

Clinical Activity in the English and Scottish NHS Before and After Devolution

In the last two decades of the 20th century, growth in clinical activity in the NHS hospital sector was broadly equal in Scotland and England. Scottish inpatient and day case hospitalisation rates increased by an average of 3.7% p.a. between 1980-81 and 1998-99, while English rates increased by 2.9% p.a. between 1985-86 and 1998-99. Scottish new outpatient referral rates increased by 1.8% p.a. between 1980-81 and 1998-99; English rates increased by 2.3% p.a. Over these time periods new A&E attendance rates in Scotland and England increased by 1.1% and 1.3% p.a. respectively.

Similar trend growth in clinical activity came to an end in the 11 year period 1998-99 to 2009-10 after Scottish devolution (Table). In the Scottish NHS, the increase in inpatient and day case hospitalisation rates slowed to 0.6% p.a. between 1998-99 and 2009-10. When the data are expressed as hospital discharges rather than episodes, excluding inter-specialty transfers and “episode inflation”, the increase fell to 0.07% p.a. or a total rise of 0.8% in 11 years. In contrast, English inpatient and day case hospitalisation rates rose by 2.9% p.a. between 1998-99 and 2009-10. When expressed as admissions rather than FCE’s, excluding “FCE inflation”, this increase fell to 2.4% p.a.

Trends in new outpatient referrals showed a similarly divergent trend. Scottish hospital referral rates increased by only 0.4% p.a. between 1998-99 and 2009-10 while English rates rose by 6.1% p.a. over this period. Scottish new A&E attendance rates increased by 1.1% p.a. between 1998-99 and 2009-10 compared with an increase of 4.2% p.a. in English rates.

In summary, increases in English inpatient and day case hospitalisation rates were 26 times those in Scotland between 1998-99 and 2009-10. Increases in new outpatient referrals were 13 times greater in England than in Scotland over this period and increases in A&E attendance rates were almost four times greater.

Interpretation of the significance of changes in Scottish trends in clinical activity in the postdevolution decade are easier to interpret than in their English counterparts. Acute admission units and rapid assessment wards were established to deal with emergency admissions and facilitate their rapid discharge. There was also considerable financial investment in waiting list initiatives and increased efforts to facilitate rapid discharge of older patients to community care or supported home care. Collectively, these initiatives resulted in a decline in winter bed crises and cancelled elective admissions with a progressive fall in inpatient, day case and outpatient waiting times and waiting lists. As noted in a previous newsletter, Office of National Statistics data indicate that Scottish waiting times for a range of elective procedures were shorter than those of England, Wales and Northern Ireland between 2005-10.

At the same time, “bottom-up” demand for emergency and elective hospital admission and new outpatient referrals from the primary care sector levelled off, and A&E self-referral rates also stabilised. These changes were accompanied

by abolition of the internal market, rejection of Payment by Results and of further privatisation of clinical services, including the creation of Independent Surgical Treatment Centres. Block grant funding to Scottish Health Boards was retained, based on a needs-assessment formula; perverse incentives to increase hospital income from tariff-based revenue remain absent. Relationships between hospitals remain based on cooperation rather than competition. In 2009-10, only 0.5% of all NHS inpatients and day cases were treated in Scottish private hospitals.

In summary, clinical trend data in the Scottish NHS in the post-devolution decade indicate a steady-state model in which demand and supply are in equilibrium. In the Scottish primary care sector, where 90% of all doctor-patient contacts occur, consultation rates have also remained constant at about three per annum. In 2005, a Commonwealth Fund survey found that within the countries of the UK, Scotland had the highest portion of recipients of NHS care who felt that the care they had received was “excellent” or “very good”.

Interpretation of

Interpretation of the significance of the much greater increases in clinical activity in the English NHS between 1998-99 and 2009-10 is much less straightforward. Several observations cast doubt on the conclusion that the increases simply represent a response to “bottom-up” demand from the primary care sector to satisfy unmet need.

First, there is a well established relationship between regional morbidity and mortality rates in the UK and hospitalisation rates. These were identified in Scotland in the classic observations of Carstairs & Morris in 1991. Standardised Mortality Rates (SMR) are a component of needs based formulae for NHS funding, retained in Scotland in the Arbuthnott formula and abandoned in England for Payment by Results in 2004. Scotland’s higher hospitalisation rates prior to devolution were closely related to its higher SMR levels, and partly justified more generous NHS funding than in England. As noted in the table, this relationship was reversed in the post-devolution decade. English inpatient and day case hospitalisation rates rose from 14% below to 7% above Scottish rates between 1998-99 and 2009-10. More remarkably, new outpatient rates rose from 11% below to 42% above Scottish rates, and new A&E rates rose from 3% below to 27% above Scottish rates over this period. This reversal of a long established relationship strongly suggests that rapid expansion of clinical activity in England may not simply represent a response to unmet demand.

Second, the rapid rise in English hospitalisation rates between 1998-99 and 2009-10 is non-linear, with only a modest increase in rates over the five year period 1998-99 to 2003-04, and accelerating expansion over the six year period between 2003-04 and 2009-10. This phenomenon is most evident for trends in inpatient and day case rates and new outpatient rates. The former expanded by only 0.8% p.a. in the five year period 1998-99 to 2003-04 but then increased fourfold to 3.7% p.a. between 2003-04 and 2009-10. Similarly, new outpatient rates increased by 2.2% p.a. between 1998-99 and 2003-04, and then also increased fourfold to 9.3% p.a. between 2003-04 and 2009-10.

Third, while inpatient and day case rates and new outpatient rates increased at broadly similar rates in Scotland and England prior to 1998-99, and in Scotland after

devolution, English outpatient rates increased by two and a half times more than inpatient and day case rates between 2003-04 and 2009-10. This implies the referral of increasing numbers of outpatients with lower degrees of morbidity than previously.

Rapid acceleration of the rise in hospital referrals of inpatient and day cases and of new outpatients from 2004 on was synchronous with a new emphasis on “modernisation”, by the Labour administration. This year marked the introduction of Foundation Trusts, and the beginning of the roll-out of Payment by Results in which the greater part of a Hospital Trust’s income derives from the volume of patients treated. There was also more emphasis on an increased role for the private sector in the provision of clinical services with the establishment of Independent Surgical Treatment Centres (ISTC’s). There is a large body of evidence, principally from the USA, that fee and tariff based health systems amplify hospital activity. If a hospital’s survival is critically dependent on patient turnover, in a competitive market powerful perverse incentives exist to drive up its activity. The coincidence of rapidly expanding clinical activity in the English NHS with the introduction of PbR and increasing emphasis on competition and privatisation suggest that the two events are causally related. The way in which these incentives operate is unclear and should now be the subject of detailed enquiry.

In 2009-10, only 1.03% of all inpatients and day cases (173,481 of 16,806,192) were treated in ISTC’s and private hospitals. Despite the Labour administration’s claims to the contrary, the role of the private sector in the expansion of clinical activity since 2004 has been negligible.

The present review of trends in clinical activity ended in March 2010 before the election of the coalition government. The impact of replacing a real terms increase in funding of about 7% per annum in the previous decade by a small real terms decrease will be severe and is likely to bring the rapid expansion in clinical activity in the English NHS to a shuddering halt.

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