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A Healthy Future for Scotland

**Symptoms, Diagnosis and Cure for the NHS in
Scotland**

Professor Nick Bosanquet

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Synopsis

Scotland's health service is well financed and can call on excellent and dedicated staff. However, despite some recent improvements, resources are used inefficiently and outcomes are below standard. Scotland should learn from reforms in Scandinavia and elsewhere to introduce greater patient choice to lower waiting lists and concentrate more resources on primary and palliative care, as well as disease prevention. This paper suggests seven practical steps towards a world class health service in Scotland.

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Symptoms and Prognosis

The burden of disease is too high in Scotland. This is exacerbated by a number of factors in the structure of the National Health Service (NHS) in Scotland and broader Scottish society. In particular, too many people are being treated in hospital, increasing waiting times and contributing to a vicious circle of delayed treatment and higher costs. The major symptoms of problems in the Scottish health service are as follows:

- Scotland has an ageing population, which will lead to higher levels of disability. Recent data from the Office of Health Economics (OHE) has shown that **life expectancy has been improving at slower rate over the last decade in Scotland, than in England**¹.
- **Current waiting times are excessive.** This means that many patients are being treated late, allowing their conditions to worsen significantly, adding further to the burdens placed on the NHS in Scotland.²

Above all, **current performance levels involve losses to patients.** At present, prolonged waiting times mean that many patients suffer a further and irretrievable loss of health. For the majority, when treatment becomes available, it is much less effective than if the patient had been treated earlier. Bed blocking affects some 2,200 patients at a time in Scotland compared to 3,600 in England (a far greater proportion of beds).³

Many of these patients will suffer much higher levels of disability as a result of their enforced stay in hospital and will then have no option other than expensive long term care. The following chart shows the chances of postoperative complications according to how long the patient has to wait.

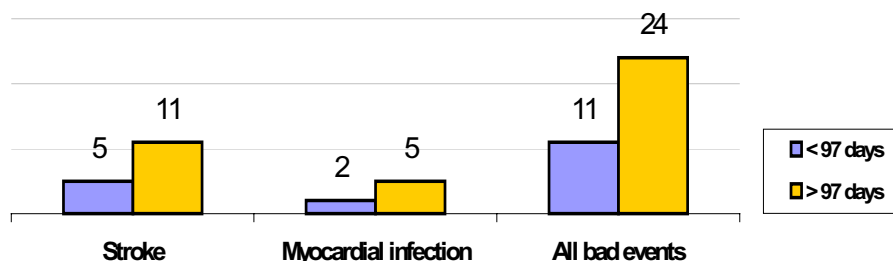
¹ OHE. Compendium of Health Statistics. 2003.

² J.Sampalis et al. Impact of waiting times on the quality of life of patients awaiting coronary artery bypass grafting. Canadian Medical Association Journal. 2001. 165 429-33.

³ Scottish Executive figures reported in The Scotsman, 1st October 2003.

The Cost of Waiting

Adverse events (% chance) after heart bypass according to length of preoperative wait



Source: Canadian Medical Association Journal 2001

- Scotland has a severe and widely documented problem of social deprivation in certain geographic locations. These urgently require investment both in direct services and in programmes for lifestyle change. Scotland has by far the worst concentration of personal loss in the UK. According to a Nuffield study published earlier in 2003 “Over half of the one million people who live in the 15 UK parliamentary constituencies with the highest rates of premature mortality (deaths under 65 years) are in nine Scottish constituencies and, in particular in Glasgow⁴”.

It is essential to search for ways in which an improved performance by health services on the inescapable priority of waiting times could free up investment and management time for improving disease prevention and health services in deprived communities.

- Scotland has been slow to develop more intensive community support and palliative care. Recently the wife of the First Minister complained about how the NHS had treated her father’s lung cancer. “There were no support services. Thank God for the extended family. Thank God we had money. We were able to buy him a bed and hire private nurses. What really shocked me was that we were given a bag by the hospital full of morphine but no instructions as to what to do with it”⁵. Most palliative care in Scotland is in fact provided by voluntary organisations. Such deficits have also affected mental health patients, with slow and patchy development of alternatives to long term hospital care.

⁴ K.Woods and D.Carter (eds) Scotland’s Health and Health Services. Nuffield 2003.

⁵ McConnell: NHS let my father down. The Scotsman 31 May 2003.

