King's Fund

Briefing

MAY 2007

Health and ten years of Labour government

ACHIEVEMENTS AND CHALLENGES

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Funding

NHS funding is now growing at more than 6 per cent in real terms a year – double the average achieved in the NHS over the last 20 years. We are increasing health spending faster than any other major country in Europe.

Tony Blair, 6 December 2001

Undoubtedly these years of Labour's government will be remembered for the decision to spend substantially more on the NHS over a sustained period of time. Between 1949/50 and 1999/2000 annual spending on the NHS had increased by an average of 3.4 per cent (in real terms). By contrast, from 2000/1 to 2007/8 there was an average annual growth rate of 7.8 per cent (*see* Figure 1, overleaf). Although those rates of growth are not expected to continue beyond 2008, they have moved the UK's level of spending much closer to the European average, fulfilling a promise made by Tony Blair in January 2000 (*see* Figure 2, overleaf).

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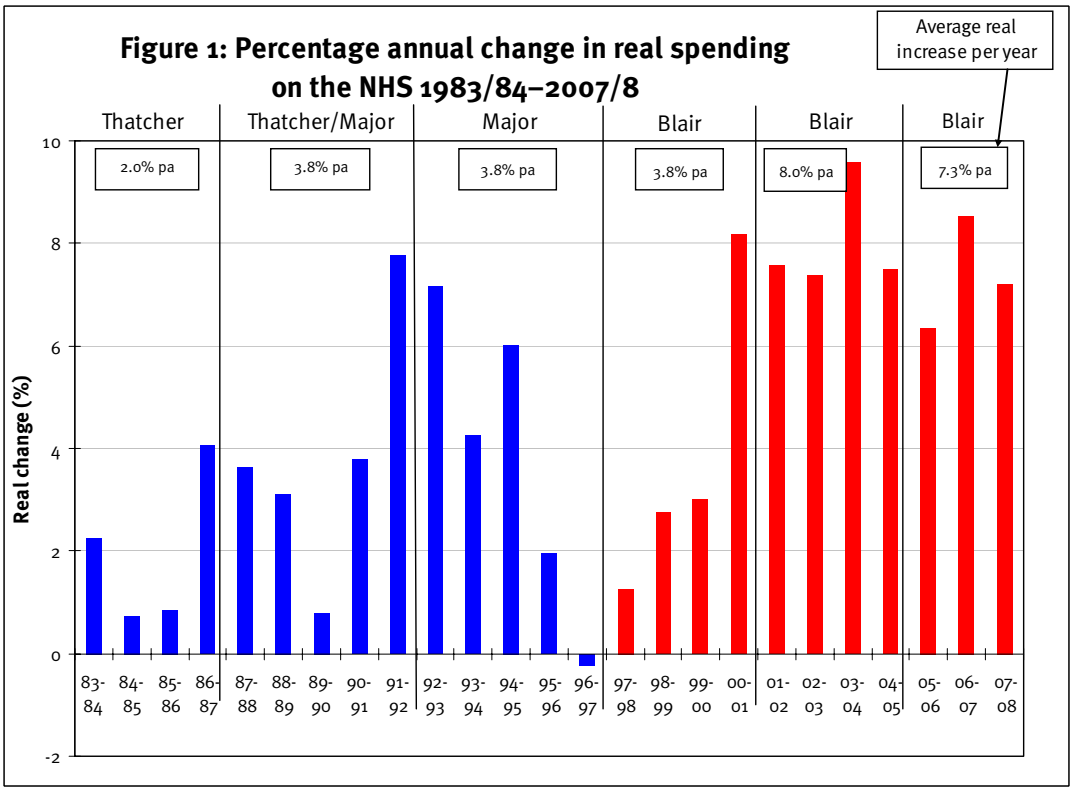
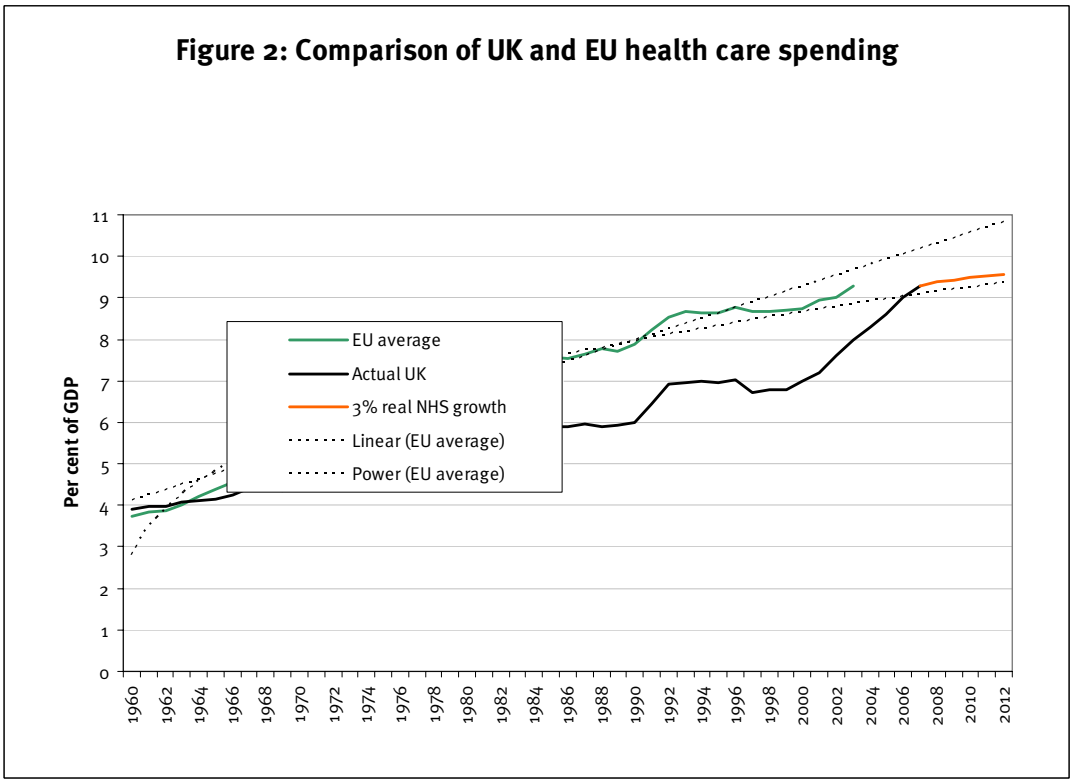


