3.3 Utilisation and activity[38]

While the population's health is a central factor explaining the level of use of health services, it is important to bear in mind that the use of services is a reflection not only of the need for care, but also the availability of services; demand (need) is not always independent of supply. In this section we examine secondary care utilisation and activity (including the independent sector). Subsequent sections examine family health services and personal social services and contain a wider ranging discussion of funding and organisation of these sectors.

3.3.1 Hospital activity

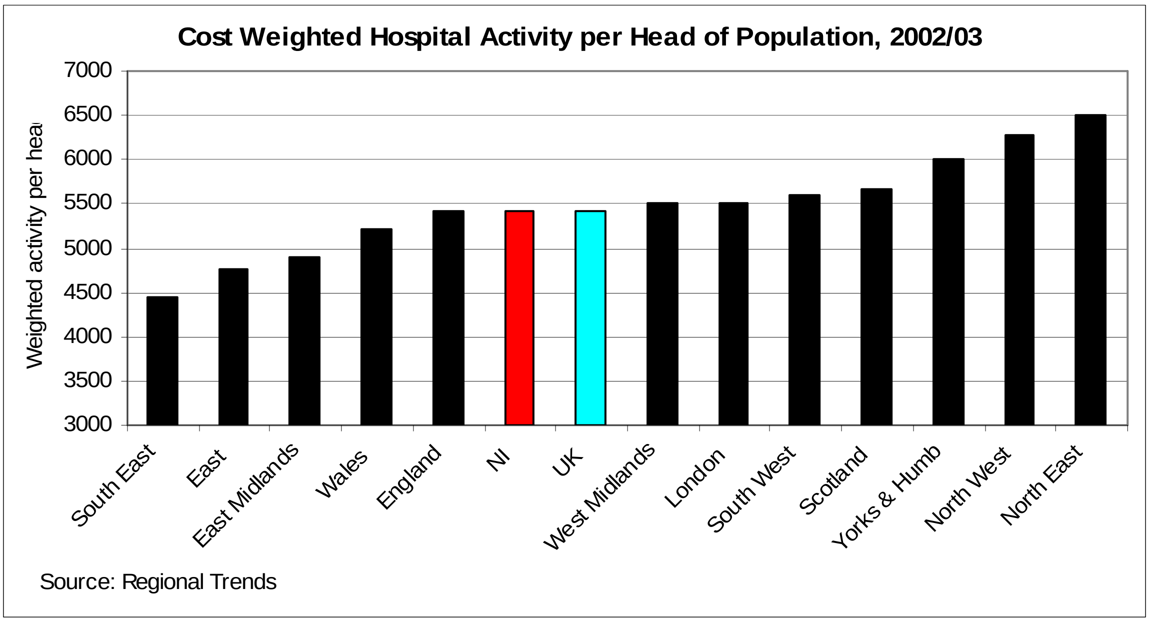
Figure 3.9 sets out an aggregate measure of secondary care activity in terms of inpatient, day case, out-patient and A&E attendances per head of population, weighted and summed on the basis of unit costs[39]. It can be seen that on this measure, Northern Ireland has a very similar level of aggregate hospital activity to England and marginally lower than the UK as a whole (see Box 3.1 regarding differences between published activity statistics and those used in this Review).

Box 3.1: Hospital activity data

Publicly available information on hospital activity has, from 1998/99, included data on renal dialysis treatments. These number around 33,000 deaths and discharges in 2003/04 - equivalent to around 10% of all inpatient cases across Northern Ireland. While these cases have been included in published statistics for hospital activity in Northern Ireland, here we exclude them as they distort comparisons (and time trends) as such cases are not included in the inpatient activity statistics for Great Britain. This exclusion has a significant impact on activity trends and productivity measures noted later in this review.

[38] In this section the terms utilisation and activity are used interchangeably.
[39] This is similar to the cost weighted activity index (CWAI) used in aggregate measures of efficiency and enables the aggregation of activities measured in different units - attendances, hospital stays etc.

Figure 3.9: Aggregate cost-weighted hospital activity per head of population in Northern Ireland is slightly below the UK average, 2002/03.