- The impacts of economic performance on health services in Scotland are highly significant. The changing demography will deter employers who are less likely to move to an environment with fewer younger workers, high sickness rates and higher local taxes. At present, Scotland's growth rate is half the UK average. With a declining and ageing population the outlook is for lower growth in the future. There is a significant linkage between the problem of low growth and that of the inadequate performance of the health service in Scotland. There is a negative effect on the whole image of Scotland of the incessant reporting of crises and problems in the health service.

Positive improvements

Despite this, there have been some positive recent improvements in health care:

- Scotland has had some success in reducing mortality. For example, mortality from Coronary Heart Disease (CHD) is now 40 per cent lower than in the early 1990s.
- There has been a clearer focus on health promotion and a new strategy for CHD⁶.
- The majority of Scottish patients with strokes have access to special units and the survival rate is better than in the rest of the UK.
- There has been a positive use of information to monitor outcomes from treatment on a more systematic basis than has been done previously. These studies show that when treatment does take place the outcomes are comparable with those elsewhere. For example, there are now many more heart bypass operations on older patients, and for 1981-96, results demonstrate a marked improvement⁷.
- There has been improvement in screening programmes both for coronary heart disease and in cancer. Scotland leads the way in using new technology to improve screening programmes for cervical cancer.
- Scotland has been a leader in using telemedicine and special access programmes for rural areas.

⁶ CHD and Stroke Task Force Report. Edinburgh Scottish Executive health department 2001

⁷ J.Pell. (Et Al) time trends in survival and readmission following coronary artery bypass grafting in Scotland, 1981-96: retrospective observational study. BMJ 2002 324 201-2.

- Scotland has given a lead in extending the role of community pharmacies. For example there are innovative programmes for improving access to medication for patients with long-term mental illness. This is now being extended to patients with CHD.

Scotland's health services have much to be proud of, which makes the situation with day-to-day access and use of staff time even more frustrating.

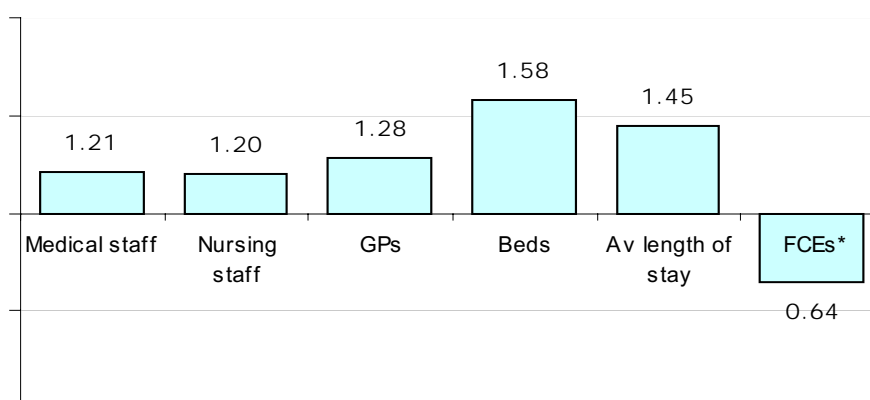
Further challenges are to come. There are likely to be significant increases in chronic illnesses such as diabetes and CHD, due in part to lifestyle changes. We must reduce morbidity and improve quality of life of survivors. We have to make a realistic assessment on whether health services in Scotland can meet this challenge.

Diagnosis

What are the reasons behind the difficulties faced by the NHS in Scotland? After all, we are living in an era of unprecedented funding growth. **The problem is that much of the new money is being poorly directed.** The following chart summarises some of the features of health resourcing and performance in Scotland compared to the rest of the UK. There follows a diagnosis with details on health spending in Scotland and why this is not having the desired effect.

Poor Health Productivity

Resources and Performance (Scotland vs UK)



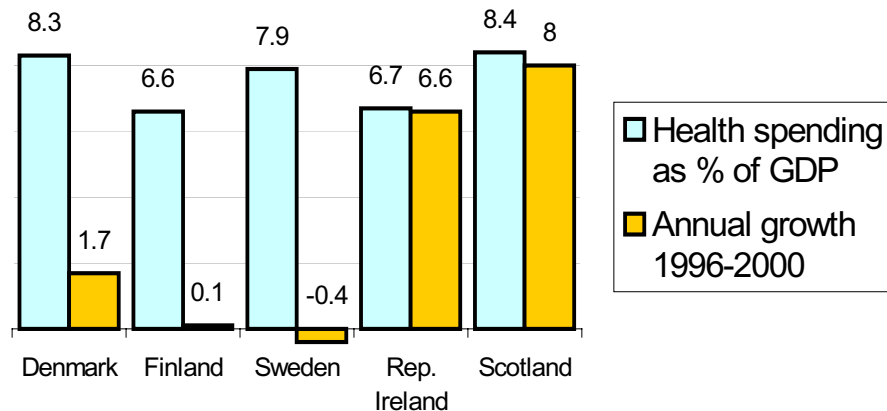
Source: OHE Compendium of Health Statistics 2002. FCEs – Finished Consultant Episodes.

