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Briefing paper

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AN INDEPENDENT AUDIT OF THE NHS UNDER LABOUR (1997–2005)

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Summary

The Labour Party came to power in 1997 promising to 'save' the NHS. Since then, it has found unprecedented increases in funding for the health service, but Prime Minister Tony Blair has emphasised that the extra money must be linked to a 'step-change' in reform.

This reform has taken four main forms: clear targets and standards set nationally; regulatory inspection and assessment; central support of professionally led collaboratives; and, more recently, the introduction of market-style incentives.

The question we ask in this paper is whether it has all worked. Has Labour delivered on its targets and has it achieved the step-change it wanted?

Spending

In January 2000, Tony Blair committed his Government to matching European levels of spending on health. The level of expenditure on health care in the United Kingdom will reach 9% of Gross Domestic Product (GDP – a measure of the nation's total wealth) by 2008 – a figure comparable to other European countries.

Therefore the Government's spending target will be achieved. The harder questions to answer are whether this investment will be 'enough' and whether it has been well spent.

In 2003/04, the NHS cost £63.7 billion pounds. In 2004/05, hospital and community services (the largest component of NHS spending) have received an additional £5.1 billion pounds. However, much of this will go on pay and other 'cost pressures', such as clinical negligence claims and the additional cost of new drugs. As a result, the extra money available for additional patient services is only 2.4%.

In addition, NHS productivity (the amount of activity provided in the NHS for every pound spent) has been falling, according to the official measure. On the face of it, this suggests that the NHS is getting worse value for money than it used to. However, the official figure does not count everything that the NHS does – or record improvement in the quality of services.

Verdict: Target met, thanks to unprecedented increases in investment. However, questions remain over the productivity of the NHS and the value for money that taxpayers are getting for their investment.

Waiting lists and access to care

During Labour's first two years in power, the number of people waiting for NHS hospital treatment and the length of time they had to wait grew. However, since 2000, the waiting list has shortened and very long waits (more than 12 months) have been eliminated.

The Government is now on course to meet its key targets to reduce the maximum time that patients have to wait for a first outpatient appointment to 13 weeks, and for inpatient treatment to six months. According to one official measure, the average time that patients have to wait has also fallen, from just over four months when Labour came to power, to less than three months last year.

The Government has tackled other difficult areas. More than 96% of Accident and Emergency (A&E) patients are now discharged, transferred or admitted to hospital within four hours; a little short of the Government's target of 98%.

And official statistics say that virtually 100% of GP practices now comply with the target that patients should wait no more than two days to see a GP (although patient surveys give a rather different picture).

Despite these successes, the Government has accepted that there are 'hidden waits', in which treatment is stalled at specific bottlenecks (for example, diagnostic tests, such as MRI scans, that will lead to a diagnosis). To address this, the Government has announced extra investment in diagnostics and a new 'total waiting time' target; patients should wait no more than 18 weeks from GP referral to treatment by 2008.

Verdict: Targets met. Huge progress in the area that was the highest priority for the Government. However, more work is required to reduce waiting times for diagnostic tests.

Three health priorities: cancer, coronary heart disease and mental health

Cancer and heart disease are the 'big killers' in the United Kingdom. The treatment of some individuals with acute mental health problems is a focus of public concern, while surveys suggest that mental health conditions, such as anxiety and depression, are becoming more widespread.

Labour has set targets to reduce deaths and improve prevention and treatment in all these areas.

Cancer

Labour's main treatment targets are a two-week maximum wait from 'urgent' referral by a GP to first outpatient appointment, and one-month maximum wait from diagnosis to treatment. By the end of 2005, the target is a two-month wait from 'urgent' referral to treatment, and this will fall to one month by 2008.

Official data suggest compliance with the first of these targets is now 99.5%. The Government has invested heavily in staff, equipment and service 'redesign' to try and meet the rest of the targets, but there are no routinely collected, publicly available data to let us judge at this stage whether they have been or are likely to be met for all types of cancer.

However, a 'snapshot' (one-off) study suggests that while only 10.1% of all patients failed to receive treatment within one month of diagnosis, 22% are not being treated within two months of GP referral; and senior NHS managers have admitted that hitting this year's targets will be 'an enormous challenge'.

Labour's main health targets have been to cut the number of people dying of cancer before the age of 75 by 20% by 2010, and to cut the number of adults smoking to 21% of the population by the same date.

A national smoking cessation service was set up, and given a target of 800,000 successful 'quitters' by 2006. The Government is on course to meet this target. However, it counts anyone who is not smoking after four weeks as a 'quitter', even though studies show many people start again later.

More cancers are being detected, and the disease is claiming fewer lives than when Labour came into power. The Government claims to be on track to meet its mortality target by 2010. However, the mortality rate has been declining for decades, so it is difficult to conclude that Labour's reforms are the only (or main) factor.

Heart disease

Labour's main service targets have been: to ensure that patients suffering a heart attack get 'clot-busting' drugs within an hour of calling for help; to establish rapid access chest pain clinics that can see patients within two weeks; a six-month maximum wait for an angiogram (a scan of the heart); and a maximum six-month wait for routine surgery by the end of this year, falling to three months by 2008. The health service is on course to meet all these targets, or has already met them.

Labour's main health target has been to cut the number of people dying of heart disease before they reach 75 by 40% by 2010. Labour's mortality target looks set to be achieved; the most recent data shows that deaths due to heart disease have fallen by 27% during the past ten years. However, over the previous 15 years, when none of its reforms were in place, the mortality rate fell by 33%.

Reducing smoking and improving diet would help to reduce heart disease and stroke further. The Government has established a free fruit and vegetable scheme for children and created a 'five-a-day' campaign to encourage adults to eat more fruit and vegetables. However, studies show consumption has not changed much.

Mental health

Labour has made a number of pledges designed to improve 'access' to services. These include more than 600 'outreach' teams for young people, adults in 'crisis' and adults who are 'hard to reach.' Some of these targets have been hit, others missed; and it is hard to tell from the publicly available data what impact the teams that have been set up are having.

The Government's main health target has been to reduce the number of suicides by 20% by 2010. Official figures show that the suicide rate has fallen by 9.2% since 1995/96/97. The suicide rate in 2003 was 8.5 per 100,000 people in the country – the lowest ever.

However, many of the reasons that people kill themselves are beyond the control of the NHS, and suicide rates have been falling since the 1980s – so it is hard to quantify the Government's contribution.

Verdict: Labour has substantially met its targets to get more beds, staff and equipment into services for treating cancer, heart disease and mental health. Mortality from cancer, heart disease and suicide have fallen, but were falling anyway. Progress on preventative measures, such as reducing smoking and improving diet, seems slow at best.

Four big issues: beds, staff, the private sector and health care associated infections

Beds

NHS bed numbers have been declining historically for many years. This has been due to policy changes, such as the decision to care for people with learning disabilities outside of hospital, and also new technologies, such as the increase in day case surgery techniques. The Government set targets to increase the numbers of 'general and acute' beds (by 2,100), 'intermediate' beds (by 5,000) and critical care beds (by 300). These targets have broadly been met (although there is a slight shortfall in the number of intermediate care beds).

Staff

The Government promised to provide 10,000 more doctors, 20,000 more nurses and 6,500 more therapists. These targets have been met. However, the position is not quite as impressive as at first it might seem.

The Government has recorded a 'headcount' (the number of people employed) rather than a 'whole-time equivalent' (the number of full-time posts regardless of whether they are filled by full or part-timers). Since more people are working part time, this reduces the impact of extra numbers.

The Government also promised 2,000 more GPs by 2004, and official figures show that it got them. However, the figures include GP assistants and doctors whose practice is restricted in some way. The increase in the numbers of traditional GPs has been far more modest and, if measured in this way, the target has not been reached.

Despite these increases, England still has relatively fewer doctors and nurses per head than many of its European neighbours.

Use of the private sector

The Government has embraced the private sector, both as provider of services to NHS patients and, through the private finance initiative (PFI), as a financier of new hospital buildings. Since 1997, 68 new hospitals have been built or are underway and the Government is well on its way to meeting the target of 100 hospital schemes by 2010.

As a result, there have been major improvements. In 1997 the average age of NHS buildings was older than the NHS itself; now in 2005, less than a quarter of NHS buildings are that old.

However, critics argue that PFI cuts beds and can deliver poor-quality buildings. Savings may be marginal in the long run.

Health care associated infections

The 'superbug' MRSA and other health care associated infections (HAI) are a significant problem for the NHS – and for health care systems worldwide. Rates of the most serious infection (bloodstream MRSA) are increasing (although the latest government figures arguably offer some evidence that the number of cases has begun to decline).

The Government has raised the profile of HAI, but it is too early to tell whether the measures it has taken will reduce the problem. Using beds less intensively might help, but would also make it more difficult for the NHS to meet waiting time and other targets.

Verdict: A substantial increase in some types of hospital beds and in hospital staff. Good progress in modernising NHS facilities. On the downside, employment numbers may not be quite as impressive as they might first appear because headcount figures are used, not whole-time equivalents, while rates of MRSA compare badly with other countries.

Are we becoming more satisfied with the NHS or healthier?

Much of this audit deals with the additional 'inputs' the Government has found for the NHS (more money, more beds, more staff) and with some hard 'outputs' (such as lower waiting times, more operations delivered and more tests done). Here we look at two less tangible outputs: satisfaction with the NHS and whether all this activity is actually making any difference to the health of the nation.

Satisfaction

Patient surveys run by the Healthcare Commission watchdog suggest patients are generally very happy with their overall care. Public surveys, such as the British Social Attitudes Survey, suggest that those without recent experience of the NHS are less happy with it, although satisfaction fluctuates over time. This suggests that negative media reporting, rather than actual experience, may influence public views of the NHS – and support for it.

Health

The Department of Health has set a target to increase life expectancy at birth (the number of years a baby can expect to live, on average) to 78.6 years for males and 82.5 years for females by 2010. In 2002, it was 76.2 years for males and 80.7 years for females (the latest year for which data is available).

It is likely that this target will be achieved, mainly as the result of fewer premature deaths from coronary heart disease, cancer and suicides. These have all been Labour priorities, but, as discussed earlier, death rates were falling in these areas anyway.

Meanwhile, there are some problems on the horizon. Obesity has increased in men and women, and if current trends continue it is possible that the improvements in life expectancy seen in the last three decades may level off or even start to decrease.

Verdict: Public satisfaction with the NHS fluctuates, but the media may have more influence than the health service or the Government. There have been improvements in life expectancy, but these were apparent under previous governments.

Conclusion

Overall, in our view, the results of this audit are very positive. The ambition for the NHS has been appropriately high. There has been unprecedented investment. There have been significant improvements in most areas that the Government has focused policies on. Has there been a 'step-change' in NHS performance? If step-change means a significant shift of gear, with more and better services, then yes there has.

However, the NHS as a whole has not yet been transformed. There are still important problems to be solved and there is as yet no firm evidence to show that Labour's reforms have produced a marked difference in health outcomes. While much of the improvement in the NHS that we describe has been achieved through central fiat and targets, it is too early to predict whether the more recently introduced tools to lever up performance – greater use of market incentives and regulation – will achieve the desired transformation.

Introduction

The Labour Party entered government in 1997 with the bold claim in its manifesto that it would 'save the NHS'.[1] During the course of two successive governments and eight years, it has proceeded to introduce a range of reforms that are transforming the fundamental nature of the health service.

Some of these changes have been controversial. Perhaps to the surprise of many Labour Party supporters, the present Government has embraced market forces and consumer rights and encouraged the private sector to provide some mainstream NHS services. As the 2005 election looms, there is arguably more that unites the two main political parties on health than divides them.

This report assesses the progress of the NHS in England since 1997, and asks to what extent the last two Labour Governments have delivered on the ambitious agenda they set themselves in this key area of public policy.

Making these judgements is not easy. The information needed is sometimes missing, or will not be available for some years. And although health services receive a lot of attention, they are only partly responsible for improvements or deteriorations in the health of the nation. Many commentators argue these have more to do with people's lifestyles, their economic circumstances and the environments they live in. This makes it hard to assess the real impact of reforms to the NHS.

Furthermore, trends in population health tend to be measured over the long term, rather than over the course of a four or five-year Parliament – so it is difficult to be clear about the impact of any one government on the overall health of the population.

Nevertheless, the NHS is under government control and it is subject to a plethora of targets and objectives, so we have tried to assess performance against them. To track every target would be a huge task, so we have identified the most important in key areas. To carry out this audit, we have used as our benchmarks the Labour Party manifestos for 1997 and 2001, and a range of other official documents.[2]

We start by outlining Labour's reform programme over two parliaments, and then assess how it has done in terms of spending and tackling the politically important challenge of reducing waiting lists. We then turn to three disease areas that Labour has declared to be priorities – cancer, coronary heart disease and mental health – and try to judge whether it has delivered on the promises to improve treatment and reduce the burden of early death and ill health that they cause.

The report then deals with some of the more technical measures that Labour has taken to produce more capacity – broadly, more beds and staff – and to tackle the 'superbug' MRSA, before looking at the difficult question of whether all this activity has actually made any difference. Has it improved satisfaction with the NHS? Has it actually improved the nation's health, or reduced inequalities in health between rich and poor? Finally, we try to draw some conclusions about Labour's performance overall.

Throughout this report, we have chosen to focus on the NHS in England. The Government has created assemblies in Wales and Northern Ireland, and a parliament in Scotland, with responsibility for their own health services. There are some interesting comparisons to be made between the differing approaches in the four countries of the United Kingdom, and where these shed light on Labour's record, we make them.

We have also set the English NHS in a broader international context, using data from a number of developed countries, to give a sense of how the NHS compares to their health systems. The countries selected are France, Germany, Ireland, Spain, Sweden and the United States of America. These countries have been selected because they share similarities with Britain, with respect to their level of development, but also because they reflect a range of different types of health system – from the state-run system in Sweden to the market-driven American system.

We begin by considering the Labour Government's vision for the NHS and its approach to health system reform.

1 Labour's vision for the NHS

In the run-up to the 1997 general election, the NHS was a key battleground. Labour committed itself to rescuing the NHS from what it saw as many years of neglect under the Conservative Government.

When it took power, Labour rejected the rhetoric of the previous Government's market-style reforms of the NHS. The 'internal market' had created a split between NHS trusts, which run hospitals and other health care services, and health authorities and GP 'fundholders', which bought health services on behalf of their local populations and patients.

In reality, however, Labour left much of the architecture of the internal market in place – trusts and health authorities remained, and providing and purchasing health care continued to be subject to contracts between them.

However, the most visible, and perhaps contentious, symbol of the Conservative period – GP fundholding – was abolished and primary care groups created. These brought together groups of practices and took a rather more collective approach to commissioning services than most GP fundholders, who were based in individual practices.

Money for reform

The Labour Party had committed itself to the notional spending plans of its predecessors for its first two years in government.[3]

However, after this initial period, and once Alan Milburn had replaced Frank Dobson as Secretary of State for Health, a more radical vision for the NHS began to emerge backed by substantial investment.

In January 2000, the Prime Minister, Tony Blair, announced on television that NHS spending would increase substantially in real terms over the next few years, reaching the average spend across the European Union. However, the additional money was not simply to be spent in the traditional way. With new money came a demand for reform. In Parliament, the Prime Minister announced that 'a step-change in resources must mean a step-change in reform'.[4] The symbol of this reform was the NHS Plan, published in 2000[5] – a ten-year programme to transform the health service in England.

The plan considered in detail many areas considered to be historical weaknesses in the NHS, made some changes to its structures; Primary Care Groups became Primary Care Trusts, responsible for planning and buying services for their local populations, and managing some non-hospital work. But essentially it was a welter of promises and targets: more staff with new roles, better information technology and fewer people waiting for treatment.

The NHS Plan was the apotheosis of central planning albeit central planning with consent, since it was endorsed by a broad range of professional and other interest groups.

National standards

National Service Frameworks (NSFs) were developed – standards of care for common conditions such as cancer and coronary heart disease based on the best evidence and backed up with support from newly created 'tsars' (national directors appointed to implement the frameworks).

A new regulatory structure was created, designed to ensure that standards of treatment and access to care were more uniform across the country.

An independent inspectorate, the Commission for Health Improvement (later to become the Healthcare Commission)[6] was created to assess the performance of individual NHS institutions and award them 'star ratings' so that the public could see whether they were served by three star ('excellent') or zero star ('failing') trusts.

The National Institute of Clinical Excellence[7] was also created to assess the clinical and cost-effectiveness of different treatments, and determine which ones should and should not be available to NHS patients.

Choice and accountability

Since 2000, new policies have been developed that devolve power away from the Department of Health and introduce very mild market-style incentives in the NHS.

Patients are being offered direct choices over the hospital at which they will receive their treatment. From December 2005, patients referred for 'elective' (non-emergency) surgery will be able to choose from four or five providers. From 2008, choice will be unlimited as long as the provider meets NHS standards and can deliver at the NHS price.[8]

The private sector is encouraged to play a greater role in providing services to NHS patients (up to 15% of NHS elective care, according to the Government), and more competition between hospitals is being engineered.

At the same time, the Government is apparently trying to devolve accountability for local NHS services back to GP practices and the public. New arrangements for practice-based commissioning that look very like GP fundholding are being put in place, and 24 'foundation' hospital trusts are now in operation.

These are independent of the Department of Health, although they are regulated by another independent body, known as Monitor.[9] They are accountable to their 'members', who are drawn from residents, patients and staff, and a board of elected governors. Indeed, John Reid, the present Secretary of State for Health, recently announced that he would no longer answer questions about operational matters at foundation trusts.[10]

In addition to these structural changes, the Government is also implementing a new method of allocating resources within the NHS, known as 'payment by results'. Under this system, there is a national tariff (prices) for operations and procedures, and hospitals will receive a set price for the care they provide to each patient.

Hospitals that attract more patients will receive more income, whereas those that lose patients may find themselves in financial trouble. At this early stage, it is not clear what the consequences will be. The Government is clearly concerned about the potential instability of the new arrangements and has already announced that the implementation of the full scheme is to be delayed by one year.[11] However, foundation trusts already have to operate under this system.

Payment by results, and new rights for patients to choose where they are treated, herald a very different environment for the delivery of health care. The Government is relying on market forces to drive change and (hopefully) improvement within the NHS.

Back to the market?

The NHS that Labour is creating cannot simply be caricatured as a market-based system, albeit one that is free at the point of use and open to all. It will be what economists call a 'quasi-market', one in which prices will be controlled and other extensive regulation will continue to take place. The NHS will still be a largely centrally planned organisation into which some market-style incentives have been introduced.

Moreover, while the Government has brought back competition, it has also introduced co-operative ventures to improve standards and increase efficiency. Clinical networks, drawing together specialists and doctors from many institutions, have been established to ensure that the best use is made of limited specialist resources. And many other 'collaboratives' or voluntary associations set up to share best practice and techniques for driving improvements, have come into being since 1997, with success.

