COMPARISON OF NHS PERFORMANCE IN ENGLAND AND SCOTLAND

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Introduction

Political debate about the NHS in Scotland has increasingly focused on its performance in recent years compared with the NHS in England. It has been argued:

- that the NHS in England has achieved significant improvements in performance compared with the NHS in Scotland in key areas such as waiting times; and

- that this difference reflects the adoption of a more radical programme of NHS reforms in England than in Scotland.

This paper provides an initial assessment of the relative performance of the NHS in England and Scotland in recent years, and considers some of the factors which may have contributed to differences in performance between the two countries.

- Section I looks at recent comparative trends in Scotland and England in patient activity in the acute sector and waiting times.

- Section II briefly outlines some indicators of demography, socio-economic circumstances, and health status in Scotland and England.

- Section III considers a number of possible influences on recent NHS performance in both countries including: the growth in resources, differences in policy objectives following devolution, and trends in efficiency in acute services.

- Section IV considers what conclusions might be drawn from the existing evidence and points to a number of areas for further work.

The work described in this paper is an early stage of a longer term programme of research into comparative trends in the NHS in England and Scotland. This early phase of the work is limited in two respects. First, the paper focuses on different *trends* in performance in the NHS in England and Scotland in recent years. There are also differences in *levels* of performance – e.g. differences in levels of patient activity per head of population or differences in unit costs. These differences, while important, need to be treated with particular caution because of possible differences in methods of recording information about activity and costs. For the moment, the paper concentrates on the question: why have key *trends* in patient activity and waiting times in England and Scotland diverged so markedly in recent years?

Second, the paper concentrates on the acute hospital sector. This is an area in which trends in performance seem to be very different, and it is the area which has attracted most attention. It is worth noting, however, that the acute sector represents about 35-40% of total expenditure on hospital, community and family health services. Performance in other areas of the NHS will also have to be taken into account to arrive at a more complete picture of performance.

The data sources used in this paper are described in Annex 1.

I Recent Performance in the NHS in Scotland and England

Tables 1a and 1b show, respectively, recent trends in waiting times and waiting lists in Scotland and England. Direct comparisons can be difficult because of differences between the two countries in the way that information is recorded. However, the general trends seem clear.

Table 1a: Waiting Times and Waiting Lists in Scotland

	Outpatients		Inpatients and Day Cases		
Year Ending 31 March	Median Wait (weeks)	Percentage waiting longer than 13 weeks	Median Wait for patients treated (weeks)	Percentage waiting over 6 months	Total Waiting List 000s
1999-00	7.0	24.5	4.4	4.5	104.7
2000-01	7.3	26.1	4.9	7.6	107.0
2001-02	8.0	30.4	4.7	8.4	97.2
2002-03	8.3	33.2	4.9	10.2	107.6
2003-04	7.7	31.3	5.9	14.1	110.3
2004-05 Q3	8.0	35.5	6.1	14.2	113.6

Notes

(1) The figures for median waits and percentages waiting longer than 13 weeks (outpatients) and 6 months (inpatients and daycases) are for the year as a whole, except for 2004-05 where the figures relate to the 3rd quarter.

(2) The waiting list figures are for the end of each financial year, except for 2004-05 where the figure relates to the end of the third quarter.

Table 1b: Waiting Times and Waiting Lists in England

	Outpatients		Inpatients and Day Cases		
Year	Median Wait (weeks)	Number waiting longer than 13 weeks 000s	Median Wait For patients waiting at end of quarter (weeks)	Number waiting over 6 months 000s	Total Waiting List 000s
1999-00	7.73	393	12.9	277	1,037
2000-01	7.46	280	12.6	243	1,007
2001-02	7.63	192	12.7	238	1,035
2002-03	7.40	120	11.9	189	992
2003-04	7.08	40	10.2	80	906
2004-05	6.89	30	8.5	41	822

Notes

(1) Outpatient figures relate to the 4th quarter of each year, except for 2004-05 where the figure is for the 3rd quarter.

(2) For inpatient and day cases the number waiting over 6 months and the total waiting list relate to the end of March in each year. The median wait figures for inpatients and day case are for the 4th quarter of each financial year.