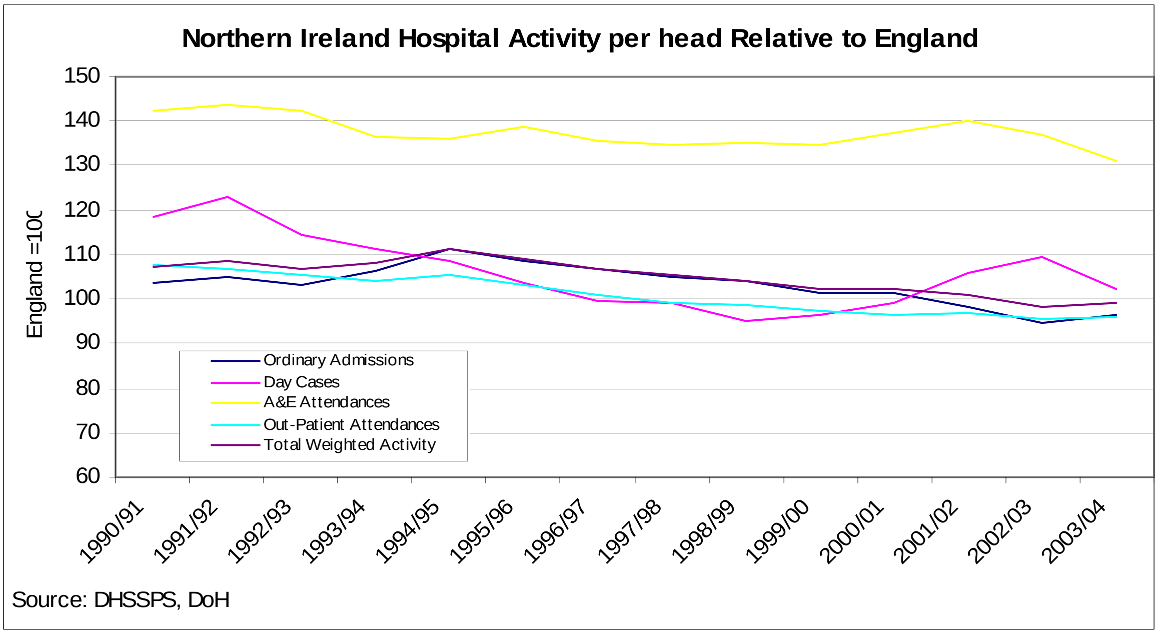


However, this aggregate measure of hospital activity masks an important difference with England. In particular, figure 3.10 shows that the level of accident and emergency attendances per head of population in Northern Ireland is 31% higher than in England[40]. Why this should be so (and indeed, why this has remained the case for many years) is not clear. Higher levels of provision and deprivation, a culture of using A&E in preference to general practice and problems with out of hours GP services have been offered as explanations, but to the knowledge of this Review there have been no in-depth studies or analysis to verify these explanations or explore the appropriateness of this level of A&E utilisation.

Recommendation 9: Further investigation is required of very high A&E use to explore reasons and find ways for reducing likely inappropriate use

[40] Provisional figures for 2004/05 indicate that the gap between Northern Ireland and England has fallen to 28% although A&E attendances in Northern Ireland still rose by 1.7% over the year.

Figure 3.10: The number of A&E attendances per head of population is 31% higher in Northern Ireland than England whilst there are 4% fewer out-patient attendances.



