

Funding and performance of healthcare systems in the four countries of the UK before and after devolution

Sheelah Connolly, Gwyn Bevan
and Nicholas Mays





The Nuffield Trust
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Funding and performance of healthcare systems in the four countries of the UK before and after devolution

A longitudinal analysis of the four countries,
1996/97, 2002/03 and 2006/07,
supplemented by cross-sectional
regional analysis of England, 2006/07

**Sheelah Connolly, Gwyn Bevan
and Nicholas Mays**



The Nuffield Trust

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In this joint effort Sheelah Connolly collected and analysed the data, and organised the presentation of the figures, tables and sources; Gwyn Bevan did most of the drafting and contextual research; Nicholas Mays was the principal investigator who oversaw the whole project and acted as the final editor.

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Foreword

The Nuffield Trust has a longstanding interest in the UK's devolution 'experiment' as it applies to healthcare. Given the emphasis in the NHS on achieving value for money, especially in the current economic climate, it is timely to look at how, over ten years on from devolution, each of the four UK health services is faring in its aims of delivering high-quality health services for patients, and value for money for taxpayers.

This report underlines the fact that the four countries have taken very different paths in healthcare since devolution, and shows that it is far from clear that they all offer an equal benefit to patients in return for taxpayers' investment. It offers, for the first time, comparisons of healthcare in Scotland, Wales and Northern Ireland with the English regions, with which they share much common ground.

The report was originally published in January 2010 and featured prominently in the media. As is often the case with analyses on comparisons, the quality of the data used was questioned by those being compared, in particular some figures for Scotland published by the Office for National Statistics (ONS). Further work by ONS with data suppliers in Scotland, Wales and Northern Ireland led to ONS making revisions to some of the data tables, which were republished later in 2010. These revisions slightly alter the analysis originally published in this report in January 2010, and this

amended edition of the original report incorporates the changes. However, the general conclusion of our original report is the same: that Scotland, Wales and Northern Ireland receive more funding than comparative areas in England, and tend to have worse performance on waiting times and crude productivity of staff.

The fact that our report highlighted the need for further work by ONS to ensure comparability of data across the four UK countries underlines another key finding of our work: that it is becoming more difficult to make such comparisons. Given the stringent economic climate, the greater need for value for money and the extent of funding of public services in the devolved nations by taxpayers in England, it is surprising that there is not more scrutiny of the productivity of healthcare across the four nations. The research team conclude that if countries 'are reluctant to allow such comparisons to be made, this suggests that they are fearful that their policies will be found wanting'. Furthermore they recommend that:

the Treasury takes on the role of ensuring that key data are collected on a consistent basis across the four countries so that there can be open public scrutiny of performance of governments empowered to pursue different policies financed by the UK taxpayer.

The Nuffield Trust fully concurs with these statements.

Together with the Health Foundation, we aim to repeat the analysis presented here in 2012 and supplement it with analysis of some indicators of quality of care previously examined in the 2009 report for the Health Foundation, *Quality of Healthcare in England, Wales, Scotland, Northern Ireland: An intra-UK chartbook*. As before, we will be working closely with data suppliers across all four UK countries to ensure comparability.

I do hope you will find this report of interest. To keep in touch with our developing work programme, please visit our website: www.nuffieldtrust.org.uk, where you can also sign up to receive regular updates.

Dr Jennifer Dixon
Director, The Nuffield Trust

Summary

The principal purpose of this report is to examine the impacts of political devolution in 1999 to the Scottish Parliament and Assemblies in Wales and Northern Ireland, on what has now become, as a result, four different National Health Services (NHSs) in the four countries of the UK: England, Scotland, Wales and Northern Ireland. Much has been written on the ways in which policies have diverged following devolution, in particular in Scotland and Wales – in Northern Ireland, so far there has been minimal development of a distinct policy from that of England. Some of these differences are obvious to patients. In Scotland there is free personal care for older people. Governments in all countries except England have abolished charges for prescriptions. Other policy differences are less obvious to patients but provide very different systems of governance for each NHS. Greer has characterised these different emphases as: in England, on markets and management; in Scotland, on the medical profession and cooperation; in Wales, on localism and wider public health issues; and in Northern Ireland, on permissive managerialism.¹

Following the 1997 election, the government in England maintained the ‘purchaser/provider’ split, introduced throughout the UK in 1991 as part of the policy of aiming for provider competition within an internal market. From 2002, the government in England has sought to reintroduce provider competition through patient choice of a plurality of providers (NHS trusts, NHS foundation trusts, independent sector treatment and private providers) in a system in which ‘money

follows the patient’. In contrast, Scotland and Wales have abolished the purchaser/provider split and the idea of provider competition, and recreated organisations responsible for meeting the needs of the population and running services within defined geographical areas. This is seen as making it easier to integrate and coordinate services, and therefore improve quality of care along the patient pathway.

The period after devolution was followed by massive increases in funding of the NHS across the UK, but only in England was this extra funding, in principle, conditional on its NHS meeting a set of demanding targets (in Public Service Agreements (PSAs) with HM Treasury, with particular emphasis on the reduction of long waiting times for access to hospitals). The governments of the other countries determined funding of their NHS from a global sum for devolved services based on a crude formula (the Barnett Formula) and bilateral negotiations with HM Treasury. The outcomes of these processes were that England had the lowest, and Scotland the highest, per capita allocations for devolved services and the NHS; but in 2006/07, England spent the highest proportion of its global sum on the NHS. The NHS in England was required to use the increased funding to meet demanding targets in the system of annual ‘star ratings’, which applied from 2001 to 2005, and subsequently in the annual ‘Health Check’. None of the other three countries introduced systems of public reporting of performance, which ‘named and shamed’ organisations that failed to meet national targets.

The terminology used in this report distinguishes between England and the three devolved countries (Scotland, Wales and Northern Ireland); the distinction emphasises the absence of a parliament or an assembly for England. This report builds on two previous cross-country comparisons, the first concerned with 1996/97 and the second comparing that year with 2002/03. This third comparison adds data for 2006/07 and therefore examines changes over a ten-year period from 1996/97 to 2006/07. In this report, the years covered by each of the three cross-country comparisons (1996/97; 2002/03; 2006/07) are referred to as 1996, 2002 and 2006. These longitudinal analyses required data that were comparable across jurisdictions and over time: this severely restricted the amount of routinely available data that could be included in this report.

In 2005, two of the authors reported a comparison of the NHS' performance in the four countries of the UK, covering the period 1996 to 2002 before and immediately after political devolution.² The main findings of that analysis were the absence of any obvious link between spending per capita and performance. In England, strong performance management against targets had resulted in much shorter waiting times in the post-devolution period than in the other countries for which there were comparable data (Wales and Northern Ireland). The present analysis extends to 2006 and shows that in all four countries since 2002, there have been large increases in spending and staffing, falls in the crude productivity of hospital medical and dental staff, and nursing, midwifery and health visiting staff, and particularly in England, further reductions in waiting times. This analysis was first published in January 2010 but, following publication, the authors

discovered two new sets of problems in extending the previous analyses to 2006; hence the publication of a revised report.

The first problem was that there was an error in the official statistics for hospital medical and dental staff for Scotland for 2006, as published by ONS and checked by officials of the Information Services Division (ISD) of National Services NHS Scotland: the published statistic erroneously included general dental practitioners, and the published statistic for nurses included unqualified nurses. This revised report uses the corrected statistic. The second problem was that, following discussions with officials from ONS and ISD, it became clear that fundamental differences in the definition of various statistics for 2006 remain unresolved, both between countries and over time. In preparing the original January 2010 report, the authors were aware of definitional problems for statistics on waiting times in Scotland, management and support staff for Northern Ireland, and day cases and outpatients for Wales for 2006. The extra definitional problems, which became clear after publication of the original report, highlight a key message of this revised report: no one appears responsible for requiring that fundamental data on staff, activity and performance are collected on a consistent basis. This is because benchmarking of the use of UK taxpayers' money across the four countries is not carried out by their respective governments. Thus it is not possible to meaningfully compare across the four countries over time the following:

- levels of beds;
- management and support staff;

- waiting times; and
- crude productivity of hospital staff (doctors, dentists and nurses).

The problems of lack of comparability for 2002 were much worse than for 1996, and for 2006 are again much worse than for 2002. This is at a time of austerity for all public services for the foreseeable future, in which it is incumbent upon the governments of each country to demonstrate to taxpayers that they are making good use of their money. Benchmarking performance across countries is one good way of doing so, and is vital for the small devolved countries, which have limited scope to learn from within-country comparisons.

Differences in definition both between countries and over time mean that we could not compare the following:

- the performance of the NHS in Scotland in reducing waiting times with that of the other countries at any time;
- the statistics on management and support staff for Scotland or Northern Ireland with each other and with England and Wales;
- statistics for inpatients for Scotland for 2006 with other countries for 2006, nor with statistics for Scotland for the earlier years;
- statistics for Wales for day cases over time for Wales, nor with the other countries; and
- statistics for Wales for outpatients for 2006 with earlier years for Wales, nor with the other countries for 2006.

There are also problems in comparing statistics for treatment rates in Northern Ireland with the other countries and for available hospital beds for Scotland with other countries (for 2006).

The principal findings from the cross-country longitudinal comparisons that the authors were able to make are as follows:

- Per capita expenditure on the NHS for 1996, 2002 and 2006 across the four countries: Scotland had the highest and England the lowest rates.
- Rates of hospital medical and dental staff per 1,000 population for 1996, 2002 and 2006 across the four countries: Scotland had the highest and England the lowest rates (except in 2002 when Wales had the same rate as England, and in 2006 when Northern Ireland had the same rate as Scotland).
- Rates of nursing, midwifery and health visiting staff per 1,000 population for 1996, 2002 and 2006 across the four countries: Scotland had the highest and England the lowest rates (except in 1996 when Northern Ireland had the same rate as Scotland).
- Rates of general practitioners (GPs) per 1,000 population for 1996, 2002 and 2006 across the four countries: Scotland had the highest and England the lowest rates (except in 2006 when Wales had the lowest rate).
- Rates of management and support staff per capita – for 1996, 2002 and 2006, we can compare England and Wales only: throughout, England had substantially lower levels of staffing than Wales.

- Rates of outpatient appointments per capita for 1996 and 2002, across the four countries: in 1996, Scotland had the highest and England the lowest rates; in 2002, Wales had the highest and Northern Ireland the lowest rates. For 2006, we can compare Scotland, England and Northern Ireland only: Scotland had the highest and Northern Ireland the lowest rates.
- Rates of day cases per capita – we can compare England, Scotland and Northern Ireland only: Scotland had the highest rate in 1996 and 2002, but the lowest rate in 2006; Northern Ireland had the lowest rate in 1996 and the highest in 2006. England had the lowest rate in 2002.
- Rates of inpatient admissions per capita for 1996 and 2002, across the four countries: England had the lowest rate in each year, Scotland had the highest rate in 1996 and Northern Ireland in 2002. For 2006, we can compare England, Wales and Northern Ireland only: Northern Ireland had the highest rate and England the lowest.
- Rates of outpatient appointments and inpatient admissions per hospital medical and dental staff member for 1996 and 2002, across the four countries: England had the highest rates in 1996 and Wales in 2002, and Scotland the lowest rates in each year. For 2006, for outpatient appointments per hospital medical and dental staff member, we can compare England, Scotland and Northern Ireland only: England had the highest rate and Northern Ireland the lowest. For 2006, for inpatient admissions per hospital medical and dental staff member, we can compare England, Wales and Northern Ireland only: Northern Ireland had the highest rate and England and Wales the same rate.
- Rates of day cases per hospital medical and dental staff member – for 1996, 2002 and 2006, we can compare England, Scotland and Northern Ireland only: England had the highest rates in each year and Northern Ireland had the lowest in 1996, and Scotland in 2002 and 2006.
- Rates of outpatient appointments per nursing, midwifery and health visiting staff member – for 1996 and 2002, we can compare the four countries, and for 2006, England, Scotland and Northern Ireland only: in each year, England had the highest rates and Northern Ireland the lowest (in 2006, Scotland had the same rate as Northern Ireland).
- Rates of inpatient admissions per nursing, midwifery and health visiting staff member for 1996 and 2002, across the four countries: England had the highest rate in each year, Northern Ireland the lowest rate in 1996 and Scotland the lowest rate in 2002. For 2006, we can compare England, Wales and Northern Ireland only: Wales had the lowest and England the highest rate.
- Rates of day cases per nursing, midwifery and health visiting staff member – for 1996, 2002 and 2006, we can compare England, Scotland and Northern Ireland only: England had highest rates in each year, Northern Ireland the lowest rates in 1996 and Scotland the lowest rate in 2002 and 2006.
- Percentages of the population waiting less than six months for an inpatient or day case admission – for 1996, we can

compare England and Northern Ireland only: England had the better performance. For 2002 and 2006, we can compare England, Wales and Northern Ireland only: England had the best performance in each year, Northern Ireland the worst performance in 2002 and Wales the worst performance in 2006.

- Percentages of the population waiting less than three months for an outpatient appointment – for 1996, we can compare Wales and Northern Ireland only: Wales had the better performance. For 2002 and 2006, we can compare England, Wales and Northern Ireland only: in both years England had the best performance and Northern Ireland the worst.
- Percentages of ambulance response rates to what may have been life-threatening emergencies in less than eight minutes – from 2000 to 2004, we can compare England and Wales only: England had the better performance. From 2004 to 2006, we can compare England, Scotland and Wales only: England had the best performance and Scotland and Wales were similar.

The longitudinal cross-country comparisons were supplemented with a cross-sectional analysis of the three devolved countries and English regions for 2006. The main reason for this additional analysis is that some of the national averages reported for England are distorted by the unrepresentative nature of London.

Comparisons are possible for all three devolved countries with the English regions for mortality and life expectancy, and three measures of inputs (resources per capita, expenditure, hospital

medical and dental staff, nursing, midwifery and health visiting staff, and GPs):

- Standardised mortality rates (SMRs) (for males and females): Scotland had the highest rates (although these were close to those for the North East); the South East and South West regions had the lowest; the rates for Northern Ireland were comparable with the highest rates of the two worst English regions (the North East and North West); and the rates for Wales were comparable with the median rate for English regions.
- Perinatal mortality rates: the West Midlands had the highest rate and the South West the lowest; most English regions had higher rates than Scotland; and Wales and Northern Ireland had rates lower than all English regions, except the South West and East of England.
- Infant mortality rates: the West Midlands had the highest rate; the South East, Wales, the East of England and the South West had the lowest rates; most English regions had higher rates than Scotland and Wales, but Northern Ireland had a rate close to those English regions with high rates.
- Life expectancy (for males and females): Scotland had the lowest rates for both genders; the South East had the highest rate for males and the South West the highest rate for females; and Wales and Northern Ireland had rates similar to the two English regions with the lowest rates (the North East and North West).
- Per capita spend: Scotland had the highest rate, and Wales and Northern Ireland had similar levels to the three English

regions with the highest per capita spend (London, the North East and North West).

- Hospital medical and dental staff: except for London (an outlier with the highest rate, which is not comparable), Scotland and Northern Ireland had the highest rates, and Wales had a rate similar to the northern regions of England.
- Nursing, midwifery and health visiting staff: Scotland and Northern Ireland had the highest rates, and Wales had a rate similar to the northern regions of England.
- GPs: Scotland had the highest rate; Northern Ireland had a lower rate than most English regions; and only the East Midlands had a lower rate than Wales.

Comparisons are possible for Scotland and Northern Ireland with the English regions for the following:

- Outpatients per capita: Scotland and Northern Ireland had rates lower than the median value for English regions, but close to the mean for England.
- Day cases per capita: Northern Ireland was at the higher end of the distribution for English regions, and Scotland at the lower end.
- Outpatients per hospital medical and dental staff member: Scotland and Northern Ireland had lower rates than any English region.
- Day cases per hospital medical and dental staff member: Scotland had lower rates than any English region except for London; and Northern Ireland had lower rates than seven

English regions (the exceptions being London and the North West).

Comparisons are possible for Wales and Northern Ireland with the English regions for the following:

- Available hospital beds per capita: Northern Ireland and Wales had higher rates than any English region, but these rates were close to that of the North East, which had a materially higher rate than the other English regions.
- Inpatients per capita: Northern Ireland had a rate close to that for the highest for the English regions (the North East), and Wales had a rate lower than the median value for English regions, but higher than the mean for England.
- Inpatients per hospital medical and dental staff member: Northern Ireland and Wales had lower rates than any English region, except for London.
- Percentage waiting more than 13 weeks for admission as an inpatient or day case or outpatient appointment: Northern Ireland and Wales had worse performance than any English region.

Comparisons are possible for Northern Ireland with the English regions for the following:

- Outpatients, inpatients and day cases per nursing, midwifery and health visiting staff member: Northern Ireland had lower rates than all English regions for outpatients and inpatients (except for London), and than

six English regions for day cases (the exceptions being London and the North West).

Comparisons are possible for Wales with the English regions for the following:

- Management and support staff per capita: Wales had a substantially higher rate than any English region.

The North East region of England is more like the three devolved countries (in terms of its size and indicators of socioeconomic, demographic and morbidity characteristics), and therefore some of the analysis focuses specifically on the differences between the North East region and the three devolved countries. Comparing Scotland, Wales and Northern Ireland with the North East as the most comparable English region showed the following:

- Scotland had the highest SMRs and lowest life expectancy at birth (for males and females); the West Midlands had the highest perinatal mortality rate; the West Midlands and Yorkshire and The Humber had the highest infant mortality rates; and Northern Ireland had the highest rate of limiting longstanding illness (LLSI).
- Scotland had the highest expenditure per capita, and Wales, Northern Ireland and the North East had similar rates.
- Scotland and Northern Ireland had the highest rates of hospital medical and dental staff per capita; the rate for Wales was similar to that of the North East.

- Scotland had the highest rate of GPs, and the rate for the North East was substantially higher than in Wales and Northern Ireland.

The authors see scope for further, more detailed work using the North East as a benchmark for comparison with the devolved countries.

These analyses can be suggestive only because of the limited set of indicators that were available for the baseline analysis in 1996, and the scope to apply that limited set has become more restricted over time with increasing inconsistencies in definition between the different countries. Despite this, the national-level analysis has shown that England has the lowest per capita funding for the NHS, and generally makes better use of its lower level of resourcing in terms of shorter waiting times and higher crude productivity of its staff. The general finding from comparisons of the devolved countries with the English regions (where the data were comparable) has shown that the devolved countries tend to be outliers (i.e. outside the distribution of the English regions). Comparing Scotland with English regions showed that Scotland had the highest SMRs, lowest life expectancy and highest levels of expenditure. Comparing Wales and Northern Ireland with English regions showed that Wales and Northern Ireland had longer waiting times for hospital, and lower crude productivity of hospital medical and dental staff, and nursing, midwifery and health visiting staff than any English region (excluding London for some measures). Other researchers have failed to find evidence that, in the devolved countries, the higher levels of per capita funding, longer waiting times and lower crude

productivity have produced offsetting material systematic benefits in other dimensions of quality of care. Although this merits further analysis, this is likely to require data that either are not readily available or have not been collected.

Current arrangements demonstrate two troubling features of governance and accountability. First, while the governments of the devolved countries are held to account by their electorates specifically for the performance of the devolved services, there is no equivalent electoral accountability for such services in England, as this accountability is exercised only through general elections to the UK Parliament. Second, the UK taxpayer funds health services in each country, but only England has been held to account for its performance by the Treasury.

The collection of data on the NHS is costly and only worthwhile if these data can be used. Systematic reviews of the industry of collecting and reporting data on healthcare have found that few of these exercises have been evaluated, and that the few which have, often have limited benefits to show for their costs. Judith Hibbard has argued that if data are to be used to have an impact by putting pressure to improve on those performing poorly, then this is best done by benchmarking through a public comprehensible ranking of performance.³ The divergences in definitions of basic NHS data between the devolved countries and England, such as for staff, hospital activity and waiting times, increasingly restrict performance benchmarking to comparisons within each country. The authors' experience in this study shows that the data collected on a comparable basis over time across the four

countries are extremely limited and, if anything, devolution seems to have reduced the willingness of the devolved administrations to collect such comparable data. While the UK Statistics Authority has a crucial role in monitoring the quality of statistics produced by each country, it does not appear to have the power to require the governments of the UK to produce comparable data on public services. If the governments of all four countries were confident that they could demonstrate that their policies would deliver better NHS performance, they would welcome the opportunity to demonstrate this in comparison with one another. If they are reluctant to allow such comparisons to be made, this suggests that they are fearful that their policies will be found wanting.

Furthermore, UK taxpayers have a right to know how well the different governments are, or are not, securing value for their money. The Treasury ought to be able to require governments to account for their performance by supplying comparative data. This report recommends that the Treasury takes on the role of ensuring that key data are collected on a consistent basis across the four countries, so that there can be open public scrutiny of the performance of the governments empowered to pursue different policies financed by the UK taxpayer. In addition, such information would inform the electorates of each country as to how well each government is running its NHS. It is suggested in this report what this minimum dataset might include.

This report has identified potentially important differences between the UK countries in funding, staffing and performance that highlight larger issues posed by devolution in terms of the way in which monies from UK taxpayers are allocated to the

devolved countries and accountability for devolved services in all countries. The House of Lords Select Committee on the Barnett Formula critically examined the way decisions have been made on public spending across the four UK countries. The authors strongly support the Committee's recommendation that funding ought to take account of both the size of populations and their relative need for public services.

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Funding and performance of healthcare systems in the four countries of the UK before and after devolution

CHAPTER 1

INTRODUCTION

On 1 May 1997, the (New) Labour Government won a landslide victory in the general election with four policy commitments in its manifesto¹ that shaped the governance, funding and performance of the healthcare systems in the UK. Only one of these was specific to healthcare with the promise to ‘save the National Health Service’ by cutting costs on the ‘bureaucratic processes of the internal market’, getting 100,000 off waiting lists and improving the quality of care through increasing spending each year in ‘real terms’.

The NHS, however, had little prospect of substantial growth monies: the manifesto made a commitment to ‘work within departmental ceilings for spending already announced’ (by the Conservative Government), which entailed prudence in fiscal policy in the Blair Government’s first term; and another manifesto commitment made it clear that the first claim on resources for public services would be for schools, as the government’s first three priorities famously were ‘Education, Education, Education’.²

This report examines the consequences for healthcare in the UK of a fourth manifesto commitment, namely devolution of power

(to the Scottish Parliament and the Welsh Assembly, which was also extended to the Northern Ireland Assembly), on funding, performance, governance and accountability of what has now become a different NHS within each of the four countries of the UK: England, Scotland, Wales and Northern Ireland.

Much of the work to date examining the impacts of devolution has focused on differences in policies, structure, values and accountability across the four systems of healthcare.³ This report draws on that literature to outline these differences, but the original contribution comes from reporting a set of indicators on populations, and resourcing and performance of systems of healthcare measured over time to raise questions about the funding, performance, governance and accountability of governments of each country. The requirement for indicators to be comparable over time and across countries limited the range and number available, and hence the scope of this report.

The authors present two kinds of comparisons of performance between the different countries of the UK: first, longitudinal analyses at three time points over ten years (1996/97, 2002/03, 2006/07, hereafter referred to as 1996, 2002 and 2006) of

national averages for each country; and second, cross-sectional comparisons of regions in England (for 2006, when the current ten strategic health authorities (SHAs) were created) with the other three countries, which show the limited value of comparing one very large country, England (50 million population), with three much smaller ones: Scotland (five million), Wales (three million) and Northern Ireland (1.7 million). These comparisons reveal two different categories of indicators: one set where the variation within England is greater than between the average for England and the three other countries; and another set where the statistics for the other countries lie outside the range for the regions in England. The authors show that the North East is a better benchmark for comparison with the devolved countries than the average for England for two reasons: the North East is more like the three devolved countries (in terms of the size of their populations and indicators of their socioeconomic, demographic and morbidity characteristics); and average per capita indicators of expenditure and supply for England are heavily influenced by the high values for London, which are caused by the high costs of labour in the capital, and concentrations of research, teaching and training.⁴

Chapter 2 of this report sets the context for the comparative analysis. It describes the background to, and the nature and arrangements for, political devolution. Following its enactment, there was a commitment by the Prime Minister of the UK to unprecedented and sustained real increases in spend on the NHS, which applied across the UK, to remedy a perceived crisis in the NHS from underfunding that had resulted in inadequate investment and staffing, poor outcomes and quality of care,

including long hospital waiting times. Subsequently, the government in England, unlike in the other three countries, linked the unprecedented increases in NHS funding to a requirement for a transformation of performance, with targets set by the Treasury and new policies for the NHS to achieve those targets. For the devolved governments in Scotland, Wales and Northern Ireland, neither was there external pressure from the Treasury on their ministries of health, nor did these governments put specific forms of pressure on their own NHSs to improve their performance.

Chapter 3 outlines the methods of comparative analysis and brings out the difficulty of obtaining comparative data on even the basic measure of hospital waiting times. Chapters 4 and 5 report, respectively, inter-country comparisons using routinely available data at three time points (1996, 2002 and 2006), which include periods before and after devolution (except for ambulance response times, which show changes since 1999); and a comparison of the English regions with the three other countries in 2006. Chapter 6 highlights findings from these comparisons and their implications for policy and research.

The analysis in this research was first published in January 2010, but following publication, two new sets of problems in extending the previous analyses to 2006 were discovered; hence the publication of a revised report. The first problem was that there was an error in the official statistics for hospital medical and dental staff, and nursing, midwifery and health visiting staff, for Scotland for 2006, as published by ONS and checked by officials of ISD of National Services NHS Scotland: the

published statistic for hospital medical and dental staff erroneously included general dental practitioners, and the published statistic for nursing, midwifery and health visiting staff included unqualified nurses. This revised report uses the corrected statistics. The second problem was that, following discussions with officials from ONS and ISD, it became clear that fundamental differences in the definition of various statistics for 2006 remain unresolved, both between countries and over time. In preparing the original January 2010 report, the authors were aware of definitional problems for statistics on waiting times in Scotland, management and support staff for Northern Ireland, and day cases and outpatients for Wales for 2006. The extra definitional problems, which became clear after publication of the original report, highlight a key message of this revised report: no one appears responsible for requiring that fundamental data on staff, activity and performance are collected on a consistent basis. This is because benchmarking of the use of UK taxpayers' money across the four countries is not carried out by their respective governments. Thus it is not possible to meaningfully compare across the four countries over time the following:

- levels of beds;
- management and support staff;
- waiting times; and
- crude productivity of hospital staff (hospital medical and dental staff, and nursing, midwifery and health visiting staff).

The problems of lack of comparability for 2002 were much worse than for 1996, and for 2006 are again much worse than for 2002.

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 4. One indication of this is the numbers of medical students. A common source for these data has not been found, but, for example, London in 2001/02 had nearly five times as many medical students as Scotland: London had about 4,400 (Department of Health, 2000) and Scotland about 900 (Calman and Paulson-Ellis, 2004). See Department of Health (2000) *Service Increment for Teaching Accountability Report 1999/2000*. London: Department of Health, p12. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139368. Calman, K and Paulson-Ellis, M (2004) *Review of Basic Medical Education in Scotland*. Edinburgh: The Stationery Office, p37. www.scotland.gov.uk/Resource/Doc/47251/0013200.pdf. London is also the home to such great institutions serving the whole of the UK: for example, Hammersmith Hospital, Great Ormond Street Hospital for Children, the Royal Marsden Hospital and the National Hospital for Neurology and Neurosurgery at Queen Square.

CHAPTER 2

DEVOLUTION: BACKGROUND, ARRANGEMENTS AND THEIR IMPLICATIONS

The historical background to devolution

Devolution followed a long and complicated historical development of governance arrangements in the UK. History obviously matters as we now have governance on a consistent basis from a strong centre for the 50 million who live in England, with quite different arrangements allowing considerable autonomy for those parts with a historical claim to being distinct countries. This brief outline of the history of the unions of the different countries aims to identify key developments leading to the creation of the UK that have had an influence on governance before and after devolution.

The outline draws on the account by Norman Davies in *The Isles – A history*,¹ in which he highlights problems of nomenclature.² Colley points out that, in 1805, a Scot representing a Perthshire constituency saw the word English as applicable to describe people from any part of the UK.³ Davies sets out to correct the ‘inability of prominent authorities to present the history of our Isles in accurate and unambiguous

terms’. These prominent authorities included the Bodleian library of Oxford University and the Library of Congress in Washington which, in 1999, had no entry for the history of the UK, and their entries for Great Britain assumed this to be identical to the history of England. This follows the practice of the entry in the index of early editions of the *Encyclopaedia Britannica*: ‘For Wales – see England’.⁴

Following a long and complex history,⁵ key developments in the formation of the current UK included historical defeats by the English of the Welsh, by the Scottish of the English; and, in Ireland, the bloody history that followed the plantation in Ulster with events that still resonate in the Protestant and Catholic communities.⁶ The Statute of Rhuddlan (1284) was imposed on, and subjugated Wales to, English jurisdiction following its conquest by Edward I. The Act of Union of England and Wales (1536) that followed the Tudor assault on Wales clearly defined the border for the first time, and renamed the Kingdom of England the Kingdom of England and Wales.

Later English common law was imposed and English declared the sole language of administration.⁷ In contrast, Scotland remained independent with its own parliament until the merger of the Edinburgh and Westminster Parliaments in the Act of Union of 1707, in which Scotland secured greater autonomy than either Wales (in its earlier union) or Ireland (in its later union).⁸ At the end of the fifteenth century, the Dublin Parliament had been obliged to pass Poyning's Law, which invalidated all Irish legislation not previously approved in England, and remained on the statute book for nearly 300 years. King James I and VI signed the Act for the confiscation of Ulster to achieve its subjugation by the plantation (by principally English leaseholders and Scottish tenants). Ulster had previously been the most Irish, Gaelic and Catholic and traditional province of Ireland. The two key legislative developments were: the merger of the British and Irish Parliaments (1800);⁹ and the partition of Ireland by the Government of Ireland Act (1920), which was confirmed by the Anglo-Irish Treaty (1921) and created the British Province of Northern Ireland.¹⁰

This history is relevant in understanding arrangements prior to devolution as it explains why historical dominance matters and also key differences between the countries that, as Colley¹¹ argues, ought not to be assumed to be similar as a 'Celtic fringe': the Welsh and the Scottish 'rarely defined themselves by reference to the kind of rich Celtic nationalism that certain Irish patriots would make so much of after the 1840s'. Although Wales, in contrast to Scotland, 'had lost its own legal system, its religious organisation was modelled on England's own, and it had no universities or capital city like Edinburgh as

a focus for cultural life... as late as the 1880s, three out of four spoke Welsh from choice'. Only in Wales does a significant population speak a native language other than English, and government publications are bilingual.

For long periods, however, for the devolved services, Wales was little more than an English region. The educational system in Wales has been described with reference to the entry in the *Encyclopaedia Britannica*: for Wales see England;¹² and prior to devolution, the NHS in Wales was perceived as 'forming an adjunct to the English health service'.¹³

In contrast, Scotland differs from England in that: Scottish banks issue their own currency (in notes; coins are minted on a UK-wide basis); Scottish civil law 'contains elements that have origins in Roman Dutch Law rather than English Common Law traditions';¹⁴ and the Scottish educational system has a system of exams and higher education which is distinctively different.¹⁵

In Northern Ireland, history continues to wrestle with the complications arising from partition (into Northern Ireland and the Republic of Ireland) and its own 'Troubles'. In terms of governance, as compared with England, Northern Ireland is more different than Wales and less different than Scotland. Before devolution, legislation for the UK consisted of three different territorial arrangements: this was on a common basis for England and Wales; but Scotland and Northern Ireland each had different Acts. (Greer and Trench explain these differences.¹⁶) After devolution, the Scottish Parliament has a wide range of legislative powers and is free to legislate on all

matters except those reserved for Westminster, which for health and healthcare include regulation for almost all the health professions. The Assembly in Northern Ireland can also legislate except for reserved matters. The powers of the Assembly in Wales are more circumscribed and were initially limited to executive matters, which were those of the Welsh Office prior to devolution. There is scope for the Assembly to acquire legislative powers, but these depend on the cumbersome process of approval by a Westminster Act of Parliament or a Legislative Competence Order, an order in Council sought by the Assembly and approved at Westminster.¹⁷

This history is also relevant in understanding the nature of devolution. Davies argues that the nature of the union of 1707 prevented the UK from developing either a federal structure (as in Germany, where each land was established on an equal basis with none designed to dominate the others) or unitary structure (as in France, which until recently possessed a highly centralised character in which the political nation developed within one territory). In contrast, the UK is ‘essentially a dynastic conglomerate, which could never equalise the functions of its four constituent parts’ and lacks a unified legal system, centralised educational system, common cultural policy or history. Davies argues that, although Scotland united with England in 1707 and Ireland with England and Scotland in 1800, as far as the English are concerned ‘England never united with anyone’. This one-eyed perspective of the impact of unions on England carried over to devolution, which was seen to require new elected bodies in Scotland, Northern Ireland and Wales, but not in England where the UK Parliament is responsible for both policies that apply to all

four countries (for example, defence, social security and foreign policy) and to England only (healthcare and education, for example), leading to the ‘West Lothian question’, which is discussed below.

Governance of the NHS before political devolution

The creation of the NHS in 1948 established largely the same organisational forms and common policies across the whole of the UK with access to the NHS free at the point of delivery (except for the subsequent introduction of prescription charges) and typically via a GP, who acts as gatekeeper to specialist services. Initial arrangements illustrate how Wales was essentially seen as an English region, with Scotland and Northern Ireland seen as distinct administratively: the regulation to control the distribution of GPs was by three Medical Practices committees: for England and Wales; for Scotland; and for Northern Ireland. A hospital management committee governed each hospital, and was accountable to regional hospital boards in England (with 14), Wales (one); Scotland (five),¹⁸ and a hospitals authority in Northern Ireland.¹⁹

The major reorganisation of the NHS (implemented in 1974 in England, Wales and Scotland, and 1973 in Northern Ireland) aimed to shift the NHS from an organisation based on hospitals to one based on populations. This resulted in a regional structure in England of 14 regional health authorities (RHAs); for the other countries, the government department of health fulfilled this role. Within English RHAs and Wales there were area health authorities, responsible for running hospital and

community health services and planning for populations within each area (in England and Wales these were later reorganised into district health authorities); and family health service authorities, for family practitioner services. In Scotland, health boards were created with the same responsibilities as area health authorities but they also covered family practitioner services. In Northern Ireland, health and social service boards were created with responsibility for health and social services. The constitution of executive teams was similar in England, Wales and Scotland, but differed in Northern Ireland (including the Director of Social Services, but excluding the Treasurer).²⁰

Before political devolution, each country was subject to a common policy that applied throughout the UK with latitude for minor variations in the devolved countries. This is powerfully illustrated by the controversial White Paper *Working for Patients*,²¹ which promulgated the policies of an internal market throughout the UK. This followed the Thatcher Government's policy of little or no increases in 'real' terms for the NHS, which, together with a policy of redistribution of resources according to estimated relative need, resulted in cuts in services in London and the perception of a crisis of underfunding.²² One issue pursued as a solution to that crisis was the exploration of a greater role for private health insurance, but that was eventually sidelined, and later dropped.²³

These events emphasise two ways in which England is the odd one out in the UK: only in England is there a strong Conservative Party and significant independent sectors for healthcare and schools. In the devolved countries the

implementation of the internal market was seen as an ideologically driven policy invented in England and imposed on them. (Its unpopularity may have contributed to there being no Conservative Members of Parliament (MPs) in either Scotland or Wales after the 1997 general election.²⁴)

The internal market created a 'purchaser/provider' split based on the idea that purchasers would contract with independent providers on grounds of price and quality with 'money following the patient'. This meant that district health authorities in England and Wales, health boards in Scotland and health and social service boards in Northern Ireland became 'purchasers' and their hierarchical role in governing providers was replaced with contractual arrangements. Providers became 'independent' NHS trusts. Another innovation of the internal market was the creation of new small-scale purchasing by GPs who opted to become fundholders, of which various forms emerged over time.²⁵ In England, the emphasis on 'light touch regulation' of the internal market resulted in the abolition of RHAs. This regulatory tier became a monitoring arm of the Department of Health and has been reorganised every few years.²⁶

Within the UK, before devolution, there were three Secretaries of State, for Scotland, Wales and Northern Ireland, who were all members of the UK Cabinet. They were accountable for expenditure within these countries on (which for simplicity will be referred to as) 'devolved services', which include health and local authority services. Decisions on spending on social security (although identifiable within each country), defence

and foreign affairs, were, and still are, made on a UK-wide basis. Secretaries of State were allocated a global sum for their ‘devolved services’ and were free to allocate money to their chosen spending priorities.