In other words, today's NHS is a complex mixture of competition and collaboration. Simon Stevens, a former advisor to Prime Minister Tony Blair, and one of the key architects of the more recent changes, says it has been subject to complex, 'three-dimensional' reform.[12]

NHS providers have received support in the shape of better infrastructure and more staff; but they have faced challenges too. These challenges come from the centre, through inspection or direct intervention, and from local forces, such as new types of commissioning, patient choice and new forms of local democracy. These different policy strands are in tension with one another and, as Stevens concedes, it is not clear what the precise balance between them should be.

The NHS Plan signalled significant reform. The Government has set out a new vision for the NHS where instead of being a monolithic structure that both commissions and provides care, it is to be a set of rights to treatment, at specified and assured standards, from a widening base of diverse suppliers, public and private.

This is an NHS that Aneurin Bevan, its Labour founder, would struggle to recognise. The Government has justified many of its policies by using the mantra 'what counts is what works.'[13] In this paper, we investigate whether they have worked.

2 Spending

In 1948, the NHS began life with a budget of £437 million (approximately £9 billion at today's prices). This year it will receive seven times that amount – more than £81.1 billion.[14] Private health care sector spending of approximately £10.5 billion brings the total UK health care spend to £92.7 billion this year.[14]

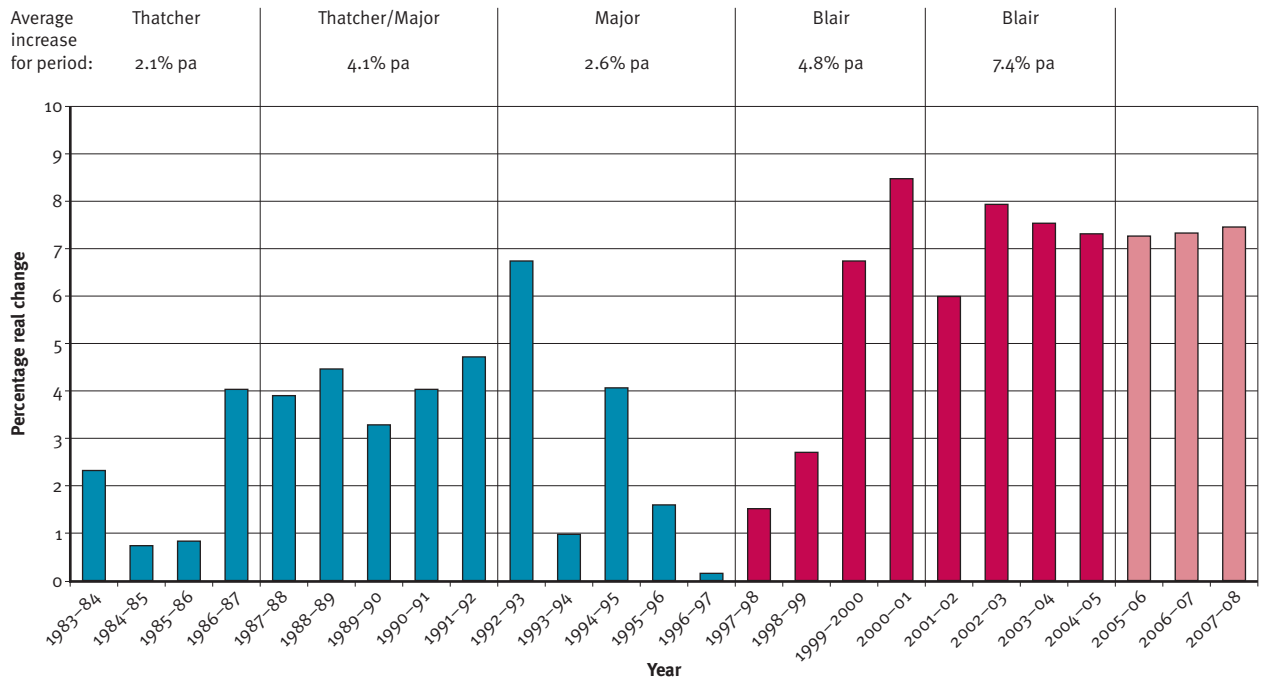
What has Labour delivered?

Industrialised countries tend to spend more on health care as their wealth increases, because of scientific advances in medicine, growing and ageing populations, and rising public and patient expectations.

Over the whole period of the existence of the NHS, the long-term average annual real growth in NHS spending (in other words, the extra money spent every year, after inflation has been taken into account) has been around 3%.

When Labour came into power in 1997, funding of the NHS by the previous Government had not been particularly generous. It increased on average by 2.6% (after taking inflation into account) over the period of the previous Parliament (*see* Figure 1).[3]

1 PERCENTAGE CHANGE IN REAL NHS SPENDING IN UNITED KINGDOM, 1983–2005, PLUS PROJECTION



Source: King's Fund (2002)[3]

In its 1997 manifesto, Labour promised to 'raise spending in real terms every year' but did not specify by how much.[1] In reality spending in the first two years was relatively parsimonious (*see* Figure 1).

A big change in approach was announced in early 2000, when, in a television interview, Tony Blair announced much bigger increases in spending, which would see the proportion of the United Kingdom's national wealth spent on health care rise to equal the average for the European Union.[3]

More detail was added in the budget later that year, when the Chancellor, Gordon Brown announced that spending would rise by over 6% a year until 2004 (making an extra £4.9 billion available in cash for 2000/01, rising thereafter).[15]

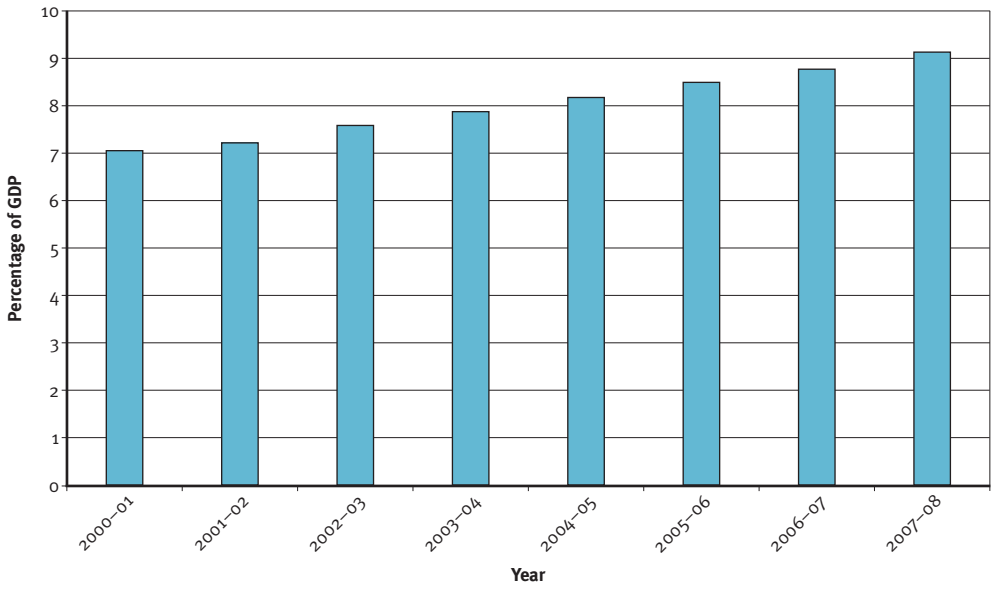
This commitment to go on increasing funds to the NHS was extended in 2002, when Gordon Brown announced that the increases would last until 2007/08, amounting to an average annual real growth of 7.4 %.[16]

Taking the increase promised in the 2004 Spending Review into account, NHS spending will have risen by the equivalent of around 2.5 percentage points of Gross Domestic Product between 2000 and 2007.

Of course, the United Kingdom also has a private health care sector. Over the next few years, the United Kingdom's total health care spend (in other words, the amount spent on both the NHS and private health care) will rise to more than 9% of GDP.

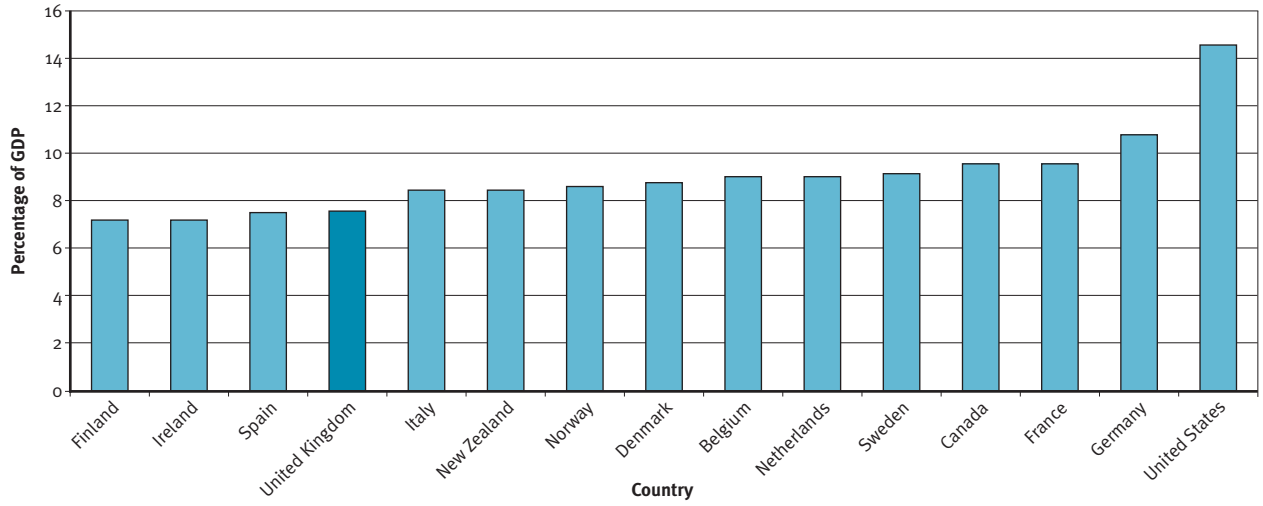
This is higher than ever before, but the United Kingdom still lags behind many other countries in terms of the proportion of its GDP spent on health. In saying this, however, it is important to remember that the amount spent is not, in itself, a measure of how effective the health care system is (*see* Figures 2 and 3).

2 **TOTAL SPENDING (PUBLIC AND PRIVATE) ON HEALTH CARE IN UK AS PERCENTAGE OF GDP, 2000–01 TO 2007–08**



Source: King's Fund (2004)

3 **TOTAL SPENDING (PUBLIC AND PRIVATE) ON HEALTH CARE AS PERCENTAGE OF GDP IN SELECTED EUROPEAN COUNTRIES, 2002**



Source: Organisation for Economic Co-operation and Development (2004)[17]

How do we pay for the NHS?

The NHS is funded from taxation. Almost every UK government since 1948 has examined alternative ways of funding health care, or looked for additional sources of money. However, most of these have been rejected on the grounds that people's access to health care would become dependent on their ability to pay, rather than on their health needs. Of the three main methods of funding health care – general taxation, social insurance and private medical insurance – taxation remains the cheapest and fairest to all.

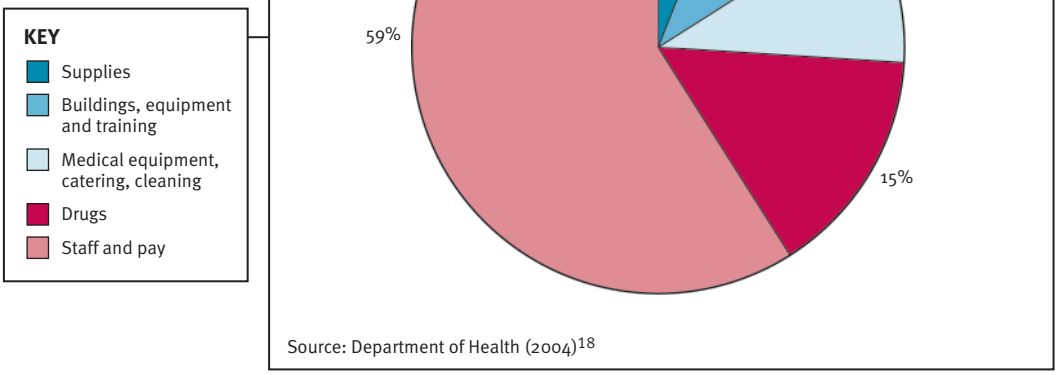
However, all countries have a mix of tax, social insurance and private medical insurance and to a lesser extent, direct payments (charges for specific services, such as a trip to the GP). Even the United States, which is often held up as the ultimate example of a privately funded health care system, devotes almost the same proportion of GDP to health care funded by taxation and to health related tax breaks as the United Kingdom (mainly because it has to fund a public health care system for the poor and the old). The United Kingdom also has its private health care sector.

Recent increases in NHS spending have come, in part, from higher taxes (in particular National Insurance). But increased funding has mainly been possible because the economy has been growing strongly, giving the Government increased tax revenues, and because Labour has made more spending a political priority.

Where has all the extra money gone?

In 2003/04, the NHS cost £63.7 billion. By far the largest proportion of this spending went on staff and pay costs (*see* Figure 4).

4 BREAKDOWN OF NHS EXPENDITURE, 2003–04

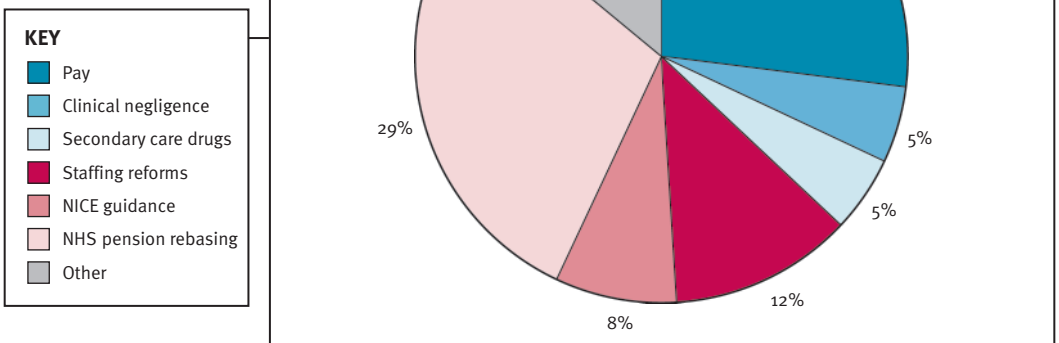


Source: Department of Health (2004)[18]

In 2005, hospital and community health services, which are the biggest component of NHS spending in England, received £5,086 billion more than they received in 2004. However, not all of this has been available to expand and develop health care services (in other words, to open more beds or perform more and better procedures).

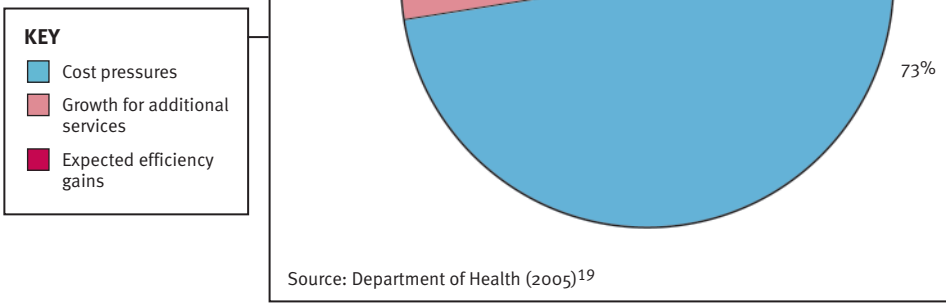
Most of the money has been 'earmarked' (or set aside) for 'cost pressures', such as increased pay and new terms and conditions for GPs, consultants and other NHS staff. Around a fifth has had to be spent on meeting other cost pressures such as clinical negligence claims, the new

5 COST PRESSURES (HOSPITAL AND COMMUNITY HEALTH SERVICES IN ENGLAND), 2004–05



Source: Department of Health (2005)[19]

6 **ALLOCATION OF HOSPITAL AND COMMUNITY HEALTH SERVICES GROWTH FUNDING, 2004–05**



Source: Department of Health (2005)[19]

staff grading exercise (Agenda for Change) and increases in costs associated with guidance on new drugs and procedures from the National Institute for Clinical Excellence (*see* Section 1, p 10) (*see* Figure 5).

In addition, part of the total growth in funding for the NHS is expected to come from 'cash releasing efficiency gains' (improvements in efficiency within the NHS that release money to be spent on other services). It cannot be guaranteed that these will actually be made.

Therefore, of that £5,086 billion (12.38%) rise in cash for hospital and community services last year, the amount of cash to be spent on beds, procedures and so on after all these known cost pressures have been met, only increased by 2.4% (excluding any cash released from current spending through greater efficiency) (*see* Figure 6).

Has the money been well spent?

All this extra investment raises other questions: Is the money being spent on the right things? Are we getting good value for money? Unfortunately, as we started to discuss above (*see* Introduction) these are difficult questions to answer.

Knowing how much health the NHS produces may be the most crucial question of all. Unfortunately, like all other health care services around the world, the NHS has never consistently and systematically measured its patients' health.

As a consequence, we do not know how much extra health an extra pound spent on the NHS buys. The main measures of the nation's health – mortality (death rates), life expectancy (the number of years we can expect to live) – have been improving since the foundation of the NHS. But the contribution of the NHS to changes in these measures is difficult to assess even for specific procedures, as we discuss in more detail below in Sections 4 and 6.

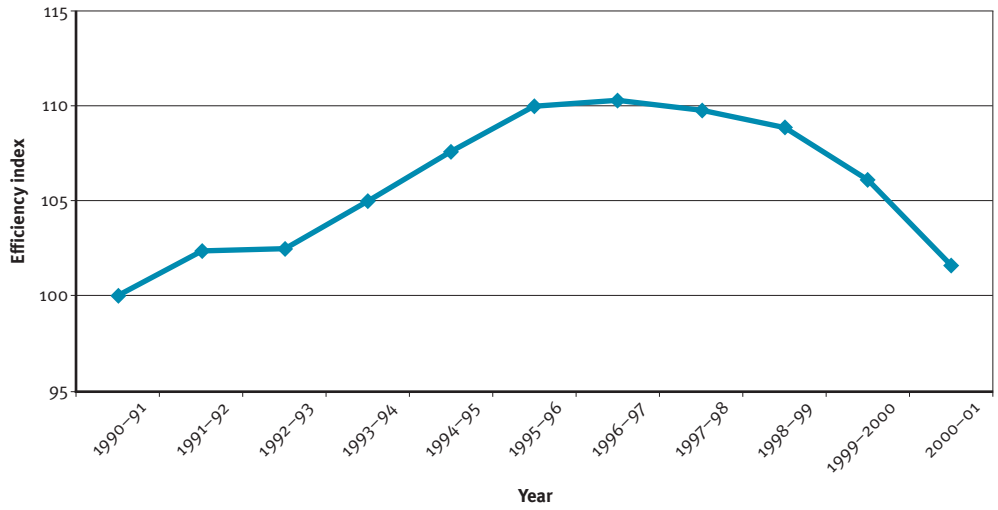
Instead, measurement has focused on what the NHS *does* rather than what it *achieves* in terms of improving health.