Source: King's Fund analysis of UK government data
Note: This is an updated UK NHS real (ie GDP Deflator deflated) spend series. Figures from 1987–005/6 are taken from the 2006 PESA report (HMT), table 3.2 (http://www.hm-treasury.gov.uk./media/376/8A/cm6811_04_Chap_3.pdf). Earlier figures come from various Department of Health reports, and later figures from government spending plans.



Source: King's Fund analysis of OECD and UK government data
Note: Projections of EU spending beyond 2002 are shown on the broken lines, both of which fit the historic data. The difference between them is a reflection of the uncertainty surrounding future spending trends.

Figure 2 shows that by 2005/6 the UK caught up with the projected EU average for the same years (at least according to one projection of the EU average weighted spend, as figures for the 15 EU countries are only available up to 2002). The figures also show that the UK is likely to maintain that position against the same EU weighted average projection even when growth rates drop back to the expected level of 3 per cent annual average change.

No one in government believed that extra money alone would solve the problems of the NHS (the accompanying reform plans are described later in the briefing). Nevertheless, making the case for such a big increase in funding was a bold political move. However, any sense of achievement that this increase in funding represents has been tempered by the fact of deficits in the NHS in England. Although the NHS is projecting a small net surplus this year, the past two years have seen serious financial difficulties in a minority of trusts. Results from the Healthcare Commission's annual health check showed that that 37 per cent of trusts failed to manage their finances adequately for the year to 31 March 2006 (Healthcare Commission 2006).

The public and the media find it hard to believe that despite the unprecedented increases in funding, some parts of the NHS have been forced to cut services in an effort to save money.
Deficits have also re-opened the much bigger question of whether Labour, as it promised in 1997, has really 'saved' the NHS or merely postponed its demise. The government and the NHS are now coming under increasing pressure to show (more clearly than they have been able to do so far) that they are making effective use of the resources at their disposal. The absence of good measures of productivity have not helped.

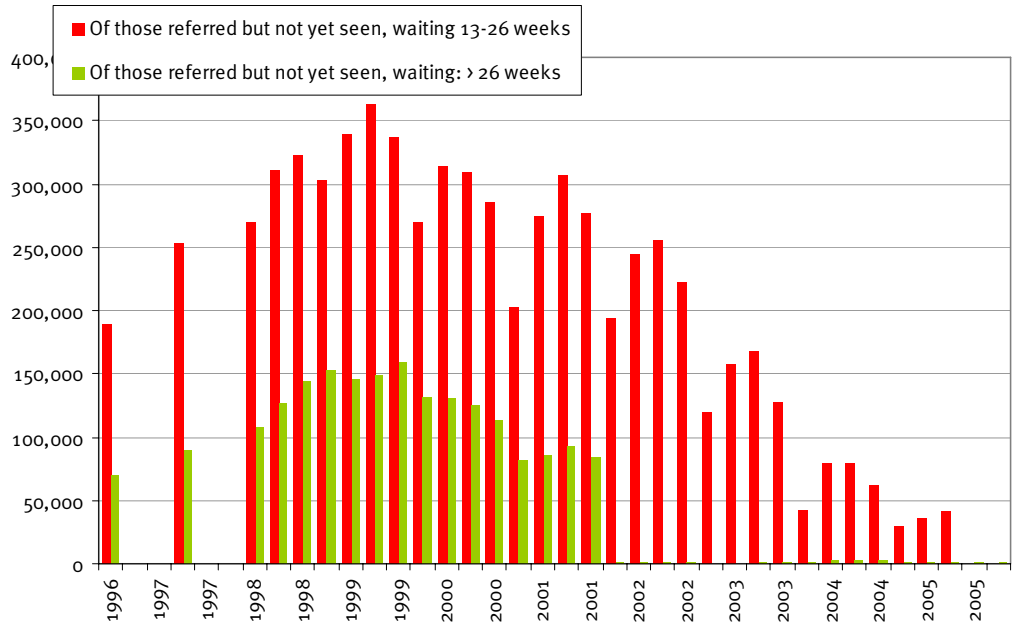
Waiting times

When you ask patients what they think is wrong with the NHS, what tops the list every time is the amount of time spent waiting. Waiting for a doctor's appointment, in casualty, for test results, for an appointment with a consultant or for an operation. Most people are happy with their treatment when they receive it, but get frustrated with the length of time they have to wait.
Tony Blair, 13 October 1999

The whole purpose of it [reform] is to make sure we get to the pledge that we have made for an 18-week maximum as an outpatient by the end of 2008, which will effectively end the concept of waiting.
Tony Blair, 22 November 2005

