



FUNDING AND PERFORMANCE OF HEALTHCARE SYSTEMS IN THE FOUR COUNTRIES OF THE UK

The health services of England, Scotland, Wales and Northern Ireland are all funded by the UK taxpayer, but since political devolution in 1999 they have developed different systems of governance and different policies. A new report from the Nuffield Trust, *Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution*, examines the impact of these changes. Key statistics for the NHS in the four countries are examined before and after devolution. Each indicator such as expenditure, staffing levels, activity (outpatient appointments, inpatient admissions and day cases), productivity and waiting times, is examined at three time points – 1996/7, 2002/3 and 2006/7. The report also undertakes a completely new comparison of the NHS in the ten English regions with the NHS in England as a whole and in the devolved countries. This paper provides a summary of the report, which is available at www.nuffieldtrust.org.uk.

Key points

- Historically Scotland, Wales and Northern Ireland have had higher levels of funding per capita for NHS care than England. The research confirms this but shows other striking differences between the four nations, some accentuated since devolution.
- The research suggests the NHS in England spends less and has fewer doctors, nurses and managers per head of population than the health services in the devolved countries (Scotland, Wales and Northern Ireland), but the NHS in England is making better use of the resources it has in terms of delivering higher levels of activity, crude productivity of its staff and lower waiting times.
- Scotland has the highest levels of poor health, the highest rates of expenditure, the highest rates of hospital doctors, GPs and nurses per capita, and yet it had the lowest rates of crude productivity of its staff and the lowest rates of inpatient admissions per head of population in 2006/7.
- The North East of England provides a better benchmark for comparisons with the devolved countries. In 2006 for a population of 100,000, expenditure in Scotland would have been about £180m, compared to £170m for the North East region. Yet Scotland's 6 per cent of additional funding resulted in 14 per cent more hospital doctors (250 to 180) and GPs (81 to 71), nearly 50 per cent more nurses (1,100 to 740), and nearly 75 per cent more managers and support staff (730 to 420). Despite its lower level of expenditure and staffing, compared with Scotland, the North East region delivered 18 per cent more outpatient attendances (105,000 to 89,300), almost 40 per cent more day cases (10,500 to 7,600) and more than 50 per cent more inpatient admissions (20,700 to 13,500); consequently staff in the North East had far higher levels of crude productivity than in Scotland.
- Some of the differences and trends may be because of historic differences in funding levels, which are not directly related to policy differences following devolution. But some will reflect the different policies pursued by each of the four nations since 1999, in particular the greater pressure put on NHS bodies in England to improve performance in a few key areas such as waiting and efficiency, through use of targets, strong performance management, public reporting of performance by regulators, and financial incentives.
- The research raises important questions about the accountability of the devolved administrations for their health services, and the availability of comparable data that allow differences in performance to be analysed in future. Without such comparable data, UK taxpayers and HM Treasury cannot know whether they are securing value for money for their health services.

BACKGROUND

Political devolution to the Scottish Parliament and the Welsh and Northern Ireland Assemblies means it is no longer possible to speak of a single NHS in the UK. The health services of England, Scotland and Northern Ireland are funded by the UK taxpayer but now have different systems of governance and pursue different policies.

The period following devolution in 1999 was followed by massive increases in funding for the NHS across the UK. Only in England, however, was this made contingent on the health service meeting Public Service Agreement targets set by the UK Treasury. Funding for the NHS in the devolved countries is determined by their governments from a global sum for 'devolved services' that is based on the Barnett formula (a 30-year-old system for dividing public money between England and the other countries of the UK) and bilateral negotiations with HM Treasury. Following devolution, marked differences in health service policy have developed between England, Scotland and Wales. In Northern Ireland, devolution was suspended between 2002 and 2007.

In England, the 'purchaser/provider' split was maintained between NHS organisations that plan and buy healthcare and those that provide it – a split first introduced to the UK during the 'internal market' of the 1990s (today, these functions are carried out by strategic health authorities/primary care trusts and by NHS trusts of various kinds).

In England, policy has also been characterised by a significant central government challenge to NHS bodies to improve through targets, robust performance management, public reporting of performance, financial incentives and, latterly, through encouraging competition between providers (including new NHS foundation trusts and independent sector treatment centres) by promoting patient choice between them. Furthermore, funding increases for the NHS in England have been contingent in part on the NHS meeting public service agreements with HM Treasury.

