United Kingdom
Health system summary
This Health System Summary is based on the *United Kingdom: Health System Review* (HiT) published in 2022. Health System Summaries use a concise format to communicate central features of country health systems and analyze available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.


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**How is the health system organized?**

**ORGANIZATION**

The United Kingdom has a national health service (NHS) with access based on clinical need, and not ability to pay. Responsibility for health care services has been devolved to Scotland, Wales and Northern Ireland since the late 1990s. These four separate health care systems across the United Kingdom are responsible for delivering health services, free at the point of use. At the local level, clinical commissioning groups in England (replaced by Integrated Care Systems by July 2022), health boards in Scotland and Wales, and the Health and Social Care Board in Northern Ireland are responsible for commissioning or planning health and care services in their respective areas. There is a complex landscape of health care regulators across the United Kingdom, with a UK-wide remit (e.g., General Medical Council) or specific to individual countries (e.g., Care Quality Commission in England).

**PLANNING**

England, Scotland, Northern Ireland and Wales have their own planning mechanisms, with different roles for their own government, and the NHS, at both national and local levels (Box 1). In England, operational responsibility for the NHS has sat with NHS England since 2013. The UK Government sets legally binding objectives and budgets for NHS England through an annual mandate, supported by detailed criteria and metrics. The NHS Long Term Plan was published in 2019 and sets out a plan for NHS England until 2029. At the local level, this Plan provides the framework from which Sustainability and Transformation Partnerships and now Integrated Care Systems develop and implement 5-year plans locally.

**BOX 1 | DISTRIBUTION OF HEALTH SYSTEM RESPONSIBILITIES**

Since devolution in the late 1990s, the respective governments in England, Scotland, Wales, and Northern Ireland have been responsible for organising and delivering healthcare services. The UK Government allocates a set budget for healthcare in England, whereas Scotland, Wales, and Northern Ireland receive a general block grant for public spending which is distributed according to funding priorities decided by each devolved government. At the local level, clinical commissioning groups (CCGs) in England (replaced by Integrated Care Systems by July 2022), health boards in Scotland and Wales, and the health and social care board in Northern Ireland are responsible for commissioning or planning health and care services in their respective areas. These local organisations are expected to implement priorities outlined with national plans or strategies, such as the NHS Long Term Plan in England; the National Performance Framework in Scotland; A Healthier Wales: long term plan for health and social care in Wales; and Commissioning Plan Directions in Northern Ireland.
PROVIDERS

General Practitioners (GPs) work under the General Medical Services Contract negotiated between the British Medical Association and NHS Employers, first introduced in 2004. The contract is held with practices, not individual GPs. Specialized care is provided across the United Kingdom by NHS or independent sector hospitals. In England and Northern Ireland, NHS-owned hospitals are called trusts. Many NHS hospitals have satellite clinics to provide these services closer to patients, particularly in large rural areas such as in Scotland.

How much is spent on health services?

FUNDING MECHANISMS

Public financing, collected through general taxation, is the primary source of funding for health in the United Kingdom. The three largest taxes, which account for approximately two thirds of revenue, are income tax, national insurance contributions and value-added taxes. Once revenue is collected by His Majesty’s Revenues and Customs (HMRC), it is distributed by HM Treasury to the Department of Health and Social Care (DHSC) in England and the devolved administrations according to the Barnett formula. According to this, the Treasury determines what changes in spending will be made in England, and then distributes funds according to a comparability percentage, which takes account of which powers are devolved and population proportions. The DHSC then allocates funding to NHS England and arm’s length health agencies.

HEALTH EXPENDITURE

Health care expenditure accounted for 10.2% of GDP in 2019 (Fig. 1), the eighth highest in the WHO European Region. The country’s per capita health expenditure is over US$ 5087 PPP, remaining below Germany and France, but above the EU/EAA average (Fig. 2). The percentage of total health expenditure in the United Kingdom coming from public funds is above the EU/EAA average, similar to Germany but below most Scandinavian nations including Sweden, Norway and Denmark (79.5% of current health expenditure). Out-of-pocket payments as a percentage of total expenditure on health have increased since 2005, reaching 17% in 2019 (Fig. 3), while private insurance has decreased since 2000, reaching 2.8% of total expenditure on health. Private medical insurance is usually used to finance a few select services not offered by the NHS or to access NHS-covered services more quickly.

