the deficit not the NHS', and to protect health relative to other expenditure areas, by increasing year on year spending each year of the Parliament. However, the commitment to protect the NHS was in cash terms (not needs) and *a*dverse movements against a number of key indicators point to a system under increasing strain and raise the prospect of retrogression. In the run up to the 2015 General Election, there is a widespread public perception that the improvements of the previous period have gone into reverse, and that the health system is going backwards rather than forwards.

In relation to the impact of the reform programme, we find that it is early days in terms of independent evaluation evidence. In the medium term an evidence base will be required to determine what impact different factors such as organisational decentralization, increased competition, emphasis on outcomes, new inspection regimes, duties to address health inequalities and the new arrangements for public health are having on access to healthcare and the quality of provision, as well as on improving health outcomes and addressing health inequalities between different social groups.

The Coalition's public service model puts central emphasis on the role of the central state as a guarantor of minimum standards, outcomes and quality. On minimum standards, measures have been introduced to improve the effectiveness of the overall system of management, regulation and inspection in identifying poor and substandard care. However, ensuring continued progress in this area remains at the top of the health agenda. The overall framework for accountability and responsibility for improving health outcomes and reducing health inequalities brought about by the

reform programme raises a number of concerns. Additional issues are raised by the localism agenda and the devolution of responsibilities for public health to local authorities. Key challenges relate to the adoption and replication of good practice, the overall integration of public health services and the alignment of local public and central goals. It is not clear that all of the necessary levers to promote public health and tackle health inequalities are genuinely within local hands. Decentralization comes with a risk of service fragmentation.

Against this background, we finally review the challenges facing an incoming Government in 2015. These include:

- The continuing squeeze on NHS resources – with expenditure lagging behind need and demand. Authoritative forecasts suggest that funding gap will increase considerably in the absence of real funding increases and productivity gains.
- Signs of pressure within the system are increasingly evident. This includes pressure on waiting times, A&E departments, cancer waiting lists and public satisfaction with the NHS.
- Demographic change, the increasing prevalence of dementia, obesity, smoking and alcohol misuse will continue to present continuing challenges for public health as well as NHS services. The NHS Five Year Forward View (NHS 2014) highlighted that investment in preventive care, and new care models such as integrated health and social care services, are important routes towards lower demand and greater efficiency. However, there is growing recognition that productivity rises alone will be insufficient to meet the funding gap.
- The Coalition's health reforms raise significant challenges for policy implementation. Challenges include the fact that many of the bodies created by the reform process - such as Clinical Commissioning Groups, Health and Wellbeing Boards and new foundation trusts – remain in their infancy. A growing number of foundation trusts are in deficit. The Coalition has also sought to implement a new public services model which emphasises a changed role for the central state focusing on minimum standards, quality and outcomes.
- On minimum standards and quality, following the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust (2013), the effectiveness of the management, inspection and regulatory system in identifying and addressing poor and substandard care remains at the top of the health agenda. An incoming Government will face the continued challenge of ensuring that new minimum standards are enforced and that the overall system for management, inspection and regulation is effective.
- Challenges also arise in relation to the overall framework of political responsibility and accountability for improving health outcomes and reducing health inequalities. Under the new arrangements for health in England, the NHS Outcomes Framework and the Public Health Outcomes Framework play critical roles as accountability tools. Challenges include the underdeveloped evidence base on the effect of provider type (independent, private and public) on quality; under-developed evidence on inequalities; and the absence of benchmarks and targets for evaluating progress. In relation to public health, questions are being asked about whether local public action is (or will remain) aligned to national public health goals; and whether all of the relevant policy instruments are genuinely within local hands.

- Some health outcomes remain disappointing by international standards, whilst health inequalities between different population subgroups remain deeply embedded. Progress in improving health outcomes and tackling inequalities will be the key barometer of failure or success.

2. Goals

In this section we examine the Coalition's aims and goals. We begin by examining the individual manifesto commitments set out in by the Conservative and Liberal Democratic parties prior to the 2010 General Election. We then set out the health policies that emerged from the process of agreement and negotiation and the formation of the Coalition (as reflected in the Coalition Agreement and Programme for Government). Finally, we consider Coalition's broader thinking about decentralization, the role of the state and public services reform, which, we contend, provides the broader context for the programme of health reforms examined in section 3.

Conservative and Liberal Democratic Manifesto Commitments on Health

As documented in Timmins (2012), the Conservative Party's 2010 general election campaign built on earlier efforts to neutralise the NHS as a political issue and to build up trust in the Conservatives on health. With public satisfaction with the NHS running at unprecedented high levels, the campaign reinforced the key political messages that the NHS would be "safe" in Conservative hands and that Cameron was personally committed to the NHS, which he regarded as one of the 20th Century's "greatest achievements". In a highly personalised poster campaign, David Cameron pledged that "I'll cut the deficit, not the NHS". This pledge built on Cameron's signalling at the 2006 Party Conference that priority would be given to health under a future Conservative administration, when he notoriously declared that whilst Tony Blair explained his priorities in three words, 'education, education, education', that 'I can do it in three letters: NHS'"[1].

Building on these sentiments, the Conservative's 2010 Manifesto pledged to "back the NHS" and made an explicit commitment to "an NHS free at the point of use ... based on need not ability to pay". A further pledge was made to increase health spending every year of the next Parliament. At the same time, the Manifesto included explicit plans for a series of health reforms including plans for de-centralization of power; for increasing patient choice over providers by ensuring the right to choose any healthcare provider that meets NHS standards within NHS prices; an independent commissioning board; new arrangements for GP budgeting holding and "putting GPs in charge" of the commissioning of local health services; ensuring that all hospitals become autonomous foundation trusts; and for cutting the costs of NHS administration by a third. These plans were set out in the context of the Conservatives "eight benchmarks for Britain", which included the key pledge to "[r]eform public services to deliver better value for money …. rais[ing] productivity growth in the public sector in order to deliver better schools and a better NHS" (Figure 1).

Timmins (2012) notes that the policy proposals set out in the 2010 Election Manifesto were taken forward in the context of medium term planning for health reforms under a future Conservative Government by Shadow Secretary of State for Health Andrew Lansley. The transition from Blair to Brown in 2007 had been associated with less emphasis on the competition and choice agenda in health (Vizard and Obolenskaya 2013). Lansley critically signalled the importance of putting new energy into a health reform agenda in a series of papers and speeches going back to 2005. Key

[1] Cited in Timmins (2012: 28).

proposals set highlighted the importance of competition, choice and a range of providers; the role of economic regulation (enforcing competition rules) as well as quality regulation; the need for strengthened patient voice (a consumer 'watchdog' to be introduced in parallel to economic regulation); decentralization (including GP budget holding and all trusts to become Foundation Trusts); accountability; and the role of autonomy and independence in the day to day running of the NHS (with a proposal for a new independent NHS Commissioning Board). These themes were elaborated in the context of a far-reaching critique of central bureaucracy (so called top down "command and control") and the need for an overall focus on 'outcomes not targets'[2].

The Liberal Democrats' Manifesto (2010) made a commitment to NHS as a "British value of fairness". The Manifesto pledged to "protect and improve" the NHS. Noting that the NHS is "too remote and complex" with "too much time spent meeting targets" and "money wasted on bureaucracy", pledges were made to "cut administration and waste" including by abolishing quangos and Strategic Health Authorities. Further pledges were made to "reduce centralized targets and bureaucracy" and to replace these "with entitlements guaranteeing timely diagnosis and treatment" backed by a private option. Particular emphasis in the Liberal Democratic Manifesto was put on plans for decentralization and strengthening local democracy and accountability. In particular, specific pledges were made to "empower local communities to improve health services through elected Local Health Boards, which will take over the role of Primary Care Trust boards in commissioning care for local people, working in co-operation with local councils, and taking on responsibility for revenue and resources over time". New local health boards would be enabled "to commission services for local people from a range of different types of provider including staff cooperatives on the basis of a level playing field in any competitive tendering (ending bias to private providers)" (Figure 2).

[2]These policies and speeches are reviewed in Timmins (2012: 25-29) and include, *inter alia*, in Lansley's speech to NHS Confederation (2005); proposals set out in the document "NHS Autonomy and Accountability: Proposals for Legislation; Proposals for NHS Autonomy and Accountability (2007); and an 'NHS independence bill' (2007).

Figure 1: Conservative Party 2010 Manifesto — commitments on health

- **Overall commitment to "back the NHS"**
- **Overall commitment to "an NHS free at the point of use .. based on need not ability to pay"**
- **Commitment to increase health spending 'every year'**
- **Cut administration costs / bureaucracy**
- Cut costs of NHS administration by a third and transfer cash to front line
- **Health reform plan involving:**
  - De-centralization of power
  - Right to choose any healthcare provider that meets NHS standards within NHS prices including private, voluntary, community sector providers
  - Strengthening the power of GPs as patients' expert guides through the health system by giving them the power to hold patients' budgets and commission care on their behalf and putting them in charge of commissioning local health services
  - Setting NHS providers free to innovate by ensuring that they become autonomous Foundation Trusts
  - New independent commissioning board to provide allocate resources and provide commissioning guidelines
  - Scrapping "politically motivated" targets that have no clinical justification
- **New arrangements for public health**
  - Turn the Department of Health into a Department for Public Health
  - Provide separate public health funding to local communities (with local accountability for results)
  - Introduce a health premium (weighting public health funding towards the poorest areas with the worst health outcomes)
  - Deliver 4200 Sure Start Health visitors
- **Other**
  - Increasing access to treatments services and information including 24/7 urgent care service, out of hours GP services
  - Funding decisions on the basis of need
  - Increase patient control over decision making, including in relation to health records
  - Spread the use of the NHS tariff, so funding follows patients' choices
  - Implement a system of payment by results
  - Link GP pay to payment by results
  - Increase transparency by publishing detailed information about healthcare performance online
  - Measure success on health results that matter
  - Enable patients to rate hospitals and doctors and introduce a patient voice organisation (Healthwatch)
  - Protection of NHS staff raising concerns about safety
  - Stop forced closure of A&E services
  - Increase number of single rooms in hospitals and end the scandal of mix sex accommodation
  - Reform the way the NHS pays for drugs
  - Create a Cancer Fund to enable patients to access the cancer drugs their doctors think will help them
  - New dentist contract
  - Devolve control over health budgets to the lowest possible level and create a single budget combining health and social care funding for people with a people with a chronic illness or a long-term condition
  - Support children's hospices
- **Eight benchmarks for Britain:**
  - "Reform public services to deliver better value for money …. rais[ing] productivity growth in the public sector in order to deliver better schools and a better NHS"

Source: Conservatives (2010)

Figure 2: Liberal Democratic Party 2010 Manifesto –– commitments on health

- **Overall commitment to NHS as building on a "basic British value of fairness"**
- **Commitment to "protect and improve" the NHS including:**
  - ➢ Make savings in management costs, bureaucracy and quangos and reinvest the sums released into healthcare
  - ➢ Cut administration and waste" including cutting the size of the Department of Health by a half, abolishing unnecessary quangos and Strategic Health Authorities
  - ➢ 'Sharply reduce centralized targets and bureaucracy and replace these "with entitlements guaranteeing timely diagnosis and treatment on time. If they do not, the NHS will pay for the treatment to be provided privately'.
- **Decentralization / strengthen local democracy / accountability**
  - ➢ Empower local communities to improve health services through elected Local Health Boards, which will take over the role of Primary Care Trust boards in commissioning care for local people, working in co-operation with local councils.
  - ➢ Over time, Local Health Boards should be able to take on greater responsibility for revenue and resources to allow local people to fund local services which need extra money.
  - ➢ Give Local Health Boards the freedom to commission services for local people from a range of different types of provider, including for example staff co-operatives, on the basis of a level playing field in any competitive tendering – ending any current bias in favour of private providers.
- **Patient choice**
  - ➢ Right to register with a GP of choice without geographical restriction;
- **Other**
  - ➢ Measures to link GP payments to prevention and to promote out of hours care
  - ➢ Extra payments to GPs for accepting patients from the most deprived areas
  - ➢ Improve patient safety and Improve mental health policy
  - ➢ Openness about mistakes
  - ➢ Competence tests
  - ➢ Extend good practice in relation to discharge, maximise the number of day case operations reduce delays prior to operations, move consultations into the community where possible, prioritise dementia within the research budget, improve access to counselling for people with mental health problems
  - ➢ Integrate health and social care to create a seamless system
  - ➢ Put front line staff in charge of wards / unit budgets
  - ➢ Tackle below-cost selling of alcohol, support in principle minimum cost pricing and review taxation to tackle excessive alcohol consumption
  - ➢ Cut air pollution and fully meet European air quality targets by 2012

Source: Liberal Democrats (2010)

The Coalition Agreement and Programme for Government

The Coalition Agreement and Programme for Government set out the "common ground" that emerged from the process of negotiation and agreement between the Conservatives and Liberal Democrats prior to the transition to Government. The Agreement included a specific pledge to increase public expenditure on health in every year of the parliament. It stated: the parties had agreed that "funding for the NHS should increase in real terms in each year of the Parliament" (Conservatives and Liberal Democrats (2010). The Programme for Government repeated this pledge and included a broad commitment to the NHS as an expression of national values, free at the point of use and based on need, not ability to pay. Plans were set out to free NHS from political micro-management and to cut quangos and administration costs by a third, releasing funding for the front line. Other plans included "enabling" GP commissioning, introducing an independent NHS Board, developing Monitor into an economic regulator and strengthening the role of the CQC as a quality regulator. Plans to and strengthen local democratic participation and accountability were reflected in plans to include elected representatives included on the boards of Primary Care Trusts. A residual role was foreseen for PCT boards. This included the commissioning of residual services 'best undertaken at a wider level' rather than directly by GPs and 'taking responsibility for improving public health for people in their area' (Figure 3).

In addressing how the goals set out in the Coalition Agreement and Programme for Action related to the individual party manifestos, it is notable that the many of the shared commitments set out in the Programme for Government reflected proposals from the Conservative Party Manifesto (summarized in Figure 1). These include the commitment to increase real year on year funding as well as proposals for economic regulation (developing the role of Monitor), an independent commissioning board and GP commissioning. However, Liberal Democratic proposals were also reflected. In particular, Liberal Democratic plans for strengthening of local democracy and accountability were reflected in the proposals for elected individuals on boards of PCTs. The inclusion of the "any provider rule", enabling private and voluntary sector providers to compete for NHS contracts, reflected commitments in the Liberal Democratic (and indeed the Labour Party Manifesto) as well as Conservative proposals. Overall commitments to the NHS as an expression of national values and fairness were also included in both individual manifestos (see Figures 1 and 2).

It is commonly predicted that coalition government will have a *moderating* influence on the plans of the dominant political parties. However, Timmins (2012) has argued that far from being a *moderating* influence on initial plans on health, the effect of the process of coalition formation was to *radically transform* both Conservative and Liberal Democratic plans for health. A process of radicalization is in fact suggested in the Programme for Government. This suggested that the process of negotiation and agreement had resulted in shared commitments that were "more radical and comprehensive than our individual manifestos". For example, the bringing together of Conservative thinking on markets, choice and competition, and the Liberal Democrat belief in advancing democracy at a local level, was identified as providing the foundation for a "truly radical" vision of the NHS (HM Government 2010b: 8).

Figure 3: The Coalition Programme for Government – commitments on health

- Commitment to NHS as expression of national values, free at the point of use and based on need, not ability to pay
- Real increases in health spending in each year of the Parliament
- Free NHS from political micro-management, increase democratic participation, make NHS more accountable to patients in order to drive up standards, support professional responsibility, deliver value for money and create a healthier nation
- "Stop the top-down re-organisations of the NHS that have got in the way of patient care"
- Cut quangos and cut cost of administration by a third, divert cash to front line
- Give every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices (including independent, voluntary and community sector providers)
- Greater involvement of independent and voluntary providers
- Strengthen the power of GPs as patients' expert guides through the health system by enabling them to commission care on their behalf
- Strengthen the role of the Care Quality Commission so it becomes an effective quality inspectorate.
- Develop Monitor into an economic regulator that will oversee aspects of access, competition and price-setting in the NHS.
- Establish an independent NHS board to allocate resources and provide commissioning guideline
- Include directly elected individuals on the boards of local primary care trust (PCT), with the remainder of the PCT's board appointed by the relevant local authority or authorities, and Chief Executive and principal officers appointed by the Secretary of State.
- Local PCTs to act as champions for patients and commission those residual services that are best undertaken at a wider level, rather than directly by GPs. It will also take responsibility for improving public health for people in their area, working closely with the local authority and other local organisations.
- Measure success based on results
- Publish detailed data about the performance of healthcare providers online / enable patients to rate hospitals and doctors according to the quality of care they received
- Require hospitals to be open about mistakes
- Stop centrally dictated closure of A&E / maternity wards (local authority right to challenge)
- Right to choice of GP (no geographical restriction)
- Develop 24/7 urgent care service + GP out of hours service + renegotiate GP contract (including incentives for access to primary care in disadvantaged areas)
- Reform NICE + move to "value based" pricing for drugs and treatment

- Improve discharge from hospital, maximising the number of day care operations, reducing delays prior to operations, enable community access to care and treatments, help elderly people live at home for longer, prioritise dementia research
- Increase patient control over decision making, including in relation to health records
- Create a Cancer Drugs Fund to enable patients to access the cancer drugs their doctors think will help them
- New dentistry contract
- Support for children's hospices
- Partnerships between NHS and police
- Language and competence tests for stop foreign healthcare professionals

Source: HM Government 2010a

It is certainly the case that key elements of the health reform programme set out in the Health and Social Care Act (2012) including economic regulation, GP commissioning, an independent NHS Board and the "any qualified provider" rule are mentioned in the Coalition Programme for Government. Nevertheless, as we will discuss in the following section (Policies), there is a wide-spread perception of a deep lacuna between the plans set out in these documents and the major programme of health reform that was developed and implemented following the transition into Government. It has been widely argued that the Programme for Government did not provide a mandate for the major health reforms that was implemented in practice (c.f. this paper 'The enactment of the Health and Social Care Act (2012)').

In explaining this perceived lacuna, Timmins cites statements by leading Conservatives which signalled plans to *refrain* from major "big bang" organisational reform, including Cameron's signaling that the Conservatives would "allow the current structures to settle down and bed in" and "work with the grain of government's reforms" (Timmins 2012: 31). As noted above, the Programme for Government also notoriously pledged to "[s]top the top-down re-organisations of the NHS that have got in the way of patient care" (HM Government 2010a and Figure 3). The scale of the changes that were set out in Health and Social Care Act (2012) - together with the compulsory and "Big Bang" nature of their implementation on April 1st 2013 - is also widely perceived as going far beyond the negotiated agreements set out in the Coalition Agreement and Programme for Government. The compulsory nature of GP commissioning cannot, for example, be necessarily inferred from the commitment to *enable* GPS to commission care (on which, see Figure 3).

Timmins (2012) has further argued that the plans set out in the Programme for Government were essentially "unworkable". He suggests that inherent ambiguities relating to the future of Primary Care Trusts (as well as Strategic Health Authorities not mentioned in the Programme for Government) meant that the plans had to be re-visited. Following the transition into Government. Lansley and Burstow worked together to combine Conservative plans for competition with Liberal Democratic plans

for extension of democracy, a greater role for local government and for health and wellbeing boards. The combination of these plans meant that there was no role left for Primary Care Trusts, which were as a consequence abolished - yet abolition of PCTs had not been mentioned in *either* the Conservative or Liberal Democratic Manifesto. According to Timmins, sorting out the "disaster" of the Programme for Government turned what would have been "merely a large shift of power and accountability within the NHS into a huge structural upheaval" characterised by David Nicholson as "so big you could see them from space" (Timmins 2012: 6, 77, 123).

Other explanations of the perceived lacuna between the health plans set out in the Programme for Government on the one hand, and the health reforms that were enacted in practice on the other, include: the dominance of the Conservatives over the Liberal Democrats within the Coalition; and the personal dominance of Lansley over health policy within the Conservative Party (for example, see Timmins 2012, Glennerster 2015). The health reform programme that was developed and implemented following the transition into Government is often presented in a highly personalised way – as reflecting Lansley's personal agenda; as taking leading Liberal Democrats by surprise; and as being forced through by a dominant Conservative Party with the Secretary of State for Health in control.

The role of the central state and the Coalition's model for public services

Yet the picture of Conservative dominance and Liberal Democrat opposition – as well as the attribution of all responsibility for the health reform programme to Lansely - is overly simplistic. The health reform programme should be seen in the context of the "big ideas" around the role of the central state and decentralization that were forward and apparently agreed by both parties in the Coalition Agreement and Programme for Government. Following the transition to power, these "big ideas" informed and shaped a broader programme of public services reform that was endorsed by the Coalition Cabinet.

Coalition "big ideas" are set out in the foreword to the Coalition Programme for Government, which sets out the "common ground" that emerged from the process of negotiation in terms of a vision of a radical, reforming government with central emphasis on the de-centralization of power and the creation of a "smaller" / "smarter" central state (HM Government, 2010: 7-9). The foreword to the Programme declared an "emphatic end" to bureaucracy, top-down control and centralisation – a priority which was reflected in subsequent health policy in terms of the rejection of central targets and performance management systems (so-called "command and control). The foreword also makes explicit reference to the idea of the "Big Society", articulated by Cameron in the run up to the 2010 General Election in the context of a far-reaching critique of the role, scale and functions of the state under Labour (1997-2010) and the proposition that "the era of big Government has run its course"[3].

Following the transition to Government, the Coalition's "Big Ideas" around decentralization and a changed role for the central state shaped and informed the development of a radical public services

[3] Cameron's analysis suggested that centralized political and bureaucratic control not only limits individual freedom but also constitute blunt instruments for dealing with a range of social problems The decentralization of power and a reduced role for the state are predicted to result in a range of better outcomes including less poverty and inequality and higher quality public services (Cameron 2009).

reform model. Deputy Prime Minister Nick Clegg declared the idea of 'Big Society' to be “the same” as liberalism and as providing foundations for a shared Conservative and Liberal Democratic programme of public services reform (Guardian 2010a). The Coalition’s “Open Public Services” White Paper (HM Government 2011) declared public services reform to be a “key progressive cause” necessitated by inequality and disadvantage. The Paper, which included forwards by both Prime Minister David Cameron and Deputy Prime Minister Nick Clegg, signalled a major change in the role of the central state away from the direct provision of public services and set out guiding principles for public services reform. These were listed as: decentralisation “to the lowest appropriate level”; a range of providers; accountability to users and tax payers; increasing choice; and an “information revolution” that would make information on quality and outcomes available to the users. New “bottom up” forms of organisation would result in a “self-improving dynamic” and a “bottom up” process of public services improvement - without the need for political intervention and political and / or bureaucratic control (including centrally imposed targets):

> “With open individual public services, higher standards will result from a range of diverse suppliers competing to provide people, armed with information and the power of choice, with the services they want. Success will be driven from the bottom up, in response to service users and flexible to their many needs, not from the top down. The role of government is to create this self-improving dynamic in every public service” (HM Government 2011).

The public services model proposed in the “Open Public Services” White Paper departs from a laissez-faire or pure market competition model in important ways. For example, the role of the central state in delivering the new model of public services has not been viewed as being limited to the establishment of the conditions of competition and choice. Key functions for the central state identified in the White Paper include the key role of the state in defining outcomes, and as a guarantor of minimum standards and quality improvement:

> “We also believe that the state has a key role in defining outcomes, and in setting standards for public services and ensuring that they continue to rise. In its capacity as guarantor of standards the state will play an important part in setting the bar for existing and new providers who want to compete to provide public services” (HM Government 2011)[4].

A central assumption of the model is that decentralization and the creation of a range of providers will result in improvements in both public service and social outcomes. Plans to break up state monopoly provision that were explicitly mentioned in the Coalition Agreement focussed on education. However, this focus was subsequently broadened. The Cabinet Office document “Big Society Plans for Better

[4] The “Big Society” agenda was explicitly articulated by Cameron as an alternative to the laissez-faire and state retrenchment models discussed on the “centre right” and retained an important, albeit reduced, role for the state. Cameron’s Hugo Young Lecture on this subject t put emphasis on the importance of a “smart”, “strategic” state - as opposed to a “big state” and drew parallels with the idea of “smart Government” previously outlined by Peter Mandelson (Cameron 2009).

Public Services" (Cabinet Office 2010) emphasised the role of mutuals, co-operatives and social enterprises as well as private providers and aimed to transfer considerable numbers of public sector workers into new employee-led companies. Evaluations later in the Parliament also made clear that breaking up state monopoly supply had become a central element of the Coalition's public services reform programme:

> "When the Coalition first came to power, the state was still the default provider of most public services. From poor performing schools to widening health inequalities, there were clear signs that the old centralised model of public service delivery was unable to meet the complex needs of the 21st century…. Through the Open Public Services programme, we are releasing the grip of state control and putting power into people's hands (HM Government 2013)".

The health reforms examined in Section 3 - with their central emphasis on decentralization, outcomes and competition – are best understood in the context of this broader thinking about the role of the central state, decentralization and public services. The Coalition Agreement and Programme for Government mapped out not only measures associated with deficit reduction (and associated cuts), but also a public policy agenda aiming at radically restructuring different areas of social policy. Whilst the health reforms are often personally identified with Lansely, the broader aims set out in the Programme for Government are an important part of the overall picture (c.f. Timmins 2012 46-47; Lupton et al 2015).

3. Policies

In this section we examine the health policies implemented by the Coalition over the period 2010-2015. The discussion begins with an overview of the major programme of health reforms proposed in the White Paper "Equity and Excellence": Liberating the NHS following the transition to Government. The politics of the Health and Social Care Act (2012), including the nature and scope of political opposition to the Health and Social Care Bill and the process of modification and amendment, are then discussed. Next, we provide a summary of the new arrangements for health in England following the enactment of the Health and Social Care Act. This includes: changes to the overall framework for political responsibility and accountability; changes in the framework for commissioning, management and delivery; changes to the framework for regulation and inspection; a new role for local government in relation to public health; and health inequalities. Finally, we turn to other policies and strategies implemented over the period 2010-2015, including the Government's response to the Mid-Staffordshire Public Inquiry (2013) and other policies and strategies including measures to promote efficiency, measures to promote integrated health and social care, and new standards on mental health.

Proposals for health reform following the transition to Government

A White Paper "Equity and excellence: Liberating the NHS" was published on 12 July 2010 (DH 2010a) - within two months of the Coalition coming to power. The speed of the development and publication of plans for a health reform programme was in line with the strategic thinking of Francis Maude, Minister for the Cabinet Office, who suggested that the new Government should "hit the ground running" by implementing several radical reforms simultaneously. The underlying aim was to "learn the lessons" of the previous Thatcher and Blair administrations, where radical reform programmes were delayed, rather than being immediately implemented following transitions into government (Guardian 2010b).

The White Paper set out a "vision for the future of the NHS" which aimed to "liberate the NHS" through a "blend of Conservative and Liberal Democrat ideas". The White Paper begins by repeating the commitment in the Coalition Agreement and Programme for Government to uphold the values and principles of the NHS, of "a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay". It also repeated the pledge to increase health spending in real terms in each year of the Parliament. Thereafter, it sets out a major programme of health reforms which amounted to a new framework for the commissioning, management and delivery of health services in England.

The White Paper announced that the improvement of healthcare outcomes for all would be the primary purpose of the NHS. In the future the NHS would be held to account against "clinically credible and evidence-based outcome measures, not process targets" and targets with "no clinical justification" would be removed. The key drivers of medium-term transformation and improvement were identified as including: patient choice and competition; a focus on outcomes rather than "bureaucratic process targets"; "empowering professionals"; strengthening autonomy, accountability and democratic legitimacy (including through decentralisation of power to local bodies); an NHS "information

revolution"; and increasing efficiency, especially by cutting bureaucracy and administrative costs. The White Paper stated that the Government's goal in pursuing the reform programme was to achieve "results that are amongst the best in the world".

Far reaching plans were set out to establish a new decentralized NHS commissioning, management and delivery model which aimed to eliminate "political micromanagement" from the centre and strictly circumscribe the role of Ministers in the day to day running of the NHS. This was to be partly achieved through the creation of a new "independent and accountable" NHS Commissioning Board which would oversee the commissioning of health services on a day to day basis. However, in addition to the central commissioning board, and in line with the objective of making decision making "as close as possible to individual patients", plans were set out to further devolve power and responsibility for commissioning health services for residents in local areas to GP consortia. Primary care trusts and strategic health authorities would be phased out. Plans for further organisational decentralization in the context of health services provision (as well as commissioning) were also outlined. The White Paper announced that "[our] ambition is to create the largest and most vibrant social enterprise sector in the world" and set out plans for (all) NHS trusts to be or be part of self-governing foundation trusts. Specific timetables and transitional arrangements for these changes were set out within the White Paper. GP consortia would take full financial responsibility from April 2013 and the NHS Commissioning Board was scheduled to make allocations for 2013/14 directly to GP consortia in late 2012.

As well setting out far reaching plans for GP commissioning and organisational decentralization, the White Paper set out a series of proposed measures relating to choice, competition and regulation. Plans to strengthen patient choice over GPs, hospitals and consultants were announced. On regulation and inspection, the role of the Care Quality Commission would be extended whilst Monitor would become an "economic regulator" responsible for promoting competition. Patient voice was to be strengthened by the creation of a new "consumer champion" Healthwatch England. Democratic legitimacy at the local level would be strengthened by requiring local authorities to "promote the joining up of local NHS services, social care and health improvement".

Finally, the health reform programme was outlined in the context of more the more general need for productivity savings and within the overall context of the resource squeeze. The White Paper reaffirmed that the NHS would be required to release up to £20 billion in efficiency savings by 2014, which would be reinvested. NHS management costs would be reduced by more than 45% over a four years period including by changes to organisational structure which would "radically delay and simplify the number of NHS bodies" (DH 2010a).

The enactment of the Health and Social Care Act (2012)

The Health and Social Care Bill was introduced in the 2010/11 session after a short period of consultation. Timmins (2012) suggests that the far-reaching nature and scope of the proposed health reforms caught many by surprise and that early period of Coalition Government was dominated by the Health Bill – by the deep political tensions and divisions it generated and the political process of getting it through Parliament. The fault-lines of debate included the rapid pace of the reforms and the compulsory, time-bound nature of the proposed major programme of organisational reform (including

the elimination of whole tiers of administration); concerns about the overall framework of political accountability and responsibility; and concerns around the major role of competition that was being proposed – including protracted discussions around the role of Monitor, EU competition law, private patient revenue, and local commissioning.

Timmins (2012) documents the nature and scope of the opposition to the planned reforms. The Kings Fund characterised the plans as being "too far too fast"; the BMA raised strong objections; and the Chairman of the Royal College of General Practitioners referred to the "end of NHS as we know it". The RCN voted "no confidence" in Lansley, whilst opposition grew within the Coalition itself, with many Liberal Democrats arguing they had not for signed up for the Bill, but for the Coalition Agreement with its commitment to no "top down reorganisation". Leading Liberal Democrats outside Parliament were opposed to the Bill, with Shirley Williams declaring that she could not support the Coalition plans for the NHS, whilst Clegg objected to pace of reforms on the Andrew Marr programme. There was Conservative opposition on the grounds that the immediate priority should be to deliver efficiency gains and that organisational reform in the context of austerity could be a major political mistake ("the Government's poll tax").

With opposition mounting, the progress of the Bill through Parliament was "paused" in April 2011 whilst a "listening exercise" ensued. In September 2011, the House of Lords, the Select Committee on the Constitution raised concerns around the structures of legal and political accountability being proposed. In particular, concerns were raised that the amendments to the statutory duties on the Secretary State for Health to provide a comprehensive health service amounted to a change in constitutional responsibilities first established in the NHS Act (1948) whereby the Secretary of State is constitutionally responsible for NHS provision. A report published by the Committee noted that "[w]e are concerned that the Bill, if enacted in its current form, may risk diluting the Government's constitutional responsibilities with regard to the NHS". It called for the Bill to be amended to put this matter "beyond legal doubt" (House of Lords Select Committee on the Constitution (2011: 4).

Achieving a majority for the Health and Social Care Bill in Parliament was a long and protracted process and the politics of Coalition Government was an important factor which drove forward the process of amendment. Leading Liberal Democrats (particularly those *outside* of Government) were opposed to aspects of the health reforms and played a pivotal role in securing a series of important amendments to the Act. As a result of this process of modification and amendment, the Health and Social Care Act (2012) differed from that introduced into Parliament in important respects and a number of important amendments were introduced before it was passed with a Government majority of 88 in March 2012. The effects of key amendments to the Bill were to strengthen the overall framework for public responsibility and accountability for health services in England (by providing for the *prioritisation* of the duty to secure a comprehensive NHS above the duty of autonomy); to impose duties of integration as well as duties of competition on Monitor (including duties of integration with social care); to cap Foundation Trust income from private patients at 49%; to clarify emphasis on quality rather than price competition (i.e. clarification of NHS tariff system); and to introduce a *pre*-failure regime for trusts (sections 5, 62, 164, 173-178; c.f. Timmins 2012).

Overview of the Coalition's health reforms

Following the enactment of the Health and Social Care Act (2012), debate turned to whether the implementation of the reform programme within the timetable envisaged was feasible and whether the anticipated cost savings would be achieved. The time-scale for the implementation of the new arrangements was intentionally made tight, with Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards, the transition to Foundation trust status and the allocation of public health budgets to local government all scheduled for April 1st 2013. Key milestones in the implementation of the new arrangements included the specification of the mandates of the new organisations including NHS England, and authorisation of all 211 CCGs, with the new healthcare system becoming operational on 1st April 2013.

A summary of the new arrangements brought about by the Health and Social Care Act and associated documents is provided in **Figure 4**. The subsections that follow provide a more detailed overview.

Political responsibility and accountability

The Health and Social Care Act (2012) enacted a **revised set of statutory duties** which modify the nature and scope of political responsibility accountability for health services in England. The 2006 NHS Act, in terminology dating back to 1948, referred to the duty of the Secretary of State to ***secure or provide*** health services (House of Lords Select Committee on the Constitution (2011); c.f. Pollock and Price 2013; emphasis added). Under the revised formulation established in the Health and Social Care Act (2012), the Secretary of State has a statutory duty to promote a comprehensive health service England and retains ministerial responsibility to Parliament for the provision of health services in England. However, the Secretary of State is required to "exercise the functions ... so as to ***secure*** that services are provided in accordance with this Act" (Section 1(1-3), emphasis added). The term "provide" no longer appears in relation to the specification of the statutory duties of the Secretary of State.

This change in terminology underpins the key organisational changes brought about by the reform programme, whereby the Secretary of State no longer has a direct duty to **"provide"** health services in England. Section 3 of the NHS Act 2006, which had previously vested in the Secretary of State direct statutory responsibility for providing hospital, nursing, medical, specialist and other services, was repealed by the 2012 Act. The emphasis of the "Liberating the NHS" document on "freeing the NHS from political interference" is reflected in a statutory duty on the Secretary of State to promote **autonomy** in health services. This new duty underpins the new "arms-length" model of NHS delivery and management and aims to strictly circumscribe Ministerial involvement in the day-to-day running of the NHS (that is, in the day-to-day "provision" of health services). As a result of the amendment process, the Act explicitly specifies that the Section 1 duties of the Secretary of State should take priority over the duty to promote autonomy in the event of a conflict (Section 5).

As well as amending the nature of the duty on the Secretary of State in relation to providing or securing a comprehensive health service in England, the Act imposes several additional statutory duties on the Secretary of State. This includes a duty to improve the quality of health services and to exercise responsibilities with a view to "securing continuous improvement in the outcomes" including

in relation to the effectiveness and safety of services and the quality of the experience undergone by patients (Section 2 paras. 1-3).

The Act also includes a statutory duty to "have regard to the NHS Constitution" (Section 3) and introduces the first ever statutory duties to reduce health inequalities, with the Secretary of State required to "have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service" (Section 4).

On charging, the Health and Social Care Act (2012) specifies that the services provided as part of the health service in England must be free of charge except for where charging is provided for in legislation (Section 1(4)). There is an essential continuity here with the 2006 NHS Act, which similarly specifies that health services must be free of charge but permits exceptions where these are provided for by legislation.

Commissioning, management and delivery

Following the passage of the Act, responsibility for the **provision** of health services in England is vested not in the Secretary of State but rather in a non-departmental body, the NHS Commissioning Board and a network of local clinical commissioning groups CCGs). The NHS Commissioning Board has the function arranging for the provision of health services (by commissioning primary and specialist health services) and the responsibility to "secure" other health services through the network of CCGs)). CCGs in turn have the function of arranging the provision of health services for local populations (with resources allocated to CCGs by the central NHS Board). With commissioning power vested in the NHS Board and CCGs, the 2012 Act provides for the abolition of Primary Care Trusts (PCTS) and Strategic Health Authorities (Section 33 and 34). Under Section 28 of the Act, all primary medical services providers are required to belong to a CCG, making this a compulsory rather than an optional measure. Following the passage of the Act, NHS hospitals are required to become autonomous foundation trusts with the new failure regime with an economic regulator, Monitor, responsible for regulating the nature and conditions of "exit".

The Act introduces a complex chain of duties and accountabilities which aim to ensure ultimate responsibility for health services in England resides with the Secretary of State. For example, the Secretary of State is responsible for setting a mandate for the NHS Board annually, including the specification of objectives and criteria for evaluating the delivery of objectives. Accountability is also promoted through a complex chain of statutory duties on both the NHS Board and CCGs. The NHS Commissioning Board is subject to the same duty as the Secretary of State to "continue the promotion in England of a comprehensive health service" and has duties to secure "continuous improvement in the quality of services" and to reduce inequalities between patients with respect to their ability to access health services and outcomes achieved by the provision of health services (Section 23). General duties on Clinical commissioning groups (CCGs) include the duty to promote patient involvement and patient choice; and the duty to reduce health inequalities (Section 26).

Regulation and inspection

The Act emphasises competition as well as quality regulation. An "any provider" rule aims to give a far greater role to choice and competition within the NHS. The NHS Commissioning Board, and the

Secretary of State, are explicitly prohibited from exercising their functions “to cause a variation” in the proportion of health services that are publicly or privately provided (Sections 23 and 147). Chapter 29 of the Act deals with competition. The Office of Fair Trading and the economic regulator Monitor are vested with concurrent powers to prevent anti-competitive behaviour (Section 72). Regulations in relation to procurement, patient choice and competition are provided for, including regulations to “protect and promote the right of patients to make choices with respect to treatment or other health care services”, regulations regarding anticompetitive behaviour and regulations which make requirements in relation to the competitive tendering for the provision of services (Section 75). The economic regulator Monitor is also given responsibility for regulating national prices for health services (116-124).

Enhanced arrangements for regulation and inspection include a key role for the Monitor, which has a duty to promote the provision of health services that are ”economic, efficient and effective” and which “maintains or improves the quality of the services” (Section 62). Monitor also has a function to promote integrated care (Section 62) and to co-operate with the Care Quality Commission (CQC) (Section 288). The CQC itself is retained as a quality regulator with new licensing arrangements for NHS and adult social care providers. Patient involvement is promoted through the creation of a patient user organisation, HealthWatch England, as a Committee within the CQC together with a new network of local HealthWatch bodies (Sections 181-189).

Outcomes as the “primary focus” of the NHS

The White Paper “Equity and Excellence” suggested that a central aim of the Coalition’s health reform programme would be to make “outcomes rather than bureaucratic targets” the focus of performance monitoring for the NHS. The Health and Social Care Act (2012) establish chains of accountability and responsibility between the Secretary of State and the NHS Commissioning Board that explicitly focus on “outcomes not processes”. For example, under the new arrangements for commissioning, the Secretary of State commissions outcomes from NHS England and holds commissioning board to account for the delivery of these outcomes.

An emphasis on outcome-orientated performance monitoring -reflects a medium term trend in health policy in England. The Darzi Review (DH 2008), carried out under the Labour administration, recommended the development of an outcome-orientated information base covering both clinical results and patient experience as an alternative to a top-down, target-driven approach to performance management and improving quality. Similarly, the findings of the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust (2013) are discussed below (’

Minimum standards and quality regulation: the Government’s response to the Francis Inquiry’). The Inquiry highlighted the importance of focusing monitoring, regulation and inspection on outcomes (including, inter alia, mortality ratios and patient experience data) (c.f. Vizard and Burchardt forthcoming). The new outcome-orientated frameworks have been developed following the enactment of the Health and Social Care Act (2012) – including the NHS Outcomes Framework, the Public Health Outcomes Framework and the Social Care Outcomes Framework – are important developments and take this approach forward.

Two key new outcome-orientated frameworks have been developed following the enactment of the Health and Social Care Act (2012) - the NHS Outcomes Framework, the Public Health

Outcomes Framework. These include a broad range of outcome-orientated statistical indicators for evaluating progress and are viewed as pivotal arrangements for ensuring accountability between the Secretary of State for Health and relevant commissioners and providers. The selection of indicators in the NHS Outcomes Framework reflects priorities that follow from both the Darzi Review and the Francis Inquiry including an emphasis on mortality ratios and patient experience. The Public Health Outcomes Framework builds on the social determinants of health approach set out in the Marmot Review (2010). We report against a number of the indicators in these frameworks in Section 6.

Public health and the new role for local Government

Building on the Coalition's decentralization and localization agenda, as well as the objective of increasing democratic participation and accountability, the health reform programme brought about a major new role for local government in public health. The Health and Social Care Act gives local authorities new statutory duties to promote public health. Each local authority is required to "take such steps as it considers appropriate for improving the health of the people in its area" (Section 12). New health and wellbeing boards, which are part of local authorities, have statutory duties to promote public health and to plan to meet local needs (Sections 194-196). Guidance from DH suggests that local authorities: "[S]hould embed these new public health functions into all their activities, tailoring local solutions to local problems, and using all the levers at their disposal to improve health and reduce inequalities. They will create a 21st century local public health system, based on localism, democratic accountability and evidence (DH 2012: 1).

To support these new responsibilities, the public health budget was devolved to local government in April 2013 in the form of a ring-fenced grant, with local government assuming a new commissioning role. Following the devolved of public health budgets to local authorities, a health premium that rewards good performance in tackling public health outcomes, including progress in reducing health inequalities, was announced. A health premium pilot scheme was introduced in 2014-15.

We noted in our companion paper, the need for greater local accountability in relation to improving public health outcomes and addressing inequalities was an important lesson from the 1997-2010 period. Measures were taken under Labour's third term (2005-2010) to order to better align health targets and indicators at the national levels, and to strengthen accountability for achieving population health improvements and reducing health inequalities. This included the introduction of Local Area Agreements (with indicators which were aligned with the overall system of PSAs) and which aimed, inter alia, to achieve local accountability in relation to national targets on health outcomes and health inequalities (Vizard and Obalenskaya: 15). The Marmot Review (2010) also made a series of recommendations on the need for local public action to complement national public action on public health and health inequalities.

The Coalition's health reforms introduce radical changes building on its localism agenda, with a much greater shift towards a locally driven "bottom-up" approach. The National Audit Office (2014) notes that the public health reforms reflect the idea that local authorities are best placed to make decisions about the best way to promote public health for their local populations. Within statutory constraints local authorities have decision making discretion. They are responsible for securing their

own public health outcomes and are accountable to local electorates for their decisions (NAO 2014b: 5).

The Health and Social Care (Act (2012) also created a new national executive agency for public health (Public Health England). The role of Public Health England is empowered to provide support, information, advice and influence and the performance of local authorities in securing health outcomes is evaluated by Public Health England using the Public Health Outcomes Framework. However, the formal role of Public Health in securing public health outcomes is limited. The primary levers of control are within local authority hands and NAO notes that, by design, PSE has been set up without direct, timely levers to secure the public health outcomes the Department of Health expects (2014b).

Health inequalities

The Health and Social Care Act (2012) established new statutory duties on the part of the Secretary of State, the NHS Commissioning Board (NHS England) and local commissioning groups to reduce health inequalities (see 'Political responsibility and accountability' and 'Commissioning, management and delivery' above). Equality statements have been published with NHS Outcomes and Public Health Frameworks. These highlight the statutory duties to promote equality established in the Equality Act (2010). These require public authorities (which include, inter alia, public healthcare providers, commissioners and regulators) to promote equality by different characteristics (including age, gender, ethnicity, disability, religion/belief and sexual orientation) and recognize the need for health outcome indicators to be disaggregated by these characteristics.