In 1979, when political devolution was first being considered, the then Labour Government introduced a new formula (the Barnett Formula) for allocating annual per capita spending increases for ‘devolved services’. This formula has recently been reviewed by the House of Lords Select Committee on the Barnett Formula:²⁷ the account contained here of the formula draws on that critical and informative report. The formula began to operate in Scotland and Northern Ireland in 1979, and in Wales in 1980. Its principle is that ‘growth’ in resources for ‘devolved services’ would be allocated to each country in proportion to its share of the UK’s population, with annual per capita spending increases derived from the percentage increase granted to the English baseline. Before the formula was used, England had the lowest per capita spend: in 1976/77, per capita spending on ‘devolved services’ was much higher than England in Northern Ireland (by 35 per cent) and Scotland (by 22 per cent) and a little higher in Wales (by 6 per cent).

The Barnett Formula was seen, at its introduction, as a short-term measure, but continued after devolution was enacted 20 years later and has remained in place, largely unaltered, for 30 years. A formula designed for the long term ought to take account of the relative needs of countries’ populations. The Barnett Formula fails to do so, and this is why the House of Lords Select Committee on the Barnett Formula concluded that it should ‘no longer be used to determine

annual increases in the block grant for the United Kingdom’s devolved administrations’. The Treasury’s two studies of needs assessment in 1979 and 1993 were disregarded, but, if implemented, would have meant a reduction in allocations relative to England in both 1979 and 1993 for Northern Ireland and Scotland; and an increase in spending in Wales in 1979 but not in 1993. Although in principle the design of the Barnett Formula implies gradual convergence in per capita spend, this did not happen for two reasons:

First, relative populations were not updated until the 1990s, despite significant changes (for example, Scotland’s share of the UK population declined from 9.3 per cent in 1976 to 8.7 per cent in 1995). Second, the formula did not determine all allocations of devolved public spending: there were extra allocations negotiated bilaterally with the Treasury outside the formula, in particular to cover public sector wage increases (which appear to have benefited Scotland and Northern Ireland).

UK political devolution and accountability

Powers were transferred to the Scottish Parliament and Welsh Assembly on 1 July 1999; and to the Northern Ireland Assembly on 2 December 1999. This is a peculiar arrangement as it lacks two key elements of normal federal governance: there is no elected body for England; and there is no basis for agreeing what should be the UK-wide elements of policy for devolved services versus those to be determined within the constituent countries of the UK. A possible explanation for these arrangements is that devolution was seen as a first step to be followed by the introduction of regional governments in

England. But that step was rejected so heavily when tried in the North East²⁸ that it is now off the political agenda for a generation. The resulting anomaly in governance is known in parliament as the West Lothian question, as articulated by the MP Tam Dalyell in the House of Commons:²⁹ that is, why should MPs from non-English constituencies be able to vote on policies for England (for healthcare, education and transport) when English MPs cannot vote on these policies for each devolved country (as these are matters for their own parliament and assemblies), even though their finance comes from the budget for the UK?

The anomaly of the absence of a parliament for England was forcefully illustrated by the introduction of two controversial policies implemented in England only: foundation trusts (that aimed to free hospitals from hierarchical control by the Department of Health, subject to scrutiny by an independent regulator) in July 2003,³⁰ and the introduction of tuition fees for undergraduates in January 2004.³¹ The governments in Scotland and Wales opposed these policies, but the Blair Government's majority in the House of Commons depended on votes from MPs from Scotland and Wales.

Devolution is essentially a political arrangement with virtually no fiscal devolution: the NHS is financed by general taxation and national insurance contributions on a UK-wide basis. Scotland only has very limited powers for raising extra taxes, which have not yet been used; the report from the Commission on Scottish Devolution (chaired by Sir Kenneth Calman) recommended 'that over one third of devolved current spending would be funded by taxes decided and raised in Scotland'.³²

The arrangements for devolution also mean that there are in essence two different systems for determining NHS budgets: one for England and another for the devolved countries. For England, the NHS budget is the outcome of UK Cabinet agreements following negotiations between HM Treasury and the Department of Health for England; and is, in principle, contingent on the NHS in England delivering performance that satisfies a set of Treasury targets set out in PSA targets agreed with the Secretary of State for Health for England. The Labour Government's 1998 *Comprehensive Spending Review*³³ sets out PSA targets for health services in England, Scotland, Wales and, to a lesser extent, Northern Ireland. The PSA targets for 2002 and 2004³⁴ had targets for government departments in England, for the Northern Ireland Office, but none for health services; and excluded the governments of Scotland and Wales. The PSA targets for 2007³⁵ applied to government departments in England only.

The baseline for allocations for 'devolved services' to the devolved countries (used in the Barnett Formula) is determined by the level of allocations for these services in England, which have been (as for healthcare), in principle, contingent on each department delivering performance that satisfied its PSA targets. The global allocations for 'devolved services' in the devolved countries are then determined by the Barnett Formula and bilateral negotiations with the Treasury. Each government then decides how much of its global allocation ought to be allocated to the NHS. This means that the devolved countries could, for example, decide to spend extra money derived from decisions designed to improve NHS performance in England to ensure that there are no tuition fees for undergraduates.

There are two problems with these arrangements. First, only the governments of the devolved countries have direct political accountability for devolved services. In England, as there is no English Parliament; political accountability for these services is through elections to the UK Parliament, which involve both English and UK-wide issues (such as the economy, spending on social security, and defence and foreign policy). Second, only the government in England is accountable for its spending against Treasury targets; for the other governments, their funding essentially follows allocations to England that, in principle, depend on the performance of these services in England against PSA targets.

English policies for the NHS before and after devolution

For schools, the Blair Government continued the Conservative reforms in England and Wales through publication of school league tables of examination results and school inspections by the Office for Standards in Education (Ofsted); and the quasi-market (where ‘money followed the pupil’).³⁶ But for the NHS in England and Wales, its initial set of policies were described as offering a ‘third way’ compared with two ‘failed’ alternatives: the ‘divisive internal market system of the 1990s’ and the ‘old centralised command and control policies of the 1970s’³⁷ (the last time there had been a Labour Government).

The government retained the organisational separation of ‘purchasers’ from ‘providers’ created for the internal market, but abandoned the rhetoric of competition so that ‘purchasers’ became ‘commissioners’: the objective of that change was

that this would foster collaborative arrangements with providers. GP fundholding was abolished, but about 450 primary care groups (PCGs) were created within the then 90 health authorities with the objective of securing the advantages of fundholding without its disadvantages (which included allegations of creating a ‘two-tier’ NHS).³⁸ The health authorities were abolished and PCGs were later reorganised into 350 and then 150 primary care trusts (PCTs), which in effect replaced health authorities. Within Wales there was the parallel creation of local health groups (LHGs) based on local authorities in place of PCGs, and these LHGs later became local health boards (see below).

But the ‘third way’ was hampered by a lack of resources for the NHS, which resulted in another perceived ‘crisis’ of underfunding, which was seen as a root cause of the malaise of poor quality. There were a series of landmark failures of self-regulation by the medical profession:³⁹ notorious examples include the women who suffered from the actions of gynaecologist Rodney Ledward⁴⁰ and the excess deaths of babies from paediatric cardiac surgery at Bristol.⁴¹ There were long waiting times at all points of access to the NHS: to see a GP; to be seen and treated in Accident and Emergency (A&E) departments; to be referred for diagnosis and treatment; and to be admitted to hospital for an elective operation. International comparisons showed the UK to have the highest mortality from major diseases in the 1990s.⁴² The Secretary of State for Health observed: ‘Despite the best efforts of the NHS staff and cancer patients across the country, decades of under-investment alongside outdated practices mean that survival rates for many of the major cancers lag behind the

rest of Europe'.⁴³ It seems that the tipping point came on 17 January 2000 when, in an interview, Lord Winston, a Labour peer and well-known doctor, described the many failings of the NHS and linked this with the appalling treatment of his 87-year-old mother, a diabetic, when she had been admitted to a NHS hospital:

*She waited 13 hours in casualty before getting a bed in a mixed-sex ward – a place we said we would abolish. None of her drugs were given on time, she missed meals and she was found lying on the floor when the morning staff came on. She caught an infection and she now has an ulcer on her leg. [He acknowledged there was nothing unusual about this litany.] It is normal. The terrifying thing is that we accept it.*⁴⁴

Three days later, on Sunday 20 January 2000, after a television interview by the Prime Minister of the UK, Tony Blair, the government made the commitment to increase spending on the NHS in the UK to the European average spend on healthcare as a percentage of gross domestic product⁴⁵ (its effects are illustrated by Figure 4.3, which shows the resultant unprecedented increases in per capita expenditure on the NHS in each UK country, and is discussed more fully below).

Only in England did the government make it clear that extra funding of the NHS was to be in return for a transformation of performance: this was in principle contingent on satisfying Treasury PSA targets (substantially reducing mortality rates from major killers; narrowing health inequalities; treating patients at a time that suits them in accordance with their medical need; reducing waiting times; and increasing patient satisfaction).⁴⁶ The government for England emphasised in the summer of

2000 in *The NHS Plan*⁴⁷ that 'investment has to be accompanied by reform' and announced ambitious targets for increases in capital development and staffing,⁴⁸ reducing waiting times for access to the NHS⁴⁹ and improving services for patients with cancers, coronary heart disease and the mentally ill. Following *The NHS Plan*, capital development was financed by the Private Finance Initiative (PFI), which had been introduced by the previous Conservative Government. Under the PFI, private consortia design, finance and build projects, and run and maintain the non-clinical services over the lifetime of the agreement (typically 30 years), with the facilities being leased back to the public sector for an annual rental payment.⁵⁰

During the Blair Government's second term (from 2001), there was an emphasis on delivery against a small set of politically important targets: for the NHS, schools and transport. These were coordinated by the Prime Minister's Delivery Unit, led by Sir Michael Barber.⁵¹ The aim was to raise standards in the NHS and schools so that those who could afford it would not need to choose to pay privately for healthcare or education to ensure high quality.⁵² (Failure to do this in effect means that those with influence go private and become unwilling to pay high taxes for a service they do not use. This then leads to a privately financed high-quality service for those who can afford to pay for it and a publicly funded service of low quality for the rest.)

The policies of delivery created a target-driven culture.⁵³ *The NHS Plan*⁵⁴ emphasised that, for the NHS in England, there would be a new regime of performance management with a

radically new system of incentives that would reward success and penalise failure. This was to replace the current system, which was described as one that ‘penalises success and rewards failure’ (for example, by bailing out hospitals with long waiting times and lists by rewarding them with extra money); and hence had inadvertently created a system of perverse incentives. The policy of ‘naming and shaming’ schools through publication of school league tables was extended to the NHS between 2001 and 2005, with the publication of annual ‘star ratings’ of NHS organisations, in which failure to achieve the government’s ‘key targets’ (dominated by waiting times for hospitals or GPs, and response time to life-threatening emergency calls by ambulances) would result in that organisation being ‘zero-rated’, publicly ‘named and shamed’ as ‘failing’, and with the threat of the sack for the chief executive.^{55 56}

Towards the end of this period, starting in 2002/03, another internal market was gradually introduced that emphasised provider competition based on patient choice between public and private providers, with a system of funding in which ‘money followed the patient’⁵⁷ (known as Payment by Results),⁵⁸ which has to date had mixed results.⁵⁹ From 2006, ‘star ratings’ were succeeded by the annual ‘Health Check’. As Preston⁶⁰ argued in *The Guardian*, the use of central targets to put pressure on providers to improve services has paradoxically become unpopular just when there is now strong evidence of its beneficial outcomes.⁶¹ A *Times* leader⁶² commented on the latest Health Check by the Care Quality Commission (CQC)⁶³ and contrasted anecdotal evidence with dramatic improvements in reported performance:⁶⁴

It is often said, and it is true, that government targets can lead to perverse consequences. Ambulances wait outside hospitals because there is a target that no patient should wait more than four hours in A&E. It is less often said that government targets, at the same time, usually work. Ninety-eight per cent of patients do, indeed, now get seen in A&E in less than four hours. The CQC also reports good performances for cancer waiting times, for MRSA and Clostridium difficile infection rates – which fell by a third in 2008/09 – and for the 18-week referral to treatment waiting time.

Policies for the NHS of devolved countries after devolution

Perhaps not surprisingly following devolution, the governments of the different UK countries have sought common ends: to reduce long waiting times for access to healthcare, improve health outcomes and reduce health inequalities. The striking differences have been in the means chosen in pursuit of these common objectives. After devolution, funding of ‘devolved services’ in the devolved countries was neither dependent on achieving PSA targets, nor was their performance subject to the scrutiny of the Prime Minister’s Delivery Unit, nor were there threats of middle-class exit to independent healthcare providers and schools. The governments in Wales and Scotland abandoned the publication of school league tables in 2001: in Wales this appears to have slowed down improvements in examination achievements in pupils’ last year of compulsory education, in comparison with England; and in Scotland to have stopped improvement altogether.⁶⁵

Although all governments in the UK countries introduced targets for waiting times for hospitals,⁶⁶ and for response times to life-threatening emergency calls by ambulances,⁶⁷ the devolved countries did not follow the English policy of ‘naming and shaming’. In Wales^{68 69} and Scotland,^{70 71} those working in the NHS perceived the traditional system of perverse incentives to continue. The governments in Scotland⁷² and then Wales⁷³ decided to abandon the purchaser/provider split and go back to a hierarchy. Greer^{74 75 76} characterised the policy approaches taken in each country as follows: for England, on markets and management; for Scotland, on the medical profession and cooperation; for Wales, on localism and wider public health issues; and for Northern Ireland, on permissive managerialism. The suspension of the Northern Ireland Assembly resulted in stasis in the development of health policy through much of the post-devolution period. Harrington and others⁷⁷ argue that Greer is wrong to claim that a ‘natural experiment’ is taking place between UK countries because there is common ground in each country in seeking to reduce inequalities in health. This misses the vital distinction that governments in each country had common policy objectives (for example, in reducing hospital waiting times and improving the speed of responses by ambulances to life-threatening emergency calls), but chose different policy instruments as the means of achieving those ends. The differences in policy instruments that Greer highlights are subject of the natural experiment. Box 2.1 outlines the differences in policy and organisational characteristics of the four countries of the UK. The rest of this section outlines how policy in Scotland, Wales and Northern Ireland differs from England.

Scotland’s distinguishing characteristics are a strong sense of national identity; a long tradition of high-status medical professionals closely connected to the policy process; large, scarcely populated rural areas; and relatively high levels of poor health and deprivation (compared with the average for England, but not the northern regions of England – see below). Jervis⁷⁸ identified a number of areas, including the governance of the NHS, the introduction of free personal care for older people and a limited role for the private sector, where a divergent Scottish approach is evident. In 2000, the publication of the White Paper, *Our National Health: A plan for action, a plan for change*, paved the way for a major reorganisation of the Scottish NHS:⁷⁹ the NHS boards, acute hospital trusts and PCTs were brought together into 15 unified boards. The restructuring was to reduce the number of ministerial appointees by one-third; which would lead to a greater reliance on professionals who would, it was envisaged, work together for the benefit of population health.

In 2003, there was clear evidence of a further rejection of the internal market with the Scottish Executive (Scotland) Act, which abolished trusts and transferred their responsibilities to the health boards. Perhaps the most controversial policy to date adopted by the Scottish Parliament was the decision, in 2002, to implement free personal and nursing care for people aged 65 years and over.⁸⁰ Smith and Babbington⁸¹ note that in Scottish health policy, the priority is now ‘to create an integrated health system with close connections between different components. The aim is to develop care pathways by building on clinical networks between specialist acute services and primary care’.

Box 2.1: Policy and organisational characteristics of the four countries of the UK

	England	Wales	Scotland	Northern Ireland
Population (millions)	50	3	5	1.7
Organisational characteristics				
Commissioner/provider split	Yes	Abolished in 2009	Abolished in 2004	Yes
Provider markets, patient choice, pluralism in delivery and providers paid by activity	From 2006	No	No	No
Integration of health and social services	No	No	No	Yes
Commitment to election for local NHS governing bodies	No	No	Yes (in 2007, but not yet implemented)	No
Performance regimes				
Targets for waiting times	Yes	Yes	Yes	Yes
Annual public reporting of performance in a rating system	By star ratings from 2001 to 2005 and the annual 'Health Check' from 2006 to 2009	No	No	No
Charges and entitlements				
Free personal care services for the over 65s	No	No	Yes	No
Free prescriptions	No	Yes	Yes	Yes

Within Wales, Greer⁸² argues that the initial emphasis was on *localism*, which meant ‘integrating health and local government in order to coordinate care and focus on the wider determinants of health rather than treating the sick’, with the ambition of transforming its NHS ‘into a national Health service rather than a national Sickness service’. The Welsh health plan, published in February 2001, proposed to abolish the five existing health authorities and to replace them with 22 local health boards, geographically identical to the existing local authorities. The change took place in April 2003.⁸³ The health boards included representatives from local authorities to ensure local accountability and to reflect a new emphasis on joint working: ‘The goal of the new design is to make sure that health services reflect local needs rather than inherited patterns of funding or the desires of elites’.⁸⁴ A distinguishing feature of health policy in Wales was an attempt to focus on the wider social determinants of health, rather than just healthcare. Greer and Trench⁸⁵ note that the Welsh health plan of 2000 was a ‘strikingly original document that focused on health rather than the provision of health services and treated the NHS Wales as one more tool available to add quality and length of life, alongside education, police, transport and economic development’.⁸⁶ However, there is some evidence to suggest that the strong emphasis on public health was relatively short-lived because of public dissatisfaction with what was regarded as the relative neglect of the health services.⁸⁷

In 2003, the Welsh Wanless report, *Review of Health and Social Care in Wales*,⁸⁸ focused mainly on acute services. The strategy, *Designed for Life*,⁸⁹ published in 2005, which was principally concerned with reforming the NHS, in looking back at

improvements to services since 2001 listed reductions in waiting times, implying a desire to balance the emphasis on the wider determinants of health with a focus on personal health services’ performance. Wales, like Scotland, has moved away from the English emphasis on markets and competition towards a system based more on cooperation and integration. Following the formation of a coalition government in 2007, Welsh Labour and Plaid Cymru published an agenda for the government of Wales, which explicitly rejected the use of the private sector and of markets in healthcare and, following consultation,⁹⁰ has abolished the internal market and the purchaser/provider split.⁹¹

Due in part to the suspension of devolution between 2002 and 2007, and in part to concerns with sectarian representation and constitutional arguments, there have been relatively few major developments in health policy in Northern Ireland since devolution. The review of public administration, implemented by Westminster during the suspension of the Assembly, examined arrangements for the administration and delivery of public services in Northern Ireland and identified 150 public bodies serving a population of 1.7 million. For the health services, the review recommended that the four health and social services (HSS) boards and 18 of the 19 HSS trusts be replaced by five new health and personal social services (HPSS) agencies. Their functions would be to assess the needs of their populations, commission services, and to provide directly or secure the provision of such services, in partnership with the independent sector⁹² (hence leaving open the possibility of a continuation of the quasi-market).

The reconfiguration of the health services is currently ongoing. It is perhaps too early to say what direction health policy development in Northern Ireland will take; however, with a population of just 1.7 million, 50 per cent of whom live in rural areas and with high incidence of mental illness, a system based on England's NHS is not likely to be feasible. As one commentator noted, 'the future direction is expected to contain elements of Scottish redesign, Welsh localism and English devolved commissioning'.⁹³

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1. Davies, N (1999) *The Isles – A history*. London: Macmillan.
 2. Davies (1999) op. cit. Great Britain ought to include Wales and Scotland but not Northern Ireland; the UK ought to include Wales, Scotland and Northern Ireland. As Davies points out, using the term the British Isles to include the Republic of Ireland ignores the vital historical fact that this country is independent of the UK (pp xxiii–xli).
 3. Colley, L (1992) *Britons: Forging the nation, 1707–1937*. London: Yale University Press, p162.
 4. Robbins, K (2001) 'More than a footnote? Wales in British history', *North American Journal of Welsh Studies* 1(1) (Winter 2001). <http://spruce.flint.umich.edu/~ellisjs/Robbins.PDF>
 5. Davies (1999) op. cit. points out that: 'Until the end of the sixth century, all the main communities of Celtic Britannia were linked by swaths of contiguous territory' (p176). These communities included Men of the West (Wales), the North (Scotland) and the South West (which became Cornwall, still known to its natives as Kerno). The 'lands of the Irish' were well established on both sides of the Celtic sea. The new kingdom of the Scottish was founded by people of Irish origin (p149) (to the North of Hadrian's wall constructed in the second century) (p156). Offa's dyke, created in the eighth century, 'ensured that the "Men of the West" would never escape the isolation of their peninsula, that their language and culture would develop in directions not shared by other insular Celts, and

that far into the future they would assume a national identity' (p179). Following the Norman conquest of England, there were continuing territorial wars between countries later known as England, Ireland, Wales, Scotland and France. In the 16th century, divisions within England were clear: with the concentration of power in England's South East (pp403–4) and serious rebellions in regions remote from the South East, which were quashed; in Cornwall, where the persistence of its own Celtic Cornish language 'strengthened the belief that Cornwall was not just a county of England, but a country in its own right' (p404); and the North, which had 'remained a land apart' from the South East (p407).

6. Ibid. Ireland's bloody history following the plantation includes the killing of Protestants in the Ulster rising (1641) followed by the killing of Catholics under Cromwell's army at Drogheda and Wexford; the siege of the Protestant 'Apprentice Boys' in Derry (1689); the victory of William of Orange in the Battle of the Boyne (1690) and 'Bloody Sunday' (30 January 1972). For the 12-year inquiry into 'Bloody Sunday', which reported on 15 June 2010, see: www.bloody-sunday-inquiry.org/
7. Ibid. 'Unlike the attack on Ireland, which had been less than half a conquest, and unlike the abortive Edwardian conquest of Scotland, it was in both political and military terms a complete success' (p317). This conquest perpetuated the division of Wales into Marchia Walliae (the March of Wales), which was created following an earlier Norman onslaught, as private principalities as a barrier between the lands to the East and Wallia Pura (Wales proper) (p241). In the first decade of the 15th century, under the leadership of Owain ap Gruffydd Glyn Dwr (known in English as Owen Glendower), 'the Welsh staged the last and greatest of their attempts to shake off English domination', and a Welsh Parliament met (in 1404–05 at Machynlleth (pp369–70). But this struggle for independence did not succeed.
8. Ibid. The Scottish victory over the English in the battle of Bannockburn (1314) 'decided the independence of Scotland' (p322) following the successes of armies led by William Wallace (vividly portrayed in the film *Braveheart*) and meant that the English were unable to impose the Ordinance of Scotland, which resembled the Statute of Rhuddlan, and had sought to impose English law and government and ban all Scottish and Gaelic customs. When James VI King of Scotland became James I of England and Wales (1603), he also became King of Ireland, and sought

- but failed to unite these three kingdoms in one United Kingdom (pp467–70). Davies emphasises that English and Scottish historians see this Act in very different ways: for the Scottish this marked a historic turning point of a treaty between two independent parties; the English fail to see its significance and see this Act as Scotland being merged with England (p550).
9. Ibid. pp479–81. By two identical Acts of Union passed simultaneously in Dublin and London, which followed the successful defeat of the struggle for independence in 1789, by the United Irishmen led by Theobald Wolfe Tone (with support from the French).
 10. Ibid. This followed the Easter Rising (1916) and the British–Irish War (1919–21). The British Province of Northern Ireland included only six of Ulster’s ancient nine counties, and excluded three ‘for having too many Catholics’ (p770). The Republic of Ireland emerged after another struggle in which the ‘pro treaty’ party led by Michael Collins was defeated by the ‘anti treaty’ faction led by Eamon de Valera (p760). For details of the Anglo–Irish Treaty see <http://cain.ulst.ac.uk/issues/politics/docs/ait1921.htm>
 11. Colley (1992) op. cit. p13–4.
 12. Bevan and Fasolo (2010) op. cit.
 13. McClelland, S (2002) ‘Health policy in Wales – distinctive or derivative?’, *Social Policy and Society* 1: 325–33.
 14. Scottish Executive (2004) *Legal System*. www.scotland.gov.uk/Resource/Doc/925/0000078.pdf
 15. Bevan and Fasolo (2010) op. cit.
 16. Greer and Trench (2008) op. cit.
 17. This was reviewed by the *All Wales Convention Report* (Chair Sir Emyr Jones) (2009). <http://wales.gov.uk/docs/awc/publications/091118/thereporten.pdf>. The result of the referendum on 3 March 2011 was strong support for the Welsh Assembly to make laws on all matters in the 20 subject areas it has powers for, without needing agreement of the UK Parliament. See BBC News (2011), ‘Wales says Yes in referendum vote’, 4 March. www.bbc.co.uk/news/uk-wales-politics-12648649
 18. Levitt, R and Wall, A (1984) *The Reorganised National Health Service* (3rd edn). London: Croom Helm.
 19. Leathard, A (2000) *Health Care Provision: Past, present and into the 21st century* (2nd edn). Cheltenham: Stanley Thornes, p294.
 20. Levitt and Wall (1984) op. cit.
 21. Secretaries of State for Health, Wales, Northern Ireland and Scotland (1989) *Working for Patients*. Cm 555. London: HMSO.
 22. Bevan, G and Robinson, R (2005) ‘The interplay between economic and political logics: path dependency in health care in England’, *Journal of Health Politics, Policy and Law* 30(1–2): 53–78.
 23. Timmins, N (1995) *The Five Giants: A history of the welfare state*. London: Fontana, pp460–1.
 24. Norris, P (1997) ‘Anatomy of a Labour landslide’, *Parliamentary Affairs* 50: 509–32.
 25. Mays, N and Dixon, J (1996) *Purchaser Plurality in UK Health Care: Is a consensus emerging and is it the right one?* London: The King’s Fund.
 26. The 14 RHAs were abolished in 1994 and replaced by eight regional offices, which were abolished in 2001 and replaced by four new regional directorates of health and social care; these were abolished and replaced by 28 SHAs in 2003, which were abolished and replaced by ten SHAs in 2006.
 27. House of Lords Select Committee on the Barnett Formula (2009) *The Barnett Formula* (HL Paper 139). London: The Stationery Office.
 28. Anonymous (2004) ‘North East votes “no” to assembly’, Friday, 5 November. http://news.bbc.co.uk/1/hi/uk_politics/3984387.stm
 29. In a debate on devolution in November 1977, Mr Dalryell said: ‘For how long will English constituencies and English Honourable members tolerate... at least 119 Honourable Members from Scotland, Wales and Northern Ireland exercising an important, and probably often decisive, effect on British politics while they themselves have no say in the same matters in Scotland, Wales and Northern Ireland’. See http://news.bbc.co.uk/1/hi/uk_politics/7702326.stm
 30. See Greer and Trench (2008) op. cit., pp21–2.
 31. The Blair Government had a majority of only five on the vote on the legislation in the House of Commons; 46 Scottish MPs voted in favour. See Anonymous (2004) ‘Scots MPs attacked over fees vote’, 27 January. <http://news.bbc.co.uk/1/hi/scotland/3432767.stm>
 32. The Scottish Parliament has the power (under Part IV of the Scotland Act) to vary the basic rate of income tax applying in Scotland by up to plus or

- minus three pence in the pound. See the report from the Commission on Scottish Devolution (Chairman: Sir Kenneth Calman) (2009) *Serving Scotland Better: Scotland and the United Kingdom in the 21st century*. Edinburgh: Commission on Scottish Devolution, p8. www.commissiononscottishdevolution.org.uk/
33. HM Treasury (1998) *Comprehensive Spending Review: Aims and objectives*. London: HM Treasury. www.hm-treasury.gov.uk/d/460.pdf
 34. HM Treasury (2002) *How Public Service Agreement Targets from the 2000 Spending Review Translate into the 2002 Targets*. London: HM Treasury. www.hm-treasury.gov.uk/d/PSA_reconciliation.pdf ; HM Treasury (2004) *Spending Review 2004 Supporting Documents*. London: HM Treasury. www.hm-treasury.gov.uk/psp_supporting_docs.htm
 35. HM Treasury (2007) *Service Transformation Agreement*. London: HMSO. http://webarchive.nationalarchives.gov.uk/+http://www.hm-treasury.gov.uk/d/pbr_csr07_service.pdf
 36. Bevan and Fasolo (2010) op. cit.
 37. Secretary of State for Health (1997) *The New NHS: Modern, dependable*. Cm 3807. London: The Stationery Office. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008869
 38. Hence, as Klein (1998) argued, this policy could be seen as either the phasing out, or universalising, of the idea of GP fundholding. See Klein, R (1998) 'Why Britain is reorganizing its national health service – yet again', *Health Affairs* 17(4): 111–25.
 39. Abbasi, K (1998) 'Butchers and grocers', *BMJ* 317: 1599.
 40. Secretary of State for Health (2000) *An Inquiry into Quality and Practice within the National Health Service Arising from the Actions of Rodney Ledward (Chair J Ritchie)*. London: Department of Health. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4093337
 41. Secretary of State for Health (2001) *Learning from Bristol: Report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary (Chair Sir Ian Kennedy)*. Cm 5207(1). London: The Stationery Office. www.bristol-inquiry.org.uk/
 42. Leatherman, S and Sutherland, K (2003) *The Quest for Quality in the NHS: A mid-term evaluation of the ten-year quality agenda*. London: The Stationery Office.
 43. Secretary of State for Health (2002) *The NHS Cancer Plan: A plan for investment, a plan for reform*. London: Department of Health. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609
 44. Riddell, M (2000) 'The New Statesman interview – Robert Winston', www.newstatesman.com/200001170011
 45. Smee, C (2005) *Speaking Truth to Power: Two decades of analysis in the Department of Health*. Oxford: Radcliffe Press. Maynard, A and Street, A (2006) 'Seven years of feast, seven years of famine: boom to bust in the NHS?', *BMJ* 332: 906–8.
 46. The four PSA targets for 2000 were as follows: 1. Reduce substantially the mortality rates from major killers by 2010: from heart disease by at least 40 per cent in people under 75; from cancer by at least 20 per cent in people under 75; and from suicide and undetermined injury by at least 20 per cent. 2. Narrow the health gap between socioeconomic groups and between the most deprived areas and the rest of the country, in childhood and throughout life. 3. Treat patients at a time that suits them in accordance with their medical need: two-thirds of all outpatient appointments and inpatient planned admissions will be pre-booked by 2003/04, on the way to 100 per cent pre-booking by 2005. 4. Reduce the maximum wait for outpatient appointments to three months, and the maximum wait for inpatient treatment to six months by the end of 2005. Secure year-on-year improvements in patient satisfaction, including with standards of cleanliness and food, as measured by independently audited local surveys. HM Treasury (2002) op. cit.
 47. Secretary of State for Health (2000) *The NHS Plan*. Cm 4818-I. London: The Stationery Office. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960
 48. The commitments were to: 7,000 extra beds in hospitals and intermediate care; over 100 new hospitals by 2010 and 500 new one-stop primary care centres; over 3,000 GP premises modernised and 250 new scanners, 7,500 more consultants and 2,000 more GPs; 20,000 extra nurses and 6,500 extra therapists; 1,000 more medical school places. Secretary of State for Health (2000) op. cit. p11.
 49. The commitments were that, by 2004, patients will be able to have a GP appointment within 48 hours, long waits in A&E departments will be

- ended, by the end of 2005 the maximum waiting time for an outpatient appointment will be three months and for inpatients, six months. Secretary of State for Health (2000) op. cit. pp12–13.
50. See Sussex, J (2001) *The Economics of the Private Finance Initiative in the NHS*. London: Office of Health Economics. Pollock, AM, Shaoul, J and Vickers, N (2002) 'Private finance and "value for money" in NHS hospitals: a policy in search of a rationale?', *BMJ* 324: 1205–9.
 51. Barber, M (2007) *Instruction to Deliver: Tony Blair, the public services and the challenge of achieving targets*. London: Politico.
 52. Greer quoted a Labour special adviser saying in July 2006 that an unsatisfactory NHS will make the 'middle classes first vote against the NHS with their feet, and then with their votes'. In Greer (2008) op. cit.
 53. Barber (2007) op. cit.
 54. Secretary of State for Health (2000) op. cit.
 55. Bevan, G and Hood, C (2006) 'What's measured is what matters: targets and gaming in the English public health care system', *Public Administration* 84(3): 517–38.
 56. Bevan, G and Hamblin, R (2009) 'Hitting and missing targets by ambulance services for emergency calls: impacts of different systems of performance measurement within the UK', *Journal of the Royal Statistical Society* 172(1): 1–30.
 57. Secretary of State for Health (2002) *Delivering the NHS Plan*. Cm 5503. London: The Stationery Office. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005818. Allen, P (2009) 'Restructuring the NHS again: supply-side reform in recent English healthcare policy', *Financial Accountability and Management* 25(4): 373–89.
 58. Dixon, J (2004) 'Payment by results – new financial flows in the NHS', *BMJ* 328: 969–70. Department of Health (2002) *Reforming NHS Financial Flows: Introducing payment by results*. London: Department of Health.
 59. Audit Commission and Healthcare Commission (2008) *Is the Treatment Working?* London: Audit Commission. www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/isthetreatmentworking.aspx
 60. Preston, P (2009) 'In praise of targets', *The Guardian*, 19 October. www.guardian.co.uk/commentisfree/2009/oct/18/targets-work-topdown-cameron
 61. The Auditor General for Wales has produced three critical reports on the consequences of a lax regime in Wales and failure to achieve national targets for waiting times for hospitals and fast responses by ambulances to life-threatening emergency calls. Auditor General for Wales (2005a) *NHS Waiting Times in Wales. Volume 1 – The scale of the problem*. Cardiff: The Stationery Office. www.wao.gov.uk/reportsandpublications/2005.asp; Auditor General for Wales (2005b) *NHS Waiting Times in Wales. Volume 2 – Tackling the problem*. Cardiff: The Stationery Office. www.wao.gov.uk/reportsandpublications/2005.asp; Auditor General for Wales (2006) *Ambulance Services in Wales*. Cardiff: The Stationery Office. www.wao.gov.uk/reportsandpublications/1015.asp
 62. Anonymous (2009) 'The quality of care', *The Times*, 15 October. www.timesonline.co.uk/tol/comment/leading_article/article6875253.ece
 63. Care Quality Commission (2009) *Performance Ratings 2008/09*. London: Care Quality Commission. www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/annualhealthcheck2008/09.cfm
 64. See also: Bevan and Hood (2006) op. cit.; Bevan and Hamblin (2009) op. cit.; Secretary of State for Health (2002) op. cit.
 65. Bevan and Fasolo (2010) op. cit. The Centre for Public Policy for Regions (CPPR), a joint research initiative of the Universities of Glasgow and Strathclyde (CPPR, 2009) reports the percentages of pupils in their last year of compulsory education who achieved five or more good grades in comparable exams in each of the four countries before and after devolution. The percentages for each country in 1998/99, from worst to best, were: Wales, 47.5 per cent; England, 47.9 per cent; Northern Ireland, 56.0 per cent; and Scotland, 57.8 per cent. In 2006/07, the percentages, from worst to best, were: Wales, 54.2 per cent; Scotland, 57.5 per cent; England, 62 per cent; and Northern Ireland, 64.5 per cent. See CPPR (2009) *Spending on School Education: Scottish government budget options briefing series no 1*. Table 3A: Attainment Data: The per cent of pupils in their last year of compulsory education who achieve five or

- more grades A–C GCSEs or SNQ equivalents, p5. www.cppr.ac.uk/media/media_133107_en.pdf
66. Auditor General for Wales (2005a) op. cit., p16.
 67. Bevan and Hamblin (2009) op. cit.
 68. Auditor General for Wales (2005b) op. cit.
 69. National Assembly for Wales (2003) *The Review of Health and Social Care in Wales*. Cardiff: National Assembly for Wales.
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 74. Greer and Trench (2008) op. cit.
 75. Greer (2004) op. cit.
 76. Greer (2008) op. cit.
 77. Harrington and others (2009) op. cit.
 78. Jervis (2008) op. cit.
 79. Jervis and Plowden (2003) op. cit.
 80. Dickinson, H, Glasby, J, Forder, J and Beesley, L (2007) ‘Free personal care in Scotland: a narrative review’, *British Journal of Social Work* 37: 459–74.
 81. BMA Health Policy and Economic Research Unit (2007) *Devolution and Health Policy: A map of divergence within the NHS – 1st annual update, April 2007*. London: British Medical Association. www.bma.org.uk/images/DevolutionPaper_tcm41-147302.pdf
 82. Greer (2004) op. cit.
 83. Jervis and Plowden (2003) op. cit.
 84. Greer and Trench (2008) op. cit.
 85. Ibid.
 86. Greer (2004) op. cit.
 87. Smith and Babbington (2006) op. cit.; Jervis and Plowden (2003) op. cit.
 88. Wanless, D (2003) *Review of Health and Social Care in Wales*. Cardiff: Welsh Assembly Government.
 89. Welsh Assembly Government (2005) *Designed for Life*. Cardiff: Welsh Assembly Government. www.wales.nhs.uk/documents/designed-for-life-e.pdf
 90. Welsh Assembly Government (2008) *Proposals to Change the Structure of the NHS in Wales*. <http://wales.gov.uk/consultations/healthsocialcare/nhswales/?lang=en>
 91. Welsh Assembly Government (2009) *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009*. <http://wales.gov.uk/publications/accessinfo/dnewhomepage/healthdrs/Healthdrs2009/lhbregs09/?lang=en>
 92. Jervis (2008) op. cit.
 93. Lang, O (2007) ‘Devolution in practice: health policy. Proceedings from a summit on devolved national health services in the UK’, *New Statesman*, 29 January.