OUT-OF-POCKET PAYMENTS

NHS care is mostly free at the point of access, but in some cases, patients do have to make co-payments (for goods and services covered by the NHS but requiring cost sharing) and direct payments (for services not covered by the NHS or for private treatment). Co-payments can apply to dental care and, in England, outpatient medicine prescription charges. Direct payments can include private treatment, social care, general ophthalmic services and over-the-counter medicines. However, some populations (e.g., individuals under 16 or over 60 years old, and those on low income), have recourse to reimbursement or exemption for some co-payments, although this varies across the United Kingdom.
FIG. 1  TRENDS IN HEALTH EXPENDITURE, 2000–2019

Note: PPP = purchasing power parity

FIG. 2  CURRENT HEALTH EXPENDITURE (US$ PPP) PER CAPITA IN WHO EUROPEAN REGION COUNTRIES, 2019

Notes: CHE, current health expenditure; PPP, purchasing power parity.
COVERAGE

All individuals, irrespective of their nationality or immigration status, are eligible to access primary, emergency and compulsory psychiatric care, free of charge. Coverage for secondary care services, however, is only available for those who are ordinarily resident, i.e., any person normally residing in the UK, resulting in undocumented migrants being left without access to many NHS services (including maternity care services). The NHS does not have an explicit list of benefits; instead, legislation outlines broad categories of health care services to be provide in the NHS. Major exclusions in England include prescription charges, dental care and optometry, but as already mentioned, exemptions exist (see also Box 2).

BOX 2 | WHAT ARE THE KEY GAPS IN COVERAGE?

The existence of an NHS across the United Kingdom whereby services are generally accessed free at the point of delivery, irrespective of ability to pay, largely protects people from the risk of financial hardship resulting from medical expenses. The United Kingdom reports some of the lowest rates of catastrophic health spending in the world. These crucial benefits are generally enjoyed across the United Kingdom, but exceptions provide stark reminders of the potential for adverse consequences.

The major gaps in coverage in the United Kingdom health and care system relate to social care, prescription charges for medicines (in England), dental care and ophthalmic services. Despite targeted exemptions, there is evidence of substantial difference in access to dental services by socioeconomic groups. For social care, public funding is restricted (to a lesser extent in Scotland) so the potential for significant financial costs being borne by individuals is substantial. The Dilnot Commission on social care in England found that one in 10 older people could face catastrophic care costs of £100 000 in their lifetime. Nevertheless, access to social care is means tested, and only those with assets lower than a certain threshold are eligible to access publicly funded social care services. To mitigate against the risk of catastrophic costs for social care, in late 2021, the United Kingdom Government announced that it would introduce a cap on the maximum amount that individuals would have to pay for social care services in England over their lifetime, initially set at £86 000 (£101 824). In 2021, both the Welsh and the Scottish Government launched consultations on the prospect of developing a National Care Service, free at the point of use for all citizens.
Paying Providers

Primary care doctors are paid predominantly through risk-adjusted capitation, with some fee-for-service activities such as vaccination. There is a decreasing use of pay-for-performance as part of the Quality Outcomes Framework, but an increasing trend for GPs to work as salaried doctors. Hospital consultants (specialists) are salaried doctors with top-up payments to incentivize performance, known as clinical excellence awards in England, distinction awards in Scotland and commitment awards in Wales. In hospital acute care, activity-based payments for units of care delivered are used, based upon tariffs set out within the Payment by Results program (in England) for both inpatient and outpatient care. Dentists working for the NHS receive activity-based payments, while pharmacists receive a combination of retained profits (difference between what they pay for drugs and the amount the Department of Health and Social Care reimburses them), fixed budgets, fee-for-service, pay-for-performance, and payments for over-the-counter medications (Fig. 4).