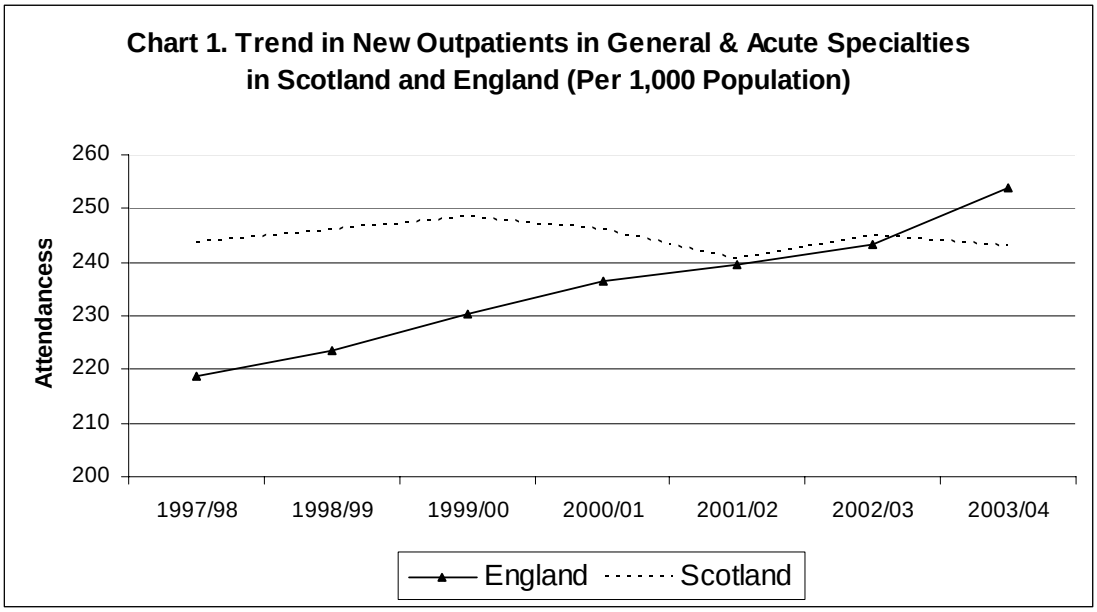
The data in Tables 1a and 1b suggest a number of significant differences between Scotland and England.

- In Scotland the percentage of outpatients waiting longer than 13 weeks for treatment increased between 1999-00 and 2004-05, while in England the number of patients waiting over 13 weeks for an outpatient appointment fell by over 90% in the same period.

- The percentage of patients waiting over 6 months for treatment in Scotland (as inpatients or day cases) has risen, while numbers in England have fallen by 85%.

- The total waiting list in Scotland for inpatient and day case treatment has risen slightly over the last few years, while in England it fell by 20% between 2001-02 and 2004-05.

These differences in waiting time performance have been linked to differences in the rate of growth in patient activity.[1] Chart 1 looks at the trend in the number of new outpatients in acute specialties per 1,000 population since 1997-98.[2]



At the start of this period, the new outpatient rate per 1,000 population in Scotland was significantly higher than in England. However, while the new outpatient rate remained relatively flat in Scotland over the period 1997-98 to 2003-04, the rate in England has grown steadily and by 2003-04 had risen above the Scottish rate.

[1] The patient activity data in this paper show all patients paid for by the NHS whether the service is delivered by the NHS or by independent providers.

[2] The figures for England are for General and Acute specialties. The figures for Scotland cover acute specialties, including geriatric assessment, which should be very close to the English definition of General & Acute. There may however be slight differences in the definitions of these specialty groups.

A broadly similar pattern is seen in the elective admission rate for acute specialties (Chart 2). In 1996-97, the admission rate in Scotland was around 33% above the rate in England. This rate remained relatively stable between 1996-97 and 2000-01, but has since declined by almost 10%. In England, the admission rate for elective cases has risen throughout this period, and by 2004-05 was the same as the Scottish rate.

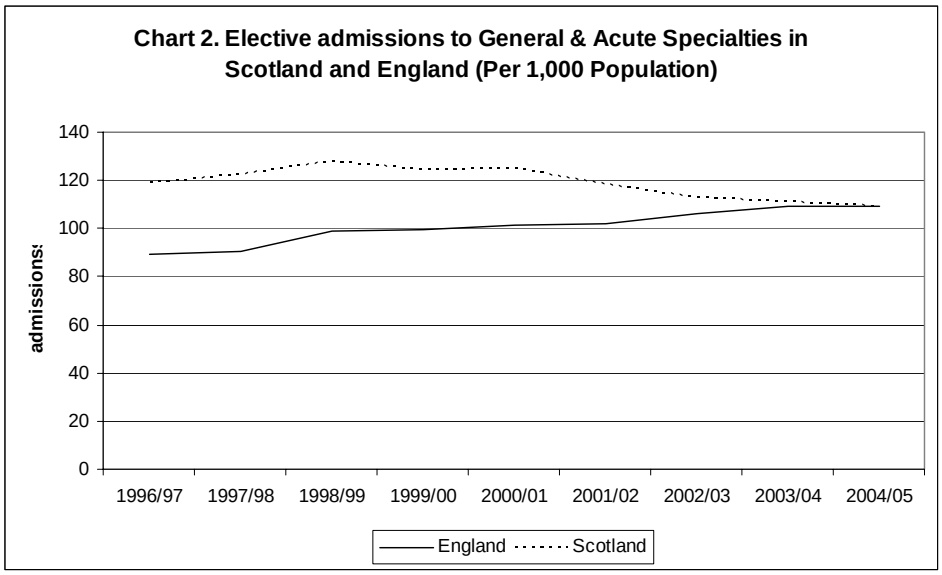
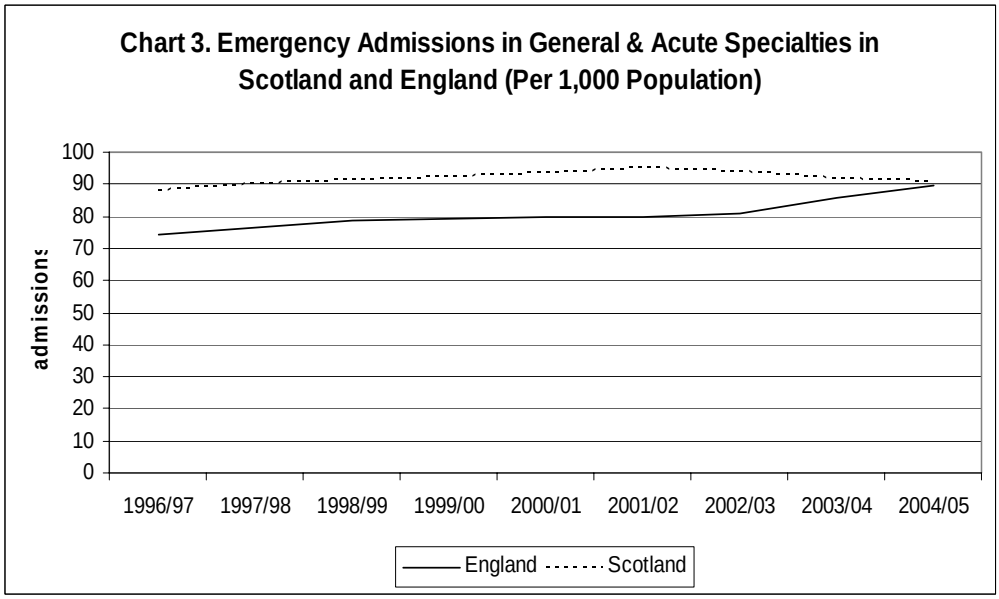