- **Funding is rising fast in Scotland.** This will raise spending on the NHS here to 10-11 per cent of Scottish GDP.

Total spending on health (including private sector) will be 11-12 per cent by 2006. Scotland will be one of the highest spenders in Europe - and far above the 6-9 per cent spent in similar European countries:

Ahead of the pack in spending

Health spending in selected countries (%)



Source: OECD statistics

- The recent and comprehensive Nuffield Hospital Trust Report confirmed yet again that, **“on every measure of resource input, whether it is the availability of hospital beds, the number of doctors and nurses in hospitals and the community or the prescribing of medicines, Scotland’s health care system is better resourced than any other part of the UK.”**⁸

- However, as in England, the increase in funding has not lead to much more activity. The health service is suffering from a severe case of stagflation. Worse, productivity appears to be lower even than in England. **Effectiveness in the use of medical time as measured by ‘Finished Consultant Episodes’ (FCEs) per medical staff is 55 per cent lower in Scotland** (126 a year compared to 196).

- There is little data on how the extra money is actually being spent. For example, it is not known how much is being spent on cancer treatment or other specific areas of care.

- Numbers on **waiting lists have risen** so there are now more than 100,000 people waiting for treatment. Previous pledges to reduce this number to 65,000 have not been

⁸ Woods and Carter loc cit p4.

achieved. Waiting times are likely soon to be much longer than in England even though the level of spending is 20 per cent higher. There is no clear plan for achieving a six months maximum wait by 2005, or three months by 2007.

- **Primary care is affected by under-investment** and has difficulty in offering the necessary depth of services. The level of referrals to hospitals is the highest in the UK. At the same time Scotland has a level of spending on prescription medicines which is 20 per cent higher than the rest of the UK. However there is little information on whether this constitutes value for patients.

- There is a **high level of hospital beds** (50 per cent above the UK average) and high length of stay in them (7.4 days average compared with 5.1 for the UK). There is also a great public attachment to local hospitals. This makes change very difficult, as was reflected in the election of Jean Turner to the Scottish Parliament on a 'Save Stobhill Hospital' ticket.

- There is **lower access to new therapies** in Scotland and greater variability in access. Scotland now has a very serious problem of postcode rationing and even if recommendations are made compulsory in the future it will take a long time to rectify the problems it has created.

Prime examples of rationed therapies are: atypical anti-psychotics; new therapies for Alzheimer's; statins for CHD and new chemotherapy in cancer treatment. For chemotherapy there are differences in the willingness or ability of different boards to fund treatments, which has affected access to new drugs such as *imatinib*, *irinotecan* and *trastuzumab*⁹.

The pattern of expenditure in Scotland's health service towards longer-stay acute care makes for great difficulties for investment in new therapies. The opportunity costs of the current system are much greater than is generally realised and are carried by patients in terms of poorer outcomes and lowered quality of life because of restricted access to new therapies.

- There is an illusion that Scotland has an almost infinite supply of trained and experienced staff. The reality is that Scotland will have many problems in maintaining, let alone

⁹ D.Cameron and JM Dixon. Postcode prescribing is alive and well in Scotland. BMJ 2002 325 101.

increasing, staff numbers **and there are likely to be specific problems in retaining experienced staff**¹⁰.

A high level of retirement is likely. In the next ten years 23 per cent of the nursing workforce will reach compulsory retirement age. In addition, there are signs of a rising rate of early retirement among some key group such as dentists.

The number of trainees in nursing is declining in contrast with the increase seen in England. Much hope for improvement is pinned on managed Clinical Networks. But without much stronger investment at the local level these are in danger of becoming a false hope.

Staff will be less likely to seek employment in services that are seen as backward and where patterns of care are outdated. Staff are working in conditions so that their “productivity” is 50 per cent below the UK average - a situation that involves a waste of scarce professional time and a loss of expertise and job interest. **The performance level of Scotland’s health services reflects a tragic waste of talent and under-use of the country’s excellent trained health staff.**

Treatment & Cure

The Ambition

The principal ambition for NHS Scotland must be to establish a world-class, high quality and effective service. Clients need to have access to services within days or weeks. They deserve to have a choice of services. Health professionals must build new kinds of partnership between patients and professionals. There need to be active disease prevention programmes. The abilities and talents of health professionals should be used to the full so patients can benefit from effective long-term programmes, which maximise support in a community setting. Finally, there ought to be a strong commitment to a patient’s rights to privacy, dignity and respect in their final phase of life.