**FIG. 4 | PROVIDER PAYMENT MECHANISMS IN THE UNITED KINGDOM**

<table>
<thead>
<tr>
<th>GPs</th>
<th>Specialists</th>
<th>Acute Hospitals</th>
<th>Hospital Outpatient services</th>
<th>Dentists</th>
<th>Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-adjusted capitation, with some fee-for-service activities. Decreasing use of pay-for-performance.</td>
<td>Salaried doctors with top-up payments to incentivise performance.</td>
<td>Activity based payments for units of care delivered.</td>
<td>Salaried doctors with top-up payments to incentivise performance.</td>
<td>Activity based payments (NHS staff), Fee-for-service (private providers).</td>
<td>A combination of retained profits, fixed budgets, fee-for-service, pay-for-performance, and payments for over-the-counter medications.</td>
</tr>
</tbody>
</table>
What resources are available for the health system?

HEALTH PROFESSIONALS

The number of doctors (2.95 per 1000 inhabitants; 2019 data) and nurses (7.78 per 1000; 2018 data) in the United Kingdom is still lower than many other high-income countries (Figures 5a & 5b). Despite an ongoing policy agenda to shift care from hospital closer to home within the community, most of this increase in physician numbers has been concentrated in hospital consultants. This is a trend seen in all United Kingdom constituent countries, which all continue to experience challenges in improving recruitment and retention of the GP workforce. While there have been ongoing attempts to increasing training numbers for GPs across the country, it will take several years for the additional training places to impact the GP workforce.

The United Kingdom has lower levels of nurses per 1000 population than most other high-income countries, and this trend has continued over the last decade. These reductions in nursing numbers are more acute among different types of registered nurses. The impact of Brexit on the United Kingdom health and care workforce is yet to be fully realized, but the United Kingdom has already seen a considerable drop in the number of EU-trained nurses registering to work in the country.

FIG 5A  NUMBER OF PRACTICING PHYSICIANS FOR 1000 POPULATION IN THE UNITED KINGDOM AND COMPARATOR COUNTRIES, 2002–2019


FIG 5B  NUMBER OF PRACTISING NURSES FOR 1000 POPULATION IN THE UNITED KINGDOM AND COMPARATOR COUNTRIES, 2000–2019

HEALTH INFRASTRUCTURE

The overall number of hospital beds in the United Kingdom is lower than most other high-income countries, and has decreased between 2000 and 2018, from 4.1 to 2.5 beds per 1000 people (Figure 6). This trend is seen in most high-income countries, and in part, reflects trends such as an increasing use of day surgery, reduced length of stay and a shift to provide care closer to home in the community. Numbers of hospital beds do also vary across the United Kingdom, with England having lower numbers of hospitals beds per 1000 people than in Scotland, Wales and Northern Ireland.

According to the latest available data, the United Kingdom has fewer CT scanners and MRI units per capita than most other OECD countries (Fig. 7). As the United Kingdom continues to have poorer cancer survival than most other high-income countries in part due to delayed diagnosis, there is a growing need to review diagnostic capacity. This will be challenging as a significant proportion of diagnostic capacity in the United Kingdom, particularly for MRI scanners, is supplied through private providers, rather than within NHS hospitals.

**FIG. 6**  TOTAL HOSPITAL BEDS PER 1000 POPULATION IN THE UNITED KINGDOM AND SELECTED COUNTRIES, 2000–2019

![Graph showing total hospital beds per 1000 population in the United Kingdom and selected countries, 2000–2019.](image)

*Source: OECD Health Statistics, 2021.*

**FIG. 7**  MAGNETIC RESONANCE IMAGING (MRI) AND COMPUTED TOMOGRAPHY (CT) SCANNERS

<table>
<thead>
<tr>
<th></th>
<th>MRI scanners per million population</th>
<th>CT scanners per million population</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>7.2</td>
<td>9.4</td>
</tr>
<tr>
<td>Range among OECD countries</td>
<td>2.9 (Mexico) to 40.3 (USA)</td>
<td>6.1 (Colombia) to 60.7 (Australia)</td>
</tr>
</tbody>
</table>

