NHS: IS THE EXTRA MONEY WORKING?

3. Has The Level Of Healthcare Supply Increased And Quality Improved?

3.1 Technological and Capital Resources
3.2 Staffing Levels
3.3 Waiting Lists and Times
3.4 Geographical Variations in Care (NICE, Inequalities of Care, and in Health)
3.5 Patient Satisfaction
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The National Plan states that: "The March 2000 Budget settlement means that the NHS will grow by one half in cash terms and by one third in real terms in just five years". The Plan continues: 'This will fund extra investment in NHS facilities….' The promise also to improve quality through reform was underscored by the Plan's 10 NHS Core Principles, which may be found in the Annexe. The following three Core Principles are directly relevant to this part of the paper:[1]

- *"The NHS will work continuously to improve quality services and to minimise errors*. The NHS will ensure that services are driven by a cycle of continuous quality improvement. Quality will not just be restricted to the clinical aspects of care, but include quality of life and the entire patient experience…."
- *"The NHS will respond to different needs of different populations*. Health services will … be available to all citizens of the UK. Within this framework, the NHS must also be responsive to the different needs of different populations in the devolved nations and throughout the regions and localities. Efforts will continually be made to reduce unjustified variations and raise standards to achieve a truly National Health Service."
- *"The NHS will help keep people healthy and work to reduce health inequalities*. The NHS will focus efforts on preventing, as well as treating ill-health. Recognising that good health also depends upon social, environmental and economic factors such as deprivation, housing, education and nutrition…..[it] will work with others to reduce health inequalities."

The following section looks at what the Plan promised and summarises the results currently available. The term 'quality' is used in its broadest sense, and therefore embraces the treatment environment (e.g. cleanliness), waiting lists and times, geographical variations both in care and in health, as well as patient satisfaction. Clinical quality indicators are touched upon in this section, but receive greater attention in section 4 – 'Are the extra billions reaching the frontline?' where for example, the implementation of NSF targets for priority areas such as coronary heart disease and cancer are detailed.

[1] The National Plan (pp3-5).

3.1 Technological and capital resources

Hospitals and hospital beds are the most obvious manifestation of a healthcare system. The following three tables (tables 3.1.1-3.1.3) show recent trends (to 2000/01) in average daily available and occupied beds in NHS, available hospital beds per nursing and midwifery staff, and available hospital beds per medical and dental staff. These tables show a fall in supply since 1980, but indicate a levelling off of that decline between 1999 and 2001. The number of NHS acute hospital beds per 1000 population is lower in England's 377 NHS Trust hospitals than that provided in the 28 Scottish hospitals.

Table 3.1.1 Average daily available and occupied beds in NHS hospitals, UK 1980-2000/01

Year	Average daily available beds per 1,000 pop.		Bed occupancy rate %	
	England	Scotland	England	Scotland
1980	7.7	11.2	80	84
1990/01	5.4	9.9	83	82
1999/00	3.8	6.5	83	84
2000/01	3.8	6.3	84	83

Source: OHE, 2002, tables 3.12 and 3.15
Notes: see OHE Compendium notes

Table 3.1.2 NHS available hospital beds per nursing and midwifery staff, 1980-2000/01

Year	Available beds per staff	
	England + *Wales*	Scotland
1980	1.0	1.1
1990/91	0.6	0.9
1995/95	0.6	0.9
1999/00	0.6	0.7
2000/01	0.5	0.7

Source: OHE, 2002, table 3.7
Notes: see OHE Compendium notes

Table 3.13 NHS Available hospital beds per medical and dental staff, 1970-2000/01

Year	Available beds per staff	
	England + *Wales*	Scotland
1970	20	20
1980	11	11
1990/91 (a)	6	9
1995/96	4	6
1996/97	4	6
1997/98	4	5
1998/99	3	5
1999/00	3	4
2000/01	3	4

Source: OHE, 2002, table 3.5
Notes: (a) Notes: see OHE Compendium notes

Although the availability of hospital beds in accessible hospitals is important, the level of technological resources found within hospitals often has a more direct impact on healthcare outcomes. Cancer care relies heavily on technology; following diagnosis, curative cancer treatment may involve surgery, radiotherapy, chemotherapy, or a combination of the three. Precise information on cancer location and size is usually obtained by CT and MRI scanning. To avoid delays in the commencement of treatment there must be an adequate number of available scanners. Treatment with radiotherapy is 'an extremely important modality in the management of cancer'.[2] It is used to kill tumour cells and may be part of curative treatment or may be used to reduce symptoms from advanced disease (palliative radiotherapy).[3] In either case, in order to provide timely treatment there must be a sufficient number of machines.[4]

The OECD has compared five-year survival with the availability of radiotherapy machines (generally LinAc machines), used to treat cancer.[5] The UK has fewer machines than many other countries and a worse survival rate. As the report states, the UK 'clearly stands out', a conclusion suggesting that inadequate facilities are correlated to the poor survival rate.[6] The OECD also compares death rates within six months of diagnosis. Again the UK has a higher rate of deaths occuring within six months suggesting that cancers are more advanced when detected. This is likely to be because of the inadequate number of staff and the shortage of equipment for early detection.

Shortage in the supply of essential healthcare technology and facilities in the NHS has been recognised by the Labour Government. In 2000, the National Plan promised:

- 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 practices modernised and 250 new scanners

The *NHS Plan Implementation Programme* pledged that the English Regions must make progress to the NHS Plan targets so that by 2004 there will be 50 new MRI scanners, 200 new CT scanners, 80 new liquid cytology units and 45 new linear accelerators.[7]

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[2] NHS Scotland, *Cancer Scenarios*. Chapter 24. Other procedures are used for certain cancers (e.g. Selectron units and HDR machines and Brachytherapy).

[3] DoH, *A Survey of Radiotherapy Services in England,* 1999. (p42)

[4] "The administration of radiotherapy changed significantly during the 1950s with the development of megavoltage radiotherapy treatment machines. … Two kinds of machines were developed which are still in widespread use. Linear accelerators which generate high energy x-rays and electrons using electricity, and Cobalt unit which use a radioactive source of high-energy gamma rays. Linear accelerators are more expensive (approximately £1 M) and require specialist support to keep them running in a safe and effective manner. Cobalt units are less expensive, more reliable and easier to maintain than linear accelerators. However, cobalt units produce a radiation beam of a lower energy than modern linear accelerators and also have inferior beam geometry. In addition, cobalt units are associated with the risks of accidental radiation exposure, which could result from a mechanical failure or fire, and the problems associated with the disposal of a spent radioactive source. " (DoH, *A Survey of Radiotherapy Services in England,* 1999 (p42))

[5] OECD Ageing Related Disease Project. Breast Cancer Study. 2002.

[6] Jacobzone, et al (2002), p. 12

[7] The NHS Plan Implementation Programme (p15)

The Results Announced So Far……..

The latest Comprehensive Spending Review (July 2002) states that by 2008, additional investment in 42 major hospital schemes will allow an increase in treatment capacity equivalent to over 10,000 beds. It has not been possible to determine how many extra beds have been opened over the past two years; however, the *Chief Executive's Annual Report 2002/03* announces that the Government has continued to expand capacity by providing additional facilities, beds and equipment:

- In the course of 2002/03, five major new hospital schemes opened with capital value exceeding £474million and five medium sized schemes with capital value exceeding £70 million
- 15 new Diagnosis and Treatment Centres opened with additional capacity of 40,000
- 1389 GP Premises were refurbished (April 2000- December 2002)
- 184 one-stop primary care centres were established (April 2000- December 2002)[8]

The NHS has also invested in some new equipment. The *Chief Executive's Annual Report 2002/03* announces that the £90 million of capital targeting cancer care, along with funding from the New Opportunities fund enabled the delivery of:

- 17 linear accelerators
- 39 CT scanners
- 11 MRI scanners, and
- 190 items of breast screening equipment.

Nigel Crisp notes that this investment means that 59% of CT scanners and 39% of MRI scanners are new since January 2000.[9] The NHS Modernisation Board's recent *Progress Report* notes that during the period October 2001 – September 2002 (the period covered by the report), the NHS received 60 CT scanners, 11 MRI scanners, and 22 LinAcs; which puts the NHS on target to meet the National Cancer plan targets in 2004.[10]

Slightly different and more up to date figures are shown in the Department of Health's *Delivering the NHS Plan – Expenditure Report* (April 2003), according to which, since April 2002, new cancer equipment provided through central programmes includes 11 new MRI scanners, 12 LinAcs, 35 CT scanners and over 180 breast screening items.[11]

Since April 2000, 39 new MRI scanners, 55 linear accelerators, 119 CT scanners and over 450 items of breast screening equipment' have been delivered.[12] Table 3.14

[8] Chief Executive's Annual Report 2002/03 (pp17-18).
[9] Chief Executive's Annual Report 2002/03 (pp17-18). Figures for Linacs are not given.
[10] NHS Modernisation Board, *The NHS Plan – A Progress Report*, (p4-5)
[11] Department of Health *Delivering the NHS Plan – Expenditure Report*, April 2003 (p12).
[12] The Annual Report (2003) of the NHS Modernisation Board

provides a summary of what treatment equipment was available in 2000/01 while table 3.15 summarises radiation treatment equipment in use in June 2002.