Figure 4: Overview of the Coalition healthcare reform programme

Overall framework of political responsibility and accountability for the health service in England

- Secretary of State retains ministerial responsibility to Parliament for provision of the health service in England;
- Services provided as part of the health service in England must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed

Duties of the Secretary of State include: to promote comprehensive NHS; to uphold the NHS Constitution; to improve quality of services "securing continuous improvement in the outcomes"; to improve public health; to reduce health inequalities; and to promote autonomy

NHS Commissioning Board (NHS England)

- Secretary of State commissions outcomes from NHS England and holds commissioning board to account
- Duties to improve outcomes + reduce health inequalities
- Functions
    - Commissions primary and specialist health services;
    - Allocate resources to local budget holders (CCGs);
    - Oversees local commissioning

Local budget holding / commissioning bodies (compulsory / time-bound, introduced April 2013)

- 211 clinical commissioning groups (CCGs) purchase services on behalf of local populations (GPs major role, multidisciplinary)
- CCG to have duties to reduce inequalities in access

Providers

- Commissioners can purchase services from **any willing provider** (includes private and third sector organisations)
- All NHS hospitals become autonomous foundation trusts (compulsory/time bound)
- New failure regime for providers that are financially unsustainable

Abolition of tiers of administration

- Abolishing Primary Care Trusts (previous commissioning bodies) and Strategic Health Authorities (provided oversight) (cut NHS administration costs by a third)

Framework for monitoring, inspection, regulation

- Quality regulation: Care Quality Commission retained + strengthened)
- Economic regulation: Monitor developed to prevent anticompetitive practices

Patient involvement

- CCGS and NHS England have duties to promote patient involvement in care
- HealthWatch England (consumer champion) and network of local HealthWatch bodies

Increased focus on outcomes

- Outcomes as the “primary focus” of the NHS
- New indicator based frameworks for monitoring outcomes (NHS Outcomes Framework, Public Health Outcomes Framework, CCG Framework)

New role for local government in public health

- Local authorities given general duties in relation to public health
- Public health budget transferred to local government (commissioning role)
- New health and wellbeing boards are part of LAs with responsibilities to promote public health / plan to meet local needs / tackle health inequalities
- New autonomous national executive agency for promoting public health (Public Health England)

Minimum standards and quality regulation: the Government’s response to the Francis Inquiry

As noted in the introduction to this paper, the need for more effective quality regulation and inspection was a key legacy issue emerging from Labour’s period in power. Reporting in 2013, the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust (2013) highlighted variations in standardised hospital mortality rates and sub-standard care. It concluded that there had been a widespread failure of the healthcare system, including regulatory as well as management failure, and put forward two hundred and ninety recommendations with the aim of ensuring the effective enforcement of fundamental standards of care in the future, including minimum standard of care and quality standards. Key recommendations were made in relation to the failure to detect poor standards of care at Mid Staffordshire and the need for enhanced systems of monitoring, inspection and regulation in the future.

In March 2013, the Government’s response to the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust (2013) announced that “quality of patient care will be put at the heart of the NHS in an overhaul of health and care in response to the Francis Inquiry” and that the Government accepted most of Francis’s recommendations either “in principle or in their entirety” (DH 2013e). A more detailed response to the Public Inquiry Recommendations was published by Department of Health in December 2013 (DH 20132013gh). As part of its response to the Public Inquiry, the Department of

Health commissioned a number of independent reviews. This included the Keogh Review (2013) which examined variations in standardised mortality rations and resulted in 11 trusts being put into special measures by Monitor and the NHS Trust Development Authority. Other reviews commissioned included the Cavendish Review (2013), which investigated what could be done to ensure that healthcare assistants treat patients with care and compassion; the Berwick Review into Patient Survey (DH 2013b); and the Clwyd and Hart Review (2013) on complaints handling. A further review of the role of standardised mortality ration in monitoring performance by Black and Darzi will report before the next General Election.

The Government's response suggested that it had accepted the vast majority two hundred and ninety Public Inquiry recommendations with only nine recommendations flagged up as "not accepted" (DH 2013h). However, some recommendations apparently accepted were not accepted in full. A number of recommendations for strengthening inspection, regulation and monitoring were partially accepted. Particular emphasis was put on the introduction of a new regulatory model under an independent Chief Inspector of Hospitals and a new ratings system for hospitals (recommendations 2-28). A proposed merger of the regulatory functions of Monitor and the CQC through the development of a single regulator was not accepted with the Government stating that co-operation rather than a transfer of functions would better achieve the desired outcomes (recommendations 60 and 61). The Government accepted in principle the need for both fundamental standards of safety and qualify (which would be enforceable) and enhanced quality standards (recommendations 13 and 14). A new duty of candour was also announced (recommendations 2 and 173-184). However, the focus has been on a *legal* duty of candour on organisations (providers) and a *professional* duty (rather than a legal duty backed by criminal sanctions) on individuals, together with a new offence of "wilful neglect" (recommendation 28). Proposals to regulate healthcare assistants were not accepted in full, with the Government putting emphasis on training and a healthcare certificate (recommendations 207-212). Transparent monthly reporting of ward-by-ward staffing levels and other safety measures were announced (2013h, Calkin 2013, BBC 2013 NAO 2014a).

As part of the overall response to the Francis Inquiry, the CQC has introduced a new inspection model and a new system of ratings building on the Public Inquiry recommendations. Sir Mike Richards was appointed as first Chief Inspector of Hospitals in 2013. Following a period of consultation and further revisions, fundamental standards of quality and safety were included in revised regulations published in November 2014. These fundamental standards are conditions of registration with the CQC covering areas such as consent, dignity and respect and protection from abuse, the fit and proper persons test, and the duty of candour[5]. The fit and proper test and duty of candour for NHS bodies came into force in November 2015; other elements of the regulations will come into force in April 2015.

The NHS Constitution was updated in order to put more emphasis on issues such as patient involvement; feedback; the duty of candour; and dignity, respect and compassion (NHS 2013a). A handbook that aims, inter alia, to set out individual rights was also published. This defines a right as "a legal entitlement protected by law". It states that the NHS Constitution sets out "a number of rights,

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[5] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Section 2 Fundamental standards, available at
http://www.legislation.gov.uk/uksi/2014/2936/contents/made, accessed December 2014.

which include rights conferred explicitly by law and rights derived from legal obligations imposed on NHS bodies and other healthcare providers” (NHS 2013b). However, these revisions did not reflect all nine of the Francis recommendations relating to the NHS Constitution (DH 2013a).

Other related initiatives include further measures to protect users from avoidable harm and to promote patient safety. A new working definition of patient experience published by the NHS National Quality Board (DH 2012a) and a White Paper ‘Caring for our future: reforming care and support’ was published in 2012 (HM Government 2012). This set out the objective of ensuring that all health and social care services treat people with respect, dignity and compassion. New policies aiming to ensure that patients and service users are treated with respect, dignity and compassion were introduced in 2013. The three year strategy ‘Compassion in Practice’ aims to ensure that staff have appropriate skills and to make it easier for staff to report concerns (HM Government 2013). A new patient feedback survey, the Friends and Family Test, asks patients if they would recommend their ward or A&E department to friends and family.

New quality guidelines have been developed by NICE in the wake of the Francis Review. In May 2014, NICE issued draft recommendations on safe staffing for nursing in adult inpatient wards in acute hospitals. These draft recommendations addressed concerns raised about the adequacy of numbers of nursing staff within the NHS and highlighted the increased of harm when the ratio of nurses to patients falls below one to eight (NICE 2012). NICE guidance establishing falling below this ratio as a “red flag” event was subsequently published (NICE 2014ab). NICE produced further draft guidance setting out safe staffing guidance for A&E in January 2015 (NICE 2015). Whilst the Government has not introduced a new national minimum staffing standard, new requirements for hospitals in England to publish monthly details of whether they have enough nurses on wards were announced in November 2013 (BBC 2013).

Other policies, strategies and measures

Additional strategies and policies listed on the DH website include “Making the NHS more efficient and less bureaucratic”; “Helping more people survive cancer”; Improving quality of life for people with long term conditions; “Making mental health services more effective and accessible”; “Improving care for people at the end of their life”; “Improving care for people with dementia”; “Helping people make informed choices about health and social care”; and “Making sure health and social care services work together”. Further early measures included the abolition of NHS Direct and the creation of NHS 111, whilst the Quality, Innovation, Productivity and Prevention Initiative (QIPP) set out plans for increasing productivity. In addition to wage restraint, the plans included reducing expensive hospital admission by involving patients in the management of conditions and treating more patients closer to home as well as exerting downward cost pressures through health commissioning. Initial plans (set out in “NHS procurement: Raising our Game”) were updated in “Creating change: innovation, health and wealth one year on”).

As noted earlier in this paper, before the Coalition cane to power, the “Nicholson challenge” highlighted the need for unprecedented efficiency savings of £15bn to 20bn over period 2011-2014/15 to offset the predicted resource squeezed (discussed above, c.f. “Inheritance”). The 2010 Spending Review suggested that £20bn in efficiency and productivity savings would be achieved over the

Spending Review Period through the Quality, Innovation, Productivity and Prevention (QIPP) initiative (HM Treasury 2010). Department of Health estimates suggested that the NHS needed to make efficiency savings of up to £20 billion in the four years to 2014-15 (House of Commons Committee of Public Accounts 2013).

Measures adopted with a view to promoting efficiency savings have included organisational change (with the elimination of PCTs and SHAs), wage restraint policies and procurement schemes (on which see c.f. 'Resources'). OECD analysis puts these measures in international context, noting that fiscal consolidation programmes which aim to reduce deficits and debts in a number of different countries have resulted in cuts in health sector workforce and salaries, reductions in feed paid to health providers and prices for pharmaceuticals, and increases in co-payments for patients (Morgan and Astolfi 2013, OECD 2014c: 12).

The sustainability of these measures, and the need for productivity gains in the NHS reflecting "genuine transformational change" is discussed below in Section 5 ('Inputs, outputs and productivity' and the Conclusion to this paper ('Challenges for an incoming Government'). Within the current period, a number of measures have also been implemented to promote integrated health and social care. The Health and Social Care Act (2012) and the Care Act (2014) both include measures to promote integrated care, including through the creation of the new Health and Wellbeing Boards (for a fuller discussion, see Burchardt et al (2015)) The Comprehensive Spending Review (2013) announced that a total of £3.8bn would be put into a pooled budget for local health and care systems, providing a new basis for health and social care services to work together to improve services and prevent hospital stays and long stays (c.f. 'Resources'). The Local Government Association and NHS England subsequently announced plans intended to "ensure a transformation in integrated health and social care" which would take full effect in 2015/16. Fourteen local pilot areas were also announced (Monitor 2014).

Two particularly controversial measures have hit the headlines in the course of 2013 and 2014. First, the issue of the central closure of local services has generated substantial media and public interest and impacted on the 2014 Local Elections in some areas. In late 2013 the Court of Appeal ruled that Hunt had acted beyond authority in attempting to cut emergency and maternity services at Lewisham hospital. Plans inserted as Clause 119 into the Care Bill that would give the health secretary greater powers to close A&E and other services caused tension within the Coalition but were ultimately voted through in March 2014 (BBC 2014).

Second, Home Secretary Theresa May flagged up in an interview with the Daily Telegraph the need "to create here in Britain a really hostile environment for illegal migration" by restricting access of non-EU nations to benefits and public services (The Telegraph, 2012). Following a period of consultation, the Immigration Act (2014) was introduced as a cross-departmental measure which limits access to health, justice, tenancy agreements, marriages and bank accounts. Under the new NHS Cost Recovery Programme, a health surcharge will result in non-EU nationals being charged 150% of the NHS tariff for hospital based health services (DH 2014a).

On public health, a White Paper *Healthy Lives, Healthy People* was published in 2010 (DH 2010b). On minimum alcohol pricing, David Cameron's announcement that the Government would bring in minimum unit pricing in March 2012 was followed a u-turn in July 2012 when the plans were dropped. However, in 2014 the Government signalled its intention to ban "deep discounting" of alcohol prices (a

measure intended to prevent supermarkets cutting the prices of alcohol to below cost price). In a further u-turn, the Government also signalled its intention to move ahead with plain, standard cigarette packaging (with the publication of draft regulations in April 2014). A free vote to allow a ban on smoking in private spaces was passed in February 2014. Regulations to ban smoking in cars where children were put before Parliament in December 2014 and will become law in October 2015 subject to a parliamentary vote before the 2015 General Election (Triggle 2014).

A strategy paper “Achieving Better Access to Mental Health Services by 2020” was published in October 2014. The paper aimed to “start” to ensure that mental and physical health services are given equal priority by 2020 and announced that the first mental health waiting time standards would be introduced in April 2015. These are: treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks; and treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis (DH 2014c).

A cancer drugs fund was established in 2010 to provide access to cancer drugs not routinely available. However, plans to restrict access to certain drugs were announced in January 2015 (BBC 2015b).

On information and transparency, the first wave of new consultant outcome data was published in November 2013. This provides a basis for comparing the performance of individual consultants comparing results for operations and treatment across a number of different specialties (vascular, adult cardiac, lung cancer, urological surgery etc). The data is publicly now available on the NHS Choices website.

New evaluations of general practices in England also were also published in November 2014. Thirty seven indicators were included in the evaluation, including evidence on patient experience, care and treatment, drawing on patient experience data (GP Patient Survey) and data from the Quality and Outcomes Framework (QOF), electronic Prescribing Analysis and Costs (ePACT), Hospital Episode Statistics (HES) and other sources. GP practics were placed into bandings from one (highest perceived concern) to six (lowest perceived concern) with 82% (6,076 practices) placed in the lowest four bands. The results will be used by CQC to inform subsequent inspection rounds (CQC 2014).

4. Resources

In this section we examine trends in resources and expenditure on health over the period 2010-2015. We begin with a discussion of trends in real public sector expenditure on healthcare in the UK. We report headline figures here for the UK and separately for England, Scotland and Wales. Trends in total (public and private) expenditure on health in the UK are then discussed and international comparisons are made with the position of the UK and other countries. Finally, the Coalition's health financing model and resource allocations formula are considered.

Trends in real public sector expenditure on healthcare[6]

Pledges in the Coalition Agreement to give relative priority to health expenditure within the overall framework of austerity and consolidation were reflected in Spending Review plans. Based on inflation forecasts at the time, the 2010 Spending Review suggested a "real terms increases in overall NHS funding in each year to meet the Government's commitment on health spending, with total spending growing by 0.4 per cent over the Spending Review period" (2010/11-2014/15). These plans for the NHS budget in England to rise every year 2010/11-2014/2015 (first year of growth between 2010/11 and 2011/12) compared with average departmental cuts of 19% over the Spending Review period. The Review noted that "some programmes announced by the previous government but not yet implemented will not be taken forward. This includes free prescriptions for people with long term conditions, the right to one-to-one nursing for cancer patients, and the target of a one week wait for cancer diagnostics". A total of £1b of the NHS budget was redirected to local authorities as funding for new ways of providing social care services, including reablement (HM Treasury 2010: 1.13, 2.10, 2.11-2.14).

The 2013 Spending Round announced further small real increases in health expenditure for 2014/5 and 2015/16 (HM Treasury 2013a). The Review announced a 10% real terms cut to administration budgets and that the resources released would be reallocated to frontline services. A total of £3.8bn was to be put into a pooled budget for local health and care systems, providing a new basis for health and social care services to work together to improve services and prevent hospital stays and long stays. A new procurement plan was announced and expected to save £1bn (HM Treasury 2013a: 2.9; c.f. 'Other policies, strategies and measures' above).

There are two main systems for reporting trends in real public expenditure on health: expenditure on services framework, based on National Accounts definitions (presentation of these

[6] In this paper, the financial year 2009/10 is taken as the final year of the Labour administration and the base year from which expenditure growth under the Coalition is evaluated. Hence:

- Change in nominal / real expenditure on health under the Coalition is calculated as change from 2009/10 to 2014/15 unless otherwise specified.
- Average real annual growth under the Coalition is calculated as the average year on year growth from 2009/10 to 2014/15 unless otherwise specified (ie the average of the growth rates in 2010/11, 2011/12, 2012/13, 2013/4 and 2014/15). This is referred in this paper as average annual growth over the period 2009/10-2014/15. Note that growth for the year 2010/11 captures the change from 2009/10 to 2010/11.
- Cumulative growth is calculated as cumulative growth from 2009/10 (base year) to 2014/15 unless otherwise specified

spending figures by function, reflect international United Nations classifications of the Functions Of Government) and the budgeting framework (reflecting domestic departmental spending arrangements). We begin here by reporting trends in real expenditure on health in the UK as a whole and for each of the four countries of the UK using expenditure on services framework. We then report trends for England based on the budgeting framework.

Real public sector expenditure on health in the UK as a whole increased from £116.9 billion in 2009/10 to £120.0 billion in 2013/14 (in 2009/10 prices) - a real terms increase of 2.7 per cent. This included real cuts in spending of 0.1% and 1.1% in the Coalition's first two years (2010/11 and 2011/12), and real increases of 1.5% and 2.4% in the subsequent two years (2012/13 and 2013/14). The average annual growth rate of real public expenditure on health in the UK as a whole over the period was 0.7%. This figure is low relative to both historical trends and the growth rates under the previous Labour administration, which averaged 5.7% a year between 1997/8 and 2009/10 (Table 1 and Appendix 1 **Table 25**)[7].

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[7] The real spending on healthcare by previous political administrations presented in Vizard and Obolenskaya (2013) differ slightly from those presented here due to revisions in HM Treasury statistics and the publication of updated GDP deflators. For example, Vizard and Obolenskaya (2013) reported average annual growth during the Labour period of 4.4%, 8.6%, 4.8% and 5.8% during the 1st, 2nd, 3rd terms and overall for the period, respectively, compared to an estimated 4.4%, 8.6%, 4.4% and 5.7% for the same periods in this report.

Table 1: Average real annual growth rate of public sector expenditure on health by political administration (United Kingdom unless otherwise stated), 1950/51 to 2014/15

	Average annual growth rate (%, real terms)
Historical trends	
Historical trend (1950/1-1996-7)	3.6
Historical trend (1950/1-2009/10)	4.0
Conservative (1979/80-1996/7)	3.3
Thatcher (1979/80-1982/3)	3.2
Thatcher (1983/4-1986/7)	2.4
Thatcher / Major (1987/88-1991/2)	3.3
Major (1992/3-1996/7)	3.8
Labour (1997/8-2009/2010)	5.7
1st term (Blair: 1997/8-2000/1)	4.4
2nd term (Blair: 2001/2-2004/5)	8.6
3rd term (Blair/ Brown: 2005/6-2009/10)	4.4
- Blair (2005/6-2006/7)	4.4
- Brown (2007/8-2009/10)	4.5
Coalition (2009/10 to 2013/14), UK	0.7
Coalition (2009/10 to 2013/14) England	0.9
Coalition (2009/10 to 2014/15), England, DEL, including planned expenditure	0.8

Sources: Authors calculations using HM Treasury (2014) and (Harker, 2011). “Historical Trends” and “Conservative” are based on the real growth rate time series in (Harker, 2011, Table 1). “Labour’ and “Coalition (2009/10 to 2013/14), UK” are calculated using nominal expenditure figures from HM Treasury (2014) and GDP deflators from HM Treasury (2014). For period “Coalition (2009/10 to 2013/14), England” – real expenditure is calculated using nominal figures from HM Treasury (2014a) and GDP deflators from HM Treasury (2014). For period "Coalition (2009/10 to 2014/15), England, DEL, including planned expenditure" - real expenditure is calculated using nominal expenditure figures and planned expenditure figures are from HM Treasury (2014) Table "1.5 Resource DEL excluding depreciation, 2009/10 to 2015-16" and GDP deflators from HM Treasury (2014).

Notes:

(a) Average annual growth rates are calculated using a geometric mean of the real annual growth rates within each time period. The annual growth rates calculated as following: annual growth rate=(present year spent-previous year spent)/previous year spent*100.

(b) Figures in “Historical Trends” and in “Conservative (1979/80-1996/97)” are in 2010/11 prices

(c) Figures in “Labour (1997/98-2009/10)”, “Coalition (2009/10 to 2013/14), UK”, “Coalition (2009/10 to 2013/14), England", and "Coalition (2009/10 to 2014/15), England, DEL" are in 2009/10 prices.

(d) Coalition expenditure growth for England 2009/10 to 2013/14 is based on HM Treasury (2014a) PESA’s expenditure framework where the figures refer to total (current and capital) identifiable expenditure on health in England for each year.

(e) Coalition expenditure growth for England between 2009/10 and 2014/15 within DEL is based on the figures in HM Treasury (2014) PESA’s budgeting framework and refers to the total Resource DEL (current and capital) excluding depreciation. Figures for 2009/10 to 2013/14 are outturn figures and 2014/15 is planned expenditure.

Table 2 reports trends in growth in real public expenditure on health, and real public expenditure on health per capita, for each of the four countries within the UK between 2009/10 and 2013/14. These figures are again based on the expenditure on services system of reporting by function. In England, there was a real increase in total expenditure on health of 3.6% over the four year period. This compares with no real change in spending in Scotland, a 4.0% decrease in Wales and a real terms increase of 4.5% in Northern Ireland.

Looking at the growth in real health expenditure per capita by country, a 0.4% increase in England compares will falls of 5.3% and 1.8% in Wales and Scotland respectively, and an increase of 2.5% in Northern Ireland. Expenditure on health per capita has remained lower in England than in the other countries in the UK (except in Wales where per capita real spending was at the same level as in England by 2013/14). The difference in expenditure on health per capita between England and Scotland decreased between 2009/10 and 2013/14 whilst the difference between England and Northern Ireland increased (Appendix 1 **Table 27**).

Table 2 Growth in real total public expenditure on health, and real public expenditure on health per capita, in England, Wales, Scotland and Northern Ireland 2009/10-2013/14 (2009/10 prices)

	England		Wales		Scotland		Northern Ireland	
	expenditure growth, %	expenditure per capita growth,%	expenditure growth, %	expenditure per capita growth,%	expenditure growth, %	expenditure per capita growth,%	expenditure growth, %	expenditure per capita growth,%
2010/11	-0.3	-1.1	0.6	0.3	-0.1	-0.7	1.8	1.1
2011/12	-0.8	-1.6	-2.9	-3.4	-0.6	-1.3	-1.0	-1.6
2012/13	1.6	0.9	-2.3	-2.6	1.0	0.7	4.5	4.0
2013/14	3.0	2.3	0.6	0.3	-0.2	-0.4	-0.7	-1.1
average annual growth, 2009/10 to 2013/14	0.9	0.1	-1.0	-1.4	0.0	-0.4	1.1	0.6
real expenditure growth 2009/10 to 2013/14	3.6	0.4	-4.0	-5.3	0.0	-1.8	4.5	2.5

Source: Authors' calculations using health expenditure data from HM Treasury (2014a, Table A11) and GDP deflators from HM Treasury (2014).

An alternative way of reporting trends in real expenditure on health uses the budgeting framework rather than the expenditure on services framework. The budgeting framework underlies the plans set out in the Comprehensive Spending Review and is the reporting mechanisms reflected in key Department of Health publications such as the Department of Health Annual Accounts (DH 2014d).

Table 3 reports trends in real public expenditure on NHS health in England within Departmental Expenditure Limits (DEL) over the period 2009/10 to 2014/15 based on both outturns (2009/10 – 2013/14) and plans (2014/15). Restricting the analysis to outturns data, real expenditure on health in England increased over the period 2009/10-2013-14 by 3.3%. Incorporating information about plans as well as outturns, real year on year growth in public expenditure on health in England is expected to be small but positive in each of the years 2011/12, 2012/13, 2013/14 and 2014/15. The increase in real growth in public expenditure on health in England over the Coalition period as a whole (2009/10-2014/15) is estimated as 4.2%. Average annual real growth over the period 2009/10-2014/15 is estimated as 0.8% (that is, a small but nevertheless positive figure).

Table 3 Trends in real public expenditure on health in England 2009-10 to 2014-15 (budgeting framework, within DEL, outturns and plans)

	2009-10 outturn	2010-11 outturn	2011-12 outturn	2012-13 outturn	2013-14 outturn	2014-15 plans
nominal spending (£m)	98,419	100,418	102,844	105,222	109,721	113,035
real spending, 2009/10 prices (£m)	98,419	97,862	98,009	99,204	101,693	102,509
year on year real increase (%)		-0.57	0.15	1.22	2.51	0.80
average annual increase, 2009-10 to 2014-15 (%)				0.8		
cumulative real growth from 2009-10		-0.6	-0.4	0.8	3.3	4.2

Source: Authors' calculations using nominal NHS (Health) spending figures including plans for 2014/15 from HM Treasury (2014) PESA, table 1.10 and GDP deflators from HM Treasury (2014) with reference year changed to 2009/10.
(1) Total DEL is given by Resource DEL excluding depreciation (Table 1.5) plus Capital DEL (Table 1.8), HM Treasury (2014)
(2) Nominal planned spending for 2014-15 consistent with Tables 1 and 2 of the Spending Round 2013 document (Cm8639) published on 26 June 2013.
(3) Average annual increase between 2009/10 and 2014/15 is a geometric mean of 2010/11 to 2014/15 annual real growth in spending

With inflation below the levels anticipated at the time of the 2010 Comprehensive Spending Review, growth in health expenditure in England is expected to outpace the rates set out in the initial budget plans discussed above. The 2010 Spending Review suggested a 0.4% real increase in spending between 2010/11 and 2014/15 for England. However, the growth rate for this period has been higher than this figure (based on the outturn figures for up to 2013/14 and revised plans for 2014-15). Adopting 2010/11 as a base year for calculations, expenditure on health in England (within

DEL) is expected to increase in real terms by 4.7% over the period 2010/11-2014/15, with an average annual growth rate of 1.17% over this period (Table 4).

Table 4 Total Departmental Expenditure Limits (DEL) – NHS Health, England, 2010/11-2014-15

	2010-11 outturn	2011-12 outturn	2012-13 outturn	2013-14 outturn	2014-15 plans
Year on year real increase in NHS (Health) (%)		0.15	1.22	2.51	0.80
Average annual real increase 2010/11 to 2014/15 (%) Average annual increase 2010/11-2014/15		1.17			
Cumulative real growth from 2010/11 (%)		0.2	1.4	3.9	4.7

Source: Authors' calculations using nominal NHS (Health) spending figures including plans for 2014/15 are from HM Treasury (2014), PESA, table 1.10 and GDP deflators from HM Treasury (2014) with reference year changed to 2009/10.
(1) Total DEL is given by Resource DEL excluding depreciation (Table 1.5) plus Capital DEL (Table 1.8), HM Treasury (2014), PESA
(2) Resource DEL excluding depreciation is the Treasury's primary control total within resource budgets and the basis on which Spending Review 2010 settlements were made.
(3) Average annual increase between 2010/11 and 2014/15 is a geometric mean of 2011/12 to 2014/15 annual real increase in spending

Pledges to give relative priority to health within the overall framework of fiscal consolidation have also been met, with the relative importance of healthcare spending, defined as proportion of total spending on public services, increasing since 2010 in comparison to earlier periods. In the last year of Labour in Government, 2009/10, the proportion of public spending that went on health in the UK was 18.2%; by 2013/14 it rose to 18.9%. Similarly, the share of health in Total Managed expenditure has increased from 17.4% in 2009/10 to 18.1% in 2013/14. Conversely, there has been a small decline in public expenditure on health as a percentage of GDP (from 8.2% to 7.9%). However, this percentage remains high in historical terms, with only Labour's last year in office witnessing a higher figure (Appendix Table 25).

Estimates of the funding gap by 2020

Yet as we show below, these historically low patterns of expenditure raise the spectre of funding not keeping up with need / demand pressures over the current Parliament and beyond. A range of authoritative forecasts paint a bleak picture in terms of the extent of the medium term funding gap that will impact on the NHS in the period up to 2020 (Appleby et al 2009; Nuffield Trust 2012; OBR 2011, 2012, 2013; Crawford and Emmerson 2012; Appleby 2013; Buck and Dixon 2013; Monitor 2013; Barker 2014). Exercises of this type apply a range of different projections for demographic

change, morbidity, income, growth, technological change, costs including pay and the management of chronic conditions, inflation and productivity gains. Some (e.g. Wanless 2002) have also introduced a range of assumptions about health related behaviours.

An estimated 1.2 - 1.5% per annum increases in real funding is required by demographic pressure alone[8]. The OBR central projection is that UK spending would have to increase by an average of 2.9 per cent a year in real terms if spending as a share of national income per capita was to be held constant (OBR 2011, 2012, 2013). Nuffield Trust analysis suggests that pressures on the NHS will grow at a rate of 4% per annum in the period to 2021 when additional factors are taken into account (Nuffield Trust 2012). Based on this assumption about the growth of demand / need, Nuffield Trust analysis suggests that if the growth in NHS real spending continues to be held flat beyond the current period, the NHS in England could experience a funding gap of £28 to £34 by 2020/21 unless offsetting productivity gains and funding increases are achieved (assumes the current round of QIPP efficiency savings to 2014/15 are achieved; Nuffield Trust 2012). In late 2013, Monitor published 'Closing the NHS funding gap: how to get better value healthcare for patients' (Monitor 2013). The regulator warned that for the decade ahead "the NHS budget is likely to remain flat in real terms or, at most, to increase in line with growth in the rest of the economy" whilst demand would increase. The funding gap could potentially amount to £30 billion a year by 2021 in the absence of off-setting productivity and funding increases (Monitor 2013). The NHS Five Year Forward View (NHS 2014) draws similar conclusions.

Trends in total (public and private) expenditure on health

ONS data suggests that total (public and private) expenditure on health in the UK fell in real terms between 2009 and 2012 from £142.2 billion to £139.2 billion (a real terms decline of £3bn, 2010 prices). Total expenditure on health as a percentage of GDP fell from 9.7% to 9.4% between 2009 and 2010, followed by a further drop to 9.2% in 2011 and remaining at that figure in 2012 (Appendix 1,**Table 26**).

The share of public expenditure within total health expenditure in the UK rose from 83.2% in 2009 to 84% in 2010 and remained at this level in 2012. The share of private expenditure in total expenditure on health fell from 19.6% in 1997 to 16.8% in 2009 (although with some increases in the interim years) with a further fall after the Coalition came to power to 16% in 2010. Following a slight rise in 2011, this percentage fell back again to 16% in 2012 (Appendix 1, **Table 26**).

Relative shares of public and private expenditure within total expenditure on health in the UK have been affected by falls in real private expenditure on health following the downturn. Private

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[8] Crawford et al (2014: 44) suggest that an average growth rate of real expenditure on health of 1.2% per annum is required by population growth and demographic change between 2010/11 and 2018-19 (with the level of spending for each person of a given age were held constant in real terms). Planning assumptions by NHS England (NHS England 2014g: Appendix A) are based on demographic pressures of 1.5% -1.7% in 2013/14 in different expenditure areas. Non demographic pressures are cited as ranging from 0.9% to 3.4% in different expenditure areas. Similar pressures are assumed for 2014/15. For CCG Programme Costs (the biggest allocation), demographic pressures are assumed at 1.5% and non-demographic pressures at 0.9% for both years.

expenditure on health in the UK fell from £25.3 billion in 2007 to £22.3 billion in 2010 (Appendix 1, **Table 26**, 2010 prices). Prior to the financial crisis and economic downturn that began in Autumn 2007, spending on private medical insurance was increasing in real terms. Laing and Buisson attributed contractions in 2009 and 2010 to recessionary pressures. Following the General Election, the demand for private medical cover rose from 3,962,000 subscribers in 2010 to 4,032,000 in 2012 (1.8%) whilst spending on private medical insurance remained broadly constant (Laing and Buisson 2012; Laing and Buisson 2014).

International comparisons

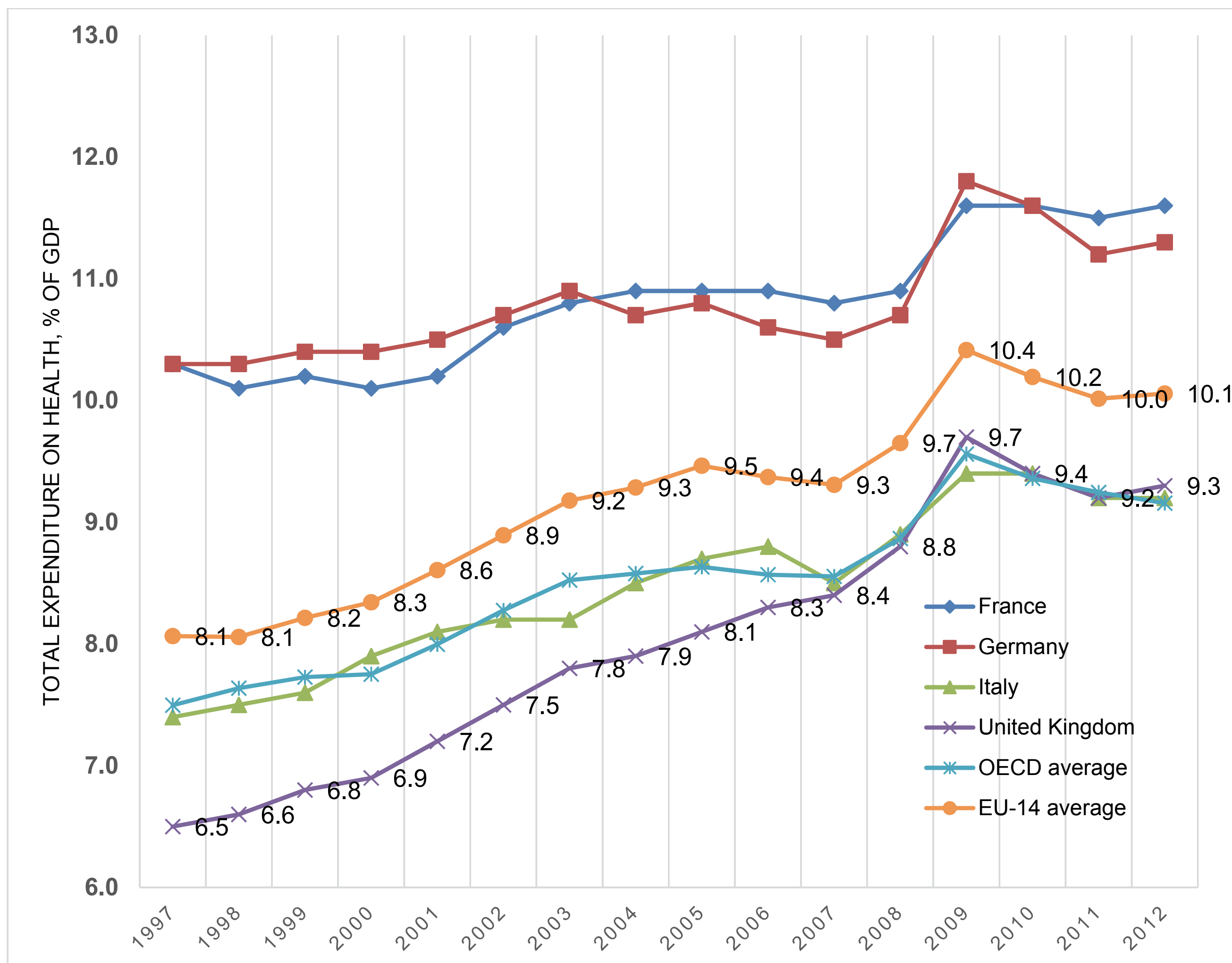
Other countries have also experienced fiscal adjustment and the need to reduce deficits and debt over the period. OECD analysis highlights pressure on health care budgets following the crisis throughout Europe. Health budgets were maintained in many countries at the beginning of the crisis and peaked in 2009. However, growth in health spending per capita slowed or fell in real terms in 2010 in almost all European countries, reversing a trend of steady increases in many countries. By 2012 though, growth rates were increasing again in a number of countries. In some countries severely affected by the recession, the proportion of public spending in total (public and private) healthcare financing was contained or cut (OECD, 2011, 2012, 2014c; Morgan and Astolfi, 2013, Morgan and Astolfi, 2014, Eurofound 2013).

Looking at the UK's expenditure on health relative to other European countries, there are some signs of slippage over the period 2009-2012. OECD data covering total (public and private) real expenditure on health can be used to compare health expenditure in the UK with the position in other countries[9]. Total average healthcare spending in the EU-14 countries was 10.4% of GDP in 2009, slightly above the figure in the UK (9.7%) By 2012, total (private and public) expenditure on healthcare as a percentage of GDP in the UK was down 0.4 percentage points to 9.3%. The EU-14 average followed a similar pattern with total healthcare spending as a share of GDP falling by 0.3 percentage points between 2009 and 2012. As a result, the gap between the UK and the EU-14 average was 0.7 percentage points in 2009 and 0.8 percentage points in 2012 (Figure 5)[10]. However, whereas in some OECD countries the share of public expenditure in total expenditure fell, in the UK, this share increased (**Table 26**).

[9] Some of the figures for the UK presented in this section differ very slightly to one decimal place to those presented in the previous section. The current section is based on data from the OECD database whereas the figures in the previous section are based on data published by ONS.

[10] The percentages have been calculated using data from the OECD Health Statistics database accessed in August 2014, with a EU-14 and OECD averages calculated as a simple average of the total healthcare expenditure to GDP ratios using non-missing data.

Figure 5: International comparisons of total (public and private) expenditure on health as a percentage of GDP, 1997 to 2012

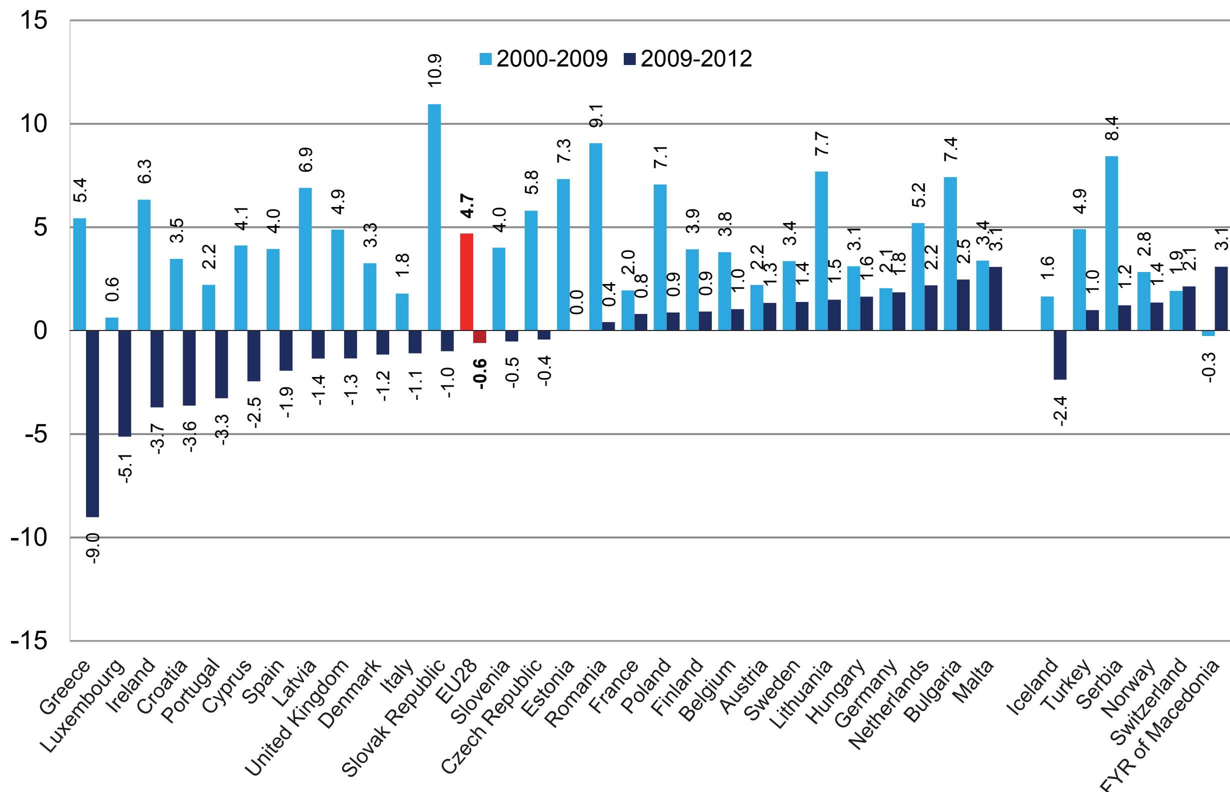


Source: OECD (2014a)
Notes:
a. EU-14 average is an arithmetic average for the EU-15 countries excluding UK, based on non-missing data. 2012 figure is based on non-missing figures for OECD counties in 2012 for all countries except Netherlands, Portugal and Spain for which 2011 data was used.
b. OECD average is an arithmetic average for the OECD countries excluding UK. 2012 figure is based on non-missing figures for OECD counties in 2012 for all countries except Australia, Netherland, New Zealand, Portugal and Spain for which 2011 data was used.

Table 5 reports OECD data on the change in the average annual growth rate in real health expenditure per capita in European countries over the period 2009 to 2012. Real health expenditure per capita fell in half of EU countries and significantly slowed in the rest over this period, with average decreases of 0.6% per annum. Whilst the reduction for the UK was smaller than that in a number of countries very hard hit by the recession, the decline in the UK was greater than the EU28 average and there is a notable contrast with comparator countries such as France, Germany and the Netherlands,

where average annual growth in per capita spending was positive. According to the OECD figures, the level of per capita expenditure on health in the UK in EUR PPP terms was lower than in France, Germany, Netherlands or Sweden in 2012.

Table 5 Annual average growth rate in per capita health expenditure, real terms, 2000 to 2012 (or nearest year, percentages)



Source: OECD 2014c: Figure 6.1.2.

The Coalition's health financing model

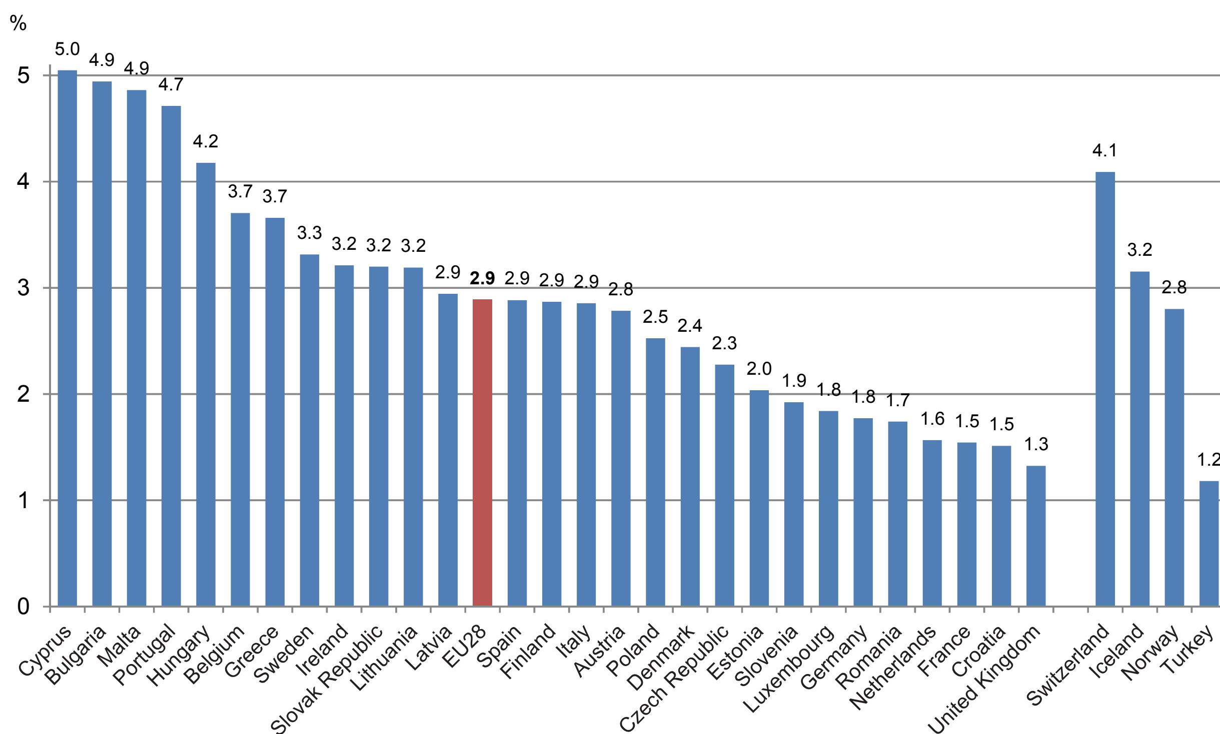
There have been no significant changes in the health financing model in England since 2010. There has not been a move towards alternative financing arrangements such as a hypothecated health tax or a social insurance model and it remains funded through general taxation, albeit with an increasing role for national insurance. The overall share of patient charges in NHS financing remains relatively low and there has been no general move to hotel charges or charges for GP consultations or A&E attendance.

The proportion of income from receipts from National Insurance remained stable at 17.9% during the Coalition's first two years in government. The share of NHS funding that came from receipts from taxation and patients' payments also remained unchanged (Appendix 1, **Table 28**). Receipts from patient charges dropped overall in real terms from £1,492m in 2009/10 to £1,465 in 2011/12 (2009/10

prices). Receipts from prescription charges fell slightly, while there were small increases in receipts from both hospital and dental charges (Appendix 1, **Table 29**).

