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

Sheelah Connolly, Gwyn Bevan and Nicholas Mays
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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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Foreword

The Nuffield Trust has a longstanding interest in the UK’s devolution ‘experiment’ as it applies to healthcare. The mantra for the NHS has recently shifted from ‘quality’ to ‘quality with efficiency’, so 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.

As part of our wider work looking at how healthcare resources are allocated, the Trust is publishing a follow-up study by the same authors, looking at the implications from this study for the allocation of healthcare resources within the UK.

This report forms part of our work theme on UK and international comparisons. By looking at established best practice internationally, we aim to bring the benefits of international experience to the attention of UK policy-makers and health leaders. Current work on this theme includes:

- a series of reports on lessons from the Netherlands for UK healthcare commissioners and policy-makers
- 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
- comparative studies of primary care within Europe, and in New Zealand
- a seminar for future leaders of European healthcare organisations
- a preparatory study testing the feasibility of comparing cancer patient pathways across Europe
- sponsoring the influential Harkness fellowships to the USA.

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. In Wales the government has abolished charges for prescriptions. The governments in Scotland and Northern Ireland are to abolish prescription charges, too. But that is not the case in England. 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.

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
hospital waiting times and ambulance response times to emergency calls. Third, the differences highlighted in these key statistics raise troubling questions about performance, governance and accountability.

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 2000, before and immediately after political devolution. 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 since 2002 there have been large increases in spending and staffing, falls in the crude productivity of hospital doctors and nurses; and, particularly in England, further reductions in waiting times.

The principal findings from the cross-country longitudinal comparisons are as follows:

- In 1996 and 2006, Scotland had the highest, and England the lowest, rates per capita of expenditure, nurses, hospital medical and dental staff, and general practitioners (GPs) (except in 2006, when Wales had the lowest rate for GPs). The relative excess of rates in Scotland over England narrowed for per capita expenditure and GPs, remained relatively constant for hospital medical and dental staff, but almost doubled for nursing staff.
In 1996 and 2006, Northern Ireland had the highest, and England the lowest, rates per capita of management and support staff (which includes health and personal social services in Northern Ireland). The excess rate of Northern Ireland over England increased from about 70 per cent in 1996 to 170 per cent in 2006.

In 1996, Scotland had the highest rates per capita for outpatient appointments, day cases and inpatient admissions. In 2006, Northern Ireland had the highest rates for day cases and inpatient admissions, and Wales had the highest rates for outpatient appointments.

In 1996, England had the lowest rates per capita for outpatient appointments and inpatient admissions, and Northern Ireland the lowest rates for day cases. In 2006, Scotland had the lowest rates for outpatient appointments and inpatient admissions, and Wales the lowest rates for day cases.

In 1996 and 2006, Scotland had the lowest rates of outpatient appointments and inpatient admissions per hospital medical and dental staff member. In 1996, England had the highest rates of outpatient appointments and inpatient admissions; in 2006, Wales and Northern Ireland had the highest rates (but the regional analysis given below shows that average rates for England are misleading).

In 1996, Northern Ireland and Wales had the lowest rates of outpatient appointments and inpatient admissions per nursing staff member; in 2006, Scotland had the lowest rates. In 1996, England had the highest rates; in 2006, England and Northern Ireland had the highest rates.

England consistently had the best performance – over the time for which comparable data exist – for waiting times for inpatients and outpatients, and for ambulance response rates to what may have been life-threatening emergencies.

In this report, the research team has supplemented the longitudinal cross-country comparison 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. The North East is more like the three devolved countries (in terms of its size and indicators of socio-economic, demographic and morbidity characteristics) and therefore some of the analysis focuses on differences between the North East region and the three devolved countries.

In general, the regional analysis showed that the devolved countries tend to be outliers (i.e. outside the distribution of performance across the English regions), with poorer performance than any comparable English region (in some cases excluding London) for hospital waiting times and crude productivity of medical, dental and nursing staff members. Comparing Scotland with English regions (except London) showed that Scotland had the highest standardised mortality ratios, lowest life expectancy, highest levels of expenditure and staffing, and the lowest levels of crude productivity of hospital medical and dental staff, and nursing staff. Comparing Wales and Northern Ireland with the North East showed that Wales and Northern Ireland had per capita expenditure similar to that of the North East, but poorer performance in terms of hospital
waiting times, and crude productivity of hospital medical and dental staff (crude productivity of nursing staff in Northern Ireland was marginally higher than in the North East, but in Wales was much lower than in the North East). The North East also had a lower per capita level of non-clinical staff.

The regional analysis highlights the contrast between the NHS in Scotland and its adjacent English region, the North East. Their populations are of similar size and have corresponding characteristics, but are within different jurisdictions. For the year ending March 2006, there were striking and puzzling differences in terms of average expenditure, staffing and services provided by each NHS for a population of 100,000:

- Expenditure and staffing in Scotland would have been about £180m, with 250 hospital doctors (medical and dental staff), 1,100 nurses, 730 non-clinical staff (management and support) and 81 GPs; and in the North East, £170m, 180 hospital doctors, 740 nurses, 420 non-clinical staff and 71 GPs.
- The services provided in Scotland would have amounted to about 89,300 outpatient attendances, 7,600 day cases and 13,500 inpatient admissions; and in the North East, about 105,000 outpatient attendances, 10,500 day cases and 20,700 inpatient admissions.

There were also striking differences in average crude productivity for the same year:

- A hospital doctor in Scotland would care for 357 outpatients, 30 day cases and 54 inpatients; and in the North East for 584 outpatients, 58 day cases and 115 inpatients. A nurse in Scotland would care for 70 outpatients, seven day cases and 12 inpatients; and in the North East a nurse would care for 142 outpatients, 14 day cases and 27 inpatients.

These differences raise questions about funding, staffing and the delivery of services:

- How could a 6 per cent additional level of funding per capita in Scotland, as compared with the North East, result in Scotland having, per capita, 14 per cent more hospital doctors and GPs, nearly 50 per cent more nurses and nearly 75 per cent more non-clinical staff? Is this because the Scottish Parliament has decided to spend its money differently (for example, without the same emphasis on capital development through schemes financed by the Private Finance Initiative)?
- How could lower levels of staffing per capita in the North East have delivered 18 per cent more outpatient attendances, nearly 40 per cent more day cases and over 50 per cent more inpatients than in Scotland?
- What explains the differences in crude productivity of clinical staff? In the North East, hospital doctors treated over 60 per cent more outpatient attendances, about 100 per cent more day cases and inpatients than in Scotland; and nurses about 100 per cent more outpatient attendances, day cases and inpatients than in Scotland.

There are three troubling features of governance and accountability following devolution. First, the UK taxpayer funds health services in each country, but only England is held to account for its performance by the UK Treasury. The funding of the NHS in England is, in principle, dependent upon
performance against the Treasury’s Public Service Agreement (PSA) targets. Since 2007, for health and other devolved services, there have been no PSA targets for the devolved governments, so their funding is not contingent upon their performance. These governments are held to account by their electorates specifically for the performance of the devolved services. Second, there is no equivalent electoral accountability for devolved services in England, as this accountability is exercised only through general elections to the UK Parliament. Third, 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 authority to require governments of the UK to produce comparable data on public services. The experience of the research team 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.

The unusual features of devolution mean that it would now be difficult for the Treasury to hold the devolved governments to account through PSA targets, but UK taxpayers have a right to know how well the different governments are, or are not, securing value for their money. If the Treasury cannot hold devolved governments to account for their performance through targets, then it ought to be able to require them to supply comparative data on that performance. The authors see such comparative information as a vital element in holding governments to account for the performance of each of the four different NHSs.

This report has identified troubling 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 limitations of the analysis have been recognised, which generally arise from the limited amount of data available on a consistent basis across countries and over time; but the analysis has shown 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. 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 material systematic benefits in other dimensions of quality of care. Although this merits further analysis it may be difficult, if not impossible, to collect such evidence as this is likely to require data that are either not readily available or have not been collected. This report will be followed by another study that will examine whether the level of NHS funding between the four countries is equitable. 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 of this report strongly support that Committee’s recommendation that funding ought to take account of both the size of populations and their relative need for public services.