CHAPTER 3

METHODS

Cross-country comparisons

The aim of the first analysis in this report is to compare a set of indicators relating to populations, NHS inputs, activity and performance at three points in time across the four NHSs of the UK. The time points were 1996/97, 2002/03 and 2006/07 (hereafter referred to as 1996, 2002 and 2006) and reflect the period before and after devolution in the UK. Data for the two earlier periods were obtained from a previous study,¹ which, in turn, determined which trend indicators could be included in the current analysis. These indicators relate to:

- life expectancy;
- NHS expenditure;
- staffing levels (hospital medical and dental staff, GPs, nursing, midwifery and health visiting staff, and management and support staff);
- activity (outpatient appointments, inpatient admissions and day cases);

- crude productivity (level of activity per hospital medical and dental staff, and nursing, midwifery and health visiting staff);
- number of various medical procedures performed;
- waiting times and ambulance response times;
- satisfaction with the NHS.

The indicators relate only to NHS patients and exclude privately financed activity. The Appendix (see p115) details the definition and source of each of the indicators included in the analysis, gives the table or figure to which each indicator relates and highlights issues surrounding the comparability of the indicators across the countries and over time. Much effort was expended to ensure that the indicators included in the analysis were defined and measured in the same way in each of the countries and at each time point. Table 3.1 gives a list of these indicators.

This report has mentioned problems in making comparisons caused by differences in definition both between countries and

over time. These differences mean that the following comparisons could not be made:

- The performance of the NHS in Scotland in reducing waiting times with that of the other countries at any time. This is because Scottish policies used before 2007 for suspension of patients on waiting lists in Scotland differed from the other countries. So, the raw data reported by each country are misleading if used for cross-country comparisons.²
- Statistics on management and support staff for Scotland or Northern Ireland with each other, or with England and Wales. This is because these statistics for Scotland include clinical support staff, and for Northern Ireland include social services.
- Statistics for inpatients for Scotland for 2006 with other countries for 2006, or with statistics for Scotland for the earlier years. This is because these statistics for Scotland for 2006 are based on spells, but the statistics for the earlier years for Scotland and all years in the other countries are based on finished consultant episodes (FCEs; a spell in hospital may include care provided by consultants in different specialties that generate a number of FCEs).
- Statistics for Wales for day cases either over time for Wales, or with the other countries for 1996 and 2006. This is because there are no data in 1996, and there was a change in the definition of day cases between 2002 and 2006.
- Statistics for Wales for outpatients for 2006 compared with earlier years for Wales, or with the other countries for 2006. This is because these statistics were affected by the change in the definition of day cases between 2002 and 2006.
- Treatment rates in Northern Ireland, as these data omit people accessing treatment in a jurisdiction other than where they are resident (for example, approximately one-third of coronary artery bypass grafts (CABG) performed on the residents of Northern Ireland take place in England or the Republic of Ireland).³

Table 3.1: List of indicators included in the cross-country analysis

Figure 4.1	Male life expectancy at birth in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.2	Female life expectancy at birth in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.3	NHS expenditure per capita in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.4	Relative per capita spend on NHS and public expenditure (2006/07; UK = 100)
Figure 4.5	Hospital medical and dental staff (whole time equivalents) per 1,000 population in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.6	GPs per 1,000 population in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.7	Nursing, midwifery and health visiting staff (whole time equivalents) per 1,000 population in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.8	Hospital management and support staff (whole time equivalents) per 1,000 population in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.9	Total outpatient appointments per 1,000 population in England, Scotland and Northern Ireland (1996, 2002 and 2006) and Wales (1996, 2002)
Figure 4.10	Day cases per 1,000 population in England, Scotland and Northern Ireland (1996, 2002 and 2006)
Figure 4.11	Inpatient admissions per 1,000 population in England, Wales and Northern Ireland (1996, 2002 and 2006) and Scotland (1996, 2002)
Figure 4.12	Outpatient appointments per hospital medical and dental staff member in England, Scotland and Northern Ireland (1996, 2002 and 2006) and Wales (1996, 2002)
Figure 4.13	Inpatient admissions per hospital medical and dental staff member in England, Wales and Northern Ireland (1996, 2002 and 2006) and Scotland (1996, 2002)
Figure 4.14	Day cases per hospital medical and dental staff member in England, Scotland and Northern Ireland (1996, 2002 and 2006)

Table 3.1: List of indicators included in the cross-country analysis (continued)

Figure 4.15	Outpatient appointments per nursing, midwifery and health visiting staff member in England, Scotland and Northern Ireland (1996, 2002 and 2006) and Wales (1996, 2002)
Figure 4.16	Inpatient admissions per nursing, midwifery and health visiting staff member in England, Wales and Northern Ireland (1996, 2002 and 2006) and Scotland (1996, 2002)
Figure 4.17	Day cases per nursing, midwifery and health visiting staff member in England, Scotland and Northern Ireland (1996, 2002 and 2006)
Table 4.1	Activity: operation rates (per 10,000) for selected hospital procedures in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.18	Percentage of the population waiting less than six months for day case or inpatient admission in England, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.19	Percentage of the population waiting less than three months for outpatient appointment in England, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.20	Percentage of category A ambulance calls met within eight minutes in England, Scotland and Wales (1999 to 2006)
Figure 4.21	Percentage of the population reporting satisfaction with the general running of the NHS in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.22	Percentage of the population reporting satisfaction with inpatient care in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.23	Percentage of the population reporting satisfaction with outpatient care in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)
Figure 4.24	Percentage of the population reporting satisfaction with GP care in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)

The second aim of the analysis is to determine how differences in policy across the four constituent parts of the UK since devolution have affected the performance of the NHS in each of the countries. Such an analysis is complicated by the fact that the four countries differ not only in terms of the policy path they have chosen, but also in terms of their size; distributions of their populations between cities, towns and sparsely populated rural areas; socioeconomic characteristics; ethnic composition; and morbidity: all of which may shape the workings of the health system regardless of the policy path pursued.

To try and untangle the impact of policy on the health services from the impact of these other influences, the authors undertook a cross-sectional, comparative analysis of the devolved countries with the regions of England. A regional analysis has two advantages. First, the demographic and

socioeconomic composition of the North East and North West regions of England are closer to those of Scotland, Wales and Northern Ireland than the averages for England: hence, differences observed between these regions and the other three countries are more likely to be explained by differences in policy. Second, this analysis brings out the heterogeneity of the regions of England, which is lost in reporting national averages. In addition to the problems of differences in definition identified above, which limit the scope for meaningful cross-country comparisons, there are similar limits to the comparisons that can be made between the devolved countries and the English regions. In particular, there is a problem in comparing the availability of hospital beds between Scotland and the other countries. Therefore Scotland has been excluded from that comparison. Table 3.2 gives a list of indicators included in the regional analysis.

Table 3.2: List of indicators included in the comparison of Scotland, Wales and Northern Ireland and the English regions

Figure 5.1	Populations of the nine English GORs and Scotland, Wales and Northern Ireland (2006)
Table 5.1	Selected socioeconomic indicators for the UK, English GORs, England, Wales, Scotland and Northern Ireland (2006)
Figure 5.2	Selected socioeconomic indicators for Scotland, Wales, Northern Ireland and the North East region of England (2006; England = 100)
Figure 5.3	SMRs (males and females separately) of the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)
Figure 5.4	Perinatal and infant mortality rates of the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)
Figure 5.5	Life expectancy at birth of the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)
Figure 5.6	Percentage of the population aged 65–74 for males and 60–74 for females and aged 75 and over in the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)
Figure 5.7	Percentage of the population reporting longstanding illness, LLSI and restricted activity in the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)
Figure 5.8	Selected health indicators for Scotland, Wales, Northern Ireland and the North East region of England (2006; England = 100)
Figure 5.9	Total NHS expenditure per capita for the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)
Table 5.2	Comparisons of SMRs and per capita spend for the nine English GORs and Scotland, Wales and Northern Ireland (2006)
Figure 5.10	Available hospital beds per 1,000 population for the ten English SHAs and England, Wales and Northern Ireland (2006)

Table 3.2: List of indicators included in the comparison of Scotland, Wales and Northern Ireland and the English regions (continued)

- Figure 5.11 Hospital medical and dental staff (whole time equivalents) per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)
- Figure 5.12 Nursing, midwifery and health visiting staff (whole time equivalents) per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)
- Figure 5.13 Management and support staff (whole time equivalents) per 1,000 population in the ten English SHAs and England and Wales (2006)
- Figure 5.14 GPs per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)
- Figure 5.15 Staff per 1,000 population for Scotland, Wales, Northern Ireland and the North East region of England (2006; England = 100)
- Figure 5.16 Total outpatient appointments per 1,000 population in the nine GORs of England and England, Scotland and Northern Ireland (2006)
- Figure 5.17 Day cases per 1,000 population in the nine GORs of England and England, Scotland and Northern Ireland (2006)
- Figure 5.18 Inpatient admissions per 1,000 population in the nine GORs of England and England, Wales and Northern Ireland (2006)
- Figure 5.19 Treatment rates per 1,000 population for Scotland, Northern Ireland and the North East region of England (2006; England = 100)
- Figure 5.20 Outpatient appointments per hospital medical and dental staff member in eight regions of England and England, Scotland and Northern Ireland (2006)
- Figure 5.21 Inpatient admissions per hospital medical and dental staff member in eight regions of England and England, Wales and Northern Ireland (2006)

Table 3.2: List of indicators included in the comparison of Scotland, Wales and Northern Ireland and the English regions (continued)

Figure 5.22	Day cases per hospital medical and dental staff member in eight regions of England and England, Scotland and Northern Ireland (2006)
Figure 5.23	Outpatient appointments per nursing, midwifery and health visiting staff member in eight regions of England and England, Scotland and Northern Ireland (2006)
Figure 5.24	Inpatient admissions per nursing, midwifery and health visiting staff member in eight regions of England and England, Wales and Northern Ireland (2006)
Figure 5.25	Day cases per nursing, midwifery and health visiting staff member in eight regions of England and England, Scotland and Northern Ireland (2006)
Figure 5.26	Percentage waiting more than 13 weeks for inpatient or day case admission for the ten English SHAs and England, Wales and Northern Ireland (March 2008)
Table 5.3	Numbers and percentage of the population waiting less than 13 weeks for inpatient or day case admission or an outpatient appointment in the ten English SHAs and England, Wales and Northern Ireland (March 2008)
Table 5.4	Percentage of the population waiting less than six weeks, six to 12 weeks and 12 weeks or more for inpatient or day case admission or an outpatient appointment in the ten SHAs of England (March 2006)
Box 5.1	Indicators for which Scotland, Wales and Northern Ireland are outliers as compared with English regions (2006)

A difficulty with the regional analysis was that some indicators are reported for the nine government office regions (GORs),⁴ while others are reported for the ten SHAs. Eight of the ten SHAs in England are geographically identical to the GORs; however, the South East region is divided into two SHAs – South East Coast and South Central. As the ten SHAs were created in 2006, it is not possible to make comparisons through time. But there may be scope for future research to develop longitudinal

comparisons using the North East, the chosen region in England to compare with the devolved countries, as the North East region can be identified for comparative purposes from 1974 to 1996 and from 2003.

Finally, Table 3.3 shows where the indicators that have been identified are and are not comparable across the four countries.

Table 3.3: Comparability of indicators across the four countries

Indicator	England	Scotland	Wales	Northern Ireland
Populations (a)	✓	✓	✓	✓
Standardised mortality ratios (SMRs) (males and females separately) (a)	✓	✓	✓	✓
Perinatal and infant mortality rates (a)	✓	✓	✓	✓
Life expectancy at birth (a)	✓	✓	✓	✓
Available hospital beds	✓	✓ question over mix of long stay and acute	✓	✓
Percentages of the population reporting longstanding illness, LLSI and restricted activity (a)	✓	✓	✓	✓
Total NHS expenditure (a)	✓	✓	✓	✓
Life expectancy at birth (a)	✓	✓	✓	✓

Note: (a) For nine English GORs also.

Table 3.3: Comparability of indicators across the four countries (continued)

Indicator	England	Scotland	Wales	Northern Ireland
Hospital medical and dental staff (whole time equivalents) (b)	✓	✓	✓	✓
GPs (b)	✓	✓	✓	✓
Nursing, midwifery and health visiting staff (whole time equivalents) (b)	Qualified only	Qualified	Qualified only	Qualified only
Management and support staff (whole time equivalents; excludes clinical support staff) (b)	Excludes clinical support staff	Includes clinical support staff	Excludes clinical support staff	Includes Social Services
Day cases (b)	✓	✓	Problem with definition of day cases	✓
Inpatient admissions (b)	Episodes	Spells	Episodes	Episodes
Outpatient appointments (b)	✓	✓	Problem with definition of day cases	✓

Note: (b) For ten SHAs also.

Table 3.3: Comparability of indicators across the four countries (continued)

Indicator	England	Scotland	Wales	Northern Ireland
Numbers waiting less than six months for day case or inpatient admission (b)	✓	Problem over patients suspended from waiting list	✓	✓
Numbers waiting less than three months for outpatient appointment (b)	✓	Problem over patients suspended from waiting list	✓	✓
Percentage of category A ambulance calls met within eight minutes (b)	✓	✓	✓	NA
Percentage of the population reporting satisfaction with (b):				
• the general running of the NHS	✓	✓	✓	✓
• inpatient care	✓	✓	✓	✓
• outpatient care	✓	✓	✓	✓
• GP care	✓	✓	✓	✓
Numbers waiting more than 13 weeks for inpatient or day case admission (b)	✓		✓	✓
Numbers waiting less than 13 weeks for inpatient or day case admission or outpatient appointment (b)	✓	Problem over patients suspended from waiting list	✓	✓

Note: (b) For ten SHAs also.

-
1. Alvarez-Rosete and others (2005) op. cit.
 2. The difference in definition applies to patients who are suspended from the waiting list. In England, patients are added back to the list once they become available for treatment, but in Scotland these patients were not added to the list when they became available. See Audit Scotland (2006) *Tackling Waiting Times in the NHS in Scotland*. Edinburgh: Audit Scotland, p52. www.audit-scotland.gov.uk/utilities/search_report.php?id=237 . In Scotland, until this practice was abolished in 2002, there were two waiting lists – a ‘true’ and a ‘deferred’ waiting list: the latter consisted of patients ‘unavailable for admission for a period of time for medical or social reasons, or if the patient did not attend on an offered admission date’. For those patients, although they could be selected for admission, they did not transfer back to the ‘true’ waiting list. Audit Scotland (2006) *Review of the Management of Waiting Lists in Scotland*. Edinburgh: Audit Scotland, p3. www.audit-scotland.gov.uk/utilities/search_report.php?id=325 . But issues remain over ‘hidden’ waiting lists. See, for example, Anonymous (2008) ‘Hidden waiting lists “abolished”’, 27 May. <http://news.bbc.co.uk/1/hi/scotland/7421205.stm> . The definitional problems posed by the Scottish practice has been the subject of commentaries from governments in Northern Ireland and Wales. Stewart, T (2006) *Comparison of UK Waiting Times Definition*. Belfast: Department of Health, Social Services and Public Safety. Eason, C and Stevenson, D (2005) *NHS Wales Hospital Waiting Times, 30 September 2005*. Cardiff: National Assembly for Wales. See also Godden, S and Pollock, A (2009) ‘Waiting list and waiting time statistics in Britain: a critical review’, *Public Health* 123(1): 47–51.
 3. Dougal, A (2009) ‘More local surgery needed’, *Journal of Northern Ireland Chest, Heart and Stroke* 27: 3.
 4. The North East, North West, Yorkshire and The Humber, East Midlands, West Midlands, East of England, London, South East and South West.

CHAPTER 4

CROSS-COUNTRY COMPARISONS

Life expectancy

Over the ten-year period of analysis (1996–2006), there were general improvements in population health in each of the four countries of the UK. Life expectancy increased by approximately 2.5 and 2.0 years for males and females, respectively (Figures 4.1 and 4.2). The percentage increase in life expectancy was similar in each country. There were also improvements in infant and perinatal mortality, and self-reported health. However, inequalities remain between the countries: males born in England in 2005 can expect to live longer than their counterparts in Scotland by two and a half years on average, in Northern Ireland by one year and in Wales by six months.

Figure 4.1: Male life expectancy at birth in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)

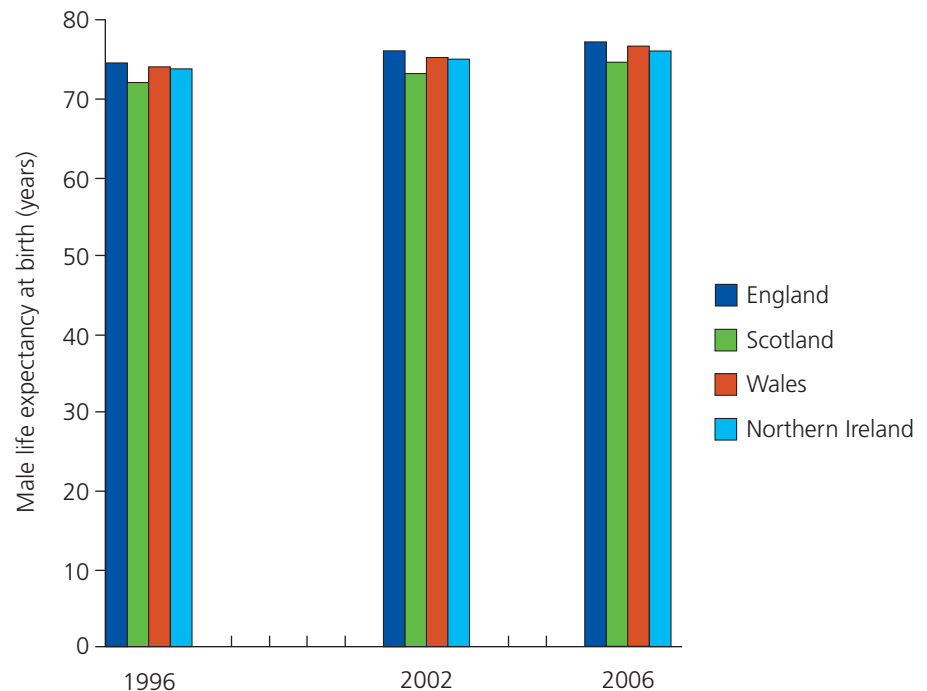
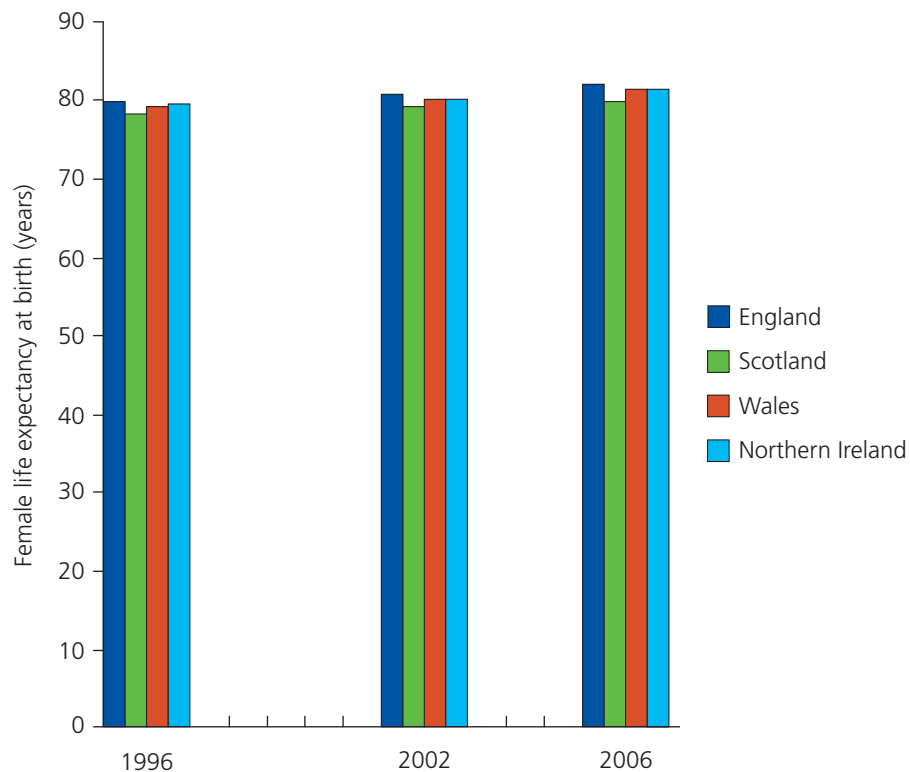


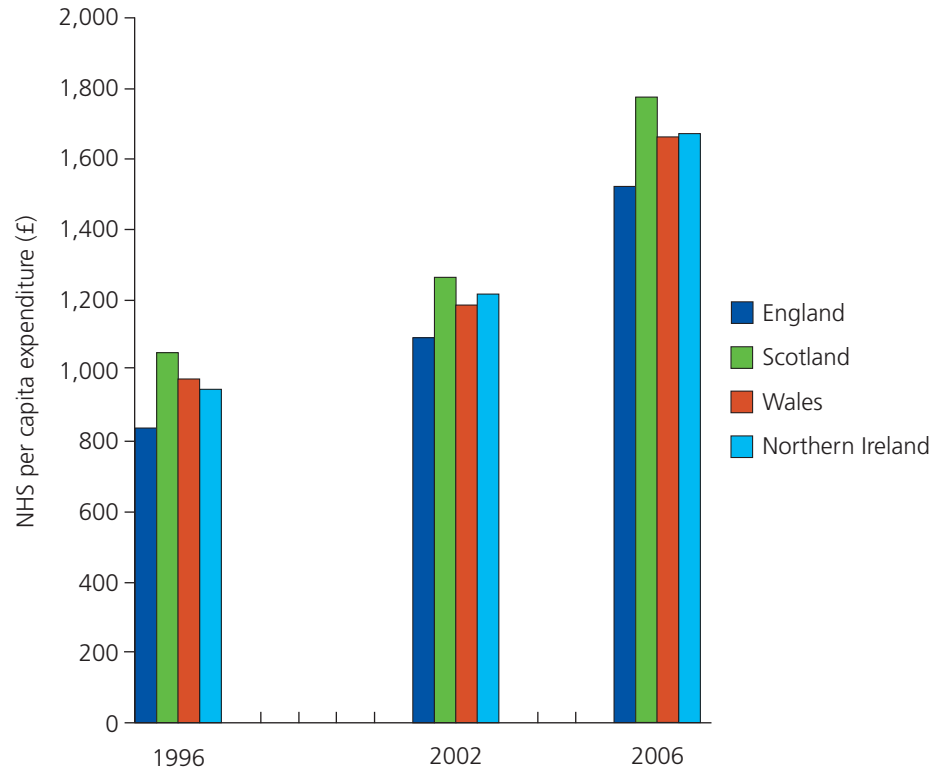
Figure 4.2: Female life expectancy at birth in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)



Expenditure

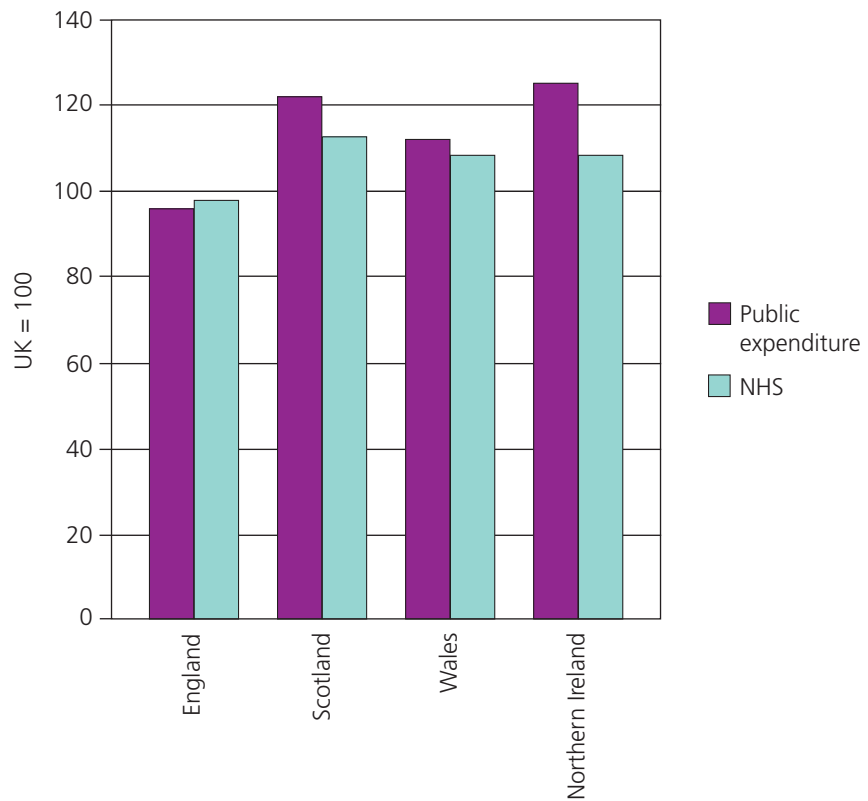
Figure 4.3 gives NHS expenditure per capita in cash (that is, not adjusted for inflation) over the ten years from 1996 to 2006 and shows that, for England this increased by 82 per cent, and for the devolved countries by a lesser extent: 69 per cent in Scotland, 72 per cent in Wales and 77 per cent in Northern Ireland. Figure 4.4 compares relative per capita spending on the NHS and total identifiable public expenditure less social security payments for each country, for 2006, standardised with the average for the UK (of 100). This shows that only in England was its per capita spend relative to the UK average greater for the NHS than for total devolved public expenditure. Figures 4.3 and 4.4 show that the increased spending on the NHS in England has been used to finance increased spending on other services in the devolved countries; but despite this, in each of the three years shown, England and Scotland had the lowest and highest per capita spend,

Figure 4.3: NHS expenditure per capita in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)



respectively. The decisions to spend more on other devolved services in Scotland mean that the percentage excess spend in Scotland over England declined from 23 per cent to 16 per cent between 1996 and 2006.

Figure 4.4: Relative per capita spend on NHS and public expenditure (2006/07; UK = 100)



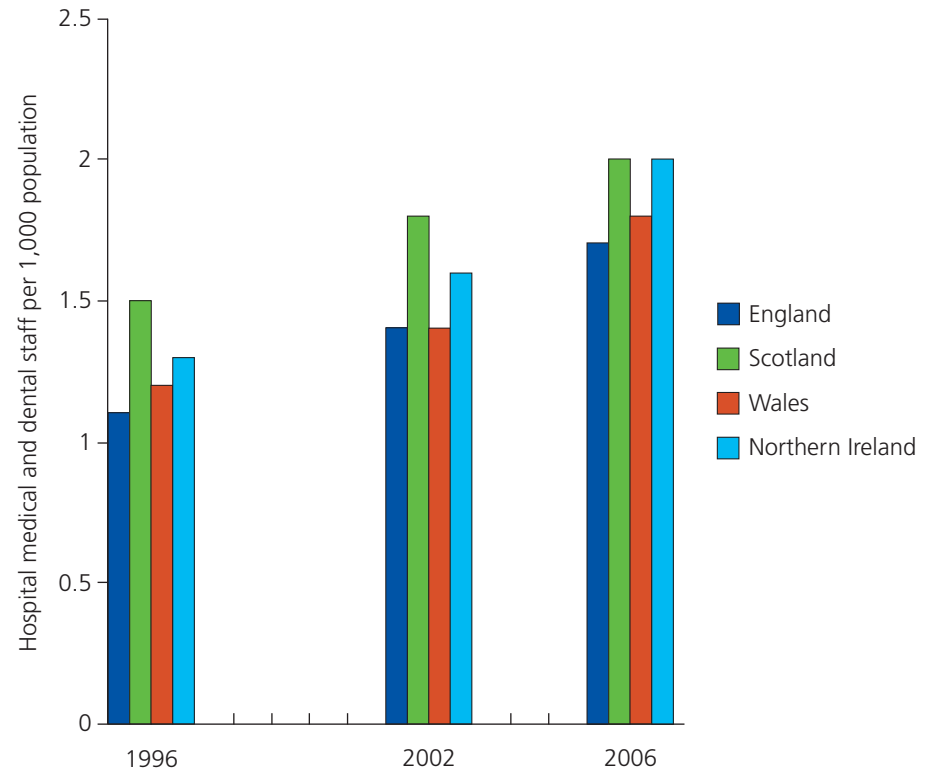
Workforce

The increases in funding that applied to each UK country had different impacts on numbers of NHS staff, depending on the staff type and the country, but tended to magnify the marked differences existing between each country in 1996. In 2006, Scotland had the highest rates per capita of clinical staff, Northern Ireland the highest rates for management and support staff while England had the lowest rates for all staff, except for GPs, for which Wales had the lowest rate.¹

Hospital medical and dental staff

Figure 4.5 gives the rates of hospital medical and dental staff per 1,000 population. This shows that Scotland had the highest rates in 1996. Between 1996 and 2006, England had the greatest increase (55 per cent), followed by Northern Ireland (54 per cent), Wales (50 per cent) and Scotland (33 per cent). In 2006, the rate was 18 per cent higher in Scotland and Northern Ireland than in England (the country with the lowest rates).

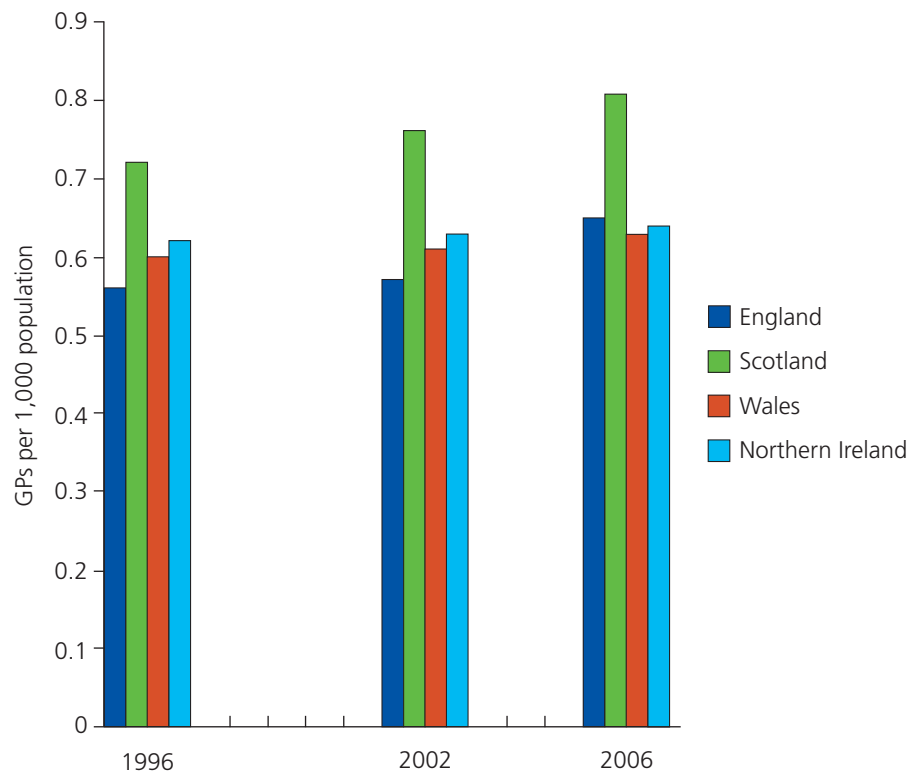
Figure 4.5: Hospital medical and dental staff (whole time equivalents) per 1,000 population in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)



General practitioners (GPs)

Figure 4.6 gives the rate of GPs per 1,000 population. This shows that Scotland had the highest rate in 1996. Between 1996 and 2006, there were only minor increases in Wales (5 per cent) and Northern Ireland (3 per cent), but substantial increases in England (18 per cent) and Scotland (16 per cent). In 2006, the rate was 29 per cent higher in Scotland than in Wales (the country with the lowest rate).

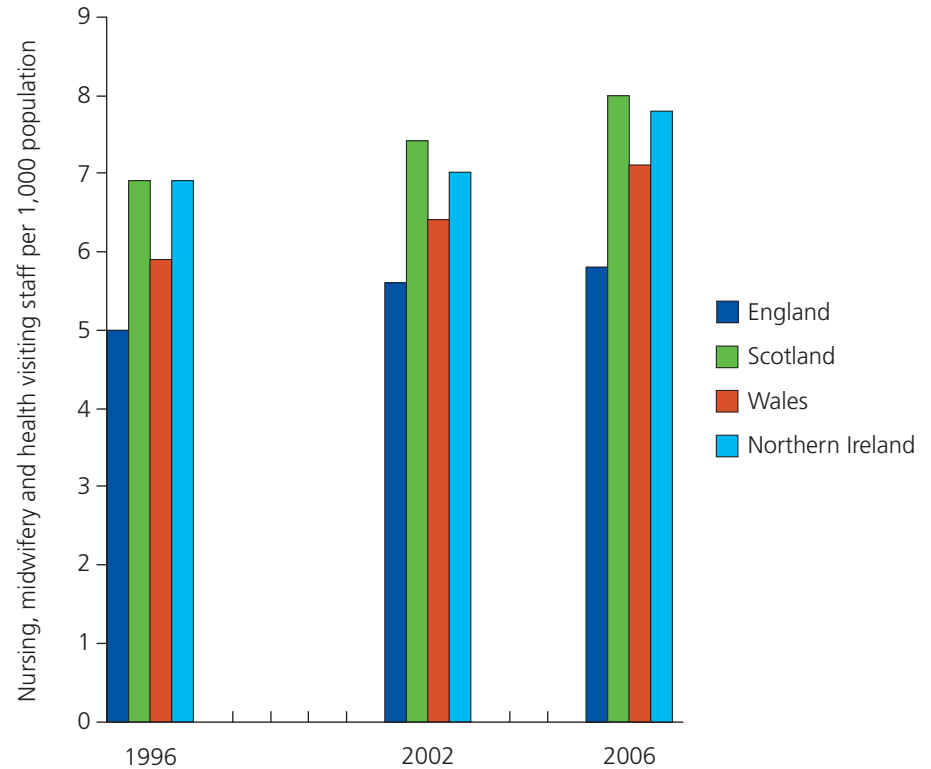
Figure 4.6: GPs per 1,000 population in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)



Nursing staff

Figure 4.7 gives the rate of nursing, midwifery and health visiting staff per 1,000 population. Rates of nursing staff increased in each country between 1996 and 2006, by 16 per cent in England and Scotland, 20 per cent in Wales and 13 per cent in Northern Ireland. In 2006, Scotland and Northern Ireland had similar rates, which were significantly greater than that of England.