NHS PRODUCTIVITY

Traditionally, the NHS has tended to count the number of patients treated, prescriptions written, operations performed, attendances at outpatient departments and other activities. In the language of economics, these are its 'outputs'.

If we combine the cost of producing these outputs, and divide it by the extra money spent on the NHS each year, we get a measure of NHS productivity or efficiency. If the increase in NHS output is higher than the increase in NHS financial inputs, then its productivity increases (broadly, it gets more work for every pound that it spends). But as Figure 7 shows, since 1996 productivity measured this way has been declining.

7 **COST-WEIGHTED EFFICIENCY INDEX* FOR THE NHS IN ENGLAND, 1990–2001**



Source: Department of Health (2002)[20]

*CWEI = cost-weighted activity index, divided by index of volume changes in NHS spending

Why is NHS productivity falling?

The reason for this is straightforward. As explained above, the traditional productivity measure is a ratio of outputs (activity) to inputs (money). There have been relatively large increases in NHS spending since 1997/98, but there has not been a similar increase in activity. Therefore, the ratio of outputs to inputs must fall.

There are essentially four factors underlying this downward trend in activity:

- Extra spending has been absorbed by higher costs (including the cost pressures discussed above). In other words, productivity has actually fallen in some areas.
- Extra spending has been invested in services and activities which may take some years to be reflected in increased outputs. In other words, some money has gone on measures that may prevent ill health, such as smoking cessation services. These may be a good thing to do (we discuss the point below, *see* Section 4), but there will not be a measurable result until some time after the year in which spending on these services took place; so there is no 'output' to capture at the moment.

- Extra spending has been increasingly channelled into activities not captured by the productivity measure. The cost-weighted efficiency measure used in the figure above, for example, does not record clinics held in GP surgeries, even though there is a trend for more work to be done there rather than in hospitals.
- Extra spending has been used to increase the (unmeasured) quality rather than the (measured) volume of outputs. Improvements such as devoting more time to each patient improves the quality of their care – but this is not captured by the figures. It also costs more – and this is captured by the figures.

Aside from these problems, there is another difficulty with activity-based measures of this kind; it may seem paradoxical, but it is not always in the patient's interests for the NHS to always do more.

For example, it is not necessarily desirable for the NHS to continually increase the number of admissions to hospitals or attendances at accident and emergency (A&E) departments. It would be better to prevent the need for them in the first place. And as some drugs (and some operations and other interventions) are only of very limited benefit to patients it makes little sense for the NHS to strive to provide more.

For the NHS, improving productivity is not just about producing more of everything for each extra pound, it is about doing the right things in the right way, as efficiently as possible.

Research has recently been commissioned by the Department of Health to investigate the issues discussed above and to address long-standing criticisms of the NHS productivity measure. It will take some time before recommendations from this work will be ready to put into practice.

Conclusion

The increase in investment in the NHS since 1999 has been greater than during any other period in the last 30 years. In 2000, Tony Blair committed his Government to matching European levels of spending on health. After two initial years of relatively modest investment after 1997, the Government increased expenditure significantly, making up for cumulative and historic underinvestment in the NHS. This funding will bring the level of expenditure on health care in the United Kingdom up to 9% of GDP by 2008 – a figure comparable to other European countries. Therefore the Government's target will be achieved, and this has allowed the debate to shift away from funding levels to how to modernise the NHS. By 2007/08, generous funding from the 2004 spending review will mean that total health care spending in the United Kingdom (as a % of GDP) will have reached levels equivalent to spending seen in France in 2001.

As discussed in more detail in the sections that follow, the extra funding has been used to pay for more staff, equipment, buildings and medicines, which in turn have helped to contribute to better care.

What cannot easily be answered are these two questions: has the investment been well spent, and has the investment been enough? Productivity using the currently available measures – activity divided by expenditure – has actually fallen since 1997. On the surface, this suggests that the NHS is getting worse value for money. Yet the measure is flawed because not all activity is counted and increases in the quality of care are not recognised. Without a better measure of

productivity, it is not possible to be sure that the additional funds have been well spent. Nor is it possible to come to firm conclusions about what level of spending on the NHS is 'enough' – although a level that is close to that of European neighbours (with respect to the proportion of gross domestic product spent) seems reasonable.

Verdict: Unprecedented levels of investment, many service improvements but it is possible that money could be better spent.

3 Waiting times and access to care

Long waits for hospital treatment have been a historical problem within the NHS. For example, in 1988, 208,000 people – more than a quarter of all patients – were waiting for more than a year for inpatient or day case treatment.

Labour's targets

A range of targets relating to waiting lists have been set by the last two Labour governments (*see* Table 1) and access to treatment has been a clear focus for their efforts to 'save the NHS'.

TABLE 1: WHAT THE GOVERNMENT PROMISED

Target	Date
Hospital services	
Reduction in total waiting list of 100,000 (Labour Party Manifesto 1997)	end of Parliament
Maximum wait for inpatient treatment: 6 months (NHS Plan 2000)	end 2005
Maximum wait for inpatient and day case: 3 months (PSA 2002)	2008
Maximum wait for outpatient appointment: 3 months/13 weeks (NHS Plan 2000)	end 2005
Maximum time from GP appointment to treatment: 18 weeks (NHS Improvement Plan 2004)	2008
Emergency care	
Maximum wait in A&E: 4 hours (NHS Plan 2000)	end 2004
75% of emergency ambulance calls to be responded to within 8 minutes (NHS Plan 2000)	2001
Primary care	
Guaranteed access to a primary care professional within 24 hours (NHS Plan 2000)	2004
Guaranteed access to a primary care doctor within 48 hours (NHS Plan 2000)	2004

What has Labour delivered?

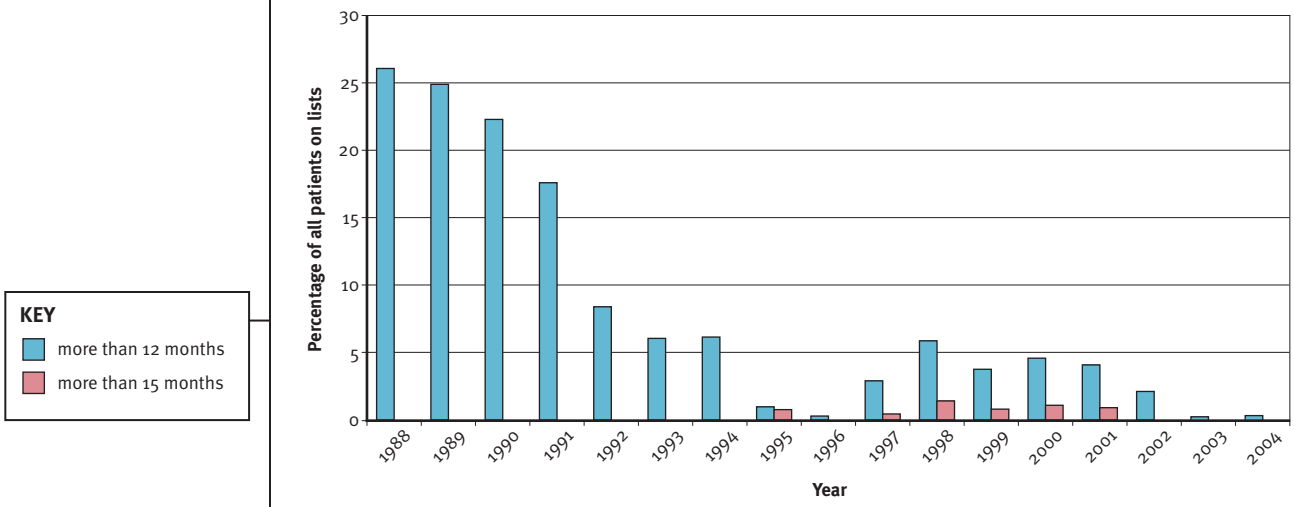
HOSPITAL SERVICES

Inpatient waiting lists

In 1997, the Government inherited an NHS that had almost eradicated waits for inpatient care of more than 12 months (*see* Figure 8). This had been achieved through tough national targets aimed at reducing long waiting times (known as the Patients' Charter). Under Labour, the proportion of patients waiting for more than 12 months (and more than 15 months) initially rose.

This was probably because Labour's focus, in its first two years in power, was the size of the waiting list, rather than the length of time patients spent waiting for treatment. Once the Government took its eye off that ball, waiting times began to creep up. Eventually, however, Labour switched its focus back to long waits. Since then, action to tackle waiting times has been successful (*see* Figure 8).

8 **INPATIENTS WAITING MORE THAN 12 MONTHS AND MORE THAN 15 MONTHS**

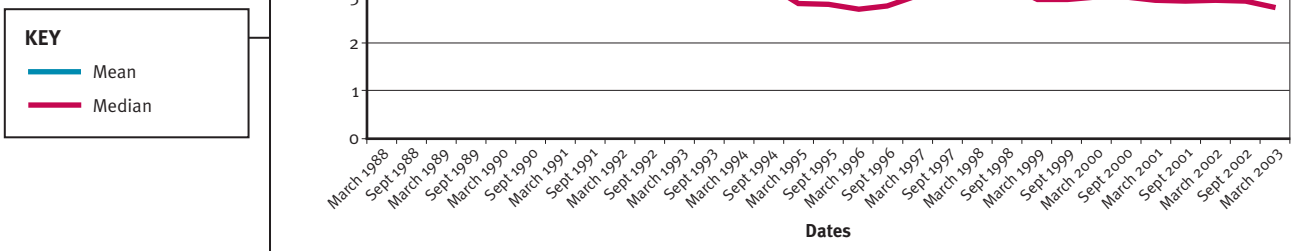


Source: Department of Health (2004)

In March 2000, when Labour published its NHS Plan, 264,370 patients had been waiting more than six months for inpatient treatment. The plan promised that no patient would wait more than six months for inpatient treatment by the end of 2005. In October 2004, 69,638 patients had been waiting more than six months for inpatient treatment. Therefore, according to NHS Chief Executive Sir Nigel Crisp, the service is 'well on target' to deliver the commitments for waiting times set out in the NHS Plan.[5] Sir Nigel Crisp's assessment is likely to be correct, as the number of people who are currently waiting longer than the target time is less than the NHS managed to take off the waiting list in the previous year.

The average waiting time for treatment has also declined since Labour came to power. There has been a 30.5% reduction in the mean average wait (the sum of individual waiting times divided by the number of patients waiting) and a 21% reduction in the median average wait (the 'middle' point of the different waiting times experienced by patients) since March 1997 (*see* Figure 9).

9 **MEAN AND MEDIAN WAITING TIMES FOR INPATIENT OR DAY CASE TREATMENT IN ENGLAND, MARCH 1988–MARCH 2003**



Source: Health Select Committee (2004)[21]

The mean average wait for inpatient treatment was just over four months in March 1997 and just under three months by March 2004. The median wait for inpatient treatment was just over three months in 1997 and two and a half months by March 2004. In other words, average waiting times are falling. With regard to the median average wait, while half of the patients waiting for treatment will wait less than two and a half months, half will wait more than two and a half months.

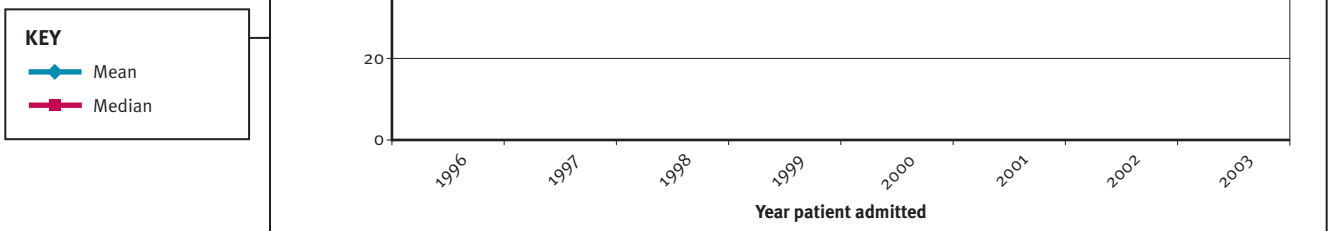
What these figures don't tell us is who these patients are. A key issue is whether patients on waiting lists are being clinically prioritised, so that the most urgent cases are seen first and fastest. Unfortunately, there is no publicly available data for us to be able to judge whether or not this prioritisation process is occurring efficiently.

Nor is there any publicly available data to let us judge whether clinical priorities are being distorted by the maximum waiting time targets (in other words, whether hospitals are dealing with some patients who are about to wait longer than the target ahead of more urgent cases).

Research by the King's Fund in the clinical specialty of orthopaedics suggests that the amount of 'clinical distortion' arising from the strategy to reduce the numbers of long waits is probably very small.[22] However, evidence given to the House of Commons' Health Select Committee, relating to the Bristol Eye Hospital, suggests that clinical priorities might be affected by waiting list management policies.[23]

Another way of measuring waiting time is the length of time patients waited *having been admitted in a particular year* – a 'completed wait' (*see* Figure 10). The average and median completed waits tend to be shorter than for those still on waiting lists. These have drifted slightly up, but over time, both ways of measuring waiting time have broadly moved in the same way and a fall can be expected.

10 **MEAN AND MEDIAN WAITING TIMES FOR INPATIENT OR DAY CASE TREATMENT FOR PATIENTS ADMITTED**



Source: Department of Health (2004)[24]

Outpatient waiting lists

The Labour Government inherited a significant outpatient waiting list problem. When it came to power, nearly 189,000 patients were waiting between 13 and 26 weeks for an outpatient appointment, and 69,000 patients were waiting for more than 26 weeks.

The situation worsened during the first few years of the Labour Government, peaking in 1999 with 363,000 patients waiting between 13 and 26 weeks for an outpatient appointment and 149,000 waiting more than 26 weeks (*see* Figure 11).

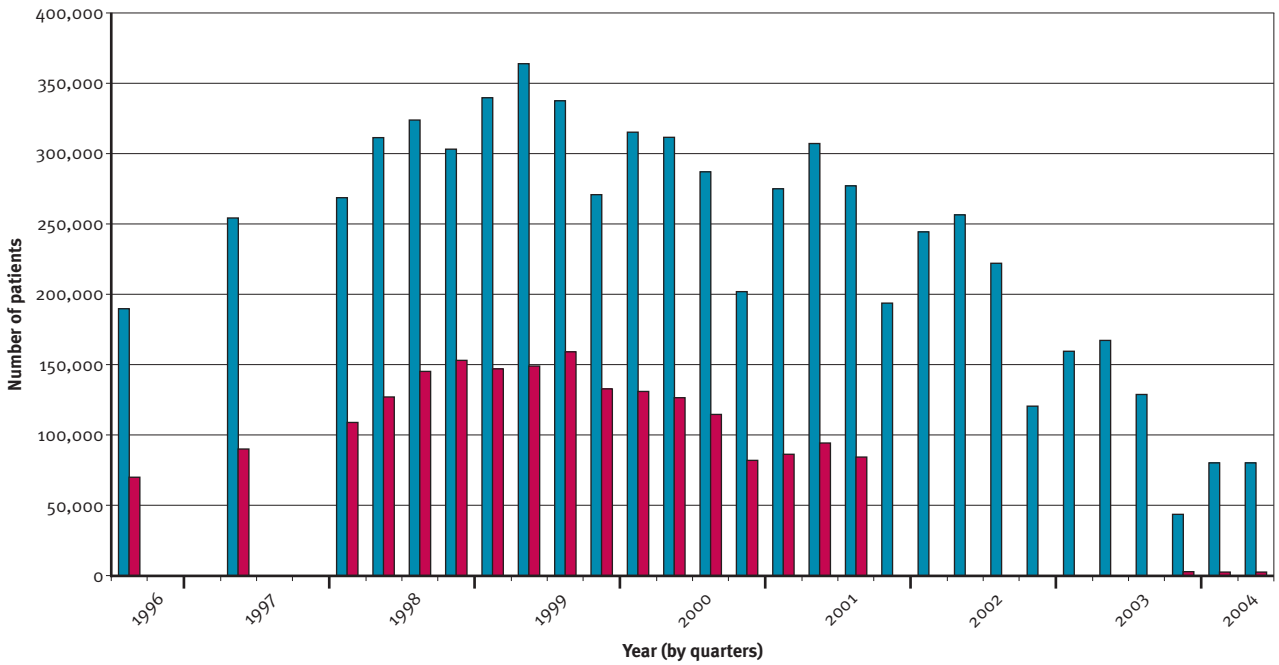
However, since 1999, significant improvements have been made towards the target of a maximum wait of 13 weeks by the end of 2005. By September 2004, the number of patients waiting 13–26 weeks for an outpatient appointment had fallen dramatically (to 77,148) and so had the number of patients waiting more than 21 weeks (to only 148 people).[18] Again, the NHS Chief Executive, Sir Nigel Crisp, is confident that the target will be achieved. On the basis of the available data, this confidence appears well placed.

The scale of Labour's waiting list achievement

To put Labour's waiting list success into context, it is worth remembering that the number of patients on the waiting list for an inpatient or day case procedure has grown steadily since the NHS was founded (*see* Figure 12). Waiting lists are in part affected by the level of demand for services (as opposed to how well the system is currently functioning). Demand for health services has been growing.

Between 1979 and 1996 (the years of the Conservative administrations) the list grew from 771,998 to 1,040,152 – a rise of 35%. While the total waiting list peaked during the first Labour Government, overall, the number of people waiting for hospital treatment has fallen by 17% since it came to power in 1997 (from 1,061,600 in 1997 to 885,503 in 2004).

11 **WAITING TIMES FOR OUTPATIENT TREATMENT IN ENGLAND, 1996–2004**



Source: King's Fund (2002)[3]
Note: These figures differ slightly to those issued in the *Chief Executive's Report to the NHS*, 2004.

KEY

- Of those referred but not yet seen, waiting 13–26 weeks
- Of those referred but not yet seen, waiting over 26 weeks

Through significant increases in NHS activity and more sophisticated ways of managing the flow of patients through the NHS (discussed in more detail in Section 4), the Government has not only met its manifesto pledge, but managed to reverse a historical trend of increasing numbers of people waiting.