Given the human and social costs of current waiting times, Scotland should be aiming at a rapid improvement. It would be unacceptable, indeed humiliating, if Scotland were to have more than the European average level of funding but still fall

¹⁰ J.Buchan and I. Seccombe. More Nurses, Working Differently A review of the UK Nursing labour market in 2002.

below that of England post-choice (see below) and far below that of most other EU members.

Scotland should be aiming for a **3 month maximum waiting time** within three years. It is essential to ask of current policies whether they can deliver on this target and so free up investment in new therapies. **There is a serious risk that high growth in NHS funding will not continue beyond 2006.** It is essential, therefore to use this period of high investment to provide improved services and for getting on a learning curve for new therapies, which could reduce admissions and save hospital bed days.

Choice and waiting lists

The development of choice programmes in Scandinavia and early experience of reforms in England point to greater availability of service. A good example is cardiac surgery in the London area where waiting times have fallen to three months. GPs are able to refer patients to wherever service is best and quickest. Hospitals are incentivised to reduce waiting times and attract patients.

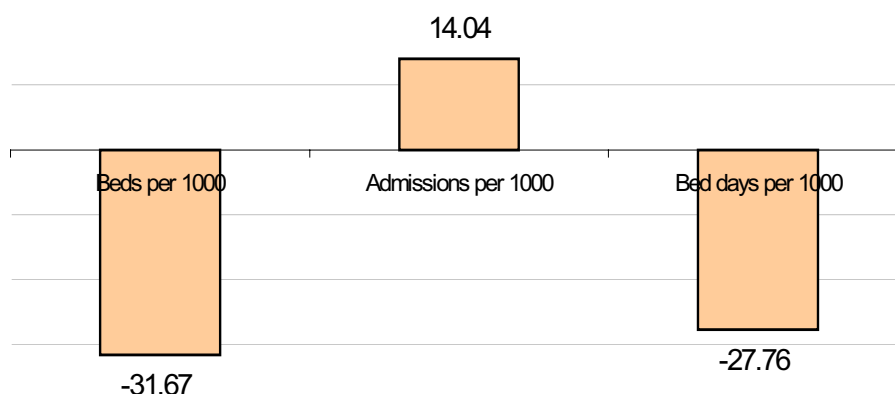
Similar reforms have been implemented in Sweden and Denmark, with dramatic effects. In both countries three crucial steps were taken:

- patients were given greater choice between service providers;
- those providers are funded according to the volume of treatment they undertake, so that money follows the patient;
- and budgets were devolved locally allowing services to respond to these new incentives.

The following chart shows how productivity in Denmark has improved since the reforms. The total number of beds has fallen – but these are used far more efficiently. The result is that total hospital admissions have increased:

More choice leads to greater productivity

Denmark: Changes in hospital usage (%) 1981 - 1995



Source: European Observatory

Scotland can use its NHS funding to give patients access to these new opportunities. The arrival of new private Treatment Centres in England even gives Scotland the chance to enjoy the gains from competition across the border.

There is every sign that the new system in England is going to lead to a rapid fall in waiting times. Unless Scotland develops its own version it will face a double embarrassment: it will have waiting times that are even longer in comparison with the rest of the UK, and it will have failed to secure value for patients from increased health funding. It is imperative therefore to make sure that Scotland can benefit fully from this turn of events. With the increased access to services there is a real possibility of reducing waiting times to three months or less for most patients.

Introducing more choice would be particularly important for deprived areas of Scotland. Direct access to services tends to be worst in such areas. Fortunately, these areas often contain densely populated towns and cities where there is most scope for patient choice.

There is a need not just for a reduction in waiting times but also for an increase in referral rates, which are currently lower in deprived areas. Such changes are much more likely in the context of a general fall in waiting times.

Disease prevention and lifestyle change

However, choice will not be enough for these most deprived areas. A concentrated drive to improve lifestyle and dietary habits is also needed.

There has been much activity over the last decade in terms of increasing emphasis on healthy lifestyles. But the overall results have been quite modest. Smoking rates remain 20-30 per cent higher than in England. There is even some evidence that diet may have worsened given the steep rise expected in obesity. The net effect so far of health promotion has probably been to increase inequalities. Groups that were heeding the message have got healthier while there has been little impact on deprived communities.