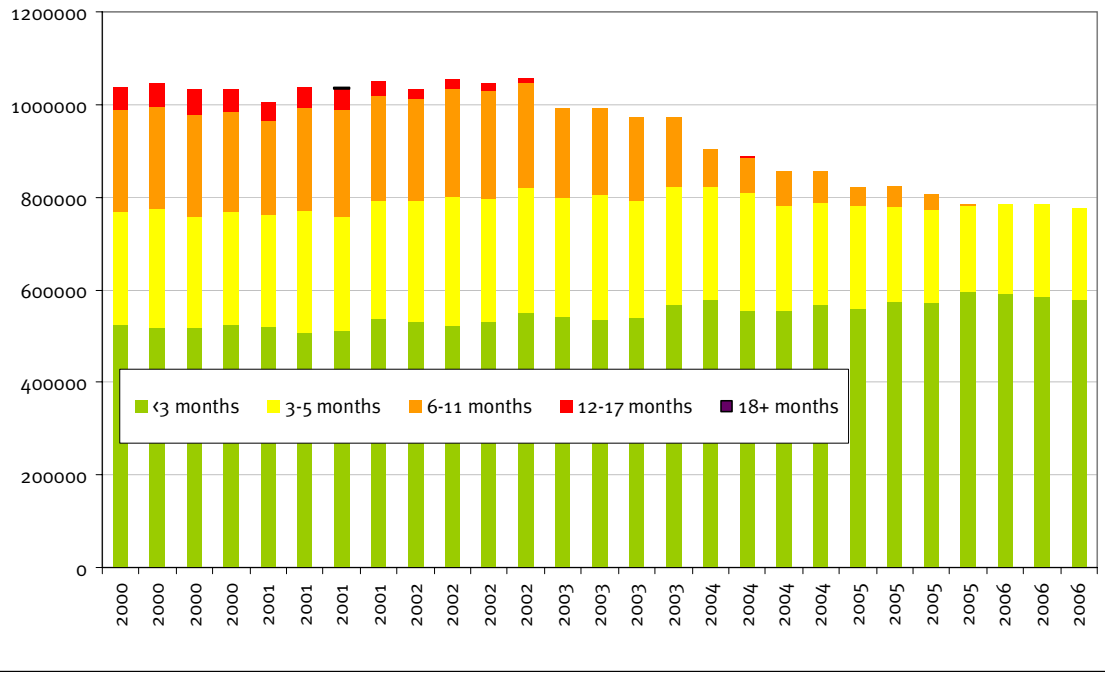
Since 1997 the government has perceived long waiting times faced by patients as the main failing of the NHS. Strategies to tackle waiting have dominated NHS policy for 10 years and the results have been considerable. The government set a series of ambitious targets in the NHS Plan in 2000 (Department of Health 2000) and these have since been achieved: by the end of 2005, the maximum wait for an outpatient appointment was successfully reduced to three months from more than six months in 2000, and for inpatient treatments to six months from 17 months in 2000 (*see* Figures 3 and 4, overleaf). This progress has so far been sustained into 2007 (Department of Health 2007d).

Figure 3: Outpatient waiting times: England, 1996–2005



Source: King's Fund analysis of Department of Health data

Figure 4: Inpatient waiting times: England 2000–2006



Source: King's Fund analysis of Department of Health data

Waiting times in Scotland and Wales offer some context for England's achievements in this area. Scotland matched England's achievement of maximum inpatient waits of six months by the end of 2005 and by the end of 2006 was outperforming England, having reduced maximum waits to four months (ISD Scotland 2007a). However, their target for outpatient waits was twice as long as England's; a maximum wait of six months by the end of 2005 compared to England's three (ISD Scotland 2007b). The story in Wales, where waiting times were not prioritised until more recently, has been less impressive. While Scotland and England achieved maximum waits of six months for inpatients at the end of 2005, Wales only just hit its target of a maximum 12-month inpatient wait in April 2006. Targets in Wales were recently met for a maximum wait of eight months for inpatients and a maximum of eight months for outpatients by the end of March 2007 (Statistical Directorate, National Assembly of Wales 2007).

The government set a further, more ambitious target for England in 2004: to reduce to 18 weeks by 2008 the maximum wait from GP appointment to treatment, including previously 'hidden' waits for diagnostics and referrals between consultants. The first data on this full wait were published at the end 2006 and revealed that only 35 per cent of patients were currently admitted in this time (18 Weeks website 2007). Achieving this target will be a significant challenge for many NHS organisations and is likely to be the principal policy focus for NHS organisations over the coming year. Combined with maintaining standards against existing waiting time targets and including the cost of buying extra diagnostic tests, reaching the 18-week target is expected to account for around a third of the additional funding earmarked for NHS resources in 2007/8 NHS (King's Fund analysis of data provided by Department of Health under the Freedom of Information Act).

Access targets have been set in other areas and have been broadly met. The NHS Plan target that by 2004 all patients attending accident and emergency departments should be treated, discharged or admitted within four hours of arrival was missed only very narrowly. In the first quarter of 2005, 97 per cent of patients were seen within this time. Data for the end of 2006 show that the proportion of patients seen in this time has been sustained (Department of Health 2007c).

The proportion of patients with suspected cancer who are seen by a specialist within two weeks of a GP's urgent referral increased from less than two-thirds in 1997 to 99 per cent in 2006 (Richards 2007) and the target for all patients with cancer to receive treatment within 31 days of diagnosis by the end of 2005 was met in 97 per cent of cases (Department of Health 2006c).