EMERGENCY CARE

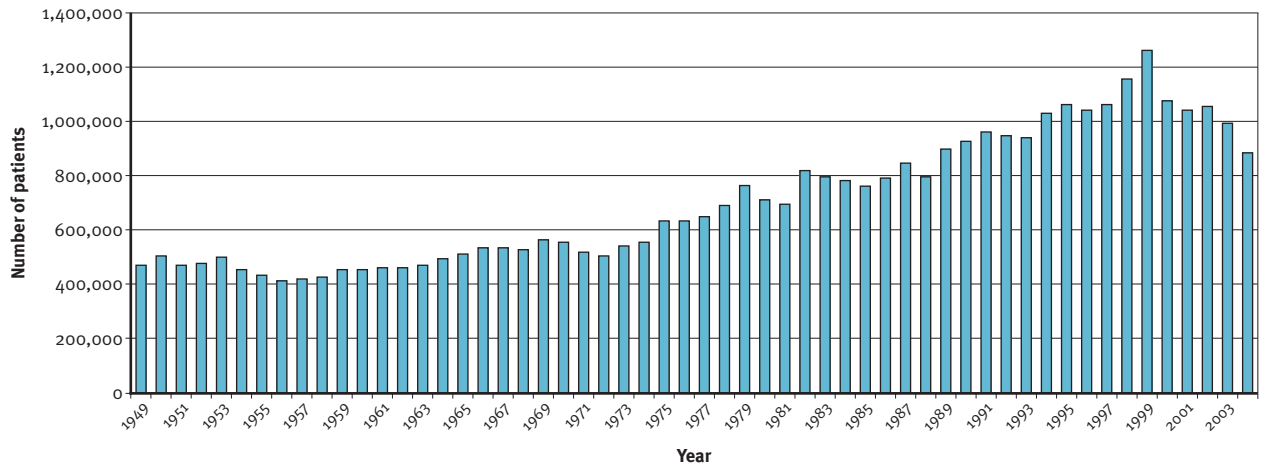
Accident and emergency

Emergency care services have been under intense pressure, with long waits in accident and emergency (A&E) departments in particular. The Government identified this problem as a key priority in the NHS Plan. It set a challenging target of ensuring that, by December 2004, no patient would wait more than four hours in A&E from arrival to discharge, transfer or admission to hospital.

According to the government spending watchdog, the National Audit Office (NAO), recent years have seen sustained and significant improvements in waiting times in A&E due to greater investment and better working practices.[25] Furthermore, the NAO suggested that the improvement in waiting times in accident and emergency departments did not appear to be achieved at the expense of other objectives, such as the reduction in cancelled operations.

However, whether the Department of Health will actually meet the waiting times target is, as yet, unclear. *The Chief Executive's Report to the NHS*, 2004[18] says that 96.4% of patients waited no more than four hours, a little way short of the required benchmark. However, serious questions have also been raised about the way the target is measured for the NHS star ratings. Hospitals are told that the target should be measured during one particular week of the year. There are suspicions that hospitals have diverted staff and resources away from other clinical areas in order to meet the target.[26]

12 **PATIENTS AWAITING INPATIENT AND DAY CASE TREATMENT IN ENGLAND, 1949–2003**



Source: King's Fund (2002)[3]

Ambulance services

Ambulance services are a crucial component of the emergency care network. There are 31 different ambulance services in England and there has been a significant rise in the number of emergency calls that they receive annually; from 3.58 million in 1997/98 to 5.34 million in 2003/04 – a rise of 49%.[27]

Against this background of rising demand, the NHS Plan set a challenging target for improved emergency response times, claiming that the earlier arrival of an ambulance by one minute to patients with a heart attack, would result in an extra 11 days of life, on average.

By 2001, it was expected that 75% of emergency (or what are known as 'category A') calls would be responded to within eight minutes. This target was not met within the timescale set. The NAO found that, in 2003/04, only 22 out of 31 ambulance services had met this target and that other services were struggling.[25] However, according to the *Chief Executive's Report to the NHS*, 2004, this target has now been met nationally.[18]

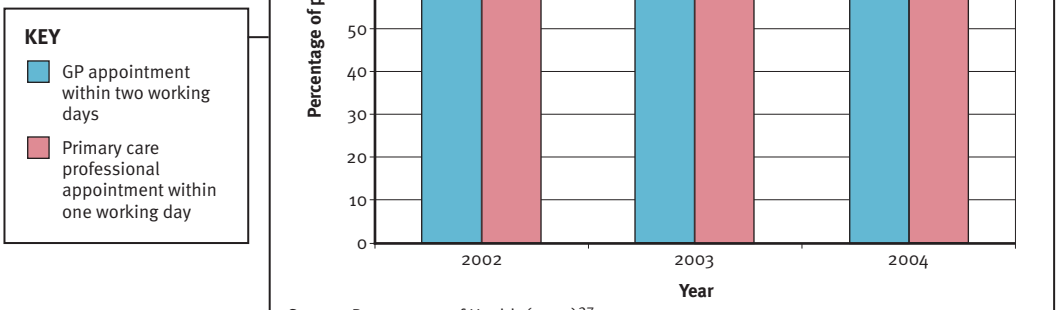
PRIMARY CARE

In the NHS Plan, the Government set a key target for access to general practitioner services. By 2004, it was intended that patients should wait no longer than 24 hours to see a primary care professional (that is a doctor, nurse, therapist or other professional working in a GP surgery or health centre) and 48 hours to see a GP.

According to official figures, this target has been achieved, with 99.2% of general practices meeting the targets by November 2004 (*see* Figure 13). However, results from the NHS Patient Survey paint a rather different picture. In 2004, 23% of patients reported that they had to wait more than two working days for an appointment with their GP.[28] Whether the difference shows up a problem with patients' memories, or with official monitoring of the target, is not known.

In addition, the Government has developed new forms of access to primary care. NHS Direct – the telephone, and later online, advice service – has expanded rapidly. Calls have risen from 1.65 million in 1999/2000 to 6.4 million in 2003/04.

13 **ACCESS TO PRIMARY CARE SERVICES IN ENGLAND, 2002–2004**



Source: Department of Health (2004)[27]

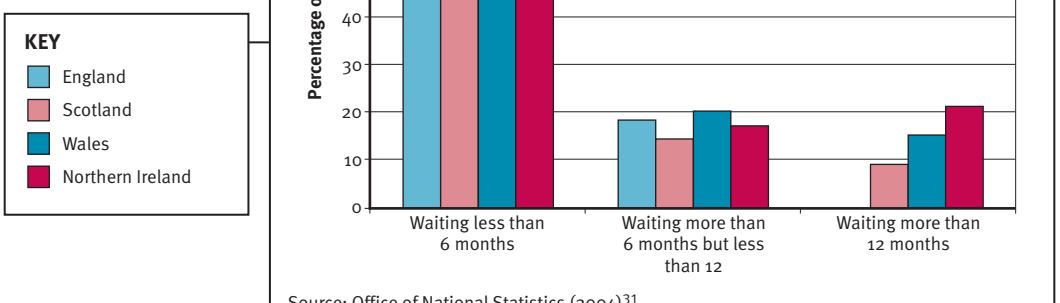
Online advice from NHS Direct has also risen sharply from 1,500,000 visits to its website in 2000[29] to 6,542,000 visits in 2003/04.[18,30] Patients can also access NHS 'walk-in centres', designed to deal with minor injuries and primary care issues. By 2003/04, 43 services had been set up and had treated 1.58 million patients.

International comparisons

As discussed in the Introduction, the Assemblies in Wales and Northern Ireland and the Scottish Parliament now have discretion over health funding and the management of the NHS. Significant differences in health policies and outcomes have emerged.

In terms of waiting times for treatment, it appears that the NHS in England has performed better than the other three countries in the United Kingdom (*see* Figure 14). For example, virtually

14 **WAITING TIMES FOR INPATIENT AND DAY CASE TREATMENT IN UNITED KINGDOM, MARCH 2003**



Source: Office of National Statistics (2004)[31]

no-one now waits for more than 12 months for treatment in England, while in Northern Ireland and Wales, 22% and 16% of patients wait for more than 12 months. A greater proportion of people in England are also waiting less than six months than in the other three countries.

Concern about waiting times is not confined to the United Kingdom. Waiting times have been described by the international think tank Organisation for Economic Co-operation and Development (OECD) as a 'serious policy issue' in a number of countries, including Finland, Ireland, Italy, Netherlands, Norway, Spain and Sweden.[32]

Research conducted by the OECD in 2000, before the major reductions in waiting times in the English NHS, revealed that England was not alone in having substantial waits for some types of surgery, such as cataract operations (*see* Table 2).[32]

TABLE 2: MEAN WAITING TIMES (IN DAYS) FOR SELECTED SURGICAL PROCEDURES IN SELECTED COUNTRIES IN 2000

Country	Cataract	Hip Replacement	Knee Replacement	Varicose
Denmark	71	112	112	99
Finland	233	206	274	280
Norway	63	133	160	142
Netherlands	111	96	85	107
Spain	104	123	148	117
Sweden	199	-	-	-
England	206	244	281	227

Conclusion

The Government set a number of challenging targets to reduce the number of people waiting for operations and to reduce the actual time spent waiting. In the first two years of the first Labour Government, the number of people waiting for NHS hospital treatment and the length of time that they had to wait both grew. However, since 2000, Labour's policies to tackle waiting times became far more effective. The Government is on course to meet its key target to reduce the maximum waiting time for an outpatient appointment to 13 weeks and an inpatient admissions to six months by December 2005. According to official statistics, the mean average waiting time for an inpatient or day case operation has dropped from just over four months in 1997 to less than three months by 2004.

The Government has also tackled the difficult area of emergency care. More than 96% of Accident and Emergency Departments now ensure that patients are either discharged, transferred or admitted within four hours (a little short of the Government's own target of 98%). Similarly, the ambulance service now answers 75% of emergency (category A) calls within eight minutes. Alongside these improvements in hospital and emergency care, access to primary care has also increased. According to the official statistics, the Government's target that patients should wait no longer than two days to see a GP is now met in virtually all practices (compared to only 75% of practices in 2002). However, when surveyed, patients suggest that compliance with this target is rather lower in practice (77%).

Despite these successes, it is accepted by the Government that there are 'hidden waits' where waiting times are not currently measured and where treatment may be stalled due to specific

bottlenecks (such as access to diagnostic tests). To address this, the Government has announced more investment in diagnostics to help meet a new waiting time target – a maximum total wait of 18 weeks between GP referral and treatment by 2008. This target is highly ambitious and shows Labour's determination above all else to transform the NHS' biggest perceived problem – waiting times.

Verdict: Greater progress on reducing waiting times than at any other stage in NHS history, with more to come. Unknown but likely to be significant waits for diagnostic tests.

4 Three health priorities: cancer, coronary heart disease and mental health

NHS services that care for people with cancer, heart disease and mental health problems have all been subject to major reform and investment by the Labour Government. Both cancer and heart disease were targeted because they are 'big killers'. According to official figures, one person in three in England will develop cancer at some stage in their lives, while one person in four will die of cancer – 120,000 a year in 2000.[33] Heart disease is also lethal on a big scale: it is still the most common cause of death, while an estimated 1.5 million men and 1.2 million women live with coronary heart disease (where the arteries that carry blood to the heart become narrowed).[34] Mental ill health does not claim so many lives, but affects many people – the Government estimates that at any one time, one adult in six suffers from some sort of mental health problem, ranging from anxiety to more serious disorders, such as schizophrenia.[35] The costs of mental health to the economy and society have been estimated at £77 billion, once the cost of NHS services is added to lost production and costs to individuals and their families.[36]

Cancer

The seeds of change in cancer care were sown under the Conservatives. A major review of cancer care, the Calman-Hine report,[37] was completed in 1995, prompted by evidence of very poor cancer outcomes for people in England and Wales compared to other European countries. The report recommended changes to the way cancer care was delivered, based on concentrating cancer expertise into special networks.

When Labour came into power, no immediate changes were made, but in 1999, the Government took the decision to review cancer care and appointed a National Director of Cancer Care – otherwise known as the cancer tsar. The aim was to improve services so that they approached the best international standards.

The first big target to reduce death rates or 'mortality' was set in 1999, in the white paper *Our Healthier Nation*.[38] More detailed targets were added in the NHS Cancer Plan of 2000.[33] Some of the big targets are due to be hit at the end of this year (*see* Table 3).[39]

Labour's strategy

The Government's strategy on cancer has been threefold: to prevent cancer, by reducing smoking and improving diet; to detect cancer earlier, by improving and extending screening and raising public awareness; and to improve cancer services.

The NHS Cancer Plan promised new funding 'rising to an extra £570 million a year for cancer services by 2003/04', and investment was made available to modernise equipment, some of it from the National Lottery. [33]

TABLE 3: TARGETS IN CANCER CARE

Target	Date
Reduce mortality rates from cancer by at least 20% for the under 75s (*Our Healthier Nation* 1999)	2010
Reduce adult smoking to 21% by 2010 (Spending Review 2004 Public Service Agreement)	2010
Two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer patients (NHS Cancer Plan 2000)	March 2000
One-month maximum wait from cancer diagnosis to treatment (NHS Cancer Plan 2000)	December 2005
Two-month maximum wait from urgent referral to treatment of all cancers (NHS Cancer Plan 2000)	December 2005
One-month maximum wait from urgent referral to treatment (NHS Cancer Plan 2000)	2008

The plan also promised more staff. By 2006, there were to be 1,000 extra cancer specialists; more radiographers; more nurses; and targeted action to address shortages of other staff who contribute to cancer diagnosis and treatment.

However, the plan recognised that problems went beyond a shortage of money, staff and equipment. It argued the whole 'patient journey' (from the patient's first visit to their GP, to the outpatient department of a hospital, to diagnosis, treatment and beyond) needed a substantial rethink in most parts of the country.

It also announced an expansion of special teams, known as cancer services collaboratives, to reform the way services were run. Initially, they began working in nine sites across England.[33]

Has Labour's strategy worked?

PREVENTION

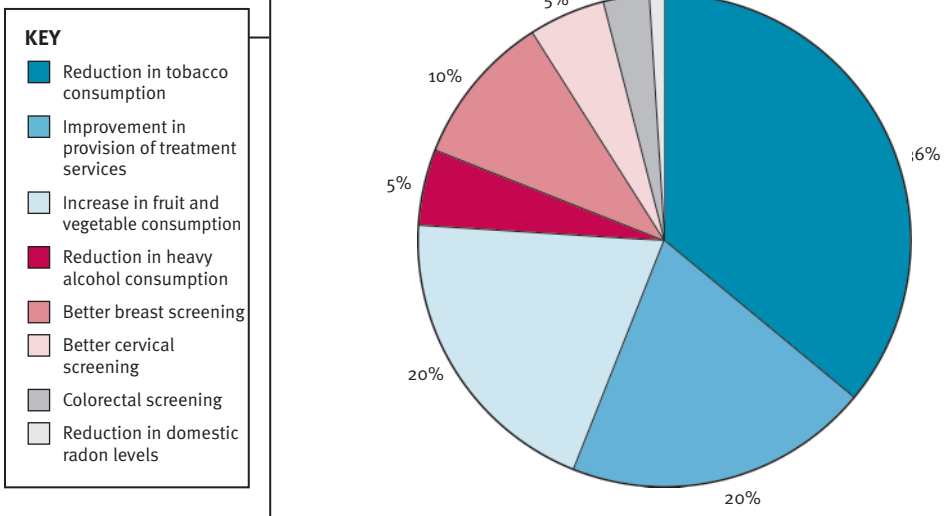
A third of cancers are attributable to smoking and up to a third are attributable to diet, according to the NHS Cancer Plan. Indeed, the Government has suggested that reductions in smoking and improvements in diet could far outweigh the benefits of better health care services in contributing to the target of reducing deaths from cancer by 20% (*see* Figure 15).[40] These also have a role to play in reducing heart disease.

Smoking

The Government set itself a target to reduce the overall number of smokers in England from 28% of the adult population in 1996 to 21% by 2010.[38] Because more manual workers smoke than professionals, and this is a major cause of their lower life expectancy, the Government also set a further target to reduce the rate of smoking among manual groups from 32% in 1998 to 26% by 2010.[33]

A commitment was made to set up a comprehensive national smoking cessation service within the NHS early in Labour's first term in office (one of a range of anti-smoking measures which included a ban on tobacco advertising).[41] The NHS Stop Smoking Service was rolled out nationally in 2000 and given a target of 800,000 successful 'quitters' by 2006.[42] Official figures

15 SOURCES OF POTENTIAL IMPROVEMENT IN MORTALITY FROM CANCER



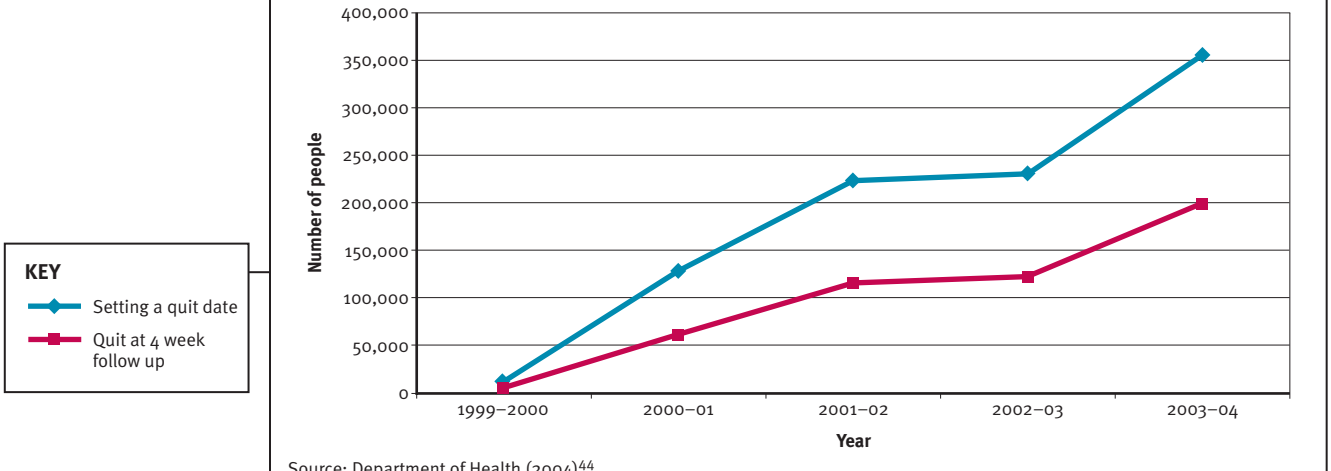
Source: Department of Health (2001)[43]

show that a significant proportion of those setting a quit date do go on to be successful quitters (*see* Figure 16).

However, this has to be put into context. The Government counts people who are not smoking after four weeks as quitters, but pilots of the quit programme in health action zones found far fewer people still managing to abstain from smoking after a year (*see* Figure 17).