The current analysis raises the obvious question: if the extra funding for Scotland were justified by greater need for healthcare, why did Scotland have relatively low rates of treatment per capita? The team also sees scope for further more detailed work using the North East as a benchmark for comparison with the devolved countries.
Funding and performance of healthcare systems in the four countries of the UK before and after devolution
On 1 May 1997, the (New) Labour Government won a landslide victory in the General Election with four policy commitments in its manifesto\(^1\) 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 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 socio-economic, 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

The second section 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, there was neither 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.

The third section outlines the methods of comparative analysis and brings out the difficulty of obtaining comparative data on even the basic measure of hospital waiting times. The fourth and fifth sections 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. The final section highlights findings from these comparisons and their implications for policy and research.


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/Managingyourorganisation/Humanresourcesandtraining/EducationTrainingandDevelopment/PostRegistration/DH_4074419 ; Calman, Sir Kenneth and Paulson-Ellis, M (2004) *Review of Basic Medical Education in Scotland*. Edinburgh: The Stationery Office, p37. ww.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 United Kingdom 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 (1992)3 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 (p162). Davies sets out to correct the ‘inability of prominent authorities to present the history of our Isles in accurate and unambiguous terms’ (p xxviii). 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 United Kingdom, and their entries for Great Britain assumed this to be identical to the history of England (pp xxxiv–xxxvi). 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) (p583).\(^8\) At the end of the fifteenth century, the Dublin Parliament had been obliged to pass Poynings’ Law, which invalidated all Irish legislation not previously approved in England, and remained on the statute book for nearly three hundred 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 (pp479–81). 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 Colley (1992)\(^11\) 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’ (p14). 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’ (p13). 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 that 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 (pp870–1). 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’ (p552). 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 general practitioner (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 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 (2009): 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’ (p7). 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 East\(^\text{28}\) 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:\(^\text{29}\) 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,\(^\text{30}\) and the introduction of tuition fees for undergraduates in January 2004.\(^\text{31}\) 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’ (p8).\(^\text{32}\)

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 Public Service Agreements (PSA targets) agreed with the Secretary of State for Health for England. The Labour Government’s 1998 Comprehensive Spending Review (HM Treasury, 1998)\(^\text{33}\) set out PSA targets for health services in England, Scotland, Wales and, to a lesser extent, Northern Ireland. The PSA targets for 2002 and 2004 (HM Treasury, 2002 and 2004)\(^\text{34}\) 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 2007 (HM Treasury, 2007)\(^\text{35}\) apply 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’). 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’ (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). 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: notorious examples include the women who suffered from the actions of gynaecologist Rodney Ledward and the excess deaths of babies from paediatric cardiac surgery at Bristol. 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.
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.\textsuperscript{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:

\textit{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.}\textsuperscript{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 product\textsuperscript{45} (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 (reducing substantially 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).\textsuperscript{46} The government for England emphasised in the summer of 2000 in \textit{The NHS Plan}\textsuperscript{47} that ‘investment has to be accompanied by reform’ (p11) and announced ambitious targets for increases in capital development and staffing,\textsuperscript{48} reducing waiting times for access to the NHS,\textsuperscript{49} and improving services for patients with cancers, coronary heart disease and the mentally ill. Following \textit{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{53} \textit{The NHS Plan}\textsuperscript{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 (p28). 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’37 (known as payment by results)38 which has to date had mixed results.39 From 2006 ‘star ratings’ were succeeded by the annual ‘Health Check’. As Preston (2009)60 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) (2009)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

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 their 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 Wales68 69 and Scotland,70 71 those working in the NHS perceived the traditional system of perverse
incentives to continue. The governments in Scotland\(^72\) and then Wales\(^73\) 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.\(^77\) Box 2.1 outlines 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). Jervis\(^78\) 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 Babbington\(^81\) 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.’

Within Wales, Greer\(^82\) 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
Box 2.1: Policy and organisational characteristics of the four countries of the UK

<table>
<thead>
<tr>
<th>Population (millions)</th>
<th>England</th>
<th>Wales</th>
<th>Scotland</th>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50</td>
<td>3</td>
<td>5</td>
<td>1.7</td>
</tr>
</tbody>
</table>

**Organisational characteristics**

<table>
<thead>
<tr>
<th>Commissioner/provider split</th>
<th>Yes</th>
<th>Abolished in 2009</th>
<th>Abolished in 2004</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider markets, patient choice, pluralism in delivery and providers paid by activity</td>
<td>From 2006</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Integration of health and social services</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Commitment to election for local NHS governing bodies</td>
<td>No</td>
<td>No</td>
<td>Yes (in 2007, but not yet implemented)</td>
<td>No</td>
</tr>
</tbody>
</table>

**Performance regimes**

<table>
<thead>
<tr>
<th>Targets for waiting times</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual public reporting of performance in a system of ‘naming and shaming’</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Charges and entitlements**

<table>
<thead>
<tr>
<th>Free personal care services for the over 65s</th>
<th>No</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free prescriptions</td>
<td>No</td>
<td>Yes</td>
<td>To be implemented</td>
<td>To be implemented</td>
</tr>
</tbody>
</table>
health policy in Wales was an attempt to focus on the wider social determinants of health, rather than just healthcare. Greer and Trench\textsuperscript{85} 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.’\textsuperscript{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.\textsuperscript{87}

In 2003, the Welsh Wanless report, \textit{Review of Health and Social Care in Wales},\textsuperscript{88} focused mainly on acute services. The strategy, \textit{Designed for Life},\textsuperscript{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,\textsuperscript{90} has abolished the internal market and the purchaser/provider split.\textsuperscript{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 sector\textsuperscript{92} (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’.\textsuperscript{93}

\begin{itemize}
\item\textsuperscript{1} Davies, N (1999) \textit{The Isles – A history}. London: Macmillan.
\item\textsuperscript{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).


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), the South West (which became Cornwall, still known to its natives as Kern). 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). Olfa’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 sixteenth 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) and the victory of William of Orange in the Battle of the Boyne (1690), and ‘Bloody Sunday’ (30 January 1972). For the continuing Inquiry into ‘Bloody Sunday’ see: www.bloody-sunday-inquiry.org.uk/index.htm

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 fifteenth century, under the leadership of Owain ap Gruffyd 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 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 (p350).

9. Ibid. 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 Theobold 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


17. This has been reviewed by the All Wales Convention (Chair Sir Emyr Jones) (2009) Report. http://wales.gov.uk/docs/awc/publications/091118thereporten.pdf
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 strategic health authorities in 2003, which were abolished and replaced by ten strategic health authorities in 2006.
29. In a debate on devolution in November 1977, Mr Dalyell 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
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. www.commissiononscottishdevolution.org.uk/
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.


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 socio-economic 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 appointment 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.


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 (p11).

49. The commitments were that by 2004 patients will be able to have a GP appointment within 48 hours, long waits in accident and emergency 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 (pp12–13).


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.


54. Secretary of State for Health (2000) op. cit.


65. Mattei and others (2009) op. cit. The Centre for Public Policy for Regions, 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, 62.0 per cent; 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 GCSE’s or SNQ equivalents, p3. www.cppr.ac.uk/media/media_133107_en.pdf


68. Auditor General for Wales (2005b) op. cit.


74. Greer and Trench (2008) op. cit.
77. Harrington and others (2009) op. cit. 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 (in, for example, 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.
84. Greer and Trench (2008) op. cit.
85. Ibid.
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 staff and hospital management and support staff – which includes health and personal social services staff in Northern Ireland)
- activity (outpatient appointments, inpatient admissions and day cases)
- crude productivity (level of activity per staff member)
- 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 data on treatment rates omits people accessing treatment in a jurisdiction other than where they are resident. For example, approximately a third of coronary bypass grafts performed on residents of Northern Ireland take place in England or the Republic of Ireland.\(^2\) Table 3.1 gives a list of these indicators.
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 | General practitioners 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 | 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, Wales and Northern Ireland (1996, 2002 and 2006) |
| Figure 4.10 | Day cases per 1,000 population in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006) |
| Figure 4.11 | Inpatient admissions per 1,000 population in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006) |
| Figure 4.12 | Outpatient appointments per hospital medical and dental staff member in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006) |
| Figure 4.13 | Inpatient admissions per hospital medical and dental staff member in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006) |
Figure 4.14 Day cases per hospital medical and dental staff member in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)

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

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

Figure 4.17 Day cases per nursing, midwifery and health visiting staff member in England, Scotland, Wales 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 (1996 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 Appendix (see page 107) 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. However, it is still possible that some differences are due to variation in the way that particular indicators were defined in the four countries. If there were significant differences in the method used to produce an indicator across the countries or over time, then either the information is not presented or a note is attached highlighting the potential lack of comparability. In particular, policies used before 2007 for suspensions of patients on waiting lists in Scotland differed from policies in the other countries, making comparisons difficult. This means that the raw data reported by each country are misleading if used for cross-country comparisons. Data on Scottish waiting times has, therefore, been excluded from the analyses. There have also been some changes in the definitions of day cases and outpatients in Wales.