In some countries, the recession and crisis has resulted in more reliance on private expenditure on healthcare, including out-of-pocket payments for health. For example, in Ireland, the proportion of public spending in healthcare financing has fallen, whilst out-of-pocket payments as a proportion of total expenditure on health have risen since 2007. In The UK, the share of out-of-pocket payments in total expenditure on health has been declining since 1997. This trend continued after the onset of recession and crisis in 2007, although with apparent small upturn after 2010 (OECD 2014b). Indeed, in 2012, out-of-pocket medical spending as a share of final household consumption in the UK was lower than in any other EU 28 country (at 1.3%) (**Figure 6** and OECD 2014c: 111).

Figure 6: Out-of-pocket medical spending as a share of final household consumption in Europe, 2012 (or nearest year)



Source: Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en.; Eurostat Statistics Database and WHO Global Health Expenditure Database for non-OECD countries.
Note: This indicator relates to current health spending excluding long-term care (health) expenditure.

Resource allocation funding formula

Following the enactment of the Health and Social Care Act (2012), the vast majority of the Department of Health resource allocations flow to NHS England. In 2013/14 (and in 2013/14 prices), of the £111.4 billion allocated to the Department of Health, £95.6 billion was allocated to NHS England and £15.7 billion to DH's other agencies and programmes (including £2.7billion for public health budget allocated to 152 local authorities via Public Health England). The NHS England budget (£95.6 billion) was then allocated between central functions (including the commissioning of public health services, £1.8bilion) and primary care, specialized care, military care and offender care (25.5billion, including £360million to fund public health activities through primary care), £65.6 billion allocated for local commissioning (£63.4 billion allocated to 211 local CCGs) and services that benefit both health and social care (£0.9billion, allocated to local authorities) (NAO 2014a). The proportion retained by the centre for central commissioning is arguably higher than might have been anticipated from initial plans.

The organisational changes brought about by the Act meant that a funding formula to allocate resources to the newly created CCGs was required. The previous formula for allocating resources to PCTs (the so called weighted capitation formula) was discussed in our companion paper (Vizard and Obolenskaya 2013). This aimed to allocate resources in a way that eventually secures 'equal opportunity of access for people with equal need across the country'. The formula took account of a range of variables including the size of a local population, gender age, need, area deprivation, costs and, by the end of Labour's period in power, included a health inequalities component which was given a 15% weighting within overall formula. Allocations to each PCT moved towards a needs-based target allocation over time ('determined by a pace of change' formula). Prior to the 2010 General Election, the rate of progress towards target formula had been criticized for being too slow, resulting in a continued misalignment between resource allocations on the one hand and need on the other.

The development of a new funding formula in the current period has proved controversial. The debate encapsulated the basic dilemma of whether to give more weight in the formula to age, reflecting the higher needs of older populations but meaning that additional funds flow to areas in the South population where populations on average are older) OR more weight to health inequalities (allocating additional funds to the North where fewer people live to an older age, but health outcomes and unmet health needs are worse). Initial proposals by the Advisory Committee on Resource Allocation (ACRA) to allocate funds to CCGs using the so-called "Nuffield formula" (developed by Nuffield Trust) gave more weight to age. However, NHS England highlighted the new statutory duty to reduce health inequalities and raised concerns that ACRA's recommendations would move funding away from the north of England and London towards the South, East of England and Midlands (Wood and Heath 2014).

The controversies meant that the old formula (with an up-rating) was used to allocate funds for the year 2013/14. Following a fundamental review of funding formulae, an NHS England Board paper set out recommendations for allocating resources for 2014/15 and 2015/16. The formula applied reflected three main factors in healthcare needs: population growth, deprivation and the impact of an ageing population. It further (re)introduced a weighting for "unmet need" (based on the standardised mortality ratio) − intended to tackle health inequalities − in the formula for CCG allocations. The Board suggested that the new formula strikes an appropriate balance between deprivation and other factors and that its application leaves "the most deprived and the least deprived areas in a broadly similar position, but the gradient between them becomes flatter, reflecting amongst other factors a more

nuanced approach to the reflection of local deprivation and differential rates of population growth in recent years (NHS England 2014g). Nevertheless, the slow pace of change towards target allocations remains an important critique (Glennerster 2014). Further details of the new funding formula are provided in NHS England Analytical Services (Finance) (2014).

In the context of public health, resource allocation has been less controversial. A new public health formula was developed with funds explicitly targeted at areas with the poorest health outcomes. In line with ACRA recommendations, the new public health resource allocation formula includes a needs based component based on the under 75 standardised mortality ratio. This is applied at the MSOA level to take account of inequalities within local authorities as well as between local authorities (DH 2013c). Like the funding formula for CCGs (and previously PCTs), the public health formula allocates resources based on a target, with funding more targeted on local needs over time. In December 2014, a NAO evaluation of Public Health England described funding allocations as moving “slowly to promote stability of existing services”, with 51 of 152 local authorities finding themselves more than 20% from their target allocation in 2013-14, decreasing to 41 for 2014/15 and 2015/16 (NAO 2014:6).

5. Provision

In this section we consider the nature of healthcare provision and what was achieved with the national resources allocated to health over the period 2010-2015. We bring together findings on inputs, outputs and productivity, and examine how growth in volume expenditure compared with that of demand and need. Finally, there is a discussion of the balance of public, private and voluntary provision.

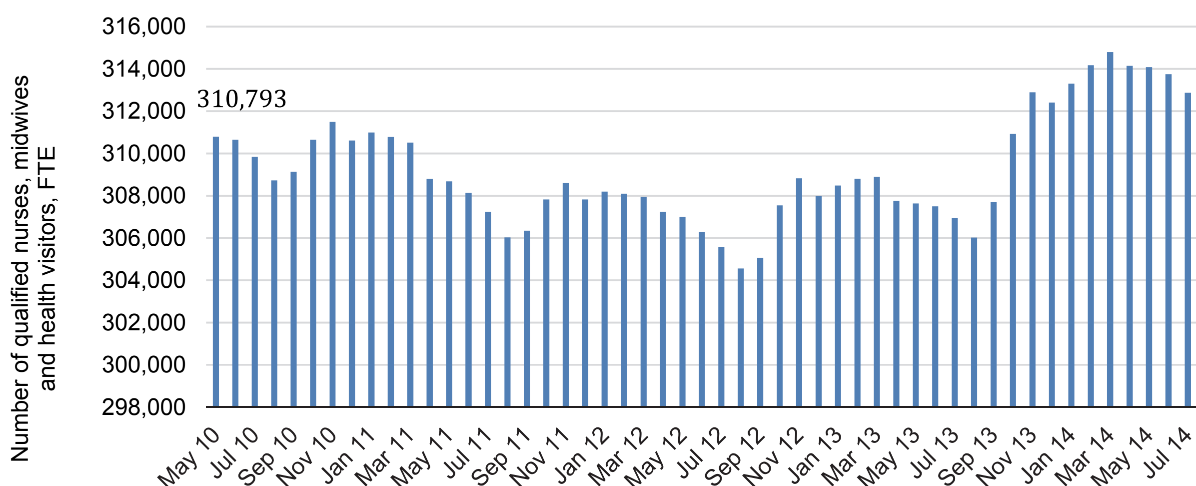
Inputs, outputs and productivity

Inputs

Health **inputs** include labour inputs (nurses, GPs, consultants, managers etc.), goods and services (prescribed drugs, clinical supplies used in hospitals and GP surgeries etc.) and capital used to produce health care (e.g. buildings, computers and machinery). The number of full time equivalent doctors increased after 2010 although the trend has tailed off during 2014 (HSCIC 2014). Initial reports following the 2010 General Election suggested a fall in the number of nurses. However, increasing the ratio of nurses was a key recommendation in the Francis Review and the latest data suggests an upturn after November 2013. As noted in King's Fund (2014), the number of managers has fallen considerably since May 2010. Estimates by Bojke et al (2014) suggest that overall input growth was positive in both 2009/10-2010/11 and 2010/11-2011/12. However, both growth rates were substantially below average growth in inputs in a time series going back to 2004/5-2005/06 (for details, see

Table 6 below).

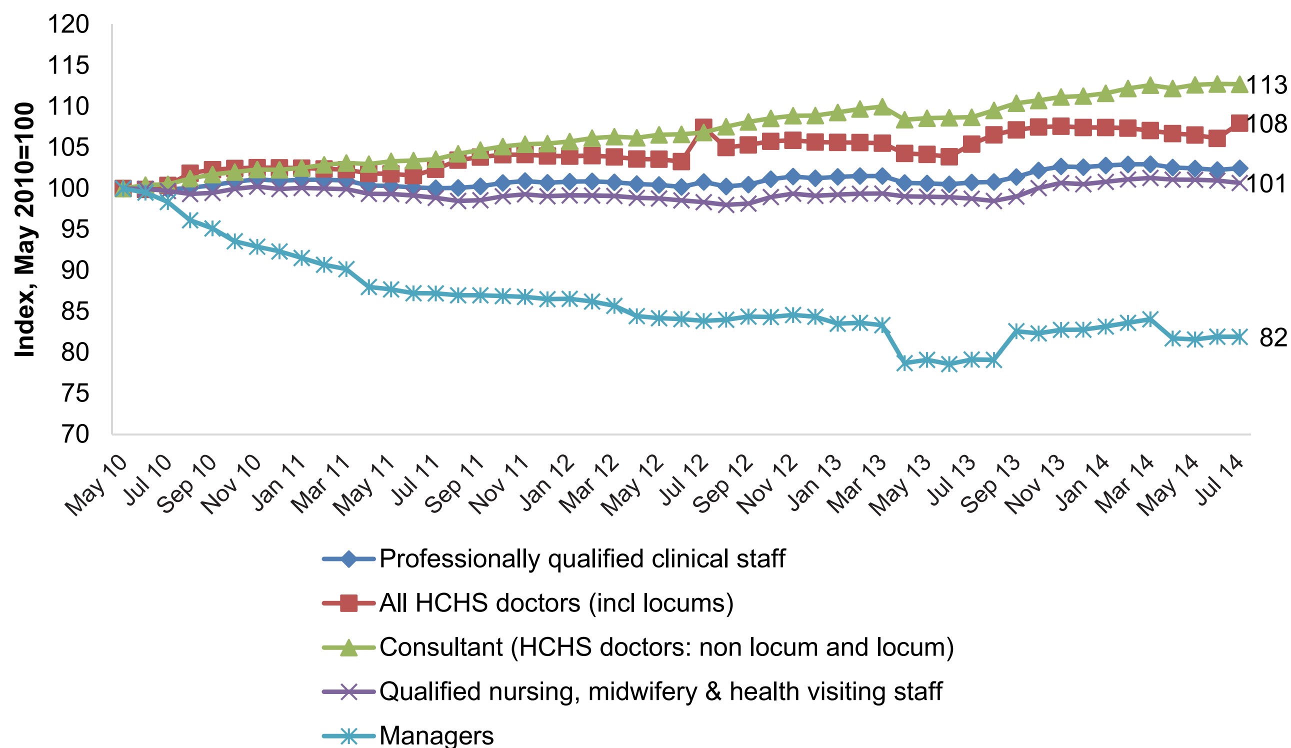
Figure 7 Number of full-time equivalent (FTE) qualified nursing, midwifery and health visiting staff, HCHS workforce, May 2010 to July 2014 (England)



Source: HSCIC (2014), National Table (excel)

Notes: Monthly Hospital and Community Health Services (HCHS) workforce statistics using data from the Electronic Staff Record (ESR). The figures do not include data for GP practice nurses.

Figure 8 Number of full-time equivalent (FTE) staff, HCHS workforce, index numbers, May 2010 to July 2014 (England)



Source: HSCIC (2014)

Notes
1) Professionally qualified clinical staff includes all Doctors (incl. locums) and all qualified non-medical staff
2) These statistics relate to the contracted positions within English NHS organisations and may include those where the person assigned to the position is temporarily absent, for example on maternity leave.
3) Full Time Equivalent (FTE) refers to the proportion of each role's full time contracted hours that the post holder is contracted to work. 1 would indicate they work a full set of hours, 0.5 that they worked half time.

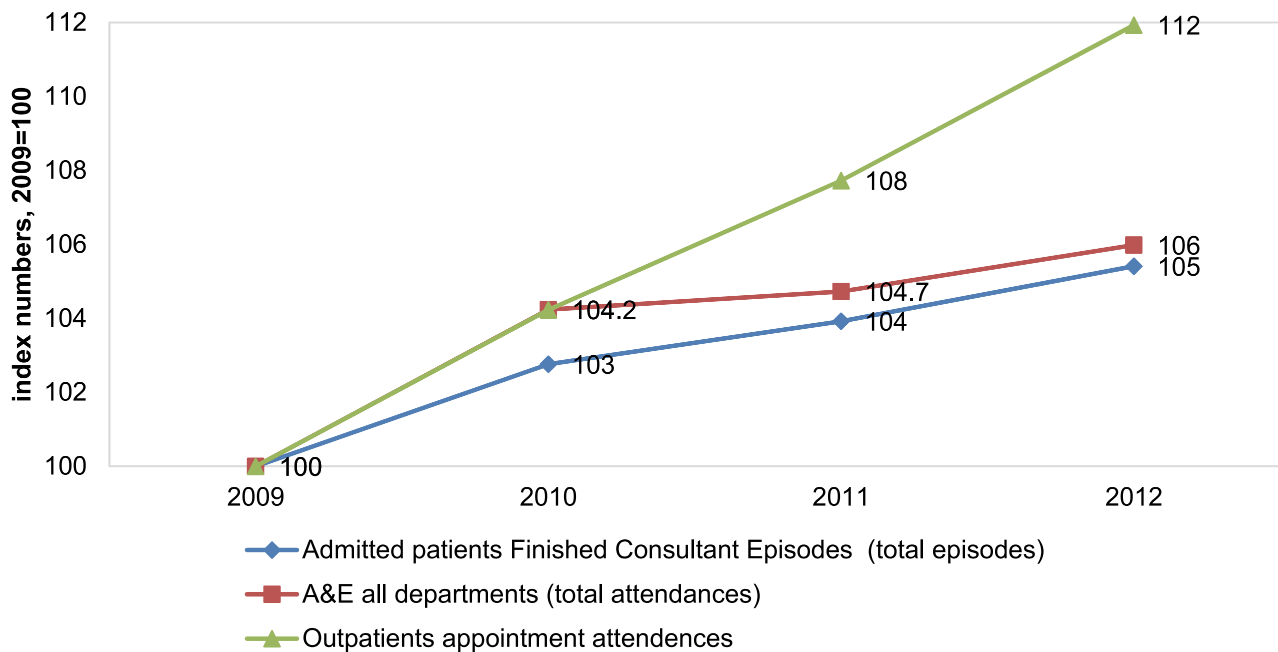
Outputs

Health **outputs** include activities such as hospital inpatient activities, A&E attendances, GP consultations and community care activities. Hospital activities as measured by finished consultant episodes and outpatient and A&E attendances continued to rise after 2009/10 (Figure 9). Estimates by Bojke et al (2014) suggest that overall output growth was positive in both 2009/10-2010/11 and 2010/11-2011/12. However, the increases were below average growth in outputs in a time series going back to 2004/5-2005/06 (for details, see

Table **6** below). The estimates provided reflect changes in the quantity of outputs (activities undertaken) but also incorporate a quality adjustment (with rescaling to account for, inter alia, changes

in post-operative 30 day survival rates, waiting times and, in the context of primary care, Quality and Outcomes Framework indicators).

Figure 9 Finished consultant episodes, outpatient appointments attendances and A&E attendances, 2009 to 2012, indexed



Source: A&E: NHS England (2014c); Admitted patients Finished Consultant Episodes: HCHS (2013c); Outpatients appointment attendances (HCHS 2013d).
Notes: data for admitted patients' episodes and outpatients appointments attendances are based on fiscal years and for A&E attendances on calendar years

Productivity

Health **productivity** is measured by the ratio of health outputs to health inputs. At the time of writing, official ONS estimates of healthcare activity only date to 2010. In the broader literature, Bojke et al (2014) report find positive productivity growth over the period 2009/10-2010/11 and 2010/11-2011/12. They note that this finding is a function of the below average output growth combined with a substantially below average growth in inputs examined in the subsection above. These trends are reflected in the data presented in

Table **6** [11]. Analysis by Bojke et al (2010) highlights regional variations in productivity performance, underlining the potential for productivity gains amongst bodies performing less well.

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[11] These findings are robust to different methodological assumptions regarding the development of input growth. However, the authors highlight two possible limitations. First, reclassification and recording practices mean that community health outputs are not included in measured output and productivity. Second, organizational reforms may have resulted in underreporting of some activities,

Table 6 NHS outputs, inputs and productivity growth 2004/5-2011/12 (summary of estimates by Bojke et al (2014))

	Input growth		Output growth		Productivity growth	
	Mixed	Indirect	Cost-weighted growth	Quality adjusted cost-weighted growth	Mixed	Indirect
2004/5-2005/6	7.19%	7.10%	6.53%	7.11%	-0.07%	0.01%
2005/6-2006/7	1.92%	1.36%	5.88%	6.50%	4.50%	5.07%
2006/7-2007/8	3.88%	3.70%	3.41%	3.66%	-0.21%	-0.04%
2007/8-2008/9	4.23%	4.24%	5.34%	5.73%	1.44%	1.43%
2008/9-2009/10	5.43%	5.83%	3.44%	4.11%	-1.25%	-1.63%
2009/10-2010/11	1.33%	0.80%	3.61%	4.57%	3.21%	3.74%
2010/11-2011/12	1.00%	0.75%	2.38%	3.15%	2.13%	2.38%

Source: Bojke et al (2014:10,18,25)

The concept of productivity is broader than that of efficiency savings. As noted above ('Other policies, strategies and measures' and 'Trends in real public sector expenditure on healthcare'), the 2010 Spending Review suggested that £20bn in efficiency savings would be achieved over the Spending Review Period through the Quality, Innovation, Productivity and Prevention (QIPP) initiative (HM Treasury 2010) and DH estimates suggested that the NHS needed to make efficiency savings of up to £20 billion in the four years to 2014-15 (House of Commons Committee of Public Accounts 2013). Whilst the latest Kings Fund quarterly monitoring report highlights deep pessimism as to whether the Nicholson challenge will be met (Kings Fund 2014), latest reports indicate that the NHS is on target to make £20b efficiency savings by end of this Parliament (Keogh 2014, BBC 2014b).

Measures adopted with a view to promoting efficiency savings have included organisational change (with the elimination of PCTs and SHAs), wage restraint policies and procurement schemes. Monitor estimates that the NHS wage freeze together with a subsequent 1% cap on wages until 2014/15 (if maintained) would save the NHS £5 billion in total (Monitor 2013). The reform programme itself was predicted to make substantial savings and to make an important contribution to the overall efficiency savings drive. NAO (2013) reported that the reforms were expected to reduce administration costs by a third, contributing to overall measures to achieve efficiency savings of £20b in the period to 2014/15. Departmental figures suggested savings of £2.4 billion in reduced administration costs up to March 2013 (NAO 2013).

Reporting in 2013, the House of Commons Public Accounts Committee highlighted Department of Health figures which suggested that the NHS made savings of £5.8 billion in 2011-12, virtually all of that year's forecast of £5.9 billion, and that projected savings by end of 2012-13 would

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meaning that the reported productivity growth figures may be underestimates. See Bojke et al (2014) for further details.

total £12.4 billion. However, the Committee raised a number of key concerns including the concern that data on efficiency savings is unreliable and concerns that the efficiency drive could be affecting the quality of care. Further concerns were raised around the means by which efficiency savings were being achieved. In particular, the Committee raised the concern that savings were being made through rationing (for example, of cataract surgery and hip and knee replacements), pay freezes and lower prices rather than through "genuine service transformation" including service centralisation (as in the case of stroke care in London) or providing more community-based care.

> "Most of the savings to date have been achieved through freezing the pay of NHS staff and reducing the prices paid for healthcare. The more challenging, and risky, part of the efficiency drive requires transformation in the way health services are actually provided. Over the four years to 2014-15, such transformational changes are expected to generate 20% of the total savings, but the Department expects that by the halfway stage—the end of 2012-13 - just 7% (£875 million) of savings will have been generated in this way (House of Commons Committee of Public Accounts 2013)".

DH (2014d) suggests that Revenue DEL administration costs (covering costs within the DH, the commissioning sector (NHS England and Clinical Commissioning Groups) and all of the Department's arms length bodies) declined since 2010/11 and notes that costs in 2013-14 were lower than forecasts had predicted. This trend is partly explained in terms of the Health and Social Care Act 2012 reforms delivering faster administration reductions than anticipated. DH (2014d) further notes that the department is on track to deliver the one third real-terms reduction to total administration costs as per the original request in the 2010 Spending review (DH 2014d).

In estimating total savings over the Parliament, savings from reduced administration costs must be subtracted from the total costs of implementing the reform programme. These have been widely cited in the press as amounting to £3 billion. In July 2013, NAO (2013) reported that, based on Department of Health figures, the cost of the reform programme was £1.1 billion to 31st March 2013 (15% above the cost estimated by that date). Forty-four per cent of these costs related to the closure of strategic health authorities and primary care trusts, and 36 per cent to setting up NHS England and CCGs. NAO reported that according to the Department of Health, the best estimate of the total costs of the reforms was £1.5 billion and that the total cost 'would not exceed' £1.7 billion. The costs of 10,000 redundancies accounted for 40 per cent of costs to the end of March 2013, around 2,200 of whom were subsequently re-employed. Based on the Departmental figures, NAO found that 'the estimated costs are outweighed by the estimated savings in administration costs arising from the reforms" (NAO 2013).

The NHS Five Year Forward View (NHS 2014) reports that "on one measure the health service has become £20 billion more efficient". The Forward View cites the longrun figure of 0.8% productivity gains annually based on estimates by the Office for Budget Responsibility. It suggests that productivity growth has been nearer to 1.5%-2% 'in recent years' and that increases of 1.5% annually will be required in the next Parliament in order to offset the financial squeeze.

Appelby et al (2014) also highlight variations in productivity amongst different providers and the potential for productivity gains. The authors suggest that, whilst not easy to verify, a combination of

pay restraint, cuts in central budgets, and the abolition of some tiers of management have delivered significant savings over the two financial years since 2010/11. However, the authors suggest that current productivity levers (including wage freezes and downward pressure on NHS tariffs) are not sustainable. Looking to the future, they argue that meeting productivity challenges will require genuine transformational change. This in turn will require time; resources for investing in new models of primary and community care and short-term support where organisations face financial difficulties); and measures to support change and value for money (including a more consolidated national focus to consolidate good practice).

The recent NHS Five Year Forward View (NHS 2014) also highlights the need for 'genuine' transformational change rather than a continued reliance on wage freezes in achieving productivity gains in the future. The Forward View mapped out a series of proposed care models that could be effective in delivering productivity gains in the next Parliament, as well as emphasizing the importance of controls on the demand side, addressed through a preventative health agenda. These are examined in the concluding section of this paper ('Challenges for an incoming Government').

The broader international context for these measures is examined in Morgan and Astolfi (2014). The authors highlight that internationally, many health systems are being restructured as part of broader attempts to reduce deficits and debts in the wake of economic crisis and downturn. Different levers being adopted internationally include reducing spending, restricting health care coverage, controlling costs (wages, drugs, administration) and / or trying to do "more for less" (including shifts to more private provision where this is more productive). Whilst many countries are cutting back public health protection and promotion as part of these overall packages, demand management policies and strategies are likely to be necessary in the medium term.

Supply, demand and need

Figure 10 shows trends in the growth in volume public expenditure on health compared with growth in national income and demographic pressure in the UK as a whole over the period 1997/8-2013/14. Growth in volume public expenditure on health outstripped growth in real GDP and real household disposable income over this period as a whole by a considerable margin (both in terms of real growth and real growth per capita). Growth in volume public expenditure on health also outstripped other common indicators of need, such as growth of over 65s and growth of over 85s in the population.

Figure 10 Growth of healthcare supply compared with national income, need and demographic pressure, United Kingdom, 1997/98 to 2013/14

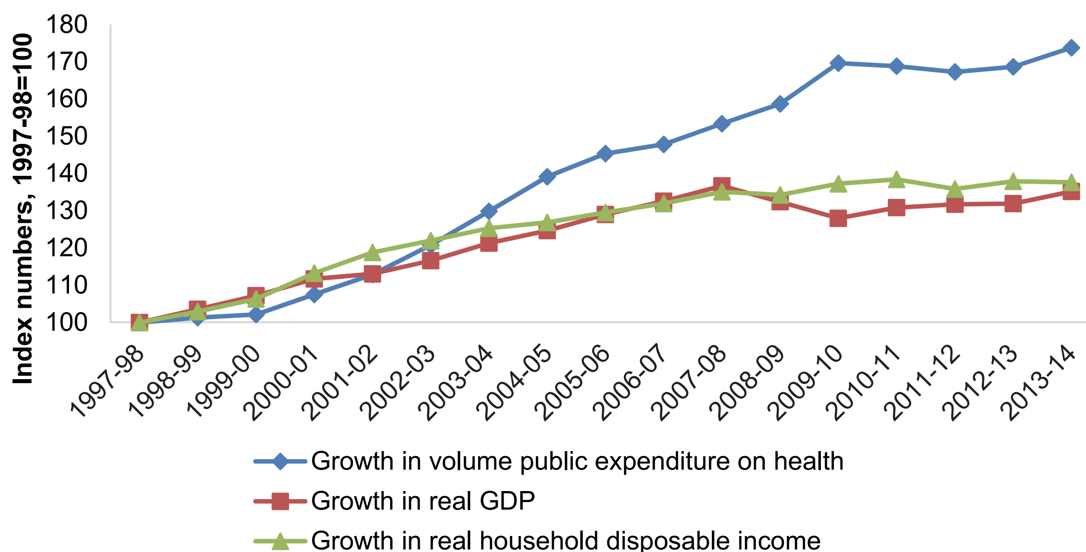


Figure 10(B) Growth rate of volume public services expenditure on health per capita, real GDP per capita and real household disposable income per capita, United kingdom, 1997-98 to 2013-14

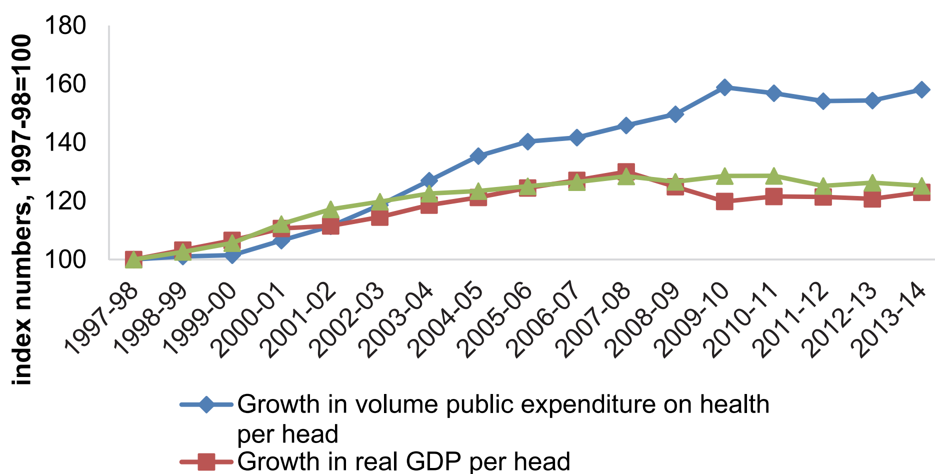
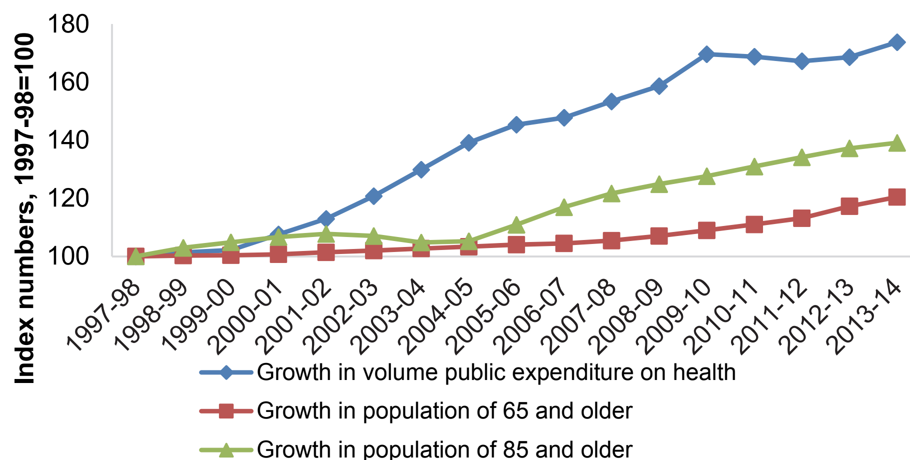


Figure 10(c) Growth rate of volume public services expenditure on health and population growth, United Kingdom, 1997-98 to 2013-14



Sources:

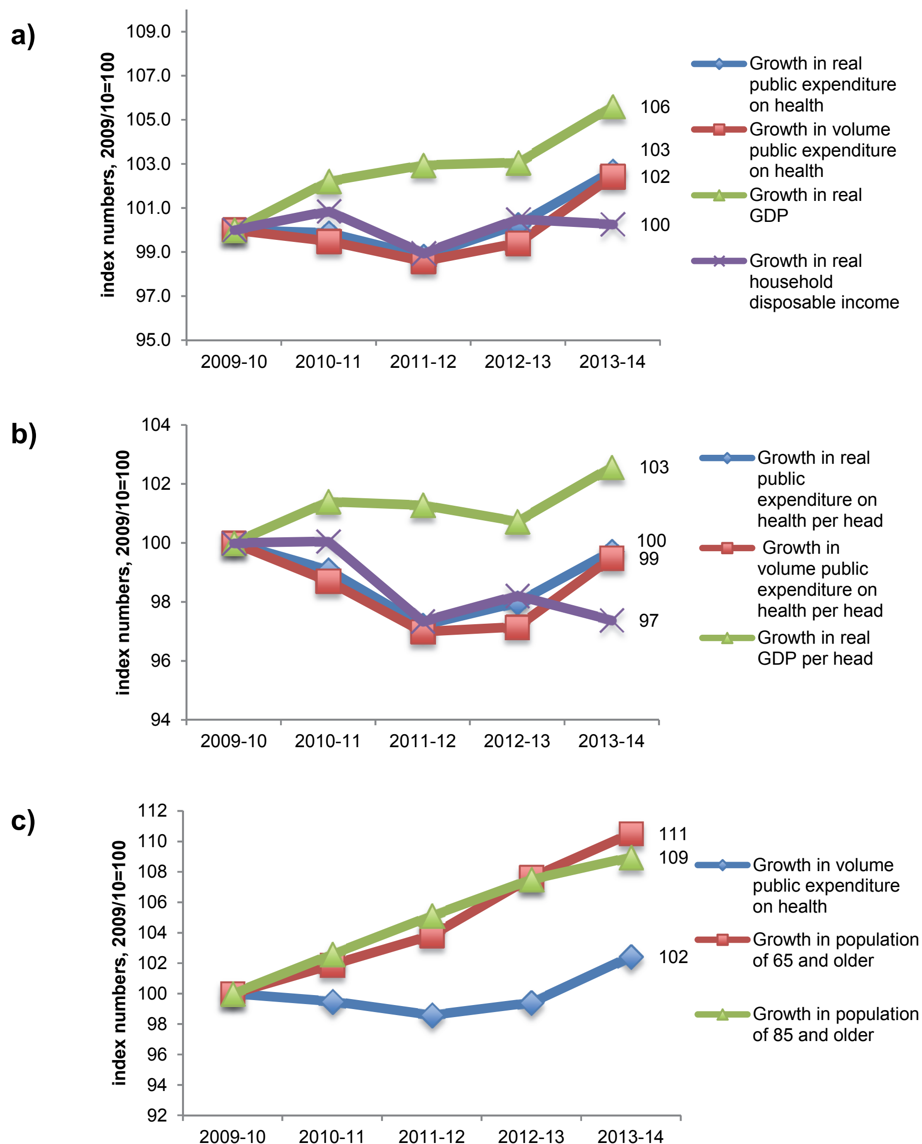
Growth in volume public expenditure: Authors calculations using nominal public expenditure figures from HM Treasury (2014) and NHS specific deflator (HCHS pay and price index) from DoH (2014b) via personal communication. Growth in real household disposable income real disposable income per head: authors' calculations using Blue Book 2014 online resource, 2011 prices (ONS 2014m). Per head calculations and growth in over 65s and 85s: author's calculations using Population estimates: up to 2000: ONS (2011), from 2001 onwards the estimates were revised using Census 2011: ONS (2013a); mid-2013 estimates from ONS (2014a), projected population figures for mid-2014 are from ONS Primary population projections by age (2013c).
Notes:
Since DoH does not produce HCHS index forecasts, HCHS pay and price index growth between 2013-14 and 2014-15 is assumed to remain at 2011-12 to 2013-14 average of 1.6%.

Figure 11 examines growth in public sector volume expenditure growth in the UK with these indicators during the current period (2009/10-2013/14). The rates of growth of volume and real expenditure on health were below the modest rates of growth of real GDP over the period 2009/10-2013/14, and very slightly below the growth in real household disposable income up to 2012/13, though above it by 2013/14 (panel A).

This trend is also apparent when accounting for population growth, with lower growth in volume and real expenditure per capita than in real GDP per head and household disposable income per head up to 2012/13 (with faster growth compared to household disposable income per head between 2012/13 and 2013/14). Indeed, in the UK as a whole, there was no growth in real expenditure per capita over this period (that is, in expenditure adjusted for general inflation) whilst volume growth per capita (adjusted for NHS specification inflation) was actually negative (Panel B).

After 2009/10, the growth in over 65s and over 85s outpaced the growth in volume and real public spending on health by a considerable margin. Whereas the growth in over 65s was 10.5% and the growth in over 85s was 9%, public sector expenditure health in volume terms grew only by 2.4% (Panel C).

Figure 11 Growth of healthcare supply compared with national income, need and demographic pressure, United Kingdom 2009/10 to 2013/14



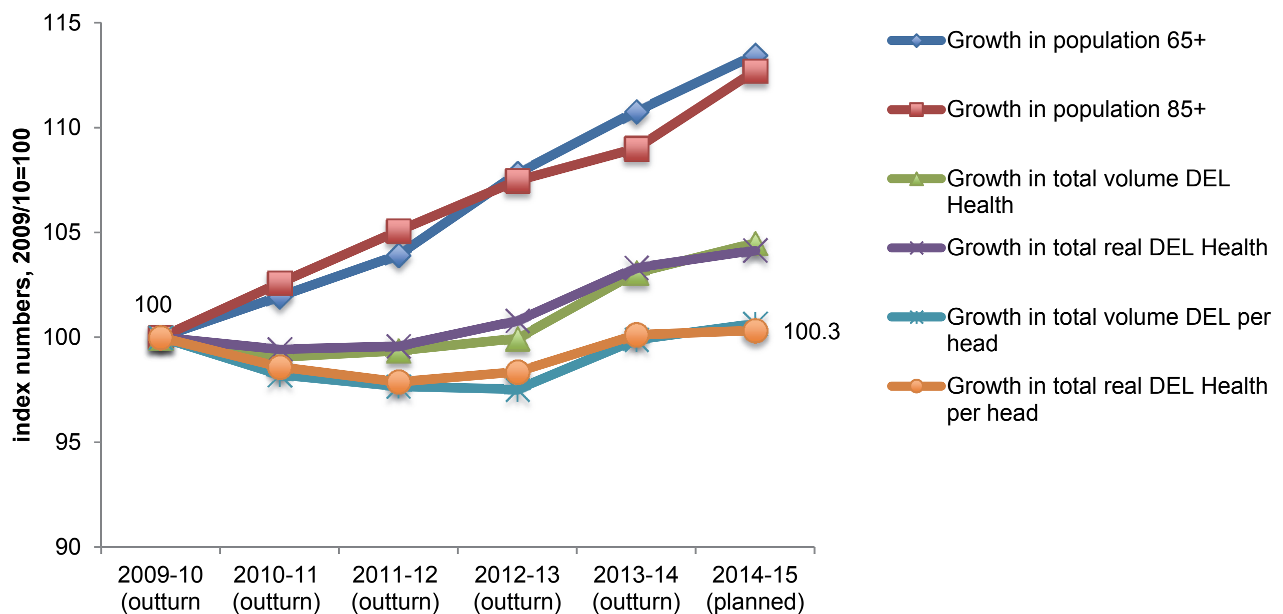
Sources: Growth in volume public expenditure: Authors calculations using nominal public expenditure figures from HM Treasury (2014) and NHS specific deflator (HCHS pay and price index) from DoH (2014b) via personal communication. Growth in real household disposable income real disposable income per head: authors' calculations using Blue Book 2014 online resource, 2011 prices (ONS 2014m). Per head calculations and growth in over 65s and 85s: author's calculations using Population estimates: from 2001 onwards the estimates were revised using Census 2011: ONS (2013a); mid-2013 estimates from ONS (2014a), projected population figures for mid-2014 are from ONS Primary population projections by age (2013c).

Notes: a. Since DoH does not produce HCHS index forecasts, HCHS pay and price index growth between 2013-14 and 2014-15 is assumed to remain at 2011-12 to 2013-14 average of 1.6%.

Figure 12 repeats this exercise for England based on the budgeting framework expenditure figures reported above (this paper section Resources) and incorporates information on plans (for 2014/15) as

well as outturns (for 2009/10-2013/14). The patterns for the UK are repeated at the England level, with growth in volume and real expenditure on health (within DELs) and growth in volume and real expenditure on health per head both considerably below growth in the population 85+ and 65+ over the period 2009/10-2014/15. Using estimated inflation indices for 2014/15, growth in real DEL and per head is expected to be slightly lower than volume spending and per head within DEL[12].

Figure 12: Growth of healthcare supply compared with national income, need and demographic pressure, England 2009/10 to 2013/14



Sources:
Growth in volume public expenditure: Authors calculations using nominal public expenditure figures from HM Treasury (including plans) (2014) and NHS specific deflator (HCHS pay and price index) from DoH (2014b) via personal communication. Growth in real household disposable income: authors' calculations using Blue Book 2012 online resource, 2010 prices (ONS 2013b). Per head calculations and growth in over 65s and 85s: author's calculations using Population estimates: up to 2000: ONS (2011), from 2001 onwards the estimates were revised using Census 2011: ONS (2013a); mid-2013 estimates from ONS (2014a), projected population figures for mid-2014 are from ONS Primary population projections by age (2013c). Growth in total real DEL Health: authors' calculations using nominal figures from HM Treasury (2014), PESA, table 1.10 and GDP deflators PESA (HM Treasury, 2014).
Notes:
a. Since DoH does not produce HCHS index forecasts, HCHS pay and price index growth between 2013-14 and 2014-15 is assumed to remain at 2011-12 to 2013-14 average of 1.6%.

Figure 13 uses the age specific average cost curves published by the Department of Health to broadly estimate the growth in HCHS allocations required to keep up with HCHS inflation and demographic

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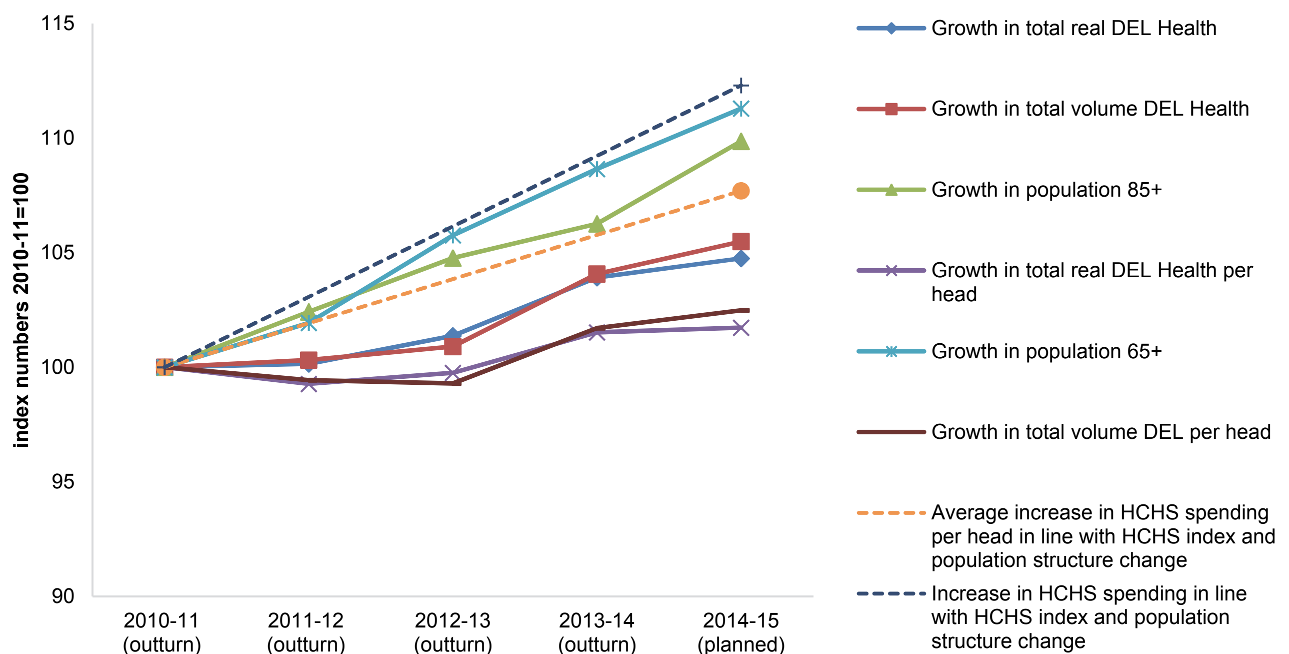
[12] Since DoH does not produce HCHS index forecasts, HCHS pay and price index growth between 2013-14 and 2014-15 is assumed to remain at 2011-12 to 2013-14 average of 1.6%. GDP deflator for 2014-15 is from HM Treasury (2014) and it was derived from Office for Budget Responsibility (OBR) forecasts for GDP deflator increases as at the Budget Report 2014

changes assuming costs per head to be constant (in real terms). This exercise is limited in a number of important respects. First, the figures only cover HCHS costs, and, within HCHS, only those costs associated with age related general, acute and maternity allocations. Second, the exercise abstracts from broader non-demographic pressures such as technological change. In broad terms, it can be said that accounting for HCHS projected inflation and demographic pressure, costs are estimated to increase by 12.3% (2010-11 to 2014-15)[13]. Over 5 years of Coalition in government, this represents a 1.5% average annual increase. A slightly higher increase in costs (13.1%) is suggested using GDP deflators (not shown here) to calculate the increase in HCHS spending. Whilst this exercise is a crude one, it is notable that there is a considerable margin between the estimates and the increases in NHS DEL expenditure as reported in the previous section (see section 'Resources - Trends in real public sector expenditure on healthcare' above).

Figure 13 Growth of healthcare supply compared with need and demographic change, England, 2010-11 to 2014-15



Sources:
Growth in volume public expenditure: Authors calculations using nominal public expenditure figures from HM Treasury (including plans) (2014) and NHS specific deflator (HCHS pay and price index) from DoH (2014b) via personal communication. Per head calculations and growth in over 65s and 85s: author's calculations using Population estimates: from 2001 onwards the estimates were revised using Census 2011: ONS (2013a); mid-2013 estimates from ONS (2014a), projected population figures for mid-2014 are from ONS Primary population projections by age (2013c). Growth in total DEL Health: authors' calculations using nominal figures from HM

[13] The figures were calculated by adjusting each age group's 2010-11 cost per head by the HCHS specific inflation index, multiplied by projected mid-2014 population figures for each age group and finally summarising these costs for the entire population. The HCHS inflation projection (for 2014-2015) is based on average HCHS inflation the previous three years.

Treasury (2014), PESA, table 1.10 and GDP deflators PESA (HM Treasury, 2014). HCHS increase (2010-11 to 2014-15): authors; calculations using cost per person by age groups and crude population estimates for 2010-11 from DoH (2010c)

The balance of public, private and third sector provision

We noted in Section 2 that goals of the Coalition included service diversification and increased involvement or a range of providers including private providers and mutuals (see 'The Coalition Agreement and Programme for Government' and 'The role of the central state and the Coalition's model for public services'). It is important to note that a medium term towards the provision of publicly financed healthcare by non-NHS providers including private, voluntary and other provider pre-dated the 2013 reforms. Our companion paper Vizard and Obolenskaya (2013) reported that, according to ONS estimates, the fastest growing area of healthcare activity over the period 1997-2010 had been in services funded by the NHS but provided by organisations in the private, voluntary or local government sector. The volume of non-NHS healthcare output was estimated to have increased by a factor of five over the period 1997-2010[14]. This included acute services, such as cataract removals and hip replacements provided by independent sector treatment centres and private hospitals; healthcare services provided within the community for older people, people with learning disabilities, people with mental healthcare needs; and packages of care for patients with long-term health conditions including within private nursing homes. The introduction of additional new services such as NHS funded nursing care in care homes, which began in England in October 2001, has been another driver of growth. Nevertheless, since these increases were from a relatively low base, the main contribution to the growth in the volume of healthcare goods and services during Labour's period in office was from growth in goods and services procured from within the NHS (Hardie et al 2011 Appendix B; Massey et al 2012).