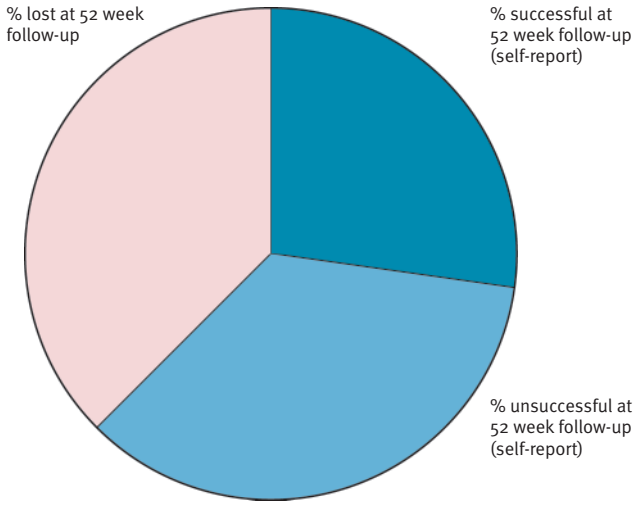
According to information released by the Department of Health under the Freedom of Information Act, local NHS organisations are no longer being asked to collect data about how many people have quit after a year, because it was proving too time consuming to find them. Figure 17 shows that many people were 'lost to follow-up' – in other words had moved house or were otherwise impossible to trace. The Department of Health concedes that a 'pilot study of

16 NHS STOP SMOKING SERVICES IN ENGLAND, 1999–2004



Source: Department of Health (2004)[44]

17 FOLLOW-UP OF SMOKING QUITTERS AT 52 WEEKS

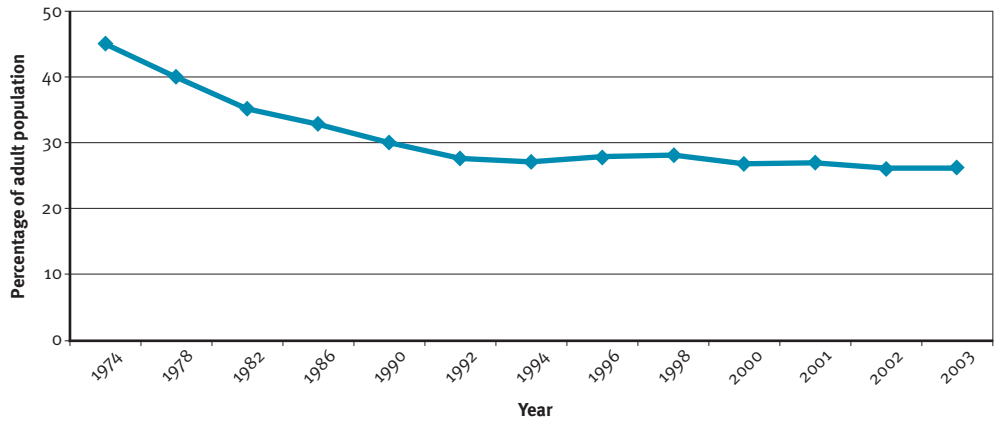


Source: Department of Health (2001)[45]

52-week quit rates in two areas suggests that longer-term quit rates are comparable with those established in clinical trials: that is, about 15% setting a quit date are still not smoking at 52 weeks'.[46]

In its most recent review of NHS progress, the Government says that a record number of people (205,000) have given up smoking, using the data from the NHS Stop Smoking Services.[19] However, if the logic of the 52-week 'follow up' is applied, this amounts to a real number of 30,750 people, a small dent in the 1.5 million people[5] that the Government calculates would need to quit to meet the wider target. Overall smoking rates have been drifting downwards, but the steep falls of earlier years have not been seen since the 1990s (*see* Figure 18). Nevertheless, it is hoped that the downward trend will be boosted by the most recent anti-smoking initiatives, including restrictions on smoking in public places, contained in last year's White Paper *Choosing Health*.[47]

18 RATE OF SMOKING IN ADULTS IN ENGLAND, 1974–2003



Source: Office of National Statistics (2004)[48]

Diet

No targets have been set for improving eating habits, even though 'increasing fruit and vegetable consumption is the second most effective strategy for reducing the risk of cancer' according the most recent departmental report.[49] Children have been a key focus of activity – a national 'free school fruit' scheme has been set up, and is now offering a free piece of fruit to all four to six-year-olds every school day – reaching an estimated 2 million children.[18]

A national 'five-a-day' programme to encourage adults to eat at least five 'portions' of fruit and vegetables per day was also set up, aimed at the food industry and consumers. Despite this, data from the Health Survey for England shows that between 2001 and 2003 there was no change in levels of consumption: on average women consumed 3.5 portions and men 3.2 portions.[50]

There is an unresolved debate about the extent to which governments can interfere in individual lifestyles. However, the slow progress made on diet raises questions about the effectiveness and cost of campaigns that may not have any lasting impact. We return to this issue below.

Cancer awareness

Raising public awareness of cancer was listed as a priority in the NHS Cancer Plan, but no quantifiable targets were set and it is not clear whether much has been achieved.

Last year, government spending watchdog the National Audit Office (NAO) issued a report on cancer that was discussed by the House of Commons' Public Accounts Committee, and both noted slow progress on this front.[51]

The Government argues that it is still awaiting the findings of research, without which a campaign cannot be targeted effectively. Some funding has been made available to voluntary sector organisations to run campaigns on particular cancers.

SCREENING

Breast cancer

Early detection of breast cancer leads to better outcomes and survival. The NHS Plan promised a 'big expansion' in cancer screening programmes, including the extension of breast screening to women aged 65–70; 72% of the women in this age group invited for screening attended in 2003/04.

A change in screening procedures was also made by 2003 – each screening now consists of two different views of the breast, improving the accuracy of the mammogram. In 2004, one case of breast cancer was detected for every 127 women screened, while in 1995, it was only one case for every 193 women screened.

Cervical cancer

The cervical screening programme in the United Kingdom was established in 1988. About 80% of women aged 25–64 have had a smear test in the past five years,[52] although problems with the test mean that about 10% are recalled unnecessarily for repeat smears.

The NHS Plan promised to introduce the more reliable liquid-based cytology screening method, to reduce the number of inadequate smears from more than 9% to 1–2%, but complete roll-out of this new technique is not expected until 2008.

Bowel and prostate cancer

As promised, the Government has also developed a national bowel cancer screening programme, which will begin in April 2006. It will target men and women in their 60s, using a technique that could cut mortality from bowel cancer by 15%. There is no national screening programme for prostate cancer, because the Government feels the present tests are too unreliable, although a risk-management programme is being evaluated.

IMPROVING THE SERVICE

Following the Calman-Hine report, the NHS under the Conservatives began to concentrate expertise in cancer care, on the grounds that it produced better outcomes for patients. Thirty-four 'cancer networks' were also formed across the country to improve services. Despite this, when Labour took office, the time waited by patients for treatment, at all stages of the patient journey, remained a problem.

Referral

The Government's first step was to promise that people who were referred to hospital by their GPs as 'urgent' cases would be seen by a consultant within two weeks.[33] The two-week maximum wait policy was implemented nationally in 2000.

Compliance with the 'two-week wait' target is high, according to official figures. The most recent data, for July to September 2004 shows that 99.5% (115, 977) of urgently referred cancer patients were seen within the two-week target. Of the 638 patients who were not seen within the two-week target, the majority were seen within three weeks.

However, a recent survey of cancer patients, conducted by the NAO, found that 37% had waited more than two weeks to see a specialist after being referred by their GP. It is not clear whether this means the targets are not working for some patients in reality, or whether they indicate that many patients who turn out to have cancer are not being referred as 'urgent' cases by their GPs.

In either case, the survey still suggests cancer services have made progress. A similar survey conducted in 2000 found that 49% of patients had waited longer than two weeks to see a specialist after being referred by their GP.[53]

Diagnosis

Two national targets are due to be met by the end of this year: a one-month maximum wait from diagnosis to treatment for all cancers, and the more ambitious 'two-month maximum wait from urgent GP referral to treatment'.[33] Both will come into force at the end of December 2005.

Meeting these targets will require investment in staff and diagnostic machinery, as well as redesigning services, so that, for instance, patients can undergo different tests on one day, instead of having to return for different appointments.

The Government has already hired more staff, in line with a commitment made in 2000.[33] It reported last year that 975 extra consultants were in post in six cancer specialties by June 2004. New diagnostic equipment has also been purchased – some of it with money from the National Lottery (*see* box, opposite).[54]

However, there is no publicly available, routine data for all cancers to let us judge whether the NHS is going to meet the one-month diagnosis to treatment and two-month 'total wait' targets. This is surprising, given that the dates for achieving them are now very close.

EXTRA CANCER RESOURCES (SEPTEMBER 1999–JUNE 2004)

Consultants

- Radiology + 352 (23%)
- Histopathology + 239 (29%)
- Haematology + 122 (24%)
- Clinical oncology + 76 (25%)
- Medical oncology + 85 (77%)
- Palliative medicine + 101 (107%)

(Total 975)

Equipment

- CT scanners + 223 (168 replacements; 55 additional)
- MRI scanners + 113 (56 replacements; 57 additional)
- Linear accelerators + 104 (76 replacements; 28 additional)

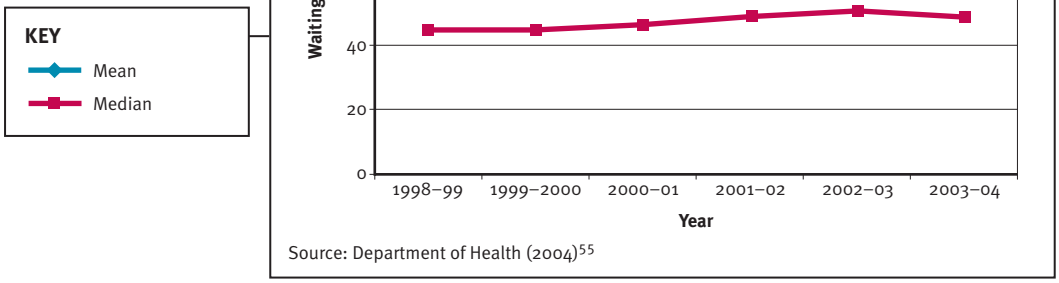
Data has been published, as promised in the NHS Cancer Plan, for breast cancer and three serious, but quite rare cancers – childhood cancers, leukaemia and testicular cancer. The most recent data reveals that 87.5% of childhood cancers, 88.9% of acute leukaemias and 92.4% of testicular cancers were treated within one month of diagnosis; while 97% of breast cancer patients were treated within two months of GP referral.

In addition, the Government has published one 'snapshot' view of all cancers. This shows that only 10.1% of all patients failed to receive treatment within one month of diagnosis, but that 22% are not being treated within two months of GP referral.[53]

Unsurprisingly, in the Government's most recent report on the NHS Cancer Plan, the cancer tsar, Mike Richards, described meeting these targets as 'an enormous challenge'.[54]

Meeting them is likely to require still more investment in staff and diagnostic procedures. Meanwhile, the NHS's Hospital Episode Statistics data set, which captures the number of

19 **WAITING TIMES FOR DIAGNOSTIC ENDOSCOPY OF THE COLON IN ENGLAND, 1998–2004**



Source: Department of Health (2004)[55]

procedures performed each year from hospital records, suggest that no improvement has taken place for some key procedures, such as using an endoscope to detect colon cancer and other diseases of the colon (*see* Figure 19).

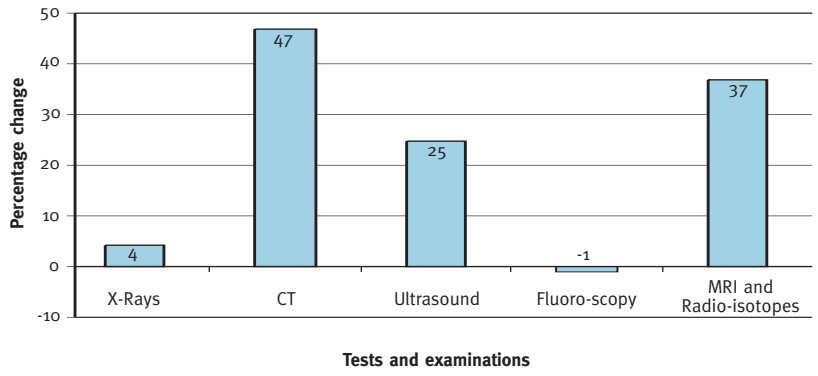
The Hospital Episode Statistics (at this level) do not tell us how appropriately patients are being prioritised: it is possible that, even though some above average waits are long, urgent cases are being seen much faster than average. Even so, it seems likely that many cancer patients have been subject to dangerously long waits in the recent past.

A glimpse of how bad the situation has been (and possibly still is) in some hospitals can be gleaned from the pilots to improve services being run by the cancer services collaboratives.

In a report on their work published in September 2004, one hospital was praised for reducing its wait for ultrasound scans to two weeks. It had done this by redesigning its appointments and undertaking simple initiatives, such as setting up a reminder service for patients before their appointment. The wait had previously been 70 weeks.[56]

Set against this, there has been an increase in the number of diagnostic procedures and examinations, such as x-rays, ultrasound and MRI scans. Altogether, almost 4 million more have been done since 1996/97, an increase of 14%. The largest increases have been in CT, MRI and ultrasound procedures (*see* Figure 20).

20 **INCREASE IN IMAGING AND RADIODIAGNOSTIC EXAMINATIONS, ENGLAND, 1996–97 TO 2003–04**



Source: Department of Health (2004)[57]

Speeding up treatment

Even once cancer has been diagnosed, there can still be delays for some treatments. The Royal College of Radiologists has conducted surveys of radiotherapy treatment for cancer patients in 1998 and 2003. It has also found that the percentage of patients needing radical radiotherapy who are being seen 'outside a maximum acceptable delay' has actually gone up: from 32% in 1998, to 72% in 2003.[58]

In evidence to the House of Commons' Public Accounts Committee, NHS Chief Executive Sir Nigel Crisp has identified a shortage of radiotherapy staff as a 'really significant bottleneck … and a very serious issue for us.'[59]

Making more drugs available across all parts of the country – ending the 'postcode lottery' was also a Government commitment. The NAO's most recent appraisal of progress in cancer services points out that while progress has been made in *approving* new drugs for use across the country, there were 'unacceptable variations' in the use of the drugs between parts of the country. Measures are now in place, according to the NAO, to address this.[60] Overall, however, despite the blockages that exist in parts of the cancer system, there does appear to have been a sustained effort to hire more staff, buy more machines and develop systems that use them to deliver better services for patients.

OUTCOMES

But has all this increased activity and greater access for patients led to better outcomes? Are fewer people getting cancer and are fewer people dying from cancer?

More cancers are being detected. According to the Government's latest progress report on cancer, the total number of new cases of cancer is increasing by 1.4% per annum.[54] This is not necessarily 'bad' news: screening is getting better (and therefore finding more cancers that would otherwise have been missed) and diagnosis is also getting more accurate. The rise in the numbers of new cases of cancer is also explained by effects of an ageing population. Cancer is predominantly a disease of old age: as more people age, more cancers will be found. However, even when the numbers of older people are taken into account, more new cancers are being found.

So, does this mean that the prevention strategy hasn't worked? The problem here is the time lag between changing a person's eating or smoking habits and getting a result: it can take years before changes (positive or negative) show up. So, some of the new cancers being detected today will be the result of individual decisions and government policies that substantially pre-date the Labour Government and many people will go on to develop cancer no matter how effective a prevention policy is in place.

Death rates

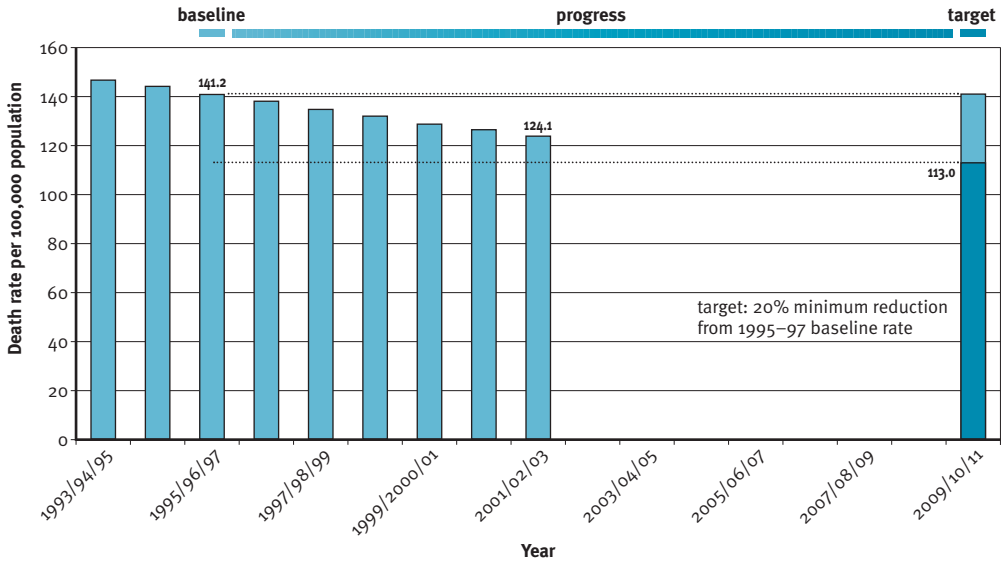
Despite this increase in the number of cases of new cancers, the disease *is* claiming fewer lives than when Labour came into power. The Government claims to be on track to meet its mortality target by 2010 (a 20% reduction from the 1995–97 baseline), as Figure 21 shows.

How much credit can the Government claim for this? Better screening, earlier diagnosis and quicker treatment may all have a role to play in cutting deaths. Better screening seems to have cut deaths from some cancers – breast cancer for instance, where the evidence suggests that prompt, earlier treatment has played a role in saving lives. But it is difficult to conclude that all the improvements Labour has made to waiting times and treatment have been driving mortality down because mortality was declining at a similar rate before Labour came to power. It is clear from Figure 22 that the trends in declining mortality (in all age groups) pre-date the Labour Government by several decades. Rates have been declining since the mid-1970s for men, and the mid-1980s for women. Experts attribute a large part of this to a decline in smoking (which began falling earlier among men), which has cut lung cancer rates in particular. Other cancers have declined without an obvious explanation – for instance stomach cancer.

Survival rates

Another way of measuring how good cancer services and treatment are is to ask what proportion of people are alive one, three or five years after their diagnosis. These are known as 'survival rates' and they are compiled both in this country and abroad, to allow comparisons.

21 MORTALITY FOR CANCER IN ADULTS UNDER 75 IN ENGLAND



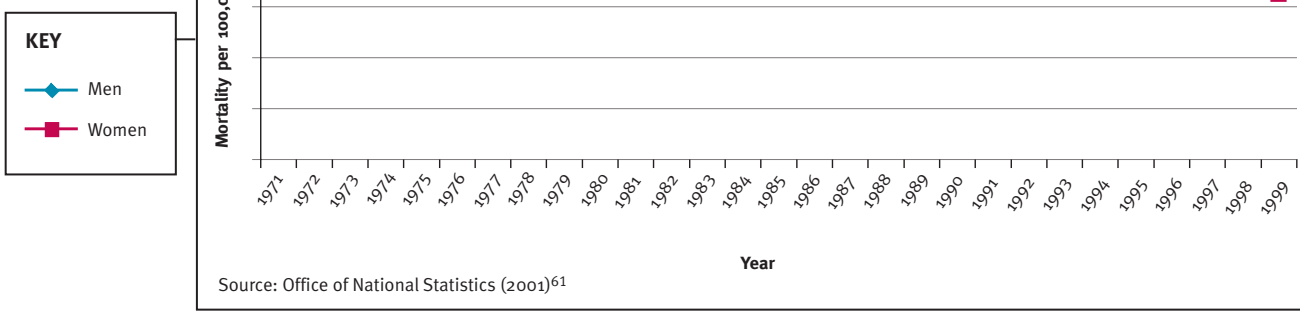
Source: Office of National Statistics (2004)[18]

Note: Due to ONS revisions to both current and historic population estimates (following a post-2001 Census study of population data), all mortality rates in the trends have been amended. Therefore baseline, target and monitoring data presented here may differ from those published previously. Rates are calculated using the European Standard Population to take account of differences in age structure. Note that there are slight differences to the baseline and target figures given here and those published in *The NHS Cancer Plan and the new NHS*, due to revised ONS population estimates. ICD9 data for 1993 to 1998 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards.