The NHS Plan also set an access target for primary care – all patients should be able to see a GP within 48 hours – which was the subject of some controversy. Complaints that the target had led to GPs not allowing patients to book appointments more than two days in advance prompted the government to introduce a new 'guarantee' that patients should also be able to book advance appointments (Department of Health 2005c). Furthermore, initial reports on compliance with the 48-hour target published by the Department of Health contrasted with the reported experiences of patients: Lord Warner (then health minister) reported in May 2005 that 99 per cent of patients were now able to book a GP appointment within 48 hours (Department of Health 2005a), but a Healthcare Commission survey of patients published in July that year reported that about a quarter of patients were unable to get an appointment within the target time (Healthcare Commission 2005b). An independent patient survey conducted by Picker Institute Europe for the Department of Health found that, in 2006, 88 per cent of patients had been given the chance of seeing a GP within 48 hours but that 30 per cent reported not being able to book an appointment more than two days in advance – a figure unchanged from 2005, despite the government's introduction of the advance booking 'guarantee' (Picker Institute 2007).

In policy terms, the search for speedier treatment has driven other innovations. These include the establishment of NHS Direct and NHS walk-in centres. The current patient choice initiative originated from pilots designed primarily to allow patients to opt for faster treatment in alternative hospitals. There has been increasing use of the independent sector in the pursuit of faster overall treatment,

initially as a source of additional capacity in existing private hospitals, but more recently to deliver new sources of surgical and diagnostic capacity in bespoke treatment centres.

It is difficult to assess the scale of the contribution made by these independent sector treatment centres (ISTCs). However, they have contributed a relatively small number of procedures when compared to the number performed in NHS facilities, and Bob Ricketts, a senior official at the Department of Health, told the House of Commons Health Committee that even in ophthalmology, where the size of the contribution made by ISTCs was large relative to other clinical areas, the reduction in waiting times for cataract operations was attributable to NHS facilities and not to the ISTC programme (House of Commons Health Committee 2006a).

Few would criticise the huge achievement of reducing waiting in the NHS, but the relentless pursuit of this policy objective has had some downsides. Although there is little evidence that targets have caused actual harm to patients through 'distortions' of waiting lists (Appleby *et al* 2005), the priority that NHS trusts have had to give the targets has, on occasion, caused resentment among some clinicians (British Medical Association 2007). In addition, some targets have unintended, negative consequences – for example, the target of 48-hour access to a GP appointment restricted advanced booking of GP appointments .

It might also be argued that the focus on 'speed of treatment' has obscured a potentially more important focus on the overall 'value' or effectiveness of treatment for patients, a focus that is gaining in importance as funding growth slows. Although reducing waiting times was a top priority for the public (and therefore important for the government to respond to) the quantifiable overall 'health gain' from pursuing shorter waits has proved surprisingly small (Department of Health 2005b), perhaps because the excessive (and unacceptable) waiting times were experienced by a minority of patients (the majority of patients have been treated reasonably promptly). As waiting times continue to fall, any future plans to reduce waiting times beyond the proposed 18 week referral to treatment target will need to be carefully scrutinised in terms of both costs and benefits.

Workforce

A modern patient-centred health service needs a bigger workforce.
Tony Blair, 10 November 2000

Money for results. Financial incentives have a key role to play in delivering better public services. I know that teachers, police officers, nurses, doctors and other NHS staff do not come into public service primarily to make money. They are motivated by a sense of vocation. That is something that is beyond price. Both the public and the government value that commitment. But I also see no reason why staff who do a good job for the public should not be rewarded for what they do.
Tony Blair, 19 March 2001

'More and better paid staff' was the top public demand when the government consulted 150,000 people ahead of the publication of the NHS Plan in 2000 (Department of Health 2000). The government has delivered on its promise to increase NHS staff numbers, and new staff contracts have led to higher salaries for most staff groups. Apart from being popular with the public (and NHS staff), quantifying the benefits in terms of patient care from the extra staff and staff pay is harder to demonstrate.

In 2006 there were 80,000 more nurses than in 1997 (25 per cent increase), 11,000 more consultants (53 per cent increase) and 6,000 more GPs (20 per cent increase). The full-time equivalent measure of staff numbers shows similar rises (26 per cent for nurses; 56 per cent for consultants; 20 per cent for GPs). However, 2006 saw the first fall in overall staff numbers since 1997, albeit a very small reduction. The number of full time equivalent doctors did increase between 2005 and 2006. The reductions in staff numbers occurred principally among non-clinical administrative, managerial and infrastructure

support staff, although ambulance staff numbers also fell by 10 per cent between 2005 and 2006 (Information Centre for Health and Social Care 2007).

The overall increases in staff numbers under the current government have slightly reduced the gap between the UK and other European countries on the number of doctors per capita, although on this measure the UK still has the lowest proportion of all the EU-15 countries (OECD 2006).

New staff contracts for GPs, consultants and nursing and other staff under Agenda for Change (the new national pay system) have led to a significant increase in earnings for some professional groups:

- **consultant pay** has increased 27 per cent in three years – from an average of £86,746 per annum in 2002/3, before the contract was introduced, to £109,974 in 2005/6 (National Audit Office 2007).
- **GP earnings** increased by 30 per cent in the year after the introduction of the contract, with average net income reaching £106,400 per annum in 2004/5 (Information Centre for Health and Social Care 2006a).
- **nurses' pay** increased by 10 per cent between 2004 (when Agenda for Change came into effect) and 2006 – from a gross average of £11.54 an hour to £12.74 an hour (Pike and Williams 2006).

The new contracts have the potential to bring some benefits for patients: the Quality and Outcomes Framework, which was introduced as part of the GP contract in 2004, rewards practices that meet targets across a range of indicators (for instance, keeping a register and offering regular check-ups for patients with diabetes or asthma). In 2005/6 GP practices achieved on average 97.1 per cent of the maximum 'points' available for clinical care, up from 91.3 per cent the previous year (Information Centre for Health and Social Care 2006c). The consultants' contract has also prevented a further increase in the time consultants give to the private sector (National Audit Office 2007).