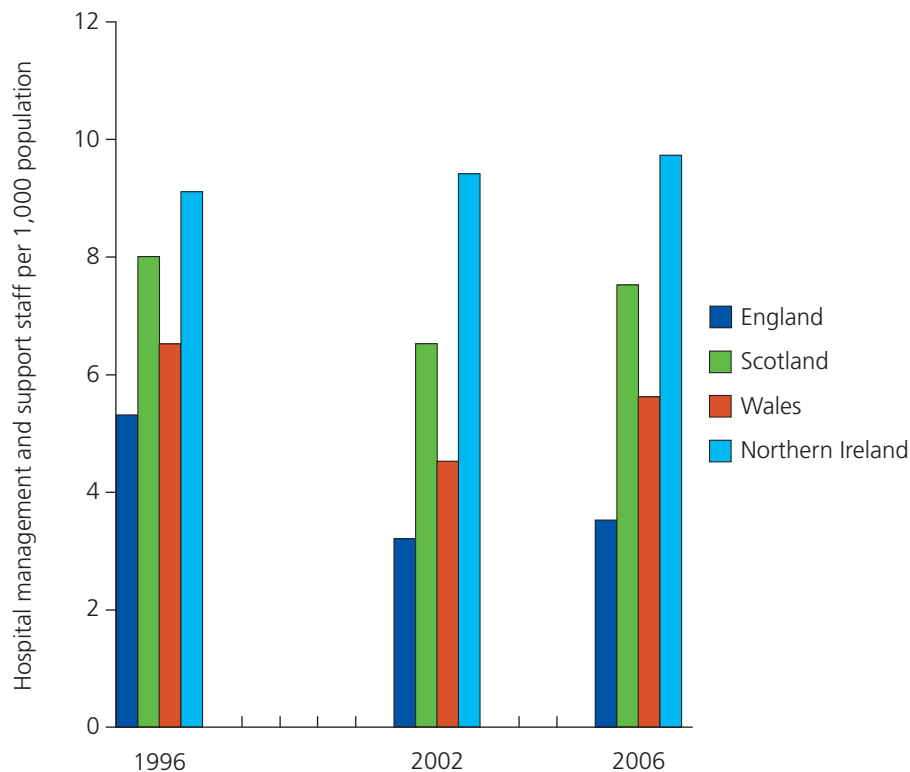
Figure 4.7: Nursing, midwifery and health visiting staff (whole time equivalents) per 1,000 population in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)



Management and support staff

Figure 4.8 shows the rate of NHS management and support staff per 1,000 population. Figures for Scotland and Northern Ireland are not directly comparable to those for England and Wales because of the inclusion of administrative and other support to direct care staff in Scotland, and the inclusion of staff working within personal social services in Northern Ireland. In England, Scotland and Wales, the rates of management and support staff decreased over the ten-year period 1996 to 2006, while in Northern Ireland the rate increased.

Figure 4.8: Hospital management and support staff (whole time equivalents) per 1,000 population in England, Scotland, Wales and Northern Ireland* (1996, 2002 and 2006)



* As health boards incorporate the NHS and social services in Northern Ireland, the figures for Northern Ireland include management and support staff working in the NHS and social services.

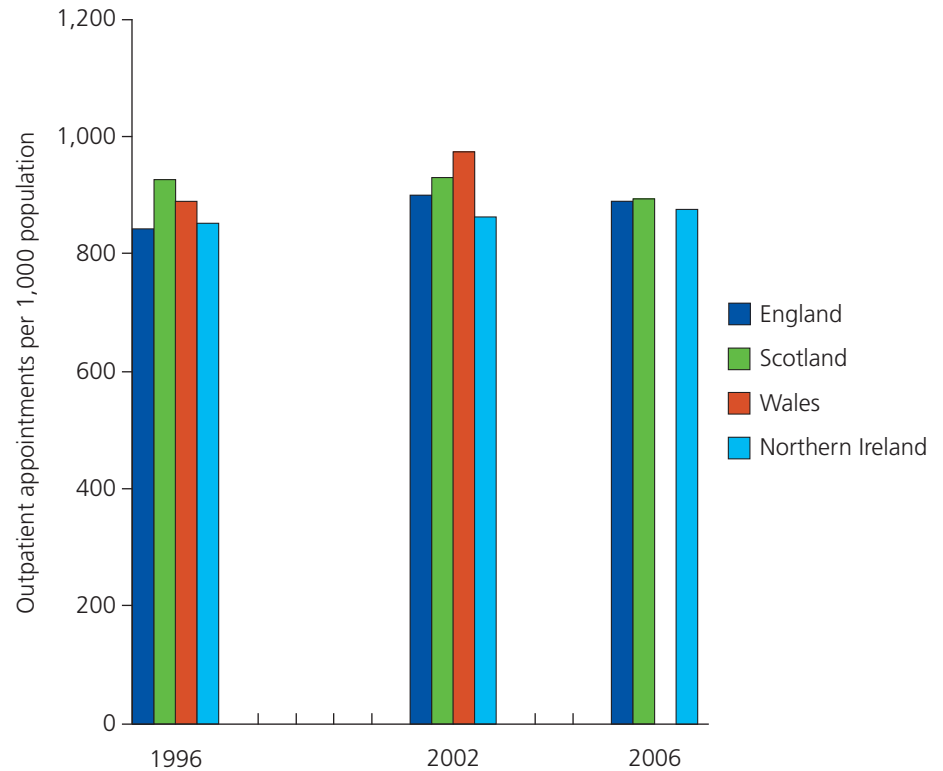
Activity

Reported here are rates, per 1,000 population, for outpatient appointments, day cases and inpatient admissions.

Outpatients

Given concerns over the comparability of data, outpatient data for Wales in 2006 have been excluded from the analysis. Figure 4.9 shows that there was a small increase in the rates of outpatient appointments between 1996 and 2002 in all four countries; however, rates decreased slightly between 2002 and 2006 in England and Scotland, and increased in Northern Ireland. In 2006, rates of outpatients ranged from 893 in Scotland to 874 in Northern Ireland.

Figure 4.9: Total outpatient appointments per 1,000 population in England, Scotland and Northern Ireland (1996, 2002 and 2006) and Wales (1996, 2002)

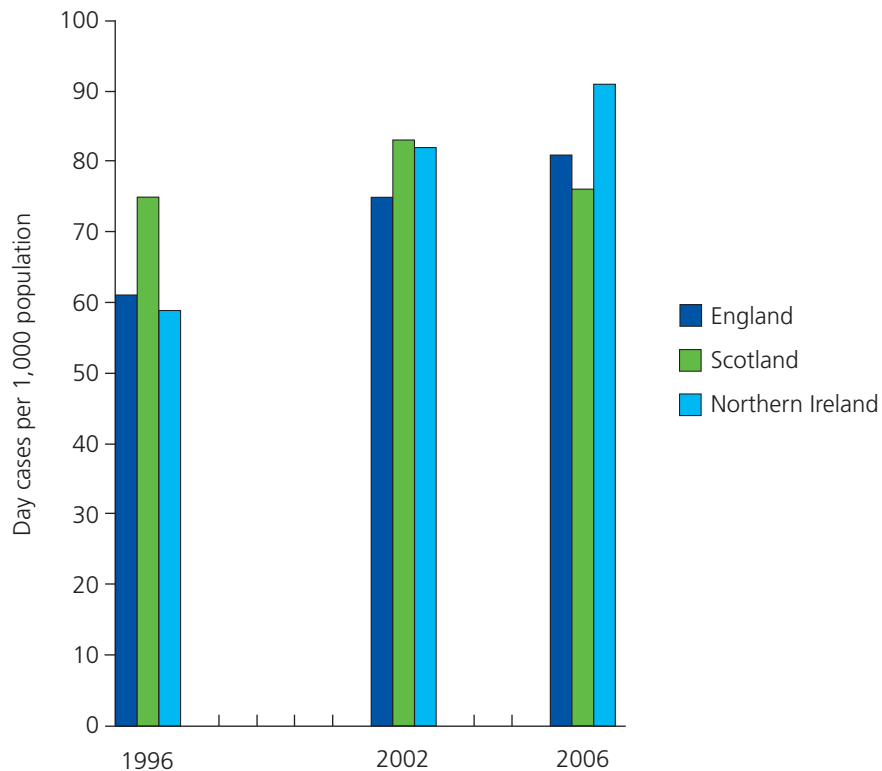


Day cases

Changes in the definition of day cases in Wales meant that it was not possible to include comparable data for Wales.

Figure 4.10 shows that there was an increase in the rates of day cases in England and Northern Ireland between 1996 and 2002, and 2002 and 2006; while in Scotland there was an increase in the first, but a decrease in the second time period. In 2006, day case rates ranged from 91 in Northern Ireland to 76 in Scotland. These data should be treated with care, since it is not absolutely clear whether the definitions of a day case are comparable between countries and over time.

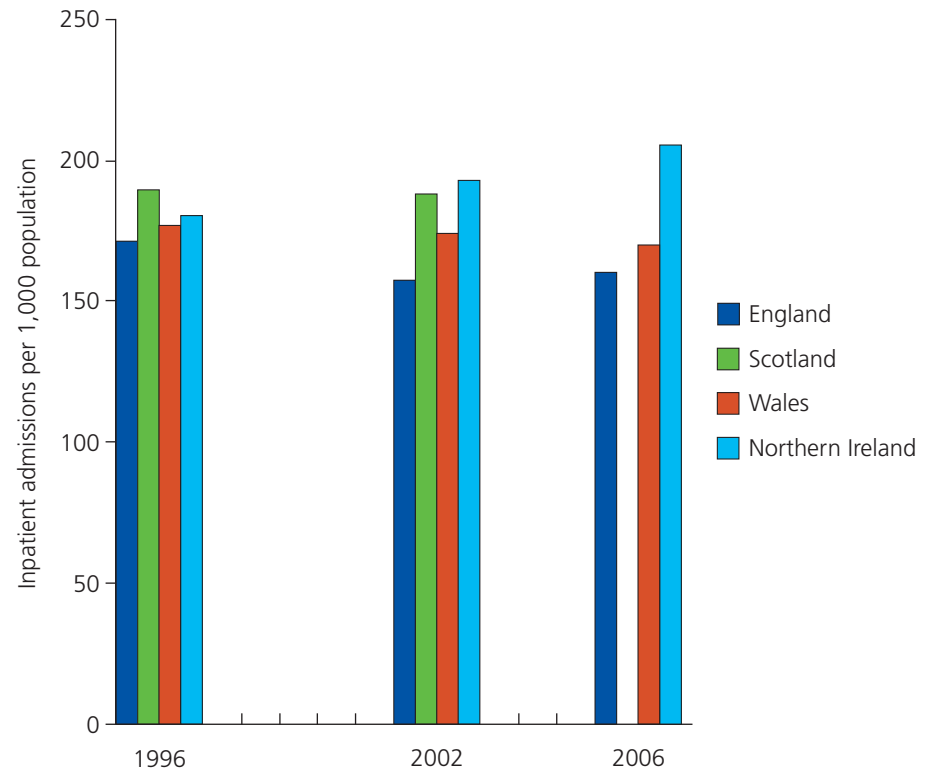
Figure 4.10: Day cases per 1,000 population in England, Scotland and Northern Ireland (1996, 2002 and 2006)



Inpatients

Figure 4.11 shows the rate of inpatient admissions per 1,000 population; data for Scotland in 2006 have been excluded. Between 1996 and 2006, there were decreases in the rate in England and Wales, but an increase in Northern Ireland. There was little change in the rate in Scotland between 1996 and 2002. In 2006, the rate varied from 160 in England to 205 in Northern Ireland.

Figure 4.11: Inpatient admissions per 1,000 population in England, Wales and Northern Ireland (1996, 2002 and 2006) and Scotland (1996, 2002)



Crude productivity²

Reported here are crude productivity rates for hospital medical and dental staff, and nursing, midwifery and health visiting staff. These are numbers of outpatient appointments, inpatient admissions and day cases per hospital medical and dental staff member or nursing, midwifery and health visiting staff member; and do not take account of changes in quality of care or outcomes. Generally, there were falls in crude productivity because increases in staff outstripped increases in activity. Crude productivity is reported in terms of changes in annual numbers of outpatient appointments, inpatient admissions and day cases per hospital medical and dental staff member, and nursing, midwifery and health visiting staff member (with percentages in parenthesis).

Crude productivity of hospital medical and dental staff

Outpatient data for Wales in 2006 have been excluded. Figure 4.12 shows that between 1996 and 2006, the reduction in the rate of outpatient appointments per hospital medical and dental staff member was 243 in England (32 per cent), 171 in Scotland (28 per cent) and 218 in Northern Ireland (33 per cent); the decrease in Wales was 46 (6 per cent) between 1996 and 2002. The rate varied from 437 in Northern Ireland to 523 in England in 2006.

Figure 4.12: Outpatient appointments per hospital medical and dental staff member in England, Scotland and Northern Ireland (1996, 2002 and 2006) and Wales (1996, 2002)

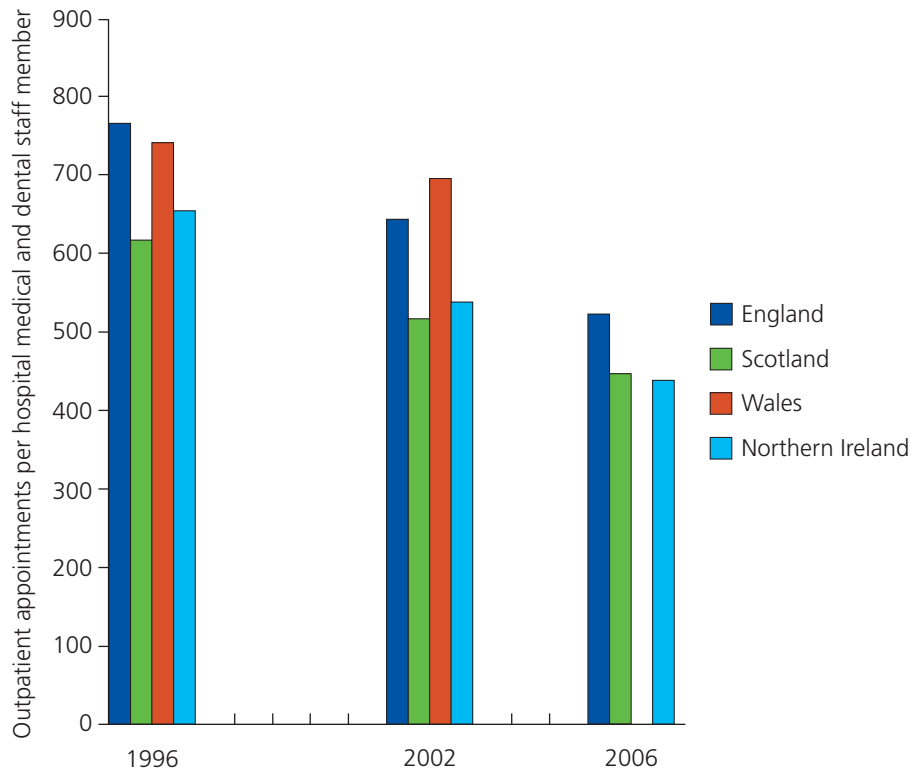
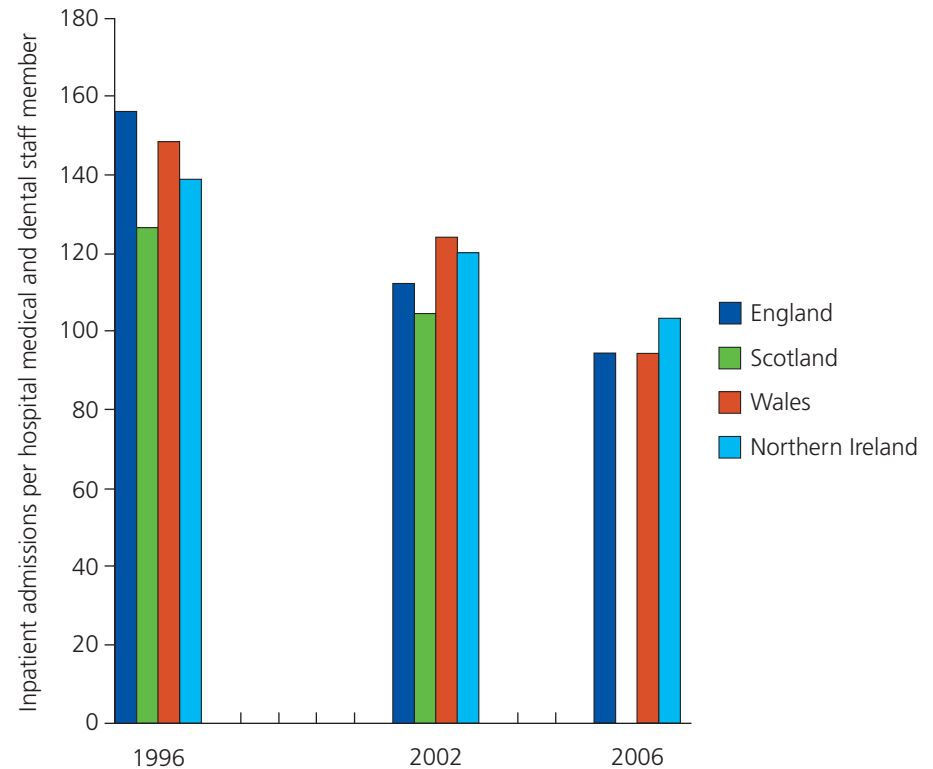


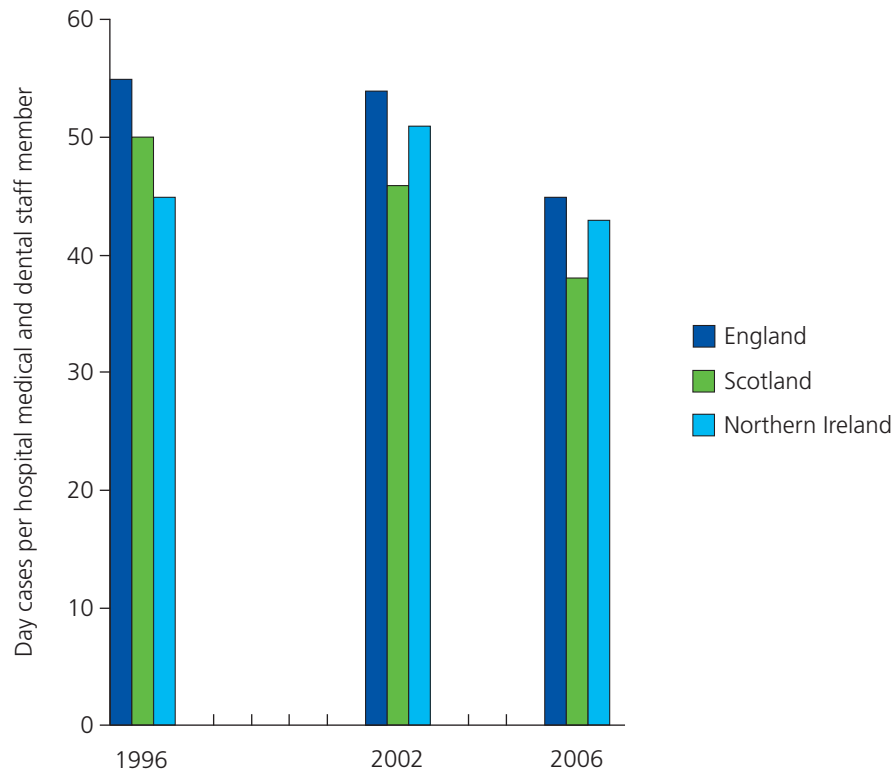
Figure 4.13 shows the number of inpatient admissions per hospital medical and dental staff member; data for Scotland in 2006 have been excluded. There was a decrease in the number of inpatient admissions per hospital medical and dental staff member in the region of 62 (40 per cent) for England, 54 (36 per cent) for Wales and 36 (26 per cent) for Northern Ireland between 1996 and 2006; in Scotland the decrease was 22 (17 per cent) between 1996 and 2002. The number of inpatient admissions per hospital medical and dental staff member ranged from 103 in Northern Ireland to 94 in England and Wales in 2006.

Figure 4.13: Inpatient admissions per hospital medical and dental staff member in England, Wales and Northern Ireland (1996, 2002 and 2006) and Scotland (1996, 2002)



Day case data for Wales have been excluded from the analysis. Figure 4.14 shows that there was a slight increase in the number of day cases per hospital medical and dental staff member in Northern Ireland between 1996 and 2002; between 2002 and 2006, the number of day cases per hospital medical and dental staff member decreased in England, Scotland and Northern Ireland. Between 1996 and 2006, the reductions were 10 (18 per cent) in England and 12 (24 per cent) in Scotland. There was very little change in Northern Ireland. The number of day cases per hospital medical and dental staff member ranged from 45 in England to 38 in Scotland in 2006.

Figure 4.14: Day cases per hospital medical and dental staff member in England, Scotland and Northern Ireland (1996, 2002 and 2006)



Productivity of nursing staff

Figure 4.15 shows the number of outpatient appointments per nursing, midwifery and health visiting staff member; data on outpatients for Wales in 2006 have been excluded. Between 1996 and 2006, the number of outpatient appointments per nursing, midwifery and health visiting staff member decreased by 16 (9 per cent) in England, 22 (16 per cent) in Scotland and 10 (8 per cent) in Northern Ireland; between 1996 and 2002, the number of outpatient appointments per nursing, midwifery and health visiting staff member increased very slightly in Wales. In 2006, the number of outpatient appointments per nursing, midwifery and health visiting staff member ranged from 112 in Scotland and Northern Ireland to 153 in England.

Figure 4.15: Outpatient appointments per nursing, midwifery and health visiting staff member in England, Scotland and Northern Ireland (1996, 2002 and 2006) and Wales (1996, 2002)

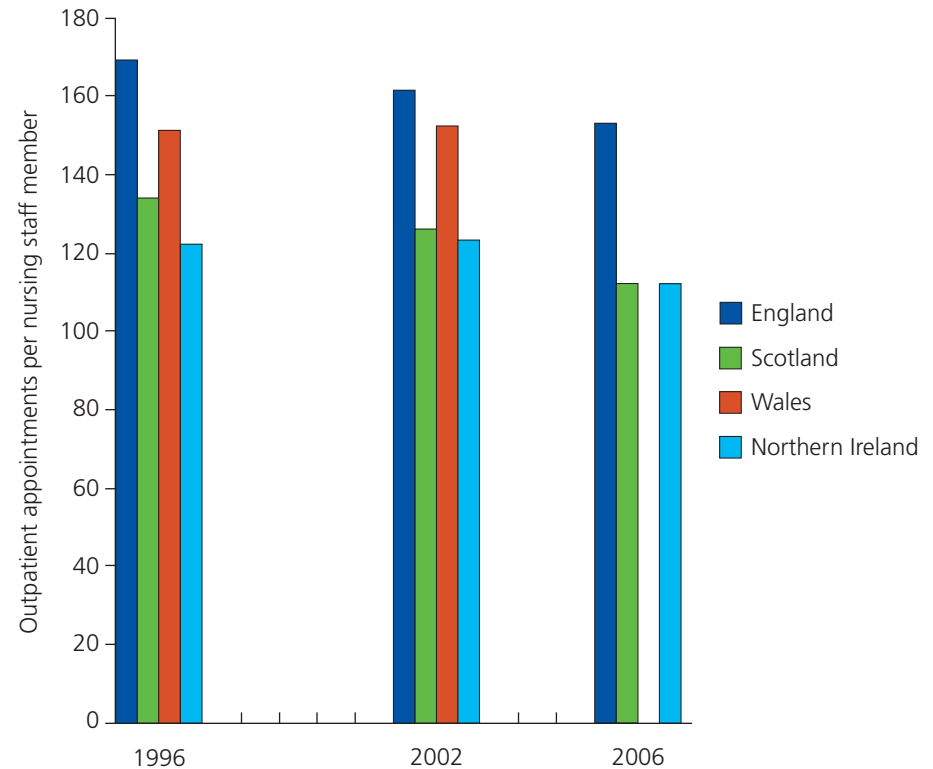


Figure 4.16 shows the number of inpatient admissions per nursing, midwifery and health visiting staff member; data for Scotland in 2006 have been excluded. Between 1996 and 2006, the number of inpatient admissions per nursing, midwifery and health visiting staff member decreased by 6 (18 per cent) in England, 6 (20 per cent) in Wales, but remained the same in Northern Ireland. Between 1996 and 2002, the number of inpatient admissions per nursing, midwifery and health visiting staff member decreased by 2 (7 per cent) in Scotland. The number of inpatient admissions per nursing, midwifery and health visiting staff member ranged from 24 in Wales to 28 in England in 2006.

Figure 4.16: Inpatient admissions per nursing, midwifery and health visiting staff member in England, Wales and Northern Ireland (1996, 2002 and 2006) and Scotland (1996, 2002)

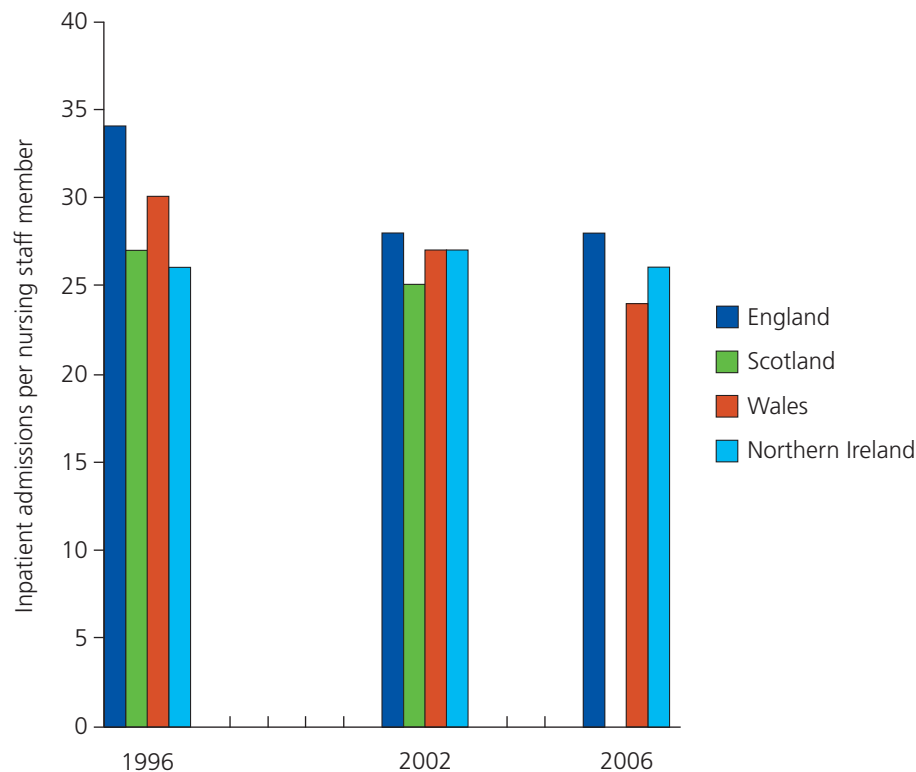
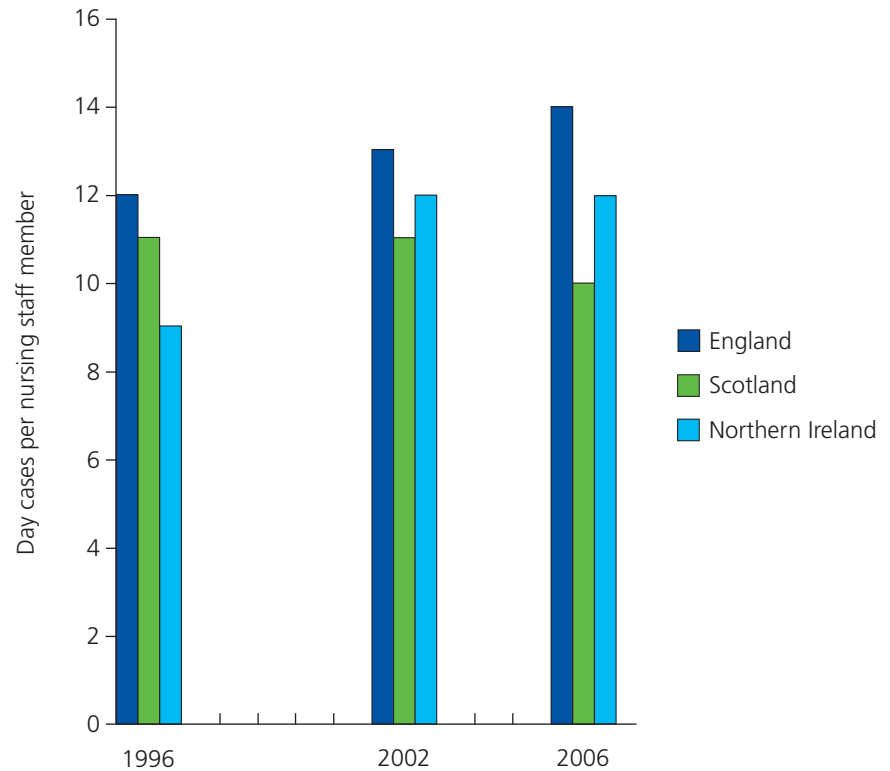


Figure 4.17 shows the number of day cases per nursing, midwifery and health visiting staff member; day case data for Wales have been excluded. Between 1996 and 2006, the number of day cases per nursing, midwifery and health visiting staff member increased by 17 per cent in England and 33 per cent in Northern Ireland, but decreased by 9 per cent in Scotland.

Figure 4.17: Day cases per nursing, midwifery and health visiting staff member in England, Scotland and Northern Ireland (1996, 2002 and 2006)



Procedures

Reported here are operation rates per 10,000 for selected common procedures (Table 4.1):

- extracapsular extraction of lens;
- prosthesis of lens;
- excision of gall bladder;
- inguinal hernia;
- total prosthetic replacement of knee joint;

- varicose vein operation;
- hip replacement;
- CABG.

CABG rates for Northern Ireland were excluded since residents are frequently treated in the Republic of Ireland and these procedures are not captured in these data. In general, operation rates have increased through time, but there were reductions for procedures for inguinal hernia (England and Wales) and varicose veins (Scotland).

Table 4.1: Activity: operation rates (per 10,000) for selected hospital procedures in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)

Procedure (OPCS4 classification)	England			Scotland			Wales			Northern Ireland		
	1996/7	2002/3	2005/6	1996/7	2002/3	2005/6	1996/7	2002/3	2005/6	1996/7	2002/3	2005/6
Extracapsular extraction of lens (C71)	NA*	54.2	56.5	31.1	40.2	53.6	31.6	55.3	57.5	29.6	39.3	47.5
Prosthesis of lens (C75)	28.7	54.6	56.3	31.7	40.6	53.9	39.2	57.1	59.6	30.0	39.5	49.1
Excision of gall bladder (J18)	7.1	9.4	10.6	10.5	11.7	14.0	10.5	11.0	13.4	9.9	12.8	12.5
Inguinal hernia (T20)	16.8	16.7	13.4	12.5	11.1	13.3	14.1	14.6	13.6	10.4	12.0	11.5
Total prosthetic replacement of knee joint (W40–W42)	5.0	8.5	11.9	4.9	6.9	11.3	5.9	8.6	12.8	3.9	4.1	6.2
Varicose vein operation (L85–L87)	11.2	9.4	17.7	26.0	24.9	20.1	17.9	12.0	16.5	11.8	12.7	15.1
Hip replacement (W37–W39)	6.9	8.7	12.5	9.2	9.9	13.4	9.4	9.4	12.6	8.9	8.7	10.0
Coronary artery bypass graft (K40–K46)	4.7	5.1	8.0	8.6	9.8	NA*	4.2	7.7	7.4			

* NA – not available

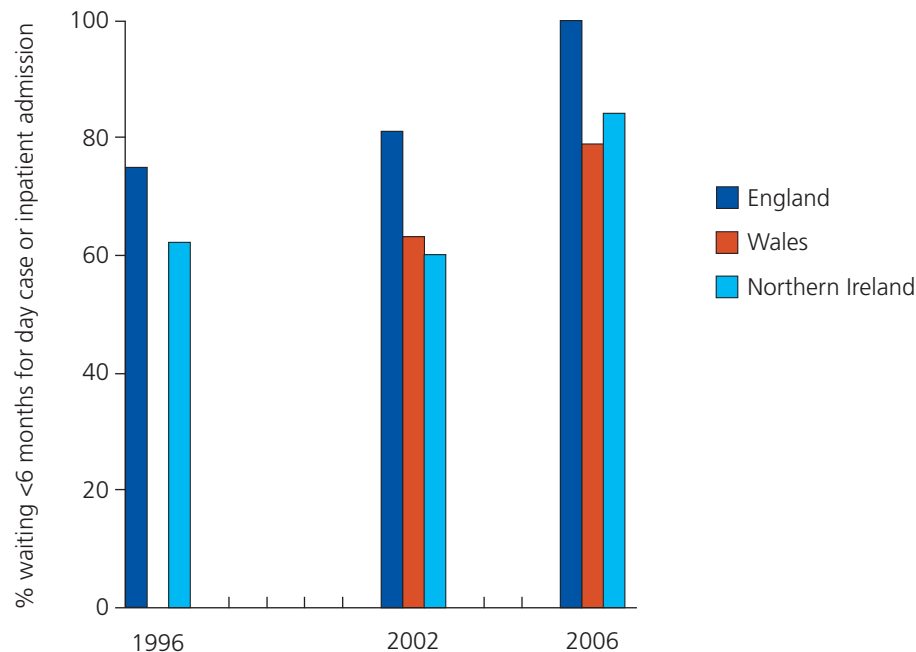
Waiting times

Reported here are proportions of the population who waited for an elective admission (as a day case or inpatient admission) and outpatient appointment for England, Wales and Northern Ireland. There are no comparable data available for Scotland for all three time points. But Propper and others³ have shown that the performance in England in reducing waiting times for elective admission has been markedly superior to that of Scotland.