In Scotland and Wales, the purchaser/provider split was abolished, and organisations recreated to meet population needs and run services within defined

geographical areas (NHS health boards in Scotland and, since October 2008, local health boards in Wales). While there have been targets in each of the devolved nations, for example to reduce waiting and healthcare acquired infections, in England they were supported by public reporting (NHS 'Star Ratings' followed by the 'Annual Health Check', now overseen by the Care Quality Commission) and strong performance management designed to penalise failure and reward success.

There were no equivalent systems of public reporting in the devolved countries. In addition, there have been other differences that are more obvious to patients. For example, in Scotland there is free personal care for older people, while in Wales the government has abolished charges for prescriptions. The governments in Scotland and Northern Ireland are to abolish prescription charges, too. Neither change is planned in England.

METHODS

The principal purpose of the report is to identify differences in performance between the NHS across the four nations. This builds on a previous study by two of the authors that compared key indicators for the four health services before and after devolution (in 1996/7 and 2002/3).¹ The present report brings this research up to date by examining NHS expenditure (per head of population in cash terms), life expectancy, staffing levels (per 1,000 population), activity (outpatient appointments, inpatient admissions and day cases per 1,000 population), 'crude' productivity (activity per staff member), some medical procedures and waiting times. The percentage of the population reporting satisfaction with health care is also examined.

There are two parts to the analysis. In the first, comparisons are made between the four countries. In the second, comparisons are made between the three devolved nations and regions in England. This second analysis allows

comparisons between the devolved nations with areas of England that are similar in scale and in their levels of health and socio-economic characteristics.

Each indicator of NHS performance is examined at three time points – 1996/7, 2002/3 and 2006/7. The indicators relate to inputs, rather than, for example, staff and patient experience (other than a broad measure of satisfaction) or health outcomes. They were chosen because it was largely possible to define and measure them in the same way in each country and at each time point. Other studies have examined the quality of care across the four nations, but not consistently over the same time points: for example in 2009 the Health Foundation published a comprehensive analysis of quality across six domains at various times, which demonstrated no systematic differences in quality across the four nations.²

MAIN FINDINGS

The main findings of the report are:

- In 1996 and 2006, England had the lowest and Scotland the highest rates per capita of expenditure, medical and dental and nursing staff and GPs (except in 2006, when Wales had the highest rate of GPs).
- In 1996, Scotland had the highest rates per capita of outpatient appointments, inpatient admissions and day cases. England had the lowest rates of outpatient appointments and inpatient admissions and Northern Ireland had the lowest rate of day cases.
- In 2006, Scotland had the lowest rates per capita of inpatient admissions, while Wales had the lowest rate of day cases and Northern Ireland of outpatient attendances. Wales had the highest rate of outpatient appointments and Northern Ireland the highest rates of inpatient admissions and day cases.
- In 1996, Scotland had the lowest rate of outpatient appointments and inpatient admissions per medical and dental member and nursing staff member. England had the highest rates.
- In 2006, Scotland still had the lowest rate of outpatient appointments and inpatient admissions per medical and dental staff member and nursing staff member. Wales had the highest rate of outpatient appointments and Northern Ireland the highest rate of inpatient admissions per medical and dental staff member. England had the highest rate of outpatient appointments and Northern Ireland the highest rate of inpatient admissions per nursing staff member.
- In 1996 and 2006, Northern Ireland had the highest and England the lowest rates per capita of NHS management and support staff, with rates in Northern Ireland more than doubling over the period. (However, the Northern Ireland figures include social services as well as NHS managers.)

It is notable that Scotland's waiting times cannot easily be compared with those of England, Wales and Northern Ireland at the three time points, because they are measured in a different way. However, the performance of Wales and Northern Ireland in key measures of waiting has also been poor compared with

England. By 2006, virtually no patients in England waited more than three months for an outpatient appointment, whereas in Wales and Northern Ireland 44 per cent and 61 per cent of patients did. By 2006,

virtually all patients in England who needed inpatient or day case treatment were seen within six months, while in Wales and Northern Ireland 79 per cent and 84 per cent of patients waited longer than this.