But expected productivity gains and benefits for patients from the new contracts have yet to be demonstrated. Research by the National Primary Care Research and Development Centre found that after the introduction of the contracts in April 2004, GPs were on average reporting a £15,000 increase in pay but a four-hour reduction in their working week compared to the previous year (House of Commons Health Committee 2007b). A National Audit Office survey of consultants found that only 11 per cent agreed that time spent on clinical care had increased as a result of the new contract, and a Department of Health survey found that the proportion of consultants' time spent on direct clinical care had reduced slightly after the introduction of the contract (National Audit Office 2007). Research by the King's Fund found that the absence of national level-guidance on how to implement the new consultants' contract at a local level had led to a considerable variation in approaches between different trusts, and that, in the case of the acute trusts included in the study at least, there was little evidence that the intended benefits for patient care were being realised (Williams and Buchan 2006).

Furthermore, workforce planning remains a significant challenge. The government has been criticised for failing to develop a long-term or strategic plan for staffing numbers; for over-shooting on some of its workforce targets; for not focusing sufficiently on staff productivity and flexibility, rather than just numbers; and for failing adequately to integrate workforce and financial planning (House of Commons Health Committee 2007b). There have also been huge increases in some staff numbers, such as consultants, while staffing levels in other specialties, such as midwifery, have remained virtually unchanged (Information Centre for Health and Social Care 2007).

Buildings

The NHS is building more new hospitals than it has ever done. 20 are under construction and 17 more are in the pipeline. The first ones open later this year. Another big achievement that will start to transform the face of the NHS.

Tony Blair, 29 February 2000

In the past 10 years there has been a massive expansion in new buildings for NHS use, both hospitals and smaller clinics, financed, in the main, by the use of the Private Finance Initiative (PFI) and its private–public partnership version for primary care facilities, known as Local Improvement Finance Trust (LIFT). These schemes use the private sector to finance, build and operate buildings, which are then leased back to the NHS. The government is confident that it will fulfil its promise of 100 new hospital projects by 2010. According to the most recent data, 63 PFI schemes are complete and 22 are under construction (with a combined capital value of £8.5 billion). This compares with 21 publicly funded schemes already operational and 4 under construction with a value of £979 million (Department of Health 2007g). By February 2007, 188 smaller clinics and GP surgeries were either built or under construction through the LIFT programme (Department of Health 2007e). Benefits of this form of private financing, according to the government, include the capacity to build far more buildings and complete them far more quickly than traditional publicly financed projects.

Early critics of PFI argued that it led to higher costs than would have been the case under public financing, since the extra financing costs were not sufficiently offset by lower operating costs (Gaffney *et al* 1999). More recently, additional concerns have been expressed about the inflexibility of these buildings in the face of changing technology and new ways of delivering care and about the subsequent financial strain on individual trusts (Palmer 2006). In January 2006, the government requested that strategic health authorities should review all PFI projects to ensure that they were consistent with the NHS reforms (Hansard 2005), particularly the requirement to move care away from hospitals into the 'community'; this is expected to reduce the extent of the capacity produced by schemes currently under consideration (House of Commons Committee of Public Accounts 2007).

While there is no doubt that PFI and LIFT have allowed for a much-needed improvement and renewal of an ageing NHS estate, the attempts to link the programmes with mainstream NHS reform policies have come rather late. The creation of more competition from the private sector (and between NHS trusts) and the transfer of 'business' to community settings set out in the White Paper *Our Health, Our Care, Our Say* (Department of Health 2006d) are exposing local trusts to the risk of being left with expensive hospital buildings that are not 'fit for purpose'.

National standards of care

For the first time the need to ensure that high quality care is spread throughout the service will be taken seriously. National standards of care will be guaranteed.
Tony Blair, 9 December 1997

More freedom for all. But not, as some would have it, a free for all. National priorities will remain important. But trusts will have more freedom on how they are achieved and more freedom to address the local as well as the national agenda.
Tony Blair, 19 March 2001

An enduring theme for the Labour government has been the reduction of arbitrary variations in the quality and quantity of services across the NHS (popularly known as the 'postcode lottery') and the creation of national standards of safety and quality for health services.

Since 1999, National Service Frameworks (NSFs) (national core standards for treatment and care) have been created in the following areas: mental health; coronary heart disease; cancer; paediatric intensive care; older people; diabetes; long-term conditions; renal care; children; and chronic obstructive pulmonary disease (COPD). An independent review of the cancer NSF in 2005 found that there had been 'substantial progress' but that more work was needed to improve local co-operation between NHS organisations (National Audit Office 2005). A similar conclusion was reached in a review of the coronary heart disease NSF, which found 'significant improvements' but room for more work, especially on prevention and rehabilitation (Healthcare Commission 2005a).

The National Institute of Health and Clinical Excellence (NICE), set up in 1999 to generate guidance on the cost-effectiveness of new treatments and procedures and to provide clinical guidelines for the NHS has been recognised internationally to have been hugely successful, notwithstanding the challenges from pharmaceutical companies over its methodology and evidence. Criticism has centred on the slow uptake of NICE guidance locally (Audit Commission 2005) and the lack of transparency in some areas of its work (Maynard 2007).

Identifying and intervening in serious institutional failings in the safety of care for patients has become more established and publicly visible as a result of the creation of the Healthcare Commission in 2004, and the Commission for Health Improvement which preceded it from 1999. The Healthcare Commission is able to intervene where there are major concerns over quality and to carry out routine inspections of trusts. It also publishes information about the performance of local NHS services against national standards. Recent examples of interventions include investigations into hospital-acquired infections in Stoke Mandeville Hospital or into maternal deaths at Northwick Park Hospital. The Healthcare Commission has significantly improved the amount and quality of information about the performance of NHS services locally and added a great deal of new information about patients' experience of those services.