The official policy response so far has been to focus on lifetime change starting with schools and the younger generation. This is praiseworthy but the return in better health is going to be a very long time in coming. This surely needs to be complemented by a much stronger drive to reach high-risk individuals in the 30-60 age group. **The new GP contract could be the basis for reaching out to these groups in a much more systematic way.**

There could also be co-operation with community pharmacies on programmes for smoking cessation and weight loss. **The Scottish Executive should develop a major new initiative on healthier eating with the main food retailers and producers** associating the theme with low cost, attractive products. As long as healthy eating is seen as a middle class fad there will be little progress in improving diet. But Scotland could take the lead in appealing to self-interest and in using private/public partnerships in new ways for improved diet.

Inspiration can again be gained from Scandinavia. North Karelia is an area of Finland (on the Russian border) which had some of the worst health statistics in Europe in the 1960s. There has been an action programme over 20 years involving the whole community to change lifestyles, particularly diet and smoking. They also sought to treat high-risk patients by lowering blood pressure. This drive has been successful in moving North Karelia outcomes so that **rates of CHD have fallen by 50 per cent** and life expectancy has improved.

Current strategy on health not enough

Current policies involve changes in structure to abolish hospital trusts and to establish control through health boards. These will increase professional and local government representation on boards. There is also to be devolution of budgets to the clinical level¹¹. These policies are still vague and ill defined, particularly in the area of budgetary devolution and their long-term impact. The aspiration for devolution of power has to be set against the day-to-day reality of greater ministerial intervention. The aspiration of speedy action to deal with the problems has also to be set against the reality of the intractable nature of many of the problems. Thus in the whole of England there are some 3,600 patients who are “blocking beds” while Scotland has 2,200. There is little in the policy mix set for the next crucial five years which will have any impact at all on the underlying problem of productivity - which appears to be the great unmentionable of Scottish health politics.

Seven Steps to better healthcare

Scotland needs to develop a more specific and positive set of policies, which will propel Scotland speedily towards a European level of service and access. This paper proposes seven practical steps that could be taken over the next three years:

One: Introduce choice via GP’s at the point of referral as planned in England from 2005. Every GP would have a choice of four or five different services, including one from the private sector. Payments should be made on the basis of the volume of treatment, so that NHS money follows the person it is there to serve – the patient. This would enable Scotland to make full use of additional capacity across the UK.

Two: Use the new GP contract as the main route for investing in support required for care pathways. This would also allow GPs to give a more effective lead in lifestyle change and disease prevention as part of a major drive on diet and lifestyle in conjunction with pharmacies, food companies and government. This would also have the aim of reducing referrals and lessening the Stobhill factor by providing alternatives to acute hospital admission. There is already a positive strategy on primary care¹².

¹¹ NHS Scotland. Partnership for Care. Scotland’s health White paper. Scottish executive. 2003.

¹² Primary Care Modernisation group. Making the Connections. Developing best practice into Common practice. 2002

Three: Progress rapidly on devolution of budgets to health boards and to care units. There is much to learn from Scandinavian countries about gains from real decentralisation and budgetary responsibility.

Four: Increase funding for voluntary organisations. They have already shown what can be done in palliative care.

Five: Increase survey information available on the actual experience of patients in Scottish health services. Scotland has been a pioneer of longer-term outcomes analysis but there has been little development on patient surveys or of standards for improving the patient experience. Such information is vital in allowing informed GP and patient choice.

Six: Develop within 12 months a much more focused investment programme on intermediate care, including budget pooling with partners in social services and the private and voluntary sectors to deal with the problem of bed blocking which is such a major feature of the Scottish scene.

Seven: Scotland needs to become a leader for international health research. There is no need to go back into the mists of the more distant past with Lind and Lister. As recently as the 1950s Scotland was a world leader in a number of areas including the development of ultrasound, geriatrics, community based maternity care in Aberdeen and knowledge about diet and nutrition.

These steps would improve access and choice for patients in Scotland without requiring further drastic structural change to the NHS. They focus on the *delivery* of healthcare rather than its financing. They do not involve introducing systems of insurance, charging or other forms of private payment, which may have merits but would require far greater upheaval and political controversy. These reforms are designed to be relatively easy and quick to implement.

There is a golden opportunity over the next three years for radical improvement in access and quality to health services for the people of Scotland. Scotland has the people and the resources required to make this happen. Can it find the motivation and drive to improve results and maximise value for patients from the Scottish health pound?

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