COMPARING PERFORMANCE BETWEEN THE ENGLISH REGIONS AND THE DEVOLVED COUNTRIES

Uniquely, the report looked at the impact of devolution by conducting a comparison of the English regions (nine Government Office Regions or ten strategic health authorities) with the NHS in England as a whole and the NHS in each of the devolved countries in 2006/7. This is the first time such an analysis has been conducted. The national differences reported are more pronounced when the devolved nations are compared with regions of England that are similar in scale, and on a range of health and socio-economic indicators.

The national averages for England are distorted by London, due to the capital's relatively young and healthy population, high labour costs and high concentration of teaching and research hospitals (which lower the crude productivity of its staff). As a result, some regions within England provide a better benchmark for comparison with the three devolved countries. This cross-regional analysis confirmed the thrust of the authors' earlier work. Putting London to one side, it showed that Scotland is an outlier in almost all the domains of performance for which there are comparable statistics; in other words, it appears to perform less well than anywhere else on almost every measure examined.

In 2006, Scotland had the highest levels of poor health, the highest rates of expenditure, the highest rates of hospital doctors, GPs and nurses, and yet the lowest rates of inpatient admissions and crude productivity for hospital doctors and nurses.

Wales and Northern Ireland show similar patterns to each other but differ from England: health services in Wales and Northern Ireland had higher rates of expenditure and hospital staff (although not GPs) but lower levels of crude productivity and poorer performance on waiting times, relative to England.

The analysis suggests that the North East region is a better benchmark for comparisons of NHS between the three devolved countries than England as a whole. Compared with Scotland it has a similarly-sized population, similar levels of income, deprivation and unemployment, and similar health status and life expectancy. Comparing the North East region and Scotland in 2006 threw up stark differences. For a population of 100,000, expenditure in Scotland would have been about £180m, compared to the North East region's £170m. Yet Scotland's 6 per cent of additional funding resulted in 14 per cent more hospital doctors (250 to 180) and GPs (81 to 71), nearly 50 per cent more nurses (1,100 to 740), and nearly 75 per cent more managers and support staff (730 to 420).

Despite its lower level of expenditure and staffing, the North East region delivered 18 per cent more outpatient attendances (105,000 to 89,300), almost 40 per cent more day cases (10,500 to 7,600) and more than 50 per cent more inpatient admissions (20,700 to 13,500); consequently its staff had far higher levels of crude productivity.

Figure 1: Total NHS expenditure per capita for the nine English GORs* and England, Scotland, Wales and Northern Ireland (2006)

* Government Office Regions

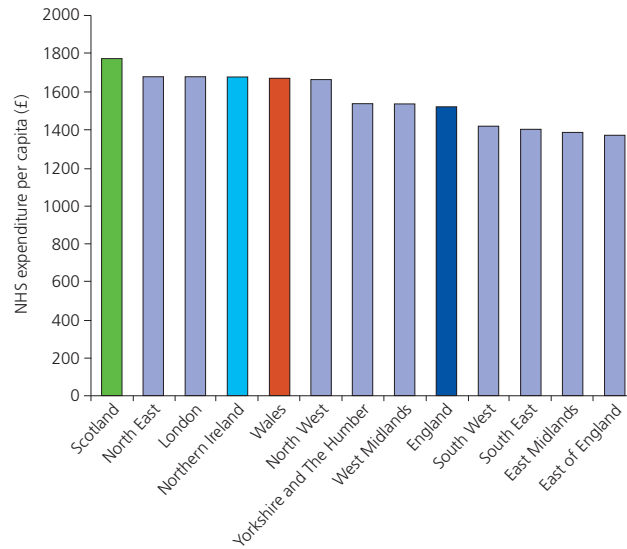


Figure 2: Hospital medical and dental staff (whole time equivalents) per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)