At the time of writing, up to date ONS estimates of the growth of Non-NHS providers have not been published. However, analysis by Nuffield Trust (Lafond et al 2014) examines total PCT spending on services by provider type between 2010/11 and 2012/13. The analysis breaks down spending on NHS bodies, "independent sector providers" including independent sector treatment centres and other private providers; and voluntary and "other" providers" (including local authorities) in three service areas: community services, mental health care services and hospital services. The findings are summarised in **Table 7**. In the community services context, the share of total PCT spending on NHS bodies fell sharply between 2010/11 and 2012/13 (from 80% to 69%) whilst there were increases in the percentage shares of both independent sector providers, and voluntary and other providers. As a result of these changes, a third of PCT spending on community health services (31%) was on services provided by private or voluntary bodies by the end of the period. In the mental health services context, the share of spending on NHS provided care remained stable (with around one fifth of services provided by non-NHS providers). In the hospital services context, the base for provision by non-NHS bodies was considerably lower in 2010/11 than in the community and mental health services context (with the share of PCT spending on NHS bodies standing at 96.3%). Furthermore, in 2012/13 PCT expenditure on independent sector health care providers within hospital spending fell back slightly.

[14] This estimates was based on data published in Masssey 2012, rebased by authors to 1997=100)

Figure 14 shows the annual percentage change in spending on ISPs and NHS bodies by PCTs over the same period for each service area. Considerable increases in spending on ISPs are observed in the context of community health services, notably in 2011/12 and 2012/13 (of around 33%) and in the context of mental health services in 2012/13 (of around 16%). In the context of hospital services, PCT spending on ISPs increased in 2011/12 (by around 19%) before falling slightly in 2012/13 (by around 1%). Total PCT spending on hospital services provided by ISPs and voluntary and other providers remained relatively small at (£1.582 billion and £0.234 billion respectively) compared with spending of £42.424 billion on NHS bodies (2012/13 prices).

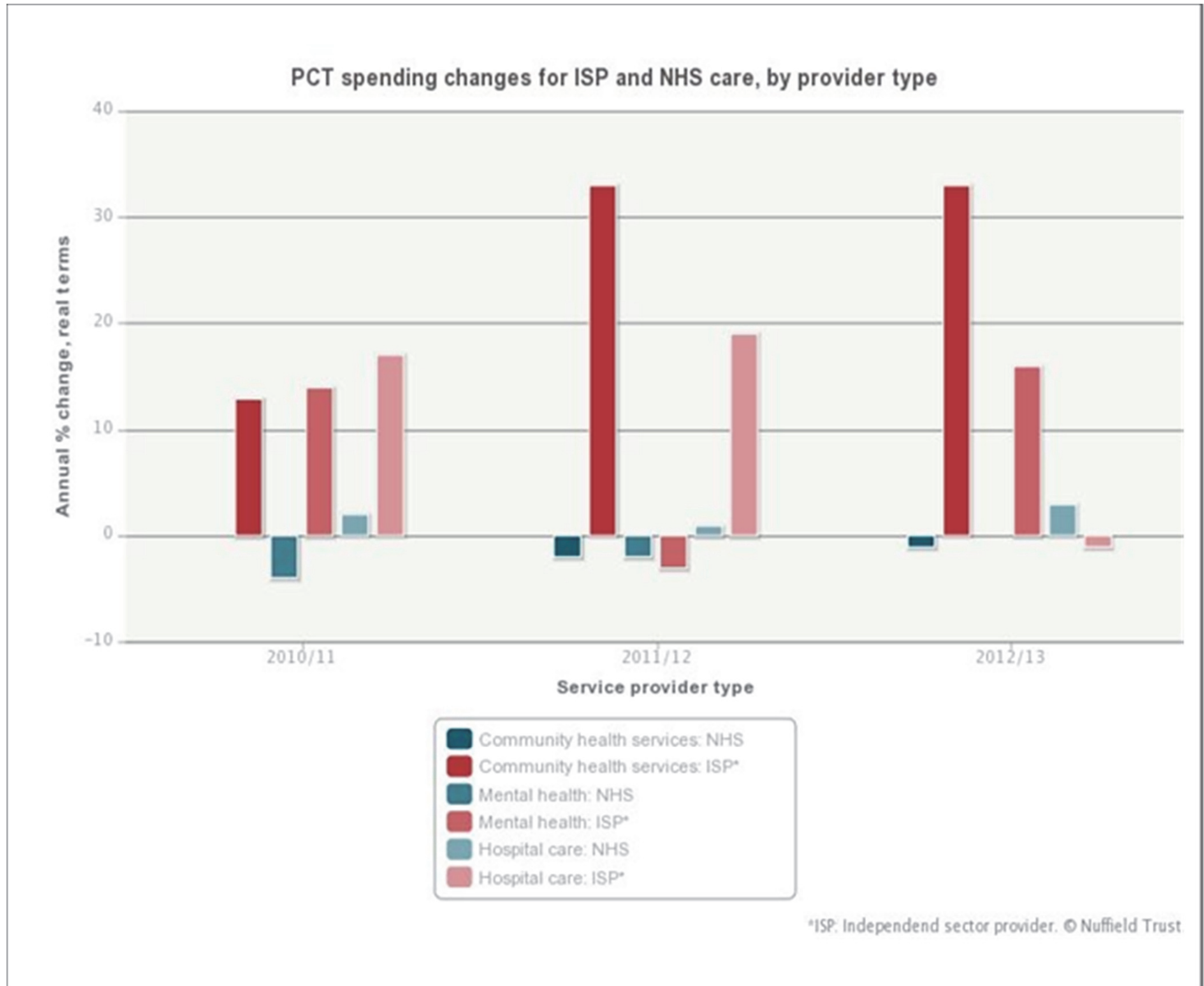
Table 7 Percentage of PCT total spending on services by provider type 2010/11-2012/13

% shares	NHS bodies	Independent sector providers (independent sector treatment centres and other private providers)	Voluntary and other providers (including local authorities)
PCT spending on Community Health Services			
2010/11	80%	12%	8%
2011/12	74%	14%	12%
2012/13	69%	18%	13%
PCT spending on mental health care services			
2010/11	82%	12%	6%
2011/12	82%	12%	7%
2012/13	81%	13%	6%
PCT spending on hospital services			
2010/11	96.3%	3.2%	0.57%
2011/12	95.8%	3.7%	0.54%
2012/13	95.9%	3.6%	0.53%

Source: Nuffield Trust 2014

Note: analysis based on 2012/13 prices

Figure 14: Changes in independent sector provision in community and mental health services and hospital care 2010/11-2012/13



Source: Nuffield Trust (2014)

Note: analysis based on 2012/13 prices

The Nuffield analysis pre-dates the major health reforms implemented in 2013. In the course of 2014, contracts for the delivery of healthcare, such as plans for the commissioning of cancer care in Staffordshire, began to receive increased media attention. Newspapers reported that the private sector was gaining most newly awarded contrasts within the NHS.

Opposition heath spokesperson for health Andy Burnham called for a cessation of "further privatisation" of the NHS until after the 2015 General Election in July 2014. Coote (2014) documents private involvement in the NHS, including the involvement of international companies such as US based healthcare providers. She raises concerns that whilst there is now a "level playing field"

between sectors, large commercial organisations have advantages in the ‘new’ NHS market place and are winning more contracts.

In December 2014, the British Medical Journal reported an analysis of CCG data covering the period April 2013 and August 2014 suggesting that non-NHS providers (private sector, voluntary sector, and other providers) secured 45% of contracts awarded. This broke down as 1,149 contracts (33% of the total) awarded to private sector providers, 335 (10%) to voluntary and social enterprise sector providers, and 100 (3%) to other types of provider, such as joint ventures or local authorities. A total of 1,910 contracts (55%) were awarded to NHS providers. This category included NHS hospitals, community and mental health providers, and general practices. However, the value of these contracts was not provided. A total of 195 contracts (6%) had been awarded by competitive tender, with the private sector most successful (being awarded 80 of these contracts, 41% of the total) (BMJ 2014).

The Financial Times reported responses to the BMJ article by Simon Stevens, chief executive of NHS England, suggesting that 94p of every pound spent on care was delivered by NHS providers and that he did not anticipate any significant change in that position. A further response from David Hare, chief executive of NHS Partners, suggested that the figure for private sector providers was “a low amount” that had changed very little in the past two years (Neville 2014).

Newspaper reports suggest that the number of public services mutuals is reported to have grown from nine in 2010 to more than 80 in 2014 in a wide range of different sectors from youth services to social care. However, the shift of public sector workers into mutual organisations has been slower than anticipated in plans set out in 2010 and plans to accelerate progress were announced in July 2014 (Plimmer and Neville 2014). In healthcare, the takeover of Hinchingbrooke Hospital in Cambridgeshire by Circle Healthcare in 2012, widely reported as the first private takeover of a NHS hospital, has been cited by Francis Maude as a possible model of “liberation of the NHS” and a mutual joint venture in healthcare (Cabinet Office 2015). However, in January 2014, it was reported that Circle Healthcare was withdrawing from the contract (BBC 2015).

In July 2014 a Kings Fund independent review suggested that staff run organisations in the NHS provide better and safer care outcomes. The report advocates mutualisation as a major alternative to both top down central performance management and “top down” regulation (Ham 2014).

6. Outcomes

This section reviews the available empirical evidence on outcomes. We begin by examining healthcare outcomes, in international comparative terms, focusing on unmet need for health and barriers to health. We then examine trends in key healthcare outcome indicators in the recent period, including waiting times for hospital treatment, A&E waiting times, satisfaction with the NHS and patient experience. Next, we comment on key health outcomes and health inequalities, including life expectancy, mortality from the major killers and infant mortality. This is followed by a discussion on recent trends on non-medical determinants of health (specifically, obesity, physical exercise, diet, smoking and alcohol consumption) and a final subsection on trends in suicide, mental health and general health[15].

As noted in the Overview to this paper (Section 'Introduction'), the Health and Social Care Act (2012) established new statutory duties on the Secretary of State, NHS England and local commissioning groups to reduce health inequalities. Reducing health inequalities are key goals of NHS England and Public Health England and the NHS Outcomes Framework and Public Health Outcomes Framework both aim to provide an evidence base on health inequalities. Equality statements have been published with NHS Outcomes and Public Health Frameworks. These highlight the statutory duties to promote equality established in the Equality Act (2010). These require public authorities (which include, inter alia, public healthcare providers, commissioners and regulators) to promote equality by different characteristics (including age, gender, ethnicity, disability, religion/belief and sexual orientation). The NHS Outcomes and Public Health frameworks indictor portals include new breakdowns by area deprivation deciles as well as breakdowns by gender and age where appropriate. However, progress in providing data that is disaggregated by the full range of equability characteristics protected in equality legislation has been patchy and relatively slow. The Equality Measurement Framework developed by CASE in partnership with the Equality and Human Rights Commission provides disaggregated data of this type across a range of different domains including health, and a full updating exercise will be undertaken in 2015. The mental health findings reported below provide an illustration of this general approach.

Healthcare access and quality

Unmet need for health and barriers to access

OECD (2014c: 114) notes that all European countries endorse equality of access to healthcare for all people as an important policy objective. Alongside other indicators including universal healthcare coverage and the extent of the burden of out of pocket payments, the OECD highlights the role of indicators of unmet health need in evaluating progress in achieving this objective. The problems that individuals report in accessing healthcare include waiting time, distance to healthcare

[15] This section makes a number of references to the UK's position on OECD international health performance tables. It should be noted that there are important limitations to this data, including non-availability of latest year data for some countries and issues of definition. Further details are provided in the relevant OECD references.

units, the financial costs of healthcare, and timing of appointments (where these conflict, for example, with work commitments).

In the UK, self-reported unmet need for health remained notably low by international standards in 2012. **Table 8** reports EU SILC data on unmet need for health where the reason given is financial cost. The UK stands out as a good performer, within the best three performing countries in Europe for which data was available in terms of the percentage reporting unmet need for medical examinations due to financial reasons. Whereas in some countries there was a considerable increase in this percentage following the economic crisis and downturn, in the UK the figure stood at 0% in 2007, 0.1% in 2009 and 0.1% in 2012. Furthermore, equality is high in the UK. On average in 2012 there was a four percentage point gap between self-reported unmet need for medical examinations between the first and fifth quintiles of equivalised income in EU 28 countries. However, in the UK, this gap was 0.3 percentage points. Self-reported unmet need for dentistry is higher than that for medical examinations, but the UK nevertheless performs well in comparative terms.

Table 8 Self-reported unmet need for medical examination where the reason given is *financial cost*, 2012

	Overall	first quintile of equivalised income	fifth quintile of equivalised income
European Union (28 countries)	2.2	4.5	0.5
European Union (27 countries)	2.2	4.5	0.5
Belgium	1.7	4.8	0.1
Bulgaria	5.9	14.3	1.0
Czech Republic	0.4	0.9	0.0
Denmark	0.3	0.4	0.1
Germany (until 1990 former territory of the FRG)	0.8	2.2	0.2
Estonia	0.9	2.8	0.2
Ireland	2.6	2.9	1.1
Greece	6.5	11.0	2.2
Spain	0.4	0.8	0.0
France	1.9	4.8	0.2
Croatia	1.3	2.9	0.4
Italy	4.9	10.5	0.9
Cyprus	3.4	5.9	0.9
Latvia	10.5	20.9	2.8
Lithuania	0.5	1.1	0.1
Luxembourg	0.5	1.9	0.1
Hungary	2.4	5.9	0.8
Malta	1.0	1.7	0.3
Netherlands	0.2	0.2	0.1
Austria	0.2	0.7	0.1
Poland	3.5	6.2	0.8
Portugal	2.6	4.9	0.4
Romania	9.6	13.3	3.5
Slovenia	0.0	0.1	:
Slovakia	0.9	2.7	0.3
Finland	0.1	0.3	0.1
Sweden	0.4	1.4	:
United Kingdom	0.1	0.3	0.0
Iceland	3.7	6.7	1.7
Norway	0.3	1.4	:
Switzerland	0.9	1.9	0.3
Turkey	:	:	:

Source: Eurostat extracted 14/01/2015
http://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_08
Note : not available. The first quintile group represents 20 % of population with lowest income and the fifth quintile group 20 % of population with highest income

Based on European Quality of Life Survey data from 2011, the UK performs best out of EU27 countries in relation to reported difficulties in accessing or using healthcare due to the cost of seeing a doctor (**Table 9**). Whilst the proportions reporting difficulties in relation to other reasons for example, distance, delay and waiting time are higher than the proportions reporting difficulties due to costs, the UK's performance is nevertheless relatively strong (c.f. Eurofound 2013)

Table 9: Percentage of individuals reporting difficulties in accessing / using healthcare by type of difficulties, EU27, EU15, EU12 and by country; 2011

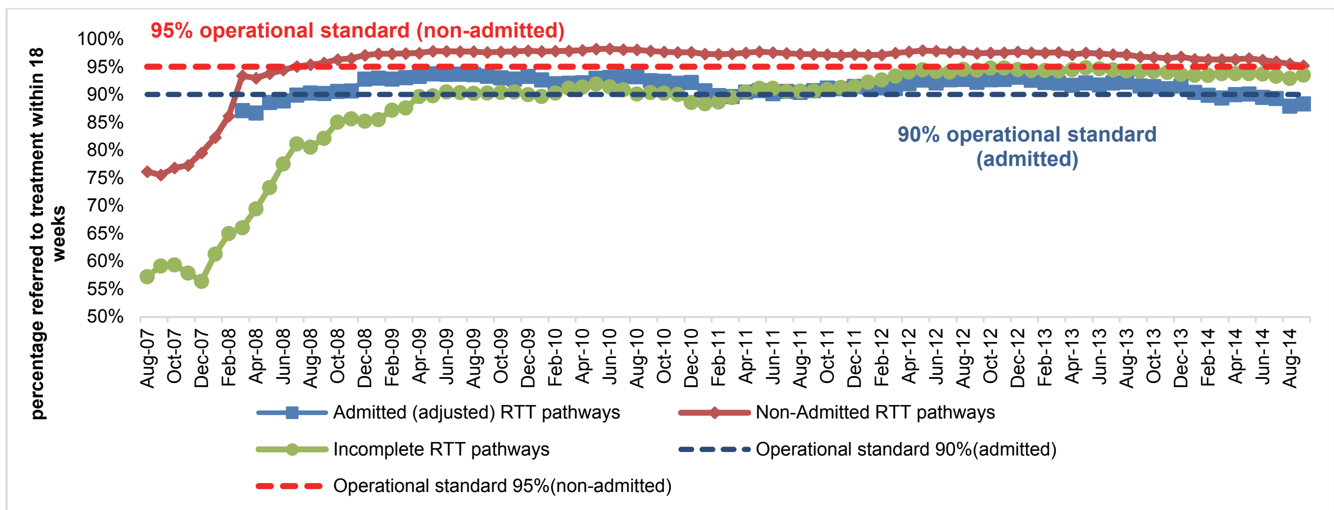
	Cost of seeing doctor	Distance to doctor's office, hospital or medical centre	Delay in getting an appointment	Waiting time to see doctor on day of appointment	Finding time because of work, care for children or other reasons
EU27	30%	22%	39%	42%	27%
EU15	27%	20%	38%	41%	27%
EU12	42%	30%	45%	48%	27%
Austria	18%	17%	30%	31%	19%
Belgium	24%	12%	21%	24%	23%
Bulgaria	37%	29%	27%	47%	22%
Cyprus	48%	19%	30%	37%	21%
Czech Republic	34%	29%	43%	59%	34%
Denmark	6%	14%	30%	19%	19%
Estonia	26%	31%	50%	40%	23%
Finland	12%	13%	29%	20%	13%
France	26%	12%	29%	31%	26%
Germany	25%	21%	39%	48%	27%
Greece	64%	45%	67%	66%	39%
Hungary	28%	29%	46%	48%	23%
Ireland	43%	14%	19%	32%	25%
Italy	57%	39%	60%	64%	40%
Latvia	37%	25%	30%	32%	26%
Lithuania	42%	18%	32%	42%	22%
Luxembourg	25%	9%	23%	26%	19%
Malta	58%	19%	41%	61%	32%
Netherlands	16%	14%	17%	24%	17%
Poland	46%	32%	58%	47%	29%
Portugal	34%	31%	45%	48%	30%
Romania	44%	28%	33%	44%	28%
Slovakia	57%	35%	37%	60%	31%
Slovenia	21%	34%	47%	48%	15%
Spain	8%	14%	29%	35%	17%
Sweden	9%	9%	23%	15%	15%
UK	5%	15%	36%	31%	28%

Source: authors calculations using European Quality of Life Survey Q47 On the last occasion you needed to see a doctor or medical specialist, to what extent did each of the following factors make it difficult or not for you to do so? (a. Distance to doctor's office/hospital/medical centre, b. Delay in getting appointment c. Waiting time to see doctor on day of appointment, d. Cost of seeing the doctor e. Finding time because of work, care for children or for other) with scale of 1 (= very difficult), 2 (= difficult) and 3 (=not difficult at all). Note: Difficulty is defined to include responses of 'very difficult' and 'difficult'. C.f. Eurofound (2013).

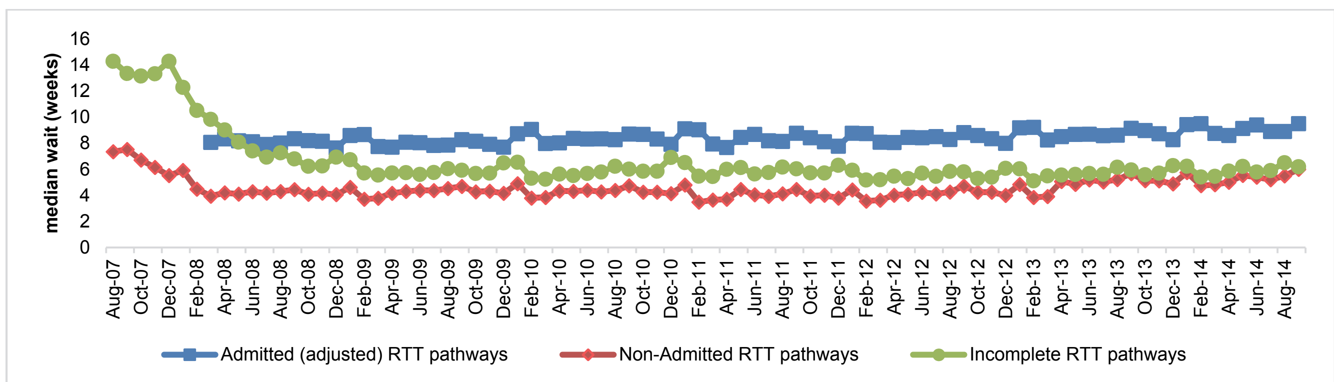
Nevertheless, after the long period of improvement reported in our companion paper (Vizard and Obolenskaya 2013) adverse movements against a number of key indicators of access and quality point towards rising pressure within the English healthcare system in the current period. Figure 15 shows waiting times from GP referral to treatment over the period 2007-2014. From May 2010 to September 2014, the proportion of patients who were admitted for treatment within 18 weeks dropped from 92.9% to 88.3% (with an operational standard of 90%). The proportion of non-admitted patients waiting for 18 weeks or more also fell from 98.2% to 95.2% (with an operational standard of 95%). Median waiting times increased from 8.4 weeks for admitted patients and 4.3 for non-admitted patients in May 2010 to 9.5 and 6 weeks in September 2014, respectively.

Figure 15: Waiting times for referral to treatment

(a) Referral to Treatment (RTT) waiting times: proportion referred to treatment within 18 weeks, 2007-2014 (up to September 2014)



(b) Referral to Treatment (RTT) waiting times (median, weeks), 2007-2014 (up to September 2014)

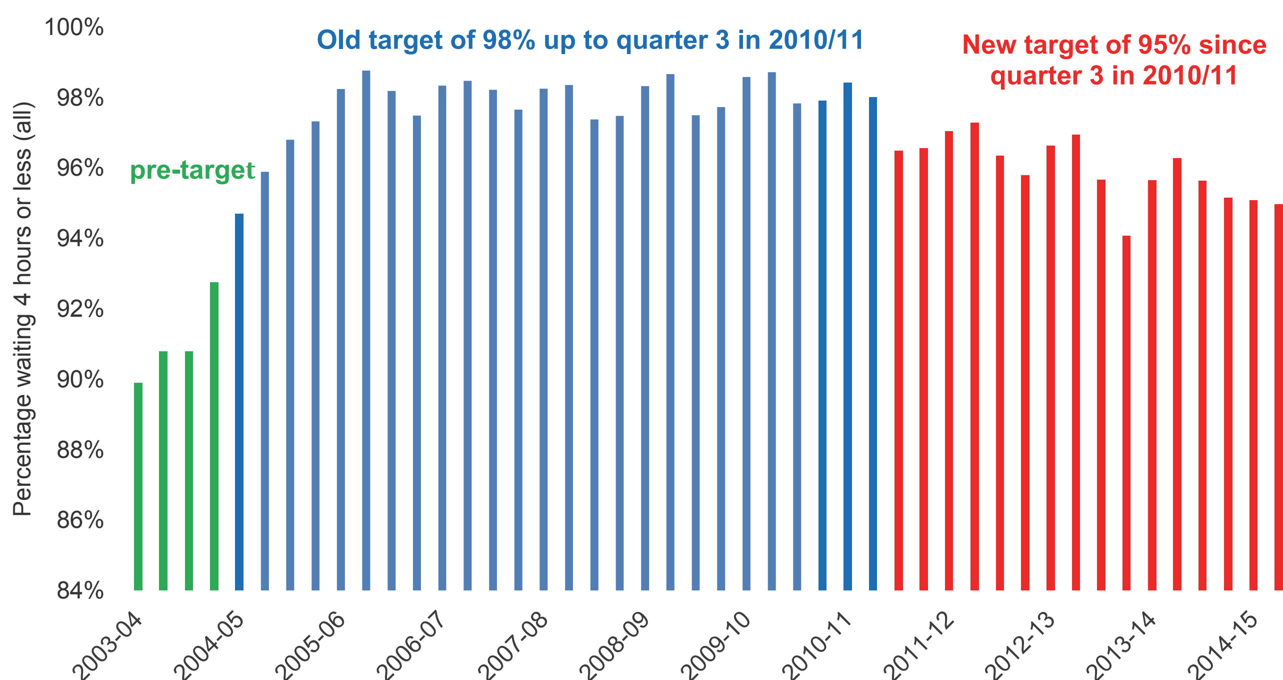


Source: NHS England (2014b): England RTT Time Series excel table
a. Commissioner based figures.
b. Adjustments are made to admitted RTT pathways for clock pauses, where a patient had declined reasonable offers of admission and chosen to wait longer.
c. Percentage within 18 weeks is calculated using total number of pathways (known).

In relation to urgent care, the revised Operating Framework for NHS in England 2010-11 announced that the operational standard for the percentage of those waiting in all A&E departments for four hours or more would be eased (with the threshold decreased from 98% to 95%). The percentage of individuals for whom the revised target was met fell from 98.4% in the first quarter of 2010-2011 to 95.1% in the first quarter of 2014-15, with particular pressure evident in the last quarter of 2012-13, when the target was breached (94.1%) (**Figure 16**). Major A&E departments (as a group) failed to meet this target consistently since the third quarter of 2011-12 NHS England (with the exception of Q2 2012-13) (2014c). Continuing pressure on the A&E departments is evident at the start of winter, where weekly data shows that in the first week of December 2014, 91.8% of patients were seen within four hours - the worst performance since April 2013 (NHS England 2014c).

In other areas, provider based figures on waiting times for cancer patients show a large drop in the proportion of people who had their first definitive treatments within 62 days from an urgent GP referral in the third and fourth quarters of 2013-14 (NHS England 2014d, Figure 7). This trend continued and in the second quarter of 2014/15 the operational standard of 85% was not reached for the third time in a row, when the proportion of those who received their first definitive treatment within 62 days from an urgent GP referral has dropped to 83.5% (NHS England 2014d).

Figure 16: Percentage waiting 4 hours or less (all) in A&E from arrival to admission, transfer or discharge (quarterly data), 2003-04 to 2014-15 (financial year quarters, up to September 2014), England

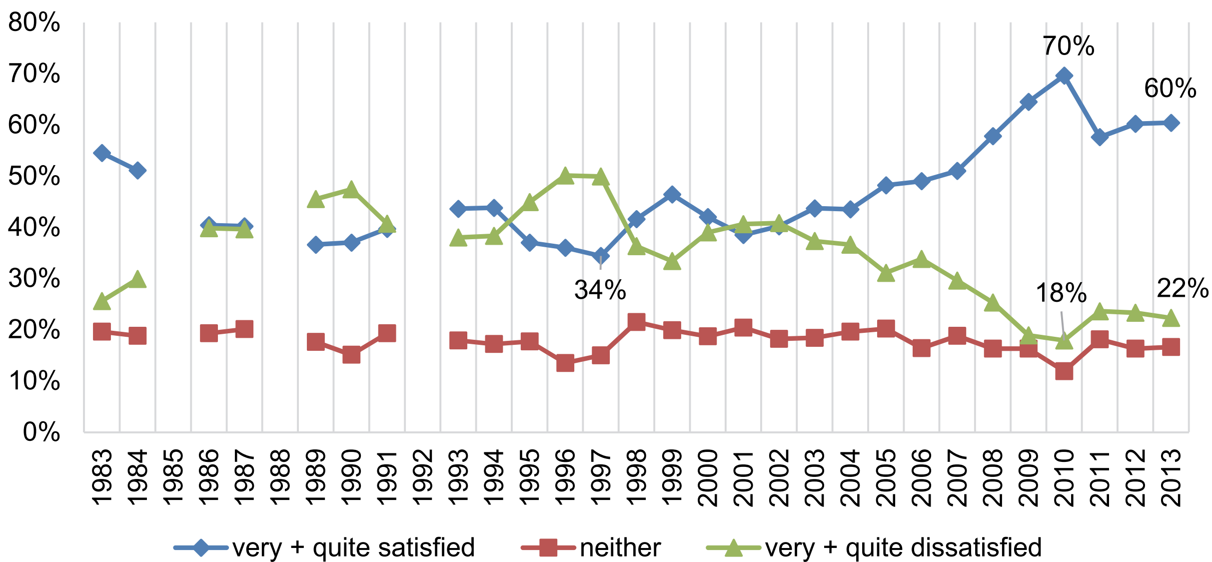


Source: figures for years 2004-05 onwards: NHS England (2014c); 2003-04 figures are based on data points in a chart by King's Fund (2013: 27)
Notes
1. QMAE data is used from 2004-05 to Q4 2010-11. WSitAE data is used from 2011-12 onwards.
2. The number of patients spending >12 hours from decision to admit to admission, and the number of emergency admissions not via A&E were not collected on the QMAE return.

Satisfaction with the NHS

Based on British Social Attitudes survey figures, overall satisfaction with the NHS experienced its biggest recorded decline following the 2010 General Election, falling from a high of 70% to 58% between 2010 and 2011, before increasing to 60% in 2012/2013 (Figure 17).

Figure 17 Overall satisfaction with National Health Service, 1983 to 2013



Source: British Social Attitudes information system (online)
Notes: answers to the satisfaction with NHS are on a five-point scale: 1. Very satisfied, 2. Quite satisfied, 3. Neither, 4. Quite dissatisfied, 5. Very dissatisfied.
Wording of the question: a) How satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?

Patient experience

DH (2013) reports adverse movements in relation to patient experiences of mental health and GP services. **Table 31** (Appendix 2) indicates that the overall patient experience score for NHS community mental health services fell significantly to 71.6 (out of 100) in 2013 from 72.2 in 2012 (NHS 2013e) [16]. In relation to GPs, media reports of worsening access focused on waiting times of more than one week, which increased from 13% in 2011/12 [17] to 16% in 2013/14 [18] (NHS 2014f). Small increases were recorded in the percentage finding the appointment time inconvenient and the percentage using A&E because they didn't get an appointment or the appointment wasn't convenient. The latest data shows that approximately 38% of patients "always or almost always" got to see their GP, a decline from 42% in 2011/12 (NHS England 2014f). Additionally there has been a significant reduction in the proportion of people reporting a 'very good' or 'fairly good' experience of GP out-of-hours services between 2011/12 and 2013/14 (Appendix 2: **Table 30**)

[16] "These scores do not translate directly into descriptive words or ratings, but present results out of 100 for specific aspects of experience for NHS patients, after they have used the NHS. If patients reported all aspects of their care as 'good', we would expect a score of about 60. If they reported all aspects as 'very good', we would expect a score of about 80" (NHS 2013e: p.6).
[17] Data for this wave of GP Patient Survey was collected during July 2011 to March 2012
[18] In the latest GP Patient Survey report an aggregate of data collected over two separate waves (July to September 2013 and January to March 2014) was used

In relation to inpatients, the score for overall experience, based on a composite indicator, was 75.6 in 2009/10 and 76.9 in 2013/14. There was a small but statistically significant increase in the proportion reporting “rarely or never” enough nurses on duty to care for them in hospital in 2013 but improvements in other areas. On dignity and nutrition, more than a third of those who needed help from staff to eat their meals reported only receiving help “sometimes” or not getting such help, whilst 81% reported they were “always” treated with respect and dignity whilst in hospital, up from 80% in 2012 (CQC 2014b). A forthcoming study will evaluate trends on dignity and nutrition in detail, with a particular emphasis on subgroup inequalities (Vizard and Burchardt, 2015).

Healthcare mortality outcomes

We reported a medium term decline in 30 day survival rates following admission into hospital in our companion paper, including in the context of admissions for stroke (Vizard and Obalenskya 2013). In the current period, Bojke et al (2014) report positive trends in 30 day survival rates as part of their “quality adjustment” of NHS outputs up to 2011/2012. HSCIC analysis suggests overall improvements over the period 2009/10-2013/14 (HSCICa).

Debates have continued about the role of variations in mortality data at the trust level as a basis of evaluating quality of care. As noted above (‘Minimum standards and quality regulation: the Government’s response to the Francis Inquiry’), following the examination of variations in standardised mortality rates as part of the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust (2013), the Keogh Review (2013) which examined variations in standardised mortality rations, resulted in 11 trusts being put into special measures by Monitor and the NHS Trust Development Authority. A further review of the role of standardised mortality ration in monitoring performance by Black and Darzi is expected to report before the next General Election.

A Summary Hospital-level Mortality Indicator (SHMI) is now produced and published quarterly as an official statistic by the Health and Social Care Information Centre with the intention of capturing information about variations on deaths associated with hospitalization. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either died while in hospital or within 30 days of discharge. The expected number of deaths is calculated from statistical models which estimate expected risk of mortality based on characteristics such as conditions, age, gender and method of admission to hospital. Based on latest data, nine trusts had a ‘higher than expected SHMI value’ in the period from 1 April 2013 to 31 March 2014, compared to seven trusts for the same period a year previously. Two trusts (Aintree University Hospital NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust) are identified as repeat outliers HSCIC 2014c: 1-7 and 12).

The SHMI methodology does not adjust for deprivation but contextual information is produced, including breakdowns of trust level standardised mortality ratios by area deprivation. For the latest data (covering the period from 1 April 2013 to 31 March 2014) this suggested that the percentage of deaths reported in the SHMI in each deprivation quintile (based on index of multiple deprivation) is:

- 21.0 per cent for quintile 1 (most deprived)
- 20.3 per cent for quintile 2
- 20.5 per cent for quintile 3
- 19.6 per cent for quintile 4
- 17.2 per cent for quintile 5 (least deprived).

HSCIC analysis shows that higher than expected repeat outliers show a higher percentage of finished provider spells and deaths reported in the SHMI which fall under deprivation quintile 1 (the most

deprived), and a lower percentage of finished provider spells and deaths which fall under deprivation quintile 5 (the least deprived), compared to trusts overall (HSCIC 2014c: 8 and 24).

In terms of the international picture, the OECD published age standardised case-fatality rates for mortality within 30 days after admission for acute myocardial infarction and stroke in 2011 (or latest year for which data is available). In the context of acute myocardial infarction amongst adults aged 45 or over, the UK is at the EU average for 21 countries on the basis of admission based (same hospital) mortality. However, the position is somewhat better in relation to patient based data (within and out of hospital), where the UK's position rises to sixth (out of twelve countries for which such data is available). A similar pattern is observed in the context of case-fatality within 30 days after admission for ischemic stroke in adults aged 45 and over for 2011 (or latest year for which data is available). The UK is worse than the EU average for 20 countries on the basis of admission based (same hospital) mortality. The position is again somewhat better in relation to patient based data (within and out of hospital) although UK remained below the best performers.

Data from the NHS Outcomes Framework shows that one- and five-year survival rates for cancers show an increasing trend, including (combined) one- and five-year rates for breast, lung or colorectal cancer (Appendix 2: Table 30)

Nevertheless, five-year survival rates remained disappointing in international comparative terms for some cancers. The UK breast cancer five-year relative survival rate for 2007-2012 was just below the average for fifteen countries for which data was available. Cervical cancer five-year survival rates were just below the EU 15 country average, and below the best performers such as Austria, Sweden and Netherlands, as well as Germany and Portugal (**Table 10)**

Table 10: Cervical cancer five-year relative survival rate, EU countries, 2007-2012 (or nearest period)

	2007-2012		
	Value		95% CI deviation
Austria	67.9		5.5
Sweden	67.3		2.8
Netherlands	66.5	2006-11	4.6
Denmark	66.4	2006-11	5.8
Belgium	66.0	2005-10	2.0
Finland	65.1	2005-10	8.4
Czech Rep.	64.9	2005-10	2.1
Germany	64.5	2004-09	1.9
Portugal	64.1	2005-10	6.4
Slovenia	63.0		8.8
EU-15	62.4		
United Kingdom	**60.9**		2.1
Latvia	58.0	2006-11	0.5
Ireland	57.2	2005-10	3.1
Poland	52.7	2003-08	2.2
Malta	52.1	2006-11	11.4
Norway	71.4	2006-11	2.8
Iceland	70.5		16.5

Source: OECD (2014c: Figure 4.6.2 / OECD Health Statistics 2014)
Note: Survival rates are age standardised to the International Cancer Survival Standards population.

Life expectancy, the "major killers" and infant mortality

Life expectancy

Life expectancy at birth in the UK continued to increase: from 78.01 years in 2008-10 to 78.91 years in 2011-2013 for males; and from 82.08 years in 2008-10 to 82.71 years in 2011-2013 for females. There remained notable variations in life expectancy at birth between the four constituent countries of the UK in 2011-2013. Life expectancy at birth in England was higher than in the other UK countries, rising to 79.21 years for males and 82.71 years for females. Life expectancy at birth in Wales in 2011-13 was 78.17 years for males and 82.19 years for females; and in Northern Ireland, 78.00 years for males and 82.29 years for females. Scotland had the lowest figures, with a life expectancy at birth of 76.77 years for males and 80.89 years for females in 2011-2013 ((**Table 11**).

Table 11: Life expectancy at birth, England, Wales, Scotland and Northern Ireland 2008/2010-2011/2013

	United Kingdom	England	Wales	Scotland	Northern Ireland
Males					
2008-2010	78.01	78.31	77.51	75.80	76.97
2009-2011	78.41	78.71	77.84	76.21	77.41
2010-2012	78.71	79.02	78.08	76.51	77.69
2011-2013	78.91	79.21	78.17	76.77	78.00
Females					
2008-2010	82.08	82.33	81.66	80.30	81.43
2009-2011	82.42	82.68	82.01	80.56	81.84
2010-2012	82.58	82.83	82.10	80.75	82.12
2011-2013	82.71	82.96	82.19	80.89	82.29

Source: ONS (2014q: Figures 1)

Data on variations in life expectancy by English region is reported in ONS (2014n). In 2011–13, life expectancy at birth in England and Wales was highest in the South East (80.4 years) for males and in London for females (84.1years). Conversely, it was lowest in the North West and North East for males (78.0 years) and in the North East and North West for females (81.7 and 81.8 years respectively)(**Table 12**). ONS (ONS 2014r) notes that whilst gender differences in life expectancy at birth are observed in all regions, with life expectancy for females higher than that for males, this differential is consistently smaller in the South East and East of England than in other regions. In 2011-13, the differential ranged from 3.5 years in the East and South East of England, to 4.0 years in the West Midlands, and 4.1 years in London.

Table 12: Life expectancy at birth: by sex and region, 2008-10 to 2011-13

Region	2008-10	2009-11	2010-12	2011-13
Males				
North East	77.1	77.5	77.8	78.0
North West	77.0	77.4	77.7	78.0
Yorkshire and The Humber	77.7	78.1	78.3	78.5
East Midlands	78.3	78.7	79.1	79.3
West Midlands	77.9	78.4	78.7	78.8
East	79.5	79.9	80.1	80.3
London	78.8	79.3	79.7	80.0
South East	79.7	80.0	80.3	80.4
South West	79.4	79.8	80.0	80.1
Females				
North East	81.1	81.5	81.6	81.7
North West	81.1	81.5	81.7	81.8
Yorkshire and The Humber	81.7	82.0	82.2	82.2
East Midlands	82.3	82.8	82.9	83.0
West Midlands	82.2	82.6	82.7	82.8
East	83.2	83.6	83.7	83.8
London	83.2	83.6	83.8	84.1
South East	83.5	83.8	83.8	83.9
South West	83.4	83.7	83.9	83.8

Source: ONS (2014n: Reference table 1).

There is substantial variation in life expectancy at birth at the local authority level. The latest data on life expectancy at birth by local area for the UK as a whole is for 2010–12. Male life expectancy at birth was highest in East Dorset (82.9 years) and lowest in Glasgow City (72.6 years). There was little improvement in inequality in life expectancy at birth between the area with the highest and lowest figures for males between 2008-2010 and 2010-12. Absolute inequality in life expectancy between the local areas with the highest and lowest figures was 10.2 years in 2008–10 and 10.3 years in 2010–12 for males. Drawing on this data, ONS analysis suggests that for males at birth, 72% of local areas in Scotland, 36% in Wales and 19% in Northern Ireland, but only 14% of local areas in England, were in the fifth of areas with the *lowest* life expectancy in 2010-12. In contrast, only one local area in Northern Ireland, and none of the local areas Scotland and Wales, were in the fifth of areas with the *highest* life expectancy - whilst a quarter of local areas in England were in this group

Table **13** and ONS 2014r). Comparable figures for females show that life expectancy at birth was highest in Purbeck (86.6 years) and lowest in Glasgow City (78.5 years). Absolute inequality (the range) reduced from 8.3 years to 8.1 years. According to ONS analysis, 72% of local areas in Scotland, 32% in Wales, 12% in Northern Ireland and 15% in England in areas with the *lowest* life expectancy. In contrast, a quarter of local areas in England were in the fifth of local areas in the UK with the *highest* life expectancy - whilst only one in Northern Ireland and none in Scotland and Wales were in this group ONS 2014r).

Table 13: Local areas with the highest and lowest life expectancy at birth (years), males, UK 2010-12

2008-10		2009-11		2010-12	
Local area	**Life expectancy at birth**	**Local area**	**Life expectancy at birth**	**Local area**	**Life expectancy at birth**
Highest					
East Dorset	82.0	East Dorset	83.0	East Dorset	82.9
Epsom and Ewell	81.9	Hart	82.6	Hart	82.9
Hart	81.8	South Cambridgeshire	82.1	South Cambridgeshire	82.8
North Dorset	81.8	Brentwood	82.0	South Northamptonshire	82.2
Harrow	81.7	Epsom and Ewell	81.9	Guildford	82.1
Elmbridge	81.7	Rutland	81.9	Kensington and Chelsea	82.1
Kensington and Chelsea	81.6	Guildford	81.9	Chiltern	82.1
Guildford	81.5	Elmbridge	81.8	Harrow	82.0
South Bucks	81.4	New Forest	81.8	Christchurch	82.0
Westminster	81.4	North Dorset	81.8	Epsom and Ewell	82.0
Lowest					
Eilean Siar	74.5	North Ayrshire	75.3	Burnley	75.7
North Lanarkshire	74.5	Belfast	75.2	Renfrewshire	75.3
Belfast	74.4	Renfrewshire	74.8	Belfast	75.2
Renfrewshire	74.0	North Lanarkshire	74.8	North Lanarkshire	74.9
Blackpool	73.8	West Dunbartonshire	74.3	Manchester	74.8
West Dunbartonshire	73.7	Manchester	74.0	Dundee City	74.3
Dundee City	73.7	Dundee City	74.0	West Dunbartonshire	74.1
Manchester	73.7	Blackpool	73.8	Blackpool	74.0
Inverclyde	73.3	Inverclyde	73.3	Inverclyde	73.7
Glasgow City	71.8	Glasgow City	72.2	Glasgow City	72.6
Absolute inequality	10.2		10.8		10.3

Source: ONS 2014s

Note: life expectancy figures are presented to one decimal place. The rankings in this table reflect differences in the unrounded numbers. Three-year rolling averages, based on deaths registered in calendar years and mid-year population estimates

One additional year of data on life expectancy at birth by local area is available for England and Wales. For males, life expectancy at birth in England and Wales in 2011-13 was highest in South Cambridgeshire (83.0 years) for males and lowest in Blackpool (74.3 years). According to ONS analysis, approximately 32% of local areas in the East, 43% in the South East and 28% in the South West were in the fifth of areas with the highest male life expectancy at birth. In contrast, there was no local area in the North East and Wales in this group (**Table 14** and ONS 2014n).

Comparable figures for females show that the highest life expectancy at birth in England and Wales was in Chiltern (86.4 years) and the lowest in Manchester (80.00) (ONS 2014n).