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, socio-economic 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 research team 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 socio-economic 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. Table 3.2 gives a list of indicators included in the regional analysis.

A difficulty with the regional analysis was that some indicators are reported for the nine government office regions (GORs), while others are reported for the ten strategic health authorities (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.


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

<table>
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<td>Management and support staff (whole time equivalents) per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)</td>
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<td>Figure 5.14</td>
<td>General practitioners per 1,000 population in the ten English SHAs and England, Scotland, Wales and Northern Ireland (2006)</td>
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<td>Figure 5.16</td>
<td>Total outpatient appointments per 1,000 population in the nine GORs of England and England, Scotland, Wales and Northern Ireland (2006)</td>
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<td>Figure 5.17</td>
<td>Day cases per 1,000 population in the nine GORs of England and England, Scotland, Wales and Northern Ireland (2006)</td>
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<td>Figure 5.18</td>
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CHAPTER 4
CROSS-COUNTRY COMPARISONS

Life expectancy

Over the ten-year period of analysis (1996–2006), there have been 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 (Figure 4.1 and 4.2). The percentage increase in life expectancy has been 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. 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 NHS support staff, while England 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 number of hospital medical and dental staff per 1,000 population. This shows that Scotland had the highest rates in 1996 and the greatest increase between 1996 and 2006 (67 per cent); these increases for England, Wales and Northern Ireland were 50 per cent, 58 per cent and 62 per cent, respectively. In 2006, the rates of hospital doctors per capita were 39 per cent higher in Scotland than in England (the country with the lowest rates).
General practitioners (GPs)

Figure 4.6 gives the number 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 number of GPs per capita was 29 per cent higher in Scotland than in Wales (the country with the lowest rate).
Nursing staff

Figure 4.7 gives the rates that nurses (nursing, midwifery and health visiting staff per capita) increased in each of the countries between 1996 and 2006. Scotland had had a rate identical to that of Northern Ireland in 1996; however, significant increases in Scotland over the ten-year period (in the region of 60 per cent) meant that in 2006 nursing rates were 44 per cent higher in Scotland than Northern Ireland.
Management and support staff

Figure 4.8 gives the number of management and support staff per capita which decreased in England, Scotland and Wales between 1996 and 2002; and, despite increases between 2002 and 2006 in each of these countries, the rates in 2006 were lower than in 1996. Northern Ireland, which includes health and personal social services, had the highest rates in 1996; and exceptionally, slight increases in both time periods. In 2006, the rates of management and support staff per capita were 171 per cent higher in Northern Ireland than in England (the country with the lowest rate). Though some of this difference is due to the statistics for Northern Ireland including staff working within the personal social services, this does not explain why the gap between England and Northern Ireland widened during this period.

* 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

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, remained constant in Wales and increased in Northern Ireland. In 2006, rates of outpatients ranged from 972 in Wales to 874 in Northern Ireland.

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

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; in Scotland there was an increase in the first but decrease in the second time period; and in Wales there was a decrease in the second time period (there are no data for 1996). In 2006, day case rates ranged from 91 in Northern Ireland to 67 in Wales. 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.

*No comparable information was available on the number of day cases in Wales in 1996; in addition, there were changes in the definition of day cases in Wales between 2002 and 2006 which makes comparison difficult.*
Inpatients

Figure 4.11 shows that there was no pattern evident across the countries and over time in terms of the rates of inpatient admissions: in Northern Ireland there was a slight increase between 1996 and 2002, and 2002 and 2006; there were fluctuations in England and little change in Wales, but in Scotland, in the second period there was a marked reduction. The diverging trends over time mean that there were large and puzzling differences in rates of inpatient admissions per 1,000 population in 2006: from 205 in Northern Ireland to 135 in Scotland. The Scottish NHS has been unable to explain the apparent large reduction in inpatient activity reported for 2006 (personal communication).2

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

Reported here are crude productivity rates for medical or dental staff members and nursing, midwifery and health visiting staff members. These are numbers of outpatient appointments, inpatient admissions and day cases per medical or dental or nursing 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 medical or dental and nursing staff member (with percentages in parenthesis).

**Crude productivity of hospital medical and dental staff**

Figure 4.12 shows that for outpatients, between 1996 and 2006, reductions in crude productivity per hospital doctor were: Scotland 261 (42 per cent), Wales 230 (31 per cent), Northern Ireland 228 (35 per cent), England 272 (36 per cent). The rates of outpatients per hospital medical or dental staff member in 2006 ranged from 511 in Wales to 357 in Scotland.
Figure 4.13 shows that for inpatients, between 1996 and 2006, reductions in crude productivity per hospital medical or dental staff member were Scotland 72 (57 per cent), Wales 59 (40 per cent), England 67 (43 per cent), Northern Ireland 39 (28 per cent). The rates of inpatients per hospital medical or dental staff member ranged from 100 in Northern Ireland to 54 in Scotland.

![Figure 4.13: Inpatient admissions per hospital medical and dental staff member in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)](image-url)
Figure 4.14 shows that for day cases, there was a slight increase in crude productivity per hospital medical or dental staff member in Northern Ireland between 1996 and 2002; between 2002 and 2006, in every country there were decreases in crude productivity. Between 1996 and 2006, reductions in crude productivity were Scotland 20 (40 per cent), Wales 19 (35 per cent), England ten (18 per cent) and Northern Ireland two (4 per cent).

The rates of day cases per hospital doctor ranged from 45 in England to 30 in Scotland.

* As no comparable information was available on day cases in Wales in 1996, it was not possible to calculate day cases per hospital medical and dental staff member in Wales in 1996.
Productivity of nursing staff

Figure 4.15 shows that for outpatients, between 1996 and 2006, reductions in crude productivity per nurse were England 28 (17 per cent), Scotland 21 (23 per cent), Wales two (2 per cent) and Northern Ireland eight (7 per cent). The rates of outpatient appointments per nurse in 2006 ranged from 141 in England to 80 in Scotland.
Figure 4.16 shows that for inpatients, between 1996 and 2006, reductions in crude productivity per nurse in England were nine (26 per cent), Scotland six (34 per cent) and Wales three (14 per cent), and a slight increase in Northern Ireland of one (26 per cent). The rates of inpatients per nursing staff member in 2006 ranged from 27 in Northern Ireland to 12 in Scotland.
Figure 4.17 shows that for day cases, there were increases in crude productivity per nursing staff member in England and Northern Ireland between 1996 and 2002. Between 2002 and 2006, crude productivity remained constant in Northern Ireland and England, and fell in Scotland and Wales (the precipitous decline in Wales may be explained by differences in definitions between the countries). Between 1996 and 2006, there were increases in crude productivity in Northern Ireland of three (33 per cent), England one (8 per cent); and a fall in Scotland of four (36 per cent) and Wales five (42 per cent).

* As no comparable information was available on day cases in Wales in 1996, it was not possible to calculate day cases per nursing, midwifery and health visiting staff member in Wales in 1996.
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
- coronary artery bypass graft.