Table 3.14 Radiation treatment equipment per million population (pmp) in 2000

Country	Radiation Treatment Equipment LAF pmp	*Number* of LinAcs LAF	MRI Scanners Rate (LAF) pmp	CT Scanners Rate (LAF) pmp
England	3.8	189 (a)	3.46 (171)	5.66 (280)
Scotland	3.0	20 (b)	3.13 (16)	(-)
OECD Average	6.6	-	6.4	16.8

Source: NHS Scotland, *Cancer Scenarios*. OECD Health Data 2002. National Cancer Services Analysis Team, NHS Executive (North West) website (www.cancernw.org.uk/ accessed 18 March 2003. And UK RT Survey 2002, A multidisciplinary survey of radiotherapy services in the UK at 04.06.02.
Notes: England figures for 2000; Scotland for 2000; OECD for 1999.
(a) 182 of these 189 were working in June 2002.
(b) We are told by the Scottish Executive that this figure is due to rise to 24 within the next year or two (personal comments from the ISD).

Table 3.15 Megavoltage radiation treatment equipment *in clinical use* at 04.06.2002, per million population (pmp)

	Catchment	Machines			Machines per million		
Country	**Populations**	**Linacs**	**Cobalts**	**Megavoltage**	**Linacs**	**Cobalts**	**Megavoltage**
England	47,321,918	168	7	171.5	3.55	0.15	3.62
Scotland	4,998,256	17	0	17.0	3.40	0.00	3.40
UK	56,830,155	199	8	203.0	3.50	0.14	3.57

Source: UK RT Survey 2002, A multidisciplinary survey of radiotherapy services in the UK at 04.06.02.
Notes: number of megavoltage machines = number of Linacs + 0.5 (number of cobalt machines)
Populations calculated from 1991 Census Population Data.

CHI and the Audit Commission reported inequity in the distribution of LinAc machines in England and of their use – which affects both costs and waiting times.[13] There is also a variation in the working hours of such machines, 'for instance, over two-thirds of all machines are used only between 9 a.m. and 5 p.m. on weekdays.' [14] The same uneven patterns of distribution and use are seen in Scotland.[15]

The *Chief Executive's Annual Report* also notes that heart patient care has also benefited from extra resources:

- 185 more automated external defibrillators (AEDs) have been installed in public places (the total is now 680)
- 1,271 modern 12 lead ECG machines/ defibrillators have been installed on emergency ambulances (enabling quick diagnosis and treatment of heart failure patients).
- Rapid action chest pain clinics are now open in every acute trust in England.
- Trusts, and PCTs have spent £35 million of the Treasury Capital Modernisation Fund on coronary heart disease equipment for heart failure, rehabilitation and appropriate primary care. [16]

[13] CHI / Audit commission (3.19-3.21) 2003
[14] CHI / Audit commission (3.22)
[15] NHS Scotland, *Cancer Scenarios*. Chapters 24-25.
[16] Chief Executive's Annual Report 2002/03 (pp17-18).

The *NHS Modernisation Board's Progress Report* puts the figures for automated external defibrillators in slightly higher at 692 – in 110 public places. The National Plan target was to place 3,000 new AEDs in public places by 2004;[17] there is a long way to go if that particular target is to be met. Nevertheless, overall these increases in supply go some way to meeting the targets set in the National Plan.

3.2 Staffing Levels[18]

The health system is the largest employer in England; just under one million people work for the NHS. In whole time equivalents, NHS England employs over 782,000, including over 99,000 hospital medical staff, and 388,000 nurses and midwives. [19] Table 3.2.1 provides a snapshot of medical staff supply and GP list sizes. Despite such a huge workforce the NHS is understaffed and patient care is crippled by shortages in certain specialties and geographical areas.

Table 3.2.1 Total number of medical staff, unrestricted GP principals and average list sizes, nurses, and acute beds (1998/9).

Country	**England**
All NHS Doctors (2001)	99,169
Hospital medical staff Numbers (2001)	67, 840
Hospital medical staff WTE (2001)	59,920
Hospital medical staff WTE per 1000 pop	1.2
GPs numbers (1999) (unrestricted GP principals) WTE	25,900
Patient list (98) (UK 33,473 (1,801))	1,867
GPs per 1000 pop	0.52
Total Nurses, midwives, etc (2001)	493,730
Qualified Nurses total WTE (2001)	266,170
Qualified Nurses per 1000 pop	5.4

Source: Department of Health HES 2001-2002 Table 21 Main operations; HPSSS Tables D5 and D6; OHE compendium of statistics; DoH, Hospital…..1991-2001, DoH, 2002; waiting Times and Waiting Lists; Directorate of Access &anp; Choice Access Delivery (Waiting Times Analysis) Team, 21/03/03.
Notes: rates per thousand are determined by using the following population: England (49,400,000);

The NHS Plan included commitments to recruit new staff. By 2004 there should be:

- 7,500 more consultants and 2,000 more GPs
- 20,000 extra nurses and over 6,500 extra therapists
- 5,500 more nurses, midwives and health visitors being trained each year compared with the year 2000.

[17] NHS Modernisation Board, *The NHS Plan – A Progress Report*, 2003 (p6-7)
[18] The effect of increases in physician staffing levels is likely to be seriously and deleteriously affected by the implementation of the European Working time Directive (working hours are to be reduced to 48 hours by 2009).
[19] HPSSS Tables D5 and D6; OHE compendium of statistics; DoH, Hospital…..1991-2001, DoH, 2002; ISD NHSiS resource - online Annual Trends Workforce and Activity.[19] Department of Health HPSSS Table D1; Wellard's NHS Handbook 2001-02. (p80). Also see: Morris C, *The Pocket Guide to NHS England 2001/2002,* The NHS Confederation, 2001.

- 1,000 more medical school places on top of the 1,100 announced earlier (giving a total increase in places since 1997 of approximately 40%.[20]

Additionally, in the short term the NHS will actively recruit doctors from abroad, (advertisements being placed in foreign press) especially those in specialities like oncology and cardio-thoracic surgery. The well-established programme of international recruitment of nurses and midwives is set to continue.

More recently (2002) the Priorities and Planning Framework (PPF) 2003-2006 again set out the Government's programme for real expansion of the NHS workforce.[21] The PPF requires that by 2004, and compared to 1999, there will be:

- 7,500 more consultants
- 2,000 more GPs
- 1,000 more specialist registrars
- 20,000 extra nurses
- and over 6,500 extra therapists[22]

The PPF incorporates targets further on the horizon. By 2005, and in comparison to 2000 there will be 20,000 more nurses and 10,000 more doctors (consultants and GPs). Then by 2008 and compared to 2001, there will be 15,000 more doctors (consultants and GPs) and 35,000 more nurses. These targets are all based on headcount rather than whole time equivalents (WTEs).[23] There is a real danger that the public is misled by headline headcount figures; it should be underlined that when WTEs figures are considered, the increase in supply of staff could effectively be halved.

Staff Working in Hospital Services

Tables 3.2.2 to 3.2.4 present further Scottish and English hospital staff data over time, taken from the Office of Health Economics' (OHE) Compendium of Health Statistics 2002.[24] These data largely predate the National Plan, but are useful indicators of trends both prior to and following the Labour Government's election in 1997.

[20] DoH, NHS Plan, 2000 Chapter 5 (pp10-11).
[21] DoH, *Staff in the NHS 2002*, 2002.
[22] DoH, *Staff in the NHS 2002*, 2002.
[23] DoH, *Staff in the NHS 2002*, 2002.
[24] Readers should note that many of these tables present data for England *and* Wales. For detailed notes on sources and definitions, see OHE Compendium notes for each table.

Table 3.2.2 Medical and dental staff employed in NHS hospitals, UK, 1970-2000.

Year	Number of medical and dental staff		Staff per 100,000 population	
	England + *Wales*	Scotland	England + *Wales*	Scotland
1970	23,299	3,224	48	54
1980	34,298	5,163	69	99
1990	44,041	5,940	87	116
1995	52,324	6,642	101	129
1996	54,257	6,974	104	136
1997	57,257	7,295	110	142
1998	59,294	7,364	113	144
1999	61,081	7,535	116	147
2000	63,050	7,578	119	148

Source: OHE, 2002, table 3.4
Notes: see OHE Compendium notes

Table 3.2.3 NHS Hospitals' nurses and midwifery staff, (WTE) UK, 1970-2000.