Table 14: Local areas with the highest and lowest life expectancy at birth (years), males, England and Wales, 2011-13

Local area	Life expectancy at birth
South Cambridgeshire	83.0
Hart	83.0
East Dorset	82.7
Waverley	82.6
Kensington and Chelsea	82.6
Harrow	82.4
Christchurch	82.4
South Northamptonshire	82.3
Winchester	82.3
Uttlesford	82.3
Neath Port Talbot	76.6
Kingston upon Hull, City of	76.6
Stoke-on-Trent	76.5
Rhondda Cynon Taf	76.5
Hyndburn	76.4
Liverpool	76.2
Burnley	75.6
Blaenau Gwent	75.5
Manchester	75.5
Blackpool	74.3

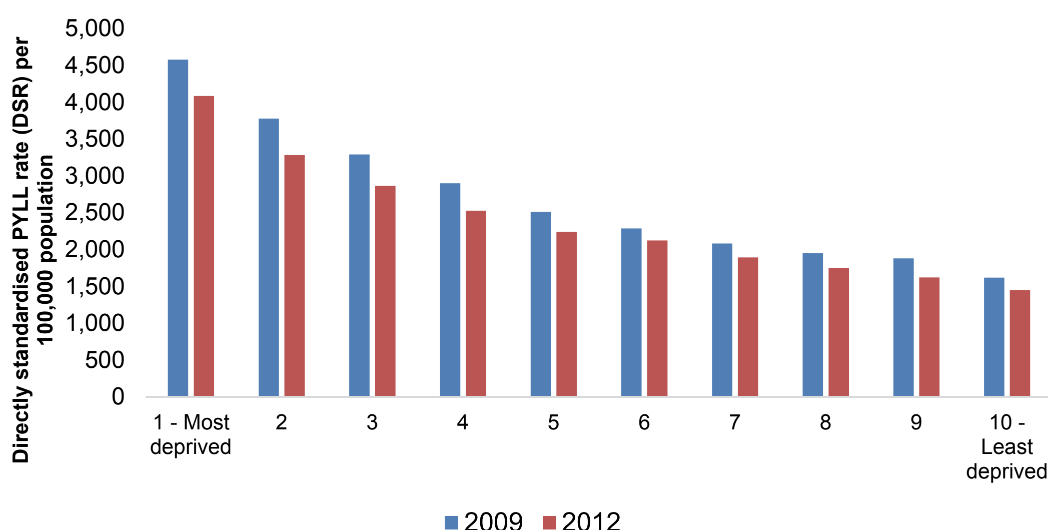
Source: ONS (2014n: Reference table 2)
Note: Life expectancy figures are presented to one decimal place. The rankings in this table reflect differences in the unrounded numbers. Three-year rolling averages, based on deaths registered in calendar years and mid-year population estimates.

The NHS Outcomes Framework uses a number of different indicators to monitor progress in Domain 1, preventing people from dying prematurely. This includes two overarching indicators - potential life years lost from causes considered amenable to healthcare, and life expectancy at age 75 - and a number of further related indicators.

The 'potential years lost' indicator is standardised for age and sex. For men, potential years of life lost per 100,000 registered patients fell from 2,936 in 2009 to 2,586 in 2013. For women, there was a fall from 2,279 in 2009 to 2,036 in 2013. Overall, the fall was from 2,598 years lost in 2009 to 2,303 in 2013 (Appendix 2: Table 30)

A strong social gradient is also observed in the figures for potential years of life lost by IMD deciles (**Figure 18**).

Figure 18 Potential years of life lost (PYLL) from causes considered amenable to healthcare



Source: HSCIC (online), NHS Outcomes Framework Indicators

Life expectancy at age 75 for men was 10.9 years in 2009, increasing to 11.1 years in 2010 and 11.3 in 2011 and 2012. Life expectancy at age 75 for women was 12.9 years in 2009, increasing to 13.2 years in 2011 before falling slightly to 13.0 years in 2012 (Appendix 2 **Table 30**)

DH (2014d: 26) highlighted the need for monitoring this trend, noting that life expectancy at age 75 for females dropped for the first time since 2003 and that, whilst fluctuations in the data might be anticipated, possible explanations include a combination of influenza and cold weather. However, statistically significant increases in the three-year average life expectancy for men and for women were observed between 2008-10 and 2010-12 (Appendix 2: Table 30).

Latest data on trends for life expectancy at age 85 in the UK, England, Scotland and Wales are reported in **Table 15** and raises similar concerns. In the UK as a whole, life expectancy at age 85 for females declined from 6.80 years in 2010-12 to 6.78 years in 2011-13. In England, life expectancy for males at age 85 remained unchanged and for females the decline was from 6.85 years to 6.84 years. There were declines in life expectancy in Wales, Scotland and Northern Ireland for females, and in Northern Ireland, the figure for males also declined from 5.62 to 5.56 years.

Table 15: Life expectancy at age 85, United Kingdom and constituent countries, 1980-1982 to 2011-2013

Year	United Kingdom		England		Wales		Scotland		Northern Ireland	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
1980-1982	4.34	5.38	4.35	5.39	4.26	5.38	4.20	5.21	4.56	5.54
2000-2002	5.09	6.17	5.11	6.20	5.11	6.07	4.93	5.92	4.96	5.93
2007-2009	5.59	6.58	5.63	6.63	5.48	6.50	5.28	6.15	5.37	6.38
2008-2010	5.66	6.66	5.70	6.71	5.53	6.56	5.40	6.26	5.49	6.49
2009-2011	5.77	6.81	5.82	6.86	5.61	6.74	5.48	6.38	5.64	6.64
2010-2012	5.79	6.80	5.84	6.85	5.61	6.72	5.50	6.37	5.62	6.61
2011-2013	5.80	6.78	5.84	6.84	5.62	6.70	5.50	6.35	5.56	6.57

Source: ONS (2014n: Reference data underlying figure 3)

The Public Health Outcomes framework uses an indicator on *healthy* life expectancy, alongside a life expectancy indicator, to track overall progress in public health. Healthy life expectancy at birth in England was 63.4 years for males and 64.1 years for females in 2010-12. ONS analysis notes that there was a "clear North-South divide' in healthy life expectancy in England in 2010-2012, with regions in the South East, South West and East of England all having a significantly higher healthy life expectancy than the England average. The West Midlands, North West, North East, and Yorkshire and The Humber all had significantly lower healthy life expectancy than the England estimate (**Table 16** and ONS 2014o)

Substantial variation in healthy life expectancy is observed at the local authority level. The upper tier local authorities in England with the highest healthy life expectancy in 2010-2012 was Richmond upon Thames for males (70.0 years) and Wokingham for females (71.0 years). Conversely, the upper tier local authority with the lowest healthy life expectancy was in Tower Hamlets for males (52.5 years) and Manchester for females (55.5 years). Absolute inequality in healthy life expectancy between local authorities is even greater than in the context of life expectancy at 17.5 years for males and 15.4 years for females in 2010-12 (**Table 16** and ONS 2014o).

Table 16: Healthy Life Expectancy for males and females at birth by English region (2010-12)

England

	Healthy life expectancy (years)
Males	
South East	65.8
South West	65.2
East	64.9
London	63.2
East Midlands	63.2
West Midlands	62.3
North West	61.3
Yorkshire and The Humber	61.2
North East	59.5
England	63.4
Females	
South East	67.1
East	66.1
South West	66.0
East Midlands	63.6
London	63.6
West Midlands	62.7
Yorkshire and The Humber	62.0
North West	61.8
North East	60.1
England	64.1

Source: ONS (2014o)
Notes: Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address. Regions are presented by gender sorted by healthy life expectancy.

The Public Health Outcomes Framework puts particular emphasis on data that is disaggregated by decile group and gender as well as area, in line with Marmot (2010) recommendations. Data for 2009-11 and 2010-12 illustrates the deeply embedded health inequalities that remain in England, with a marked social gradient reflected in both the range and the slope index of inequality for both life expectancy and healthy life expectancy by national deciles of area deprivation (measured by index of multiple deprivation at the level of LSOA). For life expectancy for males, absolute inequality between the upper and lower decile was 9.2 years in 2009-11 and 9.1 years in 2010-12, whilst inequality as measured by the slope index of inequality was 9.4 years and 9.2 years respectively. Inequality was even

higher in the context of male healthy life expectancy, with absolute inequality at 18.4 years in 2009-2011 and 18.2 years in 2010-12, and the slope index of inequality at 19.3 years and 19.4 years respectively (**Table 17**).

Table 17: Life Expectancy (LE) and Healthy Life Expectancy (HLE) at birth (a) by national deciles of area deprivation in England, Slope Index of Inequality (SII) and Range for Life Expectancy (LE) and Healthy Life Expectancy (HLE), males and females, 2009-2011 and 2010-12

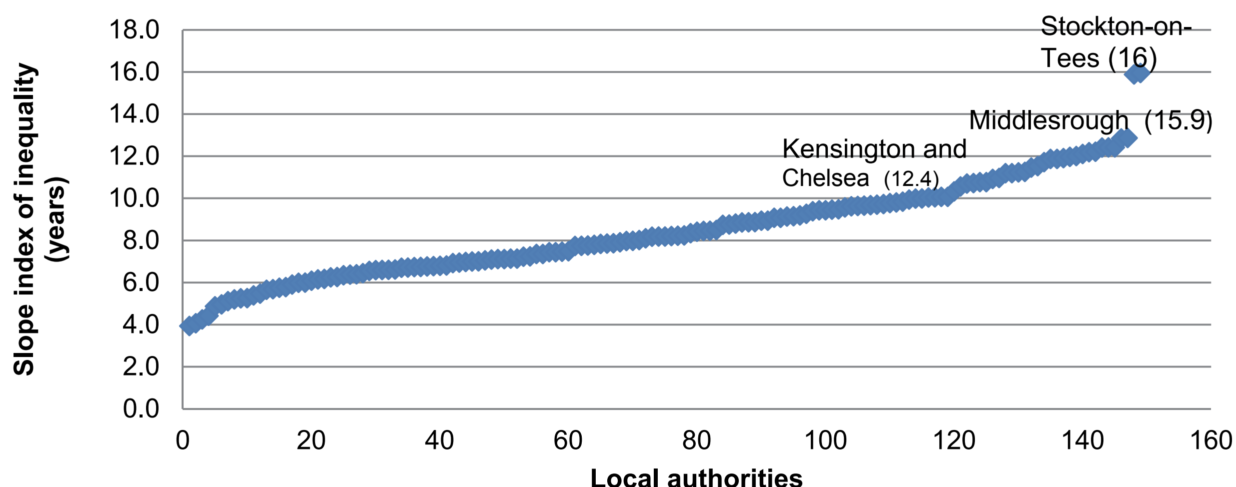
	2009-11				2010-12			
	Life Expectancy (LE)		Healthy Life Expectancy (HLE)		Life Expectancy (LE)		Healthy Life Expectancy (HLE)	
Decile	males	females	males	females	males	females	males	females
1	73.4	78.9	52.1	52.5	73.8	79.0	52.3	52.2
2	75.5	80.4	55.8	56.1	76	80.6	55.8	56.4
3	76.8	81.2	58.4	59.7	77.1	81.4	58.7	59.8
4	78	82.1	61.2	61.7	78.3	82.3	61.4	61.6
5	79	83	63.5	64.3	79.2	83.1	63.4	64.7
6	79.8	83.4	64.9	66	79.9	83.4	65.1	65.7
7	80.6	84	66.8	67.7	80.8	84.1	66.9	67.4
8	81.1	84.3	67.7	68.6	81.4	84.4	67.9	68.7
9	81.5	84.9	68.4	69.8	81.8	85.0	68.9	69.3
10	82.7	85.7	70.5	71.5	82.9	85.9	70.5	71.5
Range (years) (b)	9.2	6.8	18.4	19	9.1	6.8	18.2	19.3
SII (years) (c)	9.4	6.9	19.3	20.1	9.2	6.8	19.4	19.8

Source: ONS (2014f Reference table , 2014t)
Notes:
a) Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address.
b) Range is calculated by taking the difference between decile 1 and decile 10.
c) SII (Slope Index of Inequality) is calculated by taking the difference between the extremes of a population weighted regression line of best fit.
d) Original data is presented with confidence intervals, for details see original source

The Marmot indicator set developed in 2010 also included indicators of *within* area inequalities, including an indicator of within-area inequality in life expectancy. Within area inequality is measured by the slope index of inequality, which in this context represents the gap in years of life expectancy between the best-off and worst-off individuals within each local authority (UCL Institute of Health Equity 2012; UCL Institute of Health Equity and London Health Observatory 2012ab). Data from the Marmot 2014 update (**Figure 19**) shows that the SII ranged by upper-tier local authority from 3.9 (Islington) to 16 (Stockton) for men in 2010-2012. Many regional inequalities were found to be in the North East. In three London boroughs (Camden, Westminster, Kensington and Chelsea) life expectancy for the best-off men was 12 or more years higher than for the worst-off men. Similar data on within area inequalities in life

expectancy is available through the Public Health Outcomes Framework (**Figure 19** and Institute of Health Equity 2014).

Figure 19: Inequality in life expectancy: the slope index of inequality in life expectancy at birth within English upper-tier local authorities, 2010-12



Upper tier local authority	Slope index of inequality
Islington	3.9
Barking and Dagenham	4.1
Cornwall	4.3
Hackney	4.4
Devon	4.9
Lambeth	5.0
Isle of Wight	5.1

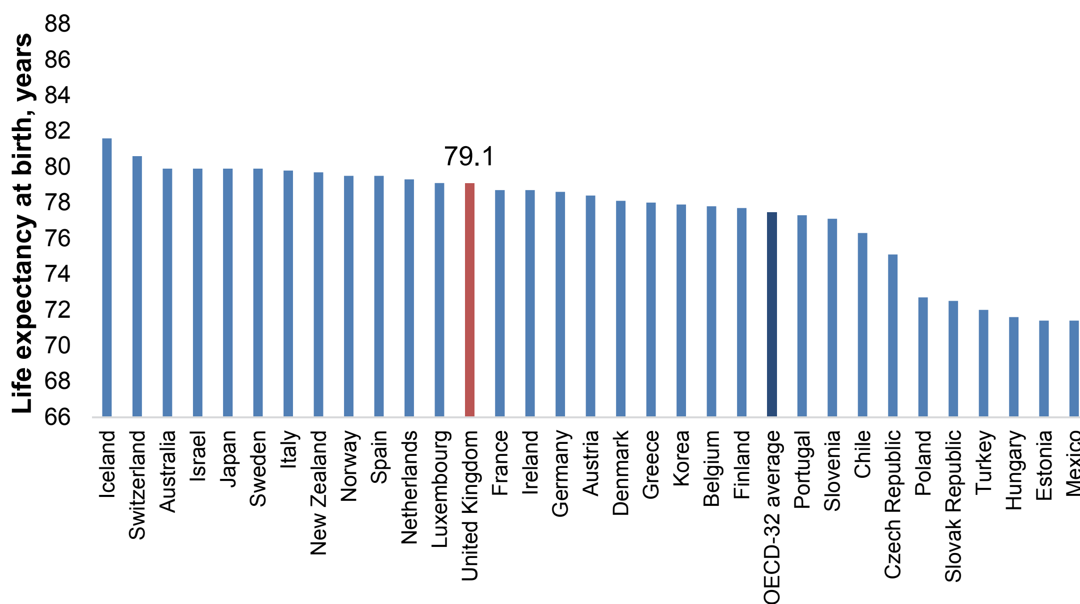
Upper tier local authority	Slope index of inequality
Camden	12.0
Bolton	12.1
Westminster	12.2
Derby	12.2
Wirral	12.4
Kensington and Chelsea	12.4
Darlington	12.4
Blackburn with Darwen	12.8
North East Lincolnshire	12.9
Middlesbrough	15.9
Stockton-on-Tees	16.0

Source: Marmot Indicators, 2014 update (Institute of Health Equity 2014 and London Health Observatory / Public Health England 2014)

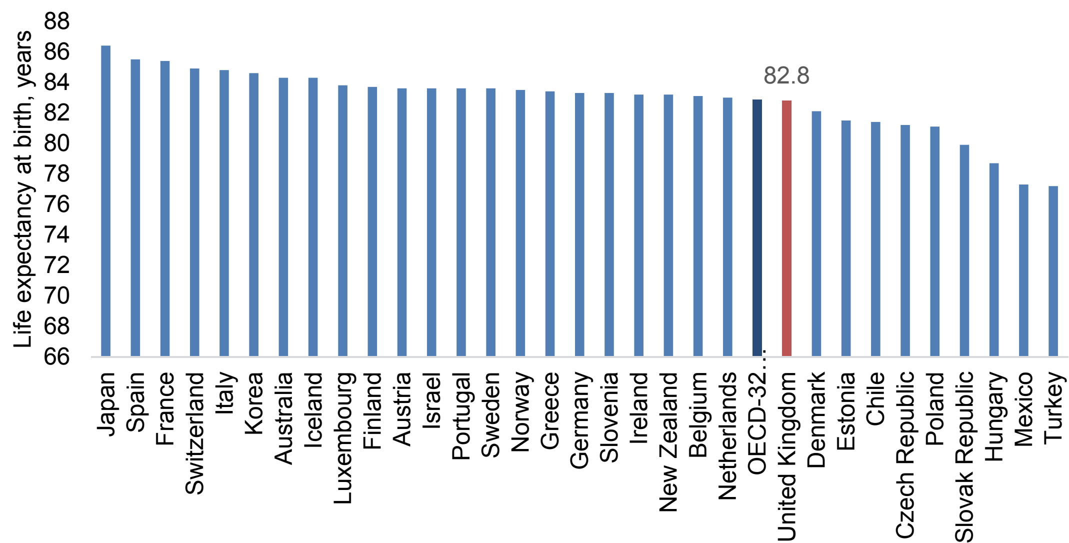
The international picture on life expectancy remained disappointing. For men, the UK was ranked 13th out of 32 OECD countries for which data was available in the OECD health data base in 2012. For women, the UK was ranked 23rd (**Figure 20)**

Figure 20: Life expectancy at birth in 32 OECD countries (2012, years)

a) Males



(b) Females



Source: OECD (2014c)

The "major killers"

In our companion paper, we reported a reduction in circulatory disease mortality to be a major achievement of Labour's period in power with a 52% reduction in the European age standardized (three-year average) circulatory disease mortality rate for men under 75 between 1995-1997 / 2008-2010. The age standardized cancer mortality rate also fell during the period (with a 22% fall over the period 1995-1997 / 2008-2010) and there were important reductions for some specific cancers (notably, a decline in the lung cancer mortality rate for men).

The mortality monitoring series that we report in our previous paper has been discontinued. However, trends in mortality rates by broad disease group for the UK as a whole, standardized to the European population, are reported in ONS (2014). The European age-standardised mortality rate from circulatory disease decreased for both men and women between 2009 and 2013. The European age-standardised mortality rate from cancer (neoplasms) decreased for both men and women over the same period. The European age-standardised mortality rate from respiratory diseases fell for men, but increased slightly for women (**Table 30)**

The NHS Outcomes Framework includes a number of indicators which are used to evaluate progress in addressing premature mortality. Indicators that are used to monitor progress in areas that "need improvement" include:

- 1.1 Under 75 mortality rate from cardiovascular disease;
- 1.2 Under 75 mortality rate from respiratory disease;
- 1.3 Under 75 mortality rate from liver disease;
- 1.4 Under 75 mortality rate from cancer;
- 1.4.i One-year survival from all cancers;
- 1.4.ii Five-year survival from all cancers;
- 1.4.iii One-year survival from breast, lung and colorectal cancer.
- 1.4.iv Five-year survival from breast, lung and colorectal cancer[19].

Indicators 1.1-1.4 are again specified as age standardised rates per 100,000 of the population, with standardisation based on the European population. Trends are reported in **Table 30**

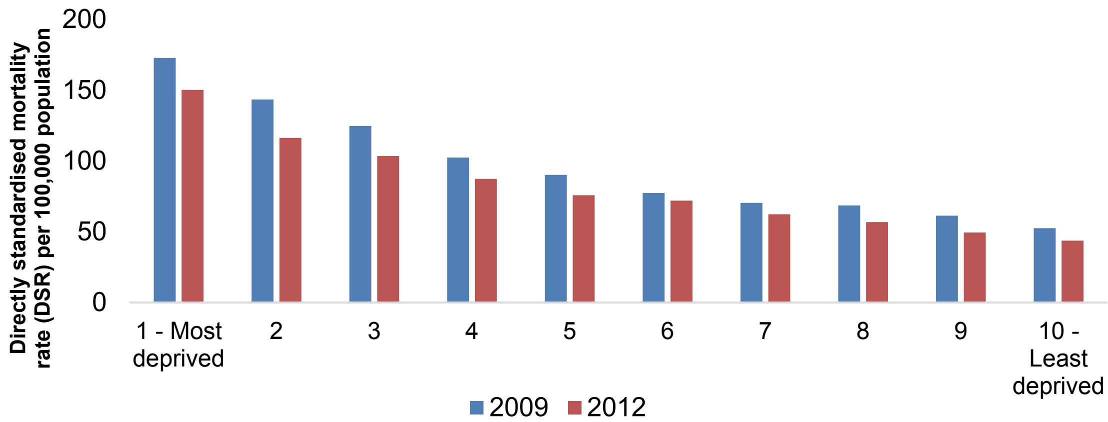
This shows a declining trend in under 75 mortality rates from respiratory disease (not statistically significant) and cancer (statistically significant) for both men and women between 2009 and 2013. No significant change in under 75 mortality rate from liver disease between 2009 and 2013, and no change in mortality rates from cardiovascular disease between 2012 and 2013.

Inequalities in mortality from the "major killers" remain a key challenge in the current period. Data from the NHS Outcomes Framework shows a strong social gradient in under 75 mortality rates per 100,000 population from circulatory diseases, cancer, respiratory and liver diseases by IMD decile in 2012.

[19]For details see the Health and Social Care Indicator Portal, https://indicators.ic.nhs.uk/webview/, accessed January 2014.

Figure 21: Inequality in mortality from cardiovascular diseases, cancer and respiratory diseases by IMD decile (England, 2012, age standardized under 75 mortality rates per 100,000 population)

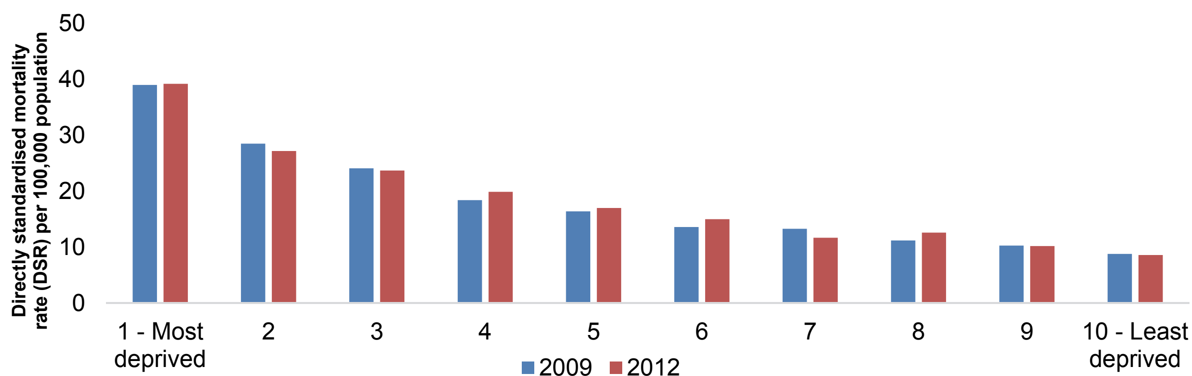
Cardiovascular disease



Respiratory disease

Cancer

Liver disease



Source: HSCIC (online), NHS Outcomes Framework Indicators

Note: for cardiovascular disease, data for 2009 is not comparable to 2012 as there were coding changes in 2011

The UK's international position remained mixed. Declines in mortality from circulatory disease in the UK have been notable compared to other European countries. However, according to OECD comparative health data remains below the best performers on international league tables. The UK was in twelfth amongst EU28 countries for standardized mortality rates from ischemic heart disease for men in 2011, below France, Netherlands, Denmark and Greece. Performance in the context of stroke was better, with the UK ranked sixth for men (OECD 2014c: Figure 1.4.2).

Based on OECD comparative data, age standardized cancer mortality rates in 2011 were one rank above the EU-28 average. For men and women separately, the data shows cancer mortality rates were below the EU-28 average for men but well above the average for women, with the UK ranked 9th and 23rd respectively. For lung cancer mortality rates, the UK was ranked 8th and 26th out of 28 EU countries for men and women, respectively, with overall mortality rate from lung cancer in the UK ranked above EU-28 average. Mortality from breast cancer is also above the EU average (with the UK ranked 18th).

Table 18: Breast cancer mortality, females, 2011

	2011	
Spain	25.5	
Portugal	27.5	
Sweden	28.2	
Finland	28.2	
Poland	29.2	
Greece	30.1	
Romania	30.6	
Lithuania	30.7	
Bulgaria	31.5	
Cyprus	32.3	
Austria	32.3	
Estonia	32.4	
Italy	33.0	
Czech Rep.	33.1	
France	33.2	
EU-28	**34.5**	
Latvia	36.1	
Germany	36.8	
United Kingdom	36.9	
Slovenia	37.0	
Luxembourg	37.2	
Croatia	38.2	
Slovak Rep.	38.3	
Hungary	39.2	
Netherlands	39.8	
Belgium	41.3	
Ireland	41.8	
Malta	41.8	
Denmark	44.1	
Norway	26.0	
Iceland	31.8	2009
Switzerland	33.6	
FYR of Macedonia	38.2	2010

Source: OECD 2014c Figure 4.7.3

Infant mortality

Overall infant mortality rates continued to fall, from 4.5 per 1,000 live births in 2009 to a historic low of 4 per 1,000 live births in 2012. Our companion paper (Vizard and Obalenskya 2013) evaluated progress towards the narrowing of the infant mortality gap during Labour's period in power (1997-2010). A target to reduce infant mortality inequalities was specified in terms of reducing the relative gap between the routine / manual occupational groups and the all England average. Progress was initially slow and both the absolute and relative gaps initially increased. However, there was a rapid fall in the relative gap toward the end of Labour's period in power, the most recent data available suggested that the absolute and relative gaps fell by 42% and 25% respectively over the period 1997-99 / 2008-2010 as a whole (England only).

The time series data made in the above evaluations of inequality was discontinued. Alternative data for the period 2008-2012 is presented below (**Table 19**). There is a break in this series after 2010, due to changing methodology adopted by the ONS involving a switch to basing the classification of occupational group on combined parental occupational group rather than the father's occupational group (see measures 1 and 2). A revised definition of occupational group has also been developed by ONS and this is also applied (measure 3). These changes mean that the data in **Table 19** up to 2010 cannot be compared with that for 2011 onwards. In addition, the methodology for evaluating inequality we apply here also differs from our previous paper. The focus here is on gaps between routine/manual/other occupational social groups (socio-economic groups 5-8) and professional/managerial/intermediate/small employers occupational social groups (socio-economic groups 1 to 4) rather than gaps with the all England average.

Whilst the different measures result in absolute and relative gaps of different magnitudes, all three measures suggest continued progress in reducing inequality. Falls in the infant mortality rate within the routine / manual occupational groups have been more rapid than in the context of the professional, higher managerial, administrative and intermediate occupations over the most recent period and both the absolute and relative gaps narrowed in 2011 and 2012 (c.f. Stewart 2015).

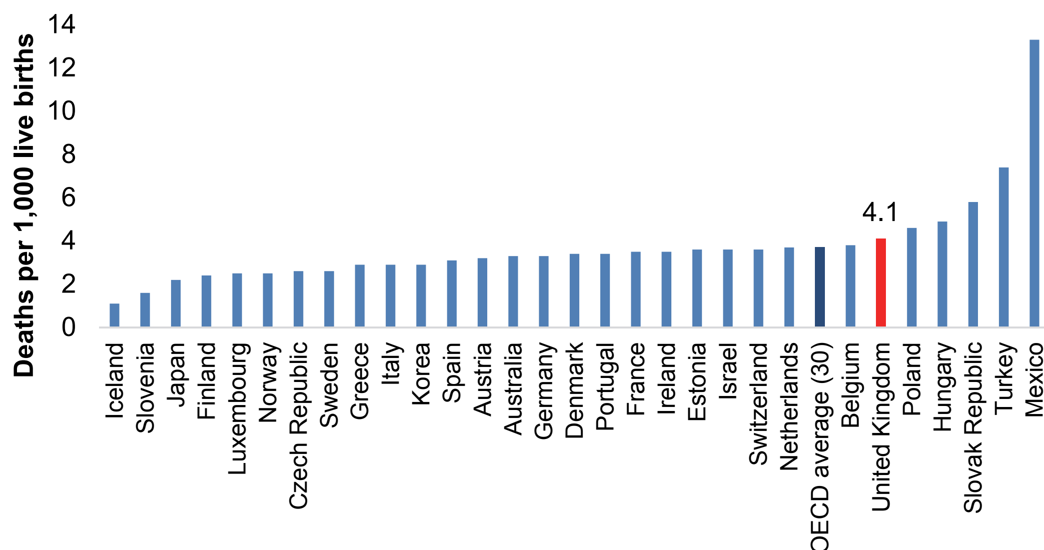
Table 19: Infant mortality rate: routine/manual/other group compared with professional/managerial/intermediate/small employers group (joint registrations, England and Wales)

	Infant mortality rate					Gap in mortality rate between Lower and Higher socio-economic groups			% reduction in mortality rate across years		
	ALL (joint/sole registrations)	all (joint registration)	professional/managerial/intermediate/small employers (socio-economic groups 1 to 4)	routine/manual /other (socio-economic groups 5-8)	all (sole registrations)	absolute	relative (%)	average relative gap for comparable years	all (joint registrations)	professional, higher managerial, administrative and intermediate occupations	Routine/ manual/ other
Measure 1)											
2008	4.5	4.4	3.4	4.9	6.8	1.5	43				
2009	4.4	4.4	3.6	4.8	5.5	1.2	34	37	-7	-3	-10
2010	4.2	4.1	3.4	4.4	5.4	1.1	32				
Measure 2) combined social class											
2008	4.5	4.4	3.6	5.4	6.8	1.8	50				
2009	4.4	4.4	3.7	5.2	5.5	1.5	41	46	-7	-6	-7
2010	4.2	4.1	3.4	5.0	5.4	1.6	47				
Measure 3) combined social class and Standard Occupational Classification (SOC)											
2011	4.1	3.8	2.6	6.2	5.5	3.6	140	135	-3	-2	-5
2012	3.9	3.7	2.6	5.9	5.1	3.3	131				

Sources:
Authors' calculations using infant mortality data for 2008 to 10 (father's social class and combined social class) from ONS (online), Live births and infant mortality statistics by father's NS-SEC and Life births and infant mortality statistics by Combined Social Class (excel documents) and data for 2010 to 2012 from ONS (2014l). Rate of infant deaths is calculated as per 1,000 live births.
Notes:
(i) Data for 2008 to 2010 is based on NS-SEC classification which was introduced in 2001 to replace the Registrar General's Social Classification (RGSC). To take account of this change in classification, the formulation of the target was changed from "manual" social class to "routine and manual" groups. A time series back to 1994 was constructed to be on an equivalent basis and is based on an approximation to NS-SEC (NS-SEC 90) available for use with data prior to 2001. See DoH (2009) Annex for further details.
(ii) Data for 2011 and 2012 is based on a changed Standard Occupational Classification (SOC) in January 2011 and is therefore not strictly comparable to previous years. A report providing more detail on the impact of rebasing NS-SEC to SOC2010 for infant mortality statistics can be found here: Rose and Pevalin (2010), Re-basing the NS-SEC on SOC2010: A Report to ONS, available: http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html, accessed February 2014.
(iii) The definition for 'inside marriage / joint registrations' changed from 2011 whereby joint registrations where a couple lived at different addressed were excluded from this analysis group and were joint with "sole registration" group. More information on this can be found in ONS (2013), planned changes to Child Mortality Outputs, available: http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/2011/stb-cms-2011.html, accessed February 2014
(iv) Mortality rates are based on infant deaths successfully linked to their birth records
(v) Father's social class: NS-SEC based on father's occupation at death registration and 'combined social class' means a household highest NS-SEC
(vi) Linked infant are deaths used here (deaths that were successfully linked to their birth registration records)
(vii) Absolute gap in mortality rate is authors' calculations of the difference in rates between higher social group (1 to 4) and routine/manual/other occupational group (5 to 8) among joint registrations. Relative gap in mortality rate is the difference in rates between higher social group (1 to 4) and routine/manual/other occupational group (5 to 8) as a percentage of the higher social group (1 to 4) rate for joint registrations.

The international picture also remained disappointing. Of 30 OECD countries with available data in the OECD health data base for 2012, the UK was ranked 25th (Figure 22).

Figure 22: Infant mortality rate in OECD countries (2012, deaths per 1000 live births)



Source: OECD (2014c)

Non-medical determinants

In this section, we review trend on non-medical determinants of health such as obesity, physical exercise, diet, smoking and alcohol consumption. The Public Health Outcomes Framework also includes a considerable number of indicators of the *social* determinants of health, building on framework for reducing health inequalities set out in the Marmot Review (2010). A large number of the indicators within the framework reflect recognition of the importance of the underlying social determinants of health (including, inter alia, child development, poverty and inequality, housing conditions, domestic violence and worklessness) as drivers of health outcomes. We do not review these broader social determinants. The 2014 Update of the Marmot Indicators identified deterioration in relevant social indicators since the downturn and crisis and pointed towards poor children's development and insufficient income to live a healthy lifestyle as likely causes of health inequalities in the future (Institute of Health Equity 2014). Trends and patterns reported in other papers in this series (Hills et al 2015, Burchardt et al 2015, Lupton and Fitzgerald 2015, Lupton and Thompson 2015, Lupton et al 2015, Mcknight 2015, Stewart 2015, Tunstall 2015) are highly relevant.

Obesity, physical exercise and diet

Obesity rates amongst adults in England continued to increase. Based on Health Survey for England data (for adults over 16), obesity prevalence amongst men, increased from 22.1% in 2009 to 24.4% in 2012 whilst those morbidly obesity prevalence increased from 1.3% to 1.7%. Prevalence of overweight (including obesity) increased from 65.8% to 66.6%. Amongst women, obesity prevalence increased from 23.9% in 2009 to 25.1% in 2012, whilst morbidly obese fell back somewhat, from 3.5% to 3.1%. Prevalence of overweight (including obesity) increased from 56.7 to 57.2. Overall, the percentage of men and women obese increased from 23% to 24.7% (Appendix 2: **Table 30).**

Vizard and Obalenskaya 2013 (111-118) reported evidence of a halt in the increase in child obesity towards the end of Labour's period in power (between 2006-08 and 2008-2010). In the current period, according to HSE data, the overall prevalence rate for overweight including obese amongst children aged 2-15 fell from 29.8% in 2009 to 27.9% in 2012. This decline was driven by improvements in the younger age group (2-10) with increases amongst those aged 10-15 (Appendix 2: **Table 30**).

Inequalities in obesity prevalence by socio-economic status remained a key challenge in 2012. Moody (2013: 2) finds that obesity prevalence was lowest in the highest income groups (21% of men and 19% of women), and highest in the fourth quintile (27% of men and 33% of women). Inequalities in obesity rates amongst children were also notable. Ryley (2013: 2 and Tables 11.3 and 11.4) finds that amongst children aged 2-15, levels of obesity were highest for boys in the lowest quintile of equivalised household income (19%) and for girls in the three lowest quintiles (15% to 17%). Likewise, the prevalence of obesity was higher among those living in the two most deprived quintiles of the Index of Multiple Deprivation (16% to 19% for both boys and girls) (c.f. Stewart 2015).

The international picture also remained disappointing. OECD analysis suggests that in 2012, the UK was at the bottom of the European league table for obesity amongst adults, with only Hungry recording higher obesity rates (**Table 20)**.

Despite efforts and campaigns around the Olympic Games held in London in 2012, there was little reported improvement in the percentage of adults meeting physical activity recommendations, rising from 59% in 2008 to 60% in 2012 (based on revised physical activity recommendations and survey measurement). Rates based on previous physical activity recommendations and measurement increased percentage increased from 36% in 2008 to 38% in 2012 (see Appendix 2 **Table 30**) , and accompanying notes section on changes in recommendations and measurement).

Physical activity rates amongst children *deteriorated* between 2008 and 2012. Scholes and Mindell (2013; 1-2, 8, Table 7, Table 3.4, Figure 3B) find that amongst boys aged 5-15, 21% were meeting guidelines in 2012, down from 28% in 2008 (a statistically significant difference). Amongst girls aged 5-15, 16% were meeting guidelines, down from 19% in 2008 (not a statistically significant fall). For both boys and girls, the proportion meeting guidelines declined with age. Conversely, the percentage falling within the low activity group increased for both genders between 2008 and 2012. There was no significant variation by equivalised household income in the proportion of children aged 5-15 achieving recommendations. However, the proportion of both boys and girls in the low activity group was greater in lower quintiles than higher quintiles of equivalised household income.

On dietary factors, consumption of fruit and vegetables is likely to sensitive to broader changes in real incomes, wages and poverty rates. The general context here is therefore the downturn that began in 2007 and related trends, including the increase of reliance on food banks. The mean portion for adults over 16 was 3.4 in 2003 rising to a peak of 3.8 in 2007 before falling to 3.5 in 2009, and rising slightly to 3.6 in 2010 and 2011 (latest data). The percentage meeting the recommended guidance of 5 or more portions of fruit and vegetables a day was 24% in 2003, rising to 30 in 2006 and 29.1 in 2007, before falling back to 26% in 2009 and 20010. There was a slight increase to 26.6% in 2011 (latest data) but the percentage remained below its prerecession peak (see Appendix 2 **Table 30)**.

Table 20: Prevalence of obesity among adults in European countries (2012 or nearest available year of data, % of the population aged 15 or above)

	Percentage obese	
Romania	7.9	2008
Italy	10.4	
Bulgaria	11.5	2008
Sweden	11.8	
Netherlands	12.0	
Austria	12.4	2006
Denmark	13.4	2010
Belgium	13.8	2008
France	14.5	
Germany	14.7	2009
Portugal	15.4	2006
Cyprus	15.6	2008
Finland	15.8	
Poland	15.8	2009
Spain	16.6	2011
EU-26	**16.7**	
Slovak Rep. [1]	16.9	2008
Latvia	16.9	2008
Slovenia	18.3	
Estonia	19.0	
Greece	19.6	2010
Czech Rep. [1]	21.0	2010
Malta	22.9	2008
Luxembourg [1]	23.0	
Ireland [1]	23.0	2007
United Kingdom [1]	24.7	
Hungary [1]	28.5	2009
Norway	10.0	
Switzerland	10.3	
Turkey	17.2	
Iceland	21.0	2010

Source: OECD (2014c:figure 2.5.1); OECD Health Statistics 2014 completed with Eurostat Statistics Database.
Note: (1) Data are based on measured rather than self-reported height and weight.

Smoking and alcohol consumption

In England, the reduction in population adult smoking prevalence stayed on trend though. According to Health Survey for England data, the rate for men fell from 24% in 2009 to 22% 2012, and for women 20% to 18%. Overall, for men and women combined, the percentage reporting being a current cigarette smoker fell from 22% to 20%. However, data from the Opinions and Lifestyle Survey time trend, which covers Great Britain rather than England, presents a slightly different picture on overall

trends to HSE data. Whereas the HSE data suggested overall falls between 2011 and 2012, the Opinions and Lifestyle Survey data suggests stability in Great Britain with overall prevalence at 20% in both 2011 and 2012 (see Appendix 2, **Table 30**).

Table 21 reports the most recent data on cigarette smoking by socio-economic classification (based on the Opinions and Lifestyle Survey). In 2012, amongst men in Great Britain, smoking with the managerial and professional occupational group stood at 16%, amongst intermediate occupational groups at 24% and amongst routine and manual groups at 33%. Amongst women, the rates were 12%, 17% and 32% respectively. Based on rounded up figures, the absolute gaps for men in Great Britain between the highest and lowest occupational social groups increased from 15 to 17 percentage points for men, and for women from 14 to 20 percentage points between 2011 and 2012. These figures reflected more rapid increases in the prevalence of smoking amongst routine and manual occupational groups for both men and women between 2011 and 2012 in GB as a whole.

Table 21: Variations in cigarette smoking by socio-economic classification in Great Britain (2011 and 2012)

		2011	2012
Men	Managerial and professional	14	16
	Intermediate	21	24
	Routine and manual	**29**	**33**
Women	Managerial and professional	12	12
	Intermediate	19	17
	Routine and manual	**26**	**32**
All	Managerial and professional	13	14
	Intermediate	20	20
	Routine and manual	**28**	**33**

Source, see Appendix 2 **Table 30** (Opinions and Lifestyle Survey data.)

The percentage of adults not meeting alcohol guidelines in England improved. The percentage of men drinking four or more units of alcohol on their heaviest drinking day fell from 43% in 2009 to 37% in 2012. For women, the percentage drinking three or more units of alcohol on their heaviest drinking day fell from 31% to 28%. Overall, the percentage of men and women not meeting recommendations on alcohol consumption fell from 37% to 33% (see Appendix 2 **Table 30**.

Suicide, mental health and general health

In the broader research literature, there is a growing body of evidence on the adverse impact of the financial crisis and economic downturn that began in Autumn 2007 on suicide rates and mental health in many different countries of the world. In major cross-country studies, Stuckler et al. (2011) highlight the reversal of the steady decline in suicide rates in EU Member States following the crisis and suggests that this indicator provided an “early warning” of increased stress in hard hit countries. Chang et al. (2013) found that there was a higher 4.2 percent (3.4-5.1 percent) suicide rate in 27 European countries, and a 6.4 percent (5.4-7.5 percent) higher rate in 18 countries in the Americas, than would

have been expected had earlier trends continued. The upturn in suicides in Greece after 2007 is examined in Kentikelenis et al. (2011) and Karanikolos et al. (2013), whilst Reeves et al. (2012) identify an acceleration in the previous (pre-crisis) upward trend in the suicide rate in the USA in the post-recession period.

OECD (2014c: 28) notes that suicide rates increased in number of European countries following the crisis particularly amongst men. However, the authors note that in any countries this trend did not persist and that in Greece, whilst the rate increased substantially, it remained relatively low compared to other countries.

Barr et al. (2012) examine the UK evidence, suggesting that regions with the largest rises in unemployment have experienced the largest increases in suicides, particularly amongst men. The impacts of recent labour market changes and social policy change on population mental health are discussed in Katikiereddi et al (2012), who found evidence that population mental health in men had deteriorated within 2 years of the onset of the current recession. However, these changes, and their patterning by gender, could not be accounted for by differences in employment status.

National targets on suicide were introduced under the last Government and suicide is included as an indicator in the Public Health Outcomes Framework. The interpretation of trends in suicide rates is complicated both by year on year fluctuations, conventions in the recording of deaths and revisions to population estimates methodology. Whilst there was a long-term improvement in the age-standardised suicide rate in the England since 1981 for both men and women, this rate increased significantly between 2007 and 2012. A similar pattern is observed for the UK as a whole, with a significant year on increase between 2010 and 2011. The apparent upward trend since 2007 reflects an increase in the age-standardised suicide rate for men but not for women (**Table 22**; ONS 2014e).

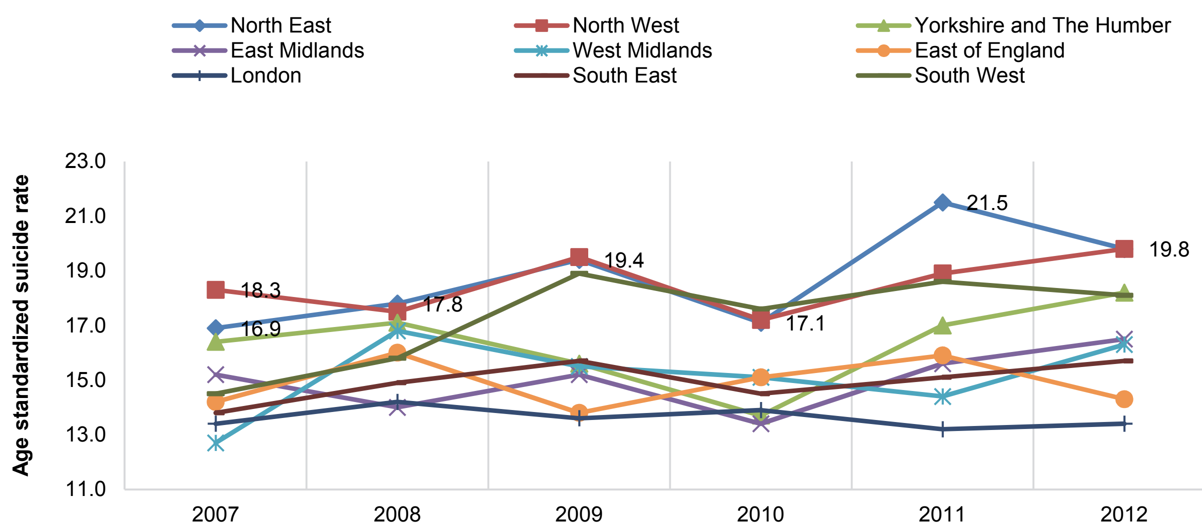
Table 22: Age-standardised suicide rates for males and females, and age-specific suicide rates, United Kingdom 2007-2012

	Persons			Males			Females			Males (45 to 49 years old)		
Year	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**
2007	10.8	10.5	11	16.8	16.2	17.3	5	4.7	5.3	19.4	17.5	21.3
2008	11.4	11.1	11.7	17.6	17.1	18.2	5.3	5	5.6	20.9	19	22.8
2009	11.2	10.9	11.5	17.4	16.9	18	5.2	4.9	5.5	21.7	19.7	23.6
2010	11	10.7	11.3	16.9	16.4	17.4	5.2	5	5.5	21.8	19.9	23.7
2011	11.8	11.5	12.1	18.1	17.6	18.7	5.6	5.4	5.9	23.9	21.9	25.9
2012	11.6	11.3	11.9	18.2	17.7	18.8	5.2	4.9	5.5	25	23	27

Source: ONS (2014e), Reference tables. Table 1 and Table 6
Notes:
1 The National Statistics definition of suicide is defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent.
2 Figures are for persons aged 15 years and over.
3 Age-standardised suicide rates per 100,000 population, standardised to the 1976 European Standard Population. Age-standardised rates are used to allow comparison between populations which may contain different proportions of people of different ages.
4 Age-specific suicide rate per 100,000 population.
5 The lower and upper confidence limits have been provided. These form a confidence interval, which is a measure of the statistical precision of an estimate and shows the range of uncertainty around the estimated figure. Calculations based on small numbers of events are often subject to random fluctuations. As a general rule, if the confidence interval around one figure overlaps with the interval around another, we cannot say with certainty that there is more than a chance difference between the two figures.
6 Deaths of non-residents are included in figures for the UK.
7 Figures are for deaths registered in each calendar year.