The most recent data for England and Wales (*see* Table 4) looks at the differences in survival between cancer patients diagnosed between 1991 and 1995, and a later group, diagnosed between 1996 and 1999. Improvement was recorded for all the major cancers, with a greater percentage of people surviving for five years.

The problem here is that the improvements largely pre-date the reforms to cancer services, so it is not yet possible to conclude that the reforms have had an impact on people's health.

22 MORTALITY FOR CANCER FOR ALL AGES IN ENGLAND AND WALES, 1971–99



Source: Office of National Statistics (2001)[61]

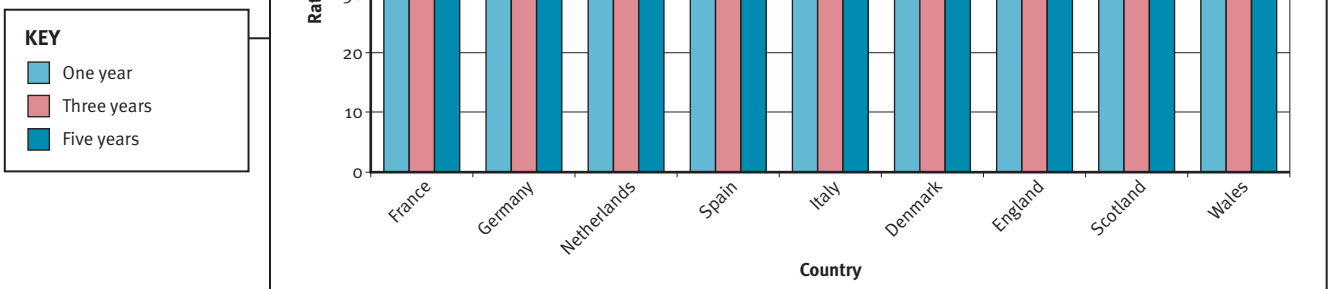
TABLE 4: IMPROVEMENTS IN SURVIVAL RATES FOR FOUR MAIN CANCERS, ENGLAND AND WALES

		Patients diagnosed 1991–95 survival %	Patients diagnosed 1996–99 survival %	Difference
Lung	Men	5.2	5.8	+ 0.6
	Women	5.4	6.4	+ 1.0
Breast	Women	72.8	77.5	+ 4.7
Colon	Men	42.1	46.9	+ 4.8
	Women	42.8	47.9	+ 5.1
Prostate	Men	53.6	64.8	+ 11.2

Source: Department of Health (2003)[62]

The same problem arises with the international data. An international team has been compiling comparable data from across Europe, following the progress of people diagnosed with cancer between 1990 and 1994. The last year for which figures are available is 1999 (in other words, five years after a 1994 diagnosis). The figures show that England, along with Scotland and Wales, experienced worse survival rates for all cancers than other countries (*see* Figure 23) – but they relate to a period before the bulk of England's cancer service reforms took effect.

23 **SURVIVAL RATES FOR ALL CANCERS FOR ALL AGES IN SELECTED COUNTRIES FOR THOSE DIAGNOSED 1990–1994**



Source: Eurocare (2003)[63]

Coronary heart disease

Coronary heart disease was a priority for governments before Labour came to power in 1997, for the simple reason that it is the commonest cause of premature death in the United Kingdom,[64] yet it is possible to both prevent it and reduce the symptoms through speedier treatment.

Despite this, Labour's blueprint for reform – the National Service Framework for Coronary Heart Disease (NSF)[64] – drew attention to the fact that the burden of heart disease is unevenly spread across the population, both in terms of social class and area.

For example, it showed that the death rate from coronary heart disease for people under 65 is three times higher in Manchester than in Kingston and Richmond. When the NSF was published in 2000, these inequalities appeared to be growing (the bigger issue of health inequality is discussed in Section 6).

Labour's strategy

The strategy to tackle heart disease was similar to that used for mental health and cancer: a comprehensive set of prevention and treatment guidelines in the form of an NSF; a tsar or national director to drive implementation; and high level national targets, including a pledge to reduce death rates from a range of heart and circulatory diseases (*see* Table 5).[65]

TABLE 5: TARGETS TO REDUCE MORTALITY FROM A RANGE OF HEART AND CIRCULATORY DISEASES

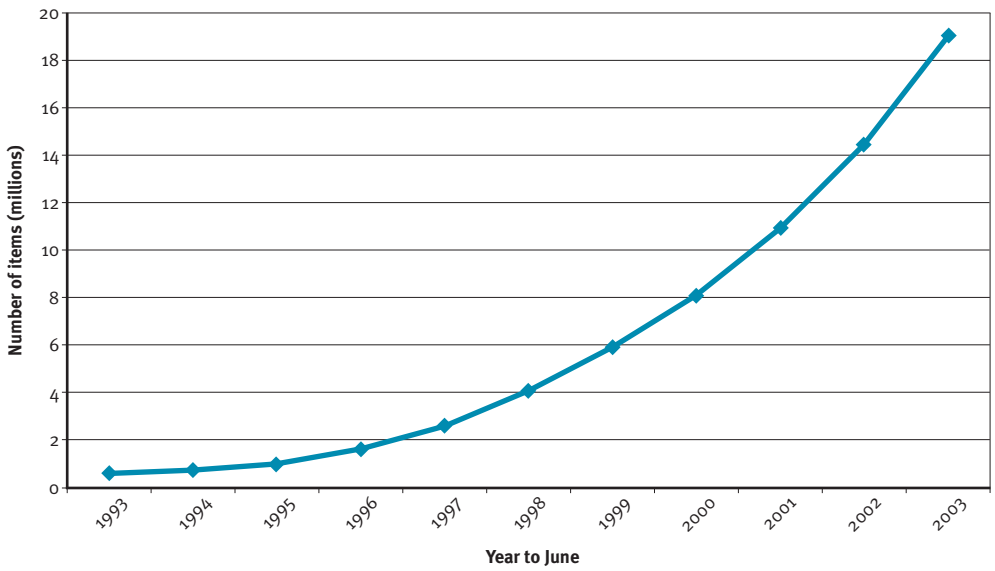
Target	Met or missed?
Health ■ Substantially reduce mortality from the major killer diseases by 2010 – from heart disease by at least 40% in people under 75.	**On course** the Government says it is 'on course' (*see* Figure 28)
Access ■ Set up rapid-access chest pain clinics nationally by 2003; seeing people within two weeks. ■ Six-month maximum wait for an angiogram by December 2005. ■ Six-month maximum wait for routine surgery by 2005 and three-month maximum wait by 2008; 6,000 extra operations to be done by 2003.	**Met** all clinics in place; 94.5% of patients seen within two weeks **On course** 40% increase in angiography since 2000 **Met** 6,000 extra operations delivered by 2002; six-month maximum wait already achieved
Treatment ■ Give clot-busting drugs to patients suffering a heart attack within 60 minutes of them calling for help. No target date set but 10% improvement to be achieved year on year.	**On course** latest data (2003–04) says 48% of patients get these drugs within the time limit, compared to 38% in 2002–03
Workforce ■ The number of cardiologists to increase by 10% each year from 1999/2000, to a total of 685 by 2003/04 – an increase of 47%. Cardiothoracic surgeons will increase by 4.5% each year for the next few years.	**Met/exceeded** 694 cardiologists; 240 heart surgeons in post

Has Labour's strategy worked?

PREVENTION

The programme for trying to prevent heart disease shares many features with the programme for trying to prevent cancer; reducing smoking, improving consumption of fruit and vegetables and reducing obesity should tackle both. As we have already discussed, progress has been mixed – smoking rates are slowly coming down, but fruit and vegetable consumption has not improved and rates of obesity are rising. The most recent review of progress conducted by the Healthcare Commission found that over half the local health 'communities' under scrutiny had no strategy in place to combat obesity.[34]

24 **STATINS DISPENSED IN ENGLAND, 1993–2003**



Source: Department of Health (2004)[18]

Nevertheless, some other risk factors specific to heart disease, such as high blood pressure, show some encouraging signs. Evidence from the *Health Survey for England*[50] (which is commissioned every year by the Department of Health and asks a sample of the population questions about their health, and takes measurements such as blood pressure), shows that the prevalence of high blood pressure, and crucially, the prevalence of untreated high blood pressure, appears to have fallen between 1998 and 2003 – suggesting that some of the efforts to target those most at risk of heart disease may be starting to have an effect.

The most recent government progress report on the National Service Framework directly links this fall in blood pressure with increased NHS expenditure on drugs such as statins, which lower cholesterol in the blood.[65]

However, there may still be some room for improvement as the Health Survey for England reports that '33% of men and 43% of women with cardiovascular disease conditions were not taking cardiovascular disease medicines', including statins, aspirin and beta blockers.[50]

The heart disease NSF required hospitals to ensure that 80–90% of patients were given cardiovascular disease medicines after a heart attack, to reduce the risk of further heart attacks, and the most recent official data suggests that the majority of hospitals in England are now achieving the NSF goals.[66]

Statins are also prescribed by GPs to those people deemed to be at risk of heart attacks. Figure 24 shows the rapid increase in the prescription of statins.

Under the terms of the NSF, GP practices are also supposed to have created, and to be maintaining, a register of all patients who are currently suffering from heart disease, and a separate register for those they believe to be at risk of heart problems. The Healthcare Commission watchdog has conducted 26 investigations into how well primary care trusts (PCTs) are following the standards for heart disease, and has now published a national report.

It says that nine out of ten GP practices now keep electronic registers of those currently suffering from heart problems, but 'only a small minority' are developing registers of those at risk of heart disease. The Healthcare Commission notes that the current GP contract (and therefore payment) requires the keeping of a register of those already diagnosed with a range of chronic conditions but not a register of those at risk.[34]

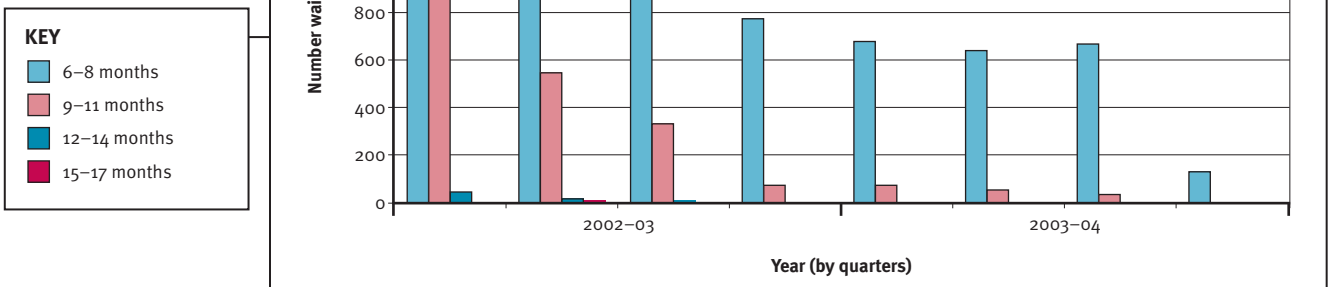
TREATING HEART ATTACKS

The NSF aimed to reform the treatment given to people who suffer a heart attack. Defibrillators (machines that can restart the heart), have also been put in public places (110 to date) and more than 6,000 people have been trained to use them since 2000. The Government estimates that 56 lives have been directly saved as a result.[65] Meanwhile, targets have been met to deliver clot-busting drugs within 30 minutes of arrival at hospital and within an hour of calling for professional help.

ACCESS TO SURGERY

The Government has had clear success in reducing waiting times for heart surgery – which were up to two years in some cases before its reforms. Its pledge is now to reduce waiting times to no more than six months by 2005 and the NHS appears to be on course to deliver this (*see* Figure 25).

25 **WAITING TIMES OF MORE THAN SIX MONTHS FOR HEART SURGERY IN ENGLAND, 2002–04**

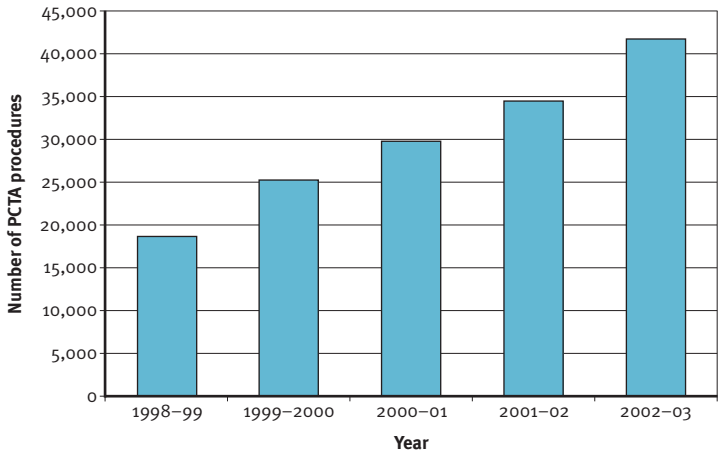


Source: Department of Health (2004)[57]

Labour has been particularly successful in reducing and removing the longest waits by increasing the numbers of operations performed. Figure 26 shows the volume of percutaneous transluminal coronary angioplasty (PTCA) procedures (an operation to restore blood supply to the heart muscle). This was one of the heart operations that was earmarked for improvement in the NSF. The number of PTCA procedures performed has increased by 50%.

However, it is also clear from data known as Hospital Episode Statistics, that while unacceptably long waits (nine months or more) have been all but removed, average waits for

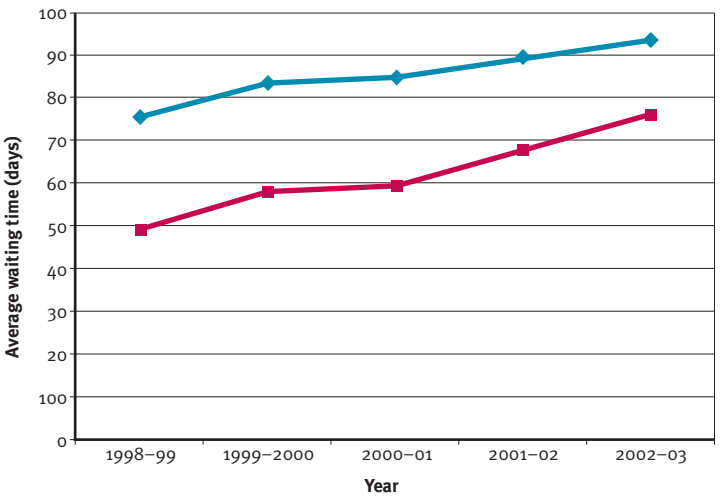
26 **PCTA PROCEDURES IN ENGLAND, 1998–2003**



Source: Department of Health (2004)[24]

some procedures have drifted up. Figure 27 shows that the average wait for coronary angioplasty now stands at 77 days or about two and a half months – a 36% increase since 1998/99.

27 **AVERAGE WAITING TIMES FOR PCTA PROCEDURES IN ENGLAND, 1998–2003**



KEY
- Mean waiting time
- Median waiting time

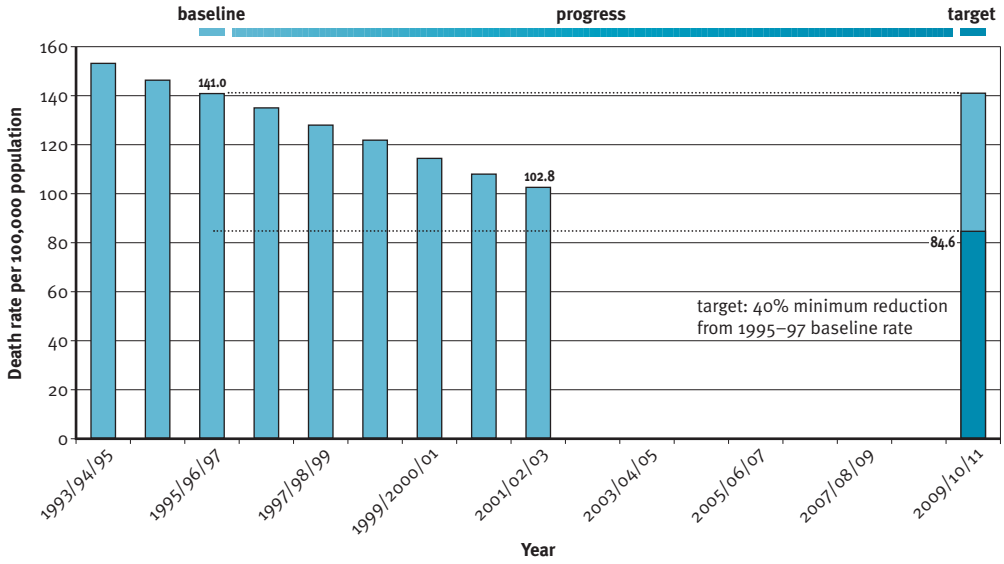
Source: Department of Health (2004)[24]

OUTCOMES

Again, the question needs to be asked whether all this activity has made any difference to the number of people dying from or living with heart disease.

The Government wants to cut the number of people aged under 75 dying from cardiovascular diseases by a fifth by 2010.[38] This looks on course to be achieved. The most recent data shows a healthy 27% drop in mortality (*see* Figure 28), compared to the baseline years of 1995/96/97.[65]

28 **CIRCULATORY DISEASE MORTALITY TARGET**



Source: Office of National Statistics (2004)[18]

Due to ONS revisions to both current and historic population estimates (following a post-2001 Census study of population data), all mortality rates in the trends have been amended. Therefore baseline, target and monitoring data presented here may differ from those published previously. Rates are calculated using the European Standard Population to take account of differences in age structure. ICD9 data for 1993 to 1998 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards.

However, the progress towards the target shown in Figure 28 has to be set against a backdrop of falling mortality from heart disease that has been going on for several decades. Over the previous 15 years, when no reforms were in place, there were still reductions in mortality from cardiovascular disease of 33%, for all age groups.