In general, operation rates have increased through time, but there were reductions for procedures for inguinal hernia (England and Wales); varicose vein (Scotland) and coronary artery bypass grafting (CABG) (Northern Ireland). Although the most striking difference in terms of the reported operation rates is the comparatively low rates in Northern Ireland in 2006, these statistics are complicated by procedures being provided in the Republic of Ireland (as for CABG surgery).
Table 4.1: Activity: operation rates (per 10,000) for selected hospital procedures in England, Scotland, Wales and Northern Ireland (1996, 2002 and 2006)

<table>
<thead>
<tr>
<th>Procedure (OPCS4 classification)</th>
<th>England</th>
<th>Scotland</th>
<th>Wales</th>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extracapsular extraction of lens (C71)</td>
<td>NA*</td>
<td>54.2</td>
<td>56.5</td>
<td>31.1</td>
</tr>
<tr>
<td>Prosthesis of lens (C75)</td>
<td>28.7</td>
<td>54.6</td>
<td>56.3</td>
<td>31.7</td>
</tr>
<tr>
<td>Excision of gall bladder (J18)</td>
<td>7.1</td>
<td>9.4</td>
<td>10.6</td>
<td>10.5</td>
</tr>
<tr>
<td>Inguinal hernia (T20)</td>
<td>16.8</td>
<td>16.7</td>
<td>13.4</td>
<td>12.5</td>
</tr>
<tr>
<td>Total prosthetic replacement of knee joint (W40–W42)</td>
<td>5.0</td>
<td>8.5</td>
<td>11.9</td>
<td>4.9</td>
</tr>
<tr>
<td>Varicose vein operation (L85–L87)</td>
<td>11.2</td>
<td>9.4</td>
<td>17.7</td>
<td>26.0</td>
</tr>
<tr>
<td>Hip replacement (W37–W39)</td>
<td>6.9</td>
<td>8.7</td>
<td>12.5</td>
<td>9.2</td>
</tr>
<tr>
<td>Coronary artery bypass graft (K40–K46)</td>
<td>4.7</td>
<td>5.1</td>
<td>8.0</td>
<td>8.6</td>
</tr>
</tbody>
</table>

* 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 others\(^5\) 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 decreased from 40 per cent to 30 per cent. In both Wales and Northern Ireland, the percentage increased from 1996 to 2002, but then decreased to 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)

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

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 than three months; 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 England and Wales, and four and six years later in Northern Ireland and Scotland. 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).

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).
Patient satisfaction with various aspects of the NHS

Figures 4.21 to 4.24 show the percentages 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 percentages of the populations 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.

* No data were available for Northern Ireland for 2002.
Figure 4.22 shows the percentages of the populations satisfied with inpatient care. These have 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.

* No data were available for Northern Ireland for 2002.
Figure 4.24 shows the percentage satisfied with general practice care, which is higher than for other aspects reported. The percentage satisfied with general practice care was high in 1996 and 2006, but fell in all countries. 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.
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 Scotland, between 1996 and 2006, there was a significant reduction in inpatient admissions per 1,000 population (from 189 to 135) but little change in the rate of day cases. Hence there appears to have been no increase in day cases to compensate for the reduction in the rate of inpatient admissions.


4. Note this is over the period from 2002 to 2006.

5. Propper and others (2008a and 2008b) op. cit.

6. The percentage of the population waiting more than three months was less than 0.05 per cent.


CHAPTER 5
COMPARISONS OF SCOTLAND, WALES AND NORTHERN IRELAND WITH ENGLISH REGIONS

The purpose of this section is to compare indicators for the devolved countries with English regions: the nine English government office regions (GORs) or the ten strategic health authorities (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. 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.

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.’ 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.

**Socio-economic and health indicators**

In this subsection, 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 socio-economic status.

Table 5.1 gives selected socio-economic 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 households in receipt of disability benefits in 2006/07 (percentage with disability benefits)
- percentage of dwellings rented from local authorities (LAs) (percentage LA rented)
- percentage of households with no use of a car in 2007 (percentage households without a car).

These indicators show no consistency for London, which appears to be relatively rich because it has the highest per capita income and lowest percentage with disability benefits; and relatively poor because it has 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 has the highest rate of unemployment, 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 has the 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 socio-economic indicators for the UK, English GORs, England, Wales, Scotland and Northern Ireland (2006)

<table>
<thead>
<tr>
<th>Geographical Region</th>
<th>Gross disposable household income (£ per head) 2006</th>
<th>Unemployment rates 2006</th>
<th>Households in receipt of disability benefits (%) 2006/07</th>
<th>Dwelling rented from local authority (%) 2007</th>
<th>Household with no use of a car (%) 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>14,053</td>
<td>5.6</td>
<td>16</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>North East</td>
<td>12,026</td>
<td>6.2</td>
<td>21</td>
<td>13</td>
<td>39</td>
</tr>
<tr>
<td>North West</td>
<td>12,778</td>
<td>5.4</td>
<td>20</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>12,660</td>
<td>5.9</td>
<td>16</td>
<td>11</td>
<td>32</td>
</tr>
<tr>
<td>East Midlands</td>
<td>13,032</td>
<td>5.5</td>
<td>15</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>West Midlands</td>
<td>12,697</td>
<td>5.9</td>
<td>19</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>East of England</td>
<td>14,855</td>
<td>5.2</td>
<td>12</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>London</td>
<td>17,512</td>
<td>8.0</td>
<td>10</td>
<td>14</td>
<td>37</td>
</tr>
<tr>
<td>South East</td>
<td>15,821</td>
<td>4.7</td>
<td>11</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>South West</td>
<td>13,968</td>
<td>3.8</td>
<td>14</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>England</td>
<td>14,285</td>
<td>5.7</td>
<td>15</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td>Wales</td>
<td>12,366</td>
<td>5.9</td>
<td>22</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Scotland</td>
<td>13,347</td>
<td>5.5</td>
<td>18</td>
<td>14</td>
<td>34</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>12,234</td>
<td>4.4</td>
<td>24</td>
<td>14</td>
<td>30</td>
</tr>
</tbody>
</table>
Figure 5.2 gives a comparison of the North East with the devolved countries for the same selected socio-economic indicators standardised with the average for England at 100. This shows 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 three devolved countries; each has its own distinctive pattern of indicators of poverty relative to that average.
Figure 5.3 gives standardised mortality ratios (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) is an outlier with the highest SMR. Wales (101) and Northern Ireland (108) fall 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 5.4 gives rates of infant and perinatal mortality, which exceptionally show 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 fall 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 is an outlier with the shortest life expectancy (75 and 80); Wales (77 and 81) and Northern Ireland (76 and 81) fall within the range of English GORs, are similar to the north of England (76 and 80) and lower than the average for England (77 and 82).
Figure 5.6 gives percentages of the population that are aged 65 to 74 for males and 60 to 74 for females and those over 75. These percentages in Scotland, Wales and Northern Ireland fall within the range of English GORs. The South West and London have the highest and lowest percentages that are old; Wales and Scotland are similar to South West and Northern Ireland to London.
Figure 5.7 gives percentages of the population reporting longstanding illness, limiting longstanding illness (LLSI) and restricted activity in the nine English GORs and England, Scotland, Wales and Northern Ireland. For all these indicators, London has the lowest rates, which is to be expected as it has the youngest population. For longstanding illness, these percentages for Scotland, Wales and Northern Ireland fall within the range of English GORs. Northern Ireland and the North East have the highest rates for LLSI and restricted activity; and Scotland and Wales the lowest rates after those for London.

Figure 5.7: Percentages of the population reporting longstanding illness, limiting longstanding illness 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 the health of the population in the North East is 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 has 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 these broadly follow 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).
Table 5.2: Comparisons of SMRs and per capita spend for the nine English GORs and Scotland, Wales and Northern Ireland (2006)

<table>
<thead>
<tr>
<th>Per capita spend in comparison with English average</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low</strong></td>
<td>East of England, East Midlands, South East, South West</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>West Midlands, Yorkshire and The Humber</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>London</td>
<td>Wales</td>
<td>North East, North West, Northern Ireland</td>
<td></td>
</tr>
<tr>
<td><strong>Very high</strong></td>
<td>Scotland</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Inputs**

Figure 5.10 shows the number of hospital beds per 1,000 population for each SHA and country with four distinct sets:

- **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
- **much higher than the English average**: Scotland.

There was no obvious pattern in the variation of the proportion of beds in acute specialities 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; data for Scotland were not comparable to those of the other countries).
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
- NHS management and support staff
- GPs.