Year	Nurses and midwifery staff ('000s)		Staff per 100,000 population	
	England + *Wales*	Scotland	England + *Wales*	Scotland
1990	380.8	56.2	749	1,102
1995	355.2	46.2	685	900
1996	356.1	45.7	685	892
1997	354.0	45.2	678	882
1998	355.9	44.7	679	872
1999	362.6	44.7	688	874
2000	370.5	44.4	700	869

Source: OHE, 2002, table 3.6
Notes: see OHE Compendium notes

Table 3.2.4 Number of hospital medical staff in Scotland and England.

Year	Number of hospital medical staff		Number per 100,000	
	England	Scotland	England	Scotland
1991	49,895	6,706	103	131
1995	55,348	7,339	113	143
1999	63,548	8,154	128	159
2000	65,374	8,226	131	161
2001	67,838	8,573	135	168

Source: OHE, 2002, table 3.8
Notes: see OHE Compendium notes

The Results So Far……..

On a headcount basis approximately 1.2 million people were employed in the NHS in September 2002; 'representing an increase of 58,000 since 2001 and an average of over 33,000 per year since 1997.'[25]

Nurses
The Modernisation Board's *Annual Report* says: 'Excellent progress has been made in recruiting and retaining nursing staff; the NHS Plan target of 20,000 extra nurses by

[25] Department of Health, *Staff in the NHS in 2002*,

2004 was met more than two years early… [and the] latest forecast is that there are now nearly 40,000 more nurses working in the NHS than in 1999.' In fact between September 1999 and March 2002 there was an increase of 28,740 nurses.[26]

The Modernisation Board's *Annual Report* also tells us that the commitment to have 500 modern matrons in place by 2002 was exceeded with ease; 1,900 matrons being in post by 2002. Less positively, and recognising that care outcomes rely on the right staff being available a the right time, CHI's investigations have found shortages of nurses in many trusts, and worrying shortages of senior and specialist nurses. [27] For example, the 2001 CHI and Audit Commission Report found serious shortages of specialist cancer nurses.[28] In June 2003 the Audit Commission reported that only 45% of Specialist acute trusts were likely to meet their target to recruit a given number of extra nurses.[29]

More positively, "CHI has found some examples of trusts coming up with imaginative schemes to keep the staff they have and to recruit new ones, and some schemes where for example, nurses are trained to provide care that would have been provided by a doctor. However, staffing issues continue to be a concern for CHI, despite increases in supply."[30] Staff shortages lead to the cancellation of operations and of clinics. The use of locums and agency staff to plug gaps can affect the quality of care, and of course is more expensive. [31] Another way to increase the supply of nurses rapidly would be to attract the tens of thousands of qualified nurses, no longer working as nurses, back to the NHS.

Hospital Doctors

Reiterating the PPF 2003-06, the latest Comprehensive Spending Review (2002) says that there are 5,000 more consultants since 1997. It also states that: 'Compared with 2001, by 2008 there will be on a headcount basis an additional 15,000 GPs and consultants.' Between September 1999 and March 2002 there was an increase of 3,130 consultants.[32] By September 2002, there were 3,749 more consultants amounting to a 50% achievement of the Priorities and Planning Framework target for 2004.

There has been an acknowledged shortage of specialist staff, from nurses and technicians to cardiac surgeons in both England and Scotland. In European comparisons the UK fares particularly badly.[33] For example in 2000 the UK had only 12 certified cardiologists per million population, compared to 26 in Germany and 65 in France (see table 3.2.5 below). Overall it had the second-lowest staffing level behind Ireland. This massive gap may in many ways be owing to the classification of

[26] Modernisation Board's Annual report 2003. This clearly met the PPF target of 20,000 more nurse by 2004.
[27] CHI, *Getting Better?* 2003
[28] Audit Commission, CHI 2001.
[29] Audit Commission, *Achieving the NHS Plan,* 2003.
[30] CHI, *Getting Better?* 2003
[31] CHI, *Getting Better?* 2003
[32] Modernisation Board's Annual report 2003
[33] Block P, Weber H , Kearney P. *Manpower in cardiology II in Western and Central Europe* (1997-2000) European Heart Journal, Feb 2003, 22; 4: 299-310

'certified' cardiologists and the standards of qualification, but even if one excludes the outliers such as Greece and Italy (Greece has 240 cardiologists per million population (pmp)), the EU average is still 43 pmp. Scotland has approximately 70 cardiologists, equating to one for every 73,000 people. England has one cardiologist for every 80,000 people (see table 3.2.6). The British Cardiac Society recommends a staffing level of one per 70,000 and the *Fifth Report on the Provision of Services for Patients with Heart Disease* recommends an increase in the number of consultant cardiologists to one per 50,000 in the next four to five years. This equates to an extra 30 consultant cardiologists in Scotland and another 390 in England.

Table 3.2.5 Certified Cardiologists per million population, 1997 and 2000, in selected European countries

	1997	2000
Country		
France	83	65
Switzerland	52	53
Germany	24	26
UK	8	12

Source: Block *et al*

Table 3.2.6 Consultant cardiologists in Scotland and England, 1995-2002

	Year							
	1995	1996	1997	1998	1999	2000	2001	2002
Scotland								
Headcount	53	60	61	65	66	72	74	74
WTE[34]	50	58.3	59	62.6	63.4	69.3	70.3	70.4
Consultant:pop^{n} (total)	96,296	84,869	83,333	78,108	76,847	70,318	68,403	68,337
Consultant:pop^{n} (WTE)	102,073	87,344	86,158	81,103	79,999	73,058	72,005	71,832
England								
Headcount	392	388	405	458	467	546	576	590
WTE	351.3	349	364.3	415.4	424.6	482.1	512.1	-
Consultant:pop^{n} (total)	123,188	124,747	119,809	106,239	104,574	89,738	85,310	83,630
Consultant:pop^{n} (WTE)	137,460	138,687	133,195	117,134	115,017	101,633	95,955	-

Source: ISD Scotland Workforce Statistics; DoH Medical and Dental Workforce Statistics

In recognition of this problem, staffing targets for certain specialties have also been set (in the Heart Disease NSF and NHS Cancer Plan). As a result, the Modernisation Board states that by March 2002, there were 590 cardiologists in post, which represents a 26 % increase since September 1999. [35]

[34] Whole-time equivalent (wte) gives a more accurate indication of provision of cardiac staffing as it takes into account part-time work, for cardiologists with academic posts, senior general medical responsibilities etc.

[35] NHS Modernisation Board Annual Report 2003.

Similarly, according to the Modernisation Board, in March 2002 there were 3,864 cancer consultants, compared with 3,362 in September 1999. The increase of 502 is equivalent to 15%. The Board considers that this means the Government is on target to meet its target of increasing cancer consultant numbers in the NHS by 1000 by 2006.[36]

The diagnostic and therapeutic machinery discussed earlier must be operated by well-qualified staff but there are serious shortages of radiographers and radiotherapy physicists (who operate LinAcs) in both England and Scotland (see tables 3.2.7, 3.2.8 and 3.2.9). Between 1992 and 1997 the number of radiographers in Scotland decreased by 3.9% overall, despite an increase in use of LinAcs by 4.6%.[37]This compares less favourably with the UK overall, which showed a 17% increase, in line with the increase in workload.[38] However, between 1997 and 2001 there has been a steady increase in radiographers in Scotland and England, with no significant difference in the rate of increase between the two countries. The change in staffing levels in Scotland and England between 1997 and 2001 is indicated below.

Table 3.2.7 Number of Radiographers

Country	1997	1998	1999	2000	2001	%change
England	9,910	10,190	10,370	10,480	10,650	+7.5
Scotland	1,360	1,368	1,419	1,408	1,466	+7.8

Source: England: NHS HCHS non-medical staff; Scotland: ISD

Table 3.2.8 Therapy Radiographers: UK Establishment and Occupancy (WTE), 2002.

Country	Substantive	Grand total	% vacant
England	737.81	796.61	6.3
Scotland	83.7	64.2	10.1
UK	882.85	958.15	6.3

Source: UK RT Survey 2002, A multidisciplinary survey of radiotherapy services in the UK at 04.06.02.