*Note: Data for United Kingdom is from 2014.*  
*Source: OECD Health Statistics, 2021.*
ACROSS THE UNITED KINGDOM, ENGLAND HAS 2.3 HOSPITAL BEDS PER 1000 PEOPLE COMPARED WITH 3.8 PER 1000 IN SCOTLAND, 3.4 PER 1000 IN WALES AND 3.1 PER 1000 IN NORTHERN IRELAND. IT IS DIFFICULT TO EXPLAIN THESE VARIATIONS; HOWEVER, IT IS LIKELY THAT A COMBINATION OF POLITICAL, HISTORICAL, MANAGERIAL AND FINANCIAL FACTORS HAS CONTRIBUTED. THERE IS A HIGHER LEVEL OF PUBLIC SPENDING PER CAPITA IN NORTHERN IRELAND, SCOTLAND AND WALES, THAN IN ENGLAND. HOWEVER, EVEN WITH THE HIGHEST LEVEL OF FUNDING PER CAPITA, NORTHERN IRELAND STILL HAS A LOWER NUMBER OF HOSPITAL BEDS THAN IN SCOTLAND AND WALES. THERE HAVE ALSO BEEN LIMITED OPPORTUNITIES FOR LEADERSHIP AND STRATEGIC VISION TO SUPPORT HOSPITAL BUILDING PROGRAMMES IN NORTHERN IRELAND BETWEEN 2017 AND 2020, A PERIOD OF 3 YEARS WHEN NORTHERN IRELAND WAS WITHOUT A GOVERNMENT (GRiffin, 2019). IN ENGLAND, THE GOVERNMENT HAS COMMITTED TO A HOSPITAL BUILDING PROGRAMME OVER THE NEXT DECADE, WHICH AIMS TO BUILD 40 NEW HOSPITALS BY 2030.

AS WITH CAPITAL, THERE ARE LOWER NUMBERS OF NURSES PER 1000 POPULATION IN ENGLAND, COMPARED WITH SCOTLAND, WALES AND NORTHERN IRELAND. FOR DOCTORS, ENGLAND HAS LOWER NUMBERS COMPARED WITH SCOTLAND AND NORTHERN IRELAND, BUT SIMILAR NUMBERS TO WALES.

HOW ARE HEALTH SERVICES DELIVERED?

PRIMARY AND AMBULATORY CARE

THE UNITED KINGDOM ENJOYS A HIGH-QUALITY PRIMARY CARE SERVICE THAT PROVIDES CONTINUOUS AND COMPREHENSIVE CARE, WHILE ACTING AS A FIRST POINT OF CONTACT TO ACCESS OTHER HEALTH CARE SERVICES (BOX 3). PRIMARY CARE INCREASINGLY MEANS NOT ONLY A GP BUT A WHOLE TEAM OF DOCTORS, NURSES, MIDWIVES, HEALTH VISITORS AND OTHER HEALTH CARE PROFESSIONALS SUCH AS DENTISTS, PHARMACISTS AND OPTOMETERS IN A COMMUNITY SETTING.

BOX 3 | WHAT ARE THE KEY STRENGTHS AND WEAKNESSES OF PRIMARY CARE?

AN INTERNATIONAL COMPARISON CONDUCTED IN 2013 INDICATED THAT THE UNITED KINGDOM HAD A STRONG PRIMARY CARE SYSTEM, WITH THE UNITED KINGDOM SCORING HIGHLY ON ALL INDICATORS OF PRIMARY CARE QUALITY, EXCEPT FOR CONTINUITY OF CARE IN WHICH THE UNITED KINGDOM WAS SCORED AS MODERATE. NO MORE RECENT STUDIES EXIST, AND WHILE THE UNITED KINGDOM PRIMARY CARE SYSTEM MAY HAVE BEEN WEAKENED SINCE DUE TO SIGNIFICANT WORKFORCE PRESSURES, IT STILL PERFORMS WELL ON MANY OTHER ASPECTS OF PRIMARY CARE QUALITY INDICATORS, INCLUDING RELATIVELY LOW RATES OF AVOIDABLE HOSPITAL ADMISSIONS FOR CONGESTIVE HEART FAILURE, HYPERTENSION AND DIABETES-RELATED COMPLICATIONS. THESE PRIORITIES HAVE BEEN PROMOTED THROUGH THE QUALITY AND OUTCOMES FRAMEWORK, WHICH INCENTIVISES REGULAR HEALTH CHECKS AND MEDICATION REVIEWS FOR PATIENTS WITH SEVERAL CHRONIC DISEASES. GPs ARE ALSO TRAINED SO THEY ARE EQUIPPED WITH THE GENERALIST SKILLS REQUIRED FOR THE CHANGING HEALTH NEEDS OF THE POPULATION THAT ARE BECOMING INCREASINGLY COMPLEX AND EXPERIENCING HIGHER LEVELS OF MULTI-MORBIDITY. HOWEVER, THERE ARE SOME IMPORTANT WEAKNESSES TO THE PRIMARY CARE SYSTEM. ALTHOUGH THE GATEKEEPING MECHANISM PROVIDED BY GPs MAY IMPROVE HEALTH SYSTEM EFFICIENCY, IT HAS BEEN CITED AS A FACTOR CONTRIBUTING TO THE DELAYED DIAGNOSIS AND POOR CANCER SURVIVAL REPORTED BY THE UK. MOREOVER, SIGNIFICANT WORKFORCE PRESSURES AND GEOGRAPHICAL VARIATION IN DENSITY OF GPs HAVE RESULTED IN SIGNIFICANT INEQUITIES IN ACCESS TO GPs ACROSS THE COUNTRY.
There is also an increasing use of the voluntary sector in some situations, such as those involving mental health or long-term conditions. Primary care nurses include both practice and district nurses; practice nurses work in GP practices, whereas district nurses work for community health service providers to deliver care in patients’ homes. GP surgeries provide a range of services, including routine diagnostic services, minor surgery, family planning, on-going care for patients with chronic conditions, antenatal care, preventive services, health promotion, outpatient pharmaceutical prescriptions, sickness certification and referrals for more specialized care. Increasingly, GPs are now seeking to adapt the provision of GP services towards a hybrid model involving a combination of face-to-face and remote consultations that best meet patients’ needs.