Chart 3 compares the trend in emergency admissions to acute specialties in Scotland and England over the same period. Between 1996-97 and 2001-02, the emergency admission rate increased in both countries, but since then the pattern has been very different. The emergency admission rate in Scotland fell between 2002-03 and 2004-05, while in England the admission rate increased by just over 10% in the same period.



These comparative trends in acute activity and waiting times provide the basis for the assertion that the NHS in England has improved its performance relative to Scotland because England has adopted more radical reforms.

How do these recent trends compare with earlier trends in acute activity in Scotland and England? Table 2 shows the trends between 1992-93 and 1997-98. The average rate of growth of new outpatients over this period in England was significantly higher than in Scotland. In contrast, growth rates for elective and non-elective admissions in Scotland were higher than in England.

Table 2: Activity in General & Acute Specialties, 1992-93 and 1997-98

	New Outpatients	**Inpatients and Day Cases**		
		Elective	Non-Elective	Total
England				
1992-93 (000s)	8,488	4,031	3,526	7,557
1997-98 (000s)	10,643	4,459	3,718	8,178
Average Annual Growth %	4.6	2.0	1.1	1.6
Scotland				
1992-93 (000s)	1,145	499	398	897
1997-98 (000s)	1,239	622	459	1,082
Average Annual Growth %	1.6	4.5	2.9	3.8

Are the different trends between England and Scotland in the acute sector in recent years also seen in other areas of healthcare? We have not yet looked across all areas of healthcare. However, Table 3 provides data for another major area of expenditure: prescribing of drugs in the community. Over the period 1999-2004 the average rate of growth in prescription items per head in Scotland has been a little lower than in England. In this area we do not seem to see major differences in recent years in the trends in the volume of activity.

Table 3: Prescribing Volumes and Costs

Year	**Prescription Items per Head**		**Average Cost per Prescription Item (£)**	
	England	Scotland	England	Scotland
1994	9.40	9.87	7.35	7.09
1999	10.70	11.58	9.74	9.26
2004	13.60	14.28	11.74	11.62
Average Growth 1994 –99	2.6%	3.2%	5.8%	5.5%
Average Growth 1999-2004	4.9%	4.3%	3.8%	4.6%

II Demography, Socio-Economic Circumstances and Health in Scotland and England

Table 4 provides some background information on underlying differences in population, socio-economic circumstances, and health status between Scotland and England.

Table 4: Demography, Deprivation, and Health in England and Scotland

	England		Scotland	
Total Population: (000s)				
1997	48,665		5,083	
2003	49,856		5,057	
Population over 75	7.60%		7.25%	
Population density (per square kilometre)	244 (UK)		65	
Households in Receipt of Benefit (2002-02)				
Family credit/working family tax credit or income support	16%		19%	
Incapacity of disablement benefit	14%		20%	
Unemployment rates (2003)	5.1%		5.9%	
Age Standardised Mortality Rates (per 100,000 population, 2001)	Male	Female	Male	Female
All causes	870	981	1,044	1,121
Ischaemic Heart Disease	201	167	238	212

- Scotland's population is around 10% of the population of England.
- While the population of England grew by almost 2.5% between 1997 and 2003, Scotland's population fell by 0.5%.
- Population density is much lower in Scotland with a significant proportion of the population living in remote and rural areas.
- Scotland has a higher proportion of its population in deprived socio-economic circumstances – reflected in the relative percentage of households in receipt of benefits and relative unemployment rates.
- The health status of the population in Scotland compares poorly with the population in England. Age-standardised mortality rates are much higher in Scotland.

These factors will influence underlying healthcare needs and the costs of delivering services in Scotland compared with England. However, they are factors which change slowly over time and are unlikely to account for the major changes seen in the last few years in the trends in acute patient activity in the NHS in Scotland relative to England.

