# Executive summary

The United Kingdom's four health systems have much in common. They all offer population-wide insurance for the vast majority of health care needs, largely free at the point of use, through tax-funded single national pools. Similar values and service-models (such as a strong primary care sector) stem from a common heritage and evolution over the past 60 years. In addition, continuously improving the quality of care is a deeply established and widely shared commitment in all of the four systems. Each benefits from a bold and clear vision to achieve care that is consistently safe, effective and person-centred. The United Kingdom's drive to continuously strengthen quality assurance, monitoring and improvement means that it has pioneered, or implemented more widely and deeply than elsewhere, several tools and approaches to monitoring and improving health care quality. The United Kingdom has become a point of reference, for example, in the development of evidence-based clinical guidelines; resources to support clinicians to stay up to date and engage in on-going professional development; use of patient surveys and patient reported outcome measures; data-linkage, transparency and public reporting; as well as reporting and learning from adverse events.

Despite the clear and consistent commitment to quality of care in all of the United Kingdom's health systems, and the ambitious policies around quality assurance and promotion, data on outcomes for the United Kingdom raise some concerns. Based on international benchmarks of health care quality, notably OECD data, some indicators for the United Kingdom show average or disappointing performance. Survival estimates for breast, cervical and colorectal cancer, for example, are all below the OECD average (of note, though, the rate of improvement in breast cancer survival over the past decade has been faster than the OECD on average; and improvements in survival rates for colorectal and cervical cancer appear to have increased marginally faster as well). Hospital admissions for asthma and COPD, which should be avoided, are also above the OECD average (they have, however, improved faster in the United Kingdom between 2008 and 2013 than the OECD average). A surprisingly limited number of indicators are published separately for the four health systems, making benchmarking within the United Kingdom nations, or indeed against other OECD

countries, challenging. From the limited country-specific data available, however, no consistent picture emerges of one of the United Kingdom's four health systems performing better than another.

There is much that is common in the tools, policies and approaches that four health systems have used to respond to the challenges of delivering ever better health care, in the face of increasing demands and tighter finances. There is divergence, however, in the degree to which inspection, regulation and public disclosure of the performance of local services by central authorities is used as a lever to assure quality. Over recent years, England has increasingly emphasised the role of regulation, inspection and transparent publication of performance indicators to drive local quality improvement. In contrast, Scotland, Wales and Northern Ireland have sought to strengthen locally-owned, grass-roots initiatives around quality assurance and improvement, whilst maintaining an emphasis on transparency. Each of the four health systems is pursuing the approach to quality assurance, monitoring and improvement that it feels is best suited to its context and challenges.

To secure continued quality gains, each system must strike the right balance between a centrally-driven, regulatory approach to quality management and locally-driven quality improvement activities. There is scope, for example, to rebalance England's current regulatory approach, focused on quality management, with greater emphasis on bottom-up approaches led by patients and professionals. Likewise, in Scotland, Wales and Northern Ireland, which consciously prioritise a locally-owned and bottom-up approach to quality assurance and improvement, there is scope for a greater degree of steering and oversight from central authorities, to provide consistency, direction and a strong accountability framework that is lacking in places. Taken together, these recommendations demonstrate the need for a responsive and flexible approach to health system governance, which balances central and local roles.

The four health systems should also move towards reporting more quality benchmarks at country or regional level, rather than the United Kingdom aggregates which are currently reported. Whilst it is naive to imagine that any one of the four systems would ever emerge as plainly "better" or "worse" than another, more disaggregated data could shed light on the relative benefits of particular aspects of each national approach. More disaggregated data may also yield some answers to, or at least allow a more nuanced analysis of, the question of why the United Kingdom's performance on some international quality benchmarks is middling, despite the attention and investment given to quality improvement in all four health systems. Regionally-disaggregated data may be even more informative than national disaggregates. Concerns over national comparability could be

overcome by comparing, for example, Wales with the north eastern region of England (which shares some demographic and socioeconomic characteristics), as well as England as a whole.

A final recommendation concerns learning and collaboration. At present, there are no standing mechanisms to enable the four health systems to collaborate on monitoring and improving health care quality in a comprehensive or on-going way. Key officials from each system (such as the Chief Medical Officers) meet regularly; relevant aspects of the health care quality agenda (such as revalidation) inevitably feature in these discussions. There is nevertheless substantial scope to develop more regular and comprehensive collaboration on the quality of care agenda across England, Scotland, Wales and Northern Ireland. A forum, meeting regularly and comprising those individuals responsible for steering and implementing the quality agenda in each country, would allow discussion of shared challenges, collaboration around proposed solutions and exchange of successful experiences – potentially being of great benefit to the four health systems, as well as to the OECD as a whole.