HOSPITAL CARE

Secondary inpatient care is accessed on either an emergency or an elective basis. Independent sector hospitals are typically not equipped to manage emergency care, and if patients experience postoperative complications following surgery, they are typically transferred to NHS hospitals. In Wales, especially, patients use hospitals across the border in England if they are actually closer than the nearest one in Wales. Various efforts are underway to strengthen the delivery of integrated care services (Box 4).

BOX 4 | ARE EFFORTS TO IMPROVE INTEGRATION OF CARE WORKING?

In an effort to provide more integrated social and health care, especially for older and disabled people, the Better Care Fund was announced in 2013. As of 2020/2021, the fund consists of £6.7 billion, collected from CCGs in England (replaced by Integrated Care Systems by July 2022) and local authorities. CCGs and local authorities are expected to agree a combined spending plan, which focuses on integrating care and avoiding hospital admissions by supporting people at home. Subsequent evaluations have concluded that while the fund has not achieved the expected reductions in emergency admissions to hospital or delayed transfers of care, the fund has encouraged integration of health and social care at the local level.

Principal health reforms in each of the UK constituent countries are focusing on facilitating cross-sectoral partnerships and promoting integration of services in a manner that improves the health and well-being of local populations, moving away from competition. These include the establishment of integrated care systems in England, integrated joint boards in Scotland, regional partnership boards in Wales and integrated partnership boards in Northern Ireland. Policies are also being developed.

PHARMACEUTICAL CARE

Patients are not charged for pharmaceuticals used in inpatient care. Patients in England are however charged for prescriptions in the community at a fixed flat rate of £9.15 (€10.80) per item as of 2020/2021. Patients can also pay for a yearly subscription service capped at £105.90 (€125) per year. Exemptions cover a broad range of people, including individuals under 16 and over 60 years of age, those with low incomes, during pregnancy, and for chronic diseases such as diabetes or epilepsy, so that about 90% of all prescriptions are distributed free of charge. Prescription charges were abolished in Wales in 2007, in Scotland in 2011 and in Northern Ireland in 2010.
LONG-TERM CARE

Long-term care in the United Kingdom is a blend of health and social care, provided in a combination of residential/institutional care and care provided in the community within people’s homes. The NHS funds long-term care for patients with complex health needs, through schemes such as NHS Continuing Health care in England, and Hospital-Based Complex Clinical Care in Scotland. Long-term care is provided to older people; people with physical disabilities, frailty, and sensory impairment; people with learning disabilities; people with mental health problems; people who misuse substances and to other vulnerable people. Residential or nursing care is provided in homes specifically for that purpose, provided by a range of for-profit and not-for-profit independent providers.