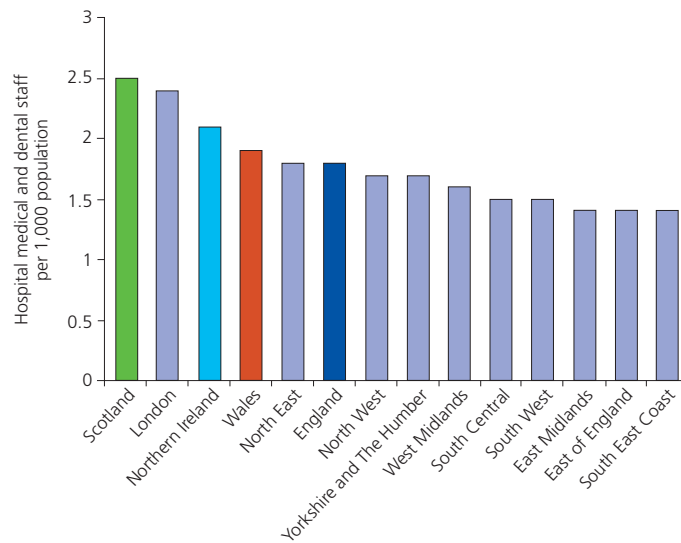


Figure 3: Nursing, midwifery and health visiting staff (whole time equivalents) per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)

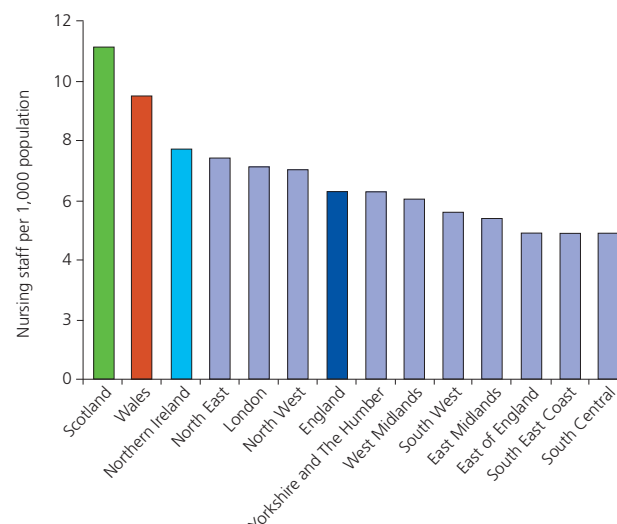
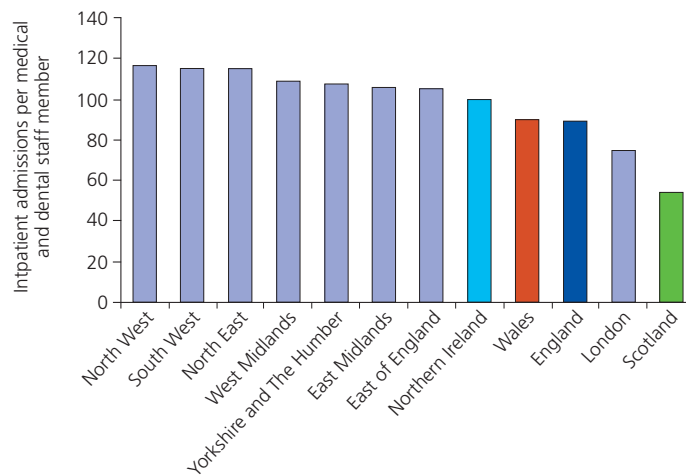
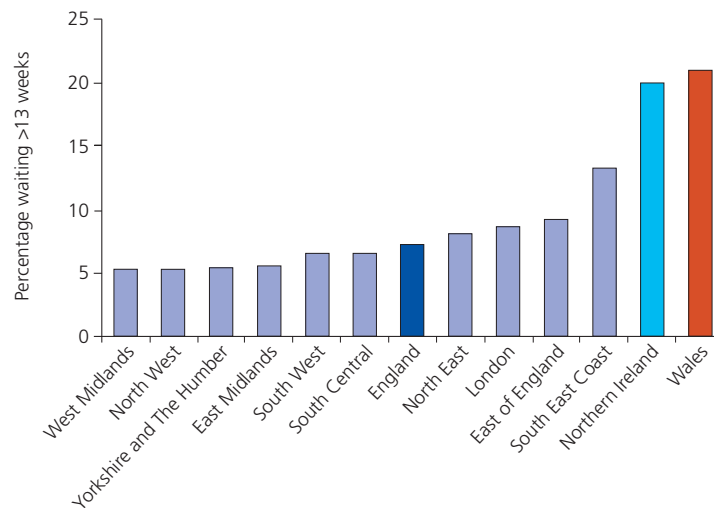


Figure 4: Inpatient admissions per medical and dental staff member in eight regions of England, and England, Scotland, Wales and Northern Ireland (2006)**



** As data on activity (outpatient appointments, day cases and inpatient admissions) are reported at the regional level and data on staffing levels at the level of the strategic health authority, it is not possible to calculate staff member activity for the two strategic health authorities (South East Coast and South Central) that are in the South East GOR.