Table 3.2.9 Number of Consultant Radiologists

Country	1997	1998	1999	2000	2001	%change
England	1,470	1,510	1,540	1,620	1,680	+14.3
Scotland	192	192	199	205	203	+5.7%

Source: NHS Statistical Bulletin 2002/4

Shortages in the number of radiographers, while a major factor in the low rates of treatment, are quicker to remedy than shortages in trained radiologists, who require considerably more time and investment to train. Improvements in technology and changes in treatment have meant that the role of the Radiologists has changed dramatically in the past 25 years. In addition to radiography and complex imaging procedures, radiologists now contribute to patient management and therapeutic procedures. Here too there is a dearth of qualified consultants, who have traditionally

[36] NHS Modernisation Board Annual Report 2003.
[37] *Equipment, workload and staffing for Radiotherapy in Scotland*. London: Royal college of Radiologists 2000
[38] *Equipment, workload and staffing for Radiotherapy in the UK*. London: Royal college of Radiologists 2000.

delivered clinical radiology in the UK. In Scotland in 2001, 11.5% of consultant radiologist posts were unfilled,[39] and in England in March 2002, eight % of posts were unfilled.[40] The Royal College of Radiologists has suggested that there needs to be an increase in the number of consultants from the current level of 1,940 to 3,300 just to meet existing workload requirements.[41]

Nonetheless, despite the apparent increases in staff levels, "many CHI reports still describe long waits in A&E, outpatients and on waiting lists, particularly because of staff shortages."[42] The length of time taken to train nursing and clinical staff[43] is clearly an important issue, but there is a danger that it is used as a fig leaf for failure to improve services. Similarly, it is too easy to demand more staff instantly. What is certain is that it is a bold government that promises and pays for significant increases in staffing, when it may not be in power to reap the future rewards of success.

Supply of Family Health Services

Tables 3.2.10 – 3.2.12 show the number of unrestricted GP principals, 1980-2001; the number and list size of unrestricted principals, 1991-2001; and the number of people aged 65 and over and those aged 75 and over, by unrestricted principal, 1991-2001. It can be seen that the number of GP principals has increased slowly, while the average list size has fallen. Perhaps reflecting the ageing population, the average number of those aged over 75 has remained fairly level between 129 and 134 per GP over the past decade.

Table 3.2.10 UK, Number of unrestricted principals 1980-2001

Year	Number of unrestricted principals		Per100,000 population	
	England + *Wales*	Scotland	England + *Wales*	Scotland
1980	23,184	2,959	46.7	57.0
1990	27,257	3,359	53.7	65.9
1995	28,421	3,524	54.8	68.6
2000	29,479	3,707	55.7	72.5
2001	29,628	3,755	55.7	73.5

Source: OHE, 2002, table 4.8. Notes: see OHE Compendium notes

Table 3.2.11 Number and list size of unrestricted principals UK, 1991-2001

Year	Number of unrestricted GPs		Average list size per unrestricted GP	
	England	Scotland	England	Scotland
1991	25,686	3,380	1,938	1,580
1995	26,702	3,524	1,887	1,506
1999	26,710	3,697	1,846	1,441
2000	27,704	3,707	1,853	1,425
2001	27,843	3,755	1,841	1,409

Source: OHE, 2002, table 4.10. Notes: see OHE Compendium notes

[39] *Workload, Workforce and Equipment in Departments of Clinical Radiology in Scotland*. London: Royal College of Radiologists 1999
[40] Department of Health Vacancies Survey. DoH 2002
[41] *Clinical Radiology: A Workforce in Crisis.* London: Royal College of Radiologists 2002
[42] CHI, *Getting Better?* 2003
[43] See Annexe 7.3.2 for details of physician training.

Table 3.2.12 Number of people aged 65 and over and those aged 75 and over, by unrestricted principal, UK 1991-2001

Year	Number of over 65s per unrestricted GP		Number of over 75s per unrestricted GP	
	England	Scotland	England	Scotland
1991	297	226	133	97
1995	290	221	129	93
1998	289	214	135	94
1999	291	212	138	93
2000	282	212	134	94

Source: OHE, 2002, table 4.12. Notes: see OHE Compendium notes

Family Doctors

The Modernisation Board's Annual report 2003 says: 'Slow progress was made on expanding numbers of family doctors.'[44] Between September 1999 and March 2002 there was an increase of 483 GPs.[45] The latest Comprehensive Spending Review says that there are 1,500 more GPs since 1997. The Department of Health's *Staff in the NHS 2002*, adds that since 1997, the number of GPs (excluding retainers) has increased on average by 359 a year, to 31,182.[46]

The DoH has made limited progress towards its PPF target for GPs. By September 2002 only 37% (735) of the 2004 target of 2,000 had been achieved.[47] More positively the DoH has made progress towards its PPF target of 550 more GP registrars (GPs in training); by September 2002, there were 460 more GP registrars – amounting to 84% of the 2004 target.

3.3 Waiting Lists and Times

Waiting times are a major concern to patients and therefore politicians in the UK; indeed, according to the National Plan, waiting time for treatment was the public's main concern about the NHS. In 2000 the average waiting time to see a consultant as an outpatient was 7 weeks, while the average wait for an operation was 3 months, though some were waiting up to 18 months for inpatient treatment. According to the Plan, 'four specialities account for most of the long waits: orthopaedics, dermatology, ear, nose and throat problems, and eye conditions'. If media coverage is used as a gauge, the first and last (specifically hip and cataract operations) provide the greatest anxiety to patients.

Headline waiting figures tend to focus on hospital care, specifically waiting for outpatient appointments and inpatient treatment, but the public experiences delays in receiving care from GPs, in the arrival of ambulances, and at A&E departments. There are also concerns over delays in admission to wards from A&E, involving long trolley waits. Once an appointment is booked patients will often experience delays when they arrive in hospital or at the surgery. These may be caused by the booking systems themselves and exacerbated by shortages of staff. Cancelled operations are an extreme form of waiting, not to mention source of frustration to patients.

[44] Modernisation Board's Annual report 2003
[45] Modernisation Board's Annual report 2003
[46] Department of Health's *Staff in the NHS 2002*, 2002
[47] Department of Health's *Staff in the NHS 2002*, 2002.

The National Plan asserts that 'patients will see waiting times for treatment cut as extra staff are recruited':

- By 2004 patients will be able to see a primary care professional within 24 hours and have a GP appointment within 48 hours.
- Long waits in A&E will be ended – by 2002 no-one should wait more than 4 hours from arrival to admission, transfer, or discharge.
- Average A&E waiting times will be 75 minutes by 2002. [48]
- 'By [2002] we will have ended inappropriate trolley waits for assessment and admission.
- Anyone with suspected cancer should be seen within two weeks of their GP deciding they need to be seen urgently.
- By the end of 2003, the maximum waiting time for an outpatient's appointment will be three months and for inpatients six months.
- By the end of 2005 the average time for an outpatient appointment would be five weeks.
- There will be shorter waits for heart operations. [49]
- By 2004 there will be little bed blocking – alleviating pressure on beds.

Reforms to Alleviate Waiting

A number of initiatives coordinated by the NHS Modernisation Agency have focused on alleviating avoidable 'blockages', through improved management, collaboration and co-ordination. [50] Additionally, the 24-hour telephone service NHS Direct was introduced to reduce pressure on other NHS services, particularly GP surgeries and A&E departments. Other reforms such as the introduction of booking systems (replacing waiting lists) are being gradually implemented. By April 2001 the National Plan determined that all hospitals would have booking systems in place for two procedures within their major specialties. The Plan also envisages the use of electronic booking by 2005, enabling patients to choose when to be treated.[51]

Waiting to see a GP,

The Plan pledged that by 2004 patients would be able to see a primary care professional within 24 hours and have a GP appointment within 48 hours. These targets should have been met for 90% of patients by March 2003, but according to the Audit Commission, only two thirds of PCTs were likely to meet the two-day target, and more than 50 % were not likely to meet the one-day healthcare professional target.[52] Staff shortages were identified as the main constraint on PCTs' ability to meet targets. These figures conflict somewhat with those in Table 3.3.1, published one month earlier, which are taken from the *Chief Executive's Report to the NHS 2002/03*, and which were seen as evidence of an improvement in the waiting time to see a GP or other primary care professional.

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[48] 'By [2002] we will have ended inappropriate trolley waits for assessment and admission. (National Plan).
[49] National Plan (pp12-13; 101-105)
[50] Audit Commission, *Achieving the National Plan*, 2003.
[51] National Plan (p105)
[52] Audit Commission, *Achieving the National Plan*, 2003.

Table 3.3.1: GP and primary care professional (PCP) appointment availability

Date	Percentage of patients offered an appointment with a GP within 2 working days	Percentage of patients offered an appointment with a PCP within 1 working day
March 2002	74.6%	71.7%
March 2003	88.2%	90.5%

Source: Primary Care Access Survey (i) of practices; (ii) estimate.