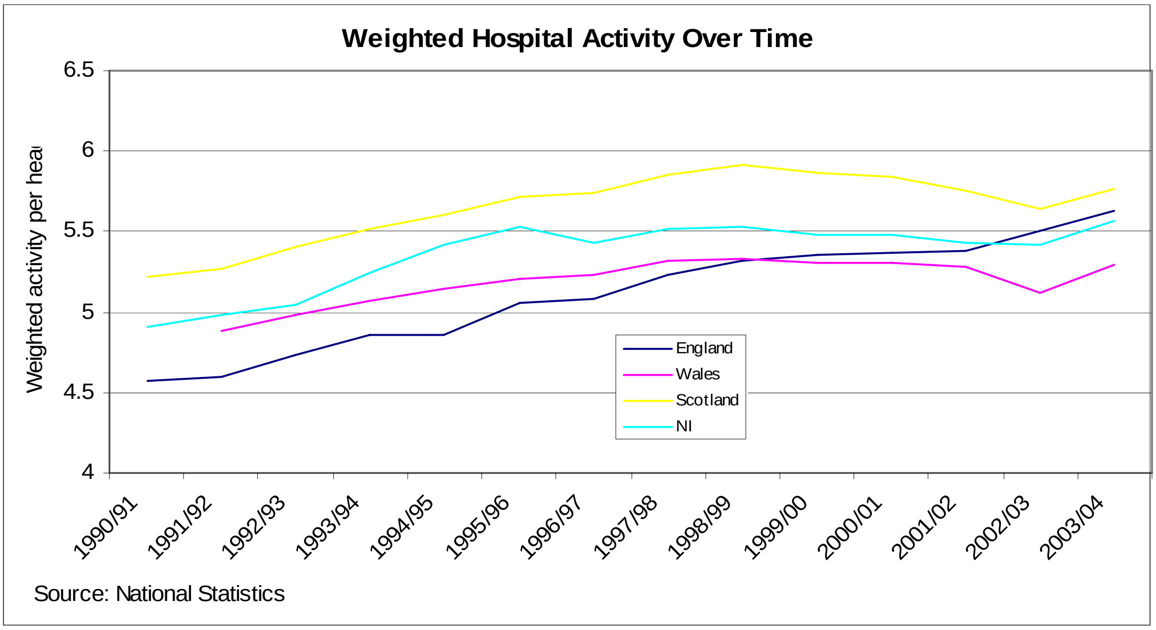
As for change in hospital activity over time, Table 3.2 shows that over the past decade there has been significant growth across the UK, with the rate of growth being highest in day cases and lowest in A&E. Unadjusted hospital activity in Northern Ireland has increased at a faster rate than in Scotland, but more slowly than England and Wales. However, once the higher weighting given to inpatient activity is incorporated, then Northern Ireland has had the second fastest growth in hospital activity

Table 3.2: Annual average growth in hospital activity, 1990/91-2003/04

	England	Scotland	Wales	NI
In-Patients	1.3	0.5	0.5	0.9
Day Cases	9.9	5.1	8.8	8.9
A&E	0.8	0.4	0.9	0.3
Out-Patients	1.7	0.1	1.6	1.0
Weighted total	1.9	0.7	0.8	1.5

Growth in utilisation and activity since 1990 has not been even, however. As figure 3.11 shows, most of the growth in activity occurred in the early part of the 1990's with slower growth subsequently. Since 1990/91, activity levels per head of population in Northern Ireland, Scotland and Wales have moved broadly in tandem, with little or no growth since 1997/98. However, levels of activity in England have been on a continual increase since 1996/7.

Figure 3.11: Scotland, Wales and Northern Ireland have not experienced significant growth in weighted hospital activity per head of population since 1997/98.



The trends in activity for Scotland, Wales and Northern Ireland show, as figure 3.11 indicates, a distinct change more recently, with sharp increases in 2003/4.

This increase in 2003/4 is also noticeable in trends for Northern Ireland in ordinary, and day case admissions and outpatient attendances (see figure 3.12). Figure 3.12 also shows that whilst the total number of ordinary admissions is now close to the level it was a decade ago, this has followed a nearly continuous decline since 1995/6.

Disaggregating ordinary activity further, shows, in figure 3.13, that the rise in ordinary activity in 2003/4 was wholly attributable to an increase in the number of emergency admissions to hospital. Importantly, the number of *elective* admissions - which include admissions from waiting lists - has been steadily falling since the mid 1990s and is now nearly a quarter lower than it was in 1994/5. This trend in elective admissions provides part of the explanation for the growth in waiting lists and times examined in more detail in section 3.6.

Recommendation 10: Detailed analysis is needed into hospital activity trends as part of a broader analysis of the dynamics of waiting times and lists.

Figure 3.12; There was a significant increase in all forms of hospital activity in Northern Ireland in 2003/04