III Possible Influences on Relative Performance

The main factors considered in this paper are:

(a) First, differences in the rate of growth of NHS resources: it is sometimes assumed that both Scotland and England have experienced the same high rates of growth in spending on the NHS in the last few years. However, there have in fact been significant differences in growth rates in NHS resources between the two countries.

(b) Second, differences in the objectives of the NHS: as noted earlier the acute sector, while important, only accounts for around 35-40% of total NHS spend and it may be that since devolution in 1999 growing differences in objectives and priorities account for some of the observed differences in performance. (There may also be differences in priorities within the acute sector.)

(c) Third, differences in the efficiency with which the resources have been used: even where there are differences in trends in productivity over this period, there may be still be a question about the extent to which such differences can be attributed to NHS reforms in England.

III (a) NHS Expenditure and Resources

Estimating trends in NHS expenditure has become more difficult because of a number of recent changes to the way that expenditure is recorded – e.g. the switch from cash to resource accounting, and the change in the interest rate used to measure the capital component of expenditure. The effect of these and other developments has been to distort the trend in NHS expenditure figures.[3]

For the moment, we use trend data on the number of staff employed in the NHS to provide a broad indicator of the overall change in resources available to the NHS in Scotland and in England. Clearly, trends in staffing provide an incomplete picture of the growth in resources; for example, they do not reflect changes in the extent to which the NHS in has made increasing use of the independent sector to purchase diagnostic and treatment services. Between 1999-2000 and 2002-03 expenditure in England on the purchase of healthcare from non-NHS bodies increased from £1,301m to £2,237m.[4] Comparable figures are not available for Scotland, but the use made by the NHS in Scotland of independent healthcare providers is relatively small.

Table 5 shows the growth in NHS staffing in England and Scotland (total and per 1,000 population) between 1998-99 and 2004-05. The growth rate in the NHS staffing in England was about double the growth rate in Scotland over this period. The

[3] For example, the Department of Health in its Memorandum to the House of Commons Health Committee in 2004 noted that the growth in NHS spending in England between 2002-03 and 2003-04 was distorted by several factors: the change in the discount rate; the effect of NHS pensions indexation; the NHS's assumption of responsibility for the cost of providing free nursing care to those in nursing homes; and the assumption of responsibility for providing healthcare in prisons. The Department estimated that the effect of adjusting for these factors was to reduce real terms growth in net NHS Expenditure in 2003-04 from 11.2% to 7.3%.

[4] Department of Health Memorandum to the House of Commons Health Committee 2004.

difference in growth rates narrows a little if the staffing levels are expressed per 1,000 population, but still remains substantial.

Table 5: Total NHS Staffing in England and Scotland (WTE), 1998-99 to 2004-05

	England		**Scotland**	
30 September	All NHS Staff	All NHS Staff per 1,000 population	All NHS Staff	All NHS Staff per 1,000 population
1998-99	855,129	17.5	111,890	22.0
1999-00	873,226	17.8	112,814	22.2
2000-01	892,230	18.1	113,090	22.3
2001-02	930,633	18.8	115,400	22.8
2002-03	977,961	19.7	119,593	23.7
2003-04	1,026,976	20.6	123,909	24.5
2004-05	1,071,203	21.5	125,997	24.9
Growth 1998-99 to 2004-05	25.3%	22.9%	12.6%	13.2%

Table 6 shows the growth over this period for specific staff groups in the NHS in Scotland and England.

- In both Scotland and England the growth in consultant numbers is well above the growth rate for all NHS staff

- In England the growth in GP numbers (10.5%) is well below the overall growth rate, though significantly higher than the growth rate in Scotland (1.1%).

Table 6: Medical and Nurse Staffing (WTE) in England and Scotland, 1998-99 and 2004-05

	All Doctors		Consultants		GPs		Qualified Nurses	
Year	England	Scotland	England	Scotland	England	Scotland	England	Scotland
1998-99	86,594	11,298	20,432	2,806	27,848	3,485	247,238	35,234
2004-05	109,224	12,978	28,141	3,344	30,762	3,524	301,877	38,907
Growth 1998-99 to 2004-05	26.1%	14.9%	37.7%	19.2%	10.5%	1.1%	22.1%	10.4%

III (b) Objectives

Devolution was introduced in 1999, and from that point on the responsibility for the NHS in Scotland was devolved to the Scottish Parliament. Before 1999, the organisation and management of the NHS in Scotland was very similar to the NHS in

England, though overall responsibility for policy and management lay with the Scottish Office, and Ministers in the Scottish Office had some discretion over the policies and priorities pursued within the NHS. It would be wrong, therefore, to assume that before devolution the NHS across the UK was a single structure with identical polices. It is clear, however, that the policy differences between the NHS in Scotland and England have become more pronounced since 1999.

The main areas in which there may be significant policy differences are:

- Priorities for health services
- Organisation/structure of the NHS
- Management systems
- Incentives

Annex 2 provides a summary of key polices in these areas in Scotland and England based on the main policy documents.

Priorities
At a very broad level there has been a similar emphasis in key policy documents in both England and Scotland pre- and post-devolution on, for example, tackling health inequalities, and improving access through reducing waiting times. In Scotland, greater emphasis may have been placed on tackling the diseases that contribute to very high rates of premature deaths, especially coronary heart disease.