Further conflicting evidence in a Department of Health survey was reported in *The Times* newspaper on 21 July 2003, having been discretely put on the Department's website on the day the CHI star ratings were published during the previous week – a move the Conservative party labelled a cover up. The survey, of more than 140,000 patients, showed that 72% of patients had to wait more than two days to see their GP. *The Times* reported that the BMA said the survey seemed far more realistic than previous government claims on waiting. "There are not enough GPs, and while we hope that the new contract should help to address that, there is still a long way to go."[53]

Ambulance Trusts

Ambulance trusts have response time targets. The Audit Commission reports that only 52% of trusts are likely to meet the 2002/03 target of responding to 75% of Category A (highest priority) calls within 8 minutes, a target the DoH estimated could save 1,800 lives per year.[54] CHI notes that response times have improved, (only 17% of ambulance trusts failed to meet the 2002/03 performance rating target[55]), but also reports examples of the misreporting of response times and of inconsistencies in the way relevant data are recorded. To summarise evidence on ambulance trust targets is mixed.

Hospital Waiting - Planned hospital care

Outpatient Waiting

The National Plan stated that:

- By the end of 2003, the maximum waiting time for an outpatient appointment would be three months
- By the end of 2005 the *average time* for an outpatient appointment would be five weeks.

Some 13 million people attended a first outpatient appointment in 2002/03.[56] As waiting times vary widely by procedure and also by trust, comparison of headline

[53] Wright O, 'Shortage of GPs creates longer waiting times', *The Times,* 21 July 2003. And
[54] Audit Commission, *Achieving the NHS Plan,* 2003.
[55] CHI, *NHS Performance Ratings,* 2002/03
[56] DoH Chief Executive's Annual Report 2003/03

rates in England should be treated with caution. Nevertheless, the Audit Commission considers that waiting times performance has improved markedly:

> "Half-way through the first year of the Plan (2001/02), auditors rated nearly two-thirds of trusts as being at high risk of missing the first milestone, which was to reduce the maximum wait to 6 months (26 weeks). Yet, after the end of that year, the [Department of Health] was able to report that in fact almost all acute trusts had met the target."[57]

Following this, the Department set a tougher target – reduction of the maximum wait to five months (21 weeks) by March 2003. Auditors expected the majority of trusts to meet this milestone, but a third of trusts would require significant effort to achieve the target. [58]

CHI's recent performance ratings showed that 11.36% of Trusts missed the outpatient-waiting target.[59] Table 3.3.2 shows median outpatient-waiting times, as set out in the *Chief Executive's Annual Report to the NHS 2002*/03; median waits have fluctuated between 7.3 and 7.6 weeks. Table 3.3.3 shows the number of patients waiting for a first outpatient appointment in March 2002 and March 2003; there has been a clear fall in the numbers of those waiting over 13 and 17 weeks. Across English Trusts, an average of 76% of patients see a specialist within 13 weeks from the date they were given their appointment.[60]

On outpatient waiting, the Audit Commission adds the following cautionary note:

> "Although undoubted progress has been made, the exact situation cannot be stated with certainty because of recently revealed inaccuracies in some trusts' waiting list information. The Audit Commission, with the agreement of the [Department of Health] and CHI, has reviewed data quality within acute trusts….Nearly all trusts had some data-system weaknesses…..A typical error was an incorrect date used for the start of waiting times."

Misreporting has become something of a feature in the waiting list target-setting environment, but is being monitored by the Audit Commission.[61]

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[57] Department of Health, *NHS Performance Ratings,* 2002 - cited in Audit Commission, *Achieving the National Plan*, 2003
[58] Audit Commission, *Achieving the National Plan*, 2003
[59] Civitas calculations based on CHI, *NHS Performance Ratings*, 2003.
[60] Coxon, I, McCall, A., eds, Good Hospital Guide, *Sunday Times*, (p9).
[61] For detailed comment on this see Audit Commission report: http://image.guardian.co.uk/sys-files/Society/documents/2003/03/05/Waiting.pdf

Table 3.3.2: Outpatient waiting times, Median waits for patients seen during the quarter

Patients seen between January and March that year	Median outpatient waiting time (weeks)
2000	7.58
2001	7.35
2002	7.58
2003	7.34

Source: QM08 (provider based), Chief Executive's Report to the NHS 2002/03

Table 3.3.3 Number of patients waiting for a first outpatient appointment in March 2002 and March 2003.

	March 2002	March 2003	% Change during 2003/04
Number of patients waiting over 17 weeks.	87,995 (i)	38,430	- 56%
Number of patients waiting 13 weeks and over.	194, 596	120,256	- 38%

Source: Chief Executive's Report to the NHS 2002/03 (i) data estimated from April 2002 figures.

Waiting for Inpatient Treatment

The reduction of waiting times for treatment is a priority of the Government. The Plan stated that by the end of 2005, the maximum waiting time for an inpatient appointment (treatment) would be six months. The March 2003 target was 12 months maximum wait. The Audit Commission's assessments show that the majority of trusts were expected to achieve that target.[62] So progress has been made. The Commission also suggests that work needs to be done in a small number of trusts – where the most serious difficulties are found. 'In September 2002 over three-quarters of the patients waiting beyond 12 months were found within only a quarter of trusts. And nearly a third of these patients were within only five trusts. CHIs recent performance ratings showed that 7.95% of Trusts missed the inpatient-waiting target.[63]

[62] Audit Commission, *Achieving the National Plan*, 2003 (p12)
[63] Civitas calculations based on CHI, *NHS Performance Ratings*, 2003.

Table 3.3.4 Monthly waiting lists – May 2002 to May 2003; England (hospital based[64])

Month Ending	Number Waiting	Change since previous month	
	(000s)	Number (000s)	Per cent
31 May 2002	1055.5	9.2	0.9%
28 February 2003	1027.4	-25.8	-2.5%
31 March 2003	992.1	-35.3	-3.4%
31 April 2003	1001.4	9.3	0.9%
31 May 2003	1003.0	1.7	0.2%

Source: DoH, Statistical Press notice – NHS Waiting List Figures, 31 May 2003, Press release reference: 2003/0253, Friday 4 July 2003.

During 2002/03 the Government achieved the psychological boost of bringing the number of people waiting for treatment below one million to 992,000 at 31 March 2003 – the lowest number for over a decade.[65] However, as table 3.3.4 shows, this number has subsequently risen. The total number waiting for admission in England fell by 52,500 (-5.0%) between May 2002 and May 2003, though it rose by 1,700 between April and May 2003. The total number of patients waiting at the end of May 2003 was 1,003,000 (c.one in 47).[66] Of these almost 237,000 waited for six months or longer for ordinary or day case admissions. The number of English patients waiting over one year at the end of September 2002 was 16,700.[67] Those waiting over one year at the end of may 2003 fell by 11 (-6.5%) since April 2003 to 159; 21,700 (-99.3%) lower than March 2003 when the total was 21,900.[68] At the end of May 2003, some 25 patients had waited over 15 months. While in March 2003 the median wait in England was approximately 51 days.[69] In March 2003, *The Sunday Times* found that the percentage of people who had their hospital inpatient appointment (all specialties) within six months of the decision to admit was 79% in England and 92% in Scotland.[70]

[64] **Hospital and Commissioner based lists:** "There are fundamental differences in coverage between commissioner based and hospital based information. Commissioner based returns exclude all patients living outside England and all privately funded patients waiting for treatment in NHS hospitals. However, they do include NHS funded patients, living in England, who are waiting for treatment in Scotland, Wales and Northern Ireland, abroad, and at private hospitals; these patients are not included in the corresponding hospital based returns. Historically there has been a 1% to 3% difference in the overall size of the waiting lists reported for NHS hospital trusts and English residents, the trust-based figure being the larger." (Source: DoH, Statistical Press notice – NHS Waiting List Figures, 31 May 2003, Press release reference: 2003/0253, Friday 4 July 2003.)

[65] Chief Executive's Annual Report 2002/03

[66] Provider based hospital waiting lists statistics. These figures relate to day case or ordinary admissions - outpatients are not included. DoH, Statistical Press notice – NHS Waiting List Figures, 31 May 2003, Press release reference: 2003/0253, Friday 4 July 2003.

[67] DoH, Statistical Press notice – NHS Waiting List Figures, 30 September 2002, Press release reference: 202/0470, Friday 15 November 2002. "The total number waiting rose by 12,800 (1.3%) between September 2001 and September 2002."

[68] DoH, Statistical Press notice – NHS Waiting List Figures, 31 May 2003, Press release reference: 2003/0253, Friday 4 July 2003.

[69] (7.22 weeks or 1.67 months) Source: information from Directorate of Access &anp; Choice Access Delivery (Waiting Times Analysis) Team, 21/03/03. The median wait, for inpatients, day cases and outpatients, is the number of *days* half of the patients will wait less than, and the other half will wait more than.