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 how the average rate for hospital medical and dental staff for England (1.8) is misleading, as it is driven by the rate in London (2.5), which far exceeds that for all of the other SHAs, reflecting the concentration of teaching, training and research. Excluding London, Scotland, Northern Ireland and Wales have higher rates than any English SHA.

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 Scotland, Northern Ireland and Wales have higher rates of nursing staff than any English SHA. Within the English SHAs, this rate is also high in London (7.1, for the same reasons as for hospital doctors); but otherwise the rate broadly follows needs of populations.
Figure 5.13 shows Northern Ireland (for health and personal social services), Scotland and Wales have higher rates for NHS management and support staff than any English SHA. Within the English SHAs, this rate broadly follows needs of populations.

*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.*
Figure 5.14 shows 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 5.15 compares staffing rates per 1,000 population (standardised to England averages of 100) for Scotland, Wales and Northern Ireland and the North East (the SHA with high levels of need, expenditure and HCHS staffing). This shows the North East had much lower rates of hospital medical and dental staff than Scotland and Northern Ireland, much lower rates of nursing staff than Scotland and Wales, much lower rates of management and support staff than each devolved country, and lower rates of GPs than Scotland. Scotland has the highest rates of hospital medical and dental staff, nursing staff and GPs. Northern Ireland has the highest rates of management and support staff for health and personal social services.
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. For all of these, 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 Coast) and highest 105 (North East)
- for inpatient admissions: mean 160, lowest 146 (South East Coast) and highest 207 (London).
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. The rates for Scotland, Wales and Northern Ireland lie within the range for English GORs for total outpatients (outpatient appointments), but Wales (together with the South East SHA) (37.4) has the lowest rate for day cases (67 – but there are questions over the comparability of Welsh data) and Scotland for inpatients (135).

Figure 5.17: Day cases per 1,000 population in the nine GORs of England and England, Scotland, Wales and Northern Ireland (2006)
Figure 5.18: Inpatient admissions per 1,000 population in the nine GORs of England and England, Scotland, Wales and Northern Ireland (2006)
Figure 5.19 compares treatment rates per 1,000 population for Scotland, Wales, Northern Ireland and the North East for all outpatient appointments and the sum of inpatient admissions and day cases. This shows both treatment rates were higher for the North East than the three devolved countries; and also that Scotland, despite having the highest levels of need and staffing of any region or country (excluding non-clinical staff in Northern Ireland), had the lowest rates of treatment. The odd variations between the countries in the ratios of outpatients to sum of inpatients and day cases probably reflects coding differences over what are classed as day cases and outpatients.

Figure 5.19: Treatment rates per 1,000 population for Scotland, Wales, 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 indicators of crude productivity based on rates for outpatient appointments, day cases, and inpatient admissions per hospital medical and dental staff and nursing staff member. The reported statistics show Scotland to have the lowest crude productivity for each measure (except for day cases per nursing staff member which is similar to that reported for Wales, but as already discussed there are problems of comparability with the Welsh data). The problems with day cases in Wales also make cross-country comparisons of rates for outpatient appointment problematic, but ought not to affect comparisons of rates for inpatient admissions. These 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).

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* 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 5.21 shows Scotland to be an outlier in low crude productivity for the number of inpatient admissions per hospital medical and dental staff member. Although London and England are ranked after Scotland, as explained above these are poor measures as they do not allow for the large staffing in London for teaching, training and research, and the low statistic for London reduces the average for England. Each other English region has higher crude productivity of hospital medical and dental staff members than the three devolved countries.

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

<table>
<thead>
<tr>
<th>Region</th>
<th>Inpatient admissions per hospital medical and dental staff member</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>140</td>
</tr>
<tr>
<td>South West</td>
<td>120</td>
</tr>
<tr>
<td>North East</td>
<td>100</td>
</tr>
<tr>
<td>West Midlands</td>
<td>100</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>100</td>
</tr>
<tr>
<td>East Midlands</td>
<td>80</td>
</tr>
<tr>
<td>East of England</td>
<td>80</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>80</td>
</tr>
<tr>
<td>Wales</td>
<td>60</td>
</tr>
<tr>
<td>England</td>
<td>60</td>
</tr>
<tr>
<td>London</td>
<td>40</td>
</tr>
<tr>
<td>Scotland</td>
<td>40</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>40</td>
</tr>
<tr>
<td>East Midlands</td>
<td>40</td>
</tr>
<tr>
<td>East of England</td>
<td>40</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>40</td>
</tr>
<tr>
<td>Wales</td>
<td>20</td>
</tr>
<tr>
<td>England</td>
<td>20</td>
</tr>
<tr>
<td>London</td>
<td>20</td>
</tr>
<tr>
<td>Scotland</td>
<td>20</td>
</tr>
</tbody>
</table>

* 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.
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. There are also questions over the comparability of data on day cases in Wales.
Figure 5.23: Outpatient appointments per nursing, midwifery and health visiting 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 5.24 shows Scotland and Wales to be outliers with low crude productivity rates for inpatient admissions per nursing staff member. London and England are ranked after Scotland and Wales, and the same qualification as for hospital medical and dental staff member will apply, although to a lesser degree. There is little variation in the measure of crude productivity of nurses between the other English regions and Northern Ireland. It is remarkable that the regions with the highest crude productivity of nurses based on this measure are the South West and the East of England, as these regions have sparsely distributed populations, and would therefore be expected to have heavier concentrations of nurses in the community, whose productivity would not be captured by measuring output in numbers of inpatients.

Figure 5.24: Inpatient admissions per nursing, midwifery and health visiting 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 5.25: Day cases per nursing, midwifery and health visiting 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. There are also questions over the comparability of data on day cases in Wales.
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. Table 5.3 shows that the performance of Wales and Northern Ireland is 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; 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 5 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 shows 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 is an outlier in terms of its poor performance.
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, England, Wales and Northern Ireland (March 2008)

<table>
<thead>
<tr>
<th>Region</th>
<th>Inpatient and day cases</th>
<th>Outpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numbers waiting</td>
<td>% of total population</td>
</tr>
<tr>
<td>North East</td>
<td>25,977</td>
<td>1.0</td>
</tr>
<tr>
<td>North West</td>
<td>78,582</td>
<td>1.1</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>52,226</td>
<td>1.1</td>
</tr>
<tr>
<td>East Midlands</td>
<td>42,396</td>
<td>1.0</td>
</tr>
<tr>
<td>West Midlands</td>
<td>52,860</td>
<td>1.0</td>
</tr>
<tr>
<td>East of England</td>
<td>64,817</td>
<td>1.2</td>
</tr>
<tr>
<td>London</td>
<td>73,629</td>
<td>1.0</td>
</tr>
<tr>
<td>South East Coast</td>
<td>42,997</td>
<td>1.0</td>
</tr>
<tr>
<td>South Central</td>
<td>36,559</td>
<td>0.9</td>
</tr>
<tr>
<td>South West</td>
<td>56,180</td>
<td>1.1</td>
</tr>
<tr>
<td>England</td>
<td>526,223</td>
<td>1.0</td>
</tr>
<tr>
<td>Wales</td>
<td>50,361</td>
<td>1.7</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>36,994</td>
<td>2.1</td>
</tr>
</tbody>
</table>
Table 5.4: Percentage of the population waiting less than six weeks, six to 12 weeks and 12 weeks or more for an inpatient admission or day case or outpatient appointment in the ten SHAs of England (March 2006)

<table>
<thead>
<tr>
<th>Region</th>
<th>Ordinary + day cases</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;6 weeks</td>
<td>6 – &lt;12 weeks</td>
</tr>
<tr>
<td>North East</td>
<td>62.2</td>
<td>28.1</td>
</tr>
<tr>
<td>North West</td>
<td>70.0</td>
<td>23.4</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>66.7</td>
<td>26.5</td>
</tr>
<tr>
<td>East Midlands</td>
<td>67.1</td>
<td>26.0</td>
</tr>
<tr>
<td>West Midlands</td>
<td>64.8</td>
<td>28.8</td>
</tr>
<tr>
<td>East of England</td>
<td>59.4</td>
<td>29.5</td>
</tr>
<tr>
<td>London</td>
<td>61.9</td>
<td>27.7</td>
</tr>
<tr>
<td>South East Coast</td>
<td>55.2</td>
<td>30.0</td>
</tr>
<tr>
<td>South Central</td>
<td>66.2</td>
<td>25.8</td>
</tr>
<tr>
<td>South West</td>
<td>61.5</td>
<td>30.3</td>
</tr>
</tbody>
</table>
The devolved countries as outliers

Box 5.1 identifies those indicators for which Scotland, Wales and Northern Ireland are 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 values 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 are comparable statistics with the highest levels of poor health; 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 doctors and nurses.