Figure 5: Percentage waiting more than 13 weeks for inpatient admission or day case for the ten English SHAs, England, Wales and Northern Ireland (March 2008) ***



*** Scottish waiting times are not included as they cannot easily be compared with those for the rest of the UK.

CONCLUSIONS

Historically Scotland, Wales and Northern Ireland have had higher levels of NHS funding per capita than England. The research confirms this but shows other striking and troubling differences between the four nations, some accentuated since devolution. In particular, these were higher numbers of doctors, nurses and managers per head of population, lower crude productivity per staff member (particularly in Scotland), and a higher percentage of the population waiting for care in Wales and Northern Ireland than in England.

The analysis presented in this report suggests that England's NHS spends less and has fewer staff per capita than the health services in the devolved countries, but that it makes better use of its resources with respect to delivering higher levels of activity and productivity and lower waiting times. Comparing the devolved nations with regions of England that are similar on a range of health and socio-economic indicators, the differences highlighted in the analysis are even more pronounced.

However, the report looks only at statistics that can be measured in the same way in the English regions and the devolved countries before and after devolution. It is possible that the comparative statistics that are available fail to capture some important dimensions of performance. Other dimensions, such as staff and patient experience and health outcomes, should therefore be the subject of further research – although previously published studies do not point to consistently higher levels of quality of care in the devolved nations that might partly offset the lower crude productivity levels of staff relative to England.

Some of the differences and trends may be because of the historical differences in funding levels, which are not directly related to policies pursued after devolution. But some will reflect the different policies pursued by each of the four nations since 1999, in particular, the greater pressure put on NHS bodies in England to improve performance in a few key areas such as waiting and improving efficiency, through means such as targets, strong performance management, regulation with public reporting of performance, and financial incentives.

Meanwhile, the report raises important questions about the accountability of public services in the devolved countries and the equity of the funding they receive. As indicated earlier, the way money is distributed to the devolved administrations means public spending is not determined by need, but by the Barnett formula and negotiation with the Treasury. The recent House of Lords Select Committee on the Barnett Formula concluded this should change. The authors agree and plan to explore the implications in a forthcoming study.

But regardless of overall levels of funding, a key question for the NHS in all four countries, especially in the current economic climate, must be whether value for money is being obtained. The results shown in this report suggest that efficiencies can be made in all four nations, but the marked differences in crude productivity of staff in the three devolved nations relative to England raise awkward questions.

Comparative analysis, such as that presented in this report, helps to increase the accountability of the public sector. But the authors had difficulty obtaining data that were comparable across the four nations. Although the UK Statistics Authority has a crucial role in monitoring the quality of statistics produced by each country, it does not have the powers to require the four countries to produce comparative data on the performance of their public services. Without these data, UK taxpayers, and HM Treasury, cannot know whether they are securing value for money in future.

REFERENCES

1. Alvarez-Rosete A, Bevan G, Mays N and Dixon J (2005) 'Effect of diverging policy across the NHS', *BMJ* 331: 946–50
2. Sutherland K, Coyle N (2009) *Quality of Healthcare in England, Wales, Scotland, Northern Ireland: An intra-UK chartbook*. London: The Health Foundation.

ABOUT THE REPORT

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- UK and international comparisons.

The report *Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution*, on which this summary is based, forms part of our work on UK and international comparisons. By looking at established best practice, we aim to bring the benefits of international experience to the attention of UK policy-makers

and health leaders. Future work on this theme includes:

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- a programme of seminars bringing together policy-makers and practitioners from the four UK countries to discuss comparative health system performance, recent advances in predictive risk modelling, and new forms of care for people with long-term conditions
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