[70] Coxon, I, McCall, A., eds, Good Hospital Guide, *Sunday Times*, (p9).

Commissioner based waiting lists and times for inpatient treatment at NHS Trusts in England, March 1997 to March 2003, are shown in table 3.3.5 The number of patients who had been waiting over nine months fell by 45% from 96,628 in March 2002 to 52,904 in March 2003. Over the same period the number of patients waiting for over six months fell by 21% from 238,091 to 189,045.[71] These cuts in waiting times were hailed as 'very good progress' in the Chief Executive's Annual Report.

Table 3.3.5 Commissioner based waiting lists and times for **inpatient treatment** at year end, NHS Trusts in England, March 1997 to March 2003

At End March	**Total number waiting ('000)**	**0-3 months ('000)**	**3-5 months ('000)**	**6-8 months ('000)**	**9-11 months ('000)**	**12 plus ('000)**
1992	995	N/a	N/a	N/a	N/a	N/a
1997	1,158	561	286	165	89	30
1998	1,298	594	305	192	118	67
1999	1,073	536	248	146	84	47
2000	1,037	518	243	138	78	48
2001	1,007	515	237	130	72	41
2002	1,035	525	259	141	75	22
2003	992	532	254	136	53	0.07

Source: KH07 (provider based), QF01 (commissioner based) Chief Executive's Annual Report 2002/03.

Table 3.3.6 shows data on waiting lists and times for England, Scotland and Wales, taken from the latest edition of *Social Trends*. These data are slightly older than those in tables 3.3.1– 3.3.5, but they reveal the effects of devolution on healthcare in the UK; the most striking difference among the countries shown is the performance of Wales – where more patients wait longer for treatment.

Table 3.3.6 Waiting times in the UK compared, March 2002

Country	Less than 6 months	6-12 months	12 months or longer	Total Waiting (thousands)
England	77%	21%	2%	1,022
Wales	63%	23%	14%	71
Scotland	81%	17%	3%	72

Source: Social Trends, No. 33. 2003 Edition. (p152-3)

Accident and Emergency Waiting

In June 2003, the Audit Commission reported that few of the acute trusts had been able to keep waits in A&E to target levels.[72] Some 70% of acute trusts were considered unlikely to achieve the target of 90% of patients spending no more than 4 hours in A&E. However, one month earlier in May 2003, the NHS Chief Executive's Annual report stated that: "preliminary management information suggests that considerable further progress was made during the winter with the result that at the

[71] Chief Executive's Annual Report 2002/03.

[72] Audit Commission, *Achieving the NHS Plan,* 2003. In 2002/03 some 200 NHS Trusts provide major A&E services, under 50 single specialty A&E departments and over 200 minor injury units in England (CE's Annual Report (p9)).

end of March [2003] 92.9% of patients were admitted, transferred or discharged within four hours of arrival. This figure compares with the March 2002 result of 77.2%."

Very long trolley waits have not been totally eliminated, though some progress has been made; according to *Delivering the NHS Plan – Expenditure Report,* in December 2002 only 88 patients (0.03% of the total needing admission), waited more than 12 hours compared with 393 patients (13%) in December 2001.

In *Achieving the NHS Plan*, Audit Commission notes on waiting that:

> "Trusts have worked hard to hit waiting times. Sometimes this has been done by improving systems – for example, making more efficient use of available operating theatres, or eliminating administrative blockages that were delaying patients' progress. And sometimes capacity has been permanently increased – for example, by recruiting extra consultants, or investing in new beds."

However, beyond those positive reports there has been a great deal of debate regarding the 'spill-over effects', most worryingly distortions of clinical priorities, of the Government's targets on waiting. For example, July 22, 2003 saw reports that waiting targets had caused some patients in Bristol to go blind, while those with much less serious conditions were being treated. These reports were inaccurate (patients had lost some vision rather than lost all vision) but offer a good example of the scope for clinical distortion that targets are widely presumed to give. Countering this view, in an interview on the BBC's Newsnight programme, Health Minister Dr Stephen Ladyman argued that there was no proof of causality between targets and any loss of sight.[73] The debate on targets and clinical priorities is analysed in Section 4.

[73] BBC 2, Newsnight interview with Health Minister Dr Stephen Ladyman, 22 July 2003.

3.4 Geographical variations in care.

The National Plan recognised that 'often the poorest services are in the poorest areas with the poorest results.[74] Aiming to eliminate these variations, the Plan reaffirmed its commitment to NSFs and introduced NICE.[75] NSFs are designed to provide and standardise treatment criteria, while 'The National Institute for Clinical Excellence will ensure that cost effective drugs like those for cancer are not dependent on where you live.'[76]

So, in the four years since NSFs were introduced and roughly 3 years of NICE work, have variations in care been diminished? In its May 2003 report, *Getting Better?,* CHI states:

> "The improvement in NHS services is…..patchy and inconsistent and sometimes made up of isolated examples of very good practice that are delivering considerably improved care, but which are not being taken up across the NHS, or even in other departments in the same organisation."

Getting Better? makes clear that patients in some parts of the NHS are not yet benefiting from all of the improvements. Many standards of care need to be adopted more widely.[77] The effect of NICE provides a good example.[78]

The introduction of explicit rationing through NICE has gone some way to spelling out entitlements to treatments. NICE was set up as a Special Health Authority for England and Wales on 1 April 1999. It is an independent organisation responsible for providing national guidance on treatments and care for those using the NHS in England and Wales.[79] All 302 Primary Care Trusts and 274 NHS Trusts in England must make decisions about which treatments to fund. Different trusts make different decisions. This means that whether or not you receive the treatment that you need is determined *by where you live*. By providing national guidance NICE aims to eliminate such inequities. However, despite the fact that since 1 January 2002 the NHS has had a statutory obligation to provide funding for NICE approved technologies once a doctor has recommended it to his or her patient, NICE rulings do not amount to concrete benefits; there is still significant geographical variation in treatment.[80] On 24 July 2003, BBC social affairs correspondent Niall Dickson reported evidence on continued postcode lottery following an interview with Professor David Bennett of St Georges Hospital in London.[81] Civitas research, using Prescription Cost Analysis data from the Department of Health website, suggests that implementation of NICE guidance is patchy.[82]

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[74] National Plan (p27).
[75] See section 2 for further detail.
[76] National Plan
[77] CHI News Release 9 May 2003.
[78] The implementation of NSFs Guidelines is examined in detail in section 4.
[79] NICE's remit is to develop authoritative guidance on the clinical and cost effectiveness of treatments. This guidance is intended to provide information on best practice for frontline NHS staff.
[80] This obligation falls on the Primary Care Trusts and NHS trusts since they, with the aid of prescribing advisors, now make the decisions on which treatments to fund. Funding decisions were devolved down to them following the changes introduced on 1st April 2002.
[81] Niall Dickson, BBC Today Programme, 24 July 2003,
[82] Unpublished research carried out by Mark Evans, of Civitas.

Geographical Variation in Treatment for Alzheimer's

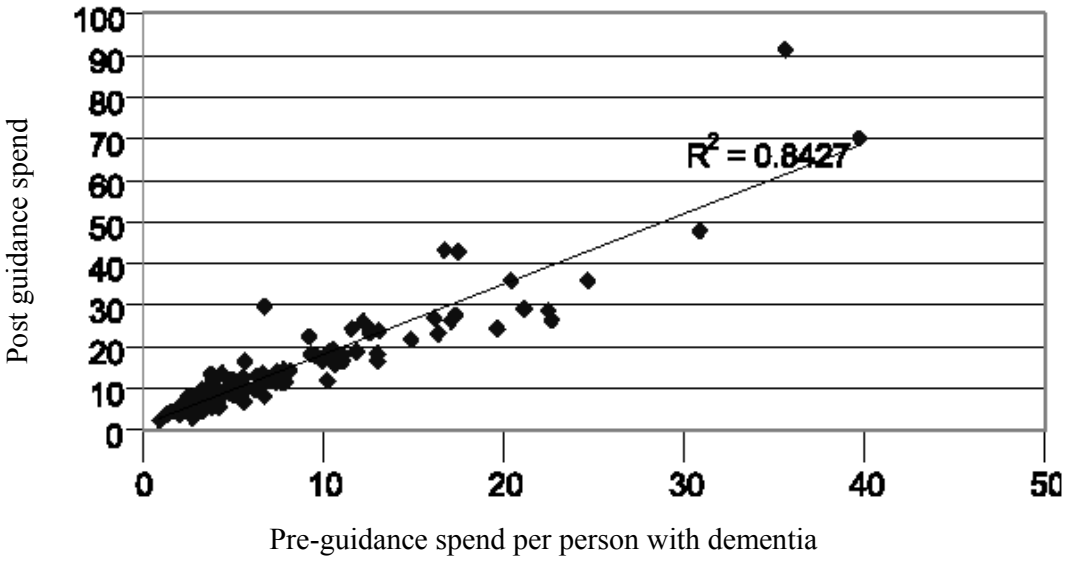
The Alzheimer's society submitted data to the Health Committee on the usage of Donepezil, Rivastigmine and Galantamine before and after NICE had issued guidance recommending their use. The data splits up the country into small geographical units and then compares the combined level of prescription of the three drugs before and after NICE's guidance. The results are summarised in table 3.4.1 below.