Another question is whether Labour's reforms have prevented people from developing heart problems in the first place. Unfortunately, we don't have the national level data to answer to this question – there is no national registry to record every new case, as there is for cancer.[67]

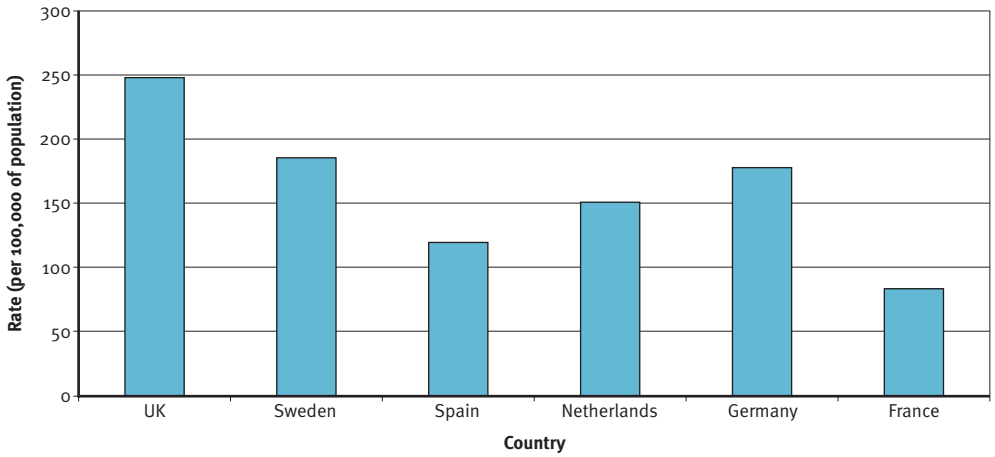
However, the Health Survey for England shows an increase in the prevalence of both coronary heart disease and stroke for both men and women, for 1994, 1998 and the most recent year that data has been collected, 2003.

The survey reports that the increases are only statistically significant for heart disease in men, (which rose from 6% in 1994, to 7.1% in 1998 and 7.4% in 2003) and for stroke and heart disease in the older age groups (over 75). Interpreting these findings is difficult: it could mean there is more illness in the population or that more people are surviving heart problems or strokes. As the survey points out, research is needed that follows people over time, to see how their conditions change.[50]

International comparisons

Can any progress be seen if England or the United Kingdom are compared to other countries? Most of the international data that is available to us to try to answer this question pre-dates the bulk of Labour's reforms: 2001 is the most recent year that enough data is available from enough countries.

29 **AGE-STANDARDISED MORTALITY FOR MEN AGED 35–74 BY SELECTED COUNTRIES, 1999**



Source: World Health Organization (2004)[68]

The most recent report from the Department of Health nevertheless argues that the gap is closing in terms of mortality.[65] Looking at Europe, it says: 'We are rapidly catching up with other countries and are much closer to the middle of the pack'. However, 'the pack' used by the Department of Health includes former Eastern Bloc countries and the Russian Federation, which have extremely high – and rising – death rates from heart disease.

When compared to Western European countries with comparable economies and levels of development, the United Kingdom still has the worst mortality rates (*see* Figure 29).

There is also data suggesting that England still lags behind mainland European countries when it comes to the number of heart procedures performed. However, the most recent data that compares a range of procedures (percutaneous coronary interventions (PCI) and open heart surgery are given as examples in Table 6) are for 2000 – which is too close to the onset of Labour's reforms to be of much help in making a valid judgement about whether the United Kingdom has caught up.

TABLE 6: COMPARATIVE RATES FOR HEART PROCEDURES IN SELECTED EUROPEAN COUNTRIES PER MILLION POPULATION, 2000

Country	PCI*	Open heart surgery
France	1,560	1,501
Germany	2,194	1,191
Ireland	537	718
Netherlands	1,091	904
Spain	581	435
Sweden	857	645
UK	564	645

* Percutaneous coronary interventions

There is more recent data available, but for a much narrower range of countries. This data suggests that the United Kingdom is making more rapid progress than the other countries by increasing the number of procedures performed (*see* Table 7).[69]

TABLE 7: RATES OF PERCUTANEOUS CORONARY INTERVENTIONS IN SELECTED EUROPEAN COUNTRIES PER MILLION POPULATION

Country	2000	2002	Percentage change
Germany	2,194	2,439	20.5%
Netherlands	1,091	1,205	10%
UK	564	758	34.6%

Mental health

The Government's reforms to mental health services have to be set against a background of a major shift in the way mentally ill people have been treated not just in the United Kingdom, but in many comparable countries in Europe, North America and Australasia.

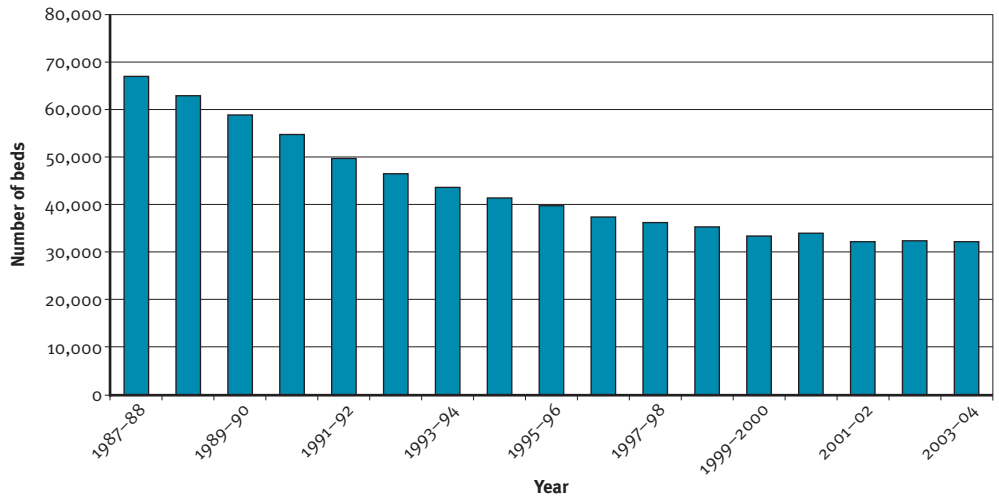
A process of moving people out of inpatient psychiatric institutions (such as hospitals or asylums) has been taking place since the 1950s, in favour of treatment in the community. One of the aims of this has been to encourage people to lead as independent a life as possible. Figure 30 shows the decline in the number of mental health beds in hospitals.

Throughout the 1980s and 1990s, the reality of 'care in the community' often fell short of the ideal. The Labour Government's first policy document on mental health, published in 1998, was sharply critical of the quality of care that many people had been receiving and declared that 'care in the community has failed'.[70]

In particular, the Government drew attention to a group of people with severe mental illness, such as schizophrenia, who were not being adequately looked after – 'hard to engage' in the official language. Dealing with this group became a priority, not least because of the perceived danger they presented to themselves and others.

In practice, however, the numbers of severely ill people are small. One in 200 people has a psychotic disorder[71] compared to one in six adults suffering from depression or anxiety. Only a

30 MENTAL HEALTH BEDS IN ENGLAND, 1987–2004



Source: Department of Health (2004)[55]

tiny number of people with a mental disorder will commit a serious act of violence (they are much more likely to be the victim of violence).

Labour's strategy

Labour's strategy did not imply a return to more inpatient beds, but better quality care in the community for people living at home, along with an increase in smaller medium and high-security facilities. The approach was subtitled 'safe, sound and supportive' and backed by £700 million of extra money.

In 1999, the Government published detailed proposals for reform in a consultation paper on reforming the Mental Health Act 1983. It also issued a National Service Framework (NSF) for mental health.

The NSF contained evidence and guidelines for a raft of interventions, ranging from 24-hour services, to more support for carers and mental health promotion (attempts to reduce the stigma and prejudice often displayed towards mental illness).

A key element of the reform was the creation of new teams across the country – assertive outreach teams, crisis resolution teams and early intervention teams – to deliver appropriate care to the hard to engage.

As part of their strategy, the Government initially set only one measurable target: to reduce the mortality (death) rate from suicide and undetermined injury (violent deaths for which the cause is not known) by at least 20% by 2010 (its progress against this target is discussed below).

FIRST TERM TARGETS

- Improve the life outcomes of adults and children with mental health problems through year-on-year improvements in access to crisis and CAMHS (Children and Adolescent Mental Health Services) services.
- Reduce the death rates from suicide and undetermined injury by at least 20% by 2010.

The Government also made some less measurable pledges on 'access' to services (*see* box, above). In the NHS Plan, published the year after the NSF, it added some more specific targets, and these form the core of the current Public Sector Agreement between the Department of Health and the Treasury (*see* box, overleaf).

The Government's progress report on the NSF estimates spending on mental health services increased in real terms since 1999 by between a fifth and a quarter.[72]

England is one of the most generous countries in Europe in terms of the percentage of its overall health budget allocated to mental health;[73] last year this was over 13%.

However, according to the mental health tsar Louis Appleby, spending has been uneven across the country and the rate of increase might be slowing as PCTs face competing demands for resources.[71]

NHS PLAN PLEDGES[5]

- 1,000 graduate primary care workers (to help 300,000 people by 2004).
- 5,000 more community mental health staff (to benefit 500,000 more patients by 2004).
- 50 early intervention teams to help young people with psychosis.
- 335 crisis resolution teams to be accessed 'at any time', to help 100,000 people a year who would otherwise have to go to hospital and reduce pressure on acute inpatient units by 30%.
- 220 assertive outreach teams to help the hard to engage – by 2003, all 20,000 people needing this service will be getting it.

Has Labour's strategy worked?

ACCESSIBILITY

Table 8 summarises Labour's progress against its targets for increasing mental health staff, outreach teams and beds, using data that is publicly available. It shows that most but not all of the targets will have been met by their target dates. However, the Government's progress report, completed in 2004, indicated that all targets will have been met by the end of that year.[72]

TABLE 8: TARGETS ON ACCESS TO MENTAL HEALTH SERVICES

Target	Met or missed?
■ 1,000 new graduate primary care workers by December 2004, to help 300,000 people	**Not on track** only 353 in post by September 2004
■ 300 prison mental health 'in-reach' staff by 2004	**Met** 370 staff in at post April 2004
■ 335 crisis resolution teams by the end of 2004	**Missed** only 243 in place at December 2004
■ 220 assertive outreach teams by 2003, serving an estimated 20,000 people	**Met** 263 teams in place at March 2004, but only 96 of these are 24-hour teams, as intended
■ 50 early intervention teams by 2004	**Met** 81 in place
Extra beds	
■ 320 fully staffed community beds by 2004	**Met**
■ 300 medium-term secure beds by 2003	**Met**
■ 200 long-term secure beds by 2004	**'Expected to be achieved'** according to the NSF five-year report

OUTCOMES

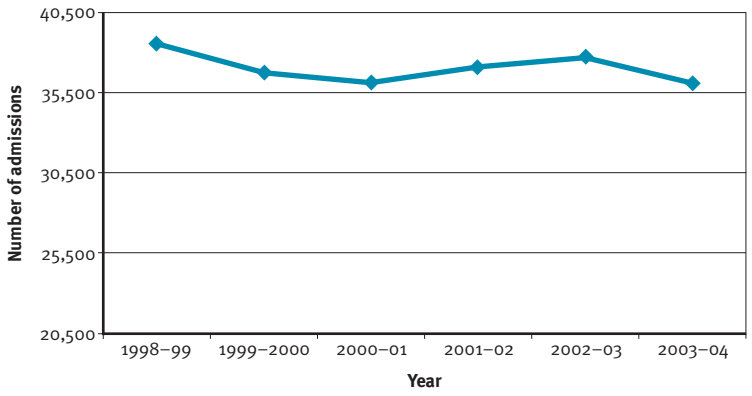
However, the key question remains: what impact are these teams and beds having in terms of better outcomes for patients? Are fewer people becoming severely ill? Are they at least being prevented from becoming so ill that they have to be admitted to hospital as an emergency?

Unfortunately, it is hard to tell, because there is very little data on outcomes for patients being put into the public domain. It is not even clear how many patients are being looked after by the specialist teams. Information requested under the Freedom of Information Act revealed that 14,882 people were being looked after by the assertive outreach teams (at 31 December 2004).[74] This is short of the target of 20,000 'adults with severe mental illness and complex problems' thought to be in need.[42]

Nor is it clear how well the crisis resolution teams are achieving one of their key aims – to 'take the pressure' off acute, inpatient beds (that is, hospital beds for patients with short-term psychiatric problems).

There have been indications that bed use has fallen in areas where the teams have been functioning for some time and that the pressure on acute units is reducing a little.[72] However, according to nationally available official data, there is no striking change in trends yet in the numbers of people being admitted to hospital with a diagnosis of acute mental illness. For example, admission trends for one type of serious mental illness (schizophrenia, schizotypal and delusional disorders) have not changed dramatically since 1998 (*see* Figure 31).

31 ADMISSIONS FOR SCHIZOPHRENIA IN ENGLAND, 1998–2004



Source: Department of Health (2004)[75]

The number of people who have been in hospital and discharged, but who have to be re-admitted as psychiatric emergencies is another possible outcome that used to be available. However, this measure appears to have disappeared from the Treasury's Public Service Agreement with the Department of Health.[76] It is still measured by the Healthcare Commission as part of the star ratings systems for individual mental health trusts, but averages for England are no longer provided.

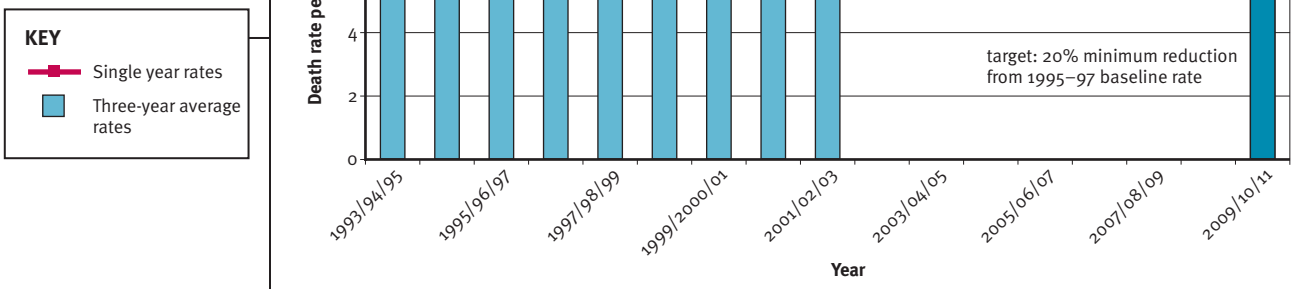
It is clear that many patients have yet to feel the impact of the crisis teams: according to the latest Department of Health patient survey in 2004, 51% of service users did not have the telephone number of someone in mental health services who they could call out of office hours (although the survey does not give figures for those who are deliberately targeted by the crisis resolution teams).[77]

SUICIDE

The Government predicts that its suicide target will be met if present trends continue. Because the suicide rate tends to fluctuate from one year to another, three-year averages are used to get a better sense of what is happening over time. The latest data for 2001/03 (*see* Figure 32) shows a rate of 8.6 suicides per 100,000 of population, down from 9.2 in 1995–97, which is the 'baseline' or figure against which the Government is measuring itself. The suicide rate for 2003 alone was 8.5 – the lowest ever recorded.

Despite the obvious trend line of the graph, it is difficult to quantify the Government's contribution to the decline in the suicide rate. Just as with cancer and heart disease, mortality

32 **MORTALITY FROM SUICIDE* IN ENGLAND, 1993–2003, PLUS TARGET FOR 2010**



Source: Department of Health (2005)[19]

*Defined as death from intentional self-harm and injury of undetermined intent excluding verdict pending.

Note: Rates are calculated using population estimates based on 2001 census, revised in light of the CNS Local Authority Population Study (2004). Rates are calculated using the European Standard Population to take account of differences in age structure. 1993 to 1998 and 2000 have been coded using ICD9; 1999 and 2001 onwards are coded ICD10.

from suicide depends on a number of factors and many of them are outside the control of the NHS – they include factors such as income, levels of family support and physical environment.

The Government concedes that rates have declined since the early 1980s, or before its reforms, but argues that it has maintained the downward trend through a comprehensive suicide prevention strategy that began in 2002. However, government research has shown that only around a quarter of people who commit suicide have been in contact with specialist mental services before their death.

Another question is whether there should be a target for suicide reduction at all. More people die from suicide than on the roads and the level is ten times that of sudden infant death syndrome.[78] Nevertheless, it remains a rare event. Official figures show that a PCT covering 100,000 people would only have about ten suicides a year.

Such a PCT would have many more people suffering from depression, and some experts have questioned whether it is worth having a target for something that affects such a small number of people.[79]

OTHER INDICATORS

Mental health trusts are given star ratings in the same way as other hospitals. Trusts are inspected on their performance on a range of indicators, including cleanliness, financial management, patient satisfaction and involvement.

There has been no striking shift in performance, despite the extra resources; the Healthcare Commission's latest star ratings for the 83 mental health trusts in England (published in July 2004) gave seven no star at all, up from three the previous year, and a further 23 only one star.

The national survey of NHS patients, commissioned by the Department of Health paints a more positive picture, with three quarters of 27,000 mental health patients surveyed rating the service they received as excellent, very good or good. On the other hand, 23% of mental health users said that their care was only fair or poor; just 8% of general patients rate the care they receive this way.[80]

A summary of official inspection reports of mental health trusts, published in 2003, found that the majority 'face significant challenges.' These include high use of agency or locum (that is, temporary) staff, long waits for children and teenagers to be seen by a specialist, long waits for psychological therapies, and problems in getting patients in and out of acute inpatient care.

The quality of inpatient units came in for specific criticism by the inspectors: while some trusts have managed to modernise their services, others 'still deliver care in buildings with Victorian fabric and infrastructure that compromises the quality of care and the privacy and dignity of service users.' The report spells out the reality of this by saying some of these environments are characterised by violence, lack of access to fresh air, locked doors and routine access to drugs and alcohol.[81]

Enduring gaps and failures

TREATMENT OF MINORITY ETHNIC PATIENTS

When Labour took office, it was clear that people from black and minority ethnic backgrounds were more likely to be admitted to mental health services and that they received poorer levels of care when they were there.

A disproportionate number of people from African Caribbean communities were diagnosed as having schizophrenia, were compulsorily sectioned (detained in hospital) under the Mental Health Act and given high levels of medication. Many people from minority ethnic communities were reluctant to engage with services and disorders such as depression went untreated.

Little has changed in the past seven years, and the situation has become even more acute with the influx of increasing numbers of refugees and asylum seekers from Eastern Europe and Africa. The most damning verdict on the Government's performance came from the official Inquiry into the death of David 'Rocky' Bennett, who died under restraint in hospital in 1998. The report accused the NHS of being institutionally racist.

Even though Mr Bennett's death took place only a year after the Government came into power, the Inquiry report was published last year and found that reforms to engage people from minority communities had not been implemented. It urged the Department of Health 'to do more to translate their intentions into action.'[82]

The Healthcare Commission has also said that 'most trusts are still struggling to meet the needs of black and minority ethnic communities, even when they are the majority population'.[81] The Government has accepted that change is long overdue and last year consulted on a strategy to deliver race equality in mental health services.

PRISONS

An official survey conducted in 1998 estimated that 10% of men waiting for trial in prison, 7% of sentenced men and 14% of women prisoners had suffered from psychotic illnesses in the past 12 months. The comparable figure for the population as a whole is 0.5%.[83]

The same team of researchers found that 90% of prisoners either have a diagnosable mental health problem or are substance (drug and alcohol) misusers or both; 20% of men and 40% of women in prison have tried to commit suicide, and the number of successful suicides is rising.

The Government has attempted to improve performance in this area. The NHS Plan set a target for 300 prison mental health 'in-reach' staff to help support mentally ill prisoners. The target was actually exceeded – by April 2004, 370 such staff were in post. Even so, the Government admits that prison is a poor environment for people with mental health problems.