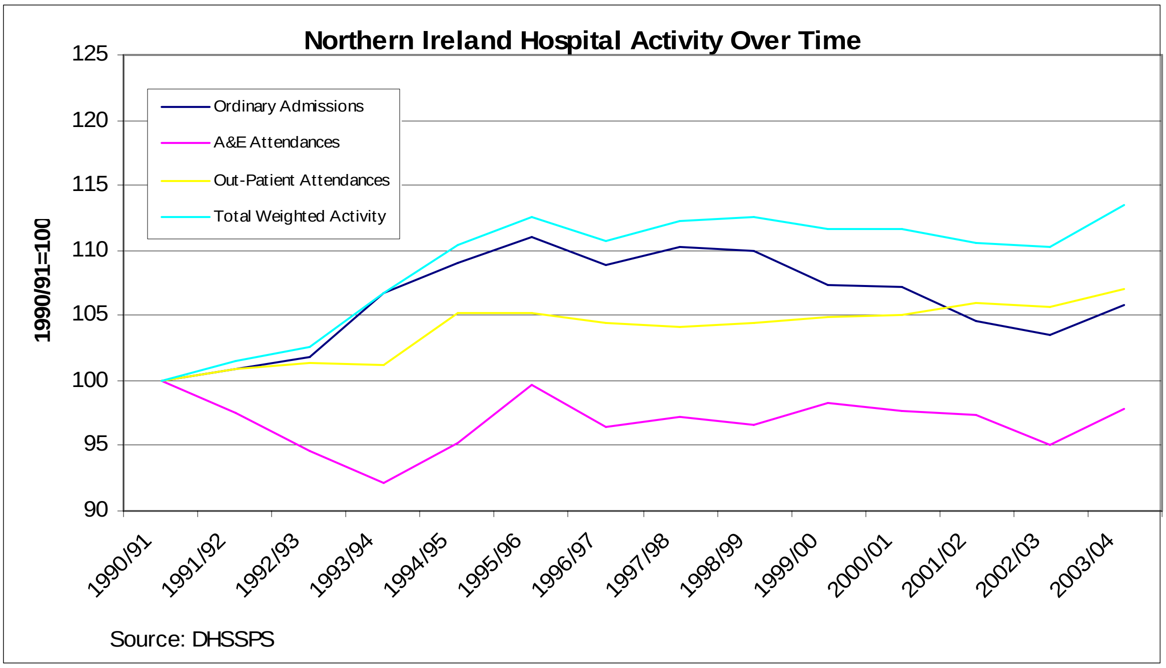
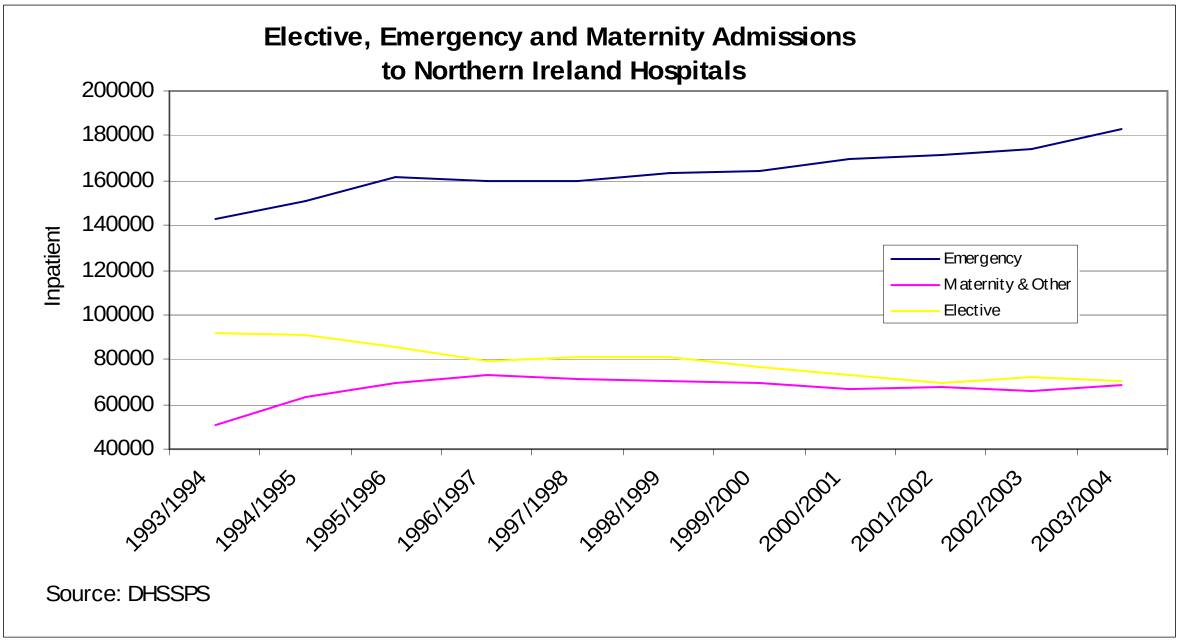


Figure 3.13: The number of emergency inpatient admissions has increased by 23% since 1993/94 whilst the number of elective admissions has fallen by 24%.