DENTAL CARE

Publicly financed dental services in the United Kingdom consist of a three-part system: general dental services in the community; secondary and tertiary dental services in acute hospitals for difficult problems; and community dental services in clinics and nursing homes, provided for those who cannot use general dental services; and also in schools to screen children for problems. Charges exist to access dental care in all United Kingdom constituent countries. For individuals who access dental services privately, they pay for private dental care through private insurance plans or directly out-of-pocket.

What reforms are being pursued?

Health policy has been devolved in the United Kingdom since the late 1990s, with governments in England, Scotland, Wales and Northern Ireland taking different approaches to health care reform. A list of major policy reforms is contained in Box 5. Health policy diverged in the 2000s, as reforms in England emphasized choice and competition as the route to improve quality of care, while governments in Scotland and Wales dismantled the internal market and promoted cooperation. There has been some policy convergence in recent years, as reforms in all countries encouraged collaboration between local agencies and integration of health and social care services.

More recently, in England, the NHS is undergoing a structural reorganisation, with Clinical Commissioning Groups being replaced from July 2022 with Integrated Care Systems, which will be responsible for delivering health and social care services to local populations of 1 to 3 million people. In Scotland, legislation over the last decades has focused on creating bodies, known as Integrated Joint Boards, to facilitate joint work for health and social care between the NHS and local authorities, and responsibilities for managing joint budgets for local populations. In Wales, the 2014 Social Services and Wellbeing (Wales) Act established regional partnerships boards with responsibility for planning and developing local services to improve health and wellbeing in their area. In Northern Ireland, there is currently a consultation on the development of a new planning model to strengthen the delivery of integrated health-care services centred around the creation of five Area Integrated Partnership Boards, that will be responsible for improving health and wellbeing of local populations, with progress monitored against agreed key performance indicators at the national level.
How is the health system performing?

HEALTH SYSTEM PERFORMANCE MONITORING AND INFORMATION SYSTEMS

There is often a lack of transparency and accountability in national and local-level decision making in the United Kingdom, exacerbated by limited public involvement. Despite efforts for broader public involvement in NHS accountability such as the publication of performance measures, and initiatives to promote patient choice in England, these have not translated into public involvement in policymaking.

Providers of healthcare in all UK constituent countries are required to collect data on activity, workforce and performance indicators to feedback to their respective health care information organizations, NHS Digital in England, Public Health Scotland in Scotland (formerly undertaken by the Information Services Division), Digital Health and Care Wales in Wales, and the Information and Analysis Directorate.
within the Department of Health in Northern Ireland. Positively, the development of health information technology has accelerated in each United Kingdom constituent country during the COVID-19 pandemic through, for example, the rapid increase in availability of remote consultations to minimize transmission of infection, efforts to develop mobile applications to monitor the spread of disease, and the development of shielded patients lists to issue guidance to vulnerable patients.

ACCESSIBILITY AND FINANCIAL PROTECTION

Despite universal access to primary, emergency and compulsory psychiatric care, established residency status determines NHS coverage for secondary care services. This means that undocumented migrants are left without access to many NHS services, including maternity care services among particularly vulnerable pregnant women. The NHS provides care across the United Kingdom, covering the spectrum from prevention, treatment, rehabilitation to palliation. Services are generally free at the point of delivery and are provided irrespective of ability to pay. This coverage protects people from the risk of financial hardship resulting from medical expenses, with the United Kingdom reporting some of the lowest rates of out-of-pocket expenditure and catastrophic health spending in Europe, as well as internationally (Cooke O'Dowd, Kumpunen and Holder, 2018).

Nevertheless, the United Kingdom also reports one of the highest levels of unmet need for a medical examination due to cost, waiting times or travel distances, at 4.5% in 2019. This differs between high- and low-income households, with 3.3% of high-income households reporting unmet need compared to 4.9% of low-income households (Figure 8).

FIG. 8 UNMET NEEDS FOR A MEDICAL EXAMINATION (DUE TO COST, WAITING TIME OR TRAVEL DISTANCE), BY INCOME QUINTILE, EU/EEA COUNTRIES, 2019

HEALTH CARE QUALITY

Despite the many challenges facing the health system, public satisfaction with the NHS remains relatively high (Box 6). There is consensus that UK citizens have access to a high-quality and well-developed primary care system, evidenced by relatively low rates of avoidable hospital admissions for congestive heart failure, hypertension and diabetes-related complications (Figure 9).