Age specific suicide rates raises the particular issue of stalling of progress in the period since the financial crisis and downturn amongst middle aged men. Looking at the position of males aged 45-49 in the UK separately, the suicide rate increased significantly between 2007 and 2012 from 19.4 to 25.0 deaths per 100,000 population (**Table 22**)[20]. Data by English region suggests that rates for men were higher in the North West and North East regions and that rates within these regions also showed signs of increasing after 2007 (although the increases are not statistically significant in either case) (**Figure 23**). The Howard League for Penal Reform reported prison suicides in England and Wales to be at a seven year high in January 2015 (BBC 2015c).

Figure 23: Age-standardized suicide rate per 100, 000 males, English regions, 2007 - 2012



Source: ONS (2014e), Reference tables. Table 5.
Notes:
1. The National Statistics definition of suicide in the United Kingdom: suicide is defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent.
2. Figures are for persons aged 15 years and over.
3. Age-standardised suicide rates per 100,000 population, standardised to the 1976 European Standard Population. Age-standardised rates are used to allow comparison between populations which may contain different proportions of people of different ages.
4. Figures are for persons usually resident in each area, based on boundaries as of August 2013.
5. Figures are for deaths registered in each calendar year.

There is also evidence of an increase in mental health risk in the period coinciding with the recession and downturn. Health Survey for England data suggests that there was an overall increase in poor mental health risk, measured by the percentage with a GHQ12 score of four or above, in the period 2008-2012. The overall percentage identified as at risk of poor mental health increased by 1.6% over this period (statistically significant at the 99% level). Disaggregating by gender, the increase for men was only 0.7% (not statistically significant at 95% level). However, there was a particularly striking increase amongst women, up by 2.5 percentage points over the period (statistically significant at the 99% significance level). Notable increases are observed amongst middle aged men and women, especially

[20]Significant increases compared with other base years (for example, over the period 2003-2011) are also observed. The evaluation here is based on the most recent data published by ONS at the time of writing. The data is being revised in line with new population estimates (on which, see Table 2, note 4). It is unlikely that this will affect the finding of a significant upturn in the rate for men aged 45-59 over the period 2007-2011 (ONS 2014e).

men in the 40-44 and 49 age bands, with 4.4 and 3.6 percentage point increases respectively (significant at the 95% level). Amongst women, the biggest rises were amongst those aged 16-24, 40-44 and 55-59. Particularly notable increases are also observed amongst individuals who experience a LLID (up by 6.3 percentage points over this period).

In 2012, there remained a strong social gradient in mental health risk by social class, whilst those from the Pakistani/Bangladeshi and African/Caribbean/Black ethnic minority group were more likely to experience risk of poor mental health than those from the White ethnic minority group. The prevalence of poor mental health risk was also substantially greater amongst those who experience a LLID than those who do not; and was greatest among men and women with the lowest quintile (25%th each) or of equivalised household income, 23.6% and 26.9% respectively, compared with 7% of men and 16% of women with the highest income (Table 23).

Table 23: GHQ-12 score of 4 or more, England, by subgroup

	All				**Males**				**Females**			
	2012 (%)		**Change 2008-2012 (percentage point)**		**2012 (%)**		**Change 2008-2012 (percentage point)**		**2012 (%)**		**Change 2008-2012 (percentage point)**	
Overall	15.0		1.6	**	11.9		0.7		18.0		2.5	**
aged 16-24	13.7		3.3		7.8		0.6		21.0		7.2	*
aged 20-24	16.7		2.2		10.7		- 1.8		21.5		5.1	
aged 25-29	15.7		1.0		11.1		- 1.1		20.1		2.7	
aged 30-34	12.3		1.2		7.6		- 1.0		16.6		3.3	
aged 35-39	15.8		2.7		13.4		2.4		18.2		3.1	
aged 40-44	17.2		4.4	*	15.5	*	3.2		18.9		5.5	*
aged 45-49	16.5		3.6	*	12.2		3.5		20.2		3.8	
aged 50-54	16.7		-1.1		13.4		- 1.5		20.2		-0.8	
aged 55-59	16.1		1.7		10.9		- 2.3		21.1		5.8	*
aged 60-64	15.2		3.1		17.4	**	7.1		13.1	*	-0.7	
aged 65-69	9.5		-1.5		7.2		- 1.5	**	11.8	*	-1.5	
aged 70-74	12.2		0.4		14.8	*	5.1		10.1	**	-3.5	
aged 75-79	12.3		-2.6		10.7		- 1.8		13.8		-2.9	
aged 80 or over	16.1		-1.2		13.2		- 3.3		17.7		-0.1	
Not disabled	9.9		0.9		7.3		-0.1		12.4		1.8	*
Disabled	34.9	**	6.3	**	32.3	**	6.0		36.8	**	6.5	**
								**				
White	14.6		1.4	*	11.7		0.8		17.4		2.0	*
Mixed	14.2		-1.6		3.9		-10.7		24.8		7.7	
Indian	16.3		-1.7		15.1		-3.3		17.5		-0.1	
Pakistani/Bangladeshi	22.9	*	6.5		18.6		4.3		28.2	*	9.1	
African/Caribbean/Black	19.9	*	6.6		15.7		4.1		22.5		7.8	
Other	13.0		0.0		7.6		-3.4		18.5		3.9	

Male	11.9		0.7		11.9		0.7		0.0		0.0	
Female	18.0	**	2.5	**	0.0		0.0		18.0		2.5	**
Higher managerial, administrative and professional	9.9		1.2		8.1		0.3		13.8		2.7	
Lower managerial, administrative and professional	14.0	**	2.1		9.9		-0.2		17.5		4.0	**
Intermediate	14.3	**	0.3		10.6		0.0		15.5		0.5	
Small employers and own account workers	15.3	**	4.0	*	15.9	**	5.3		14.1		1.4	
Lower supervisory and technical	14.0	*	1.0		12.4	*	1.1	*	18.0		0.3	
Semi-routine	16.8	**	1.1		11.7		-1.7		19.9	*	2.9	
Routine	18.5	**	2.2		15.9	**	0.9		21.5	*	3.7	
Never worked or long-term unemployed	15.1		-7.0		0.0		0.0		16.7		-4.6	
North East	17.0		3.7		11.5		0.8		22.3		6.4	*
North West	15.6		1.8		14.5		2.5		16.6	*	1.2	
Yorkshire and The Humber	16.8		2.3		12.2		-0.5		21.4		5.1	
East Midlands	15.3		1.4		11.0		0.5		19.4		2.3	
West Midlands	16.1		1.0		13.8		1.1		18.3		0.9	
East of England	15.4		3.5	**	11.9		-0.2		18.7		7.0	**
London	17.2		2.0		12.1		-0.2		21.7		3.5	
South East	12.7	*	1.4		11.7		1.9		13.6	**	0.8	
South West	10.5	**	-1.7		7.8		-0.7		13.4	**	-2.3	
Lowest quintile of household equivalent income (<£10,598)	25.4		4.1	*	23.6		3.6		26.9		4.6	*
2nd lowest Quintile (>=£10,598< £16,852)	15.2	**	-0.5		13.6	**	-0.3		16.6	**	-0.8	
Middle quintile of household equivalent income (>=£16,852< £25,114)	13.2	**	0.9		10.3	**	1.6		16.1	**	0.2	
2nd highest quintile of household equivalent income (>=£25,114< £40,373)	11.6	**	1.0		8.0	**	-0.5		15.4	**	2.6	
Highest quintile of household equivalent income (>=£40,373)	11.1	**	2.5	*	6.7	**	-0.7		15.7	**	5.7	**

Source: CASE calculations using HSE 2008 and 2012

Note: 2012 * denotes a statistically significant difference at the 95% level; ** denotes a statistically significant difference at the 99% level. For the cross-sectional 2012 analysis, significant differences relate to subgroup differences compared to a reference group marked in bold. For the change over time analysis, significant differences relate to the change in the subgroup proportion over time. Significance testing has been performed using a logistic regression test

New findings using the 2011 Census suggest the importance of targeted analyses to capture the position of at risk groups. Specific analysis provides a basis for comparing the rates of bad and very bad general health by ethnic minority group. Rates of bad and very bad general health are strikingly high amongst the Gypsy and Traveller ethnic group (**Table 24**).

Table 24: Variations in bad and very bad self-reported general health (England and Wales, 2011)

			Percentage	
		Bad	**Very bad**	Total
White	**British**	4.6	1.3	5.9
	Irish	6.9	2.3	9.2
	Gypsy or Irish Traveller	9.5	4.6	14.1
	Other White	2.4	0.8	3.2
Mixed/multiple ethnic groups	**White and Black Caribbean**	2.7	0.9	3.6
	White and Asian	1.9	0.6	2.5
	White and Black African	2.1	0.7	2.8
	Other Mixed	2.5	0.9	3.4
Asian/Asian British	**Indian**	3.4	1.1	4.5
	Pakistani	4.1	1.4	5.5
	Bangladeshi	4.1	1.5	5.6
	Chinese	1.6	0.4	2.0
	Other Asian	2.5	0.8	3.3
Black/African/Caribbean/Black British	**African**	1.7	0.6	2.3
	Caribbean	4.9	1.8	6.7
	Other Black	3.0	1.1	4.1
Other ethnic group	**Arab**	3.7	1.5	5.2
	Any other ethnic group	4.2	1.5	5.7

Source, ONS (2014p), original source Census 2011
Note: Figures have been rounded

7.Conclusions, overall evaluation and looking forward

This section concludes by drawing together the findings, provides an overall evaluation and setting out the challenges facing an incoming Government in 2015.

Continuity or change?

In drawing overall conclusions about the nature and scope of the Coalition's health reforms, it is important to note that the Coalition has fulfilled its commitment to an NHS that is free at the point delivery, based on need not ability to pay. Under the new statutory framework, the Secretary of State retains a duty to secure a comprehensive NHS. The Act includes also new statutory duties to improve outcomes and to reduce health inequalities.

It is also important to note that there is a difference between current model of public service delivery and health service *privatisation*. Health services in England are publicly commissioned, paid for by the public purse, free at the point of delivery and provided within an overall framework of political accountability and responsibility for outcomes and standards. There is a major contrast here with a pure privatisation model - with direct contracts between individuals and privatised companies, private exchanges at market prices, no public commissioning function and minimal regulation.

There has been no major change to the health services *financing* model over the period 2010-2014. The NHS remains funded through general taxation, albeit with an increasing role for national insurance. The overall share of patient charges in NHS financing remains relatively low and there has been no general move to hotel charges or charges for GP consultations or A&E attendance. There has *not* been a move towards alternative financing arrangements such as a hypothecated health tax or a social insurance model.

Growth of the private sector *outside* of the framework of public commissioning has also been limited. Total real private expenditure on healthcare has not increased as a percentage of GDP and expenditure on private medical insurance has remained stable. Challenges to the protection of the right to health that arise in some countries and contexts - such as high out-of-pocket payments, catastrophic health expenditure and gaps in healthcare coverage - continue to be avoided in the UK. In the UK out of pocket payments on health are extremely low by international standards and the share of out-of-pocket payments in total expenditure on health has been declining since 1997. This trend continued after the onset of recession and crisis in 2007, albeit with an apparent small upturn after 2010 (OECD 2014). The UK's performance in relation to an important measure of health equity, unmet need for health (medical examination) due to financial reasons, remains good.

Cross-party political commitment to the NHS has been an important element of this overall story. As we discussed in Section 2 ('goals'), the Conservative Party (2010) Manifesto included an overall commitment to "an NHS free at the point of use … based on need not ability to pay" whilst the Liberal Democrats included a commitment to the NHS as a "basic British value of fairness". The Coalition's Programme for Government included a commitment to the NHS as expression of national values, free at the point of use and based on need, not ability to pay, as well as to prioritise expenditure on health in relative terms.

Overall resilience in a time of downturn and crisis?

Arguably, there is an important story to be told of the overall resilience of the NHS in the period of crisis and downturn. This is certainly the argument put forward in the NHS Five Year Forward View,

which suggests that, despite global recession and austerity, the NHS has generally been "generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care" (NHS 2014:6). The Forward View further suggests that the NHS has been a "remarkable exception" in the period of crisis and downturn, and that "no other health system in the world in recent times "has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception.

Key international evaluations in the current period include the Commonwealth Fund international assessment (2014). This ranked the UK in first overall place for healthcare performance, above ten other countries (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the United States). The evaluation covers quality of care (effective care, safe care, co-ordinated care, patient centred care), access (cost related problems and timeliness), efficiency, equity, health lives and health expenditure. The UK was ranked first under many categories with the exception of equity (ranked second), timeliness of care (ranked third) and healthy lives (ranked 10th).

Continuities with Labour's reforms

Some analysts have argued that, far from constituting a radical shift in policies, there is an essential continuity in the health reforms implemented under the Coalition and previous Labour administrations. Le Grand has argued the measures introduced in the Health and Social Care Act (2012) constituted a "logical, sensible, extension of [changes] put in place by Blair". Labour's health reform programme is documented in our companion paper (Vizard and Obolenskaya 2013). Certainly, there is an essential continuity in terms of a number of the principles underpinning the two health reform programmes, including an emphasis on organisational decentralisation (with the creation of autonomous foundation trusts in 2004); commissioning (with the retention of the purchaser / provider split which Labour itself inherited in 1997, and the introduction of practice based GP commissioning); competition and patient choice (for example, the use of private treatment centres and extensions of patient choice); extensions of democratic participation and accountability (for example, the NHS Constitution) and inspection and regulation (with the introduction of a new regulatory framework after 1997). In 2008, William Moyes, then Chair of Monitor, announced that he had reached the halfway point in the process of changing the NHS from a nationalised industry into a network of competing organizations; and forecast that all hospitals in England would become free of government control by 2011 or 2012 (Carvel 2008). Timmins (2012: 81) notes that EU competition law arguably already applied before the Health and Social Care Act and that a Cooperation and Competition panel already established. The idea of an Independent NHS Board was floated by Gordon Brown (Timmins 2012: 29; Glennerster 2015).

Labour's 2010 Manifesto provides further evidence of commonalities. This made a commitment to "reform our public services to put people in control" with a greater emphasis on legal guarantees of outcomes in healthcare backed up both by private options and the possibility of provider exit. The role of mutualisation and other new forms of organisation such as social enterprises was also firmly on the party's health policy agenda:

> "[W]e will build public services that are more personal to people's needs: with clear guarantees about standards, the best providers taking over others where they don't make the grade, and with new ways of organising services such as mutuals. In health, this means if we don't meet our guarantees, for example on waiting lists, the NHS will fund you to go private. In education it means that if the local school is underperforming it will be taken over; and parents who believe

their school is not good enough can trigger a ballot to change the leadership" (Labour Party Manifesto 2010: 4-5).

Factors pointing towards a break with the past

Others, though, have emphasised the radical nature of the break with the past that was brought about the Health and Social Care Act (2012). The likely magnitude of private involvement in future, the extent of the shift towards commissioning, the possibility of hospital trusts retaining 49% private patient revenue, the trust failure regime and the central role of competition have all been cited as the basis of a significantly changed new public policy landscape in health. Multiple reforms have been implemented simultaneously. The scale, speed and compulsory nature of the organisational changes implemented on 1st April 2013 have also been contrasted by some with an "incremental" process of healthcare reform during the Labour period (see Timmins 2012: Glennerster 2015).

Pollock and Price (2013) have argued that the revisions to the framework of statutory duties brought about by the Health and Social Care Act (2012) are so far-reaching that they also represent an end of the post-1945 welfare settlement as it related to health. In their view, the duty to "secure or provide" a comprehensive NHS, reflected in the framework of statutory duties *prior* to 2012, as the cornerstone of the welfare state model of the NHS and as enshrining government legal responsibility for health universal healthcare. Conversely, they characterise the revisions to the framework of statutory duties and the passage of the Act as "the end of a National Health Service in England".

"Repeal (of the section 1 duty) was the fulcrum of the free market agenda because the duty compelled the minister to allocate resources according to need instead of leaving allocation to a combination of market forces, actuarial measures and unaccountable organisations ... [T]he proposed market system, was inconsistent with the NHS founding duty... Quite simply, markets do not and cannot deliver equitable, comprehensive health care; that is not what they are for" (Pollock and Price 2013: 9).

Coote (2014) has argued that the growing emphasis on competition, markets, commercial values, contracts and penalties is resulting in a fundamental departure from a public service culture and ethos within the NHS, critiquing the involvement of large, sometimes international, private healthcare companies and highlighting the potential application of international competition law (including the implications of TTIPs).

Undoubtedly, the healthcare reform programme, underpinned the Coalition's "Big Ideas" and public services reform agenda, has resulted in a major transformation of the health landscape. In the absence of further reforms, the balance in the public / private provision of health services looks set to undergo a much more substantial transformation that was hitherto the case. The trend towards decentralization and autonomous providers was evident prior to 2010. Since 2010, the increase in publicly financed healthcare supply by non-NHS providers appears to have been concentrated in mental and community health services. However, as we noted in section 4, it is anticipated that delivery by non-NHS providers will increase considerably in coming years. In the absence of further reforms, the "any provider" rule could potentially result in a fundamental shift in the balance between NHS and non-NHS providers in the medium term.

The marco-economic context of the health reforms implemented under Labour on the one hand, and the Coalition on the other, has also been entirely different. As Mays and Dixon (2011) note, whereas Labour sought greater competition and choice in the NHS against backdrop of sustained spending increases and supply side expansion, the Coalition's reform programme raises far-reaching questions as

to whether fundamental organizational change can be successfully delivered in a period of resource constraints, and what the effects of increased competition in the context of a resource squeeze will be.

Resources and signs of retrogression

Indeed, perhaps the most notable break with the pre-2010 period relates to the magnitude of the financial squeeze and adverse movements against some of the headline indicators reviewed in Section 6. The Coalition committed to 'cut the deficit not the NHS', and to protect health relative to other expenditure areas, by increasing year on year spending each year of the Parliament. However, the commitment to protect the NHS was in cash terms (not needs). Whilst real annual average rates of growth have been positive they have been exceptionally low in historical terms and have lagged behind the rates widely deemed necessary to keep up with rising need and demand. Independent analyses point towards an increasing gap between the growth in need and demand on the one hand, and real expenditure on the other, that will need to be addressed in the next Parliament.

Adverse movements against a number of key indicators also raise the prospect of retrogression and moving backwards. After the long period of improvement in key indicators such as waiting times and satisfaction with the NHS reported in our companion paper (Vizard and Obalenskya 2013) there have been adverse movements in the current period and a growing body of evidence suggesting that that the health system in England is under increasing strain (c.f. Section 6: 'Healthcare access and quality'). As a result, in the run up to the 2015 General Election, there is a widespread public perception that the improvements of the previous period have gone into reverse, and that the health system is going backwards rather than forwards.

Evaluating the impact of the reform programme

In the medium term, the evaluation of Coalition's health reform programme will require an extensive evidence base on the impact of the policy changes on the protection of the right to health in England and efforts to address health inequalities. Key questions for the medium time highlighted in the literature (e.g. Timmins 2012; Glennerster 2015; Kings Fund (Appelby et al 2014; Mays and Dixon 2011; Ham et al 2014); Nuffield Trust (2014); Institute of Health Equity (2014); NAO (2014ab):

- What will be the impact of the various potential drivers (autonomy, choice and competition, commissioning, regulation and inspection, democratic participation and accountability, enforceable minimum standards, staffing levels etc.) on access, quality, outcomes and equity?
- Will the goal service diversification put forward in the "Open Public Services" White Paper materialise with a greater range of providers? Will Non-NHS involvement be dominated by the private sector or will a "culture of mutuals" be brought about? Will provider diversification drive up productivity and quality in the ways have been claimed?
- Will strengthened arrangements for inspection and regulation result in the enforcement of minimum standards and the elimination of substandard care?
- Will service decentralization strengthen accountability and drive up standards and quality, or result in the major fragmentation of the system and the break-up of a national service?
- Will the new arrangements for public health, with a leading role for local government, increase accountability for health inequalities and drive up overall health outcomes?

At the time of writing, however, it is very early days in terms of the assessment of the impacts of the health reform programme. The availability of robust evidence on impacts of the new arrangements

for health are extremely limited. The discussion in this paper has been based on the limited data and number of independent evaluations that are currently available and in many ways is only an interim assessment.

Early independent review evidence

The early implementation of the reform programme was evaluated by the National Audit Office in July 2013. NAO reported that the transition to the reformed health system was successfully implemented in that the new organisations were ready to start functioning. However, the Parliamentary overrun had squeezed the timetable and not all organisations were operating as intended. Some parts of the system were less ready than others with staffing gaps, data gaps, a lack credible financial plans and NHS England adjusting budgets after 1/4/2013 causing delays in contracts. Transfers of assets and liabilities also posed a challenge. Overall, there were "[m]ajor challenges in implementing the reforms by 1 April 2013 … reforms are regarded as the most wide-ranging and complex since the NHS was created … more than 170 organisations have been closed and more than 240 new bodies created"(NAO 2013).

In separate reports, the NAO has found that Monitor has "done a good job" and "achieved value for money" in regulating NHS foundation trusts(2014d); and that although some clinical commissioning groups are achieving value for money, this is not the case for the commissioning of all out-of-hours GP services (NAO 2014e). Other independent evaluations include a mid-term assessment by the Kings Fund (Gregory et al 2012) and an evaluation of the setting up of clinical commissioning groups by Kings Fund and Nuffield Trust (Naylor et al, 2013). A further Kings Fund report (Ham 2014) concluded that despite the explicit aim of disengaging politicians from the day to day operational NHS, the current Secretary of State Jeremy Hunt has been more interventionist than his predecessors. The report calls for less political intervention, and greater local accountability, for "operational" matters including A&E waiting times. A number of recent reports (NAO 2013b; Kings Fund 2014, Lafond et al 2014; Audit Commission 2014) highlight signs of increasing pressure and the issue of the financial solvency of NHS Trusts. Examining the nature and scope of financial deficits, the Public Accounts Committee report concluded in July 2014 that "[t]he number of NHS foundation trusts in difficulty is growing, casting doubt on Monitor's effectiveness as their regulator" (House of Commons Committee of Public Accounts 2014).

NAO (2014c) evaluated progress towards integrated health and social care. It found "almost universal support for integration but progress has been slow, with few successful examples". On public health, an assessment by the Local Government Association suggested that despite earlier concerns regarding the transfer of responsibility for public health to local government, "great strides (were made) ... to tackle the wider social and economic determinants of poor health" in the months following April 2013 (Local Government Association, 2013).

Our companion paper (Vizard and Obolenskaya 2013) provided a summary of the evidence of the impact of competition and choice within the NHS as well as an overview of international comparative evidence on the performance of the NHS and UK health outcomes. Key publications since that date include the latest of Nuffield Trust's "four country" reports examining the impact of policy divergence in the four countries of the UK following devolution. The impact of different policy trajectories (for example, performance management, decentralization, competition between providers and patient choice in England) on the achievement of common objectives (such as improving quality and productivity) provides so-called "natural experiment" evidence on this issue. The previous four country reports suggested that the performance of the NHS in England was better than in the other four countries of the UK across a range of outcome indicators, and this finding was has been widely interpreted as providing evidence of the positive impact of policy measures in England (including competition and institutional ratings) (e.g. see Connolly et al: 2011). However, in its latest report, Nuffield Trust suggests that the

marked differences in crude productivity identified in previous reports were accounted for by definitional differences supplied by each country and published by ONS. Furthermore, outcome gaps were found to have narrowed, with Scotland in particular improving its performance on waiting times. The authors conclude that different policies adopted in the devolved countries appear to have made little difference to long-term national trends on most of the indicators evaluated. This lack of clear-cut differences in performance, the authors contend, "may be surprising given the extent of debate about differences in structure, provider competition, patient choice and use of non-NHS providers across the four countries" (Bevan et al 2014).

Outcomes, minimum standards and the role of the central state

The Coalition's new public services model, examined in Section 2 ('The role of the central state and the Coalition's model for public services'), puts central emphasis on a new role for the central state in public services in defining outcomes and as a guarantor of minimum standards and quality improvement (with a range of providers). Yet the overall framework for accountability and responsibility for improving health outcomes and reducing health inequalities raises a number of important issues. A key question is how progress in improving outcomes and tackling health inequalities is to be evaluated in the absence of targets. The critique of central targets has meant that the PSA regime - which benchmarked overall progress in improving health outcomes and reducing inequalities under Labour - was dropped after 2010. A subsequent decision was made not to include "levels of ambition" alongside the new NHS outcomes framework:

> "In light of the consultation the Department of Health has decided not to set levels of ambition. We have explained this is because although the principle of focusing on outcomes received strong support, there was criticism from some that the proposals for setting levels of ambition were too reliant upon precise technical assumptions for which the evidence base is not robust. Additionally, some were concerned that these would be perceived as local 'targets'. Instead, the mandate requires the NHS Commissioning Board to make progress on all areas of the NHS Outcomes Framework".

Evaluating progress in tackling health inequalities has been further complicated by the cessation of publication of progress against a number of outcomes under the old PSA targets and the transition to the new frameworks, which has resulted in breaks and discontinuities in key series. Whilst emphasis has been put on producing new statistics on health outcomes by sub-national level and IMD, the regular production of health outcome statistics that are disaggregated by a range of equality statistics, as promised in the equality statements which accompany the various health outcomes frameworks, remains patchy and slow. The old system for comparing health outcomes in spearhead areas versus all England averages was criticised by Marmot for its failure to capture and reflect *within* area health inequalities. However, the move away from monitoring spearhead versus all England averages - and the cessation of the publication of key series such as Mortality Monitoring, which included a consistent series on progress in addressing health inequalities going back to 1997 – makes time series evaluation problematic.

The empirical evidence base for making overall evaluations of progress in improving outcomes and tackling health inequalities also remains under-developed. Whilst publications such as DH (2014d) attempt to summarise overall progress against the indicators in the health outcomes frameworks, the new system is highly complex. In addition to the two main outcomes frameworks other new indicator sets include the CCG indicator set and the basket of 160 indicators developed by CQC as part of its new acute hospital inspection model. There is a case for alignment of the frameworks as well as for revising

the selection of indicators in some cases. The NHS outcomes framework is currently entering into a further round of consultation and further development. Whilst this inherently desirable in order to improve the selection of indicators, it is likely to result in turn in the need for a further round of technical development and delays in the delivery of data.

On minimum standards, whilst the Coalition responded to the Francis Inquiry with the series of measures examined in Section 3 ('Minimum standards and quality regulation: the Government's response to the Francis Inquiry'). This included the commissioning of the Keogh and other reviews, the appointment Sir Mike Richards as first Chief Inspector of Hospitals in 2013 and the introduction of new fundamental standards which began to come into force in November 2014. The CQC has introduced a new inspection model and a new system of ratings building on the Public Inquiry recommendations. However, it is very early days in terms of evaluating whether the strengthened arrangements for inspection and regulation result in the enforcement of minimum standards, eliminate variations in performance and drive up quality. The effectiveness of the overall system of management, regulation and inspection in identifying poor and substandard care, the enforcement of fundamental standards and the capacity of the system to make progress in this area in an era of austerity remains at the top of the health agenda and will continue to be a key barometer of success or failure.

Health inequalities and the localism agenda

Additional issues are raised by the devolution of responsibilities for public health to local authorities. As noted in Section 2, the Coalition's health reforms reflect its localism agenda and introduced a radical change in public health with a much greater shift towards a locally driven "bottom-up" approach. Under the new arrangements, local authorities and health and wellbeing boards control resources and have responsibilities and powers to adopt innovative and appropriate measures at the local level to promote public health and tackle health inequalities. The framework of statutory duties aims to ensure overall political accountability and responsibility. However, the consequences of introducing an entirely "bottom up" to promoting public health and health inequalities are unknown. Key challenges relate to the overall integration of public health services and the alignment of local and central public action on public health. Full evaluations will be necessary to examine whether decentralized mechanisms of control and responsibility will be adequate to secure improvements in public health outcomes and reductions in health inequalities.

The first year of the functioning of Health and Wellbeing Boards was evaluated in Humphries and Galea (2013), who conclude that the new bodies were successfully set up but in danger of becoming a side show. Institute of Health Equity (2014) highlight examples of good practice in promoting the social determinants approach whilst emphasising the challenges of replicating and generalising good practice models on a national basis.

The performance of Public Health England (PHE) was examined by the National Audit Office in late 2014 (NAO 2014b). Given the statutory arrangements of PHE (examined in Section 3, 'Overview of the Coalition's health reforms'), NAO notes that PHE has worked well to establish itself at the centre of the new public health system. On the question of localism, NAO (2014b) notes that whilst local autonomy has certain advantages, it also has risks. The public health reforms reflect the idea that local authorities are best placed to make decisions about the best way to promote public health for their local populations. Within statutory constraints local authorities have decision making discretion. They are responsible for securing their own public health outcomes and are accountable to local electorates for their decisions. The role of Public Health England is to provide support, information, advice and influence. However, formal role in securing public health outcomes are only limited and, by design, it has been set up *without* direct, timely levers to secure the public health outcomes the Department of Health

expects. The new Public Health Outcomes Framework allows the performance of local authorities to be compared; and the health premium will help to incentive local authorities to achieve public health outcomes. However, in parts of the system, local authority spending is not fully aligned to areas of concern and the autonomy of local authorities gives no guarantee that PHE can secure improvements in outcomes. Therefore, it is too early to conclude yet on whether PHE is delivering value for money. (NAO 2014b: 5).

A related issue is whether the necessary levers to promote public health and tackle health inequalities are genuinely within the hands of local authority. The social determinants approach – highlighted by Marmot and captured and reflected in the Public Health Outcomes Framework – suggests that the drivers of health include broader socio-economic variables including housing, income, inequality and employment – as well as the healthcare system itself. Innovative local public action is required to promote the social determinants approach and there is evidence of emerging good practice within both the healthcare system (for example, "social prescribing" within GP practices, whereby patients are referred to a range of support services for a wide range of underlying factors such as social isolation and worklessness, on which, see BBC 2014e) and public health (on which, see Institute of Health Equity 2014).

A recent report of the London Health Commission highlights a range of measures that can be adopted locally, for example, measures to address pollution, additional local smoking bans (such as the proposed ban on smoking in places in the London context), bans on fast food and bans on fast food outlets near to schools. The report also cites the introduction of variable alcohol pricing policies in Newcastle under relevant by laws. It suggests that the scope for local public action may be greater in the context of cities with Mayors and that there have been calls for an extension of local powers to promote health and reduce health inequalities. (London Health Commission 2014).

However, the instruments that are available locally are limited in scope and some levers for promoting public health and equality may be inherently national rather than local. For example, underlying social determinants of health identified in the Marmot Report includes worklessness, poverty levels, benefits and child development and many of the public policy instruments affecting these outcomes are influenced by national public policy. The recent report of the London Health Commission suggested that some drivers, notably a tax on sugar, considered as driver on healthy lifestyles, may be inherently national (London Health Commission 2014).

De-centralisation versus service fragmentation

More broadly, concerns have been expressed that the trend towards a decentralized organisational structure will result in health service fragmentation. A central premise of the health reform programme is that greater diversity and variety in provision can drive up standards. The shift towards a more decentralized organisational structure is viewed as promoting local accountability and responsiveness to the needs of local populations as well as exploiting and harnessing local knowledge and understanding of challenges, priorities and "what works". Yet key challenges relate to overall integration of health services the adoption and replication of good practice. Furthermore, decentralization by its very nature is in tension with the model of a single, uniform health service. As Lee and Mayo noted in their early proposals for mutualisation of the NHS:

> "[a] non-profit, mutual health service can be more efficient and appropriate at delivering health services than for-profit private companies. A greater diversity of health service provision will reduce health inequalities and raise standards more effectively than the attempt to continue to run a uniform, national service (Lea and Mayo 2002).

To date, the evidence base on the impact of provider type on quality remains limited. Furthermore, the recent NHS five year review (NHS 2014) suggests that whilst local variation is necessary in order to meet local needs and promote service innovation and improvement, there nevertheless should *not* be "an infinite number of new care models". While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. Rather, there should be a fixed "menu" of good practice care models and local health services should be free to select the most appropriate model for their areas from this list.

New thinking about social rights

Regardless of the outcome of the 2015 General Election, in many ways the medium-term trend away from public services that are exclusively provided by the state seems irreversible. It seems likely that in the future, health services will be increasingly be publicly commissioned and regulated and inspected by the state - but provided by a range of suppliers. The shift towards a decentralized organisational structure – with more local variation and diversity – also seems embedded and entrenched. New thinking about the protection and realisation of the right to health (and social rights generally) is required in this context. The emergence of a new model of social rights focussing on outcomes rather than mechanisms of delivery was examined in Vizard (2014). Whereas the old model of social rights focussed on the idea of individual entitlements to a flow of services that are directly provided by the state (such as state provided health or education), the emergent new model focuses on the right to the protection and promotion of certain outcomes (or 'capabilities', such as good health) backed by different types of public action. Clear thinking about the nature of outcome orientated quality guarantees, together with guarantees of minimum standards and equality, will be essential (Vizard 2014; c.f. Alldritt et al., 2009: 54–5).

Challenges for an incoming Government

Against this background, an incoming Government in 2015 will fact a number of important challenges. The resources squeeze - with expenditure and supply lagging behind demand and need, and the emergence of a considerable funding gap in health - will be an immediate key concern. As we discussed in Section 3 ('Trends in real public sector expenditure on healthcare'), analysis by Nuffield Trust (2012). Monitor (2013) and The NHS Five Year Forward View (NHS 2014) suggests that if real public spending on health is held flat beyond the current period, the NHS in England could experience a funding gap of £30 in 2020/21 unless offsetting productivity gains are achieved (assuming current the current round of QIPP efficiency savings to 2014/15 are achieved). However, the gap is narrowed and even eliminated under alternative scenarios assuming a combination of offsetting productivity gains and real funding increases.

An incoming Government in 2015 will also inherit an NHS which is showing increased signs of pressure. In addition to the financial pressures on trusts, this includes the signs of pressure on outcomes that were discussed in section 5. There have been adverse movements under a number of indicators of access to healthcare, including waiting times. Some aspects of patient experience also appear to be under strain. Satisfaction with healthcare has declined since 2010 and there has been a decline in population mental outcomes in the period coinciding with the crisis and recession.

With the period of fiscal consolidation and austerity poised to continue into the medium term, the role of productivity gains in closing the funding gap is currently moving up the political and public policy agendas. Recent analysis by Monitor has highlighted the urgent need for productivity increases in response to the "greatest financial challenge of recent times" (Monitor 2013). The recent NHS Five Year

Forward View (NHS 2014) suggests that a further £22b of efficiency gains will be necessary over the next five years (to 2020/2021).

There is a broad consensus that transformational change in service delivery will be required in order to deliver medium term savings of this magnitude. The possible savings that can be achieved through the provision of integrated health and social care services were highlighted in HM Government (2010) and Monitor (2013) estimates that preventing hospitalisations through integrated care would save £1.2 billion to £2 billion. However, as we discuss in Burchardt et al 2015 (this series), delivering integrated care is notoriously difficult and doubts have been raised about the delivery of efficiency savings, resulting in revised conditions relating to the Better Care fund introduced by the Coalition in July 2014 (for references, see Burchardt et al 2015). A new Government in 2015 will inherit the challenge of ensuring successful implementation and extension of these measures.

A range of other new care models that could result in reduced demand for hospital beds, treat non-emergency episodes outside of A&E and result in greater integration between hospital services and GPs are also being widely discussed. Monitor (2014) emphasised the role of centres of excellence and the House of Commons Public Accounts Committee (2013) raised the need for service centralisation in some cases. The recent NHS five year review (NHS 2014) highlights a range of new care models that aim to break down the traditional divide between hospitals and GPS and to introduce savings by moving beyond the old “silo based” approach. These include ‘vertically’ integrated Primary and Acute Care Systems (PACS) bringing together GP, hospital, mental health and community care services; Multispecialty Community Providers (MCPs) targeting patients with complex ongoing needs such as the frail elderly or those with chronic conditions and bringing together nurses, therapists and GPS; large groups of GPs operating together from modern sites providing services (such as xray services and minor surgery) usually provided in hospitals. Other innovations – including technological innovations such as digital records – have also been highlighted as providing potential for medium term savings.

The NHS Five Year Forward View (NHS 2014) concludes that 1.5% net efficiency increase each year over the next Parliament is possible based on the continuation and extension of existing efficiency saving measures (although there is a recommendation that reliance on wage freezes to achieve efficiency savings is non-sustainable). Over the next decade, with productive investments in new care models of the type described phased in over time, gains of 2-3% annually could be achieved. This scenario results in a considerable narrowing of the funding gap that is forecast to emerge by 2020/2021.

Glennerster (2015) has suggested that the health reform programme undertaken by the Coalition, and the organisational changes and disruption it has brought about, have diverted attention away from medium challenges such as tackling the health consequences of an aging population, the increasing prevalence of dementia, lack of integration of health and social care, the rise of obesity and underlying lifestyle and behavioural risk factors including prevalence of inactivity, poor diets and smoking and alcohol consumption. The Coalition inherited from Labour the challenge of halting and reversing this trend and incoming Government in 2015 will face similar challenges. Trends in smoking amongst manual occupational groups also remain a particular priority.

The challenge of achieving long-term behavioural change and healthy lifestyles – and the positive implications of such for NHS finances – were set out in the Wanless Review and subsequent extensions and updates (Wanless 2002, 2004; Wanless et al 2007). In evaluating the potential for medium term efficiency savings, the NHS Five Year Forward View (NHS 2014) puts central emphasis on the challenge of controlling the demand side and of a major shift towards a more activist prevention and public health agenda, with intensified efforts to address obesity, smoking and alcohol consumption. It concludes that preventative measures of this type - alongside the supply side measures and the transformation of service provision discussed above – are necessary conditions for sustaining a comprehensive NHS, free

at the point of delivery and funded through tax, over the next five years. With measures of this type in place, it concludes that there is nothing that suggests that "continuing with a comprehensive tax-funded NHS is intrinsically undoable" (NHS 2014: 37).

An incoming Government will also face the challenging of making the new public services model work, and will have to cope with the fall out if it does not. Short run challenges of policy implementation include staffing, pressures on budgets, arrangements in the context of failure and exit, and generally making the new bodies - many of which are still in their infancy - function effectively.

The Coalition's public service model puts central emphasis on the role of the central state as a guarantor of minimum standards, outcomes and quality. Looking forward, there are a number of medium term challenges. On minimum standards, measures have been introduced to improve the effectiveness of the overall system of management, regulation and inspection in identifying poor and substandard care. However, ensuring continued progress in this area remains at the top of the health agenda. The overall framework for accountability and responsibility for improving outcomes and reducing health inequalities raises important concerns. Additional issues are raised by the devolution of responsibilities for public health to local authorities. Key challenges again relate to the adoption and replication of good practice and the overall integration of public health services and the alignment of local and central action and goals. Important questions remain as to whether the necessary levers to promote public health and tackle health inequalities are genuinely within local hands. Localization and decentralization raise the risk of service fragmentation.

To date, there remains a broad consensus that de-centralization and localism in the absence of outcome and quality guarantees and national minimum standards is likely to result in an unacceptable laissez-faire. Continued emphasis on the role of the central state as a guarantor of outcomes, quality and minimum standards - and effective public action to ensure the implementation and enforcement of these standards within the context of diversity and localism - will be a critical element of the protection of the right to health in the future and remains a central challenge - perhaps the central challenge - of the upcoming period.