3.3.2 Private sector health & social care[41]

Despite recent growth, the private sector contributes only a small proportion of health care activity in the United Kingdom and an even smaller share for Northern Ireland. The private sector has the potential to benefit the health care system through raising

[41] Although the main focus here is on hospital activity, the private sector also has a significant role to play in the provision of nursing homes places as well as community/social care packages.

capacity, and, given a competitive economic environment, increasing pressure on public sector providers to improve performance by providing an alternative to the public sector[42]. However, private healthcare providers can also have a detrimental impact by exacerbating staff shortages in the public sector as well as creating financial uncertainty.

Prior to 2000, the Government's policy in England was to oppose any expansion of the use of the private sector to provide clinical services to NHS patients. However, with the publication of the NHS Plan and the identification of short term NHS capacity constraints as a hurdle in tackling waiting times targets set by the Plan, the purchase of private sector capacity by the NHS on behalf of NHS patients was seen as a way forward. By the end of 2005, private providers will carry out 4 per cent of publicly financed elective treatments in England, rising to 15% under Government plans[43]. There are no immediate plans for the Northern Ireland health & social care sector to follow such an approach, despite having longer waiting lists. Whilst acknowledging that in the coming years an increased number of patients will be treated in the private sector, the DHSSPS Regional Strategy for 2005-2025[44] raises concern regarding competition for staff.

The distinction between the public and private sector can be defined in terms of payment and provision. In terms of payment, 10% of all households in Northern Ireland have Private Medical Insurance whilst in Great Britain the range is from 8% in the North-East of England to 26% in the South-East, with a UK average of 17%[45]. In terms of provision, there are currently only two private hospitals in Northern Ireland with a total of 84 beds. This equates to approximately 0.05 beds per 1,000 population compared to 0.18 for the UK as a whole and 0.11 in Wales.

Private activity also takes place in public sector facilities. And in addition, Health Boards purchase treatments on behalf of the NHS from private health care providers not only in Northern Ireland but Great Britain and the Republic of Ireland as well.

Private activity in Northern Ireland's HPSS hospitals accounted for 1.4% of all finished consultant episodes in 2003/04, and 0.6% of out-patient attendances. Over half of all these outpatient attendances were for two specialties, gynaecology and cardiology.

[42] But this depends on how competitive the private sector is. For example, the NAO Wales report into NHS waiting times found that the average private sector costs for certain procedures was higher in the NHS whilst private treatment centres in England are being paid at rates above the national average.
[43] Source: The Economist 9-15 April 2005
[44] DHSSPS: A Healthier Future, A Twenty Year Vision for Health and Well-being in Northern Ireland 2005 – 2025
[45] Source: Family Resources Survey 2002/03

***Table 3.3: Northern Ireland NHS hospitals treat a higher proportion of patients privately than in England or Wales.*[1]**

	In-Patients	Day Cases	Out-Patients
Northern Ireland	0.7	2.9	0.6
Wales	0.3	1.1	0.3
England		0.9	0.5

Source: DHSSPS, NAW, DoH
NI data is for 2003/04 whilst England and Wales are for 2002/03

Whilst this is a relatively small proportion, it is higher than in England and Wales (see table 3.3). However, the level of NHS income derived from private patients per head of population in Northern Ireland is less than half that for the UK as a whole[46]. This would suggest that either private activity in Northern Ireland hospitals is less costly than in Great Britain or that the HPSS is not charging the full economic cost for the use of facilities. Over the past five years, whilst the number of private day cases in Northern Ireland hospitals has fallen by 3%, the number of in-patients has increased by 13% and out-patients by 42%.

In 2003/04, Health Boards spent £10m on the treatment of 3,000 patients transferred to private health care providers - mainly as part of initiatives to reduce waiting lists[47]. This is equivalent to around 4.4% of the elective inpatient finished consultant episodes carried out in the HPSS in 2003/04. Whilst the number of patients treated under these initiatives has increased by 64% since 2001/02, expenditure has risen by 125%. The cost per treatment appears to be higher under these waiting list initiative than the unit cost for elective procedures in the HPSS. There is also some variation in cost between Boards[48]. Although this may simply reflect differences in case mix, in light of the concerns raised by the Welsh Audit Office[49] with respect to the use of private provision by the NHS in Wales it is important that this spending is audited for value for money.

