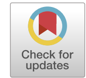
The return of inverse care: Case study of elective hip surgery



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A new paper has found that inequalities in access to treatment for elective hip replacement have increased for the poorest groups compared with the richest group in England over a ten-year period from 2006 to 2016. This is not the case for Wales. Wyatt, Rowena, Moore and Revell investigate inequalities in access through the prism of hip replacement, a highly cost-effective elective operation.[1] The authors estimate need for hip replacement for England by applying the Oxford Hip Score to data from the English Longitudinal Study of Ageing for the years 2006, 2008, 2010, 2012, 2014 and 2016 and for each deprivation quintile. Using negative binomial regression modelling they calculate age and sex adjusted incidence risk ratios for need. They compared need for hip replacement for patients living in the most and least socio-economically deprived parts of England with the middle quintile, the reference group. They found that the most deprived group were 136% and 148% more likely to need a hip replacement in 2006 and 2016 respectively where as their counterparts in most affluent areas were 55% and 34% less likely in 2006 and 2016 respectively.

Using routine hospital data from NHS England Hospital Episode Statistics and NHS Wales Patient Episode Dataset to analyse socioeconomic differences in NHS funded elective treatment rates they found that, compared with the middle quintile reference group, patients in the most deprived areas of England were 19% and 20% less likely to receive a hip replacement in 2006 and 2016 respectively. Conversely, the least deprived group were 5% less likely and 3% more likely to receive treatment in 2006 and 2016 respectively.

A key limitation of the study is the lack of need measures for the Welsh population as survey data from the English Longitudinal Study of Ageing was used to derive need for each deprivation quintile of Wales. Other limitations include sample sizes impacting on precision of estimates for older people, differences in deprivation measures between England and Wales and imperfect alignment between the survey data and Oxford Hip scores used to determine need for surgery.

The question that arises from these figures is, what has been the impact of English NHS reforms since 2002?

Since 2002, government policy in England has been to increase the use of the private sector in the NHS for elective surgery and diagnostics. This is not the case in Wales. Our own analysis of Hospital Episode Statistics has found that in the last quarter of 2018/19, 33.5% of NHS funded elective hip replacements were performed by the private sector. We don't have comparable data for Wales. In 2012 the policy of NHS contracting to buy in private sector provision became mandatory in England.

Instead of rebuilding the critical lack of NHS capacity exposed by covid and manifest as rising waiting lists,[2] government policy is to use the private independent sector to fill the gap. Its "National Increasing Capacity Framework" anticipates annual spend of £2.5 billion on elective activity from independent sector providers which is almost double the spend in 2018 and 2019.[3] At the same time, NHS hospitals in England are now permitted to generate up to half their income from private activities, such that up to half the NHS beds and capacity and workforce can be dedicated to private patients.

In 2006, the then president of the Royal College of Surgeons Bernard Ribeiro warned that the policy of using the private sector was "leaving existing NHS facilities under-utilised with a concurrent deleterious effect on fragile NHS Trust financial balances."[4]

Current research[5,6] is overturning earlier conclusions that pro-competitive policies were having positive effects in the NHS.[7] Wyatt et al's findings of no improvements in inequity and worsening secondary care inequality in England in 20 years of marketisation should be a red flag for further market reforms. Our own research has shown that in both England and Scotland, NHS funded private provision has both substituted for NHS provision and favoured patients living in the most affluent areas.[8,9]

Recent research found that for each one percent annual increase in NHS outsourcing to the private sector, the annual increase in treatable mortality was 0.29 deaths per 100,000 population. Since 2014, outsourcing was found to be associated with an estimated 557 additional treatable deaths across the 173 Clinical Commissioning Groups analysed.[10]

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The Health and Care Act 2022 for England places a duty on each integrated care board to reduce inequalities in patients' ability to access health services and in the outcomes achieved by them. Julian Tudor Hart's inverse care law states that the "availability of good medical care tends to vary inversely with the need for it in the population served" and "operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced."

Current research into market driven health care policies in England suggest that access to health care will increasingly be available on the basis of ability to pay and not need.

Contributors

Graham Kirkwood and Allyson Pollock cowrote the commentary and revised drafts between them.

Declaration of interests

Neither author has relationships/activities/interest to declare.

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