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 doctors and nurses; 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 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)

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>Scotland</th>
<th>Wales</th>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMRs (males and females)</td>
<td></td>
<td>&gt;</td>
<td></td>
</tr>
<tr>
<td>Perinatal mortality rates (males and females)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td></td>
<td>&lt;</td>
<td></td>
</tr>
<tr>
<td>% population &gt;65–74 (males) and 60–74 (females)</td>
<td></td>
<td></td>
<td>&lt;*</td>
</tr>
<tr>
<td>% population reporting limiting longstanding illness</td>
<td></td>
<td></td>
<td>&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supply per capita</th>
<th>Scotland</th>
<th>Wales</th>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS expenditure</td>
<td></td>
<td>&gt;</td>
<td></td>
</tr>
<tr>
<td>Available hospital beds</td>
<td></td>
<td>&gt;</td>
<td>&gt;</td>
</tr>
<tr>
<td>Hospital doctors</td>
<td></td>
<td>&gt;</td>
<td>&gt;*</td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
<td>&gt;</td>
<td>&gt;</td>
</tr>
<tr>
<td>Non-clinical staff</td>
<td></td>
<td>&gt;</td>
<td>&gt;</td>
</tr>
<tr>
<td>GPs</td>
<td></td>
<td>&gt;</td>
<td></td>
</tr>
</tbody>
</table>

| Treatment rates per capita                                                         |          |       |                  |
| Total outpatient appointments                                                      |          |       |                  |
| Day cases                                                                         |          |       | <                |
| Inpatient admissions                                                              |          |       | <                |
### Crude productivity

<table>
<thead>
<tr>
<th>Measure</th>
<th>Scotland</th>
<th>Wales</th>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients per hospital doctor</td>
<td>&lt;</td>
<td>&lt;*</td>
<td>&lt;</td>
</tr>
<tr>
<td>Inpatients per hospital doctor</td>
<td>&lt;</td>
<td>&lt;**</td>
<td>&lt;**</td>
</tr>
<tr>
<td>Day cases per hospital doctor</td>
<td>&lt;</td>
<td>&lt;*</td>
<td>&lt;*</td>
</tr>
<tr>
<td>Outpatients per nurse</td>
<td>&lt;</td>
<td>&lt;</td>
<td>&lt;</td>
</tr>
<tr>
<td>Inpatients per nurse</td>
<td>&lt;</td>
<td>&lt;</td>
<td>&lt;**</td>
</tr>
<tr>
<td>Day cases per nurse</td>
<td>&lt;</td>
<td>&lt;</td>
<td></td>
</tr>
</tbody>
</table>

### Waiting times

<table>
<thead>
<tr>
<th>Measure</th>
<th>Scotland</th>
<th>Wales</th>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>% waiting &gt;13 weeks for outpatient appointment</td>
<td>NA</td>
<td>&gt;</td>
<td>&gt;</td>
</tr>
<tr>
<td>% waiting &gt;13 weeks for elective admission</td>
<td>NA</td>
<td>&gt;</td>
<td>&gt;</td>
</tr>
</tbody>
</table>

**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 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
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. 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. 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. Earlier this year, 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. 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). 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), though 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 socio-economically 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
- 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 doctors and nurses. 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. There are also 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.5 From April 2009, in England only there has been the introduction of patient reported outcomes following hospital discharge6 (for hip replacements, knee replacements, groin hernia surgery and varicose vein surgery).

The measures 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).7 The authors have reported a limited set of cross-country indicators over time. Even those indicators have some problems: the different definition of waiting times for patients on waiting lists in Scotland; and questions over the comparability of data on Welsh day cases and outpatients, and Scottish inpatients.

The principal findings from cross-country longitudinal comparisons are as follows:

- In 1996 and 2006, Scotland had the highest, and England the lowest, rates per capita of expenditure, nurses, hospital medical and dental staff, and GPs (except in 2006, when Wales had the lowest rate for GPs). The relative excess of rates in Scotland over England narrowed for per capita expenditure and GPs, remained relatively constant for hospital medical and dental staff, but almost doubled for nursing staff.

- In 1996 and 2006, Northern Ireland had the highest, and England the lowest, rates per capita of management and support staff (which includes health and personal social services in Northern Ireland). The excess rate of Northern Ireland over England increased from about 70 per cent in 1996 to 170 per cent in 2006.

- In 1996, Scotland had the highest rates per capita for outpatient appointments, day cases and inpatient admissions. In 2006, Northern Ireland had the highest rates for day cases and inpatient admissions, and Wales had the highest rates for outpatient appointments.

- In 1996, England had the lowest rates per capita for outpatient appointments and inpatient admissions, and Northern Ireland the lowest rates for day cases. In 2006, Scotland had the lowest rates for outpatient appointments and inpatient admissions, and Wales the lowest rates for day cases.

- In 1996 and 2006, Scotland had the lowest rates of outpatient appointments and inpatient admissions per hospital medical and dental staff member. In 1996, England had the highest rates of outpatient appointments and
inpatient admissions; in 2006, Wales and Northern Ireland had the highest rates (but regional analysis given below shows that average rates for England are misleading).

- In 1996, Northern Ireland and Wales had the lowest rates of outpatient appointments and inpatient admissions per nursing staff member; in 2006, Scotland had the lowest rates. In 1996, England had the highest rates; in 2006, England and Northern Ireland had the highest rates.

- England consistently had the best performance – over the time for which comparable data exist – for waiting times for inpatients and outpatients, and for ambulance response rates to what may have been life-threatening emergencies.

This report presents for the first time a comparison 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:

- Population characteristics: the north/south divide means that the socio-economic 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 regional analysis shows that the devolved countries have not matched the performance in England:

- All English regions had better performance than Wales and Northern Ireland for hospital waiting times (there were no comparable data for Scotland).

- All English regions (except London) have higher crude productivity of hospital doctors for inpatients than Scotland, Wales and Northern Ireland.

- All English regions (except London) have higher crude productivity of nurses for inpatients than Scotland or Wales (but not Northern Ireland).

- Comparing Scotland with all English regions (except London) shows that Scotland had the highest standardised mortality ratios, lowest life expectancy, highest levels of expenditure and staffing, and the lowest levels of crude productivity of hospital doctors and nurses.

- Comparing Wales and Northern Ireland with the North East shows that Wales and Northern Ireland had expenditure similar to that of the North East, but worse performance in terms of hospital waiting times, ambulance
response times and crude productivity of hospital doctors (crude productivity of nurses in Northern Ireland was marginally higher than in the North East, but in Wales was much lower than in the North East). The North East also had a lower level of non-clinical staff.

It may, of course, 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. 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 (p27):

*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 others 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 numbers 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.

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. They emphasise 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 Street\textsuperscript{12} 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.\textsuperscript{13} 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 point 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 off-setting 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 Commons,\textsuperscript{14} on the Welsh Wanless report,\textsuperscript{15} Members of Parliament (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 in-patient 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).\textsuperscript{16} 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’.

The regional analysis highlights the contrast between the NHS in Scotland and its adjacent English region, the North East. Their populations are of similar size and characteristics, but within different jurisdictions. For the year ending March 2006, there were striking and puzzling differences in terms of average expenditure, staffing and services provided by each NHS for a population of 100,000:

- Expenditure and staffing in Scotland would have been about £180m, with 250 hospital doctors (medical and dental staff), 1,100 nurses, 730 non-clinical staff (management and support) and 81 GPs; and in the North East, £170m, 180 hospital doctors, 740 nurses, 420 non-clinical staff and 71 GPs.