Table 3.4.1 Spend Per Patient With Dementia[83]

	Pre-guidance (£)	**Post guidance (£)**
Mean	8.77	16.06
Range	38.78	89.22
Minimum	0.9	2.24
Maximum	39.68	91.46

One trend we can observe is the increase in expenditure following NICE's guidance, though there is still some way to go to reach the recommended level. However the data also reveals serious and widening geographical iniquities. The range has increased considerably following NICE's guidance which means that there is more variation in expenditure than before the guidance. This result is clearly illustrated in graph 3.4.1 below, which plots each geographical unit's spending before guidance against expenditure post guidance.

Graph 3.4.1 Expenditure before and after NICE guidance[84]



[83] Data from Appendix 1 to Memorandum from Alzheimer's Society to Health Committee Report 20th June 2002

[84] Data from Appendix 1 to Memorandum from Alzheimer's Society to Health Committee Report 20th June 2002

The general trend we can observe from the graph is that those areas that were spending the most before guidance was issued are still spending the most, and those that were spending the least are still spending the least. There is no observed movement towards a recommended level, such a movement would appear on the graph as a broadly straight horizontal line at a particular post guidance expenditure level. It would appear that NICE's guidance has the most impact in those areas that were already positive on these drugs, and least impact in those areas that were less keen to prescribe them. While this result is unsurprising, it is nevertheless a failure. Patients with Alzheimer's are not getting access to treatment that could alleviate the symptoms of dementia because of where they live.

Geographical Variations in use of Taxol

The Association of the British Pharmaceutical Industry (ABPI) submitted data to the health select committee regarding the use of Taxol, a treatment for breast cancer before and after NICE recommended it. The results are shown in chart A and chart B below.

Chart A – Prior to Release of First NICE HTA for Taxol

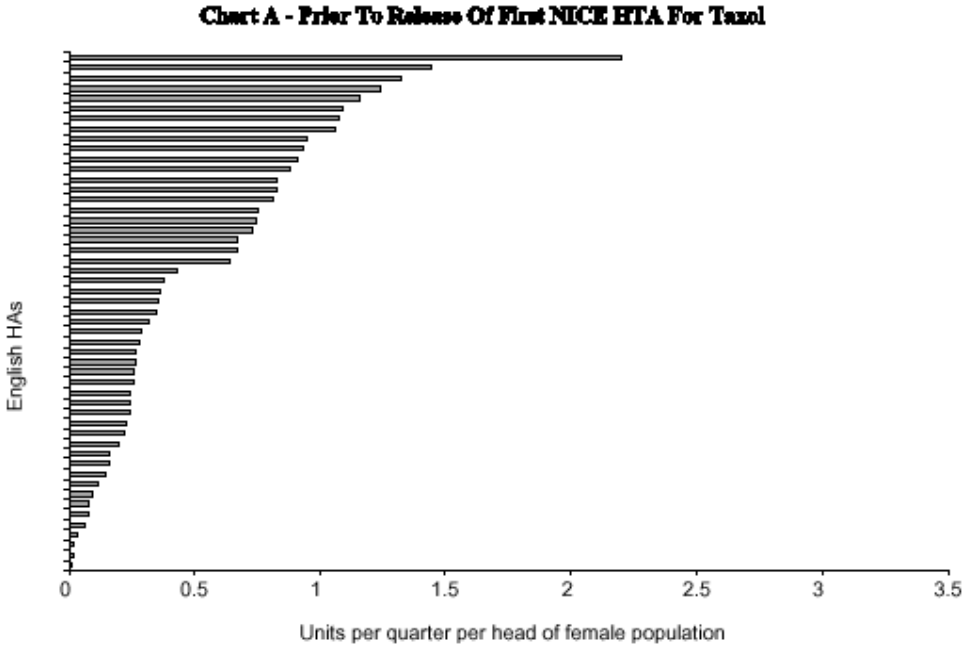
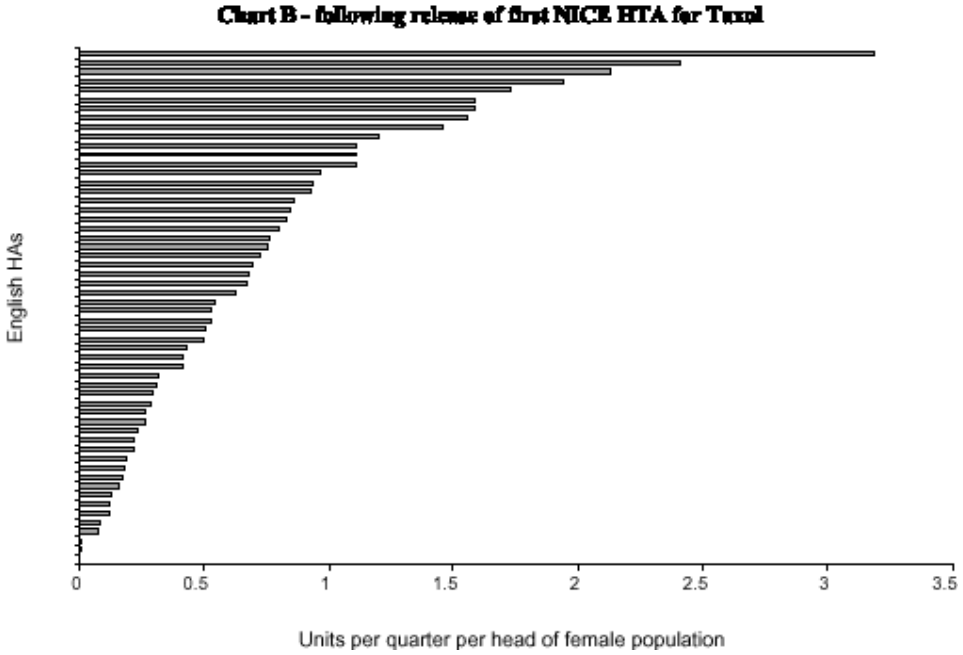


Chart B – Following Release Of First NICE HTA For Taxol



There is clearly extensive disparity in use even after NICE has issued its guidance. We can at least note that use has risen after NICE's guidance, but the inequality of access remains entrenched. Again this means that because of where they live women are not getting access to a treatment that could extend their life.

The fact that 'fashionable' conditions seemed to experience greater growth in treatment is a serious concern for equitable access. It would appear that those patients with less of a voice are failing to get the treatment NICE recommends. There is also the issue of topic selection. The Department of Health and the National Assembly for Wales decide which treatments are assessed by NICE, now with input from NICE itself. It seems likely that here too 'unfashionable' conditions will not be sent to NICE for appraisal. There will not be a statutory obligation to fund them, and they might suffer cuts in provision in order to fund those treatments that are NICE recommended. In fact, it is likely that in the short term these treatments will grow in absolute terms since there is a projected growth of 8.8% in NHS spending in 2002/3, but they will fall in relative terms since the forecast increase in drug expenditure for 2002/3 is higher at 11-13%[85], and the majority of NICE recommended treatments are drugs. This phenomenon is likely to recur annually and slowly shift treatment away from these conditions. This problem is clearly not NICE's responsibility but it is a serious issue for the appraisal system as a whole. NICE must appraise a wider range of treatments to ensure we do not end up with a covertly politicised system of rationing.

Another serious issue regarding equity of access is NICE blight. This is the process whereby some trusts refuse to fund a treatment while it is undergoing appraisal. The key point to note is that it is only in *some* trusts. Others will fund the treatment. This means we will inevitably see inequitable access while NICE blight persists. The Department of Health has acted before to try and eliminate this problem with relation

[85] Audit commission, Primary Care Prescribing, March 2003, http://www.audit-commission.gov.uk/subject.asp?CatID=ENGLISH^HEALTH^SUBJECT^H-PRIM-COMM-SERV

to chronic myeloid leukaemia, but it must take more general action to root out the problem before it becomes entrenched practice for some trusts.

