United Kingdom: health care indicators
Group 6: Hungary, Ireland, Italy, New Zealand, Norway, Poland, United Kingdom

A. Efficiency and quality

B. Amenable mortality by group of causes

C. Prices and physical resources

D. Activity and consumption

E. Financing and spending mix

F. Policy and institutions

Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country).

In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).

In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.

In Panel F, data shown are simple deviations from the OECD average.

UNITED KINGDOM

GROUP 6: Mostly public insurance. Health care is mainly provided by a heavily regulated public system, with strict gate-keeping, little decentralisation and a tight spending limit imposed via the budget process.

<table>
<thead>
<tr>
<th>Efficiency and quality</th>
<th>Prices and physical resources</th>
<th>Activity and consumption</th>
<th>Financing and spending mix</th>
<th>Policies and institutions</th>
<th>Weaknesses and policy inconsistencies emerging from the set of indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below average DEA score</td>
<td>About average spending per capita</td>
<td>Large public spending share, mostly tax-financed</td>
<td></td>
<td></td>
<td>The quantity and quality of health care services remain lower than the OECD average while compensation levels are higher. Reinforcing competitive pressures on providers could help mitigate price pressures, e.g. by increasing user choice further and reforming compensation systems</td>
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<tr>
<td>Mixed scores on output efficiency in the acute care sector</td>
<td>Less acute care beds per capita and high-tech equipment</td>
<td>Less hospital discharges per capita</td>
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<td></td>
<td>More restricted choice among providers</td>
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<tr>
<td>Mixed signals on the quality of out-patient and preventive care</td>
<td>Less doctors per capita</td>
<td>Less doctor consultations per capita</td>
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<tr>
<td>No internationally-comparable data on administrative costs</td>
<td>High relative income level of health professionals</td>
<td>Low out-of-pocket payments</td>
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<td></td>
<td>Efforts to increase consistency in the allocation of responsibility across government bodies could contribute to raise spending efficiency. Improve availability of comparable data on the allocation of spending across sub-sectors</td>
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</table>