However, perhaps inevitably, local variations in standards of care persist, despite the presence of national standards and assessment by the Commission.

For example, hospital-acquired infections, which have become a source of much public anxiety since 1997, are now the object of close surveillance by the Commission and other agencies. Latest figures on *Clostridium difficile* show that the national rate of increase has, at least, begun to slow (there were 55,681 cases of *Clostridium difficile* infections in patients aged 65 and over in England in 2005/6, representing an annual increase in reported infections of 8 per cent compared to the 17 per cent rise between 2004 and 2005). However, hospitals with the highest rates have nearly six times the rate of infection of those with the lowest rates, with the highest rates generally found in small acute hospitals. Similarly, there is a four-fold variation between individual trusts in the rate of MRSA infection per 10,000 bed days, even though nationally the rate of MRSA infections has begun to fall. Not all this variation between hospitals can be eradicated (as some hospitals have more complex cases to treat than others) but there is clearly room for improvement (Health Protection Agency 2007).

Health and illness

...to balance spending on tackling the causes of ill health with treating illness, to develop a more systematic approach to treating people at risk from chronic diseases and persuade more people to play their part in achieving better health by adopting a more healthy lifestyle.
Tony Blair, 22 March 2000

The focus since 1997 has been on treating the acutely and chronically ill. The question of how to prevent ill health, has, by comparison, been given much less attention. Targets have been in place since 1998 to reduce premature deaths from cancer and heart disease by 2010, and according to the most recent figures the government is on course to meet them (*see* box, overleaf).

Target	Progress
Cancer: reduce mortality by 20 per cent by 2010 for people under 75 (1995 baseline)	15.7 per cent drop so far; rates have fallen for each period since the baseline. Target is likely to be met if the current trend continues
Heart disease and stroke: 40 per cent drop by 2010 for people under 75 (1995 baseline)	35.9 per cent drop so far, rates have fallen for each period since. Target is likely to be met if the current trend continues

Source: Department of Health 2006a

It is not clear how much of this is due to the action of the NHS, as deaths from both cancer and heart disease have been falling at similar rates since 1971 (Office for National Statistics 2006). Nevertheless, services to treat these conditions were among the earliest to have had National Service Frameworks in place, aimed in part at speeding up access to treatment and improving the quality of care. It seems likely that progress during the Labour administration has, at the very least, been maintained in the fight against these two important causes of premature mortality.

Progress in mental health – the third of the government's clinical priorities alongside cancer and heart disease – has been less certain. In 1999, the government set a target of reducing the death rate from suicide (against a 1995/6/7 baseline) by 20 per cent by 2010. While the rate is dropping, and is now in fact at an all-time low, there is some doubt whether the target will be achieved (Department of Health 2006a). Mental health services have received considerable extra funding since 2000, largely targeted at developing services for people with more severe and acute illness, such as crisis resolution teams and medium-secure beds. However, there has been no evidence yet of a reduction in the overall prevalence of mental health problems.

Although less in the public eye than the 'big killer' diseases, there has been considerable effort expended on improving the care of those people who experience chronic ill health. The reforms to GP services under the Quality and Outcomes Framework have led to better routine monitoring of conditions such as diabetes. Many primary care trusts (PCTs) have begun to invest in 'community matrons' (to better look after those chronically unwell people who might otherwise be admitted to hospital) and better IT programmes that can identify the patients most at risk of hospital admission.

Set against these improvements is a more ambiguous legacy in tackling some of the upstream determinants of ill health, particularly of cancer and heart disease. There has been slow, but steady progress so far in reducing the rate of smoking in the population since 1997, with the 2005 target (of a fall in smoking rate from 28 per cent to 26 per cent in the adult population) met and the 2010 target on track. However, there has been less progress in reducing the higher rate of smoking amongst poorer socio-economic groups (Department of Health 2006a). The government's decision to ban smoking in public places, which comes into force in July 2007, has been hailed as a crucial step towards speeding up progress on smoking cessation.

By contrast, the trend in obesity has moved steadily upwards for both adults and children, raising concerns about risk factors for cancer, diabetes and heart disease. A target was set in 2004 to halt the year on year rise in childhood obesity by 2010, which looks very challenging indeed (Zaninotto *et al* 2006). There has been some limited progress in increasing the amount of fruit and vegetables in the diet, but the average of less than four portions for adults and less than three for children is still below the government's recommended level of 'five portions a day', which is itself a modest target (Information Centre for Health and Social Care 2005). The proportion of adults taking 30 minutes of exercise five times a week has risen slightly from 1997, but the target of 70 per cent of adults is still

looking very challenging (Information Centre for Health and Social Care 2005). This data suggests that reducing the risk factors for ill health will remain an uphill task.

Health inequalities

This government is committed to sustaining an ethos of fairness and equity – good health for everyone in England. We are already taking action throughout society to tackle the causes of ill health and reduce inequalities.

Tony Blair, 16 November 2004

The government set itself targets to narrow the gaps that exist between the bottom socio-economic groups and the rest of the population in life expectancy and in infant mortality. Although the national averages for infant mortality and life expectancy have been moving in the right direction, for infant mortality the gap between 'routine and manual' groups and the rest of the population has widened since the baseline years (1997–9) (Department of Health 2006a). Similarly, the gap in life expectancy between the poorest areas (known as the Spearhead group) and the rest of the country has grown for both men and women since the baseline years (Department of Health 2006a).

Better progress has been made in meeting the inequalities targets for two specific disease areas, cancer and heart disease (and related illnesses) (Department of Health 2006a).