Inpatient admission and day case

The proportion of the population waiting for an inpatient admission or day case decreased in England between 1996 and 2006. In both Wales and Northern Ireland there was an increase between 1996 and 2002, but a decrease between 2002 and 2006. The proportion of the population waiting for an inpatient admission or day case in England in 2006 was about 35 per cent lower than in the other countries (data not shown). Figure 4.18 gives the proportions of the population waiting less than six months for their elective admission. The performance in England on waiting times was far superior throughout this period to that of Wales and Northern Ireland. Between 2002 and 2006, the percentages of the population waiting 12 months or more fell

Figure 4.18: Percentage of the population waiting less than six months for day case or inpatient admission in England, Wales* and Northern Ireland (1996, 2002 and 2006)



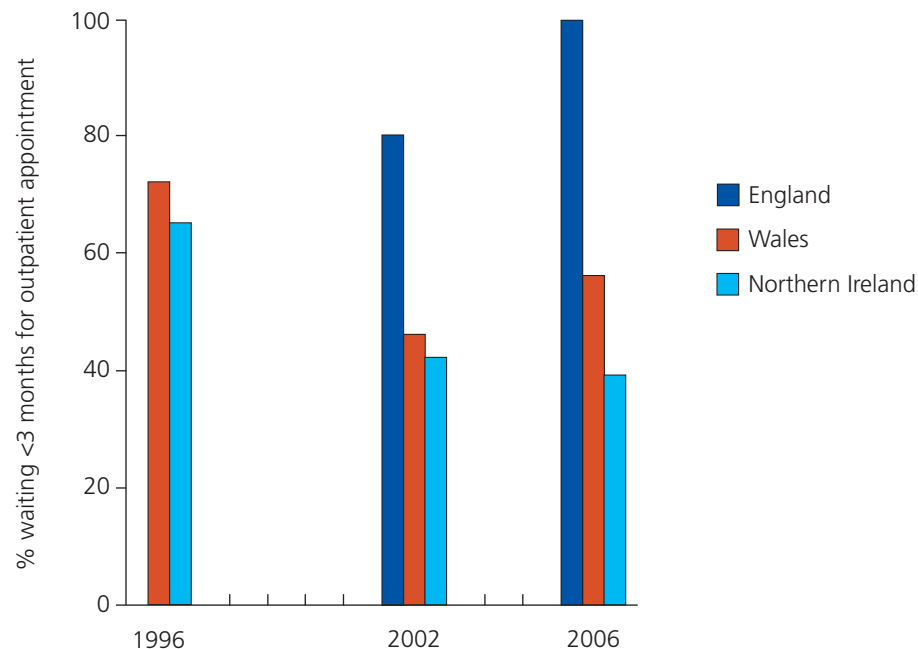
* No comparable information was available on inpatient or day case waiting times in Wales in 1996.

to zero in Wales (from 15.9 per cent) and in Northern Ireland (from 22 per cent); the percentage of the population waiting between six and 12 months increased slightly in Wales (from 21 per cent to 21.4 per cent) and decreased slightly in Northern Ireland (from 18.4 per cent to 15.8 per cent). By 2006, virtually all patients in England had their appointment within six months, but for Wales and Northern Ireland the percentages were 79 per cent and 84 per cent, respectively.

Outpatients

In Northern Ireland the percentage of the population waiting for an outpatient appointment more than doubled between 1996 and 2006 (from 4 per cent to 10 per cent). In Wales this percentage more than doubled between 1996 and 2002 (from 3.5 per cent to 7.4 per cent) but decreased slightly in the second time period. The proportion of the population waiting for an outpatient appointment in 2006 was more than four times greater in Northern Ireland than in England. Figure 4.19 gives proportions of the population waiting less than three months for an outpatient appointment. By 2006, following steady improvements, virtually no one in England waited more three months;⁴ the percentages waiting more than three months were 44 per cent in Wales and 61 per cent in Northern Ireland.

Figure 4.19: Percentage of the population waiting less than three months for outpatient appointment in England,* Wales and Northern Ireland (1996, 2002 and 2006)

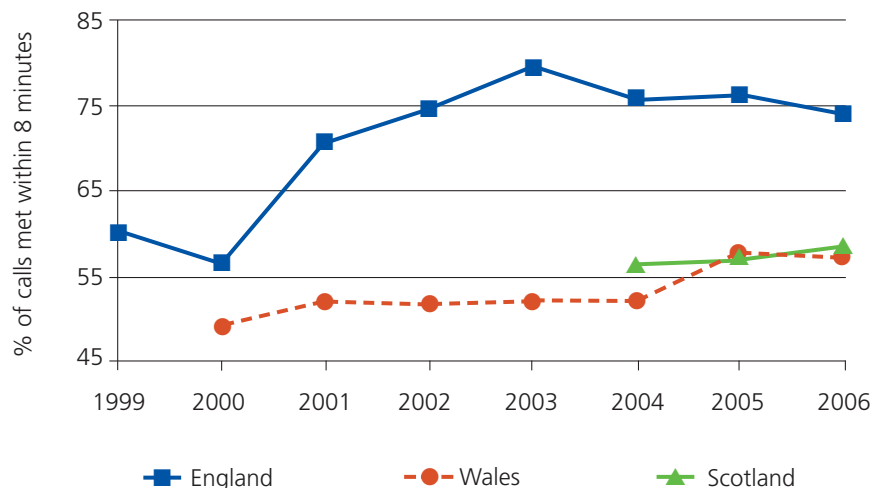


* No comparable information was available on outpatient appointment waiting times in England in 1996.

Ambulance response times

Each of the countries of the UK have introduced a common target for ambulance trusts, that 75 per cent of emergency calls (made by someone telephoning 999) that may be immediately life-threatening (category A) should be met within eight minutes. This target was to be achieved in 2001 in England⁵ and Wales,⁶ and four and six years later in Northern Ireland⁷ and Scotland.⁸ However, following failure to meet that target in Wales, it was reduced for the Welsh Ambulance Service to 65 per cent (from April 2004) and then to 60 per cent (from April 2005).⁹ Figure 4.20 gives performance (where data are available) for England, Wales and Scotland, from 1999/2000 to 2005/06. This shows that the services: in England achieved the 75 per cent target on average from 2003; in Wales achieved neither the 75 per cent target set in 2001, nor the 65 per cent target set in 2004, nor the 60 per cent target set in 2005; and Scotland has had a similar performance to that of Wales since 2004, meeting less than 60 per cent of category A calls within eight minutes. The only information available on the performance of the service in Northern Ireland was that, in 2005/06, 51 per cent of category A calls were responded to within eight minutes (Rooker, 2006).¹⁰

Figure 4.20: Percentage of category A ambulance calls met within eight minutes in England, Scotland and Wales (1999 to 2006)

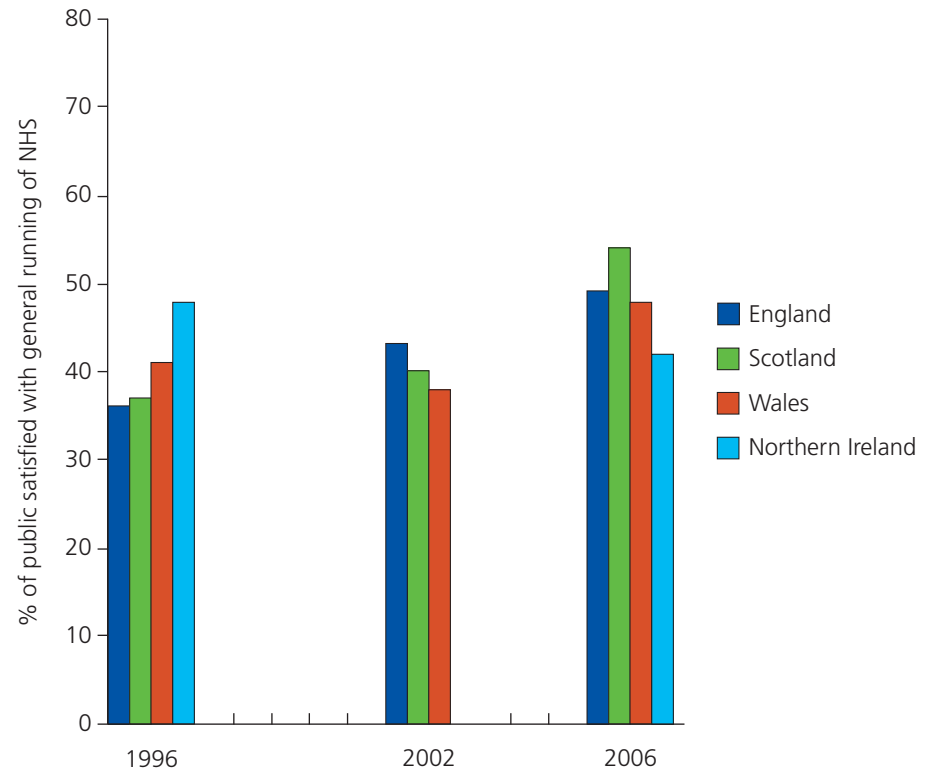


Patient satisfaction with various aspects of the NHS

Figures 4.21 to 4.24 show the percentage of the population reporting satisfaction with various aspects of the NHS in England, Scotland and Wales in 1996, 2002 and 2006, and Northern Ireland in 1996 and 2006 (no comparable data were available for Northern Ireland for 2002). No country stands out as being markedly different from the others for each of the three snapshots between 1996 and 2006.

Figure 4.21 shows the percentage of the population that reported that they were 'very satisfied' or 'quite satisfied' with the general running of the NHS. With the exception of Northern Ireland, the percentage satisfied increased gradually over the ten-year period, 1996 to 2006. The ordering in terms of levels of satisfaction varied between countries over time. The greatest increase between 1996 and 2006 was in Scotland (17 per cent), which had the highest rate in 2006.

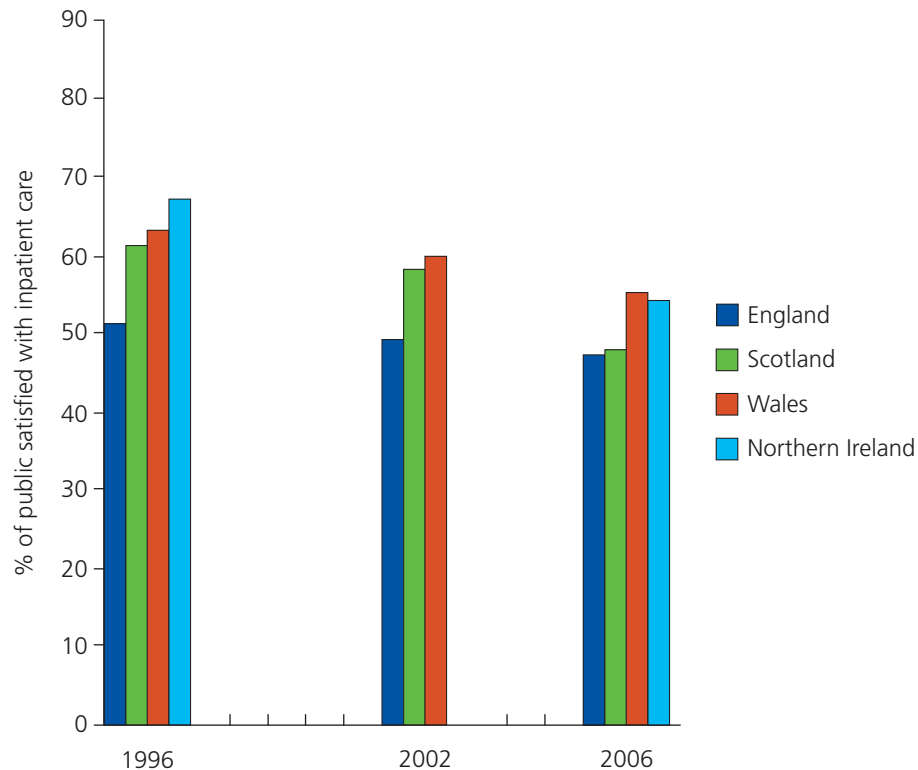
Figure 4.21: Percentage of the population reporting satisfaction with the general running of the NHS in England, Scotland, Wales and Northern Ireland* (1996, 2002 and 2006)



* No data were available for Northern Ireland for 2002.

Figure 4.22 shows the percentage of the population satisfied with inpatient care. This decreased over time in each of the four countries, with England consistently having the worst score. The biggest decrease in satisfaction over time was in Scotland (the percentage satisfied with inpatient care fell from 61 per cent in 1996 to 48 per cent in 2006). Over time, Wales and Northern Ireland had the highest levels of satisfaction.

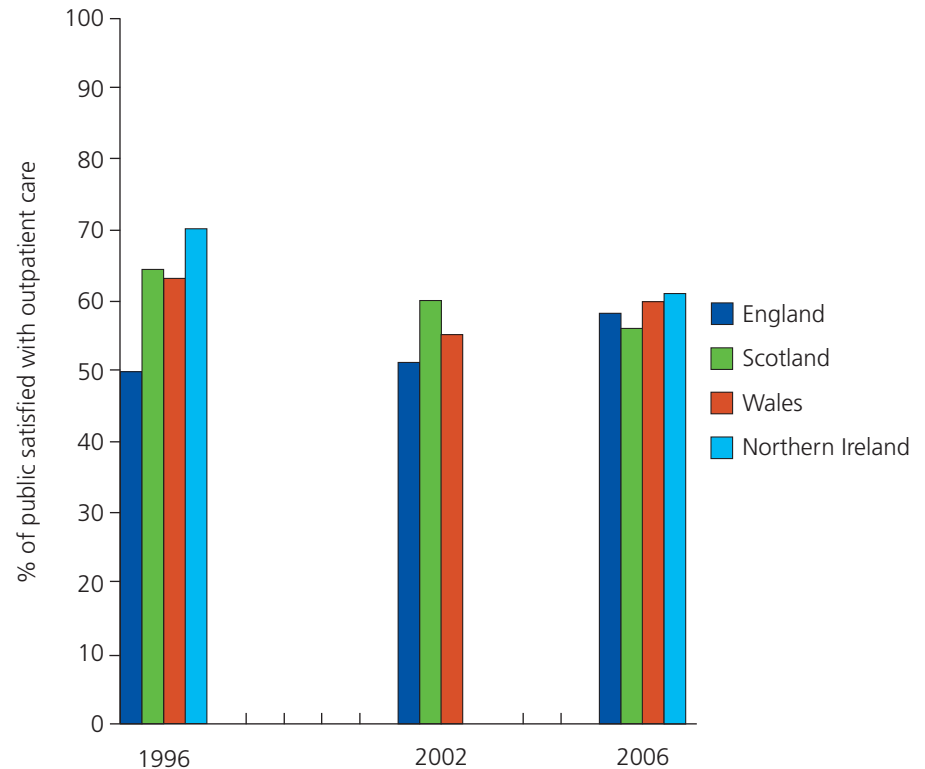
Figure 4.22: Percentage of the population reporting satisfaction with inpatient care in England, Scotland, Wales and Northern Ireland* (1996, 2002 and 2006)



* No data were available for Northern Ireland for 2002.

Figure 4.23 shows the percentage of the population reporting satisfaction with outpatient care. In 1996, England had much lower levels of satisfaction than the other three countries. Over time, however, the percentage of the population satisfied increased in England (from 50 per cent in 1996 to 58 per cent in 2006) and declined in the other countries, so that, in 2006, there were minimal differences between the four countries.

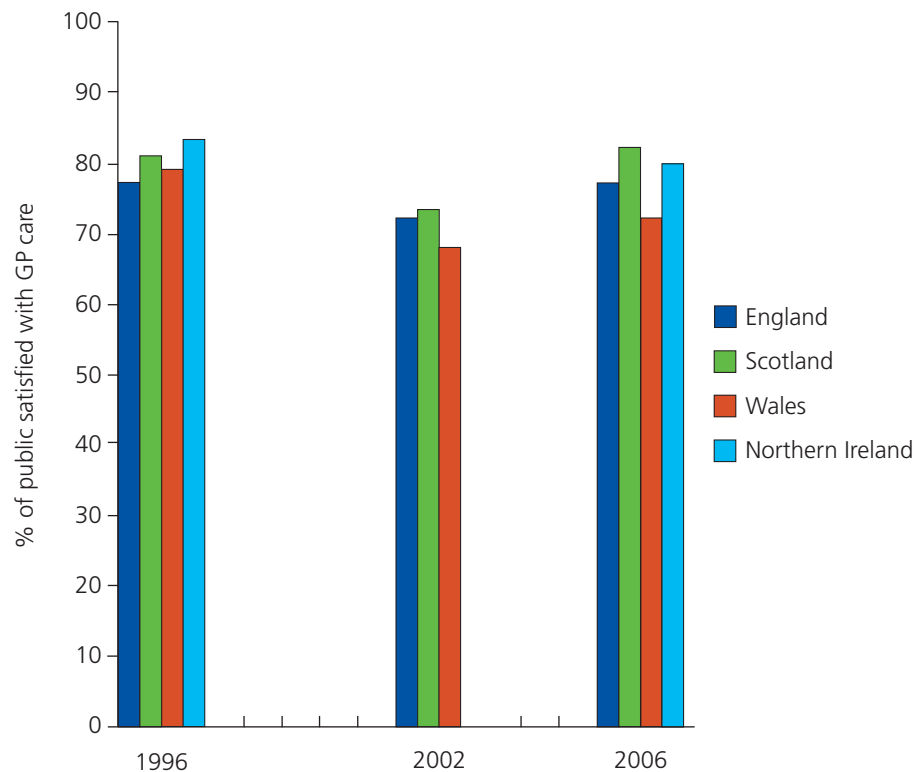
Figure 4.23: Percentage of the population reporting satisfaction with outpatient care in England, Scotland, Wales and Northern Ireland* (1996, 2002 and 2006)



* No data were available for Northern Ireland for 2002.

Figure 4.24 shows the percentage of the population satisfied with GP care, which is higher than for other aspects reported. The percentage satisfied with GP care was high in 1996 and 2006. Scotland and Northern Ireland had the highest levels of satisfaction in 1996 and 2006. England had the lowest level in 1996 and Wales the lowest levels in 2002 and 2006. In 2006, the percentage reporting satisfaction ranged from 72 per cent in Wales to 82 per cent in Scotland.

Figure 4.24: Percentage of the population reporting satisfaction with GP care in England, Scotland, Wales and Northern Ireland* (1996, 2002 and 2006)



* No data were available for Northern Ireland for 2002.

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1. The numbers for all staff are for whole time equivalents except for GPs, for which the data give a head count only.
 2. In the final chapter the authors refer to the comparative study of changes in hospital productivity between England and Scotland by Farrar and others (2007 and 2009). See Farrar, S, Sussex, J, Yi, D, Sutton, M, Chalkley, M, Scott, A and Ma, A (2007) *National Evaluation of Payment by Results*. Aberdeen: Health Economics Research Unit. www.astrid-online.it/Politiche-/Studi--ric/HERU_report_dec07.pdf ; Farrar, S, Yi, D, Sutton, M, Chalkley, M, Sussex, J and Scott, A (2009) 'Has payment by results affected the way that English hospitals provide care? Difference-in-differences analysis', *BMJ* 339: b3047.
 3. Propper and others (2008a and 2008b) op. cit.
 4. The percentage of the population waiting more than three months was less than 0.05 per cent.
 5. NHS Executive (1996) *Review of Ambulance Service Standards: Final report of the Steering Group*. Leeds: NHS Executive.
 6. National Assembly for Wales (2001) 'General notes for Chapter 12: patient transport services'. *Health Statistics Wales 2001*. Cardiff: National Assembly for Wales.
 7. Rooker, Lord (2006) 'Ambulance Service: Northern Ireland'. *Hansard*, HL Col. WA193, 13 December. www.publications.parliament.uk/pa/ld200607/ldhansrd/text/61213w0001.htm
 8. Scottish Ambulance Service (2004) *Your Story: 2003–2004 annual report*. Edinburgh: Scottish Ambulance Service, p34.
 9. Auditor General for Wales (2006) op. cit., p28. Welsh Assembly Government (2007) *NHS Wales: Annual Operating Framework 2008/2009*. (WHC (2007) 086). Cardiff: Welsh Assembly Government, p34.
 10. Rooker (2006) op. cit.

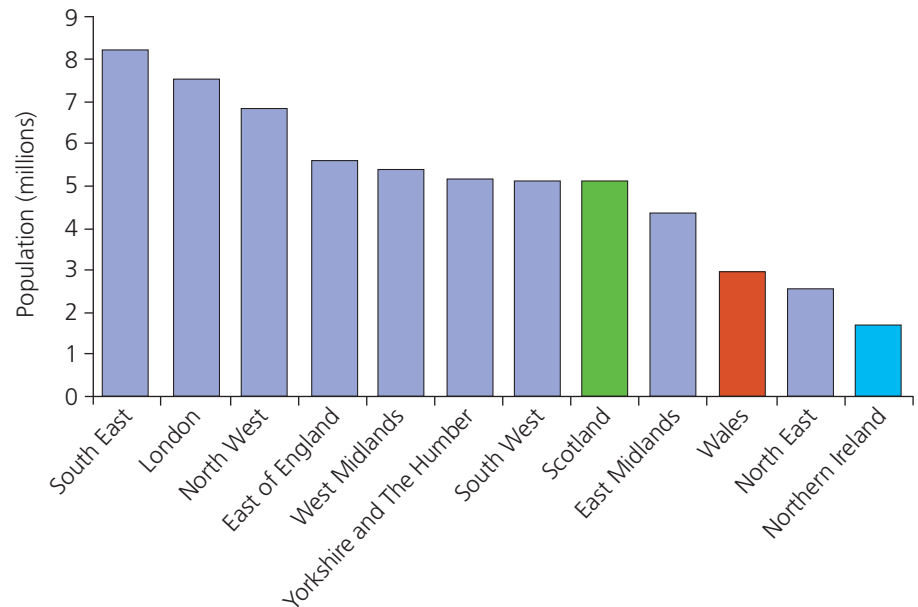
CHAPTER 5

COMPARISONS OF SCOTLAND, WALES AND NORTHERN IRELAND WITH ENGLISH REGIONS

The purpose of this chapter is to compare indicators for the devolved countries with English regions: the nine English GORs or the ten SHAs. Figure 5.1 gives the populations of the nine GORs and Scotland, Wales and Northern Ireland, and shows how this comparative analysis of devolved countries overcomes the limitations of cross-country comparisons of countries of very different population sizes.¹ The analysis that follows demonstrates two kinds of regional variations that need to be considered in making sense of cross-country comparisons.

First, the ‘north/south divide’ in England, which is particularly marked between the South East and the north (North East and North West); with the statistics for the north being more similar to those of the devolved countries than those for England.

Figure 5.1: Populations of the nine English GORs and Scotland, Wales and Northern Ireland (2006)



Second, in London there are high labour costs and massive concentrations of teaching, training and research, which mean that London's relatively high NHS spending and hospital medical and dental staff per capita do not translate into relatively high rates of supply of services to its population. Its comparative statistics for crude productivity of NHS staff are also, likewise, misleading. The statistics for London also distort national averages for England. For these reasons, the North East has been chosen as a benchmark for comparison with the other three countries. When comparing Wales with the North East of England, the Wanless Report had this to say: 'While there are some differences, the North East of England is very similar to Wales across a range of socio-economic indicators and expenditure on private healthcare'.² A comparison has been drawn between the North East and the devolved countries to show how they all differ from the averages for England. Those performance indicators for which the devolved countries are outliers as compared with all the English regions (GORs and SHAs) are also highlighted.

Socioeconomic and health indicators

In this section, various indicators of health for the nine English GORs and England, Scotland, Wales and Northern Ireland for 2006 are discussed. These all show a substantial regional variation within England in terms of average health status and the tendency for a north/south divide: with the populations in the north being generally less healthy than in the south, reflecting differences in socioeconomic status.

Table 5.1 gives selected socioeconomic indicators for the English GORs and the four countries:

- gross disposable household income in £s per capita for 2006 (income per capita);
- unemployment rates for 2006 (unemployment rate);
- percentage of households in receipt of disability benefits in 2006/07 (percentage with disability benefits);
- percentage of dwellings rented from local authorities (LAs) in 2007 (percentage LA rented);
- percentage of households with no use of a car in 2005 (percentage households without a car).

These indicators show no consistency for London, which appeared to be relatively rich because it had the highest per capita income and lowest percentage with disability benefits; and relatively poor because it had the highest unemployment rate and percentages of households without a car and of LA rented dwellings. These indicators do, however, show a consistent pattern of the north/south divide in England. This is illustrated by comparing the North East with the South East:

- The North East had the highest rate of unemployment, the highest percentage of households renting dwellings from LAs and the highest proportion of households without access to a car, as well as the lowest per capita income.
- The South East had the second lowest percentage of households without a car, the second lowest rate of unemployment (after the South West) and second lowest percentage of households renting dwellings from LAs (after London), and the second highest per capita income (after London).

Table 5.1: Selected socioeconomic indicators for the UK, English GORs, England, Wales, Scotland and Northern Ireland (2006)

	Gross disposable household income (£ per head) 2006	Unemployment rates 2006	Households in receipt of disability benefits (%) 2006/07	Dwelling rented from local authority (%) 2007	Household with no use of a car (%) 2005
UK	14,053	5.6	16	10	25
North East	12,026	6.2	21	13	35
North West	12,778	5.4	20	7	26
Yorkshire and The Humber	12,660	5.9	16	11	27
East Midlands	13,032	5.5	15	11	22
West Midlands	12,697	5.9	19	9	23
East of England	14,855	5.2	12	8	17
London	17,512	8.0	10	14	35
South East	15,821	4.7	11	5	18
South West	13,968	3.8	14	5	17
England	14,285	5.7	15	9	24
Wales	12,366	5.9	22	12	23
Scotland	13,347	5.5	18	14	31
Northern Ireland	12,234	4.4	24	14	24

Figure 5.2 gives a comparison of the North East with the devolved countries for the same selected socioeconomic indicators standardised with the average for England at 100. This shows that each compared with the average for England had lower per capita income; and higher percentages of households without a car, renting dwellings from LAs and in receipt of disability benefits. Unemployment rates (in 2006), as compared with the average for England, were, however, much lower in Northern Ireland, lower in Scotland, but higher in Wales and the North East. Comparing the North East and the devolved countries, the lowest rate of income per capita was in Northern Ireland; the highest rate of unemployment in the North East, of disability benefits in Northern Ireland, of LA rented in Scotland and Northern Ireland, and of no car access in the North East. These indicators therefore illustrate complex influences at work including culture and geography: for example, not having a car has a very different meaning in London as opposed to other parts of the UK. These comparisons suggest three principal inferences: the North East is as different from the average for England as the two devolved countries and each area has its own distinctive patterns of indicators of poverty relative to that average.

Figure 5.2: Selected socioeconomic indicators for Scotland, Wales, Northern Ireland and the North East region of England (2006; England = 100)

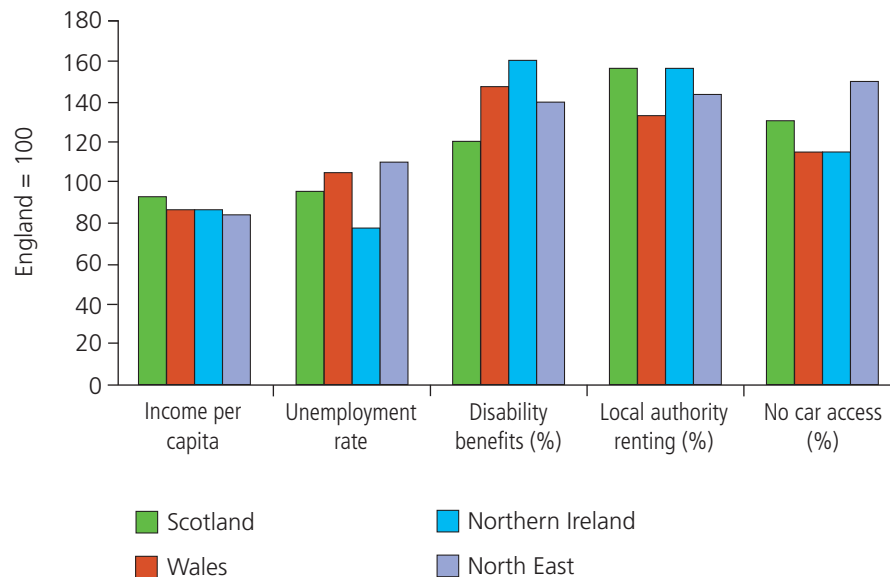


Figure 5.3 gives SMRs for males and females. These are good indicators of relative health and exhibit a pattern that is common to the various health indicators (except infant and perinatal mortality). The average SMR for England was the lowest of the four countries, but within England this ranged, for men, from a low of 89 in the south (South East and South West) to a high of 110 in the north (North East and North West). Scotland (118) was an outlier with the highest SMR. Wales (101) and Northern Ireland (108) fell within the range of English GORs. Figure 5.3 shows four distinct sets in terms of health, as indicated by SMRs:

- Healthier than the English average: London, East of England, South East, South West.
- About the English average: Yorkshire and The Humber, West Midlands, Wales, East Midlands.
- Sicker than the English average: North East, North West, Northern Ireland.
- Much sicker than the English average: Scotland.

Figure 5.3: SMRs (males and females separately) of the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)

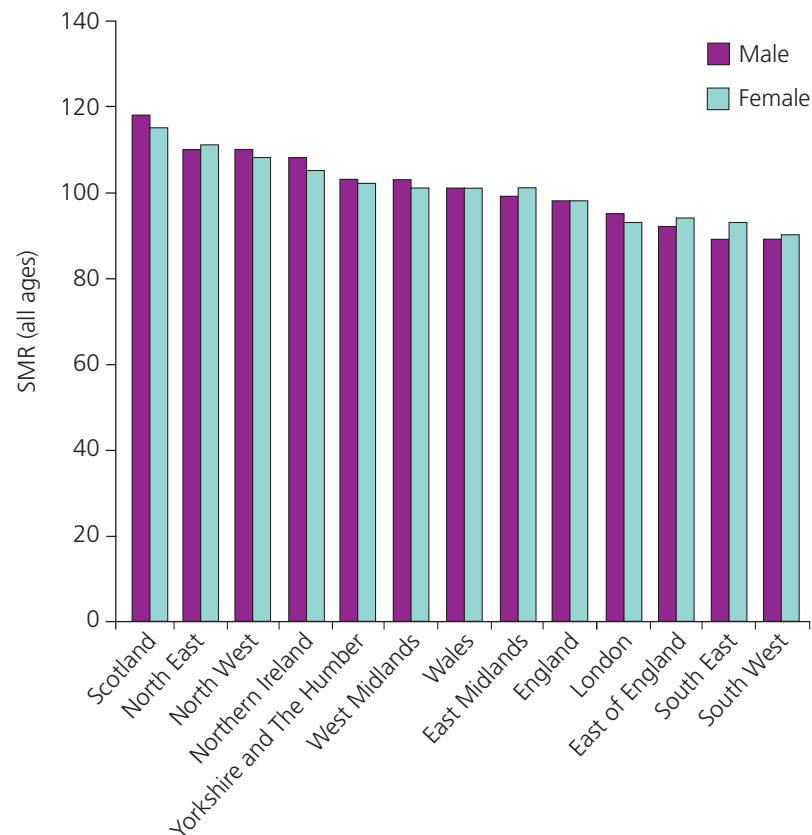


Figure 5.4 gives rates of infant and perinatal mortality, which exceptionally show that the averages for England and most GORs were worse than the other UK countries (perhaps because of differences in their ethnic composition). The rates for Scotland, Wales and Northern Ireland fell within the range of English GORs.

Figure 5.4: Perinatal and infant mortality rates of the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)

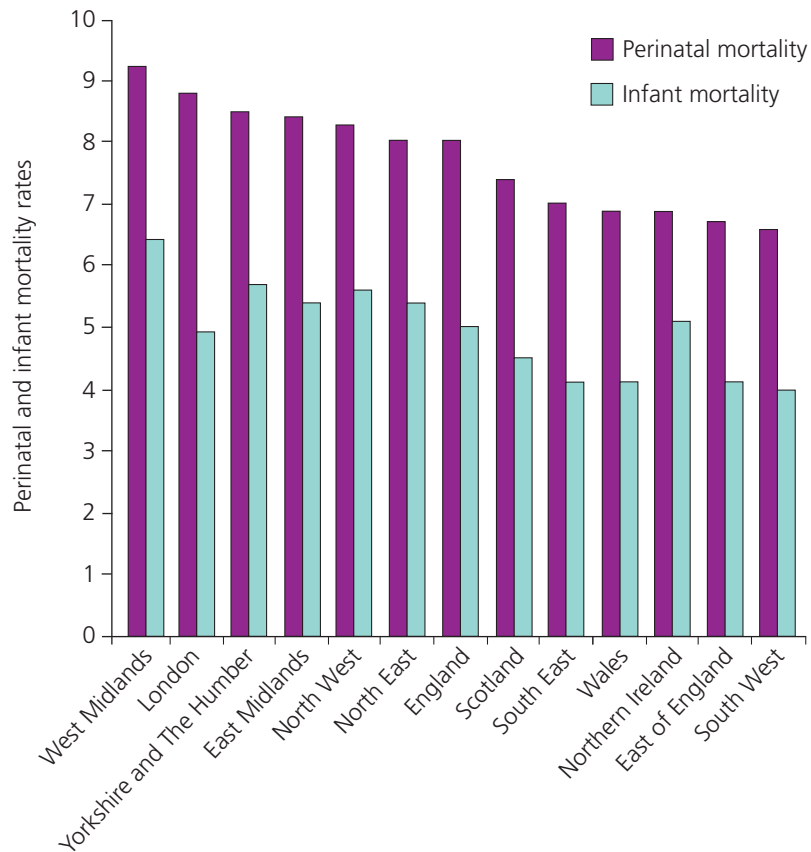


Figure 5.5 shows differences in life expectancy at birth for males and females. Scotland was an outlier with the shortest life expectancy (75 and 80); Wales (77 and 81) and Northern Ireland (76 and 81) fell within the range of English GORs, were similar to the North West region of England (76 and 80) and lower than the average for England (77 and 82).

Figure 5.5: Life expectancy at birth of the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)

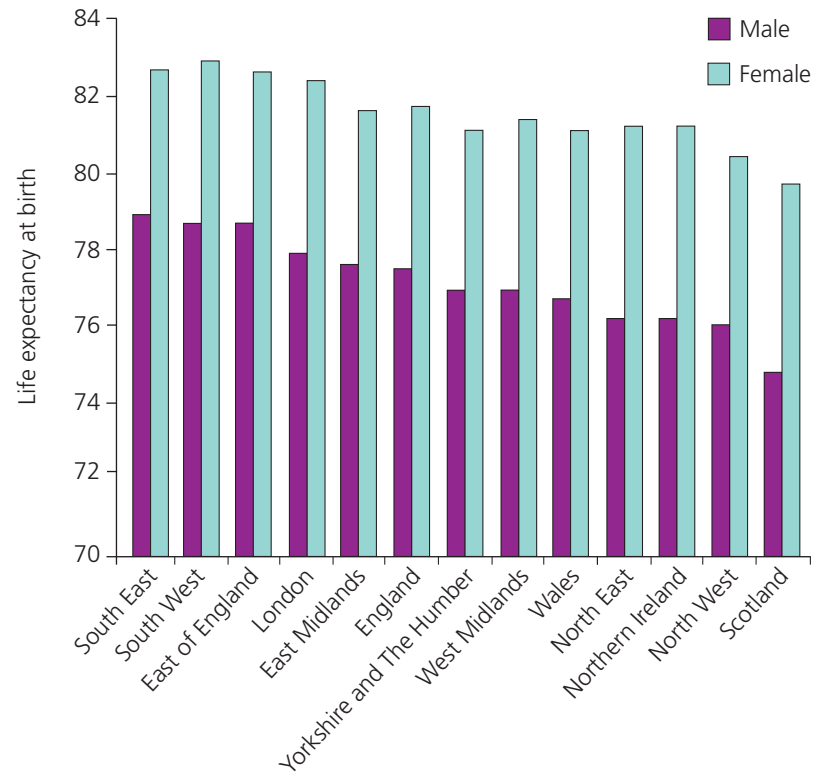


Figure 5.6 gives percentage of the population that are aged 65 to 74 for males and 60 to 74 for females and those over 75. The percentages in Scotland, Wales and Northern Ireland fell within the range of English GORs. The South West and London had the highest and lowest percentages that are old; Wales and Scotland were similar to the South West and Northern Ireland to London.