Whilst the private sector remains a relatively insignificant provider in terms of the entirety of health service provision in Northern Ireland, at the margins it can make an important contribution to certain areas, in particular in tackling waiting lists[50]. However, while purchasing NHS care from the private sector can add a useful element of flexibility, value for money remains a stumbling block to any long term use of this capacity.

The impact on overall effectiveness of private activity in HPSS hospitals depends on the extent to which it represents additional capacity as opposed to an inequitable skewing of resources towards those who are willing and able to pay. In addition, whilst the treatment of HPSS patients in private health care facilities may represent a

[46] Laing's Healthcare Market Review estimate NHS income from private patients to be £408m in the UK in 2003/04 whilst HPSS income generated from private patients in NI for 2003 was £585k (Source: DHSSPS).

[47] Waiting list initiatives accounted for 98.2% but only 78.2% of spend as the remaining treatments were under Extra Contract Referrals where patients are referred to private healthcare providers as the specialist treatment they require is not available locally in a NHS hospital.

[48] In 2002/03 the cost per treatment under private health care Waiting List Initiatives was £2,600 (range £1,739-3,982 between Boards) whilst the unit cost per elective FCE was approximately £1,800.

[49] : NHS Waiting Times in Wales Volume 2 Tackling the Problem, National Audit Office Wales

[50] There were more people treated under private health care Waiting List Initiatives in 2003/04 (2,908) than there were Excess Inpatient Waiters in December 2004 (2,381)

pragmatic approach to supply constraints, it is important, as noted earlier, that value for money is achieved.

The level of private sector provision depends on a range of factors, including income levels, service provision in the public sector and Government policy. The current relationship with the private sector appears to have grown more out of necessity than design. It is important that there is clear direction from DHSSPS as to the role of private health care providers in the broader Northern Ireland health & social care sector so that their capacity and capabilities can, where appropriate, bring most benefit to patients.

Recommendation 11: DHSSPS to develop a more coherent strategy towards partnership with private sector

3.3.3 Cross Border Co-operation

The Republic of Ireland (RoI) has a different system of health and social care from that in Northern Ireland, with service users in the RoI having to pay for treatment provided free north of the border. For example, there are charges for GP appointments and hospital attendances - although around a third of the population are entitled to free health care and there are limits on the cost of services provided by the state. In addition, a large proportion of the population in the Republic of Ireland are privately insured (in which some Northern Ireland Hospitals participate[51]). Eligibility for care in both jurisdictions depends mainly on residency, although there are a number of exceptions under EU regulations, such a cross border workers.

In 2001/2, there were 2,430 RoI residents treated in Northern Ireland hospitals - under 1% of the total hospital activity in Northern Ireland. In comparison, 902 Northern Ireland residents were treated in RoI hospitals in 2002, equivalent to 0.17% of admissions. However, around 90% of the activity involving RoI residents in Northern Ireland hospitals is paid for either privately or through contracts between health boards. In addition, emergency treatment is covered by a reciprocal arrangement between RoI and Northern Ireland. Whilst Northern Ireland trusts do receive payment for non-emergency activity from the Republic of Ireland there is a question, as with private activity in general, as to whether the full economic cost is being charged.

The main cross border health and social care initiative is ‘Co-operation and Working Together’ (CAWT), which was established in 1992 by the four health boards located along the border between Northern Ireland and the Republic of Ireland, to facilitate cross border co-operation.

Through CAWT, the Southern and Western Health and Social Services Boards in Northern Ireland and the North Eastern and North Western Health Boards in the Republic of Ireland agreed to co-operate in order to improve the health and social well being of their respective populations. Recent projects have been taken forward in the area of emergency planning and pre-hospital emergency care.

However, the projects to date appear to have been rather small scale, not involving major issues such as the location of hospitals specifically to provide services on both

[51] Royal Victoria Hospitals, Altnagelvin and Daisy Hill.

sides of the border. Although this issue was considered by the Acute Hospitals Review Group in terms of the provision of hospital services in the south-west of Northern Ireland, there appears to have been very little in the form of joint planning of hospital services.

Given the relatively small scale of the health & social care system in Northern Ireland it is entirely sensible that services are provided on a cross-border basis where appropriate. This would ensure that as broad a range of services can be provided as close to patients as possible. Whilst there is reluctance on the part of some patients in border areas to access services in the Republic of Ireland, it does not make economic sense to, for example, have two small hospitals on either side of the border when one larger hospital could provide a better service to both communities.