Maximum waiting times have been set for treatment in both England and Scotland for some years, though initially the NHS in Scotland seemed to place most emphasis on reducing the maximum waiting times for inpatient and day case treatment rather than waiting times for outpatient appointments. In *Our National Health: a plan for action, a plan for change* published in 2001 the Scottish Executive set a maximum 9 months waiting time target for treatment to be achieved by 2003. No explicit target was set for maximum outpatient waiting times. Targets were also set, however, for specific conditions including access to diagnosis and treatment for coronary heart disease. In England, *The NHS Plan: a plan for investment, a plan for reform* (July 2000) set a maximum waiting time of 6 months for inpatients and day cases to be achieved by the end of 2005, and a maximum wait of 3 months for outpatients by the same date.

The targets for waiting times have continued to develop in both countries. Currently the NHS in England is committed to a maximum waiting time of 18 weeks from GP referral to hospital treatment by the end of 2008. In Scotland the current commitment is that by the end of 2007 the maximum wait for an outpatient appointment should be 18 weeks, and once a decision is made that the patient requires treatment the maximum wait for treatment should also be 18 weeks.

Organisation/Structure
Post-devolution, significant differences have emerged between Scotland and England in the organisation and structure of the NHS. In Scotland, trusts have been abolished and providers are now managed directly by NHS Boards. Scotland has not created

equivalent of Primary Care Groups in England. A further significant difference in recent years is that much greater use has been made in England of services provided by the independent sector. The English model is more centred on markets in which independent trusts, similar to private firms, will contract with each other for care while regulatory organisations will ensure quality.

Management
In this area a number of differences have also emerged post-devolution. The NHS in both Scotland and England adopted a performance management system based on a range of indicators. In England this formed the basis of a star rating system, and the performance of healthcare organisations under this system achieved considerable publicity. The NHS in Scotland did not adopt a similar performance scoring system.

It has also been suggested that professional clinical groups, especially doctors, have acquired a stronger influence on the development and operation of the NHS in Scotland through, for example, the establishment of managed clinical networks. In contrast, England has placed more emphasis on the development of a market-like structure.[5]

Incentives
The major difference that has developed in this area since devolution is the introduction of the system of Payment by Results in the NHS in England. So far Scotland has not adopted a similar policy, though consideration is being given to the use of fixed tariffs for cross boundary movement of patients between NHS Boards areas.

III (c) Trends in Efficiency

The problems involved in measuring trends in productivity in public services, including health, have recently been examined in the Atkinson Report.[6] These problems include:

- incomplete measures of the volume of services provided;
- the absence of measures of the quality and effectiveness of services; and
- difficulties around the measurement and valuation of inputs (e.g. capital services).

Work is underway to improve the measurement of trends in productivity in health, though it may be sometime before better data become available.

In this section of the paper we provide a simple comparison of recent trends in productivity in the acute hospital sector in Scotland and England based on standard measures of patient activity and expenditure figures adjusted for health service inflation. The data sources used in this comparison are explained in Annex 2.

[5] S Greer; Four Way Bet: How devolution has led to four different models for the NHS. The Constitution Unit (2004)
[6] Atkinson Review: Final Report, Measurement of Government Output and Productivity for the National Accounts (HMSO 2005)

Outputs

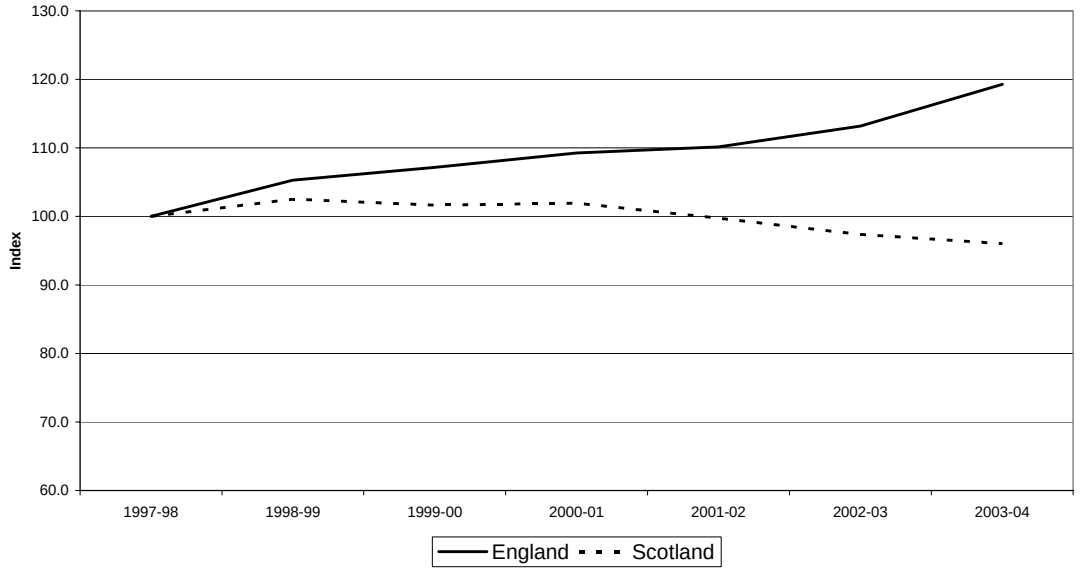
Recent trends in the main outputs of the acute sector (inpatient and day cases, new outpatients, and first attendances at A&E departments) in Scotland and England are summarised in Table 7.