- The services provided in Scotland would have amounted to about 89,300 outpatient attendances, 7,600 day cases, and 13,500 inpatient admissions; and in the North East, about 105,000 outpatient attendances, 10,500 day cases and 20,700 inpatient admissions.

There were also striking differences in average crude productivity for the same year:

- A hospital doctor in Scotland would care for 357 outpatients, 30 day cases and 54 inpatients; and in the North East for 584 outpatients, 58 day cases and 115 inpatients. A nurse in Scotland would care for 70 outpatients, seven day cases and 12 inpatients; and in the North East a nurse would care for 142 outpatients, 14 day cases and 27 inpatients.

These differences raise questions about funding, staffing and delivery of services:

- How could a 6 per cent additional level of funding per capita in Scotland, as compared with the North East, result in Scotland having, per capita, 14 per cent more hospital doctors and GPs, nearly 50 per cent more nurses, and nearly 75 per cent more non-clinical staff? Is this because the Scottish Parliament has decided to spend its money differently (for example, without the same emphasis on capital development through schemes financed by the Private Finance Initiative)?

- How could lower levels of staffing per capita in the North East have delivered 18 per cent more outpatient attendances, nearly 40 per cent more day cases and over 50 per cent more inpatients than in Scotland?

- What explains the differences in crude productivity of clinical staff? In the North East, hospital doctors treated over 60 per cent more outpatient attendances, about 100 per cent more day cases and inpatients than in Scotland; and nurses about 100 per cent more outpatient attendances, day cases and inpatients.

These questions merit further research into changes over time and in health outcomes. (The recent analysis by Sutherland and Coyle did not analyse variations by regions within England.) One particularly fruitful line of analysis, as suggested above, would be to compare devolved countries with the North East region. This report analyses issues over equitable funding of each country and the accountability of each government for the performance of its NHS.
To what extent are major differences between the countries in funding per capita justified by differences in need? 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. 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’ (p8). The authors of this report strongly endorse the Committee’s recommendation that (p8):

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.

The implications of formulas that aim to do this for healthcare will be examined in a future report. The point being made here is that if the extra funding for Scotland were justified by increased need for healthcare, it could be expected that Scotland would have the highest rates of hospital treatment. This was so in 1996, but, in 2006, Scotland had the lowest rates of outpatient appointments and inpatient admissions per capita.

The vexed and crucial issue of accountability is now considered. The funding of the NHS in England is, in principle, conditional upon performance against the Treasury’s Public Service Agreement (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. There are no PSA targets for the devolved governments, so their funding is not dependent upon their performance. These governments are held to account by their electorates specifically for the performance of the devolved services. There are therefore three troubling features of governance and accountability following devolution.

First, the UK taxpayer funds health services in each country, but only England is held to account for its performance by the UK Treasury. Scotland has the lowest rates of crude productivity for hospital doctors and nurses on all the measures reported here. So, even if Scotland were to justify its higher funding on the basis of higher relative need, the UK taxpayer may rightly question whether the generous funding of NHS Scotland has been directed not at meeting its greater needs, but at allowing its clinical staff to do less work than, for example, in the North East of England. On the basis of the data reported here, the authors can only pose that question, but are not in a position to answer it.

Second, there is no equivalent electoral accountability for devolved services in England, as this accountability is exercised
only through general elections to the UK Parliament. 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?

Third, 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 authority to require governments of the UK to produce comparable data on public services. 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. The authors acknowledge that the point of devolution is to allow governments of each country to differ in their policies and priorities.

The unusual features of devolution mean that it would now be difficult for the Treasury to hold the devolved governments to account through PSA targets. Yet UK taxpayers have the right to know how well the different governments are securing value for their money. It may be that the higher spending per capita in Scotland is compensated by other aspects of performance than those reported here, but other studies have failed to find any evidence of this and it is likely to be difficult to produce such evidence. If the Treasury cannot hold devolved governments to account for their performance through targets, then it ought to be able to require them to supply comparative data on that performance to justify differences in spending per capita as this is the basis ostensibly used for allocating funds between each country. The House of Lords Select Committee on the Barnett Formula highlighted the problem of inadequate comparable data published by the Treasury (paragraph 62):

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.

The authors of this report see such comparative information as a vital element in holding each devolved government to account to the UK taxpayer for performance of their own NHS. Another possibility might be for the European Union (EU) to require comparable information to be produced by each government within the EU.

This report has identified troubling 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 analysis 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.

This report will be followed up with another that examines whether the levels of NHS funding between the four countries is equitable. There is also scope for further, more detailed, work using the North East region as a benchmark for comparison with the devolved countries. Such research ought to further inform two fundamental questions. First, how do the experiences of patients and NHS staff differ between the different countries of the UK? Second, has the ‘natural experiment’ of policy differences between the four countries, funded by the UK taxpayer, resulted in the devolved countries spending more on the NHS than England, yet doing worse?

2. 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) differences in life expectancy by levels of deprivation for 2004–06 (pp96–101).
3. Sutherland and Coyle (2009) ibid. report median and 90th percentile waiting times for the same 11 selected procedures as reported by the Office of 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 of National Statistics (2008) United Kingdom Health Statistics. Basingstoke: Palgrave Macmillan, p82. www.statistics.gov.uk/downloads/theme_health/UKHS3/UKHS2008web.pdf


8. Propper and others (2008b) op. cit. 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.


10. As unified boards were introduced in 2001, and NHS trusts ceased to exist as entities independent from their boards in 2004.

11. The largest increase was of about 2.6 per cent in volume for NHS (non-foundation) trusts (pp4–5).


13. 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.).


15. Wanless (2003) op. cit.


17. 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.


21. 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


23. Although each country has common objectives for hospitals to reduce long waiting times for treatment and for ambulances to respond quickly to what may be life-threatening emergencies.


26. CPPR (2009) op. cit. report 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’.
## APPENDIX
### INDICATOR DEFINITIONS AND SOURCES