Figure 5.6: Percentage of the population aged 65–74 for males and 60–74 for females and aged 75 and over in the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)

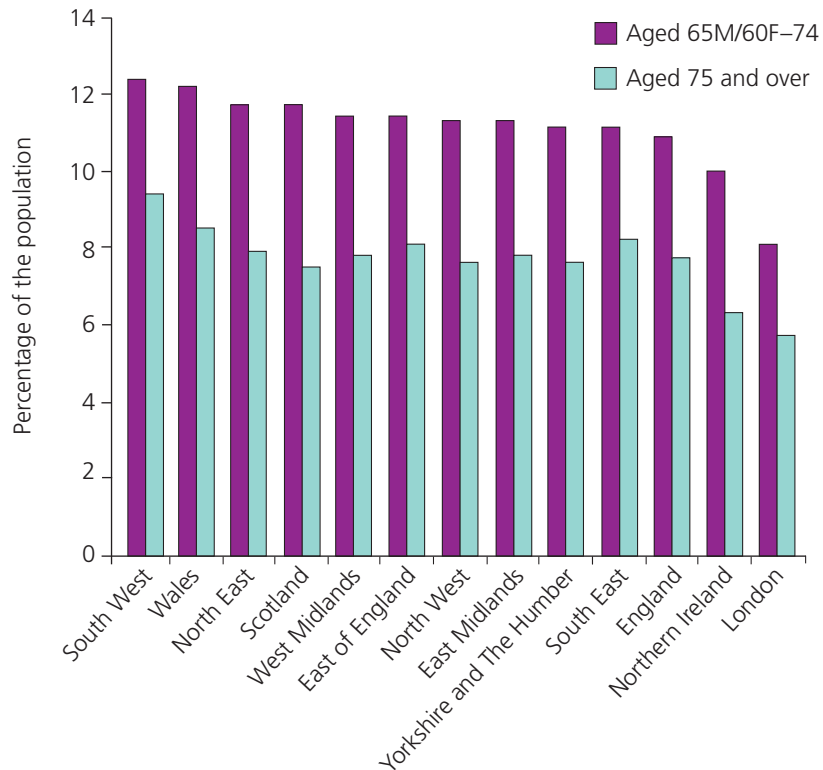


Figure 5.7 shows the percentage of the population reporting longstanding illness, LLSI and restricted activity in the nine English GORs and England, Scotland, Wales and Northern Ireland in 2006. London had the lowest proportion of its population reporting a longstanding illness or a LLSI, which is likely to be related to its relatively young population. The percentage of the population reporting a longstanding illness in Wales and Northern Ireland was within the range of English GORs. Northern Ireland and Wales had the greatest proportion of their population reporting a LLSI. The North East had the greatest proportion reporting restricted activity, while Scotland had the lowest.

Figure 5.7: Percentage of the population reporting longstanding illness, LLSI and restricted activity in the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)

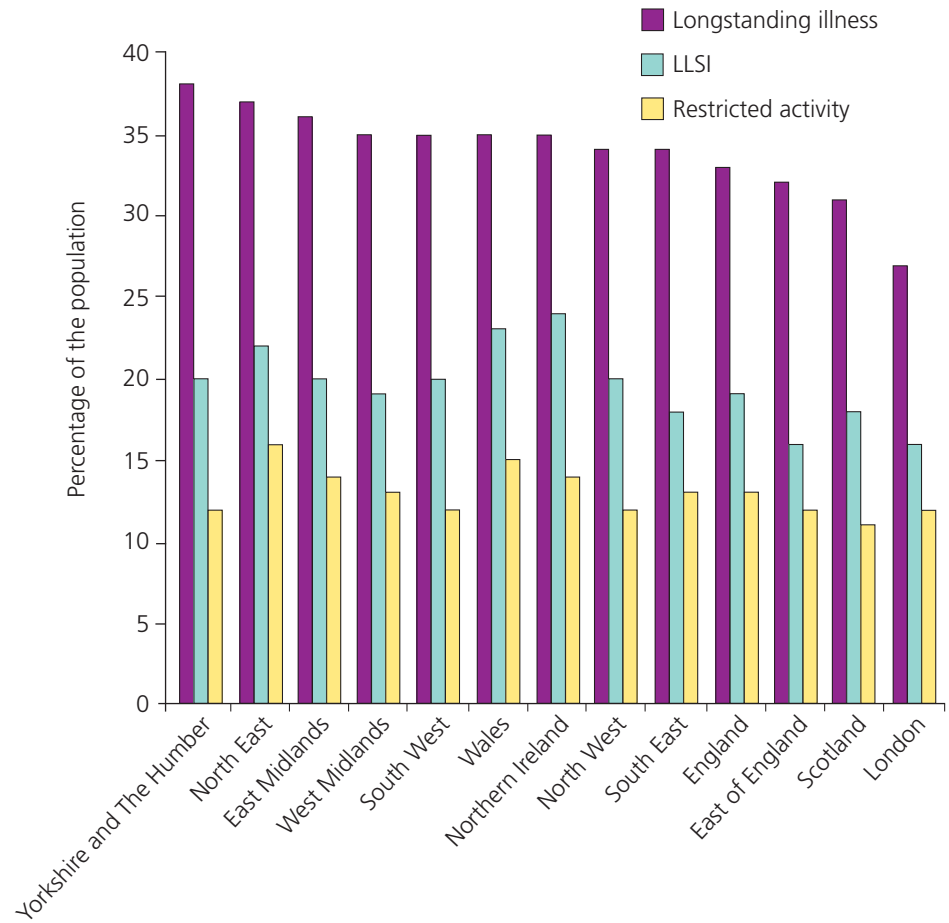
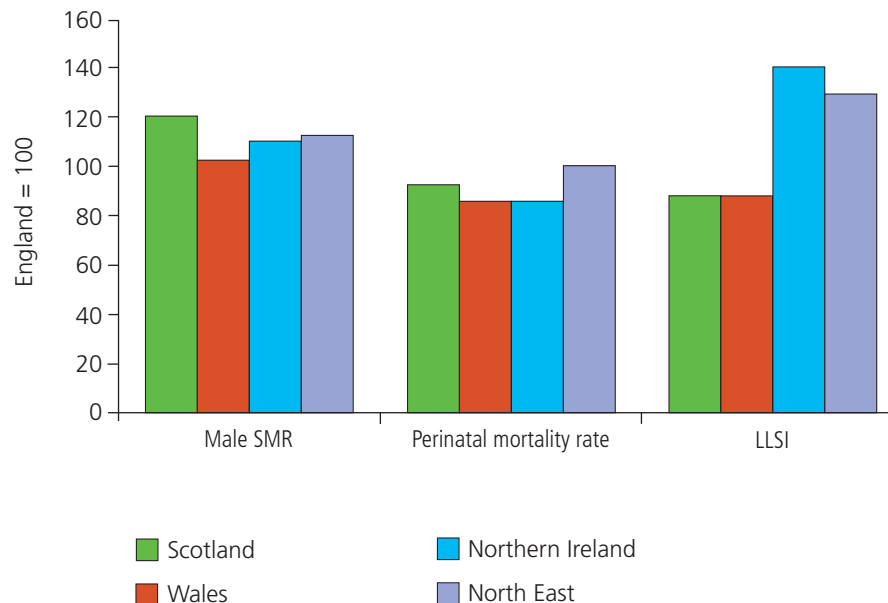


Figure 5.8 gives selected health indicators for devolved countries and the North East, standardised with the average for England as 100: for male SMR, perinatal mortality and LLSI. This shows that the health of the population in the North East was worse than the average for England for male SMR and LLSI, but the same for perinatal mortality. Comparing the devolved countries and the North East, Northern Ireland had the highest LLSI and Scotland the highest male SMR. Each of the devolved countries had much lower perinatal mortality than the North East.

Figure 5.8: Selected health indicators for Scotland, Wales, Northern Ireland and the North East region of England (2006; England = 100)



Expenditure per capita

Figure 5.9 shows NHS expenditure per capita in 2006 for each GOR and country. Although the average for England (£1,514) was the lowest of the four countries, these comparisons show four distinct sets:

- Lower than the English average: East of England, East Midlands, South East, South West.
- About the English average: West Midlands, Yorkshire and The Humber.
- Higher than the English average: North West, Wales, Northern Ireland, London, North East.
- Much higher than the English average: Scotland.

Table 5.2 shows that spending per capita for GORs and the devolved countries broadly followed the categorisation by SMR except for London (where the higher than average spend does not indicate high spend on the population) and Wales (with high spend but average SMR).

Figure 5.9: Total NHS expenditure per capita for the nine English GORs and England, Scotland, Wales and Northern Ireland (2006)

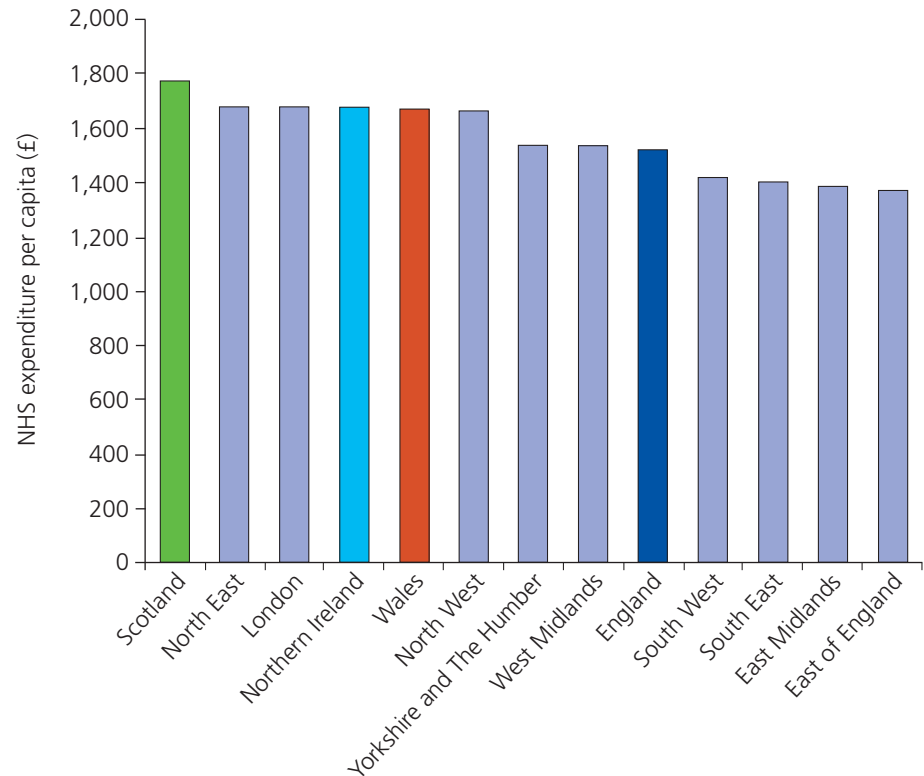


Table 5.2: Comparisons of SMRs and per capita spend for the nine English GORs and Scotland, Wales and Northern Ireland (2006)

		SMRs in comparison with English average			
		Low	Average	High	Very high
Per capita spend in comparison with English average	Low	East of England, East Midlands, South East, South West			
	Average		West Midlands, Yorkshire and The Humber		
	High	London	Wales	North East, North West, Northern Ireland	
	Very high				Scotland

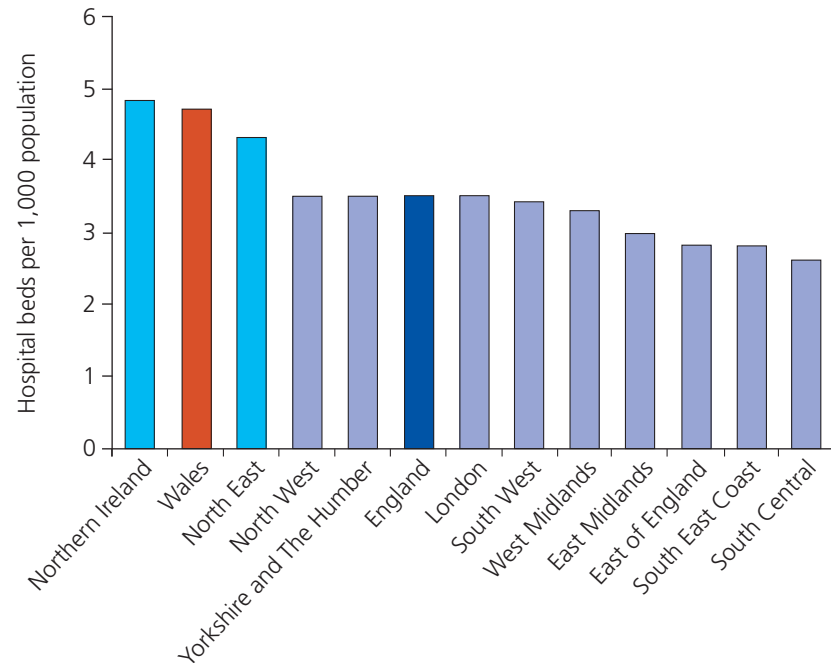
Inputs

Figure 5.10 shows the number of hospital beds per 1,000 population for each SHA and country. Scotland has been omitted due to some uncertainty about the definition of 'hospital' and 'acute' beds in Scotland. Three distinct groupings are apparent:

- Lower than the English average: South Central, South East Coast (these two make up the South East GOR), East of England, East Midlands.
- About the English average: West Midlands, South West, London, Yorkshire and The Humber, North West.
- Higher than the English average: North East, Wales, Northern Ireland.

There was no obvious pattern in the variation of the proportion of beds in acute specialties across SHAs and countries (this is not shown but varied from 85 per cent in the South West to 72 per cent in Northern Ireland).

Figure 5.10: Available hospital beds per 1,000 population for the ten English SHAs and England, Wales and Northern Ireland (2006)



Figures 5.11, 5.12, 5.13 and 5.14 give staffing rates per 1,000 population in the ten SHAs, England, Scotland, Wales and Northern Ireland for:

- hospital medical and dental staff;
- nursing, midwifery and health visiting staff;
- NHS management and support staff;
- GPs.³

Within England, the variations in staffing for hospital and community health services (HCHS) per 1,000 population broadly followed that of per capita spend and (with the exception of London) of SMR: with high and low levels of staffing in the North and South, respectively. This did not, however, apply to GPs.

Figure 5.11 shows that the average number of hospital medical and dental staff per 1,000 population for England was driven by London, reflecting the concentration of teaching, training and research staff in that region. Northern Ireland and Scotland had higher rates of hospital medical and dental staff than any English region (except for London), and Wales and the North East had the same rate, which was higher than the other English regions (except for London).

Figure 5.11: Hospital medical and dental staff (whole time equivalents) per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)

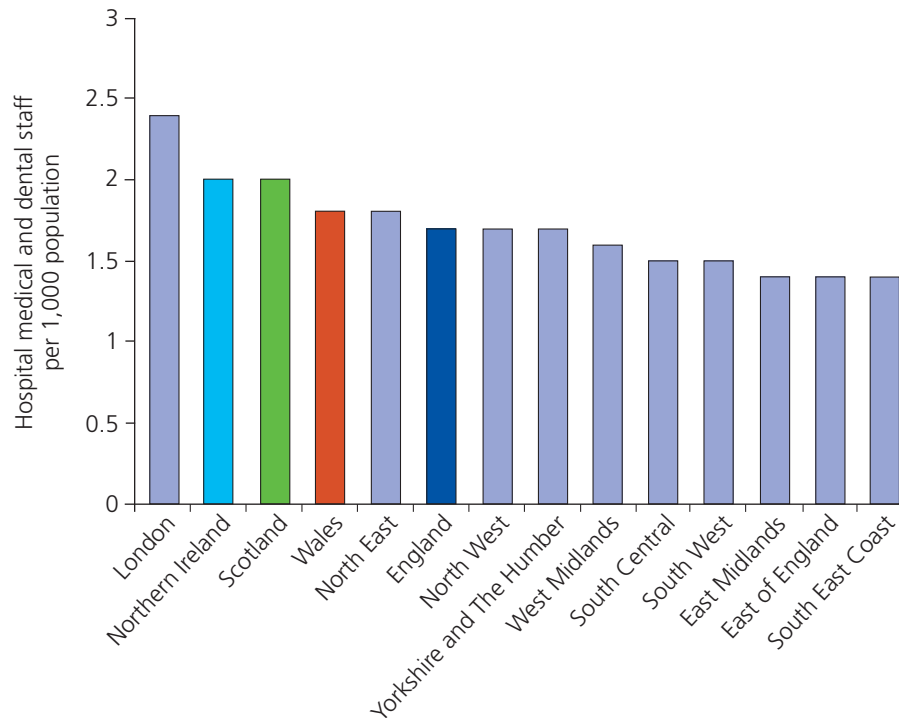


Figure 5.12 shows that Scotland and Northern Ireland had slightly higher rates of nursing, midwifery and health visiting staff than the regions of England; while Wales had a rate similar to the northern regions and London, which were both higher than the other English regions.

Figure 5.12: Nursing, midwifery and health visiting staff (whole time equivalents) per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)

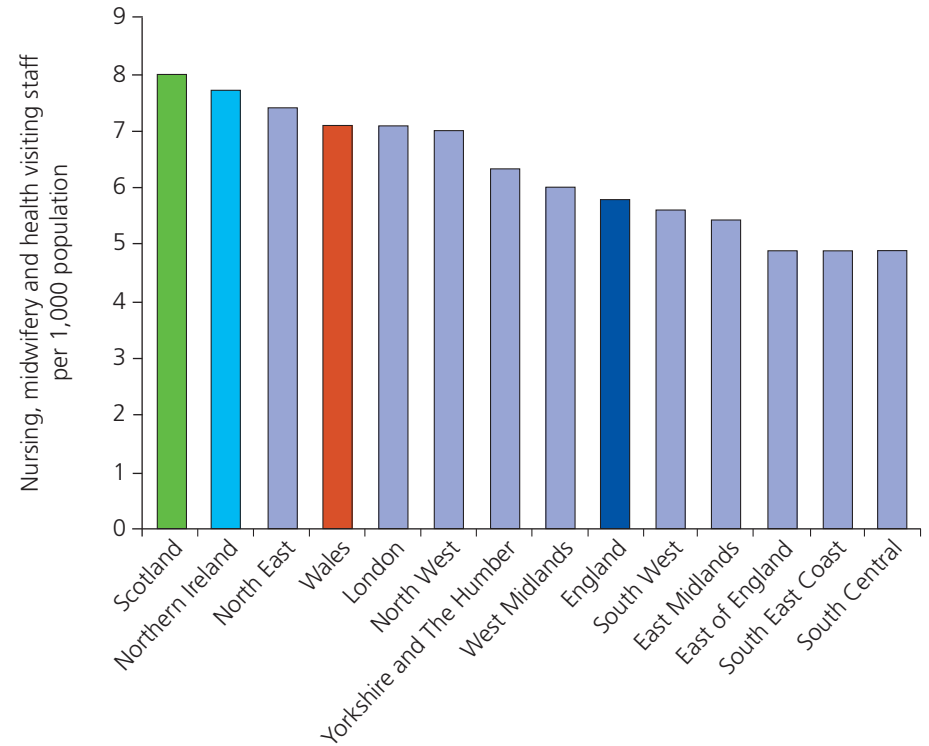


Figure 5.13 shows that within England, the northern SHAs tended to have higher levels of management and support staff than the healthier southern SHAs. Wales had more management and support staff per capita than all the regions of England. Due to differences in the method used to quantify management and support staff across the four countries, data for Scotland and Northern Ireland have been excluded.

Figure 5.13: Management and support staff (whole time equivalents) per 1,000 population in the ten English SHAs and England and Wales (2006)

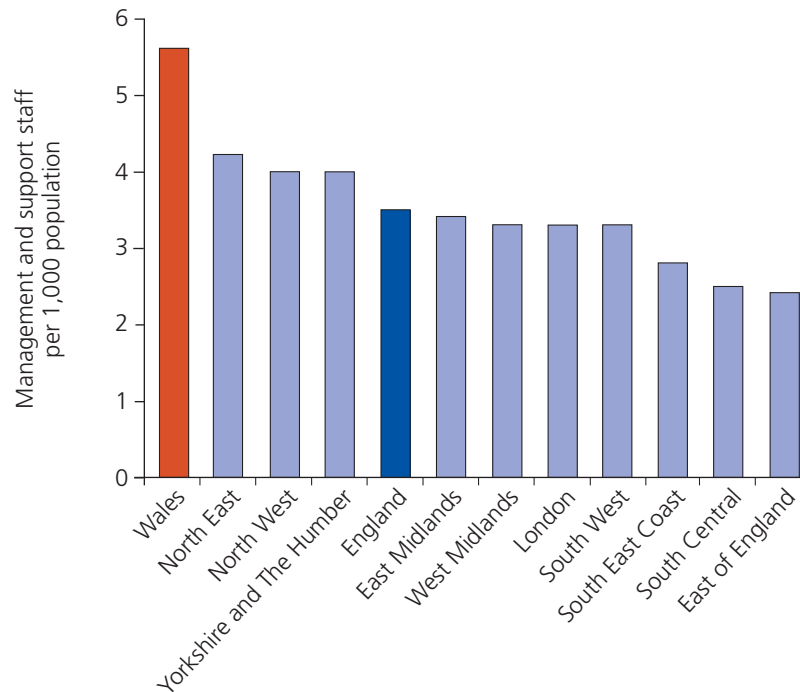


Figure 5.14 shows that Scotland had the highest rates for GPs, and that most English SHAs, Northern Ireland and Wales had similar rates (the highest rates being for the South West and the North East).

Figure 5.14: GPs per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)

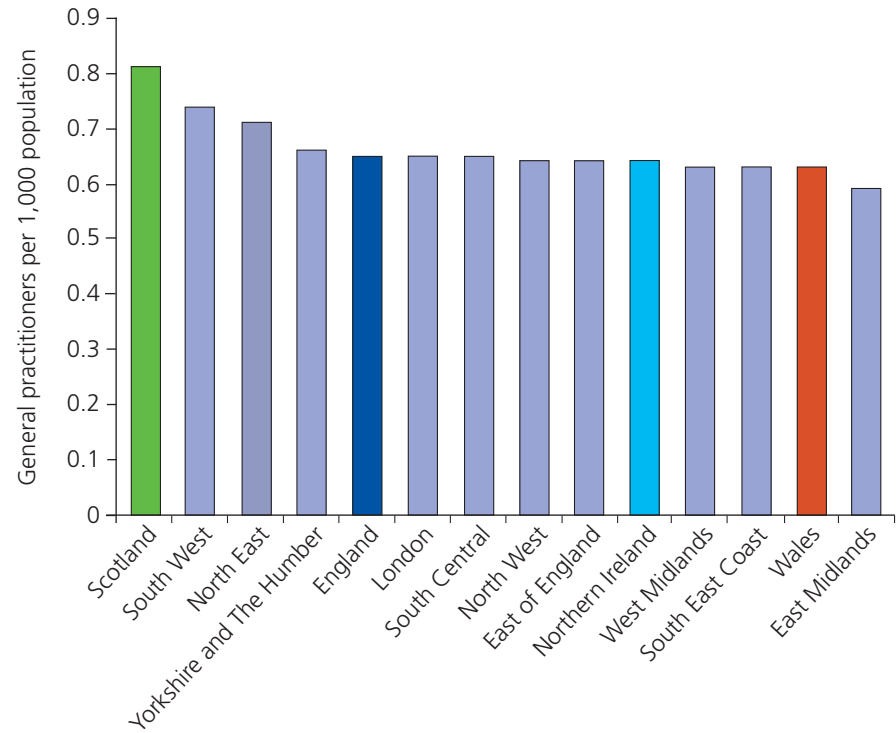
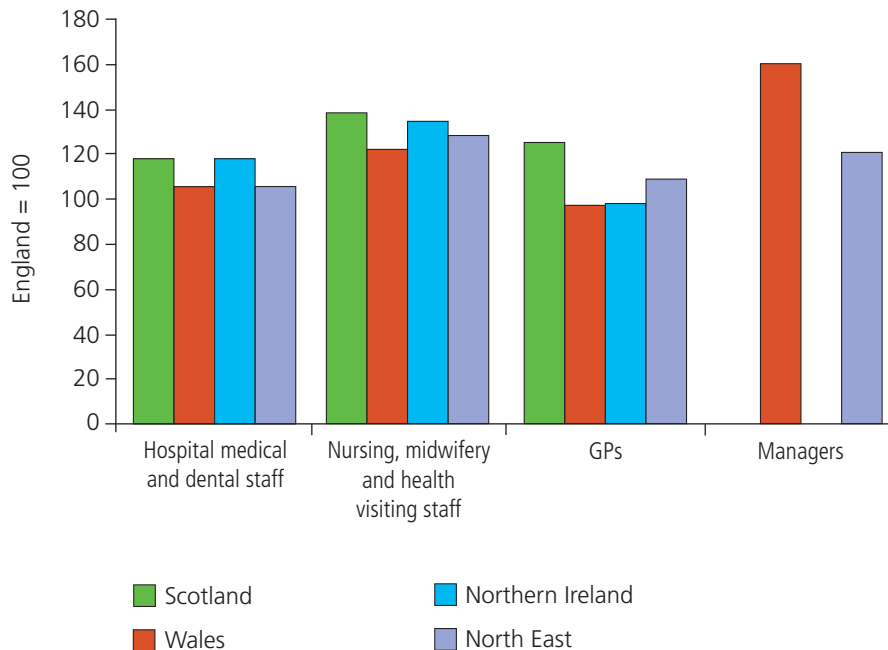


Figure 5.15 compares staffing rates (standardised to England averages of 100) for Scotland, Wales, Northern Ireland and the North East (the SHA with high levels of need, expenditure and staffing). As previously mentioned, data on management and support staff members have been omitted for Scotland and Northern Ireland. The North East had slightly lower rates of hospital medical and dental staff, and nursing, midwifery and health visiting staff than Scotland and Northern Ireland, but similar rates to Wales; it also had fewer GPs per capita than Scotland, but more than Wales and Northern Ireland. Differences in the method used to estimate management and support staff across the countries makes it difficult to comment meaningfully on the numbers.

Figure 5.15: Staff per 1,000 population for Scotland, Wales, Northern Ireland and the North East region of England (2006; England = 100)

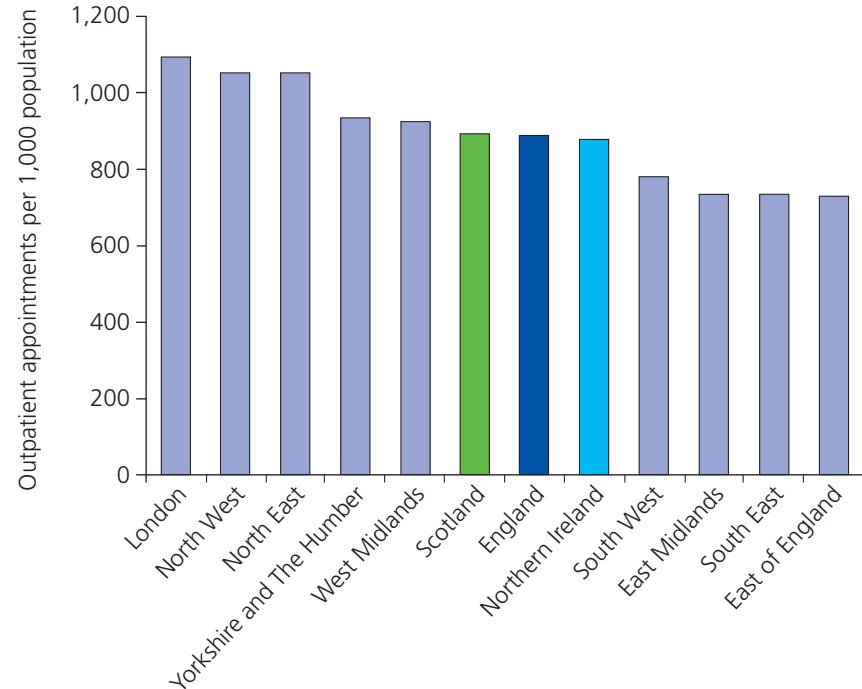


Activity

Figures 5.16, 5.17 and 5.18 give variations in rates of NHS-financed activity, per 1,000 population, for the English GORs and the four countries. Due to differences in definition, data on outpatients and day cases for Wales and inpatients for Scotland have been excluded. For outpatient appointments, day cases and inpatients, the average rates for England mask large regional variations; the means and ranges are as follows:

- For outpatient appointments (total): mean 889, lowest 726 (East of England) and highest 1,090 (London).
- For day cases: mean 81, lowest 67 (South East) and highest 105 (North East).
- For inpatient admissions: mean 160, lowest 146 (South East) and highest 207 (North East).

Figure 5.16: Total outpatient appointments per 1,000 population in the nine GORs of England and England, Scotland and Northern Ireland (2006)



GORs with higher rates of outpatient appointments also tended to have higher rates of day cases and inpatient admissions, probably reflecting greater need for healthcare and suggesting that day case activity is not necessarily a substitute for inpatients.

Figure 5.17: Day cases per 1,000 population in the nine GORs of England and England, Scotland and Northern Ireland (2006)

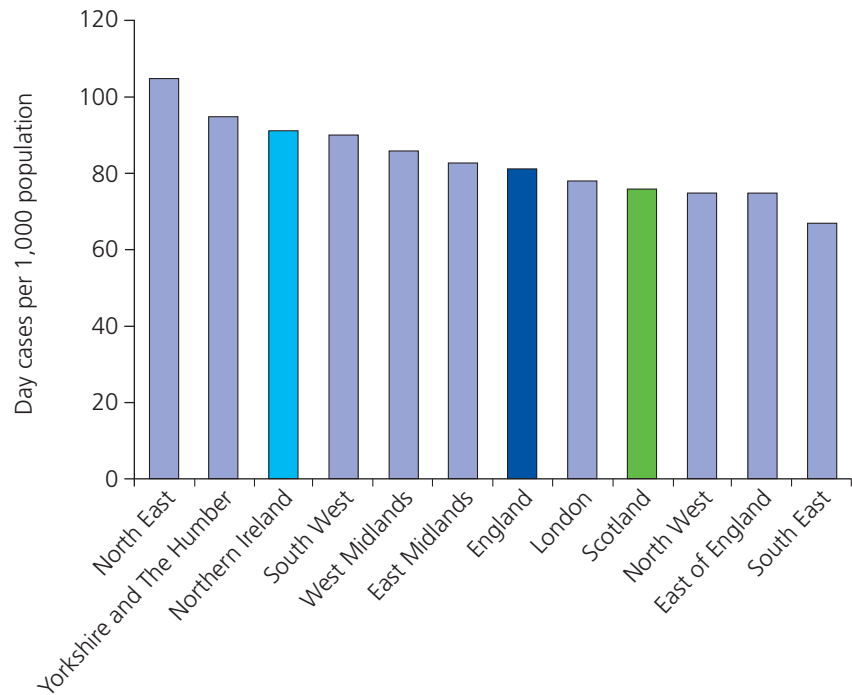


Figure 5.18: Inpatient admissions per 1,000 population in the nine GORs of England and England, Wales and Northern Ireland (2006)

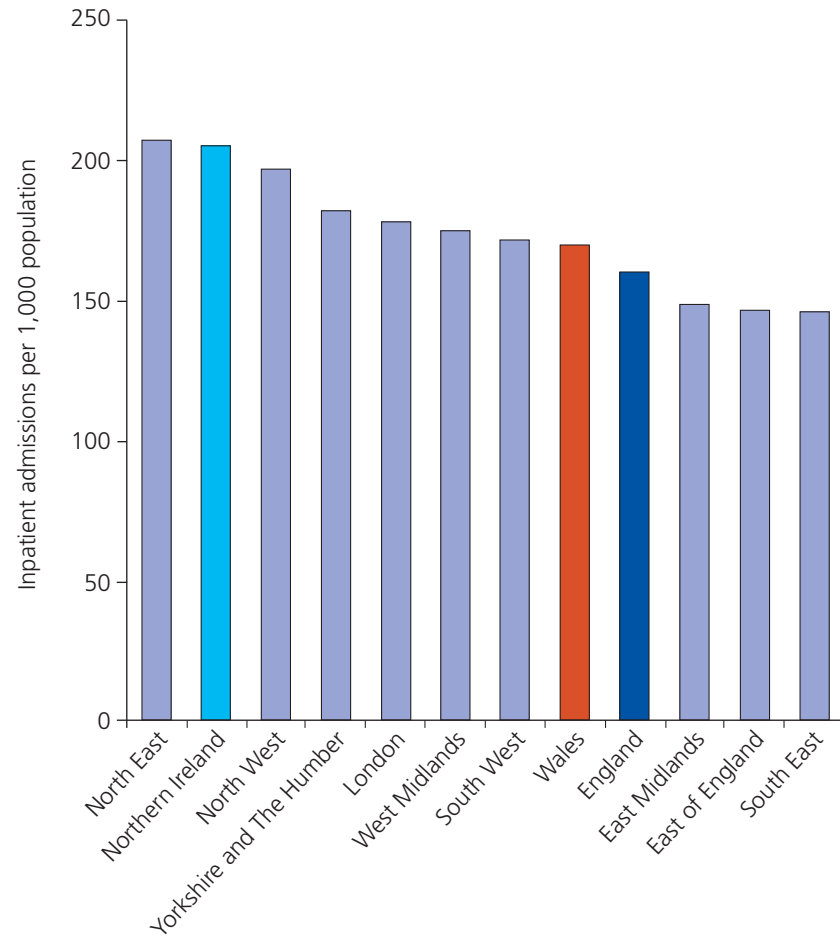
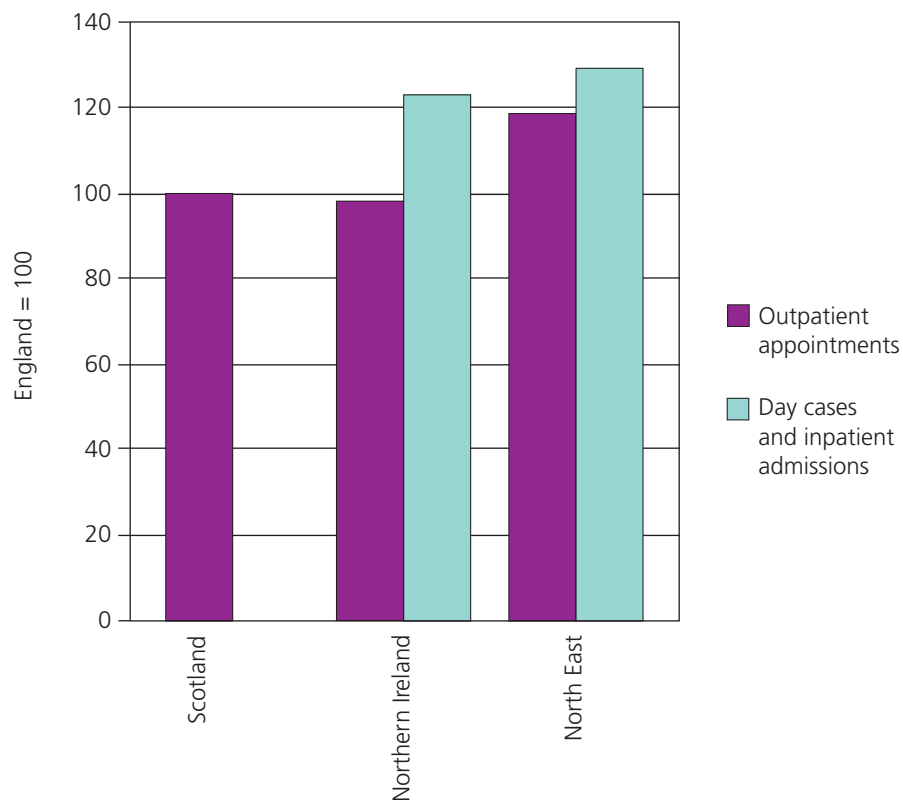


Figure 5.19 compares outpatient appointments for Scotland, Northern Ireland and the North East region of England, and day cases and inpatient admissions for Northern Ireland and the North East region. Day cases and inpatients combined were higher in the North East than in Northern Ireland, while outpatient appointments were greater in the North East than in Scotland and Northern Ireland.