Table 7: Patient Activity in Acute Hospitals in England and Scotland (000s)

	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
England							
Inpatient & Day Cases	8,162	8,698	8,800	8,967	9,021	9,293	9,744
New Outpatients	10,643	10,919	11,294	11,637	11,838	12,080	12,650
First A&E Attendances	12,794	12,811	13,167	12,953	12,901	13,253	15,313
Scotland							
Inpatient & Day Cases	1,082	1,113	1,095	1,105	1,080	1,045	1,027
New Outpatients	1,239	1,249	1,260	1,245	1,219	1,238	1,228
First A&E Attendances	1,354	1,366	1,393	1,387	1,393	1,370	1,399

These outputs have been weighted together by the share of expenditure on each type of patient activity. The resulting overall trends in output are shown in index form with 1997-98=100 in Chart 4. Between 1997-98 and 2003-04, patient activity in acute specialties in England rose by 20% compared with a fall of 4% in Scotland.

Chart 4: Trends in Patient Activity in Acute Specialties in England and Scotland (1997-98=100)



Total expenditure on acute services has been adjusted for health service inflation using the index of HCHS pay and prices compiled by the Department of Health in England. This index is based on English data but has also been applied to the Scottish expenditure figures. This assumes that pay and price inflation in the NHS in Scotland has been the same as in England, which may be a reasonable assumption given that wage and salary levels for NHS staff are generally based on UK-wide agreements.

The resulting trends in expenditure in volume terms on acute services are shown in Table 8.

Table 8: Expenditure on Acute Services in England and Scotland, 2002-03 Prices

		1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
England	£m	15,546	16,179	16,459	16,877	17,832	19,289	n/a
	Index	100.0	104.1	105.9	108.6	114.7	124.1	
Scotland	£m	1,924	2,002	1,943	2,084	2,197	2,226	2,306
	Index	100.0	104.1	101.0	108.3	114.2	115.7	119.9

Notes
(1) The expenditure figures are adjusted to 2002-03 prices using the Department of Health's HCHS pay and price index.
(2) The drop in expenditure on acute services in Scotland in 1999-2000 seems surprising and out of line with the general trends in both Scotland and England during this period.
(3) Expenditure figures for acute services in England are taken from the Department of Health's Memorandum to the House of Commons Health Committee 2004. This includes expenditure figures for programme budgets up to 2002-03.

In the period between 1997-98 and 2001-02 the rate of expenditure growth (in volume terms) on acute services in Scotland and England was broadly similar with expenditure rising by just under 15% in both countries.[7] In 2002-03 expenditure increased sharply in England by around 8% while in Scotland expenditure rose by just over 1%.

Although expenditure on acute services in England are not available for 2003-04, it seems likely that expenditure on acute services in that year will also have increased more rapidly than in Scotland. (The workforce data in Table 5 above show significantly higher rates of growth in NHS staffing in England than in Scotland in 2003-04 and 2004-05.)

The trend estimates in acute activity and expenditure on acute services have been combined to provide an overall measure of relative productivity changes in England and Scotland (Chart 5).

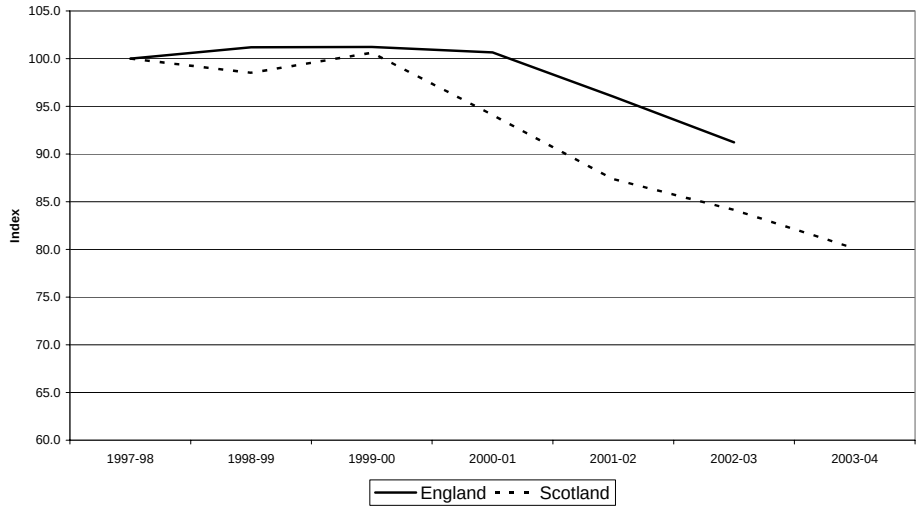
The main points which emerge from this comparison are:

- Over the period 1997-98 to 2002-03 as a whole, productivity in acute services appears to have fallen in both England and Scotland. The more recent figure for Scotland for 2003-04 indicates that this decline has continued.