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<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Source*</th>
<th>Comments</th>
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<tr>
<td></td>
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<td>National</td>
<td>Regional</td>
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<tr>
<td>Population</td>
<td>Total population</td>
<td>Office for National Statistics (ONS): Population Trends 132; Table 1.2 (Table 5.1)</td>
<td>ONS: Population Trends 132; Table 1.3 (Table 5.1)</td>
</tr>
<tr>
<td>Proportion of population aged 65M/60F–74</td>
<td>The proportion of the population aged 65–74 for males and 60–74 for females</td>
<td>ONS: Population Trends 132; Table 2.1 (Figure 5.6)</td>
<td>ONS: Population Trends 132; Table 1.3 (Figure 5.6)</td>
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<tr>
<td>Proportion of population aged ≥75 (%)</td>
<td>The proportion of the population aged 75 and over</td>
<td>ONS: Population Trends 132; Table 2.1 (Figure 5.6)</td>
<td>ONS: Population Trends 132; Table 1.3 (Figure 5.6)</td>
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<td>Indicator</td>
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<tr>
<td>Standardised mortality ratio</td>
<td>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</td>
<td>ONS: Key Population and Vital Statistics 2006; Table 4.1b (Figure 5.3)</td>
<td>ONS: Key Population and Vital Statistics 2006; Table 4.1b (Figure 5.3)</td>
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<tr>
<td>Life expectancy (at birth)</td>
<td>The average number of years to be lived by those born in a particular year</td>
<td>ONS: Population Trends 135; Table 2.2 (Figures 4.1 and 4.2)</td>
<td>ONS: Regional Trends 41: Table 6.8 (Figure 5.5)</td>
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<tr>
<td>Perinatal mortality/1,000</td>
<td>The number of stillbirths and deaths under 1 week per 1,000 live births and stillbirths</td>
<td>ONS: Population Trends 132; Table 2.1 (Figure 5.4)</td>
<td>ONS: Key Population and Vital Statistics 2006; Table 4.1b (Figure 5.4)</td>
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<tr>
<td>Infant mortality/1,000</td>
<td>The number of deaths at age under one year per 1,000 live births</td>
<td>ONS: Population Trends 132; Table 2.1 (Figure 5.4)</td>
<td>ONS: Key Population and Vital Statistics 2006; Table 4.1b (Figure 5.4)</td>
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<td>Proportion reporting illness</td>
<td>Proportion of the population reporting a longstanding illness or a limiting longstanding illness</td>
<td>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)</td>
<td>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?</td>
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<tr>
<td>Restricted activity in the 14 days before interview</td>
<td>Proportion of the population reporting restricted activity in the 14 days before interview</td>
<td>England, Scotland and Wales: ONS: General Household Survey 2006. Northern Ireland: NISRA Central Survey Unit, Continuous Household Survey 2006/07 (Figure 5.7)</td>
<td>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?’</td>
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<tr>
<td>NHS expenditure per capita</td>
<td>Per capita expenditure on health</td>
<td>HM Treasury Public Expenditure Statistical Analyses 2008; Table 9.11 (Figure 4.3)</td>
<td>HM Treasury Public Expenditure Statistical Analyses 2008; Table 9.11 (Figure 5.9)</td>
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<td>Relative per capita spend on NHS and public expenditure</td>
<td>Relative per capita spend on NHS and public expenditure with the UK as reference</td>
<td>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)</td>
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<tr>
<td>Available hospital beds</td>
<td>Average daily available beds per 1,000 population</td>
<td>ONS: United Kingdom Health Statistics 2008; Table 6.1 (Figure 5.10)</td>
<td>Department of Health’s Hospital Activity Statistics website – <a href="http://www.performance.doh.gov.uk/hospital_activity/data_requests/download/beds_open_overnight/bed_07_detail.xls">www.performance.doh.gov.uk/hospital_activity/data_requests/download/beds_open_overnight/bed_07_detail.xls</a> (Figure 5.10)</td>
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<tr>
<td>Hospital medical and dental staff per 1,000 population</td>
<td>The number of directly employed whole time equivalent hospital medical and dental staff per 1,000 population</td>
<td>Calculated from data in ONS: United Kingdom Health Statistics 2008; Table 8.3 (Figure 4.5)</td>
<td>NHS Information Centre website – <a href="http://www.ic.nhs.uk/">www.ic.nhs.uk/</a> (Figure 5.11)</td>
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<td>Excludes general practitioners, includes hospital medical and dental staff holding permanent, paid and/or honorary appointments in NHS hospitals and community health services</td>
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<tr>
<td><strong>Nursing, midwifery and health visiting staff per 1,000 population</strong></td>
<td>The number of whole time equivalent nursing, midwifery and health visiting staff per 1,000 population</td>
<td>Calculated from data in ONS: United Kingdom Health Statistics 2008; Table 8.3 (Figure 4.7)</td>
<td>NHS Information Centre website – <a href="http://www.ic.nhs.uk/">www.ic.nhs.uk/</a> (Figure 5.12)</td>
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<tr>
<td><strong>General practitioners per 1,000 population</strong></td>
<td>The number of general practitioners per 1,000 population</td>
<td>Calculated from data in ONS: Regional Trends 40; Table 7.13 (Figure 4.6)</td>
<td>Calculated from data in ONS: Regional Trends 40; Table 7.13 (Figure 5.14)</td>
</tr>
<tr>
<td><strong>Management and support staff per 1,000 population</strong></td>
<td>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</td>
<td>Calculated from data in ONS: United Kingdom Health Statistics 2008; Table 8.3 (Figure 4.8)</td>
<td>NHS Information Centre website – <a href="http://www.ic.nhs.uk/">www.ic.nhs.uk/</a> (Figure 5.13)</td>
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| **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 | 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 was 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 | 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 was for the financial year 2005/06 rather than 2006/07                                                                                     |
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<td>Inpatient admissions per 1,000 population</td>
<td>The number of inpatient admissions per 1,000 population</td>
<td>ONS: United Kingdom Health Statistics 2008; Table 6.1 (Figure 4.11)</td>
<td>ONS: Regional Trends 40; Table 7.11 (Figure 5.18)</td>
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<td>Outpatient appointments per hospital medical and dental/nursing, midwifery and health visiting staff member</td>
<td>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</td>
<td>Based on staff numbers and activity data above (Figures 4.12 and 4.15)</td>
<td>Based on staff numbers and activity data above (Figures 5.20 and 5.23)</td>
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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 was 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.
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<td>Inpatient admissions per hospital medical and dental/nursing, midwifery and health visiting staff member</td>
<td>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</td>
<td>Based on staff numbers and activity data above (Figures 4.13 and 4.16)</td>
<td>See comment above for outpatient appointments per hospital medical and dental/nursing, midwifery and health visiting staff member</td>
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<tr>
<td>Day cases per hospital medical and dental/nursing midwifery and health visiting staff member</td>
<td>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</td>
<td>Based on staff numbers and activity data above (Figures 4.14 and 4.17)</td>
<td>See comment above for outpatient appointments per hospital medical and dental/nursing, midwifery and health visiting staff member</td>
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<tr>
<td>Operation rates for selected hospital procedures per 10,000 population</td>
<td>The number of selected procedures performed per 10,000 population</td>
<td>England: Department of Health Hospital Episode Statistics online – <a href="http://www.hesonline.nhs.uk/Scotland">www.hesonline.nhs.uk/Scotland</a>: Special request from ISD Scotland Wales: Health Solutions Wales, PEDW statistics: 2005/06 Northern Ireland: Special request from DHSSPS (Table 4.1)</td>
<td>The specific procedures chosen (C71, C75, J18, T20, W40–W42, L85–L87, W37–W39, K40–K46) are relatively common procedures in each country</td>
</tr>
<tr>
<td>Percentage of inpatient and day cases waiting less than six months for admission or day case</td>
<td>The percentage of inpatient and day cases waiting less than six months for admission or day case</td>
<td>England: Department of Health Hospital Waiting Times/list statistics – <a href="http://www.performance.doh.gov.uk/waitingtimes/index.htm">www.performance.doh.gov.uk/waitingtimes/index.htm</a> Wales: Health Statistics Wales 2008 – <a href="http://new.wales.gov.uk/topics/statistics/publications/hsw2008/?lang=en">http://new.wales.gov.uk/topics/statistics/publications/hsw2008/?lang=en</a> Northern Ireland: Statistics Release on Northern Ireland’s waiting lists in March 2006 – <a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a> (Figure 4.18)</td>
<td>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</td>
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<td>Indicator</td>
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| 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  
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  
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) |
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<tr>
<td>Regional</td>
<td>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</td>
<td>(Figure 4.21, 4.22, 4.23 and 4.24)</td>
<td></td>
</tr>
</tbody>
</table>
## Indicator Definitions and Sources

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Source*</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross disposable household income</td>
<td>The gross disposable household income per head, where income covers the income received by households and non-profit institutions serving households</td>
<td>ONS: Regional Trends 41; Table 3.7 (<a href="#">Table 5.1</a>)</td>
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<td>ONS: Regional Trends 41; Table 3.7 (<a href="#">Table 5.1</a>)</td>
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<tr>
<td>Unemployment rate</td>
<td>The percentage of the economically active population who are unemployed, seasonally adjusted</td>
<td>ONS: Regional Trends 40; Table 5.14 (<a href="#">Table 5.1</a>)</td>
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<td>ONS: Regional Trends 40; Table 5.14 (<a href="#">Table 5.1</a>)</td>
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<tr>
<td>Households in receipt of disability benefits</td>
<td>The percentage of households in which at least one member is in receipt of disability benefits</td>
<td>ONS: Regional Trends 41; Table 8.7 (<a href="#">Table 5.1</a>)</td>
<td>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</td>
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<td>ONS: Regional Trends 41; Table 8.7 (<a href="#">Table 5.1</a>)</td>
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<tr>
<td>Dwellings rented from local authority</td>
<td>The percentage of dwellings rented from a local authority</td>
<td>ONS: Regional Trends 41; Table 7.3 <em>(Table 5.1)</em></td>
<td>ONS: Regional Trends 41; Table 7.3 <em>(Table 5.1)</em></td>
</tr>
<tr>
<td>Household with no use of a car</td>
<td>The percentage of households without regular use of a car</td>
<td>ONS: Regional Trends 41; Table 10.2 <em>(Table 5.1)</em></td>
<td>ONS: Regional Trends 41; Table 10.2 <em>(Table 5.1)</em></td>
</tr>
</tbody>
</table>

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