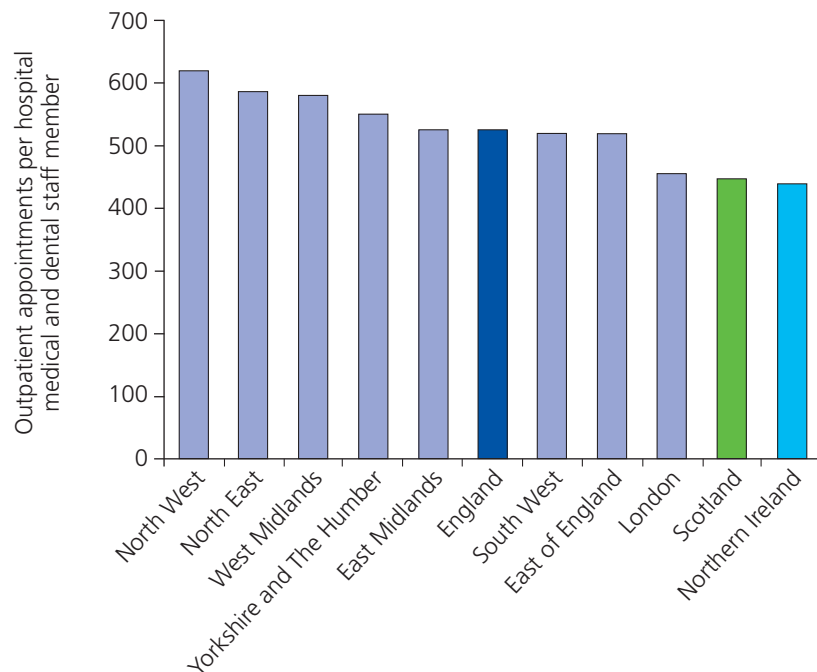
Figure 5.19: Treatment rates per 1,000 population for Scotland Northern Ireland and the North East region of England (2006; England = 100)



Figures 5.20, 5.21, 5.22, 5.23, 5.24 and 5.25 show the number of outpatient appointments, inpatient admissions and day cases per hospital medical and dental staff member, and nursing, midwifery and health visiting staff member. Data have been excluded on outpatients and day cases for Wales, and inpatients for Scotland. The comparisons are for the eight regions in England where the SHAs and GORs are identical (and exclude the South East GOR and South Central and South East Coast SHAs). In general, where it is possible to make comparisons, the numbers of appointments and admissions per hospital medical and dental staff member, and nursing, midwifery and health visiting staff member, in the devolved countries tended to be lower than in the English regions (with the exception of London).

Northern Ireland and Scotland had fewer outpatient appointments per hospital medical and dental staff member, and nursing, midwifery and health visiting staff member, than all the English regions. Inpatient admissions per hospital medical and dental staff member were lowest in London, which significantly reduced the average for England; the numbers for Northern Ireland and Wales

Figure 5.20: Outpatient appointments per hospital medical and dental staff member in eight regions of England and England, Scotland and Northern Ireland (2006)



were lower than for all English regions, except London. Inpatient admissions per nursing, midwifery and health visiting staff member were lowest in Wales, followed by London and Northern Ireland; again, the English average was reduced by the relatively low number for London. The number of day cases per hospital medical and dental staff member was lowest in London, followed by Scotland, and highest in the South West and East Midlands; day cases per nursing, midwifery and health visiting staff member were lowest in Scotland, followed by the North West.

Figure 5.21: Inpatient admissions per hospital medical and dental staff member in eight regions of England and England, Wales and Northern Ireland (2006)

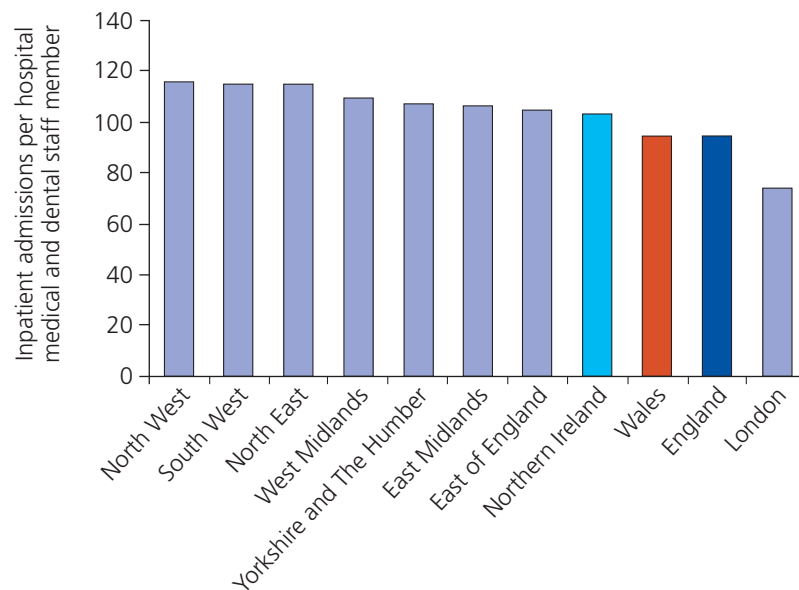


Figure 5.22: Day cases per hospital medical and dental staff member in eight regions of England and England, Scotland and Northern Ireland (2006)

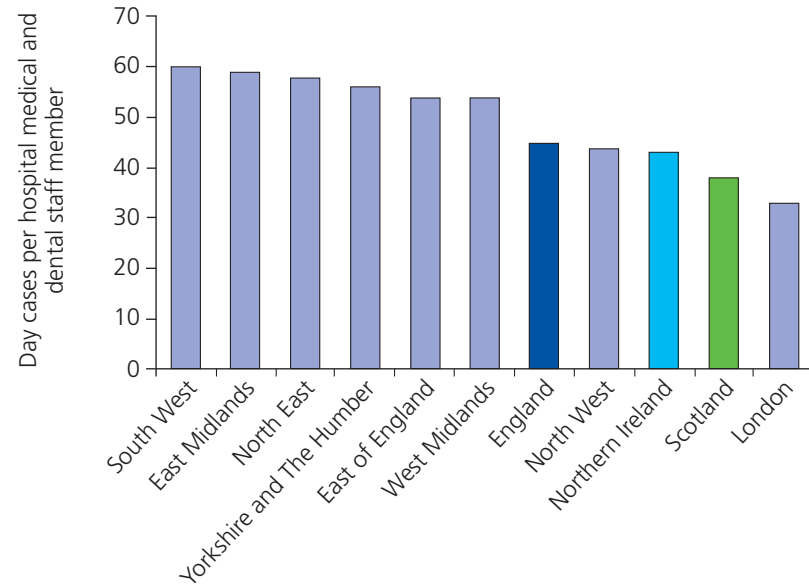


Figure 5.23: Outpatient appointments per nursing, midwifery and health visiting staff member in eight regions of England and England, Scotland and Northern Ireland (2006)

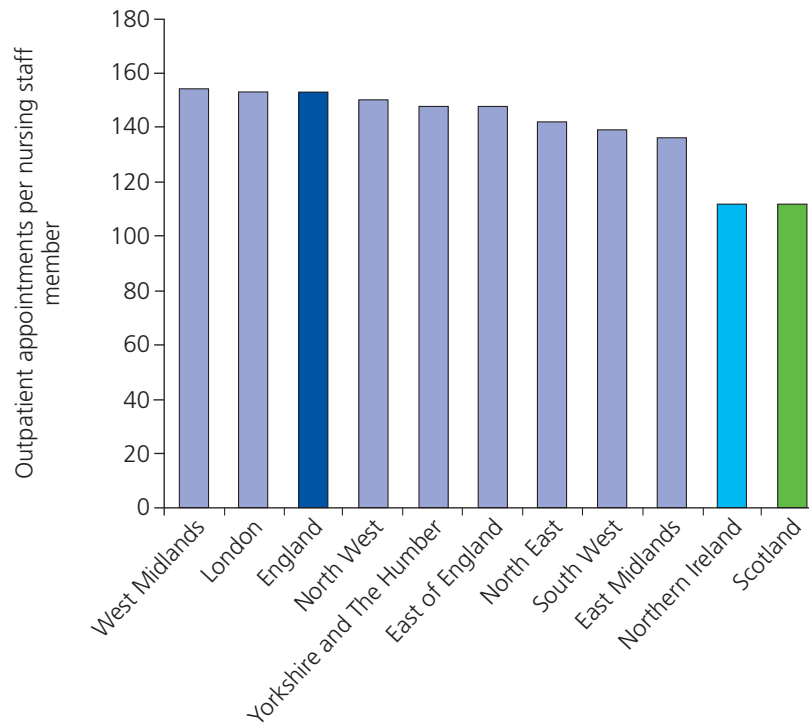


Figure 5.24: Inpatient admissions per nursing, midwifery and health visiting staff member in eight regions of England and England, Wales and Northern Ireland (2006)

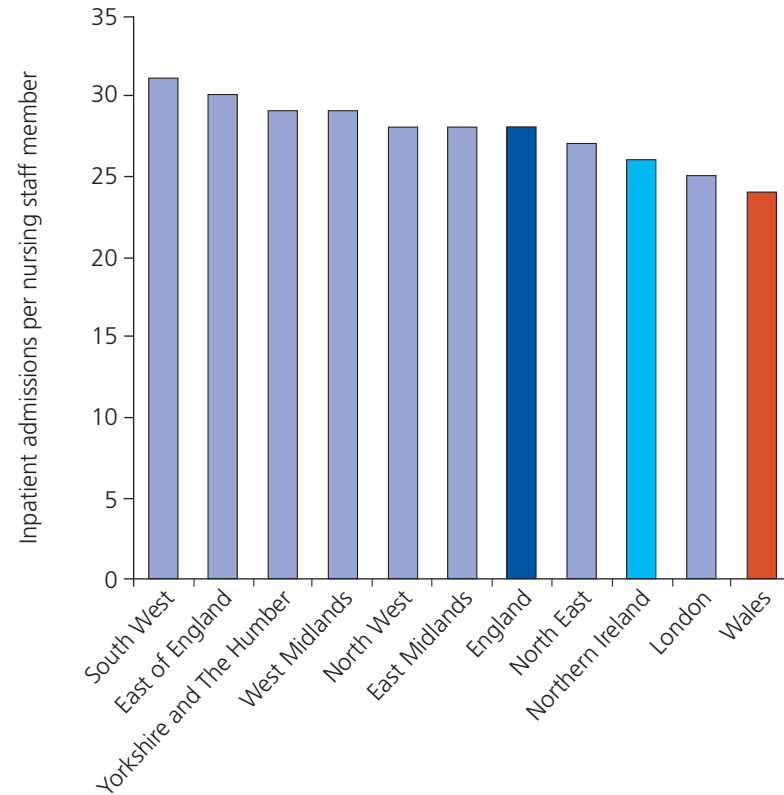
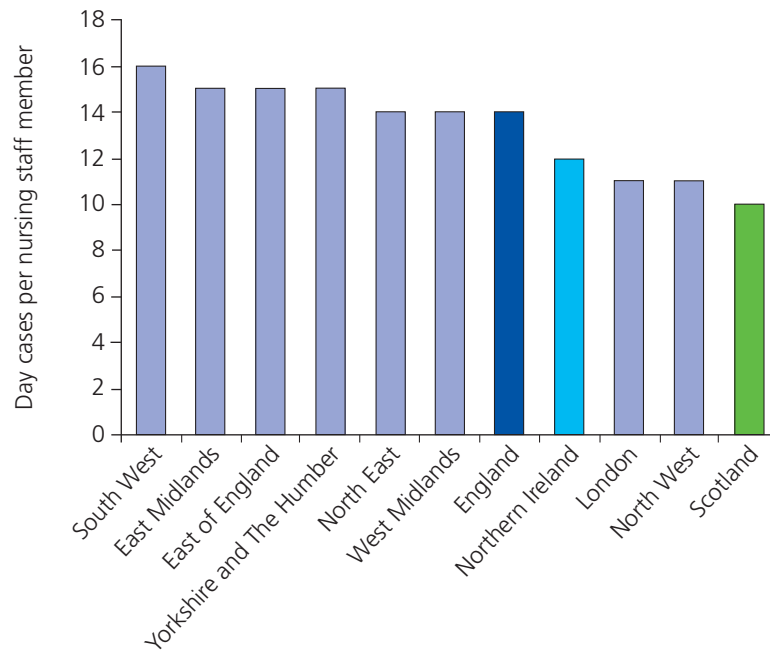


Figure 5.25: Day cases per nursing, midwifery and health visiting staff member in eight regions of England and England, Scotland and Northern Ireland (2006)



Waiting times

Table 5.3 gives waiting times for inpatient and day case admissions and outpatient appointments for the ten English SHAs and the country statistics for England, Wales and Northern Ireland in 2008.⁴ Table 5.3 shows that the performance of Wales and Northern Ireland was worse than each of the English regions. At the end of March 2008, across English SHAs, 1 per cent to 1.5 per cent of the population was waiting for an elective (inpatient or day case) admission and an outpatient appointment, respectively; in Wales, these percentages were 1.7 per cent and 5 per cent; and in Northern Ireland 2.1 per cent and 4 per cent. Figure 5.26 gives the ranking in terms of percentages waiting more than 13 weeks for an elective hospital admission. For all English SHAs this was less than 10 per cent, except for the South East Coast, with 13 per cent; for Northern Ireland and Wales, this was over 20 per cent. Virtually no one in any English region and Northern Ireland waited more than 13 weeks for an outpatient appointment; but 17 per cent did in Wales. Table 5.4 presents an analysis of waiting times for the ten English SHAs (which was not available in a consistent format for the other three countries), showing that the South East Coast SHA was an outlier in terms of its poor performance.

Figure 5.26: Percentage waiting more than 13 weeks for inpatient or day case admission for the ten English SHAs and England, Wales and Northern Ireland (March 2008)

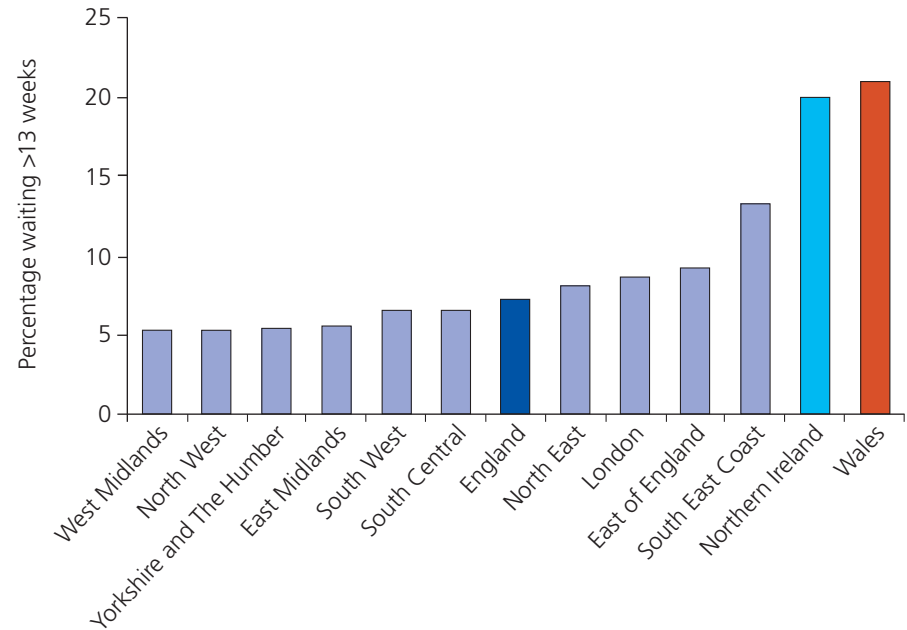


Table 5.3: Numbers and percentage of the population waiting less than 13 weeks for inpatient or day case admission or outpatient appointment in the ten English SHAs and England, Wales and Northern Ireland (March 2008)

	Inpatient and day cases			Outpatients		
	Numbers waiting	% of total population	% waiting <13 weeks	Numbers waiting	% of total population	% waiting <13 weeks
North East	25,977	1.0	91.8	38,013	1.5	100
North West	78,582	1.1	94.6	103,181	1.5	99.9
Yorkshire and The Humber	52,226	1.1	94.5	72,618	1.4	100
East Midlands	42,396	1.0	94.4	61,442	1.4	100
West Midlands	52,860	1.0	94.7	79,390	1.5	100
East of England	64,817	1.2	90.8	80,767	1.4	100
London	73,629	1.0	91.3	122,156	1.6	100
South East Coast	42,997	1.0	86.7	70,393	1.7	100
South Central	36,559	0.9	93.4	51,074	1.3	100
South West	56,180	1.1	93.5	75,935	1.5	100
England	526,223	1.0	92.7	754,969	1.5	100
Wales	50,361	1.7	79.0	149,832	5.1	83.3
Northern Ireland	36,994	2.1	80.0	72,957	4.2	99.9

Table 5.4: Percentage of the population waiting less than six weeks, six to 12 weeks and 12 weeks or more for inpatient or day case admission or outpatient appointment in the ten SHAs of England (March 2006)

	Ordinary + day cases			Outpatient		
	<6 weeks	6 – <12 weeks	≥12 weeks	<6 weeks	6 – <12 weeks	≥12 weeks
North East	62.2	28.1	9.7	90.9	9.1	0.0
North West	70.0	23.4	6.6	94.2	5.7	0.1
Yorkshire and The Humber	66.7	26.5	6.8	91.1	8.9	0.0
East Midlands	67.1	26.0	7.0	92.5	7.5	0.0
West Midlands	64.8	28.8	6.4	94.2	5.7	0.0
East of England	59.4	29.5	11.2	92.6	7.4	0.0
London	61.9	27.7	10.4	87.6	12.3	0.1
South East Coast	55.2	30.0	15.2	85.0	14.8	0.2
South Central	66.2	25.8	8.0	93.6	6.4	0.0
South West	61.5	30.3	8.2	91.8	8.2	0.0

The devolved countries as outliers

Box 5.1 identifies those indicators for which Scotland, Wales and Northern Ireland were outliers, as compared with the distribution for English regions. Box 5.1 identifies outliers in three ways, as areas having a value more extreme than:

- the value for all English regions and the average for England (< or >);
- the value for all English regions except London (<* or >*);
- the value for all English regions except London and the average for England (<** or >**).

Box 5.1 shows Scotland to be an outlier in all domains for which there were comparable statistics, with the highest levels of poor health; the highest rates per capita of expenditure and all types of staff; the lowest rates of inpatient admissions; and the lowest rates of crude productivity for hospital medical and dental staff, and nursing, midwifery and health visiting staff.

Box 5.1 shows Wales and Northern Ireland also to be outliers in similar ways, with high rates per capita of expenditure and staff for HCHS (but not GPs); low crude productivity for hospital medical and dental staff, and nursing, midwifery and health visiting staff; and poor performance in terms of long waiting times for outpatients and inpatients.

-
1. In the extreme case, comparing Northern Ireland (population 1.7 million) with England (population 50 million) is misleading as about half of the population of Northern Ireland live in the urban area of Belfast.
 2. Wanless (2003) op. cit.
 3. As above, the numbers for all staff are for whole time equivalents except for GPs, for which the data give a head count only.
 4. As explained above, the way Scotland reports these statistics is not comparable with the other countries, but Propper and others (2008a and 2008b) op. cit. have shown that Scotland's performance has been worse than England in waiting for elective admission.

Box 5.1: Indicators for which Scotland, Wales and Northern Ireland are outliers as compared with English regions (2006)

	Scotland	Wales	Northern Ireland
Health indicators			
• SMRs (males and females)	>		
• Life expectancy at birth (males and females)	<		
• % population >65–74 (males) and 60–74 (females)			<*
• % population reporting LLSI			>
Supply per capita			
• NHS expenditure	>		
• Available hospital beds	NA	NA	>
• Hospital medical and dental staff	>*	>*	>*
• Nursing, midwifery and health visiting staff	>		>
• Management and support staff	NA	>	NA
• GPs	>		
Treatment rates per capita			
• Day cases		NA	
• Inpatient admissions	NA		

Box 5.1: Indicators for which Scotland, Wales and Northern Ireland are outliers as compared with English regions (2006) (continued)

	Scotland	Wales	Northern Ireland
Crude productivity			
• Outpatients per hospital medical and dental staff member	<	NA	<
• Inpatients per hospital medical and dental staff member	NA	<***	<***
• Day cases per hospital medical and dental staff member	<*	NA	
• Outpatients per nursing, midwifery and health visiting staff member	<	NA	<
• Inpatients per nursing, midwifery and health visiting staff member	NA	<	<*
• Day cases per nursing, midwifery and health visiting staff member	<	NA	
Waiting times			
• % waiting >13 weeks for outpatient appointment	NA	>	>
• % waiting >13 weeks for elective admission	NA	>	>

Key to Box 5.1:

> denotes value greater than the average for England and for all English regions

< denotes value less than the average for England and for all English regions

>* denotes value greater than the average for England and for all English regions except the London region

<* denotes value less than the average for England and for all English regions except the London region

>** denotes value greater than the average for English regions except the London region

<** denotes value less than the average for English regions except the London region

CHAPTER 6

DISCUSSION

The various commentators on policy developments following political devolution in the UK have pointed out that the resultant policy differences mean that it is no longer meaningful to talk of a 'UK NHS': there are now four different NHSs with four governments' policies set on different paths. The period of policy divergence developed over a period of massive increases in NHS funding for each country, which financed large increases in staffing. Each country had targets for hospital waiting times and ambulance response times; but only in England from 2000 was there a system of public reporting in the form of annual 'star ratings' and the 'Health Check', backed up by active performance management that sought to change the culture from one of perversely rewarding failure (by giving extra resources to hospitals with long waiting times, for example) to a new system of penalising managers for provider failure and rewarding them for success in achieving targets.

From 2002, these systems were accompanied by a package of system reforms designed to develop a pluralistic provider market driven by patient choice. The target-driven approach together with increased funding was followed by a

transformation in waiting times for elective care: in 2001, in England, the targets for waiting times would allow a patient having been referred by a GP to wait more than two years for an elective admission to hospital; by 2008 that target was reduced to 18 weeks.

The reintroduction of a provider market, however, appears to have had minimal impact so far.¹ Government policies in Scotland and Wales have increasingly diverged from those in England: instead of an emphasis on patients choosing between competing pluralist providers, these governments favour a publicly owned NHS run by authorities that are integrated with providers. Political devolution in the UK provides a unique opportunity in the form of a natural experiment to examine the impact of diverging policies in translating inputs into service delivery and improving quality.

In 2005, two of the authors reported a comparison of the performance of the NHS in the four countries of the UK covering the period 1996 to 2002, before and immediately after political devolution.² The headline findings of that analysis were the absence of any obvious link between spending per capita

and performance (the data did not suggest that the UK countries with higher levels of real healthcare resources or expenditure had more activity, better population health or higher levels of public satisfaction), and the fact that England had much shorter waiting times in the post-devolution period than Wales or Northern Ireland (there were no comparable data for Scotland).

This latest cross-country analysis takes the story as far as 2006 and produces similar findings. In 2009, Sutherland and Coyle reported cross-country comparisons at various times (mainly cross-sectional) of a range of indicators of quality of care, using routinely collected data, across six domains of quality: effectiveness, access and timeliness, capacity, safety, patient centredness and equity.³ Some of these domains overlap with what has been reported here. They too found that Scotland had the highest per capita spend and England the lowest (for 2007/08); England had the highest life expectancy (for both males and females); Scotland continued to have the highest mortality rates in most major disease groups (but the steepest decreases in recent years); and problems in comparing waiting time performance (they reported median waiting times for selected procedures).⁴ Other key messages included:

- in terms of the three guidelines of the Royal College of Radiotherapists for waiting for treatment for radiotherapy, Scotland performed relatively poorly and Northern Ireland well;
- general practices in Scotland and Northern Ireland generally recorded the highest rates for providing care consistent with evidence-based practice;

- reported rates for timely reperfusion in heart attack patients were much lower in Wales than in England;
- the lowest vaccination rates for two-year-olds were in England, and for flu (for the over-65s) were in Wales;
- all countries face problems with healthcare associated infections (in particular for MRSA and *Clostridium difficile*), although rates for MRSA have been reduced substantially in England;
- respondents in Scotland were most positive about their quality of care (based on surveys in 2005 and 2006 by the Commonwealth Fund);
- in all countries, there were material differences in life expectancy and mortality rates from major diseases between the least and most socioeconomically deprived sections of the population.

The analysis by Sutherland and Coyle of performance of the four countries across a range of indicators in six domains of quality of care showed that:

- across the UK, there have been improvements in quality and outcomes, but the UK is still often worse than, for example, other European countries;⁵
- there were few important differences between each country;
- there is no systematic pattern in which one country consistently performed better than any other.

In contrast, the current analysis has identified important and systematic differences between countries in terms of waiting times, ambulance response times to emergency calls, and

crude productivity of hospital medical and dental staff, and nursing, midwifery and health visiting staff. England continues to have the lowest level of funding per capita, but appears from the limited data available to have a more responsive service as assessed by waiting times and seems to make better use of its key resources – its staff. The regional analysis helps corroborate these findings, as indicators at this level show systemic differences that are more likely to be due to policy differences.

The limited scope of the report is largely due to the lack of routinely collected data on healthcare performance that are comparable across the four countries and over time. This report has highlighted how, because of lack of oversight, there have been increasing differences in definition between countries, which mean that the scope for meaningful cross-country comparisons has diminished from even the limited set that was available in 1996. The measures we are able to report of crude productivity do not fully capture the value of outputs (changes in quality and outcomes) or costs of inputs (the large pay awards made to hospital medical and dental staff and the new GP contract).⁶ They cannot be supplemented because of important gaps in data on quality of care and in patients' experiences of the NHS across the UK. In England, there have been important developments since 2001 in annual reporting of patients' experiences with NHS hospital and GP care.⁷ Since April 2009, in England only there has been the introduction of patient reported outcomes following hospital discharge⁸ (for hip replacements, knee replacements, groin hernia surgery and varicose vein surgery).

Before summarising the differences between the countries, it is worth emphasising the similarities between them. Since 2002, in all four countries there have been large increases in NHS spending and staffing per capita, falls in the crude productivity of hospital medical and dental staff, and nursing, midwifery and health visiting staff, and reductions in waiting times, with the last most marked in England.

The principal findings from the cross-country longitudinal comparisons that the authors were able to make are as follows:

- Per capita expenditure on the NHS for 1996, 2002 and 2006 across the four countries: Scotland had the highest and England the lowest rates.
- Rates of hospital medical and dental staff per 1,000 population for 1996, 2002 and 2006 across the four countries: Scotland had the highest and England the lowest rates (except in 2002 when Wales had the same rate as England, and in 2006 when Northern Ireland had the same rate as Scotland).
- Rates of nursing, midwifery and health visiting staff per 1,000 population for 1996, 2002 and 2006 across the four countries: Scotland had the highest and England the lowest rates (except in 1996 when Northern Ireland had the same rate as Scotland).
- Rates of GPs per 1,000 population for 1996, 2002 and 2006 across the four countries: Scotland had the highest and England the lowest rates (except in 2006 when Wales had the lowest rate).

- Rates of management and support staff per capita – for 1996, 2002 and 2006, we can compare England and Wales only: throughout, England had substantially lower levels of staffing than Wales.
- Rates of outpatient appointments per capita for 1996 and 2002, across the four countries: in 1996, Scotland had the highest and England the lowest rates; in 2002, Wales had the highest and Northern Ireland the lowest rates. For 2006, we can compare Scotland, England and Northern Ireland only: Scotland had the highest and Northern Ireland the lowest rates.
- Rates of day cases per capita – we can compare England, Scotland and Northern Ireland only: Scotland had the highest rate in 1996 and 2002, but the lowest rate in 2006; Northern Ireland had the lowest rate in 1996 and the highest in 2006. England had the lowest rate in 2002.
- Rates of inpatient admissions per capita for 1996 and 2002, across the four countries: England had the lowest rate in each year, Scotland had the highest rate in 1996, and Northern Ireland in 2002. For 2006, we can compare England, Wales and Northern Ireland only: Northern Ireland had the highest rate and England the lowest.
- Rates of outpatient appointments and inpatient admissions per hospital medical and dental staff member for 1996 and 2002, across the four countries: England had the highest rates in 1996 and Wales in 2002, and Scotland the lowest rates in each year. For 2006, for outpatient appointments per hospital medical and dental staff member we can compare England, Scotland and Northern Ireland only: England had the highest rate and Northern Ireland the lowest. For 2006, for inpatient admissions per hospital medical and dental staff member, we can compare England, Wales and Northern Ireland only: Northern Ireland had the highest rate and England and Wales the same rate.
- Rates of day cases per hospital medical and dental staff member – for 1996, 2002 and 2006, we can compare England, Scotland and Northern Ireland only: England had the highest rates in each year, and Northern Ireland had the lowest in 1996, and Scotland in 2002 and 2006.
- Rates of outpatient appointments per nursing, midwifery and health visiting staff member – for 1996 and 2006, we can compare all four countries, and for 2006, England, Scotland and Northern Ireland only: in each year, England had the highest rates and Northern Ireland the lowest (in 2006, Scotland had the same rate as Northern Ireland).
- Rates of inpatient admissions per nursing, midwifery and health visiting staff member for 1996 and 2002, across the four countries: England had the highest rate in each year, Northern Ireland the lowest rate in 1996 and Scotland the lowest rate in 2002. For 2006, we can compare England, Wales and Northern Ireland only: Wales had the lowest and England the highest rate.
- Rates of day cases per nursing, midwifery and health visiting staff member – for 1996, 2002 and 2006, we can compare England, Scotland and Northern Ireland only: England had highest rates in each year, Northern Ireland the lowest rates in 1996 and Scotland the lowest rate in 2002 and 2006.

- Percentages of the population waiting less than six months for an inpatient or day case admission – for 1996, we can compare England and Northern Ireland only: England had the better performance. For 2002 and 2006, we can compare England, Wales and Northern Ireland only: England had the best performance in each year, Northern Ireland had the worst performance in 2002 and Wales had the worst performance in 2006.
- Percentages of the population waiting less than three months for an outpatient appointment – for 1996, we can compare Wales and Northern Ireland only: Wales had the better performance. For 2002 and 2006, we can compare England, Wales and Northern Ireland only: in both years, England had the best performance and Northern Ireland the worst.
- Percentages of ambulance response rates to what may have been life-threatening emergencies in less than eight minutes – from 2000 to 2004, we can compare England and Wales only: England had the better performance. From 2004 to 2006, we can compare England, Scotland and Wales only: England had the best performance and Scotland and Wales were similar.

This report presents for the first time a cross-sectional comparison for 2006 of the three devolved countries with the English regions. The analysis has highlighted the limitations of using average statistics for England and offers a much sounder basis for comparisons with the three devolved countries for the following reasons:

- Size: the populations of the nine English GORs range from 2.4 to 8.2 million people and are hence more comparable than England with Northern Ireland, Wales and Scotland (with populations ranging from 1.7 to five million).
- The unrepresentative nature of London distorts the national averages for spending and staffing per capita, and the crude productivity of hospital medical and dental staff, and nursing, midwifery and health visiting staff, because of the higher costs of its labour markets; and expenditure and staffing per capita due to the massive concentrations of teaching, training and research.
- Population characteristics: the north/south divide means that the socioeconomic and morbidity characteristics of the north are more typical of the devolved countries, and the North East, in particular, is a much better benchmark than England as a whole in terms of comparing inputs, crude productivity and performance with the three devolved countries.

The comparisons between the devolved countries and the English regions are limited by all the definitional problems that have so impeded the cross-country comparisons. For the additional indicator that is reported here of available beds per capita, there are problems comparing Scotland with the other devolved countries and the English regions.

Comparisons are possible for all three devolved countries with the English regions for mortality and life expectancy, and three measures of inputs (resources per capita, expenditure, hospital medical and dental staff, nursing, midwifery and health visiting staff, and GPs):

- SMRs (for males and females): Scotland had the highest rates (although these were close to those for the North

East); the South East and South West regions had the lowest; the rates for Northern Ireland were comparable with the highest rates of the two worst English regions (the North East and the North West); and the rates for Wales were comparable with the median rate for English regions.

- Perinatal mortality rates: the West Midlands had the highest rate and the South West the lowest; most English regions had higher rates than Scotland; and Wales and Northern Ireland had rates lower than all English regions except the South West and East of England.
- Infant mortality rates: the West Midlands had the highest rate; the South East, Wales, the East of England and the South West had the lowest rates; most English regions had higher rates than Scotland and Wales, but Northern Ireland had a rate close to those English regions with high rates.
- Life expectancy (for males and females): Scotland had the lowest rates for both genders;⁹ the South East had the highest rate for males and the South West the highest rate for females; Wales and Northern Ireland had rates similar to the two English regions with the lowest rates (the North East and the North West).
- Per capita spend: Scotland had the highest rate, and Wales and Northern Ireland had similar levels to the three English regions with the highest per capita spend (London, the North East and the North West).
- Hospital medical and dental staff: except for London (an outlier with the highest rate, which is not comparable),

Scotland and Northern Ireland had the highest rates, and Wales had a rate similar to the Northern regions of England.

- Nursing, midwifery and health visiting staff: Scotland and Northern Ireland had the highest rates, and Wales had a rate similar to the Northern regions of England.
- GPs: Scotland had the highest rate; Northern Ireland had a lower rate than most English regions; and only the East Midlands had a lower rate than Wales.

Comparisons are possible for Scotland and Northern Ireland with the English regions for the following:

- Outpatients per capita: Scotland and Northern Ireland had rates lower than the median value for English regions, but close to the mean for England.
- Day cases per capita: Northern Ireland was at the higher end of the distribution for English regions, and Scotland at the lower end.
- Outpatients per hospital medical and dental staff member: Scotland and Northern Ireland had lower rates than any English region.
- Day cases per hospital medical and dental staff member: Scotland had lower rates than any English region except for London, and Northern Ireland had lower rates than seven English regions (the exception being London).

Comparisons with the English regions are possible for Wales and Northern Ireland for the following:

- Available hospital beds per capita: Northern Ireland and Wales had higher rates than any English region, but these

rates were close to that of the North East, which had a materially higher rate than the other English regions.

- Inpatients per capita: Northern Ireland had a rate close to that for the highest for the English regions (the North East), and Wales a rate lower than the median value for English regions, but higher than the mean for England.
- Inpatients per hospital medical and dental staff member: Northern Ireland and Wales had lower rates than any English region, except for London.
- Percentage waiting more than 13 weeks for admission as an inpatient or day case, or outpatient appointment: Northern Ireland and Wales had worse performance than any English region.

Comparisons are possible for Northern Ireland with the English regions for the following:

- Outpatients, inpatients and day cases per nursing, midwifery and health visiting staff member: Northern Ireland had lower rates than all English regions for outpatients and inpatients (except for London), and than six English regions for day cases (the exceptions being London and the North West).

Comparisons are possible for Wales with the English regions for the following:

- Management and support staff per capita: Wales had a substantially higher rate than any English region.

Comparing Scotland, Wales and Northern Ireland with the North East as the most comparable English region showed the following:

- Scotland had the highest SMRs and lowest life expectancy at birth (for males and females); the West Midlands had the highest perinatal mortality rate; the West Midlands and Yorkshire and The Humber had the highest infant mortality rates; and Northern Ireland had the highest rate of LLSI.
- Scotland had the highest expenditure per capita, and Wales, Northern Ireland and the North East had similar rates.
- Scotland and Northern Ireland had the highest rates of hospital medical and dental staff per capita; the rate for Wales was similar to that of the North East.
- Scotland had the highest rate of GPs, and the rate for the North East was substantially higher than in Wales and Northern Ireland.