The United Kingdom does, however, report relatively high avoidable hospital admission rates for respiratory diseases including asthma and chronic obstructive pulmonary disease. Suggested factors driving these trends include lack of availability of pulmonary rehabilitation, poor adherence to inhaler therapy and delayed referral to specialist services.

BOX 6 | WHAT DO PATIENTS THINK OF THE CARE THEY RECEIVE?

While public confidence in the NHS is still high in comparison to health systems in other countries, several headlines in recent years have reported drops in confidence, particularly with general practice (63% satisfaction in 2018, the lowest since 1983, although this recovered to 68% in 2019), inpatient (64% satisfaction in 2019) and emergency services (54% satisfaction in 2019). Overall satisfaction with the NHS was 60% in 2019, with patients citing the quality of care received, accessing care free at the point of use and a good range of services, as key reasons for high satisfaction. The main reasons people gave for being dissatisfied with the NHS were staff shortages, waiting times for GP and hospital appointments, and the perception that the government does not spend enough money on the NHS. Surveys also indicate that 90% of the public support the founding principles of the NHS and that two thirds (66%) were willing to pay more of their own taxes to support the NHS. In contrast, satisfaction with social care services is markedly lower than with the NHS, with only 29% satisfaction in 2019.

FIG. 9 AVOIDABLE HOSPITAL ADMISSION RATES FOR ASTHMA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CONGESTIVE HEART FAILURE, HYPERTENSION AND DIABETES-RELATED COMPLICATIONS, 2017

For hospital care, the United Kingdom reports particularly poor performance in terms of mortality following hospital admission associated with ischaemic and haemorrhagic stroke when compared to other high-income countries. Mortality rates are also poor for hospital admission associated with acute myocardial infarction when compared to other high-income countries, and only lower than those reported in Japan and Germany (Figure 10).

**FIG. 10** IN-HOSPITAL MORTALITY RATES (DEATHS WITHIN 30 DAYS OF ADMISSION) FOR ADMISSIONS FOLLOWING ACUTE MYOCARDIAL INFARCTION AND STROKE, 2017

**HEALTH SYSTEM OUTCOMES**

Increases in life expectancy have stalled in the United Kingdom, and now the health of the population is lagging behind that of many other comparable high-income countries (McKee et al., 2021). These trends in life expectancy are similar across UK constituent countries, although there remain significant differences in life expectancy between each UK constituent country, with life expectancy consistently reported as higher in

**BOX 7 | ARE PUBLIC HEALTH INTERVENTIONS MAKING A DIFFERENCE?**

The United Kingdom and its devolved administrations have introduced several national policies that have demonstrated benefit in terms of improving population health or impacting health behaviour change. A smoking ban in public places was introduced in July 2007 (March 2006 in Scotland), and subsequent analyses have demonstrated this had a positive effect of declining smoking rates and improving cardiovascular health. In 2018, the UK Government introduced a tax on manufacturers of soft drinks related to sugar content, which 1 year after implementation, resulted in a 10% reduction in sugar content in soft drinks, without impacting sales. Scotland introduced minimum unit pricing for alcohol purchases in 2018, and Wales followed suit in 2020, with subsequent analysis demonstrating an 8% reduction in alcohol sales in both of these countries.

There is also evidence from the United Kingdom that several specific public health programmes or interventions are either cost-saving or cost-effective, for example, pre-conception care, case management programmes and chronic disease management programmes. However, the degree to which these interventions can be implemented is dependent upon funding, and while the economic case for investment in prevention is strong, too often policymakers ignore this evidence and have prioritised funding for treatment over prevention.
England than in the other three nations, with Scotland lagging far behind.

When focusing on international comparisons, the United Kingdom reports an age-standardised amenable mortality rate (i.e., mortality that should not occur if people have access to timely and effective health care) of 84.4 per 100 000 in 2016, that is above many other comparable high-income countries such as France and Germany. The United Kingdom performs better in relation to preventable mortality (i.e., mortality that could have been avoided through effective public health and primary prevention interventions) reporting an age-standardised mortality rate of 47.3 per 100 000 in 2016, France and Germany (Figure 11; see also Box 7).