Table 25: Growth of real and volume public expenditure on health: UK time series (1991/2-2013/14)

Prime Minister (c)	Years (d)	Nominal expenditure (£ billion)	Real expenditure (£ billion)	Real expenditure (per capita) (£) (e)	Real GDP (£ billion)	Real expenditure as % of GDP	Annual growth (%) (f)	Real expenditure on health as a % real TME (g)	**Real** expenditure on health as % of **real** total expenditure on public services (h)	Volume expenditure (£ billion) (i)	Volume annual growth
Thatcher/Major	**1991/92**	30.9	45.6	793.5	905.7	5.0		12.2	13.0	59.0	
	1992/93	34.2	49.5	859.3	920.2	5.4	8.6	12.5	13.1	61.1	3.5
	1993/94	36.6	51.9	900.1	959.5	5.4	5.0	12.8	13.5	63.2	3.5
Major	**1994/95**	39.4	55.2	954.7	1004.5	5.5	6.3	13.2	13.9	66.3	4.9
	1995/96	41.4	56.6	975.9	1038.7	5.5	2.5	13.3	14.0	67.0	1.0
	1996/97	42.8	57.0	979.3	1077.3	5.3	0.6	13.6	14.1	67.4	0.6
	1997/98	44.5	58.2	997.5	1119.0	5.2	2.1	13.8	14.4	68.9	2.2
Blair (1)	**1998/99**	46.9	60.2	1028.8	1158.6	5.2	3.4	14.1	14.7	69.8	1.3
	1999/00	49.4	62.1	1058.9	1199.9	5.2	3.3	14.3	14.9	70.4	0.8
	2000/01	54.2	67.7	1149.7	1250.3	5.4	8.9	15.8	15.4	74.1	5.3
	2001/02	59.8	72.7	1230.1	1265.1	5.7	7.4	15.2	15.9	77.8	5.0
Blair (2)	**2002/03**	66.2	78.7	1325.2	1304.9	6.0	8.2	15.6	16.4	83.2	7.0
	2003/04	74.9	87.3	1464.2	1357.5	6.4	11.0	16.3	17.1	89.5	7.5
	2004/05	82.9	94.0	1568.7	1394.8	6.7	7.7	16.7	17.6	95.9	7.1
Blair (3)	**2005/06**	89.8	100.0	1656.1	1443.3	6.9	6.4	17.0	17.9	100.2	4.5
	2006/07	94.7	102.6	1686.1	1483.6	6.9	2.5	17.1	18.1	101.9	1.7
	2007/08	101.1	106.8	1741.8	1529.6	7.0	4.1	17.2	18.2	105.7	3.7
Brown	**2008/09**	108.7	111.7	1806.4	1481.8	7.5	4.6	17.1	18.1	109.4	3.5
	2009/10	116.9	116.9	1877.6	1432.2	8.2	4.7	17.4	18.2	116.9	6.9
	2010/11	119.8	116.8	1860.3	1463.9	8.0	-0.1	17.2	18.1	116.3	-0.5
Coalition	**2011/12**	121.2	115.5	1825.1	1474.4	7.8	-1.1	17.4	18.4	115.2	-0.9
	2012/13	124.3	117.2	1839.6	1476.1	7.9	1.5	18.4	18.6	116.2	0.8
	2013/14	129.5	120.0	1872.3	1512.7	7.9	2.4	18.1	18.9	119.7	3.0

Source: Authors calculations. Expenditure figures: nominal figures from HM Treasury (2014) and GDP deflators from HM Treasury (2014) with reference year changed to 2009/10. NHS specific deflator (HCHS pay and price index) from DoH (2014b) via personal communication. Population estimates: up to 2000: ONS (2011), from 2001 onwards the estimates were revised using Census 2011: ONS (2013a). Mid-2013 estimates are from ONS (2014a)

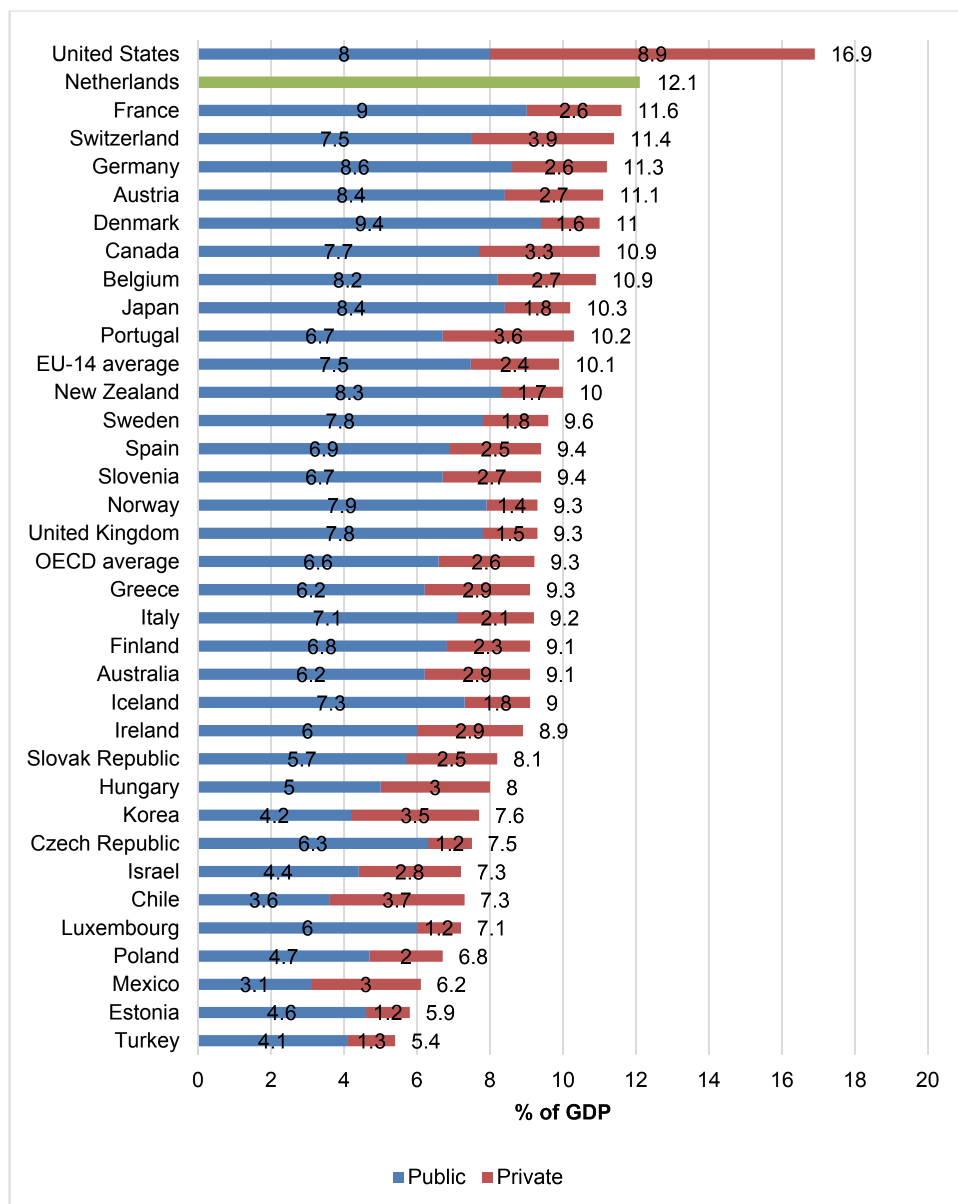
Notes:
a. Total expenditure on health excludes spending on Personal Social Services. Data for public sector expenditure on services are on a cash basis up until 1997-98, and on an accruals basis thereafter. “Accruals accounting recognises when costs occur rather than when the payment is made, i.e. having the heating on is a cost that accrues each day whereas the bill might be paid quarterly” (TM Treasury 2014: 208).
b. The real public expenditure on health series has been constructed using the GDP deflator published in HM Treasury with a base year changed to 2009/10
c. Time in office: Margaret Thatcher 4 May 1979 – 28 November 1990 (1st term 4 May 1979-June 1983, 2nd term June 1983-June 1987, 3rd term June 1987-November 1990); John Major: 28 November 1990 (election in April 1992) - 2 May 1997; Tony Blair: 2 May 1997 - 27 June 2007 (1st term 1997-2001, 2nd term 2001-2005 and 3rd term 2005-2007); Gordon Brown 27 June 2007 - 11 May 2010; Coalition of Conservatives (David Cameron) and Liberal Democrats (Nick Clegg): from 11th of May 2010.
d. All years are reported as financial years
e. The estimated resident population of an area includes all people of all ages who usually live there, whatever their nationality. People arriving into an area from outside the UK are only included in the population estimates if their total stay in the UK is 12 months or more. Visitors and short term migrants (those who enter the UK for 3 to 12 months for certain purposes) are not included. Similarly, people who leave the UK are only excluded from the population estimates if they remain outside the UK for 12 months or more. This is consistent with the United Nations recommended definition of an international long-term migrant. Members of UK and non-UK armed forces stationed in the UK are included in the population and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address. Population figures for the United Kingdom do not include the population of the Channel Islands or the Isle of Man.
f. Year on year percentage growth rate in real terms health expenditure
g. TME=Total Managed Expenditure, includes total expenditure on public services, EU transactions and Accounting Adjustments
h. Real expenditure on Total Public Services includes EU transactions but excludes Accounting Adjustments
i. Department of Health (2014b) HCHS Pay and Prices Series used to deflate nominal figures

Table 26: Total real (public and private) expenditure on healthcare in the UK, 1997 to 2012 (2010 prices)

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Public	£ billion	58.9	61.7	66.3	69.3	73.9	79.1	84.6	91.1	96.6	101.7	104.7	110.2	118.3	116.9	115.7	116.9
	% GDP	5.2	5.2	5.5	5.5	5.7	6.0	6.2	6.4	6.6	6.8	6.7	7.2	8.1	7.9	7.7	7.8
	% Total	80.4	80.4	80.6	79.5	79.5	79.7	79.3	81.4	81.3	81.7	80.5	81.4	83.2	84.0	83.4	84.0
Private	£ billion	14.4	15.1	15.9	17.9	19.0	20.1	22.1	20.9	22.2	22.8	25.3	25.1	23.9	22.3	23.0	22.3
	% GDP	1.3	1.3	1.3	1.4	1.5	1.5	1.6	1.5	1.5	1.5	1.6	1.6	1.6	1.5	1.5	1.5
	% Total	19.6	19.6	19.4	20.5	20.5	20.3	20.7	18.6	18.7	18.3	19.5	18.6	16.8	16.0	16.6	16.0
Total expenditure	£ billion	73.3	76.8	82.2	87.2	92.9	99.3	106.7	112.0	118.8	124.4	130.0	135.3	142.2	139.3	138.7	139.2
	% GDP	6.5	6.5	6.8	6.9	7.2	7.5	7.8	7.9	8.1	8.3	8.4	8.8	9.7	9.4	9.2	9.2

Source: Authors’ calculations using current prices figures from ONS (2014b) and GDP deflators from Blue Book (ONS 2014c) online database [accessed August 2014].
ONS (2014b): Reference table 3 (for total/current/capital and public revised expenditure figures up to 2011), data behind figure 1 (for 2012 total expenditure); current/capital and public/private expenditure is authors' calculations using reference table 2 (ratios of current/capital and public/private expenditure for 2012)

Figure 23a: International comparisons of total (public and private) expenditure on health as a percentage of GDP (2012)



Source: OECD (2014a)
Notes:
b. OECD average is an arithmetic average for the OECD countries excluding UK
c. Figures are 2012 apart from for Austria, New Zealand, Portugal, Spain (2011 figures)
d. No breakdown for public/private spending on health is available for Netherlands since 2002, so the total expenditure on health as a proportion of GDP is presented here for this country

Table 27: Public sector expenditure on health in England, Scotland, Wales and Northern Ireland 1998/99-2012/13

	England				Scotland				Wales				Northern Ireland			
	real expenditure (£m)	real expenditure annual growth, %	per capita real expenditure (£)	per capita real expenditure annual growth, %	real expenditure (£m)	real expenditure annual growth, %	per capita real expenditure (£)	per capita real expenditure annual growth, %	real expenditure (£m)	real expenditur e annual growth, %	per capita real expenditure (£)	per capita real expenditure annual growth, %	real expenditure (£m)	real expenditure annual growth, %	per capita real expenditure (£)	per capita real expenditure annual growth, %
	PESA 2004															
1997/8*																
1998/9	49,038		1,004		5,947		1,171		3,204		1,105		1,855		1,106	
1999/2000	50,262	2.5	1,025	2.1	6,175	3.8	1,218	3.9	3,347	4.5	1,154	4.4	1,985	7.0	1,182	6.9
2000/01	54,873	9.2	1,115	8.7	6,589	6.7	1,301	6.9	3,565	6.5	1,226	6.3	2,163	9.0	1,286	8.7
	PESA 2006															
2001/2	59,439		1,202		6,929		1,368		3,678		1,264		2,209		1,308	
2002/3	63,787	7.3	1,284	6.8	7,734	11.6	1,527	11.6	4,133	12.4	1,414	11.9	2,378	7.6	1,401	7.1
2003/4	70,713	10.9	1,416	10.3	8,558	10.7	1,689	10.6	4,647	12.4	1,582	11.9	2,621	10.2	1,537	9.7
2004/5	76,643	8.4	1,527	7.8	8,716	1.8	1,714	1.5	4,868	4.8	1,646	4.1	2,720	3.8	1,587	3.3
	PESA 2011 (July)															
2005/6	81,558		1,612		9,539		1,867		5,180		1,744		2,930		1,696	
2006/7	83,210	2.0	1,633	1.3	9,785	2.6	1,906	2.1	5,398	4.2	1,808	3.6	3,095	5.6	1,776	4.7
2007/08	87,921	5.7	1,711	4.8	10,276	5.0	1,988	4.3	5,552	2.8	1,847	2.1	3,122	0.9	1,772	-0.2
2008/9	92,393	5.1	1,783	4.2	10,458	1.8	2,010	1.1	5,697	2.62	1,883		3,389	8.6	1,905	
	PESA 2014 (Oct)															
2009/10	96,117		1,841		10,616		2,029		5,926		1,950		3,442		1,919	
2010/11	95,849	-0.3	1,821	-1.1	10,600	-0.1	2,014	-0.7	5,963	0.6	1,955	0.3	3,503	1.8	1,941	1.1
2011/12	95,101	-0.8	1,791	-1.6	10,536	-0.6	1,988	-1.3	5,789	-2.9	1,890	-3.4	3,467	-1.0	1,911	-1.6
2012/13	96,608	1.6	1,806	0.9	10,640	1.0	2,002	0.7	5,658	-2.3	1,840	-2.6	3,624	4.5	1,987	4.0
2013/14	99,553	3.0	1,848	2.3	10,621	-0.2	1,993	-0.4	5,692	0.6	1,847	0.3	3,598	-0.7	1,966	-1.1

Source: Authors' calculations using the following public health expenditure data: 1998/99 to 2000/01: HM Treasury (2004a, Tables 8.5a-8.7b); 2001/02-2004/05: HM Treasury (2006, Tables 7.6a-7.9b); 2005/06-2008/09: HM Treasury (2011, Table 9.1); 2009/10 to 2013/14: HM Treasury (2014a, Table 9.11). GDP deflator: HM Treasury (2014) GDP deflators at market prices, and money GDP. Per capita calculated using population estimates 2011 and 2012 ONS (2013a), 2002 to 2010: ONS (2013), 1997 to 2001: ONS (2011)

Notes:

a) No consistent figures for health expenditure alone in each country is available for the years 1997/8 to 2000/01. Expenditure figures for years 1997/8 to 2000/01 are consistently available only for health and personal social services together (PESA 2003),

b) 2004 PESA which is used here covers health separately from personal social services but does not have figures for 1997/8.

By country

c) Expenditure figures *between* PESA editions are not strictly comparable. Figures *within* PESA editions are comparable.

Table 28: NHS sources of finance, United Kingdom, 1949 to 2011/12, current prices

Year	Taxation		NHS contribution from National Insurance		LHA[d]		Patients' payments[e]		Total NHS income	NHS income as a % of UK government receipts[f]
	£m	%NHS	£m	%NHS	£m	%NHS	£m	%NHS	£m	
1949	437	100.0	-	-	-	-	-	-	437	8.2
1950	477	100.0	-	-	-	-	-	-	477	8.7
1960	671	77.5	118	13.6	77	8.9	43	5.0	866	9.8
1970	1,635	82.6	209	10.6	135	6.8	60	3.0	1,979	8.7
1980	9,951	88.4	1,042	9.3	-	-	264	2.3	11,257	11.5
1990	22,992	80.9	4,288	15.1	-	-	1,146	4.0	28,426	12.9
1991	26,300	82.0	4,513	14.1	-	-	1,265	3.9	32,078	14.1
1992	29,548	83.4	4,612	13.0	-	-	1,276	3.6	35,436	15.4
1993	31,347	84.2	4,717	12.7	-	-	1,167	3.1	37,231	16.0
1994	33,875	85.3	4,869	12.3	-	-	971	2.4	39,715	15.8
1995	35,833	85.6	5,101	12.2	-	-	919	2.2	41,853	15.4
1996	37,284	85.7	5,360	12.3	-	-	879	2.0	43,522	15.3
1997	39,064	85.6	5,691	12.5	-	-	906	2.0	45,660	15.0
1998	41,037	85.3	6,162	12.8	-	-	939	1.9	48,138	14.5
1999	44,569	85.3	6,690	12.8	-	-	1,006	1.9	52,264	14.9
2000	49,103	86.0	6,905	12.1	-	-	1,058	1.9	57,067	15.2
2001	54,116	86.0	7,610	12.1	-	-	1,166	1.9	62,892	16.1
2002	62,169	86.2	8,732	12.1	-	-	1,263	1.7	72,164	18.3
2003	62,608	77.9	16,391	20.4	-	-	1,349	1.7	80,348	19.4
2004	67,562	77.0	18,857	21.5	-	-	1,288	1.5	87,707	19.8
2005	75,803	78.5	19,510	20.2	-	-	1,271	1.3	96,583	20.3
2006	82,882	80.3	18,988	18.4	-	-	1,326	1.3	103,197	20.1
2007	89,663	80.0	21,081	18.8	-	-	1,391	1.2	112,135	20.9
2008	94,825	79.7	22,729	19.1	-	-	1,448	1.2	119,002	21.8
2009	102,535	80.9	22,679	17.9	-	-	*1,485*	1.2	126,699	24.6
2010	105,689	80.9	23,375	17.9	-	-	*1,521*	1.2	130,586	26.0
2011	107,619	80.9	23,799	17.9	-	-	*1,537*	1.2	132,955	25.2

Source: Hawe and Cockcroft (2013: 51), Table 2.5, drawing on Economic Trends (ONS), Government's Expenditure Plans (DH), Economic and Labour Market Review (ONS), Annual Abstract of Statistics (ONS), Freedom of Information (FOI) request to Department of Health (DH).

Notes:
a. All figures relate to calendar years.
b. Figures in italics are OHE estimates.
c. %NHS refers to the percentage of total NHS funding from each source.
d. Prior to 1974 total NHS income includes services provided by former Local Health Authorities (LHAs). From 1979 onwards, services provided by LHAs were transferred to NHS.
e. Patient charges for 2004 onwards are not comparable to earlier years, as reliable data for PDS in England and Wales are not available before 2004/05 and therefore data prior to 2004/05 are based on GDS patient charges alone. In 2005/06 there was a shortfall in patient charge income, in part attributable to PDS pilots income being based on the old GDS system of patient charges in England and Wales.
f. UK government receipts include taxes and National Insurance contributions.
g. All figures are in current prices.

Table 29: NHS patient charges, United Kingdom, 1991/92 to 2011/12 (2009/10 prices)

Financial year	Hospital (b) £m	% of payments	Prescriptions (c) £m	% of payments	Dental (d) £m	% of payments	Total (£m)
1991/92	775	42.0	387	21.0	684	37.1	1846
1992/93	709	39.7	417	23.3	660	36.9	1786
1993/94	506	32.5	445	28.6	605	38.9	1556
1994/95	150	12.1	463	37.3	629	50.6	1242
1995/96	55	4.6	505	41.7	651	53.8	1212
1996/97	54	4.9	486	43.5	578	51.7	1119
1997/98	63	5.2	518	43.1	621	51.7	1201
1998/99	108	8.9	502	41.4	603	49.7	1212
1999/00	174	13.5	509	39.5	608	47.1	1291
2000/01	172	12.9	531	39.8	632	47.3	1335
2001/02	188	12.9	581	39.9	687	47.2	1457
2002/03	204	13.4	627	41.1	694	45.5	1526
2003/04	226	14.1	695	43.5	678	42.4	1599
2004/05	245	16.7	582	39.8	636	43.5	1463
2005/06	265	18.8	581	41.3	562	39.9	1408
2006/07	282	19.3	570	39.0	608	41.7	1459
2007/08e	298	20.1	525	35.3	662	44.6	1484
2008/09e	312	20.8	507	33.8	683	45.4	1502
2009/10e	326	21.8	473	31.7	694	46.5	1492
2010/11e	339	22.7	457	30.6	696	46.6	1492
2011/12e	352	24.1	406	27.7	707	48.2	1465

Sources: Authors' calculations using GDP deflators (HM Treasury 2013b) and nominal figures from personal communication with OHE (2014)

Note:

The following notes were included in a source document given by OHE (2014) via personal communication:

a. Prescription charges were introduced in 1952 and temporarily abolished in 1966 - 1968. Ophthalmic Services were part-privatised in 1985.

b. From 1994 hospital charges no longer include pay-bed and similar income collected locally by NHS Trusts

c. Figures prior to 2004/05 are taken from the Annual Abstract of Statistics and relate to by patients for pharmaceutical services. These data were last published for 2003/04. Comparable data are not available since 2003/04 and data shown relate to prescription charge revenue, including income received by pharmacists and dispensing doctors and income from the sale of pre-payment certificates.

d. Data for 2004/05 onwards are not strictly comparable with earlier data, as reliable data for PDS in England and Wales are not available before 2004/05 and therefore data prior to 2004/05 are based on GDS patient charges alone. In 2005/06 there was a shortfall in patient charge income, in part attributable to PDS pilots income being based on the old GDS system of patient charges in England and Wales.

e. Figures for 2007/08 onwards are OHE estimates based on linear trend

Table 30: Supplementary data on miscellaneous health outcomes

Health outcomes, 1993 to 2013, England/UK (got better / got worse)		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	revised 2008	revised 2012
High Blood pressure (%), England																								
Men	Normotensive untreated											68.3	-	66.7	68.8	68.9	68.3	**68**	68.5	68.9	**69.1**			
	Hypertensive controlled											5.4	-	7.4	6.8	8	8.3	**8.3**	10.3	10.6	**9.4**			
	Hypertensive uncontrolled											6.3	-	6.8	6.3	6.2	6.3	**6.1**	6.5	6.3	**5.2**			
	Hypertensive untreated											20.1	-	19	18.1	16.9	17.1	**17.6**	14.7	14.2	**16.3**			
	All with high blood pressure											31.7	-	33.3	31.2	31.1	31.7	**32**	31.5	31.1	**30.9**			
Women	Normotensive untreated											70.5	-	72.7	72.2	71	71.4	73.1	71	72	73.2			
	Hypertensive controlled											6	-	7.9	7.8	8.4	9.2	**7.2**	10.9	10.2	**9.4**			
	Hypertensive uncontrolled											7.7	-	8.1	7.2	7	7	**7.1**	7.8	6.5	**6.4**			
	Hypertensive untreated											15.8	-	11.4	12.8	13.6	12.3	**12.6**	10.3	11.3	**11**			
	All with high blood pressure											29.5	-	27.3	27.8	29	28.6	26.9	29	28	26.8			
All	Normotensive untreated											69.4	-	69.8	70.6	70	69.9	**70.6**	69.8	70.5	**71.2**			
	Hypertensive controlled											5.7	-	7.7	7.3	8.2	8.7	**7.7**	10.6	10.4	**9.4**			
	Hypertensive uncontrolled											7	-	7.5	6.7	6.6	6.7	**6.6**	7.1	6.4	**5.8**			
	Hypertensive untreated											17.9	-	15	15.3	15.3	14.7	**15**	12.5	12.7	**13.6**			
	All with high blood pressure											30.6	-	30.2	29.4	30	30.1	**29.4**	30.2	29.5	**28.8**			
Body Mass Index, England																								
Men	Underweight	1.4	1.2	1.3	1.2	1	1.2	1.5	1.1	1.2	1.4	1.4	1.4	1.5	1.2	1.2	1.6	**2.2**	1.3	1.4	**1.3**			
	Normal	41	40.7	39.5	37.7	36.9	36	36	33.4	31.1	33.1	33.2	32.1	33.8	31.7	33.8	32.5	32	30.9	33.6	32.1			
	Overweight	44.4	44.3	44	44.6	45.2	45.5	43.9	44.5	46.6	43.4	43.2	43.9	42.6	43.4	41.4	41.8	**43.7**	41.6	41.4	**42.2**			
	Obese	13.2	13.8	15.3	16.4	17	17.3	18.7	21	21	22.1	22.2	22.7	22.1	23.7	23.6	24.1	**22.1**	26.2	23.6	**24.4**			
	Morbidly obese	0.2	0.4	0.3	0.4	0.8	0.6	0.8	0.6	0.6	0.8	1	0.9	0.9	1.5	1.3	1.1	**1.3**	1.6	1.7	**1.7**			
	Overweight including obese	57.6	58.1	59.3	61	62.2	62.8	62.5	65.5	67.7	65.5	65.4	66.5	64.7	67.1	65.1	65.9	**65.8**	67.8	65	**66.6**			
Women	Underweight	1.9	2.2	2.2	2	1.9	2.1	1.8	1.8	1.6	1.9	2.1	1.7	1.7	2.1	2	2	2.5	1.9	2.2	2.3			
	Normal	49.5	49.1	47.4	46	45.6	44.6	44.3	43.1	41.9	41.6	42.3	41.2	41.9	41.8	41.6	41.1	40.8	40.4	39.4	40.6			
	Overweight	32.2	31.4	32.9	33.6	32.8	32.1	32.8	33.8	32.9	33.7	32.6	33.9	32.1	31.9	32	32	32.8	**31.7**	32.5	**32.1**			
	Obese	16.4	17.3	17.5	18.4	19.7	21.2	21.1	21.4	23.5	22.8	23	23.2	24.3	24.2	24.4	24.9	**23.9**	26.1	25.9	**25.1**			
	Morbidly obese	1.4	1.6	1.4	1.4	2.3	1.9	1.9	2.3	2.5	2.6	2.9	2.4	2.7	2.7	2.2	2.8	**3.5**	3.8	3.2	**3.1**			
	Overweight including obese	48.6	48.7	50.4	52	52.5	53.3	53.9	55.1	56.4	56.5	55.5	57.1	56.3	56.1	56.4	56.9	**56.7**	57.8	58.4	**57.2**			
All	Underweight	1.6	1.7	1.8	1.7	1.5	1.7	1.7	1.5	1.4	1.7	1.8	1.6	1.6	1.6	1.6	1.8	**2.3**	1.6	1.8	**1.8**			
	Normal	45.5	45.2	43.7	42.2	41.6	40.6	40.4	38.6	37	37.7	37.8	36.7	37.9	36.8	37.7	36.8	36.4	35.6	36.5	36.4			
	Overweight	38	37.4	38.1	38.7	38.5	38.3	38	38.8	39.2	38.1	37.9	38.8	37.3	37.6	36.7	36.9	**38.3**	36.7	36.9	**37.1**			
	Obese	14.9	15.7	16.4	17.5	18.4	19.4	20	21.2	22.4	22.5	22.6	22.9	23.2	23.9	24	24.5	**23**	26.1	24.8	**24.7**			
	Morbidly obese	0.8	1	0.9	0.9	1.6	1.3	1.4	1.5	1.7	1.8	1.9	1.7	1.8	2.1	1.8	2	2.4	2.7	2.5	2.4			
	Overweight including obese	52.9	53.1	54.5	56.2	56.9	57.7	57.9	60	61.6	60.6	60.5	61.8	60.5	61.6	60.8	61.4	61.3	62.8	61.7	61.9			

Health outcomes, 1993 to 2013, England/UK got better / got worse	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	revised 2008	revised 2012
Children's overweight and obesity prevalence, England																							
Boys																							
2 to 10																							
Overweight			13.1	14.3	13.3	14.8	14.3	13.8	15.9	13.5	15.1	14.6	16.5	12.4	13.4	13.8	16.2	14.3	14.9	13.1			
Obese			9.7	11	11.4	11.8	16.5	12.4	13.6	15.5	15.4	16.2	17.1	17.4	16.5	14.4	13.7	15.3	12.4	10.8			
Overweight including obese			22.7	25.3	24.6	26.6	30.8	26.2	29.5	29	30.5	30.7	33.6	29.8	29.8	28.3	29.9	29.6	27.4	24			
10 to 15																							
Overweight			13.9	15.2	12.9	14.9	15.2	10.4	14.3	14.5	14.5	12.9	15.5	15.3	15.7	15.7	14	14.3	14.6	15			
Obese			13.9	14.3	15.9	16.6	17.9	18.9	19	20.3	20.4	24.3	20.5	17.9	18.2	20.6	19.7	19.9	23.8	19.1			
Overweight including obese			27.8	29.5	28.8	31.5	33.1	29.3	33.3	34.8	34.9	37.2	36	33.2	33.9	36.3	33.7	34.3	38.4	34			
2 to 15																							
Overweight			13.3	14.6	13.1	14.8	14.6	12.6	15.3	13.9	14.9	13.9	16.1	13.5	14.3	14.6	15.4	14.3	14.8	13.9			
Obese			11.1	12.1	12.9	13.4	17	14.7	15.6	17.3	17.4	19.4	18.5	17.6	17.1	16.8	16.1	17.1	16.6	14			
Overweight including obese			24.5	26.7	26.1	28.2	31.6	27.2	30.9	31.2	32.3	33.3	34.6	31.1	31.4	31.4	31.4	31.4	31.4	27.9			
Girls																							
2 to 10																							
Overweight			12.8	11.3	12.1	12.6	13.6	11.7	14.5	13.5	14.2	15.1	12.8	13.2	13.9	13	11.5	13	8.7	12.5			
Obese			10.6	10.7	10.8	12	13.2	11.8	13	16.1	12.7	12.8	17.4	13.5	14.6	13.3	15.2	13.9	15.5	10.3			
Overweight including obese			23.4	22	22.9	24.6	26.8	23.5	27.5	29.6	26.9	27.9	30.2	26.7	28.6	26.3	26.7	26.8	24.3	22.8			
10 to 15																							
Overweight			14.3	13.7	15.6	15.8	13.7	14.7	18.1	15.4	16.9	19.7	14.5	16.5	15	15.6	15.3	16.8	19.2	18			
Obese			15.5	15.8	16.4	17.8	15.6	18.6	18	19.8	22.2	26.7	21.1	17.3	19.4	18.3	15.4	16.6	16.5	18.7			
Overweight including obese			29.8	29.5	31.9	33.6	29.3	33.3	36.1	35.2	39.1	46.4	35.6	33.8	34.4	33.9	30.7	33.4	35.7	36.7			
2 to 15																							
Overweight			13.3	12.1	13.2	13.8	13.6	12.9	15.8	14.2	15.2	16.9	13.5	14.5	14.3	14	12.9	14.4	12.6	14.6			
Obese			12.2	12.4	12.6	14	14	14.3	14.8	17.4	16.4	18.5	18.8	15	16.4	15.2	15.3	14.8	15.9	13.5			
Overweight including obese			25.5	24.4	25.8	27.8	27.6	27.2	30.5	31.6	31.6	35.4	32.3	29.4	30.8	29.2	28.2	29.2	28.5	28			
All children																							
2 to 10																							
Overweight			12.9	12.8	12.7	13.8	14	12.8	15.2	13.5	14.6	14.8	14.6	12.8	13.6	13.4	13.9	13.6	11.9	12.8			
Obese			10.1	10.9	11.1	11.9	14.9	12.1	13.3	15.8	14.1	14.6	17.3	15.5	15.5	13.9	14.4	14.6	13.9	10.6			
Overweight including obese			23.1	23.7	23.8	25.7	28.8	24.9	28.5	29.3	28.7	29.4	31.9	28.3	29.2	27.3	28.3	28.2	25.8	23.4			
10 to 15																							

Health outcomes, 1993 to 2013, England/UK got better / got worse		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	revised 2008	revised 2012
	Overweight			14.1	14.5	14.2	15.4	14.5	12.6	16.1	15	15.6	16.2	15	15.9	15.4	15.7	14.6	15.5	16.8	16.4			
	Obese			14.7	15	16.1	17.2	16.8	18.7	18.5	20	21.3	25.5	20.8	17.6	18.8	19.5	**17.7**	18.3	20.2	**18.7**			
	Overweight including obese			28.8	29.5	30.3	32.6	31.3	31.3	34.7	35	36.9	41.7	35.8	33.5	34.2	35.2	**32.3**	33.8	37.1	**35.2**			
	2 to 15																							
	Overweight			13.3	13.4	13.2	14.3	14.1	12.7	15.5	14	15	15.4	14.8	14	14.3	14.3	14.2	14.3	13.7	14.2			
	Obese			11.7	12.2	12.8	13.7	15.5	14.5	15.2	17.4	16.9	18.9	18.6	16.3	16.8	16	**15.7**	16	16.3	**13.7**			
	Overweight including obese			25	25.6	25.9	28	29.7	27.2	30.7	31.4	31.9	34.3	33.4	30.3	31.1	30.3	**29.8**	30.3	30	**27.9**			
Cigarette smoking status, England																								
Men	Used to smoke cigarettes regularly	33	32	31	30	31	31	30	30	31	29	28	29	28	27	28	27	27	28	28	26			
	Current smoker	28	28	29	30	29	28	27	28	26	27	27	24	27	24	24	24	**24**	22	23	**22**			
Women	Used to smoke cigarettes regularly	22	22	21	21	21	21	21	19	22	20	20	22	20	22	21	22	22	23	22	22			
	Current smoker	26	27	27	27	27	27	26	25	25	26	24	23	24	21	21	20	**20**	18	19	**18**			
All	Used to smoke cigarettes regularly	27	27	26	25	26	26	25	24	26	24	24	25	24	24	25	25	24	25	25	24			
	Current smoker	27	27	28	29	28	28	27	26	25	26	25	23	25	23	22	22	**22**	20	21	**20**			
Cigarette smoking by socio-economic classification, UK																								
Men	Managerial and professional																			14	16			
	Intermediate																			**21**	**24**			
	Routine and manual																			**29**	**33**			
	Total (men)																			21	22			
Women	Managerial and professional																			12	12			
	Intermediate																			19	17			
	Routine and manual																			**26**	**32**			
	Total (women)																			19	19			
All	Managerial and professional																			13	14			
	Intermediate																			20	20			
	Routine and manual																			**28**	**33**			
	Total (all)																			20	20			
Alcohol units (consumed on the heaviest drinking day last week), England																								
Men	None						24	25	25	24	25	24	25	26	28	27	29	28	30	31	33			
	Up to and including 4						40	39	39	39	38	37	38	37	31	30	30	29	29	30	30			
	More than 4, up to and including 8						16	16	17	18	16	17	16	17	17	17	16	18	18	17	17			
	More than 8						20	20	20	19	21	22	21	21	24	26	25	**25**	23	22	**21**			

Health outcomes, 1993 to 2013, England/UK (got better / got worse)		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	revised 2008	revised 2012
	More than 4						36	36	36	37	36	39	37	37	41	42	41	43	41	39	37			
Women	None						39	40	39	39	39	39	40	41	42	43	42	44	46	46	47			
	Up to and including 3						40	39	41	39	39	38	38	37	25	25	26	25	26	26	25			
	More than 3, up to and including 6						13	13	13	14	13	14	13	14	17	16	16	16	15	14	16			
	More than 6						7	8	7	8	9	9	9	8	16	15	15	15	14	13	13			
	More than 3						20	21	20	22	23	23	22	22	33	31	32	31	28	28	28			
All	None						33	33	33	33	33	32	32	33	35	36	36	36	38	39	40			
	Up to and including 3/4						40	39	40	39	39	38	38	37	28	28	28	27	28	28	28			
	More than 3/4, up to and including 6/8						15	15	15	16	14	15	15	15	17	16	16	17	16	16	16			
	More than 6/8						13	13	13	13	15	15	15	14	20	20	20	20	18	17	16			
	More than 3 /4						27	28	27	29	29	31	29	29	37	37	36	37	34	33	33			
Fruit and vegetables consumption (portions per day), England																								
Men	None									8	8	9	8	7	7	7	7	7	8	8				
	Less than 1 portion									4	4	3	4	3	3	2	3	3	3	3				
	1 portion or more but less than 2									19	19	18	16	16	16	16	16	18	17	17				
	2 portions or more but less than 3									19	19	18	19	18	17	18	18	19	18	17				
	3 portions or more but less than 4									17	17	17	16	15	16	16	17	16	16	17				
	4 portions or more but less than 5									12	12	12	14	14	13	13	15	13	13	13				
	5 portions or more									22	22	22	23	26	28	27.5	25	25	25	24.5				
	Mean portions									3	3	3.2	3.3	3.5	3.6	3.6	3.5	3.4	3.4	3.5				
	Standard error of the mean									0	0	0.03	0.05	0.06	0.05	0.06	0.03	0.07	0.05	0.06				
	Median									3	3	3	3	3	3	3.2	3	3	3	3				
Women	None									6	6	6	6	5	5	5	6	6	6	5				
	Less than 1 portion									4	3	4	3	3	3	3	3	3	3	3				
	1 portion or more but less than 2									15	16	16	16	15	14	13	14	14	15	15				
	2 portions or more but less than 3									18	18	17	18	17	16	17	16	17	18	17				
	3 portions or more but less than 4									18	17	17	16	16	17	17	17	17	17	17				
	4 portions or more but less than 5									14	14	14	14	16	14	15	15	15	15	14				
	5 portions or more									25	25	26	27	30	32	30.7	29	28	27	28.6				
	Mean portions									3.5	3.5	3.5	3.6	3.8	3.9	3.9	3.8	3.7	3.7	3.8				
	Standard error of the mean									0.03	0.04	0.03	0.05	0.05	0.04	0.05	0.03	0.06	0.05	0.05				
	Median									3.0	3.2	3.0	3.3	3.5	3.6	3.5	3.5	3.3	3.3	3.3				

Health outcomes, 1993 to 2013, England/UK got better / got worse		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	revised 2008	revised 2012
All	None									6.7	6.9	7.6	7	5.9	5.7	5.9	6.1	6.5	6.8	6.6				
	Less than 1 portion									3.8	3.5	3.6	3.1	3	2.5	2.6	2.8	3	2.9	2.9				
	1 portion or more but less than 2									16.9	17.2	17.1	16.3	15.4	14.7	14.5	14.9	16.1	15.9	16.1				
	2 portions or more but less than 3									18.4	18.3	17.8	18.3	17.1	16.8	17.4	17.3	17.6	17.7	17.1				
	3 portions or more but less than 4									17.4	17	16.8	16.3	15.7	16.8	16.2	17.1	16.5	16.7	16.9				
	4 portions or more but less than 5									13.2	13.2	13.2	14	15	13.8	14.3	14.7	14.2	13.9	13.8				
	5 portions or more									24	24	24	25	28	30	29.1	27	26	26	26.6				
	Mean portions									3.4	3.4	3.4	3.5	3.7	3.8	3.8	3.7	3.5	3.6	3.6				
	Standard error of the mean									0.02	0.03	0.03	0.01	0.04	0.04	0.04	0.03	0.06	0.04	0.05				
	Median									3.0	3.0	3.0	3.0	3.3	3.3	3.3	3.3	3.2	3.0	3.2				
Physical activity, England																								
Men	Meets recommendations					32	34					36	37		40		42				43		66	66
	Some activity					33	30					31	31		30		29				29		10	10
	Low activity					35	36					32	32		30		29				28		24	24
Women	Meets recommendations					21	21					24	25		28		31				32		53	54
	Some activity					38	36					36	36		34		33				31		14	13
	Low activity					41	42					40	39		38		37				37		33	33
All	Meets recommendations					26	27					30	31		34		36				38		59	60
	Some activity					36	33					34	34		32		31				30		12	11
	Low activity					38	40					36	35		34		33				33		29	29
Self-reported general health (%), England																								
Men	Very good/good health	77	78	77	77	76	75	75	75	74	75	76	77	76	77	77	76	77	78	77	78			
	Very bad/bad health	5	5	5	6	6	7	7	7	7	8	7	6	7	7	6	6	7	7	6	6			
	At least one longstanding illness	40	39	42	43	44	44	44	44	45	44	44	43	42	41	42	40	**41**	40	38	**35**			
	Acute sickness[b]	12	12	13	15	15	15	15	16	14	14	15	14	13	14	13	14	13	14	13	13			
Women	Very good/good health	76	75	76	75	73	73	75	73	74	74	75	74	75	75	74	75	76	75	76	74			
	Very bad/bad health	4	5	5	5	7	7	7	6	7	7	6	7	7	7	7	7	7	7	6	7			
	At least one longstanding illness	40	40	41	43	44	44	44	45	46	46	46	47	45	44	44	44	**43**	43	41	**41**			
	Acute sickness[b]	14	15	17	19	19	19	18	19	19	18	18	19	18	18	18	18	17	18	18	18			
All	Very good/good health	76	76	76	76	74	74	75	74	74	74	75	75	75	76	75	76	76	76	76	76			
	Very bad/bad health	5	5	5	6	6	7	7	6	7	7	6	7	7	7	7	6	7	7	6	7			
	At least one longstanding illness	40	39	42	43	44	44	44	44	46	45	45	45	44	43	43	42	**42**	42	40	**38**			

Health outcomes, 1993 to 2013, England/UK got better got worse		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	revised 2008	revised 2012
	Acute sickness[b]	14	14	15	17	17	17	17	18	17	16	17	16	15	16	16	16	15	16	16	15			
Prevalence of IHD, stroke, IHD or stroke (ever) (%), England																								
Men	IHD		6				7.1					6.4			6.5					5.7				
	Stroke		1.8				2.3					2.4			2.4					2.7				
	IHD/Stroke		7.1				8.5					7.9			8.1					7.5				
Women	IHD		4.1				4.6					4.1			4					3.5				
	Stroke		1.6				2.1					2.2			2.2					2.1				
	IHD/Stroke		5.2				6.2					5.8			5.6					5				
All	IHD		5				5.7					5.2			5.2					4.6				
	Stroke		1.7				2.2					2.3			2.3					2.4				
	IHD/Stroke		6.1				7.2					6.8			6.8					6.3				
Doctor-diagnosed diabetes (%), England																								
	Men		2.9				3.3					4.3			5.6			6.5	6.3	7	6.7			
	Women		1.9				2.5					3.4			4.2			4.5	5.3	4.9	4.9			
	All		2.4				2.8					3.9			4.9			5.5	5.8	5.9	5.8			
Limiting long-standing illness or disability(%), GB																								
	Men													21	20	21	19	21	20	21	18			
	Women													23	24	23	21	22	23	24	20			
	All													22	22	22	20	21	21	23	19			
GHQ Score of 4 or more, UK																								
	All											20	19.3	19.3	20.6	20	19.5	20.5	18	18	19			
GHQ Score of 4 or more, England (HSE)																								
	Men			14					*13*				11				11				*12*			
	Women			20					*18*				15				15				*18*			
Suicide rate (per 100,000 population), England*																								
	Men	19	18.5	18.8	17.8	17.5	19.8	19.1	18.1	17.5	16.8	16.6	16.5	16.1	15.4	14.8	15.8	16	15	16.1	16.4			
	Women	6.1	5.7	5.7	5.7	5.7	5.8	5.7	5.9	5.3	5.3	5.3	5.6	5.4	4.8	4.4	4.7	4.8	4.7	4.9	4.5			
	All	12.4	11.9	12.1	11.6	11.4	12.7	12.2	11.8	11.3	10.9	10.8	10.9	10.6	10	9.5	10.1	10.3	9.8	10.4	10.4			
Suicide rate (per 100,000 population), UK*																								
	Men	20.5	19.9	20.2	19.2	19	21.1	20.7	19.9	19.3	18.7	18.1	18.1	17.5	17.4	16.8	17.6	17.4	16.9	18.1	18.2			
	Women	6.5	6.1	6.1	6	6.1	6.2	6	6.2	5.8	5.8	5.8	6.1	5.8	5.3	5	5.3	5.2	5.2	5.6	5.2			

Health outcomes, 1993 to 2013, England/UK got better / got worse	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	revised 2008	revised 2012
All	13.3	12.8	13	12.4	12.4	13.5	13.2	12.9	12.4	12.1	11.8	11.9	11.5	11.2	10.8	11.4	11.2	11	11.8	11.6			
Infant mortality																							
Rate per 1,000 live births	6.3	6.2	6.1	6.1	5.9	5.7	5.8	5.6	5.4	5.2	5.3	5.0	5.0	5.0	4.7	4.6	**4.5**	4.3	4.2	**4.0**			
Infant mortality rate by combined social clas, England and Wales																							
all (joint registration)																4.5	3.8	3.7	3.8	3.7			
routine manual (joint registration)																5.4	6.3	6	6.3	6			
Under 75 mortality from cardiovascular disease (standardised rate), NHS Outcomes Framework indicator, England*																							
Men											191.7	176.9	164.5	153.6	144.8	137.4	129	125.9	113.6	107.6	107.5		
Women											88.9	79.9	75	70.5	65.6	62.5	56.7	55.1	49.1	49.4	47.3		
All											138.2	126.5	118.1	110.7	103.9	98.8	91.8	89.5	80.5	77.7	76.6		
Under 75 mortality from respiratory disease (standardised rate), NHS framewoek indicator, England*																							
Men											48.5	44.8	45.5	42.9	42.6	43	40.7	39.7	39.7	38.7	38.9		
Women											35	31.2	31.6	29.9	30	30.9	29	28.9	28.6	27.9	28.6		
All											41	37.3	37.9	35.8	35.7	36.4	34.2	33.7	33.6	32.7	33.2		
Under 75 mortality from cancer (standardised rate), NHS Outcomes Framework indicator, England*																							
Men											189.5	184.2	180.5	178.3	174.6	172	**168.9**	165.9	164.1	160.8	**157.9**		
Women											144.7	143.1	141.3	139.1	138.6	136.8	**133.5**	131.2	131.5	129.7	**126.5**		
All											165.8	162.5	159.8	157.7	155.7	153.6	**150.5**	147.8	147.1	144.6	**141.5**		
Under 75 mortality from liver disease (standardised rate), NHS Outcomes Framework indicator, England*																							
Men											22.5	21.9	22.5	23.7	23.6	24.2	23.3	24	24	23.1	23.6		
Women											11	11.8	11.2	12	12.4	12.1	12	12.2	12.9	12.5	12		
All											16.6	16.7	16.8	17.7	17.9	18	17.5	18	18.3	17.7	17.7		
Potential years of life lost (PYLL) from causes considered amenable to healthcare (standardised rate), NHS Outcomes Framework indicator, England*																							
Men											3,680	3,506	3,365	3,223	3,116	3,027	**2,936**	2,847	2,711	2,556	**2,586**		
Women											2,799	2,689	2,608	2,508	2,423	2,379	**2,279**	2,191	2,122	2,063	**2,036**		
All											3,224	3,083	2,974	2,855	2,759	2,694	**2,598**	2,510	2,409	2,303	**2,303**		
One-year net survival (%) from all cancers combined by calendar year of one-year follow-up, NHS Outcomes Framework indicator, England																							
All					59.2	59.7	60.0	60.4	60.8	61.2	61.8	62.3	62.9	63.6	64.3	65.0	**65.8**	66.57669	67.37917	**68.2**			
Five-year net survival (%) from all cancers combined by last calendar year of follow-up period, NHS Outcomes Framework indicator, England																							
All									41.4	41.9	42.2	42.6	43	43.5	44	44.7	**45.4**	46.1	47	**47.9**			
One-year net survival (%) from breast, lung and colorectal cancer combined by calendar year of one-year follow-up, NHS Outcomes Framework indicator, England																							
All					61.6	62.2	62.7	63.2	63.7	64.1	64.7	65.2	65.7	66.3	66.8	67.3	**67.9**	68.4	68.9	**69.5**			
Five-year net survival (%) from breast, lung and colorectal cancer combined by last calendar year of follow-up up period, NHS Outcomes Framework indicator, England																							
All									44.2	44.8	45.4	46.0	46.6	47.2	47.8	48.5	**49.2**	49.9	50.6	**51.4**			

Health outcomes, 1993 to 2013, England/UK got better (green) / got worse (orange)	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	revised 2008	revised 2012
Emergency admissions for alcohol related liver disease (standardised rate), CCG indicator, England																							
Persons																		23.6	24.3	24.9	24.1		
Mortality from breast cancer in females (standardised rate), CCG indicator, England																							
Women																		34.3	34.6	34.7			
Access to community mental health services by people from Black and Minority Ethnic (BME) groups, CCG indicator, England																							
Persons																			1,709	1,801	2,036		
Patient experience of GP out-of-hours services, England*																							
Weighted % of respondents reporting a good experience																			**70.9**	70.2	**66.2**		
Life expectancy at 75, NHS framewoek																							
Men	8.5	8.9	8.8	8.9	9.0	9.2	9.2	9.5	9.6	9.7	9.8	10.1	10.2	10.4	10.6	10.7	**10.9**	11.1	11.3	**11.3**			
Women	11	11.4	11.3	11.3	11.4	11.5	11.5	11.7	11.8	11.8	11.7	12.1	12.2	12.4	12.5	12.5	12.9	12.9	13.2	13			
Life expectancy at 75 (three year averages), NHS framework indicator, England*																							
Men	8.8	8.8	9.0	9.0	9.1	9.2	9.4	9.5	9.7	9.8	9.9	10.1	10.4	10.6	10.8	10.9	**11.1**	11.4	**11.5**				
Women																							
Life expectancy at birth (three year averages), England and Wales*																							
Men	73.9	74.1	74.3	74.5	74.7	75.0	75.3	75.6	75.9	76.1	76.4	76.8	77.2	77.5	77.8	78.1	**78.4**	78.8	79.1	**79.3**			
Women	79.3	79.4	79.6	79.6	79.8	79.9	80.1	80.3	80.6	80.6	80.8	81.1	81.5	81.7	81.9	82.2	**82.4**	82.8	82.9	**83.0**			
Life expectancy at birth (three year averages), England*																							
Men	74.0	74.2	74.4	74.6	74.8	75.1	75.4	75.7	76.0	76.2	76.5	76.9	77.3	77.6	77.9	78.2	**78.5**	78.9	79.2	**79.4**			
Women	79.4	79.4	79.6	79.7	79.8	80.0	80.2	80.4	80.7	80.7	80.9	81.1	81.5	81.8	82.0	82.3	**82.5**	82.9	83.0	**83.1**			
National Statistics Hospital Episode Statistics, England																							
Admitted patients Finished Consultant Episodes (numbers)										12,755,899	13,174,480	13,706,765	14,423,506	14,784,581	15,359,062	16,232,579	16,806,196	17,269,882	17,465,425	17,715,046			
Outpatients appointment attendences (numbers)																60,607,226	67,414,037	70,265,964	72,620,492	75,455,584			
A&E (all departments), total attendances, thousands	13,289	13,812	14,234	14,126	14,364	14,280	14,629	14,293	14,044	14,046	16,517	17,837	18,759	18,922	19,077	19,588	20,512	21,381	21,481	21,739	21,779		
Age-Standardised Mortality Rates by cause of death, UK																							
Circulatory																							
Men	841	781	768	752	715	691	667	626	625	611	589	543	514	481	461	447	**417**	406	357	347	**342**		
Women	547	508	500	489	468	458	440	412	416	410	401	368	349	326	314	308	**286**	275	237	238	**229**		
Neoplasms																							
Men	457	447	442	434	422	421	407	399	412	409	403	395	386	384	380	376	**368**	363	362	359	**353**		
Women	283	281	278	277	272	269	266	263	268	267	264	259	259	256	256	255	249	248	247	247	243		
Respiratory																							
Men	330	291	311	303	305	289	305	289	209	212	223	204	205	194	190	194	**182**	174	172	175	**178**		
Women	200	174	191	189	197	187	204	190	136	142	153	139	144	135	134	139	126	123	120	123	127		

Sources and notes:

Sources:

Health and Social Care Information Centre (2013a, b, c, d); Office for National Statistics (2014d); Office for National Statistics (2014e); Office for National Statistics (2014g); Office for National Statistics (2014g,h,i, j, u); Health and Social Care Information Centre (online); NHS England (2014c)

Notes:

The colour coding represents either and improvement (green) or deterioration (red) in outcomes between highlighted years, not all of these changes were avialable with Confidence intervals to test for their significance.