- The rate of decline in Scotland has been greater than in England. Between 1997-98 and 2002-03 the decline in productivity in England was 8.8% while the fall in Scotland over the same period was 15.9%.

[7] The close similarity between Scotland and England in the growth in acute expenditure in volume terms over the period 199798 to 2001-02 is a little surprising. The staffing data in Table 5 suggest that the volume of resources in the NHS in England was growing more rapidly than in Scotland during these years, and this might have been expected to be reflected in the relative growth in the volume of resources in the acute sector.

Chart 5: Productivity Trends in Acute Specialties in England and Scotland



- The figures suggest that there was little change in productivity in Scotland relative to England in the early years of this period. However, as noted earlier, the figure for expenditure on acute services in Scotland in 1999-2000 seems surprisingly low and the estimate of the productivity figure for this year may be distorted.

- The apparent decline in productivity in acute services in England seems to have occurred only since 2000-01. Before this productivity was flat. In Scotland the decline may have started earlier. Productivity, on this measure, fell in Scotland in both 1998-99 and in 2000-01.

IV Conclusions and Further Work

As this work is at an early stage it is difficult to draw general conclusions at this point, but there are a few points to note.

- First, significant differences seem to have emerged over the last few years in relative trends in patient activity and waiting times in the acute sector in England and Scotland.

- Part of this difference would seem to reflect differences in the rate of growth of resources available to the NHS in Scotland and England. The rate of growth in NHS staffing has been greater in England than in Scotland, though staffing levels per head of population in Scotland remain significantly above the level in England.

- Differences in objectives may also have had some influence on these relative trends in the acute sector. For example, England seems to have put more emphasis on reducing maximum waiting times for outpatient appointments at an earlier stage than Scotland.

- While the simple measure of relative productivity improvements in the acute sector in Scotland and England needs to be treated with considerable caution, the figures suggest that the decline in productivity in the acute sector in Scotland may have been greater than in England – and may also have started earlier than in England.

- How far such differences in productivity trends can be attributed to specific reforms introduced in the NHS in England is another matter. There is clearly an issue about timing. Some of the reforms in England are quite recent. Foundation trusts, for example, were first introduced in April 2004, though earlier announcement of the policy could have affected behaviour before foundation trusts were formally established. Some of the marked differences in trends in acute activity between Scotland and England seem to have emerged around the years 1999 and 2000.

Further work will focus on:

a. A more detailed analysis of policy developments in England and Scotland in recent years and the timing of these developments.

b. A more complete assessment of trends in the volume of services in Scotland and England across the NHS as a whole.

c. An assessment of whether the different trends in acute activity in Scotland and England in recent years are reflected in different trends in health status/health outcomes.

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Annex 1: Data Sources

Waiting Times and Waiting Lists

England: data are taken from the Statistical Supplement to the Chief Executive's Report to the NHS May 2005.
http://www.dh.gov.uk/assetRoot/04/11/04/16/04110416.pdf

Scotland: data come from the Information Services Division of NHS National Services Scotland
http://www.isdscotland.org/isd/info3.jsp?pContentID=669&p_applic=CCC&p_service=Content.show&

Acute Activity

England: data are taken from the Statistical Supplement to the Chief Executive's Report to the NHS May 2005.

Scotland: data come from the Information Services Division of NHS National Services Scotland.

Prescribing

England: data are taken from the Statistical Supplement to the Chief Executive's Report to the NHS May 2005.

Scotland: data come from the Information Services Division of NHS National Services Scotland.
http://www.isdscotland.org/isd/info3.jsp?pContentID=2226&p_applic=CCC&p_service=Content.show&

Socio-Economic Factors and Mortality Data

England and Scotland: data come from Regional Trends 2004 Edition (Office for National Statistics)
http://www.statistics.gov.uk/downloads/theme_compendia/Regional_Trends_38/rt38.pdf

Staffing

England: data are taken from information published by Department of Health
http://www.dh.gov.uk/assetRoot/04/10/67/32/04106732.xls

Scotland: data come from the Information Services Division of NHS National Services Scotland.
www.isdscotland.org/wf_allstaff

Expenditure on Acute Services

England: expenditure figures are taken from the programme budget data provided by the Department of Health in their Memorandum to Health Committee of the House of Commons 2004.
http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/1113/111301.htm

Scotland: figures come from Scottish Health Services Costs published by the Information Services Division of NHS National Services Scotland
http://www.isdscotland.org/isd/info3.jsp?pContentID=2161&p_applic=CCC&p_service=Content.show&