The difficulty here is that the factors that drive these inequalities in health extend beyond the immediate control of the NHS (encompassing, among other things, poor housing, low incomes, poor quality schools, poor quality of the environment, personal lifestyle and behaviour) and solutions require joint working between health services and other bodies. The government has been active in reducing some facets of inequality, for example, reducing the level of overall relative child poverty since 1997 through welfare reform and multi-agency projects such as Sure Start. But it is difficult to evaluate the impact of these projects on health status and identify which interventions lead to health improvements. Some schemes designed to tackle inequalities in health, such as Health Action Zones, were short-lived and this too makes their impact difficult to measure. The government has also emphasised the need for better 'joined up' action at a local level, and encouraged PCTs and local authorities to work towards common local goals. Local Strategic Partnerships and Local Area Agreements have been used to develop local partnerships and common local visions and targets. There have been huge difficulties in doing this well locally as well as nationally, for example, in connection to reducing childhood obesity (National Audit Office 2006). The most recent Commissioning Framework on Health and Wellbeing also recommends developing Joint Strategic Needs Assessments' to identify common needs and promote service integration between different statutory agencies (Department of Health 2007a).

Criticism has also focused on the disproportionate 'pull factor' on health funding since 1997 by the hospital and primary care sector at the expense of the primary prevention and inequalities agenda (Hunter *et al* 2005). This has been compounded by the apparent vulnerability of public health budgets in the face of deficits in some areas (House of Commons Health Committee 2006b). Although the government plans to improve the quality of commissioning for public health needs in local areas (Department of Health 2007a), it is hard to tell whether this will be enough to outweigh the impact of the current NHS reforms which tend to incentivise a 'business case' for health service investment. This inevitably focuses on short-term gains, for instance, saving money by reducing emergency admissions among the already-ill, and neglects the possibility of longer term, but more uncertain, gains from keeping people well.

In the long term, the government is unlikely to make much progress on reducing inequalities in health since they are closely linked to wealth inequalities and poverty. Despite the considerable efforts expended by government on, for example, reducing child poverty since 1997, latest figures show a recent rise in the number of children living in relative poverty, driven partly by slower growth of low

incomes compared to incomes nearer the middle of the spectrum (Brewer *et al* 2007). Nevertheless, the drive to identify those on low incomes at risk of ill health or hospital admission, and support them by providing them with better-tailored services, may help to reduce some risks of poor health and improve the quality of their lives.

Accountability, public involvement and the NHS

We are also pioneering new forms of civic engagement in our public services – foundation hospitals truly accountable to their local communities, schools with a stronger voice for parents and local employers, local councils more open and accountable, including directly elected mayors where local people vote for them.
Tony Blair, 17 June 2003

The question of how the public should be involved with the NHS, beyond their capacity as patients (and voters/tax-payers), remains unresolved. A new vision for local public involvement was articulated with the creation of foundation trusts. Each trust was to set up a 'membership' base drawn from patients and the local community and, from this body, elect 'governors' for the trust, with some (limited) powers, including appointing the chair and non-executive directors. By contrast, the arrangements for public involvement in the ongoing work of non-foundation trusts has been in flux. Community Health Councils, which had been in place since 1974, were abolished in 2001. Their replacement, Patient and Public Involvement Forums began work in 2003, but in July 2004 the government announced that they, too, were to be abolished. They are now to be replaced by another organisation, Local Involvement Networks (or LINKS), designed to be more flexible in form than the forums. A change in the 2001 Health and Social Care Act, (which strengthens the 'duty' on the NHS to consult) is also planned. There has been criticism that the changes have been unnecessary and badly thought out (House of Commons Health Committee 2007a).

There is still a great deal of confusion at the heart of government policy about the role of public involvement in the NHS. It is not clear how much energy (and money) the NHS should expend to 'consult' the public (in their capacity as service 'users') in the ongoing design and delivery of more efficient and more appropriate local services. It is not clear how much the local 'citizen' should have to be (or want to be) involved in local scrutiny of health services. It has been suggested that the NHS has a 'democratic deficit' in particular with respect to the local accountability of PCTs, which dispose of more than 80 per cent of the NHS budget. There also needs to be some consideration of role of the patient as a 'consumer' and to what extent collective decisions by patients about which providers they use, should determine the shape of local health services.

NHS reform

We must develop an acceptance of more market-oriented incentives with a modern, reinvigorated ethos of public service. We should be far more radical about the role of the state as regulator rather than provider, opening up health care, for example, to a mixed economy under the NHS umbrella.
Tony Blair, March 2003

The most profound changes to the health service – known collectively as NHS reform – began in 2002 and are still incomplete. These include reforms to all aspects of the NHS system in England. The idea underpinning these reforms is a shift from a centrally driven 'top down' system of targets and standard setting (which lay at the heart of the NHS Plan) to a more self-improving system in which providers compete for patients and contracts with PCTs, those providers delivering high-quality services are rewarded and pressure is put on those who perform badly and lose patients (and contracts). 'Supply-side' reforms include creating more autonomous foundation trusts and permitting contracts with more independent sector and third sector providers. 'Demand-side' reforms include more choice for patients and better commissioning by PCTs and GPs under the practice-based commissioning (PBC) initiative. Transactional reforms include the introduction of a national tariff under Payment by Results (PbR),

paying providers for each episode of care (for example, an inpatient admission) provided. These reforms are underpinned by robust regulation to which the government is currently considering changes.