Practising physicians also fear that NICE and its Scottish equivalent, the Health Technology Board for Scotland (HTBS), have not succeeded in ironing out the postcode lottery for treatment with drugs and new technologies. Illustrating this concern Edinburgh based experts David Cameron (a medical oncologist) and J Michael Dixon (a consultant breast surgeon), wrote the following in a letter to the BMJ:

> "EDITOR—We had understood that one of the intentions of the National Institute for Clinical Excellence (NICE) was to rationalise the introduction of new drugs and technologies across the United Kingdom so that NHS patients would have equitable access. This has plainly not happened. We illustrate the problem with three recently licensed drugs, imatinib, irinotecan, and trastuzumab.
>
> Imatinib has yet to be appraised by the National Institute for Clinical Excellence, but our local haematologists completed the paperwork for approval by Lothian Health Board's drug evaluation panel. The drug was not approved. Shortly afterwards the Scottish Medicines Consortium issued guidance to indicate that it should be made available: we await the result of an appeal to the drug evaluation panel. Meanwhile patients in Fife can get it.
>
> Irinotecan was approved by the National Institute for Clinical Excellence and the Health Technology Board for Scotland. However, the drug evaluation panel for Lothian has rejected it—despite knowing the decisions of the institute and the board—on the grounds that the improved survival does not justify the cost. If the patients live in the west of Scotland, however, they can receive it. In Aberdeen doctors are allowed to prescribe it but without any additional funding, so that expenditure on irinotecan competes with that on other drugs.
>
> Trastuzumab was approved by the institute after a year's deliberation, and then by the Health Technology Board for Scotland. It is already available in the west of Scotland; but recognising that the real decision about its availability in the east of Scotland lies with the Lothian Health Board, we have to carry out a detailed assessment of the total cost before applying to the drug evaluation panel. The only reason we have any optimism about its decision is that some funding may already have been identified.
>
> The current system seems no more equitable than previously……."[86]

Inequalities in Health

Achieving a reduction of inequalities in health was a target of the National Plan. This target may have been missed – it is clear that income inequality has worsened since New Labour took office in 1997.[87] Since the mid 1990s there has also been an increasing acceleration in mortality inequality trends. Perhaps responding to this the Government published *Tackling Health Inequalities: A Programme for Action* in July 2003. One result of inequality in health is geographical variation in mortality. Those living in deprived areas may not survive as long as the more affluent. The strongest evidence of this is for lung cancer, but in 38 out of 43 cancers studied in England and Wales there is a 'gap in survival to the advantage of the most affluent'.[88]

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[86] Cameron D, and Dixon JM, Letters, 'Postcode prescribing is alive and well in Scotland', *BMJ 2002; 325:101* (13 July).
[87] Davey Smith, G., *et al,* 2002.
[88] CHI/Audit commission, NSF Assessments, Supporting Data, 1, (p11-17).

3.5 Patient Satisfaction

Data collection for the widely cited Eurobarometer patient satisfaction surveys pre-date the latest increase in NHS funding and so are not directly relevant; nevertheless, they do show that satisfaction was fairly low, and that citizens thought more should be spent on health care. Now that extra funds have been forthcoming from the Government, there is a risk that additional spending will fail to improve care quickly and therefore not lead to increased satisfaction.

Choice and involvement in care decision-making
Choice of provider is at the centre of the Government's agenda on health reform. On 1 July 2002, almost 2000 heart patients who had been waiting six months for an operation became eligible to choose to be treated elsewhere in the NHS or in the private sector. As part of a pilot, the same choice has been extended to Londoners waiting more than six months for cataract surgery. By early 2003 Londoners waiting for orthopaedic operations, ear, nose and throat treatment, general surgery and other specialities were able to exercise similar choice. On 3 October 2002, the then Secretary of State Alan Milburn said that if these pilots are successful, choice will be extended to other parts of the country."

Table 3.5.1 Number of patients offered choice for CHD and cataract operations, and those exercising the option.

	Patients offered Choice	Patients who exercise their choice to move to another provider
CHD Nationally	4,675	2,082 (45%
Cataracts, general surgery and ENT in London	3,242	2,2,4 (68%)

Source: P9 Chief Executive's Report,.2002/03.

In a speech on 23 January 2003, the Prime Minister confirmed Alan Milburn's statement saying 'I can announce today that from this summer, we will extend this scheme to cover almost all elective surgery in London. And from summer next year these choices will be offered to all elective surgery patients nationwide.'

Table 3.5.1 shows the number of patients offered choice for CHD and cataract operations, and those exercising the option. Clearly people did decide to exercise their choice to change provider; their desire and capacity to do so was emphasised by Secretary of State John Reid in a speech in July 2003, during which he announced an extension of the choice after six months policy to all elective specialties throughout England. Reid also announced that by 2005 patients will be able to choose from at least four alternative providers at the point of referral, and that choice in services such as chronic diseases, primary care and maternity services will be introduced.[89]

[89] Rt Hon John Reid MP, Secretary of State For Health, Speech To The New Health Network 16 July 2003

Although very few patients benefit from choice as yet, according to CHI, the NHS has made 'significant progress in respecting a person's right to be fully involved in decisions about their healthcare.'[90]

Treatment Environment
According to CHI, half of their NHS reviews raise concerns regarding cleanliness, décor, privacy or security. Although this finding is of aesthetic concern, the rundown environment particularly of older buildings can increase the risks of infection spreading. Worryingly, control of infection was noted as an area of concern in a quarter of CHIs reports on NHS trusts.[91]

In the conclusion of *Getting Better?* CHI notes: "Despite the money being spent on buildings, NHS staff too often do not see how dilapidated or dirty places seem to the public. For the staff it is the same as it was yesterday. For the person arriving anxious about their appointment and fearing the worst it is easy to assume that an organisation that doesn't care for its waiting rooms and public toilets, doesn't care about the people who use its services. The NHS still underestimates how important a well cared for environment is to the public." In its report of June 2003, the Audit Commission noted widespread improvements in cleanliness.[92] Perhaps reflecting this, 100% of NHS Hospital Trusts met the CHI target on cleanliness according to the latest ratings.[93]

Although declining in prevalence, the continuing existence of mixed wards and washing facilities in the NHS, also commented upon by CHI, is certain to impact on patient perceptions of privacy and security. Though not 'rationing' of care, older people are 'more likely to be placed in inappropriate wards than other people' according to CHI.[94] This impacts on quality of care for the most vulnerable.

3.6 Innovations – Designed to Improve Care

NHS Direct
The telephone service NHS Direct was introduced to reduce pressure on other English NHS services, particularly GP surgeries and A&E departments. In 2002/03 there were some 6,319,000 callers to NHS Direct, representing an increase during 2002/03 of 1,106,000 (21%).[95]

Walk-In Centres
NHS Walk-In Centres are designed to provide faster and more convenient access (no appointment is required) to primary care services, including advice and treatment for minor ailments and injuries. More than 3 million visits have been made to the 42 existing sites since 2000. Table 3.6.1 shows average Walk-In centre activity since December 2000.

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[90] CHI, *Getting Better?* 2003
[91] CHI, *Getting Better?* 2003
[92] Audit Commission, Achieving the NHS Plan, 2003.
[93] CHI, NHS Performance Ratings, 2002/03.
[94] CHI *Getting Better?* 2003
[95] DoH, Chief Executive's Annual Report 2003. Note: the service does not operate in Scotland.

Table 3.6.1 Average activity in Walk in Centres, England 2000-2002

Year	Number of sites	Average number of visits per site per day	%change	Year	Total Activity for all sites open ('000)
December 2000	35	55		2001-01	574
December 2001	40	74	35%	2001-02	1,145
December 2002	42	83	12%	2002-03	1,374

Source: Walk in centre activity reports

On July 2003 Health Minister John Reid announced a further £40m investment package for 11 new centres.

Summary of Key Points

Considering the three Core Principles set out at the start of this section, the following can be said about staffing, technical resources and so forth:

- There are more NHS staff (Consultants, GPs and Nurses), but there are still shortages in key areas and GP numbers in particular are only rising slowly.
- There are more units of advanced diagnostic and treatment technology, but there are concerns that technology is not be being used even though it is available.
- Waiting times are falling.
- Waiting lists are rising again.
- Though we are far from universal access to the same standard of care, there is arguably some greater consistency in treatment.
- However inequality of health may have worsened.
- Quality in terms of waiting, cleanliness, privacy, etc appears to have improved.

CHI Chairman, Dame Deirdre Hine has said: "We do not reach a conclusion that everything is rosy in the NHS, but nor do we conclude that it is generally failing."[96] However, CHI also admits 'that some parts of the NHS are not improving and may be getting worse.

The following section builds on section 3 and examines in greater detail whether the extra billions are reaching the 'front line', and what distortions in care, are now being encountered by patients and their physicians.

[96] CHI "NHS is improving" reports health watchdog , News release 9 May 2003.