Annex 2: Policy framework: position pre and post devolution

	SCOTLAND		ENGLAND	
POSITION PRE - DEVOLUTION	HEALTH PRIORITIES ▪ Tackle inequalities and deprivation ▪ Better access to treatment ▪ New emphasis on public health ▪ Promotion of partnership working ▪ A concern with the quality of clinical practice ▪ Improvements in access to care through the reductions in waiting lists and times *Designed to Care: Renewing the National Health Service in Scotland* (1997)	ORGANISATION ▪ Replace the internal market ▪ But also creation of Primary Care Trusts (no provision through Primary Care Groups) ▪ They will be responsible for all primary health care and will typically comprise community hospitals and mental health services as well as networks of general practices in Local Health Care Co-operatives ▪ These Co-operatives will replace the standard GP fund holding system ▪ The number of Trusts operating within the NHS in Scotland will be reduced *Designed to Care: Renewing the National Health Service in Scotland* (1997)	HEALTH PRIORITIES ▪ Tackle inequalities and deprivation ▪ Better access to treatment ▪ Better access to information for patients and information technology ▪ Promotion of partnership working *The New NHS: Modern, Dependable* (1997)	ORGANISATION ▪ Replace the internal market created with the Thatcher reform ▪ Maintains the separation between purchaser/ provider ▪ Replaces the annual contracts with 3 years service agreements ▪ System based on collaboration ▪ Abolish the GP fund holding because it produced greater inequalities between practices and a concern for equity ▪ Replace them with new structures the Primary Care Groups (PCG) to which all GPs in an area will belong *The New NHS: Modern, Dependable* (1997)
	MANAGEMENT ▪ "Health Boards have the lead role in its development and will retain their existing responsibilities in relation to public health protection, health improvement, needs assessment, service strategy and performance management" *Designed to Care: Renewing the National Health Service in Scotland* (1997)	INCENTIVES ▪ Greater flexibility in the use of resources and incentives for all GPs to develop their prescribing patterns *Designed to Care: Renewing the National Health Service in Scotland* (1997)	MANAGEMENT ▪ Introduction of a NHS Performance Assessment Framework (March1999) ▪ Commitment to improve performance through greater benchmarking across the NHS ▪ Performance indicators *The NHS Performance Assessment Framework* (1999)	INCENTIVES ▪ New incentives and new sanctions to improve quality and efficiency ▪ Clear incentives to improve performance and efficiency ▪ Contractual obligations and incentives support quality, efficiency and effectiveness ▪ Offering greater stability and incentives through long-term agreements between Health Authorities, Primary Care Groups and NHS Trusts ▪ Contain incentives for improvement, with funding conditional in part on satisfactory progress against key targets *The New NHS: Modern, Dependable* (1997)

	SCOTLAND		ENGLAND	
POSITION POST - DEVOLUTION	HEALTH PRIORITIES ▪ Tackle inequalities and deprivation ▪ Emphasis on prevention ▪ Address the problem of remote and ruralness ▪ Involve patients ▪ Tackle waiting ▪ The delivery of high quality health care supported by effective information technology ▪ A new priority for the health of children and older people *Our National Health: a plan for action, a plan for change* (2001)	ORGANISATION ▪ Health boards and NHS trusts were retained but brought together in unified health boards ▪ Integration of services ▪ Devolution of decision-making ▪ Final abolition of NHS trusts in April 2004 *Partnership for Care: Scotland's Health White Paper* (2003) ▪ Creation of 15 regional health boards, with devolution of decision-making Providers are now managed directly by NHS Boards ▪ Has not created equivalent of PCG *Our National Health: a plan for action, a plan for change* (2001)	HEALTH PRIORITIES ▪ Increase health spending ▪ Renewing the NHS requires more funds ▪ It requires also significant changes in social services, NHS staff groups etc. ▪ Targets for cutting waiting times ▪ Increase and improve primary care in deprived areas ▪ Introduce screening programmes for women and children ▪ Step up smoking cessation services ▪ Improve the diet of young children by making fruit freely available in schools for 4-6 year olds *The NHS Plan: a plan for investment, a plan for reform* (2000)	ORGANISATION ▪ Increasing use has been made of services provided by the private and independent sector ▪ Model more centred on markets in which independent trusts, similar to private firms, will contract with each other for care while ▪ Regulatory organisations will ensure quality *Greer S., Four Way Bet: How devolution has lead to four different models for the NHS* (2004)
	MANAGEMENT ▪ Commitment to performance assessment ▪ Created Managed Clinical Networks ▪ Aims to give more power to professionals ▪ Performance system based on a number of indicators *Our National Health: a plan for action, a plan for change* (2001)	INCENTIVES ▪ Publish a core set of key performance indicators relating to the NHS priorities and drawn from the PAF ▪ Develop a new Performance Incentive Framework ▪ Agree with NHS Board Chairs how senior managers' pay progression and bonuses can best be linked to performance on the NHS priorities as part of their annual appraisal in a way that is felt to be fair and reinforces motivation *Partnership for Care: Scotland's Health White Paper* (2003)	MANAGEMENT ▪ Performance Assessment Framework (PAF) ▪ Defines and publishes performance indicators ▪ Star rating performance system (2001) ▪ Aims to classify NHS trusts in England on their performance ▪ Based on a series of performance measures like waiting times and ward cleanliness *The NHS Performance Assessment Framework* (1999)	INCENTIVES ▪ Extra pay for staff and pay linked to performance will create stronger incentives to deliver personalised care ▪ Incentives will be aligned with patients and professionals ▪ The performance management regime for commissioners will support more effective purchasing of care ▪ Primary care trusts will be supported to develop incentives to enable GPs to deliver care that is more responsive and of a higher standard ▪ Payment by Results (PbR) This new funding system, planned to be fully operational by April 2008, is designed to underpin patient choice by enabling money to 'follow the patient', thus rewarding providers for the activity they undertake *The NHS improvement plan* (2004)