*for these items changes were checked for significance using upper and lower confidence intervals

High Blood Pressure

"a In the 1998 report the systolic blood pressure (SBP) and diastolic blood pressure (DBP) thresholds for hypertension were changed from 160/95 to 140/90 mmHg, in accordance with the latest guidelines on hypertension management.1,2,3 From 2003, participants were placed in one of the treated categories if they were currently taking a drug prescribed for high blood pressure, whereas previously they had been described as treated if they were prescribed any drug which had the effect of lowering their blood pressure.

Refs

1 Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure and the National Blood Pressure Education Program Coordinating committee. The sixth report of the Joint National Committee on prevention, detection, evaluation, and treatment of high blood pressure. Arch Intern Med 1997;157:2413-2446.

2 1999 World Health Organisation - International Society of Hypertension Guidelines for Management of Hypertension. J Hypertens 1999;17:151-183.

3 Ramsey LE, Williams B, Johnston GD, MacGregor GA, Poston L, Potter JF, Poulter NR, Russell G,. British Hypertension Society guidelines for hypertension management 1999: Summary BMJ 1999;319:630-635."

b From 2003 the Dinamap monitor was replaced by the Omron. Omron measures are the preferred measure.

c Participants were classified into one of four groups as follows:

Normotensive untreated: SBP below 140mmHg and DBP below 90mmHg, not currently taking medication for blood pressure.

Hypertensive controlled: SBP below 140mmHg and DBP below 90mmHg, currently taking medication for blood pressure.

Hypertensive uncontrolled: SBP at or greater than 140mmHg and DBP at or greater than 90mmHg, currently taking medication for blood pressure.

Hypertensive untreated: SBP at or greater than 140mmHg and DBP at or greater than 90mmHg, not currently taking medication for blood pressure.

d Blood pressure was not measured in 2004.

e All adults from core and boost samples in 2005 were included in analysis of 65-74 and 75+ age groups but only the core sample was included in the overall total. Thus it should be noted that the 'All Men', 'All Women' and 'All adults' totals are not the sum of the individual age groups.

f Data from 2003 onwards are weighted for non-response.

Body Mass Index

a All young adults from core and boost samples in 2002 were included in analysis of those aged 16-24 but only the core sample was included in the overall total. Thus it should be noted that the 'All Men', 'All Women' and 'All adults' totals are not the sum of the individual age groups.

b Data up to and including 2002 are unweighted; from 2003 onwards data have been weighted for non-response.

c All adults from core and boost samples in 2005 were included in analysis of 65-74 and 75+ age groups but only the core sample was included in the overall total. Thus it should be noted that the 'All Men', 'All Women' and 'All adults' totals are not the sum of the individual age groups

d Underweight = BMI less than 18.5.

e Normal = BMI 18.5 to less than 25.

f Overweight = BMI 25 to less than 30.

g Obese = BMI 30 or more (includes morbidly obese).

h Morbidly obese = BMI 40 or more.

Children's overweight and obesity prevalence, England

a In 2008 the definitions for children who were overweight or obese were revised from those used in previous years to correct an error which meant that small numbers of children that should have been classified as either ‘overweight’ or ‘obese’ were omitted from these categories because of rounding of age and BMI thresholds. In no cases were results significantly different from those presented previously. This table uses the new definitions for all years.

b All years were weighted to adjust for the probability of selection; from 2003 non-response weighting was also applied (unshaded columns).

Smoking status

a Data up to and including 2002 are unweighted; from 2003 onwards data have been weighted for non-response.

b In the 1996 Health Survey Report the ‘Never regularly smoked cigarettes’ category was split into ‘Never smoked cigarettes’ and ‘Used to smoke cigarettes occasionally’. The data presented in the 1996 HSE report were calculated incorrectly, and therefore the categories are shown recombined in this table.

Alcohol consumption

a All young adults from core and boost samples in 2002 were included in analysis of those aged 16-24 but only the core sample was included in the overall total. Thus it should be noted that the 'All Men', 'All Women' and 'All adults' totals are not the sum of the individual age groups.

b Data up to and including 2002 are unweighted (grey shaded columns); from 2003 onwards data have been weighted for non-response.

c All adults from core and boost samples in 2005 were included in analysis of 65-74 and 75+ age groups but only the core sample was included in the overall total. Thus it should be noted that the 'All Men', 'All Women' and 'All adults' totals are not the sum of the individual age groups.

d In 2006, the method of calculating units was reviewed, and the conversion to unit equivalents for wine, strong beers and lagers and alcopops have been revised. See the 2006 HSE report, Volume 1 Chapter 9 for details of revised conversion factors; www.hscic.gov.uk/pubs/hse06cvdandriskfactors. Results for 2006 are presented in this table calculated using the revised unit assumptions (blue shaded columns).

"e The method of calculating units in 2007 was the same as for the revised 2006 method. There was a further adjustment for glasses of wine: the 2007 survey asked about the size of glass, and different conversion units were used for the different glass sizes. See the 2007 report, Volume 1 Chapter 7 for details: www.hscic.gov.uk/pubs/hse07healthylifestyles. Results for subsequent years use the 2007 revised conversion units.

f The thresholds for men and women are different, reflecting the different recommended daily limits for each, as shown in the relevant sections. The 'All Adults' data use the different thresholds for men and women, eg 'Up to and including 3/4' means 'up to and including 3 units for women/4 units for men', and so on.

Fruit and vegetable consumption

a All young adults from core and boost samples in 2002 were included in analysis of those aged 16-24 but only the core sample was included in the overall total. Thus it should be noted that the 'All Men', 'All Women' and 'All adults' totals are not the sum of the individual age groups.

b Data up to and including 2002 are unweighted (shaded columns); from 2003 onwards data have been weighted for non-response.

c The fruit and vegetable questions were only asked of the core sample in 2005, so (unlike some other tables in this series) there is no boost of the age groups 65 and over.

Physical activity levels

a The categories for physical activity were renamed in 2008 to describe more accurately what they represent, since the category formerly labelled 'High' is in fact the group that meets government recommendations for the minimum level of activity to achieve health benefits.

b Data up to and including 2002 are unweighted (grey shaded columns); from 2003 onwards data have been weighted for non-response.

c In 2008, an enhanced physical activity questionnaire was introduced for adults, and in 2011 new physical activity recommendations were introduced. To allow comparison across HSE years, 'original' results have been calculated for 2008 and 2012 based on the previous recommendations (at least 30 minutes per day of at least moderate intensity on at least five days per week). These results are directly comparable with previous years; episodes of activity of less than 30 minutes have been excluded, and occupational activity has been included without using additional data from the extended questionnaire.

d The enhanced physical activity questionnaire was introduced for adults in 2008, with additional questions relating to occupational activity, sedentary activity, and follow-up questions for certain activities. The reference period for bouts of activities to report was 10 minutes. Further refinements to the questionnaire were introduced in 2012, mainly to reflect the new physical activity recommendations introduced in 2011; however these further refinements have not been used in the revised method presented here in the trend tables so that results for 2008 and 2012 are directly comparable. Revised results for 2008 and 2012 are presented in this table (blue shaded columns) based on the new recommendations for physical activity (at least 150 minutes moderate intensity physical activity or 75 minutes vigorous activity per week or an equivalent combination of these). Note that the figures in these tables for 2012 are slightly different from those shown in the 2012 report for adults aged 16 and over (which took into account the 2012 questionnaire refinements). Full details of the revised methods are outlined in the 2012 report, Chapter 2, at www.hscic.gov.uk/pubs/hse2012.

d Meets recommendations

Up to 2011: at least 30 minutes of moderate or vigorous activity on at least 5 days a week

New guidelines: at least 150 minutes moderate or 75 minutes vigorous activity per week or an equivalent combination of these."

e Some activity

Up to 2011: 30 minutes or more of moderate or vigorous activity on 1 to 4 days a week

New guidelines: 60-149 minutes moderate or 30-74 minutes vigorous activity per week or an equivalent combination of these. "

f Low activity: lower levels of activity than above.

Self-reported general health

a Data up to and including 2002 are unweighted; from 2003 onwards data have been weighted for non-response.

b Acute sickness is any illness or injury (including any longstanding condition) that causes the participant to cut down on usual activities in the last two weeks.

Prevalence of IHD, stroke, IHD or stroke (ever)

a IHD: Ischaemic heart disease.

b Data up to and including 2002 are unweighted; from 2003 onwards data have been weighted for non-response.

c Bases vary for each condition: those shown are for those aged 16 and over in the overall sample.

Prevalence of limiting long-standing illness or disability (ONS 2014)

a 2005 data includes the last calendar quarter of 2004, due to a change in reporting period from financial year to calendar year.

b Results from 2006-2011 include longitudinal data.

c All unweighted samples are rounded to the nearest 10.

GHQ12 score of 4 or more (Percentage with some evidence indicating probable psychological disturbance or mental ill health), HSCIC (2013), General mental and physical health

a Percentages exclude missing and proxy values . Data for 2009/10 uses a self-completion cross-sectional weight, from 2010/11 onwards the individual main interview cross-sectional weight was used.

b In 2009 the British Panel Household Survey was incorporated into the Understanding Society UK Household Longitudinal Study. Therefore, data from 2009/10 onwards cannot be compared to previous years due to an increase in the sample size.

GHQ12 score of 4 or more (Percentage with some evidence indicating probable psychological disturbance or mental ill health), HSE 2012

a A score of 4 or more is referred to as "high GHQ-12 score", indicating probable psychological disturbance or mental health

b no weighting was applied in 1995 and 2000. Data from 2003 onwards are weighted for non-response.

Suicide rate (ONS 2014 Suicides in the United Kingdom, UK and England)

a In the United Kingdom, suicide is defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent.

b Figures are for persons aged 15 years and over.

c Age-standardised suicide rates per 100,000 population, standardised to the 1976 European Standard Population. Age-standardised rates are used to allow comparison between populations which may contain different proportions of people of different ages.

d Figures are for persons usually resident in England/UK, based on boundaries as of August 2013.

e Figures are for deaths registered in each calendar year.

Infant mortality Rates by combined social class

2008-10 (combined social class) based on ONS, Live births and infant mortality statistics by father's NS-SEC; 2010-12: ONS (2014)

Notes:

(i) Data for 2001 to 2010 is based on NS-SEC classification which was introduced in 2001 to replace the Registrar General’s Social Classification (RGSC). To take account of this change in classification, the formulation of the target was changed from “manual” social class to “routine and manual” groups. A time series back to 1994 was constructed to be on an equivalent basis and is based on an approximation to NS-SEC (NS-SEC 90) available for use with data prior to 2001. See DoH (2009) Annex for further details.

(ii) Data for 2011 and 2012 is based on a changed Standard Occupational Classification (SOC) in January 2011 and is therefore not strictly comparable to previous years. A report providing more detail on the impact of rebasing NS-SEC to SOC2010 for infant mortality statistics can be found here: Rose and Pevalin (2010), Re-basing the NS-SEC on SOC2010: A Report to ONS, available: http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html, accessed February 2014. The definition for 'inside marriage / joint registrations' changed from 2011 whereby joint registrations where a couple lived at different addressed were excluded from this analysis group and were joint with "sole registration" group. More information on this can be found in ONS (2013), Planned changes to Child Mortality Outputs, available: http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/2011/stb-cms-2011.html, accessed February 2014

(iii) Mortality rates are based on infant deaths successfully linked to their birth records

(iv) Father's social class: NS-SEC based on father’s occupation at death registration and 'combined social class' means a household highest NS-SEC

Potential years of life lost (PYLL) from causes considered amenable to healthcare, NHS Outcomes Framework indicator

Directly age and sex standardised potential years of life lost (PYLL) per 100,000 registered patients, 95% confidence intervals (CI)

Under 75 mortality from cardiovascular disease/respiratory disease/cancer/liver disease, NHS Outcomes Framework indicators

Directly age and sex standardised mortality rate (DSR) per 100,000 registered patients, 95% confidence intervals (CI)

Data from 2012 for cardiovascular disease is not comparable to previous years due to change in coding in 2011

Emergency admissions for alcohol related liver disease, CCG indicator

Directly standardised rate (DSR) for over 18s per 100,000 registered patients, 95% confidence intervals (CI)

Data is for 2010/11, 2011/12, 2012/13, Provisional 2013/14

Mortality from breast cancer in females, CCG indicator

Directly age standardised mortality rate (DSR) per 100,000 registered female patients, 95% confidence intervals (CI); 2009-2011 to 2011-2013 (3 years pooled)

Access to community mental health services by people from Black and Minority Ethnic (BME) groups, CCG indicator

Access to community mental health services by people from BME groups, crude rates per 100,000 population

2011/12, 2012/13, 2013/14

Patient experience of GP out-of-hours services, NHS Outcomes Framework Indicator, England

Percentage of people reporting a 'very good' or 'fairly good' experience of GP out-of-hours services, weighted for design and non-response; July 2011 to March 2012, July 2012 to March 2013, July 2013 to March 2014

Life expectancy at 75, NHS Outcomes Framework indicator, England

Calendar years

Life expectancy at 75 (three year averages), NHS Outcomes Framework indicator, England

Three year averages: so for example, data for 1993 in the table refers to the average of 1992-1994, etc. The increase in life expectancy at 75 in England between 2008-10 and 2011-13 was statistically significant for both men and women.

Life expectancy at birth, England and Wales

Three year averages: so for example, data for 1993 in the table refers to the average of 1992-1994, etc. The increase in life expectancy in England and Wales between 2008-10 and 2011-13 was statistically significant for both men and women. The increase in life expectancy in England between 2008-10 and 2011-13 was also statistically significant for both men and women.

National Statistics Hospital Episode Statistics, England

Admitted patients Finished Consultant Episodes (numbers), fiscal years

Age-Standardised Mortality Rates by cause of death, UK

Rates per 100,000 population

1. The number of deaths registered in a year and mid-year population estimates by age and sex were used to calculate age-specific mortality rates for all ages except for babies aged less than 1 year where the number of live births registered in a year was used as the denominator.

2. Age-standardised to the 2013 European Standard Population using 5 year age groups up to 90

3. International Classification of Diseases (ICD-10) cause codes: C00-D48 Neoplasms (Cancers); I00-I99 Diseases of the circulatory system; and J00-J99 Diseases of the respiratory system

Table 31: Patient experience, England, 2002/03 to 2013/14

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2009/10 adjusted	2010/11	2011/12	2012/13		2012/13 adjusted	2013/14	
Adult Inpatient survey																
Access & waiting		83.5		84.9	84.8	83.8	84.9	85		84.2	83.8	84.3	*S*		84.6	*S*
Safe, high quality, coordinated care		65.5		65.1	65.1	64.9	65.3	64.4		64.6	64.8	65.4	*S*		66.4	*S*
Better information, more choice		67.9		69.1	67.3	66.7	67.7	66.8		67.2	67.2	68.2	*S*		68.8	
Building closer relationships		83.3		83.1	83.1	83	83.2	82.9		83.0	83.0	84.6	*S*		84.7	*S*
Clean, friendly, comfortable place to be		78.4		78.6	78.4	78.1	79.2	79.1		79.3	79.4	79.8	*S*		80.1	*S*
Overall		75.7		76.2	75.7	75.3	76	75.6		75.7	75.6	76.5	*S*		76.9	*S*
Outpatient survey																
Access & waiting[a]		68.2		69				72.5	73.3		74.9		*S*			
Safe, high quality, coordinated care		83		82.2				83.2	83.2		83.6		*S*			
Better information, more choice		77.2		77.3				79.1	79.1		78.6		*S*			
Building closer relationships		86.4		86.5				87.3	87.3		87.7		*S*			
Clean, friendly, comfortable place to be		69.7		68.5				70.9	70.9		71.3		*S*			
Overall		76.9		76.7				78.6	78.8		79.2		*S*			
Emergency Services survey																
Access & waiting	68.6		69.4				66.6					64.3	*S*			
Safe, high quality, coordinated care	74.7		74.7				75.1					74.5	*S*			
Better information, more choice	72.7		73.5				74.4					74.8				
Building closer relationships	78.9		80.4				81.3					80.8	*S*			
Clean, friendly, comfortable place to be	80.3		81				81.4					82.2	S			
Overall	75		75.8				75.7					75.4	S			
Primary Care survey[d]																
Access & waiting	67.6	68.5	69.8	69.3		69.4										
Safe, high quality, coordinated care	79.3	80.1	81.5	80.4		80.9										
Better information, more choice	81.6	80.7	80.7	79.7		80.5										
Building closer relationships	87.5	86.2	86.2	86		86.4										
Clean, friendly, comfortable place to be	69.5	69	69	69.5		70.1										
Overall	77.1	76.9	77.4	77		77.5										
Mental Health Services survey																
Access & waiting		80.5	80.3	79.7	80.1						71.1	72.4	S	72.4	72.4	
Safe, high quality, coordinated care		69.9	70.2	70.8	71.7						72.1	71.3	S	68.0	67.4	
Better information, more choice		60.7	61.8	60.8	62						68.3	69.1	S	65.8	65.4	
Building closer relationships		85.9	86.2	86.6	86.9						84.7	84.7		82.4	81.1	S
Overall		74.2	74.7	74.5	75.2						74.0	74.4		72.2	71.6	S
Primary Care																
Involvement in choice of provider[i,j,k]				27.3		42.7										
Involved in decisions about treatment [l,m,n]		-	77.1	-	-	-	76	-								
Emergency services survey		-	81.7	-	-	-	-	82.3								
Outpatients survey		70.9	-	71.9	70.9	70.3	71.3	71								
Adult Inpatients survey		63.3	62.7	63.5	63.7	64.2	-	-								
Mental health services survey		82.1	82.5	81.9	-	82.9	-	-								
Primary care survey[o]		-	77.1	-	-	-	76	-								

Source: Figures up to and including 2009/10: Department of Health (2010d): National Patient Survey Programme [Adult Inpatient and Outpatient surveys, Emergency Services survey, Primary Care survey and Mental Health Survey; involvement and choice about treatment]. Figures from 2009/10 adjusted: NHS England (2013c), Summary Tables; and for 2013/14 adult inpatient survey figures: NHS England (2014a), overall results tables.

Notes:

a. Outpatients: The scoring regime used for the question about length of wait for an appointment (question A1 in 2002-03 and question 1 in 2004-05) has been adjusted from that published by the contractor appointed to run the NHS Survey Advice Centre, to allow comparison across years. The 2009-10 scores for outpatient survey are adjusted to allow for direct comparison with 2011-12.
b. There were substantial changes in the wording of a question related to arrival in the accident and emergency department. (question B1 in 2002-03 and question 3 in 2004-05). Results are not directly comparable for these two years. The scoring regime for this question has also been adjusted from that published by the contractor appointed to run the NHS Survey Advice Centre.
c. Due to the substantial changes within the access & waiting domain (see note b), overall aggregated domain scores for these two years are not directly comparable
d. Care should be taken when comparing results from 2002-03 with later years. The 2002-03 survey asked a series of questions regardless of the healthcare professional seen by the patient, whilst later surveys ask specifically about seeing a doctor. The 2002-03 figures have been adjusted by removing those respondents who indicate that they did not see a doctor. Results therefore may not be directly comparable.
e. For 2002-03, the scoring regime used for questions about length of wait for an appointment (Question A3), the length of wait to be seen (Question B4) and whether someone told the respondent how long they would wait (Question B5) differs from that published by the contractor appointed to run the NHS Survey Advice Centre.
f. Figures for access and waiting should not be compared for 2002-03 and later years. A change in the ordering of options in one question (Question A3 in 2002-03 and A2 in 2003-04) is likely to have had a large impact on the results.
g. Due to the substantial changes within the access & waiting domain (see note f), overall aggregated domain scores for these two years are not directly comparable
h. Figures for better information, more choice should not be compared for 2003-04 and 2004-05. Changes in the wording of one of the questions means that results are not comparable. Overall aggregated domain scores for these two years are not directly comparable.
i. Involvement in choice of provider: age-gender standardised score
j. In 2005/06 patients were asked the question "The last time you were referred to a specialist, were you given a choice about where you were referred (i.e. which hospital)?". A response of "Yes" was scored 100, a response of "No, but I would have liked a choice" was scored 0 and a response of "No, but I did not mind" scored 0.
k. In 2007/08 patients were asked the question "When you were referred to see a specialist were you offered a choice of hospital for your first hospital appointment?". A response of "Yes" was scored 100 and a response of "No" was scored 0.
l. Patients were asked the question "Were you involved as much as you wanted to be in decisions about your care and treatment?", A response of "Yes, definitely" was scored 100, a response of "Yes, to some extent" was scored 50 and a response of "No" was scored 0.
m. Cells containing a hyphen (-) indicate that the survey was not conducted in that particular year
n. Surveys in different settings are conducted on different patient groups and sometimes with differently worded questions. Results from different settings should not be compared
o. The score for the Primary Care Survey 2005/06 was based on a small national survey, carried out in exactly the same way as the National Patient Survey Programme but with a smaller sample size. Differences from earlier years may not be statistically significant.
p. Mental health services Survey: Due to changes in the scoring methodology for some questions in 2013/14, the 2013/14 score is not directly comparable to previous years. The 2012/13 scores for outpatient survey are adjusted to allow for direct comparison with 2011-12. Furthermore, a series of changes to the survey mean that results for years prior to 2011/12 are not comparable with later years either.
q. Results marked with an S show a statistically significant change from previous year
r. “The scores represent results out of 100 for specific aspects of experience for NHS patients, after they have used the NHS. If patients reported all aspects of their care as ‘good’, we would expect a score of about 60. If they reported all aspects as ‘very good’, we would expect a score of about 80” (NHS England, 2014: p.6).

Figure 24: Percentage of admissions where the patient died within 30, 60 and 90 days, covering impatient episodes of care, 1998-99 to 2013-14

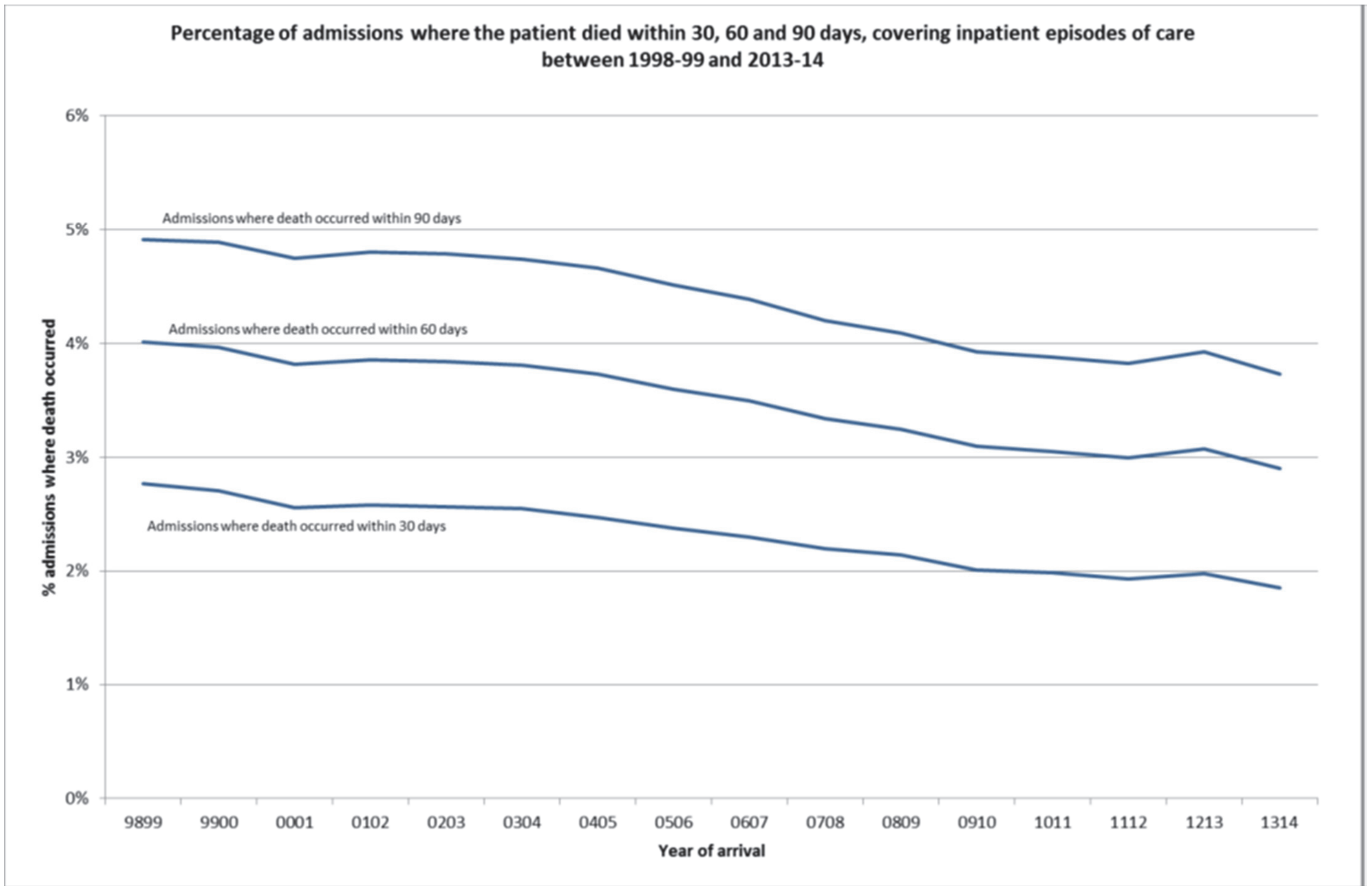
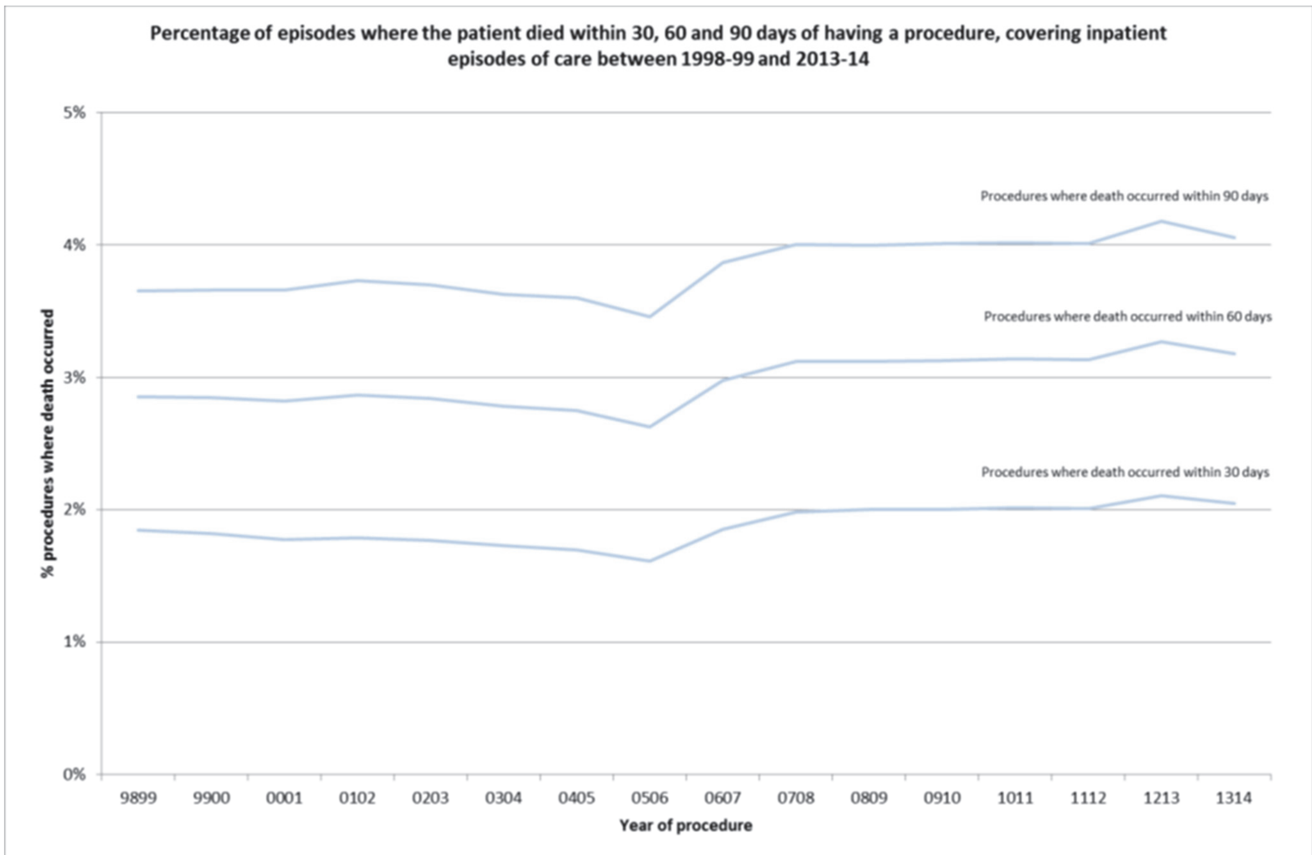


Figure 25: Percentage of episodes where the patient died within 30, 60 and 90 days, covering impatient episodes of care, 1998-99 to 2013-14



Source: HCHS (2014a), Monthly topic of interest: Linked HES-ONS mortality data. Available: http://www.hscic.gov.uk/catalogue/PUB16081 [accessed December 2014].

Table 32: Life expectancy in selected countries, males, 2011-2013

	Life expectancy at birth	Life expectancy at age 65	Life expectancy at age 85
Iceland (2013)	80.8	19.1	5.9
Switzerland (2012)	80.5	19.1	..
Sweden (2013)	80.1	18.7	5.6
Japan (2012)	79.9	18.9	6.0
Australia (2010-2012)	79.9	19.1	6.1
Norway (2013)	79.7	18.4	5.7
Italy (2012)	79.6	18.3	5.6
Spain (2012)	79.4	18.5	5.9
Canada (2009-2011)	79.3	18.8	6.5
New Zealand (2010-2012)	79.3	18.8	5.9
England (2011-2013)	**79.2**	**18.5**	**5.8**
Netherlands (2012)	79.1	17.9	..
France (2012)	78.4	18.1	..
Wales (2011-2013)	**78.2**	**18.0**	**5.6**
Denmark (2012-2013)	78.0	17.4	5.3
Northern Ireland (2011-2013)	**78.0**	**17.9**	**5.6**
Germany (2009-2011)	77.7	17.5	5.5
Scotland (2011-2013)	**76.8**	**17.1**	**5.5**
Poland (2013)	73.1	15.5	5.6
Estonia (2012)	71.1	14.4	5.2
Brazil (2011)	70.6	16.1	..
Latvia (2013)	69.5	13.8	4.7

Source: ONS (2014w,) using Swiss Federal Statistical Office, Statistics Iceland, Australian Bureau of Statistics, Statistics Bureau of Japan, The National Institute of Statistics Italy, Statistics Netherlands, National Statistics Institute of Spain, Statistics New Zealand,
Statistics Norway, ONS, Federal Statistical Office of Germany, Statistics Denmark, Central Statistical Office of Poland, Brazilian Institute of Statistics and Geography, Statistical Office of Estonia, Central Statistical Bureau of Latvia, Statistics Sweden,
National Institute of Statistics and Economic Studies- France, and Statistics Canada.

Notes:

·· Indicates that the figure was not available at the time of publication of this report.

Countries have been selected based on the availability of data for the selected years and are ordered by life expectancy at birth.

Annex 4 Department of Health Business Plan 2013-15 impact and input indicators - December 2013

Department of Health Business Plan 2013-15 impact and input indicators - December 2013

	Type of data	Current	Previous	Brief commentary on data trend	Indicator format (details in separate annex)
Better Health and Well-being for all					
Potential years of life lost from causes considered amenable to healthcare (males)	Impact Indicator	**2201** (2012 calendar year)	**2325** (2011 calendar year)	The trend continued to improve in 2012	European age-standardised rate per 100,000 population
Potential years of life lost from causes considered amenable to healthcare (females)	Impact Indicator	**1811** (2012 calendar year)	**1844** (2011 calendar year)	The trend continued to improve in 2012	
Life expectancy at 75 (males)	Impact Indicator	**11.3** (2012 calendar year)	**11.3** (2011 calendar year)	Life expectancy for men did not increase in 2012, for the first time since 1999	Number of years
Life expectancy at 75 (females)	Impact Indicator	**13.0** (2012 calendar year)	**13.2** (2011 calendar year)	Life expectancy for women dropped in 2012, for the first time since 2003	Number of years
Infant mortality	Impact Indicator	**4.1** (2012)	**4.2** (2011)	The rate continues to fall.	Per 1,000 live births
Life expectancy/differences: at birth (males) (years)	Impact Indicator	**9.9** (2007-10)	**9.6** (2003-06)	Inequality in male life expectancy between the least and most deprived areas in England increased between 2003-06 and 2007-10, part of a longer term pattern of persistent inequality.	Differences in life expectancy at birth by deprivation quintile across England, as measured by the Slope Index of Inequality
Life expectancy/differences: at birth (females) (years)	Impact Indicator	**7.0** (2007-10)	**6.6** (2003-06)	Inequality in female life expectancy between the least and most deprived areas in England increased between 2003-06 and 2007-10, part of a longer term pattern of persistent inequality.	
Disability-free Life expectancy/differences: at birth (males) (years)	Impact Indicator	**16.9** (2007-10)	**15.6** (2003-06)	Inequality in male disability-free life expectancy between the least and most deprived areas in England increased between 2003-06 and 2007-10, part of a longer term pattern of persistent inequality.	Differences in disability-free life expectancy at birth by deprivation quintile across England, as measured by the Slope Index of Inequality
Disability-free Life expectancy/differences: at birth (females) (years)	Impact Indicator	**15.5** (2007-10)	**13.3** (2003-06)	Inequality in female disability-free life expectancy between the least and most deprived areas in England increased between 2003-06 and 2007-10, part of a longer term pattern of persistent inequality.	
Low birth weight of term live births (%)	Impact Indicator	**2.94** (2011)	**2.85** (2010)	There is a very slight increase in the percentage of low birth weight of term live births in 2011 compared to previous year.	%

Low birth weight of all live births where father's occupation is classified as managerial, professional or intermediate (%)	Impact Indicator	**6.6** (2011)	**6.1** (2010)	No commentary available at present	%
	Type of data	**Current**	**Previous**	**Brief commentary on data trend**	**Indicator format** (details in separate annex)
Low birth weight of all live births where father's occupation is classified as routine and manual occupations, never worked or long-term unemployed (%)	Impact Indicator	**7.1** (2011)	**7.2** (2010)	No commentary available at present	%
Mortality rate from causes considered preventable	Impact Indicator	**143.3** (2011)	**148.6** (2010)	In England and Wales preventable mortality decreased by 26% between 2001 and 2011, although methodology has changed slightly over this period	European age-standardised rate per 100,000 population
Better Care for all					
Health related quality of life for people with long term conditions	Impact Indicator	**0.73** (2012-13)	**0.73** (2011-12)	Unchanged over 2 years - it is too early in the data series to comment further.	Average self reported score measuring health status, with 1 representing perfect health
Emergency admissions (avoidable)	Impact Indicator	**314.9** (Q4 2012-13)	**317.1** (Q3 2012-13)	Increasing trend in the rate for the period 2003/04 to 2012/13 for all persons, males and females – average increase of 4% per year for all persons. This is the opposite of what can be seen for emergency admissions due to ambulatory care sensitive long-term conditions, which showed a decreasing trend over the same time period.	Rate per 100,000 population
Emergency readmissions within 30 days of leaving hospital	Impact Indicator	**11.78** (2011-12)	**11.78** (2010-11)	Steady increase of emergency readmissions within 30 days for persons, males and females from 2002/03 to 2010/11 which levels out in 2011/12. The readmission within 30 days percentage for persons increased from 9.5% in 2002/03 to 11.8% in 2011/12.	Percentage of emergency admissions
Patient experience: primary care (GP services)	Impact Indicator	**86.74** (Jul 2012-Mar 2013)	**88.28** (Jul 2011-Mar 2012)	Latest data shows an unfavorable reduction of 1.74% on the previous period in the number of people rating their experience as Good or Very good. Due to the changes to the questionnaire design and survey frequency, as well as the change to the weighting methodology, no results from 2011-12 onwards can be compared to previous years, even where questions remain the same.	Survey - percentage rating their experience as

	Type of data	Current	Previous	Brief commentary on data trend	Indicator format (details in separate annex)
Patient experience: primary care (GP out of hours services)	Impact Indicator	**70.21** (Jul 2012-Mar 2013)	**70.86** (Jul 2011-Mar 2012)	Latest data shows a small but unfavorable reduction of 0.92% n the previous period in the number of people rating their experience as Good or Very good. Due to the changes to the questionnaire design and survey frequency, as well as the change to the weighting methodology, no results from 2011-12 onwards can be compared to previous years, even where questions remain the same.	Good or Very good
Type of data	**Current**	**Previous**	**Brief commentary on data trend**	**Indicator format** (details in separate annex)	
Patient experience: primary care (NHS dental services)	Impact Indicator	**83.98** (Jul 2012-Mar 2013)	**83.43** (Jul 2011-Mar 2012)	Latest data shows a small but unfavorable reduction of 0.66% n the previous period in the number of people rating their experience as Good or Very good. Due to the changes to the questionnaire design and survey frequency, as well as the change to the weighting methodology, no results from 2011-12 onwards can be compared to previous years, even where questions remain the same.	Survey - percentage rating their experience as Good or Very good
Patient experience: hospital care	Impact Indicator	**76.5** (2012)	**75.6** (2011)	Latest data shows an improvement of 1.2% on the previous period in the average score of hospital care. There is no clear trend in the data over time but the latest value of 76.5 is the highest for eight years. A score of 80 would suggest that patients, on average, found the service "very good".	Survey - score out of 100
Quality of life for adults receiving social care	Impact Indicator	**18.8** (2012-13)	**18.7** (2011-12)	Marginal improvement, however it is too early in the data series to comment on any underlying pattern or changes.	Survey - score out of 24
Satisfaction with adult social care services	Impact Indicator	**64.1** (2012-13)	**62.8** (2011-12)	Marginal improvement, however it is too early in the data series to comment on any underlying pattern or changes.	Survey - percentage very or extremely satisfied with services received
Safety incidents reported by NHS/healthcare provider that lead to severe harm or death	Impact Indicator	**5.0** (Jan-Mar 2012)	**4.9** (Oct-Dec 2011)	Latest data shows a 2.0% increase on the previous period in the rate of safety incidents reported and this change is in line with the steady, upward trend seen over recent years. Higher number of incidents is likely due to increased reporting because levels of reporting are believed to be less than levels of occurrence. For the time being, therefore, increases in the indicator are being seen as positive – reflecting increased willingness to recognise and address safety problems.	Per 100,000 population

Safety incidents reported by NHS/healthcare provider	Impact Indicator	**645.7** (Apr-Jun 2012)	**609.8** (Jan-Mar 2012)	Latest data shows a 5.9% increase on the previous period in the rate of safety incidents reported and this change is in line with the steady, upward trend seen over recent years. Higher number of incidents is likely due to increased reporting because levels of reporting are believed to be less than levels of occurrence. For the time being, therefore, increases in the indicator are being seen as positive – reflecting increased willingness to recognise and address safety problems.	
Better Value for all					
Unit cost of treatment for patients staying in hospital for treatment they have chosen (£)	Input indicator	**1317** (2012-13)	**1303** (2011-12)	No commentary available at present	Cost per Finished Consultant Episode
	Type of data	**Current**	**Previous**	**Brief commentary on data trend**	**Indicator format** (details in separate annex)
Unit cost of treatment for patients staying in hospital for emergency treatment (£)	Input indicator	**1610** (2012-13)	**1570** (2011-12)	No commentary available at present	Cost per Finished Consultant Episode
Unit cost of patients visiting hospital for treatment (£)	Input indicator	**111** (2012-13)	**108** (2011-12)	No commentary available at present	Cost per A&E or Outpatient attendance including Outpatient procedure and Cancer Multi-Disciplinary Team patient treatment plan
Unit cost of patients being treated for mental health problems (£)	Input indicator	**25** (2012-13)	**28** (2011-12)	No commentary available at present	Cost per attendance, occupied bed day, contact, Cluster days and initial assessment
Unit cost of a prescription item dispensed in the community	Input indicator	**8.52** (2012)	**9.16** (2011)	The downward trend since 2004 continues. This has seen the average cost of an NHS prescription item fall by some 27% as the NHS continues to get better value from the £12m+ spent on NHS medicines and appliances each year.	Average net ingredient cost per NHS prescription item dispensed in the community
Breakdown of adult social care spend (£ billion)	Input indicator	**17.2** (2012-13)	**17.2** (2011-12)	Almost unchanged (a decrease of less than half of one per cent) in cash terms from 2011-12, but this represents two per cent decrease in real terms. Over the five-year period from 2007-08, when the figure was £15.3 billion, expenditure increased by 12 per cent in cash terms (a decrease of a half of one per cent in real terms).	Gross adult social care expenditure (incl. Supporting People)
Unit cost of receiving community care (£)	Input indicator	**52** (2012-13)	**51** (2011-12)	No commentary available at present	Cost per attendance, contact, visit and vaccination
Unit costs: older people residential and nursing care (£)	Input indicator	**522** (2012-13)	**521** (2011-12)	No commentary available at present	Average gross weekly cost

Unit costs: older people home help (£)	Input indicator	**17** (2012-13)	**17** (2011-12)	No commentary available at present	Average gross hourly cost
Unit costs: older people day care (£)	Input indicator	**103** (2012-13)	**91** (2011-12)	No commentary available at present	Average gross daily cost

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