**FIG. 11 AMENABLE AND PREVENTABLE MORTALITY IN UNITED KINGDOM AND OTHER EEA COUNTRIES, 2000 AND 2017**

*Source: WHO Mortality Database. Amenable causes as per list by Nolte & McKee, 2004.*
HEALTH SYSTEM EFFICIENCY

The Commonwealth Fund has consistently named the United Kingdom as the most efficient health system among 11 high-income countries because of factors such as relatively low expenditure levels per capita as a proportion of GDP and low administrative costs resulting from a single payer system based on general taxation. However, the latest report from the Commonwealth Fund does also acknowledge the UK’s poor performance in terms of health outcomes, with the United Kingdom performing second from worst on the composite indicator of healthy lives, due to relatively high rates of amenable mortality, comparatively high infant mortality rates and low healthy life expectancy at age 60 years, despite ranking as the most technically efficient.

These findings are reflected in Fig. 12, which shows that when compared to other G7 countries, the United Kingdom has the lowest per capita health expenditure, except for Italy, and the highest amenable mortality per 100,000 population, except for the United States.

Regarding technical efficiency, the United Kingdom compares favourably to other countries. For example, in 2018, the United Kingdom had an average length of stay for inpatient care of 6.8 days, below the OECD average of 8.1 days. The United Kingdom also performs a relatively high proportion of surgical procedures such as cataract surgeries, at 97.8%, and tonsillectomies, at 62.2%, in 2019, as day cases rather than inpatient procedures, compared to OECD averages of 37.8% and 76.6%, respectively. Historically, the United Kingdom is known as a country with one of the highest rates of generic prescribing in the world, at 85% as a share of volume in 2017, compared to the OECD average of 52% (see also Box 8).

FIG. 12 AMENABLE MORTALITY PER 100 000 POPULATION VERSUS HEALTH EXPENDITURE PER CAPITA, 2017

Source: WHO Global Expenditure Database, 2022; WHO Mortality Database.
Established in 1948, the NHS led globally in terms of universal health coverage. The underlying principles, that the NHS should be funded predominantly through progressive general taxation, that care be comprehensive, and access be based on clinical need and not on ability to pay, are still largely true. This has provided several key benefits including high levels of protection against the financial consequences of ill-health, the redistribution of wealth from the rich to the poor and relatively low administrative costs. Devolution in the late 1990s led to the development of four distinct health care systems in the United Kingdom, but these health care systems retain more commonalities than differences.

Several barriers persist across the four nations to facilitate meaningful integration between health care services, such as unlinked health information technology systems, duplication of governance arrangements and a lack of strategic planning. Northern Ireland is the only United Kingdom constituent country where the NHS and social care are fully organizationally integrated, although efforts to promote such integration with cross-sectoral partnerships in England, Scotland and Wales have accelerated in recent years. While the COVID-19 pandemic has been responsible for major setbacks in objectives outlined in UK national strategies and plans, it has also accelerated developments such as the use of teleconsultation and online tools to access primary care services, and greater integration between health and social care services.
### POPULATION HEALTH CONTEXT

#### KEY MORTALITY AND HEALTH INDICATORS

<table>
<thead>
<tr>
<th>Life Expectancy (Years)</th>
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<tbody>
<tr>
<td>Life expectancy at birth, total</td>
<td>81.2</td>
</tr>
<tr>
<td>Life expectancy at birth, male</td>
<td>78.4</td>
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<tr>
<td>Life expectancy at birth, female</td>
<td>82.4</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Mortality (per 100 000)</th>
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<tr>
<td>All causes</td>
<td>895.9</td>
</tr>
<tr>
<td>Circulatory diseases*</td>
<td>192.6</td>
</tr>
<tr>
<td>Malignant neoplasms*</td>
<td>216.4</td>
</tr>
<tr>
<td>External causes of death*</td>
<td>34.9</td>
</tr>
<tr>
<td>Infant mortality rate (per 1 000 live births)</td>
<td>3.7</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100 000 live births)</td>
<td>6.5</td>
</tr>
</tbody>
</table>

**Notes:** *Age-adjusted rates with the European standard population 2010. Life expectancy and infant mortality data are for 2019. Mortality data are for 2016. Maternal mortality data are from 2017.

**Source:** WHO Regional Office for Europe, 2022; World Bank, 2022

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### REFERENCES


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