The authors see scope for further, more detailed work using the North East as a benchmark for comparison with the devolved countries.

These analyses can be suggestive only because of the limited set of indicators that were available for the baseline analysis in 1996, and the scope to apply that limited set has become more restricted over time, with increasing inconsistencies in definition between the different countries. The general finding from comparisons of the devolved countries with the English regions where the data were comparable showed that the devolved countries tend to be outliers (i.e. outside the distribution of the English regions). Comparing Scotland with English regions showed that Scotland had the highest SMRs, the lowest life expectancy and the highest levels of expenditure.

Comparing Wales and Northern Ireland with the English regions showed that Wales and Northern Ireland had longer waiting times for hospital, and lower crude productivity of hospital medical and dental staff, and nursing, midwifery and health visiting staff, than any English region (excluding London for some measures).

Of course, it may be that the better relative performance of the NHS in England on the measures reported here, compared with that of the devolved countries, is offset by those countries having better performance on dimensions that were not measured in this report. However, three more detailed studies that compared performance in England with Scotland (two) and with Wales (one) found little evidence that this was so. Propper and others compared the effects of different policy emphases and instruments for targets for waiting times after devolution between England and Scotland.¹⁰ They found some evidence of waiting list manipulation in England (where the number of suspensions and removals increased as a result of the policy), but their principal conclusion was that:

This paper provides evidence that, contrary to popular views, a policy of targets for waiting lists in the English NHS appears to have achieved its objectives. The length of time patients waited fell and admissions for elective care rose. This fall in waiting times was achieved without many of the gaming activities that had been forecast. The waiting times distribution did not stack up at the maximum waiting point, the order in which patients were treated from the list did not appear to change, the proportion of urgent cases treated did not fall and there is no evidence of a decrease in several measures of quality of care as a result of the policy.

Farrar and others¹¹ sought to examine the impact of the new system of 'Payment by Results' (PbR), introduced in England so that hospitals are paid a fixed tariff (based on estimated national average costs) for different types of cases (defined by Healthcare Resource Groups). PbR was introduced at different times for NHS foundation trusts and NHS (non-foundation) trusts from 2003/04 to 2005/06. PbR creates financial incentives for hospitals to reduce costs and increase the number of cases they treat, with concerns over incentives to skimp on quality or discharge patients too early. In contrast, in Scotland, there was no tariff system for funding hospitals (other than for cross-boundary flows), and hence only weak financial incentives to reduce costs and treat more numbers.¹²

Farrar and others compared productivity for different types of hospitals in England with hospitals in Scotland over the period from 2003/04 to 2005/06, and estimated that productivity improved slightly in England as compared with Scotland.¹³ They emphasised that PbR was not the only key difference driving this improved productivity and specifically cited the greater pressure on English hospitals to reduce waiting times. They found no statistically significant differences between hospitals in England and Scotland for the three variables they used to measure quality (in-hospital mortality, 30-day postsurgical mortality, and emergency readmission after treatment for hip fracture), except that for NHS foundation trusts, there was a *reduction* in in-hospital mortality (as compared with hospitals in Scotland) after the impact of two years of PbR. They tentatively concluded that reductions in hospital costs in England had been achieved by increases in efficiency rather than reductions in quality.

Hauck and Street¹⁴ compared the performance of four NHS hospitals on the border between England and Wales – three were located in England and one in Wales (the North East Wales Trust) – over six financial years (from 1997/98, prior to devolution, to 2002/03). They too drew attention to the different policy emphases and instruments after devolution between England and Wales.¹⁵ They concluded:

There is evidence that the English hospitals exerted more effort than the Welsh hospital over the six-year period. When comparing trends across hospitals, there are similarities among those located in England and differences to the North East Wales Trust. The English hospitals increased levels of activity, reduced length of stay and undertook proportionately more day case activity over the period. Activity levels remained constant at the Welsh hospital, the proportion of day case activity fell, and proportionately more non-elective patients were admitted.

There is no evidence that the English hospitals achieved activity increases by compromising on quality. Mortality rates at the English hospitals remained low or declined further over the period, but the high and rising hospital mortality rates at the North East Wales Trust are cause for concern. It may be that higher mortality rates at the North East Wales Trust are due partly to the proportionate increase in non-electives admitted to the hospital.

Hauck and Street also pointed out that commentators have suggested that in the immediate post-devolution period the Welsh Minister for Health and Social Services reduced attention on waiting-time targets in Wales and instead ‘emphasised what has been termed “joined up working” focusing on partnerships

between health, local government and the voluntary sector’. It is unclear whether sufficient offsetting benefits were generated to justify the shift in policy focus but, as they argued, the subsequent reintroduction of targets in Wales suggests not. Indeed, in an adjournment debate in 2003 in the (UK) House of Commons¹⁶ on the Welsh Wanless Report,¹⁷ MPs representing constituencies in Wales highlighted the poor performance of the NHS in Wales on waiting times:

Although there have been significant improvements in the performance of the NHS in Wales thanks to the government’s record investment in public services, waiting lists are still unacceptably high and there is a danger that if the Assembly does not pursue reform as vigorously as it is pursued in England, the NHS in Wales will fall even further behind... . Of course, waiting lists and times are not the only measure of performance, but I believe that they are a crucial indicator of the extent to which extra investment is being used effectively... . Of those Welsh residents waiting for inpatient treatment on that date [31 March 2003], 16 per cent had been waiting for more than 12 months, compared with zero per cent in England, and 5,200 Welsh residents – seven per cent of the total – had been waiting for more than 18 months for treatment... some people on orthopaedic waiting lists have to wait four and a half years for the operation that they need.

The NHS in each country, having experienced seven years of ‘feast’ (from unprecedented annual increases in ‘real’ growth), now faces the prospect of a similar period of ‘famine’ (or at best little or no ‘real’ growth).¹⁸ The government in England used the years of ‘feast’ to reduce long waiting times,

and governments in the other countries may find it hard to catch up with performance in England during the years of ‘famine’.

To what extent are major differences between the countries in funding per capita justified by differences in need?¹⁹ For over 30 years, each country has developed and implemented complex formulas to ensure that within each country, resources have been allocated with the objective of equal opportunity of access for equal need.²⁰ In contrast, the Barnett Formula for ‘devolved services’ has used crude, outdated population statistics (that benefited Scotland) and additional funding was determined in bilateral negotiations (that benefited Scotland and Northern Ireland). The House of Lords Select Committee on the Barnett Formula concluded that ‘the resulting per capita allocations are arbitrary and unfair’.²¹ The authors of this report strongly endorse the Committee’s recommendation that:

Public spending per head of population should be allocated across the United Kingdom on the basis of relative need, so that those parts of the United Kingdom which have a greater need receive more public funds to help them pay for the additional levels of public services they require as a result. (p8)

Current arrangements demonstrate two troubling features of governance and accountability. First, while the governments of the devolved countries are held to account by their electorates specifically for the performance of devolved services, there is no equivalent electoral accountability for such services in England, as this accountability is exercised only through general elections to the UK Parliament.²² This also means that there is no answer to

the ‘West Lothian question’: why should MPs from non-English constituencies be able to vote on policies for England (for healthcare, education and transport), when English MPs cannot vote on these policies for each devolved country (as these are matters for their own parliament and assemblies), even though their finance comes from the budget for the UK? Second, the UK taxpayer funds health services in each country, but only England is held to account for its performance by the Treasury. In principle, the funding of the NHS in England has been dependent upon performance against the Treasury’s PSA targets. As discussed earlier, the global sum for funding ‘devolved services’ in the other UK countries is the outcome of global allocations to England for ‘devolved services’, which are in principle contingent on government departments in England achieving their Treasury PSA targets, use of the Barnett Formula and bilateral negotiations with the Treasury. Each devolved country then decides how much of that global sum to allocate to healthcare. Since 2007, for health and other devolved services, there have been no PSA targets for the devolved governments, so their funding was not contingent upon their performance.

This report shows that the data collected on a comparable basis over time across the four countries are extremely limited and, if anything, devolution seems to have reduced the willingness of the devolved administrations to collect such data.²³

The House of Lords Select Committee on the Barnett Formula highlighted the problem of inadequate comparable data published by the Treasury:²⁴

Despite its importance, the Treasury only publish limited data about devolved public spending, and the published official data

*appear in a number of places – in the Statement of Funding Policy, the Public Expenditure Statistical Estimates, and the annual reports of the Scotland and Wales Offices. Older published data do not distinguish clearly which level of government is responsible – United Kingdom or devolved – for particular spending in the breakdowns published in the Public Expenditure Statistical Estimates. There is no time series showing how expenditure has changed as a result of spending decisions made in previous years or spending reviews. It is difficult to establish comparable levels of spending in England for devolved functions as they are different in each part of the United Kingdom.*²⁵

Collecting data on the NHS is costly and only worthwhile if these data can be used. Systematic reviews of the industry of collecting and reporting data on healthcare have found that few of these exercises have been evaluated, and that the few which have, often have limited benefits to show for their costs.^{26 27} Hibbard²⁸ has argued that if data are to be used to have an impact by putting pressure on those performing poorly to improve, then this is best done by benchmarking through a public comprehensible ranking of performance. The divergences in definitions of basic NHS data between the devolved countries and England, such as for staff, hospital activity and waiting times, increasingly restrict benchmarking of performance to comparisons within each country. The small devolved countries have limited scope to learn from benchmarking based on within-country comparisons. The

authors' experience in this study shows that the data collected on a comparable basis over time across the four countries are extremely limited. While the UK Statistics Authority has a crucial role in monitoring the quality of statistics produced by each country, it does not appear to have the power to require governments of the UK to produce comparable data on public services. If the governments of all four countries were confident that they could demonstrate that their policies would deliver better NHS performance, they would welcome the opportunity to demonstrate this in comparison with one another. If they are reluctant to allow such comparisons to be made, this suggests that they are fearful that their policies will be found wanting.

Furthermore, UK taxpayers have a right to know how well the different governments are, or are not, securing value for their money. The Treasury ought to be able to require governments to account for their performance by supplying comparative data. This report recommends that the Treasury takes on the role of ensuring that key data are collected on a consistent basis across the four countries, so that there can be open public scrutiny of the performance of governments empowered to pursue different policies financed by the UK taxpayer. In addition, such information would inform the electorates of each country as to how well each government is running its NHS. Box 6.1 gives what is suggested as a minimum dataset that ought to be comparable across countries.

Box 6.1: Recommended minimum dataset that ought to be made comparable across countries

Populations
Standardised mortality ratios (SMRs) (males and females separately)
Perinatal and infant mortality rates
Life expectancy at birth
Available hospital beds
Percentages of the population reporting longstanding illness, LLSI and restricted activity
Total NHS expenditure
Hospital medical and dental staff (whole time equivalents)
GPs
Nursing, midwifery and health visiting staff (whole time equivalents)
Management and support staff (whole time equivalents)
Day cases
Inpatient admissions
Percentage of category A ambulance calls met within eight minutes
Numbers waiting more than 18 weeks from referral by a GP to admission as an inpatient or day case
Percentage of the population reporting satisfaction with the general running of the NHS inpatient care, outpatient care and GP care

This report has identified potentially important differences between the UK countries in funding, staffing and performance that highlight larger issues posed by devolution in terms of the way monies from the UK taxpayer are allocated to the devolved countries and accountability for devolved services in all countries. The authors recognise the limitations of the analyses that arise from the data that are available on a consistent basis across countries and over time. But the cross-sectional analyses using regional data from England, and analyses by others, tend to confirm the principal finding that England has the lowest per capita funding for the NHS and makes better use of its lower level of resourcing in terms of shorter waiting times and higher crude productivity of its staff. Others have also failed to find any systematic evidence that the higher levels of per capita funding, longer waiting times and lower crude productivity of staff in the devolved countries are associated with superiority in other dimensions of quality of care. This looks to be a subject that merits further analysis. There is also scope for further, more detailed, work using the North East region as a benchmark for comparison with the devolved countries.

Following political devolution, the governments of the different UK countries have tended to pursue similar ends (for example, reducing long waiting times for access to healthcare, improving health outcomes and reducing health inequalities) with different means. On the one hand, the devolved countries have advantages in pursuit of common objectives of being smaller and easier to govern than England, and of having more resources available per capita. On the other hand, Scotland and Wales in particular have sparsely populated rural areas, where delivering healthcare may be more difficult and costly, and all three devolved countries have generally higher needs for healthcare. Further research ought to tackle three fundamental questions. First, if there are important differences in performance, are they justifiable? Second, how do the experiences of patients and NHS staff differ between the different countries of the UK? Third, has the ‘natural experiment’ of policy differences between the four countries, funded by the UK taxpayer, really resulted in the devolved countries spending more on the NHS than England, yet doing worse?

1. Audit Commission and Healthcare Commission (2008) op. cit.
2. Alvarez-Rosete and others (2005) op. cit.
3. Sutherland, K and Coyle, N (2009) *Quality in Healthcare in England, Wales, Scotland, Northern Ireland: An intra-UK chartbook*. London: The Health Foundation. This analysis shows considerable resourcefulness in obtaining data from many different sources, but an inevitable consequence is that different indicators cover different periods: for example, life expectancy for 1991–93 and 2005–07 (pp20–1); cancer mortality and survival rates from 1993 to 2005 (pp24–33); ischaemic heart disease mortality for 1999 and 2006 (p36); indicators from the Quality and Outcomes Framework (for example, indicators of blood pressure and cholesterol, p37) for 2006/07 and 2007/08; median and 90th percentile waiting times for selected procedures for 2005/06 and 2006/07 (pp62–7); waiting times for radiotherapy for 2007 (p68); and differences in life expectancy by levels of deprivation for 2004–06 (pp96–101).
4. Sutherland and Coyle (2009) *ibid.* report median and 90th percentile waiting times for the same 11 selected procedures as reported by the Office for National Statistics (2008) in Table 6.5(a): Time waited in days for elective hospital admission: selected procedures, 2005/06 and 2006/07 (p78). Unfortunately, these data are not comparable across the four countries because they too are subject to the idiosyncratic treatment of patients in Scotland on a waiting list who were ‘at some point unavailable for treatment’, or if the procedure the patient was waiting for was judged to be of low clinical priority or to be of a highly specialised nature, or if the patient had failed to attend a previous appointment. See Office for National Statistics (2008) *United Kingdom Health Statistics*. Basingstoke: Palgrave Macmillan, p82. www.statistics.gov.uk/downloads/theme_health/UKHS3/UKHS2008web.pdf
5. This has also been highlighted for cancers because of problems of late diagnosis by the second official annual report on the cancer reform strategy. See Department of Health (2009) *Cancer Reform Strategy: Achieving local implementation – second annual report*. London: Department of Health, p6. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109338
6. Maynard and Street (2006) op. cit.
7. Care Quality Commission (2009) *About NHS Patient Surveys*. London: Care Quality Commission. www.cqc.org.uk/usingcareservices/healthcare/patientsurveys/aboutpatientsurveys.cfm
8. Department of Health (2009) *New Guidance to Support Collection of Patient-reported Outcome Measures from April 2009*. London: Department of Health. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092647
9. Furthermore, the extraordinary differences in life expectancy within Glasgow (using pooled data from 1998–2002) that ranged from 54 (in Calton) to 82 (in Lenzie N) were used to illustrate inequalities in global health by the Commission on Social Determinants of Health. CSDH (2008) *Closing the Gap in a Generation: Health equity through action on the social determinants of health*. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization, p32. www.who.int/social_determinants/thecommission/finalreport/en/index.html
10. Propper and others (2008b) op. cit, p27. They point out that in England, the government took an aggressive target-based policy to reduce the very long waiting lists for non-emergency care; but in Scotland the government initially focused on the abolition of the internal market and the reintroduction of a professionally led, integrated system based on concepts such as managed clinical networks; and when the emphasis shifted to waiting-time targets, these were not accompanied by publication of performance at hospital level nor were there the managerial sanctions that operated in England for failure to achieve targets.
11. Farrar and others (2007 and 2009) op. cit.
12. As unified boards were introduced in 2001, and NHS trusts ceased to exist as entities independent from their boards in 2004.
13. The largest increase was of about 2.6 per cent in volume for NHS (non-foundation) trusts (pp4–5).
14. Hauck, K and Street, A (2007) ‘Do targets matter? A comparison of English and Welsh national health priorities’, *Health Economics* 16(3): 275–90.
15. The government in Wales in the immediate post-devolution period abandoned targets relating to waiting lists/times. In response to pressure as patients were waiting longer in Wales than in England, targets were

reintroduced in March 2001 but Wales did not introduce a system of strong performance management akin to that in England (see Auditor General for Wales, 2005b, op. cit.).

16. *Hansard*, House of Commons, HC Deb, 18 November 2003, vol. 413 cc746–54. <http://hansard.millbanksystems.com/commons/2003/nov/18/nhs-wales>
17. Wanless (2003) op. cit.
18. Maynard and Street (2006) op. cit.
19. This is unlikely to be explained easily by differences in pay as these scales are agreed largely on a UK-wide basis. See, for example, the NHS Staff Council (2009) *NHS Terms and Conditions of Service Handbook*. www.rcn.org.uk/__data/assets/pdf_file/0018/261045/afc_service_handbook.pdf. There appear to be slight variations in pay of doctors as recommended by the Review Body on Doctors' and Dentists' Remuneration (2008) *Thirty-seventh Report 2008*. Cm 7327. London: The Stationery Office, Appendix A, pp81–93. www.ome.uk.com/downloads/DDRB%20report.pdf
20. Bevan, G (2009) 'The search for a proportionate care law by formula funding in the English NHS', *Financial Accountability and Management* 25(4): 391–410.
21. House of Lords Select Committee on the Barnett Formula (2009) *The Barnett Formula* (HL Paper 139). London: The Stationery Office, p8.
22. As mentioned above, the Calman Commission has recommended that funding for Scotland should be by the UK and Scottish Parliaments sharing the yield of income tax:
Part of the Budget of the Scottish Parliament should now be found from devolved taxation under its control rather than from grants from the UK Parliament. The main means of achieving this should be by the UK and Scottish Parliaments sharing the yield of income tax: a. Therefore the Scottish Variable Rate of income tax should be replaced by a new Scottish rate of income tax, collected by HMRC, which should apply to the basic and higher rates of income tax. b. To make this possible, the basic and higher rates of income tax levied by the UK Government in Scotland should be

reduced by ten pence in the pound and the block grant from the UK to the Scottish Parliament should be reduced accordingly. c. Income tax on savings and distributions should not be devolved to the Scottish Parliament, but half of the yield should be assigned to the Scottish Parliament's budget, with a corresponding reduction in the block grant. d. The structure of the income tax system, including the bands, allowances and thresholds should remain entirely the responsibility of the UK Parliament.

See Commission on Scottish Devolution (Chairman Sir Kenneth Calman) (2009) op. cit., p10.

23. Alvarez-Rosete and others (2005) op. cit. highlighted how they had been unable to report details of expenditure on hospital and community health services, family health services and personal social services, unlike the earlier four-country comparison prior to devolution by Dixon and others (1999). See Dixon, J, Inglis, S and Klein, R (1999) 'Is the English NHS underfunded?', *BMJ* 318: 522–6.
24. Select Committee on the Barnett Formula (2009) op. cit, paragraph 62.
25. The Centre for Public Policy for Regions (CPPR) (2009) op. cit. reports spend per pupil on primary and secondary education in 2007/08 in each of the four countries (rounded estimates are given here). For primary education: Northern Ireland £2,500; Wales, £3,200; England, £3,580; Scotland, £4,600. For secondary education: Wales and Northern Ireland, £3,900; England, £4,260; Scotland, £6,300. See CPPR (2009) op. cit. Table 1: Spending on primary and secondary education in Scotland, England, Wales and Northern Ireland – 2007/08 (£), p2. The report observes that the scale of the differences in spending per pupil between Scotland, and Wales and Northern Ireland is 'scarcely credible'.
26. Marshall, MN, Shekelle, PG, Leatherman, S and Brook, RH (2000) 'The public release of performance data: what do we expect to gain? A review of the evidence', *JAMA* 283: 1866–74.
27. Fung, CH, Lim, YW, Mattke, S, Damberg, C and Shekelle, PG (2008) 'Systematic review: the evidence that publishing patient care performance data improves quality of care', *Annals of Internal Medicine* 148: 111–23.
28. Hibbard (2008) op. cit.

APPENDIX

INDICATOR DEFINITIONS AND SOURCES

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Population	Total population	Office for National Statistics (ONS): Population Trends 132; Table 1.2 (Table 5.1)	ONS: Population Trends 132; Table 1.3 (Table 5.1)	
Proportion of population aged 65M/60F–74	The proportion of the population aged 65–74 for males and 60–74 for females	ONS: Population Trends 132; Table 2.1 (Figure 5.6)	ONS: Population Trends 132; Table 1.3 (Figure 5.6)	
Proportion of population aged ≥75 (%)	The proportion of the population aged 75 and over	ONS: Population Trends 132; Table 2.1 (Figure 5.6)	ONS: Population Trends 132; Table 1.3 (Figure 5.6)	

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Standardised mortality ratio	The ratio of the number of events observed in a population to the number that would be expected if the population had the same distribution as a standard or reference population	ONS: Key Population and Vital Statistics 2006; Table 4.1b (Figure 5.3)	ONS: Key Population and Vital Statistics 2006; Table 4.1b (Figure 5.3)	
Life expectancy (at birth)	The average number of years to be lived by those born in a particular year	ONS: Population Trends 135; Table 2.2 (Figures 4.1 and 4.2)	ONS: Regional Trends 41: Table 6.8 (Figure 5.5)	Data for the regions of England relate to the period 2005–07
Perinatal mortality/ 1,000	The number of stillbirths and deaths under one week per 1,000 live births and stillbirths	ONS: Population Trends 132; Table 2.1 (Figure 5.4)	ONS: Key Population and Vital Statistics 2006; Table 4.1b (Figure 5.4)	
Infant mortality/ 1,000	The number of deaths at age under one year per 1,000 live births	ONS: Population Trends 132; Table 2.1 (Figure 5.4)	ONS: Key Population and Vital Statistics 2006; Table 4.1b (Figure 5.4)	

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Proportion reporting illness	Proportion of the population reporting a longstanding illness or a LLSI	England, Scotland and Wales: ONS: General Household Survey 2006. Northern Ireland: the Northern Ireland Statistics and Research Agency (NISRA) Central Survey Unit, Continuous Household Survey 2006/07 (Figure 5.7)	ONS: General Household Survey 2006 (Figure 5.7)	Respondents in England, Scotland and Wales were asked an identical question to respondents in Northern Ireland. These were: (1) Do you have any longstanding illness, disability or infirmity? (2) Does this illness or disability limit your activities in any way?
Restricted activity in the 14 days before interview	Proportion of the population reporting restricted activity in the 14 days before interview	England, Scotland and Wales: ONS: General Household Survey 2006. Northern Ireland: NISRA Central Survey Unit, Continuous Household Survey 2006/07 (Figure 5.7)	ONS: General Household Survey 2006 (Figure 5.7)	Respondents in England, Scotland and Wales were asked an almost identical question to respondents in Northern Ireland. It was: 'Now I'd like you to think about the two weeks ending yesterday. During those two weeks, did you have to cut down on any of the things you usually do because of illness or injury?'
NHS expenditure per capita	Per capita expenditure on health	HM Treasury Public Expenditure Statistical Analyses 2008; Table 9.11 (Figure 4.3)	HM Treasury Public Expenditure Statistical Analyses 2008; Table 9.11 (Figure 5.9)	

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Relative per capita spend on NHS and public expenditure	Relative per capita spend on NHS and public expenditure with the UK as reference	NHS expenditure per capita as above. Public Expenditure: from House of Lords Select Committee on the Barnett Formula (2009); Table 3, p15 (Figure 4.4)		
Available hospital beds	Average daily available beds per 1,000 population	ONS: United Kingdom Health Statistics 2008; Table 6.1 (Figure 5.10)	Department of Health's Hospital Activity Statistics website – www.performance.doh.gov.uk/hospital-activity/data_requests/download/beds_open_overnight/bed_07_detail.xls (Figure 5.10)	
Hospital medical and dental staff per 1,000 population	The number of directly employed whole time equivalent hospital medical and dental staff per 1,000 population	Calculated from data in ONS: United Kingdom Health Statistics 2008; Table 8.3 (Figure 4.5)	NHS Information Centre website – www.ic.nhs.uk/ (Figure 5.11)	Excludes general practitioners; includes hospital medical and dental staff holding permanent, paid and/or honorary appointments in NHS hospitals and community health services

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Nursing, midwifery and health visiting staff per 1,000 population	The number of whole time equivalent nursing, midwifery and health visiting staff per 1,000 population	Calculated from data in ONS: United Kingdom Health Statistics 2008; Table 8.3 (Figure 4.7)	NHS Information Centre website – www.ic.nhs.uk/ (Figure 5.12)	Includes healthcare assistants; excludes nurse teachers and student nurses
General practitioners per 1,000 population	The number of general practitioners per 1,000 population	Calculated from data in ONS: Regional Trends 40; Table 7.13 (Figure 4.6)	Calculated from data in ONS: Regional Trends 40; Table 7.13 (Figure 5.14)	
Management and support staff per 1,000 population	The number of whole time equivalent management and support staff (defined as staff essential to the day-to-day running of the organisation) per 1,000 population	Calculated from data in ONS: United Kingdom Health Statistics 2008; Table 8.3 (Figure 4.8)	NHS Information Centre website – www.ic.nhs.uk/ (Figure 5.13)	Northern Ireland data include administrative and clerical staff in personal social services as well as NHS

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Outpatient appointments per 1,000 population	The number of outpatient appointments per 1,000 population	Calculated from data in ONS: Regional Trends 40; Table 7.11 The number appearing in the above table for Scotland in 2006 was significantly lower than that appearing on the Information Services Division (ISD) for Scotland website; as a result the number from the ISD website for Scotland was used instead (Figure 4.9)	ONS: Regional Trends 40; Table 7.11 (Figure 5.16)	An outpatient is a non-resident of a hospital seen by a consultant for treatment or advice at a clinical outpatient department. A new outpatient is one whose first attendance is part of a continuous series for the same course of treatment falling within the period in question Data were for the financial year 2005/06 rather than 2006/07
Day cases per 1,000 population	The number of day cases per 1,000 population	ONS: United Kingdom Health Statistics 2008; Table 6.1 The method used to count day cases changed in Wales in 2006/07, making comparisons in Wales over time and across the countries problematic. The figures reported here for Wales come from a document about the changes produced by the Welsh Assembly Government, available at http://wales.gov.uk/topics/statistics/articles/adjustnhsday/?lang=en (Figure 4.10)	ONS: Regional Trends 40; Table 7.11 (Figure 5.17)	A day case is a patient who comes for investigation, treatment or operation under clinical supervision on a planned non-resident basis, who occupies a bed for part or all of that day, and returns home the same day Data were for the financial year 2005/06 rather than 2006/07

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Inpatient admissions per 1,000 population	The number of inpatient admissions per 1,000 population	ONS: United Kingdom Health Statistics 2008; Table 6.1 (Figure 4.11)	ONS: Regional Trends 40; Table 7.11 (Figure 5.18)	
Outpatient appointments per hospital medical and dental/nursing, midwifery and health visiting staff member	The number of outpatient appointments per 1,000 population divided by the number of hospital medical and dental/nursery, midwifery and health visiting staff per 1,000 population	Based on staff numbers and activity data above (Figures 4.12 and 4.15)	Based on staff numbers and activity data above (Figures 5.20 and 5.23)	England is divided into nine regions and ten strategic health authorities (SHAs). The regions and SHAs are identical with the exception of the South East region, which has been divided into two SHAs – South East Coast and South Central. As the data on outpatient activity were reported at the regional level and the staff data at the SHA level, it was not possible to look at output per staff member for the South East Coast and South Central SHAs

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Inpatient admissions per hospital medical and dental/nursing, midwifery and health visiting staff member	The number of inpatient admissions per 1,000 population divided by the number of hospital medical and dental/nursery, midwifery and health visiting staff per 1,000 population	Based on staff numbers and activity data above (Figures 4.13 and 4.16)	Based on staff numbers and activity data above (Figures 5.21 and 5.24)	See comment above for outpatient appointments per hospital medical and dental/nursing, midwifery and health visiting staff member
Day cases per hospital medical and dental/nursing midwifery and health visiting staff member	The number of day cases per 1,000 population divided by the number of hospital medical and dental/nursing, midwifery and health visiting staff per 1,000 population	Based on staff numbers and activity data above (Figures 4.14 and 4.17)	Based on staff numbers and activity data above (Figures 5.22 and 5.25)	See comment above for outpatient appointments per hospital medical and dental/nursing, midwifery and health visiting staff member

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Operation rates for selected hospital procedures per 10,000 population	The number of selected procedures performed per 10,000 population	England: Department of Health Hospital Episode Statistics online – www.hesonline.nhs.uk/ Scotland: Special request from ISD Scotland Wales: Health Solutions Wales, PEDW statistics: 2005/06 Northern Ireland: Special request from DHSSPS (Table 4.1)		The specific procedures chosen (C71, C75, J18, T20, W40–W42, L85–L87, W37–W39, K40–K46) are relatively common procedures in each country
Percentage of inpatient and day cases waiting less than six months for admission or day case	The percentage of inpatient and day cases waiting less than six months for admission or day case	England: Department of Health Hospital Waiting Times/list statistics – www.performance.doh.gov.uk/waitingtimes/index.htm Wales: Health Statistics Wales 2008 – http://wales.gov.uk/topics/statistics/headlines/health2008/hdw20080731/?lang=en Northern Ireland: Statistics Release on Northern Ireland's waiting lists in March 2006 – www.dhsspsni.gov.uk (Figure 4.18)		See note above regarding waiting times for Scotland It was not possible to get comparable data on waiting times for the regions of England and the other countries for 2006

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Percentage of patients waiting less than three months for outpatient appointment	The percentage of patients waiting less than three months for outpatient appointment	England: Department of Health Hospital Waiting Times/list statistics – www.performance.doh.gov.uk/waitingtimes/index.htm Wales: Health Statistics Wales 2008 – http://wales.gov.uk/topics/statistics/headlines/health2008/hdw20080731/?lang=en Northern Ireland: Statistics Release on Northern Ireland’s waiting lists in March 2006 – www.dhsspsni.gov.uk (Figure 4.19)		See note above regarding waiting times for Scotland It was not possible to get comparable data on waiting times for the regions of England and the other countries for 2006
Percentage waiting more than 13 weeks for inpatient admission or day case	The percentage of patients waiting more than 13 weeks for an inpatient admission or day case	England: Department of Health Hospital Waiting Times/list statistics – www.performance.doh.gov.uk/waitingtimes/index.htm Wales: Health Statistics Wales 2008 – http://wales.gov.uk/topics/statistics/headlines/health2008/hdw20080731/?lang=en Northern Ireland: Statistics Release on Northern Ireland’s waiting lists in March 2006 – www.dhsspsni.gov.uk (Figure 5.26)	England Department of Health Hospital Waiting Times/list statistics – www.performance.doh.gov.uk/waitingtimes/index.htm (Figure 5.26)	

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Percentage of category A ambulance calls met within 8 minutes	Emergency calls (made by dialling 999) that were judged as possibly 'immediately life-threatening'. The target initially agreed for each UK country was that 75 per cent of such calls be met within 8 minutes.	<p><i>England</i></p> <p>For 1999 to 2001: Department of Health (1999) <i>Ambulance Services, England: 1998–99</i>. London: Department of Health.</p> <p>Department of Health (2000) <i>Ambulance Services, England: 1999–2000</i>. London: Department of Health.</p> <p>Department of Health (2001) <i>Ambulance Services, England: 2000–01</i>. London: Department of Health.</p> <p>www.dh.gov.uk/assetRoot/04/02/14/73/04021473.pdf</p> <p>For 2002 to 2007: Information Centre (2007) <i>Ambulance Services, England 2006–07</i>. Leeds: Information Centre.</p> <p>www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/ambulance/ambulance-services-england-2006-07</p>		

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
		<p><i>Wales</i> For 2000 to 2004: National Assembly for Wales (2005) Chapter 13: Patient Transport Services, in <i>Health Statistics Wales 2006</i>. Cardiff: National Assembly for Wales. http://wales.gov.uk/topics/statistics/publications/publication-archive/hsw2006/?lang=en For 2005 and 2006: Auditor General for Wales (2006) <i>Ambulance Services in Wales</i>. Cardiff: The Stationery Office, p37. www.wao.gov.uk/assets/englishdocuments/Ambulance_Inquiry.pdf For 2007: Welsh Assembly Government (2007) <i>Ambulance Services in Wales: 1 January–31 March 2007 (revised)</i>. Cardiff: Welsh Assembly Government. http://new.wales.gov.uk/topics/statistics/headlines/health-2007/hdw200705301/?lang=en</p>		

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
		<p><i>Scotland</i> For 2004 to 2006: Auditor General for Wales (2006) op. cit. For 2007: Audit Scotland (2007) <i>Scottish Ambulance Service – report on the 2006/07 audit</i>. Edinburgh: Audit Scotland, p2. http://audit-scotland.gov.uk/docs/health/2007/fa_0607_ambulance_service.pdf (Figure 4.20)</p>		
Percentage of the public satisfied with general running of the NHS; with inpatient care; with outpatient care; with general practice care	The percentage of survey respondents who replied that they were ‘very satisfied’ or ‘quite satisfied’ with the general running of the NHS; with inpatient care; with outpatient care; with general practice care	<p>England, Scotland and Wales: calculated from responses to the British Social Attitudes 2006 Survey. Northern Ireland: calculated from responses to Northern Ireland Life and Times 2007 Survey (Figures 4.21, 4.22, 4.23 and 4.24)</p>		

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Gross disposable household income	The gross disposable household income per head, where income covers the income received by households and non-profit institutions serving households	ONS: Regional Trends 41; Table 3.7 (Table 5.1)	ONS: Regional Trends 41; Table 3.7 (Table 5.1)	
Unemployment rate	The percentage of the economically active population who are unemployed, seasonally adjusted	ONS: Regional Trends 40; Table 5.14 (Table 5.1)	ONS: Regional Trends 40; Table 5.14 (Table 5.1)	
Households in receipt of disability benefits	The percentage of households in which at least one member is in receipt of disability benefits	ONS: Regional Trends 41; Table 8.7 (Table 5.1)	ONS: Regional Trends 41; Table 8.7 (Table 5.1)	Disability benefits include incapacity benefit, disability living allowance, severe disablement allowance, industrial injuries disablement benefit, war disablement pension, attendance allowance and disability elements of working tax credits

<i>Indicator</i>	<i>Definition</i>	<i>Source*</i>		<i>Comments</i>
		National	Regional	
Dwellings rented from local authority	The percentage of dwellings rented from a local authority	ONS: Regional Trends 41; Table 7.3 (Table 5.1)	ONS: Regional Trends 41; Table 7.3 (Table 5.1)	
Household with no use of a car	The percentage of households without regular use of a car	ONS: Regional Trends 40; Table 10.2 (Table 5.1)	ONS: Regional Trends 40; Table 10.2 (Table 5.1)	

*Source relates to the data source for 2006 data only. Data for other years were obtained from a previously published study.

Funding and performance of healthcare systems in the four countries of the UK before and after devolution

Political devolution means there are now four National Health Services in the United Kingdom. The health services of England, Scotland, Wales and Northern Ireland are all funded by the UK taxpayer, but have developed different systems of governance and different methods of providing healthcare.

Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution examines the impact of this, by looking at key performance indicators for the NHS in the four countries before and after devolution, and by undertaking a completely new comparison of NHS performance

in the English regions and the devolved countries. The authors suggest that it is far from clear whether, post-devolution, patients in all four UK countries are faring equally; they also point to the need for a reexamination of how healthcare resources are allocated across the UK (the subject of a forthcoming Trust report).

This report will be of interest to healthcare leaders and policy-makers across the UK, as well as academics and students interested in healthcare and health policy, and in UK politics generally, following devolution.