The reforms have only just begun and their effects are still unknown. Although nationwide 'choice at the point of referral' has been in place for more than a year, more than half of patients cannot remember their GP offering them a choice of hospital (Department of Health 2007h). It is not known how many patients have switched hospitals in search of better-quality care. Payment by Results now applies to about 60 per cent of hospital income, but early evaluation suggests that it has not yet had a major impact on hospital behaviour (Sussex *et al* 2007). Practice-based commissioning is still in its infancy. By February 2007 96 per cent of practices had engaged in an initial planning stage of the initiative in return for an incentive payment (Department of Health 2007f), but concrete examples of actual savings realised from these plans, or a change in behaviour by GPs, are still limited (Department of Health 2007b).

Despite the controversy generated by the expansion of the independent sector, the use of the independent sector in providing acute hospital services to NHS patients is currently quite limited. The ISTCs that are currently open (wave 1) were expected to perform an average of 170,000 procedures (finished consultant episodes) a year for the duration of their five-year contract – around 3 per cent of the number completed by the NHS as a whole each year (House of Commons Health Committee 2006a; Information Centre for Health and Social Care 2006b). The Department of Health is committed to investing £550 million a year on procurement from the independent sector – around 0.6 per cent of NHS budget in 2007/8 (House of Commons Health Committee 2006a).

Contracts for a second wave of provision of acute care by the private sector – including treatment centres and using capacity in existing NHS sites – are still in negotiation. This second wave of contracts was originally intended to provide an additional 250,000 elective procedures and two million diagnostic procedures to NHS patients each year, but the programme was later scaled back from 24 to 17 elective schemes, suggesting a corresponding reduction in capacity (House of Commons Health Committee 2006a). Even if the full 250,000 electives were performed each year, together with the planned 170,000 from wave 1, the total contribution by the independent sector for NHS patients would only be 7 per cent of the elective cases currently completed by the NHS as a whole (Information Centre for Health and Social Care 2006b).

The effectiveness and cost-effectiveness of ISTCs relative to NHS treatment centres and care in the NHS is currently being reviewed by the Healthcare Commission, at the request of the Secretary of State following concerns raised by the Health Select Committee.

The 'take or pay' contracts issued for the first wave of contracts (and in a modified form for the second wave) mean that these providers are guaranteed a certain level of income irrespective of the number of procedures they perform. Concerns had been raised about these centres running at low capacity and so offering the NHS poor value for money; the House of Commons Health Committee found examples of centres running at only 50 and even 40 per cent of the capacity for which they were being paid (House of Commons Health Committee 2006a). The Department of Health classifies information on individual centres as 'commercially sensitive' but has reported that, in 2005/6, ISTCs were running on average at 80 per cent of capacity (Hansard 2007).

The use of the independent sector is one of the reforms to the 'supply side' of the NHS: they are the 'new entrants' to the market. However, there has been less attention paid to the question of whether (and how) trusts that fail to perform in this new competitive environment should be managed. Last year, the Healthcare Commission identified 87 trusts that failed to meet their financial targets as well as failing on other indicators of financial management and value for money (Healthcare Commission 2006). The government's approach has been to commission specialist help (turnaround teams) for

those trusts in the worst difficulties. However, it has been recognised that not all trusts are viable in their current form but the detail of how mergers and reconfigurations should be regulated, or indeed what an appropriate failure regime should look like (Palmer 2005), has still to be worked out. There are also other areas still awaiting further detail – such as how to extend Payment by Results beyond non-elective surgery into areas such as mental health services and a range of community services – hence an assessment of the potential impact of the reforms remains speculative.

The future of the NHS

I don't just want to save the NHS, I want to give it a new lease of life.
Tony Blair, 9 December 1997

Has the NHS been 'saved'? If the NHS is understood as a tax-funded, free-at-the-point-of-use service, then the answer is probably 'yes', at least for the time being. Although the principle of tax funding is subject to periodic question from right-of-centre think tanks, the acceptance of tax funding by the Conservative Party is perhaps one of the most important legacies of the period. Public attitudes to a tax-funded, universal health service have also remained positive, with the strongest support recorded in 2004 (Appleby *et al* 2005).

This consensus does not preclude further debate about the scope of free-at-the-point-of-use care, not least about the uncomfortable boundary between 'free' health care and paid-for social and dental care, or about the limits to NHS services and how they should be determined either locally or nationally.

The question of whether the NHS has been given a new lease of life is a more open one. There can be no doubting the scope of the proposed reforms to the NHS: they represent a bold departure from the top-down, centrally planned management of the NHS that characterised government during the early part of Tony Blair's period in office. Despite the unknown effects of some of the policies, these reforms have the potential to deliver the significant, if not transformational, change in the NHS that is needed alongside the big increases in funding. The big gap remains in commissioning, which is extremely weak. Important questions remain about what spending on health care actually delivers in terms of reducing illness and better health, questions that are just as important for the current NHS reform. It will be crucial to keep these questions central in the future and to improve the collection of data on clinical and health 'outcomes' to understand them better.

But improving productivity and efficiency is only part of the objective of health service reform. Responding to patient and public expectations is key, not least because they, as tax-payers, also fund the NHS. It is only since 2004 that patient experience of the NHS has been systematically measured by the Healthcare Commission. Results of surveys show, for instance, that most patients (90 per cent) report positive experiences of the NHS as hospital inpatients. But general public attitudes are cooler towards the NHS: overall 'net' public satisfaction with the NHS over the Labour government's period in office was at its highest in 1999 (+13), hit its lowest point in 2001 (-1) and slowly began to creep up in 2004 (+7), according to the most recent figures available from British Social Attitudes Survey (Appleby and Alvarez-Rosete 2005). It is not known what effect the more recent media coverage of staff and public protests against deficits and threatened hospital closures will have had on overall public attitudes, but convincing both NHS staff and the public that the reform efforts are delivering a positive 'transformational' change remains a substantial challenge for the future.

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