DUAL DIAGNOSIS

The Government says there has been a significant increase in the number of people with a 'dual diagnosis' of mental health problems and drug or alcohol problems. Yet only 17% of local implementation teams have a dual diagnosis strategy in place, two years after guidance was issued on drawing one up.[72]

MENTAL HEALTH PROMOTION

The inclusion of mental health promotion within the NSF in 1999 was hailed as a break through for improving the mental health of the population. However, few resources have been made available for it. Just 0.07% (or £2.7 million) of the nearly £4 billion total investment in mental health has been allocated to it.[72]

The Government's own review of progress estimated that spending on mental health promotion in England was low in comparison to other countries.

Conclusion

The Government's ambition was to improve cancer, heart disease and mental health services in the NHS in England and bring them up to the same standard seen in other European countries. As shown in earlier sections, funding levels are approaching the European average (with respect to % of GDP), but it is much harder to establish whether services have also improved to a similar extent.

Much of the Government's own account of progress involves counting *how much* has been done: how quickly patients have been seen; how many operations performed; how many new machines have been bought; and how many drugs have been dispensed. By these measures there has been a huge improvement compared to 1997 as a whole. For cancer, more patients are being seen faster by more specialist staff with more equipment available to them. There are still shortcomings – waiting times for diagnostic tests are too long and while the latest drugs are being approved for use nationally, there is variation in local take-up. For heart disease, waiting times for operations have reduced, and progress has been made in providing better quality care to those at risk of heart disease. And for mental health, the Government has delivered on promises to restructure specialist care through the speedy creation of 'crisis resolution and assertive outreach' teams working in communities across the country.

But has all this activity saved lives? The information available tells a mixed story. Fewer people are now dying of cancer and heart disease, but the numbers were dropping before Labour's reforms of the NHS. Nor has there been enough time for the reforms to show an expected impact. For example, one outcome measure of Labour's reforms to cancer care might be improved five-year survival rates, but it is currently too early to tell whether or not these

have been achieved. In some cases, information is simply not available – for example, data are not routinely collected on the number of people suffering heart attacks each year, or the number of people who are depressed.

The information on the prevention, rather than treatment, of disease does not show much change. For example, there has been no increase in the number of people eating 'five-a-day' (fresh fruit and vegetables), and levels of obesity and exercise are not improving. The proportion of people who smoke is dropping, but slowly.

Verdict: Huge effort leading to improvements in care, but no real change in underlying trends in health or the major risk factors contributing to ill health, apart from smoking.

5 Four big issues: beds, staff, the private sector and health care associated infections

Beds

The number of hospital beds has been declining within the NHS for many years. This decline was, in part, a reaction to changing technologies that allowed care to be given without the need for such long stays in hospital (for example, the rapid expansion of 'day case' surgery). However, the Labour Government was concerned that the reductions in the number of hospital beds may have gone too far, and established a National Beds Inquiry.[84] The inquiry examined the different factors that would impact on the need for hospital beds in the future and concluded that the NHS did not have the right number of the right sort of hospital beds in the right place.

The NHS Plan set out an ambitious programme to expand the 'capacity' (that is, the facilities, staff and equipment) of the NHS.

What did Labour promise?

Labour's key pledges on hospitals, beds, staff, facilities and equipment are set out below. The box also contains Labour's promises on medical school places, which will eventually translate into more doctors, and crèches, which should help the NHS to retain the staff it has.

NHS CAPACITY: KEY LABOUR PLEDGES

Hospitals

- 100 new hospitals by 2010 and 500 new one-stop primary care centres
- 7,000 extra beds in hospital/intermediate care
- 307 extra beds (30% increase) in adult critical care beds by 2003

Facilities and equipment

- 3,000 GP premises modernised
- 250 new scanners

Staff

- 7,500 more consultants
- 2,000 more GPs
- 20,000 more nurses
- 1,000 more nurse consultants
- 6,500 more therapists

Other

- 1,000 new medical school places
- 100 on-site nurseries

What has Labour delivered?

BED NUMBERS

The total number of hospital beds in the NHS in England has been falling steadily (*see* Figure 33). This trend has been driven by new ways of treating people, including an increase in the rates of surgery carried out in one day, or with just an overnight stay. It has also been driven by policy initiatives, such as the decision to provide more community-based mental health and learning disability services. The same trend can be observed in Wales, Northern Ireland and Scotland, and in other developed countries.[17,31]

In comparative terms, England has fewer beds per 1,000 population than Germany, Italy or France. However, it uses its beds more intensively. The occupancy rates for NHS beds has increased from 84% in 2000/01 to 85.8% in 2003/04 (meaning that every NHS bed will be occupied, on average, 85% of the time, and empty just 15% of the time).[85] This is higher than other developed countries.[17]

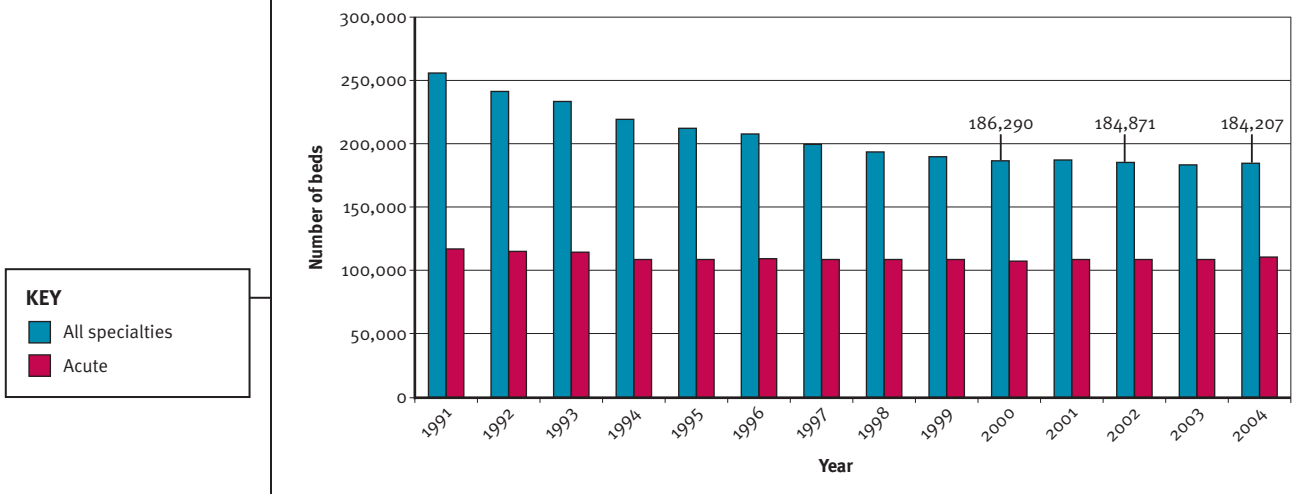
This means that the NHS uses its hospital beds more 'efficiently' than other countries. However, it also places the NHS under considerable strain, because there is very little 'slack' in the system. That strain shows up when there are sudden increases in the demand for care – for example, when there is an influenza epidemic.

At first glance, therefore, the Government does not seem to have delivered its promise of 7,000 extra beds in hospital and intermediate care, since total bed numbers have not risen. However, this total hides some other trends.

Most of the reductions in hospital beds have taken place in the long-term or non-acute specialties, such as learning disabilities. However, the additional beds were to be targeted at the 'general and acute' sector (2,100 extra beds) and intermediate care (5,000). By 2003/04, 2,197 extra general and acute beds and 4,455 intermediate care beds had been delivered.[27] Therefore, the target is very close to being met.

Of course, this may look like juggling with the data. However, it is appropriate to categorise hospital beds very carefully. For example, the number of hospital beds for people with learning

33 **NHS HOSPITAL BEDS IN ENGLAND, 1991–2004**



Source: Department of Health (2004)[85]

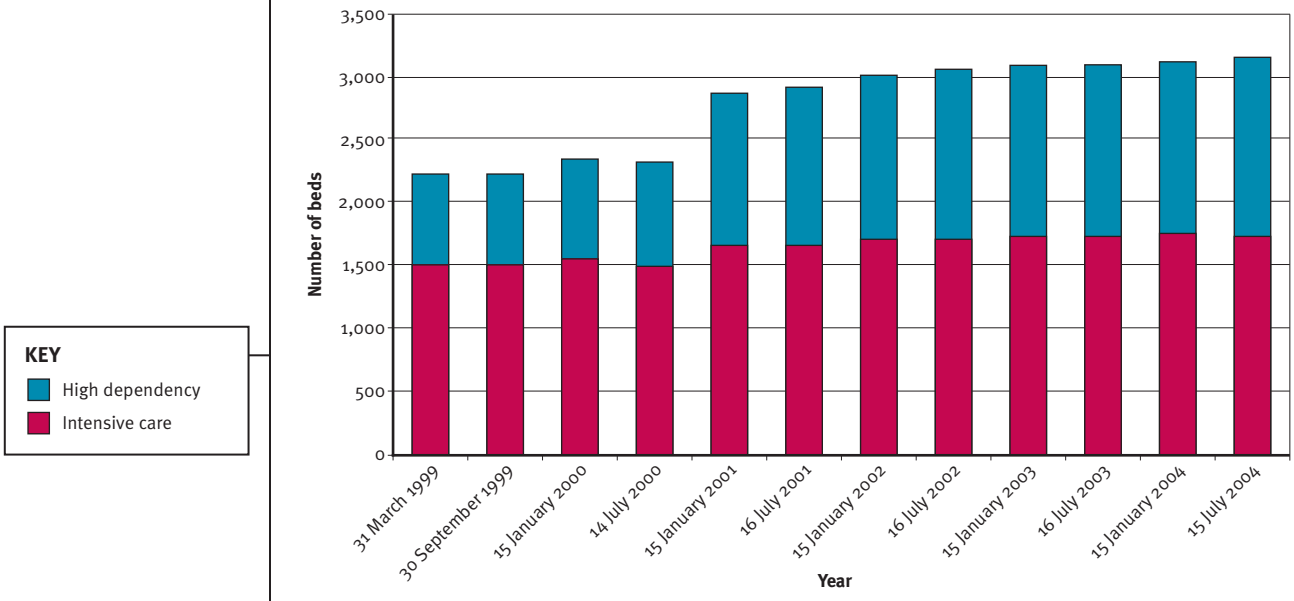
disabilities has fallen by 1,622 since 2000,[86] but this is not a policy 'failure' if the intention is to shift the focus of care from a hospital to a community-based setting.

CRITICAL CARE BEDS

There is a scarcity of adult 'critical care' beds (a term that incorporates beds in intensive care and high dependency units), which are intensively staffed and expensive to maintain. Indeed, this has been acknowledged as an important bottleneck in the NHS. One cause of cancelled operations in the NHS (which have been rising) is the sudden non-availability of a bed in a high dependency unit for a patient who needs one.

Despite this, between January 2000 and July 2004, the number of adult critical care beds has risen from 2,362 to 3,160 – a rise of 34% (*see* Figure 34). So the Government has met its target in this area.

34 OPEN AND STAFFED CRITICAL CARE BEDS, MARCH 1999–JULY 2004



Source: Department of Health (2004)[87]

Staff

What did Labour promise?

The NHS Plan committed the Government to increase the number of hospital consultants by 7,500 and the number of GPs by 2,000 by 2005. The 2001 Labour Party Manifesto extended this pledge by promising to increase the number of all doctors by 10,000. With regard to nurses, a commitment was made to an even larger increase (20,000 new posts by 2004); and in addition, 6,500 new therapists (or 'allied health professionals') were promised.

Significant increases in clinical staff of all types have been recorded since 1997 and there has been an overall increase in doctors of 16% since the NHS Plan (*see* Table 9). The Government, therefore, has met its 2001 manifesto target.

TABLE 9: NUMBER OF DOCTORS, NURSES AND ALLIED HEALTH PROFESSIONALS IN THE NHS IN ENGLAND (HEADCOUNT)

Year	All doctors (excluding GP retainers)	Consultants	GPs (excluding retainers, registrars and locums)	Qualified nurses (inc. practice nurses), midwives and health visiting staff	Qualified allied health professionals
1996	86,580	20,400	27,810	319,150	43,910
1997	89,620	21,470	28,050	318,860	45,020
1998	91,840	22,320	28,250	323,460	46,450
1999	93,980	23,320	28,470	329,640	47,920
2000	96,320	24,400	28,590	335,950	49,360
2001	99,170	25,780	28,800	350,380	51,320
2002	103,350	27,070	29,200	367,520	53,460
2003	108,990	28,750	30,360	386,360	55,950
Average annual change (1998–2003)	3.5%	5.2%	1.5%	3.6%	3.8%

What has Labour delivered?

CONSULTANTS

The number of consultants has increased by 23% (or 5,430), bringing the total number of consultants in England to 28,750 in 2003. However, there is no data available yet to confirm whether or not the NHS Plan target of an extra 7,500 consultants by 2004 has been met.

Achieving this target would mean that a total of 30,820 consultants would have been in post by September 2004. This would represent an increase of more than 7% on 2003, rather more than the average annual increase of 5.2% achieved between 1998 and 2003. However, the latest headcount of staff in June last year showed the number of consultants in post was 30,170.[18] It therefore appears that the Government may well be on target to meet its pledge, or will at least get close to it (the term 'headcount' is important and is discussed in some detail below, *see* p 61).

FAMILY DOCTORS

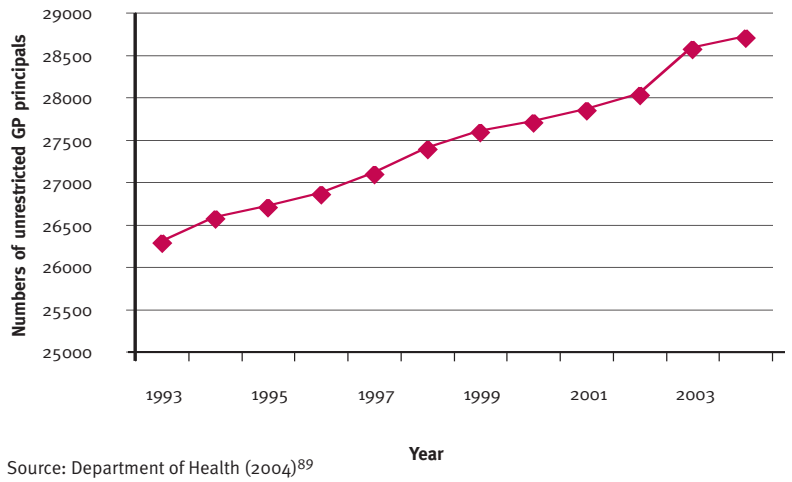
The additional 2,000 GPs promised for 2004 would require a total number of 30,470 GPs to be in place and practising. The headcount for June 2004 recorded 31,220 GPs.[88] This means that the pledge has been delivered and, indeed exceeded.

However, the figures include GP Assistants (doctors that are employed by and assist a GP) and Restricted Principals (doctors whose list is limited or who only provide maternity and contraceptive services).

If we look at the statistics relating to what are known as Unrestricted Principals or Equivalent (UPEs), we get a rather different picture. UPEs are practitioners who provide the full range of general medical services and whose list of registered patients is not restricted in any way (in other words, they are GPs in the sense that an ordinary patient would probably understand the term).

The total increase in the number of of UPEs between 1999 and June 2004 was only 1,111; a 4% increase and some way short of the Government's target (*see* Figure 35). Indeed, this increase

35 UNRESTRICTED GP PRINCIPALS IN ENGLAND, 1993–2003



Source: Department of Health (2004)[89]

is virtually identical to that of the previous five years, 1994 to 1999, which saw a growth of 1,024 (3.9%) in UPEs.

OTHER STAFF

The Government has met its target in relation to medical school places, which have increased by 52% from 3,972 in 1999/2000 to 6,030 in 2003/04.[90] And with regard to nurses and allied health professionals, the Government has more than met its pledges to increase numbers by 20,000 and 65,00 respectively. Indeed, between 1999 and 2003, the number of nurses has increased by 5,6720 (17%) and the number of therapists by 8,030 (17%).

Are the numbers as good as they look?

On a number of key staffing measures, the Government can rightly claim that it has met its pledges and substantially increased the numbers of doctors, nurses and therapists working in the NHS, although exactly how 'GPs' should be defined is open to question.

However, while this is impressive at first sight, the Government has chosen to count staff using a measure known as a 'headcount', rather than counting 'whole time equivalent' (WTE) staff. The headcount measures the number of individuals employed within the NHS, while the WTE measures the number of full-time hours available to the NHS (that is, two staff members working for two and half days each week would represent a headcount of two, but only one WTE).

This is significant, because there is a trend towards part-time working in the NHS, which means that the hours worked per staff member are falling on average. In other words, two or more people may be doing one WTE job.

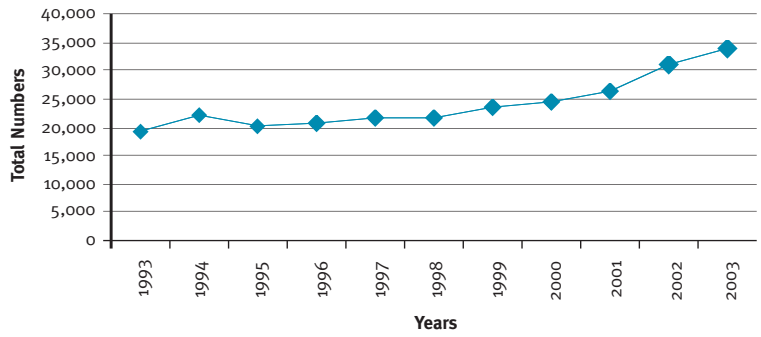
In this context, staff headcounts must continually increase simply to keep the real supply of staff constant. Given this, impressive increases in the number of people working in the NHS may not add up to impressive increases in its capacity to deliver care.

Data on different types of clinical staff as measured by WTEs are not available. However, Department of Health statistics show that the number of WTE doctors employed within the NHS rose by 13,651 (15%) between 1999 and 2003.[88] While not quite as impressive as the increases in the headcount, this still represents a major increase in the medical workforce.

NHS MANAGERS

Unsurprisingly, the Government did not set targets for increasing the number of NHS managers. However, NHS management has increased significantly since Labour came to power. Between 1997 and 2003, the number of managers rose by 12,376 (from 21,434 to 33,810), representing an increase of 58% (*see* Figure 36).

36 MANAGERS AND SENIOR MANAGERS IN NHS IN ENGLAND, 1993–2003



Source: Department of Health (2003)[88]

Some of this increase simply reflects the fact that the total number of NHS staff increased significantly during this time frame. Managers as a percentage of total NHS staff rose by 32% (from 2.5% of total NHS staff in 1997 to 3.3% of total NHS staff in 2003).

It is also important to recognise that the NHS is often considered by health commentators to be 'under-managed'. For example, US 'managed care organisations' (health organisations with similar responsibilities to the English NHS) typically spend 12–15% of their total budget on administrative support.[91]

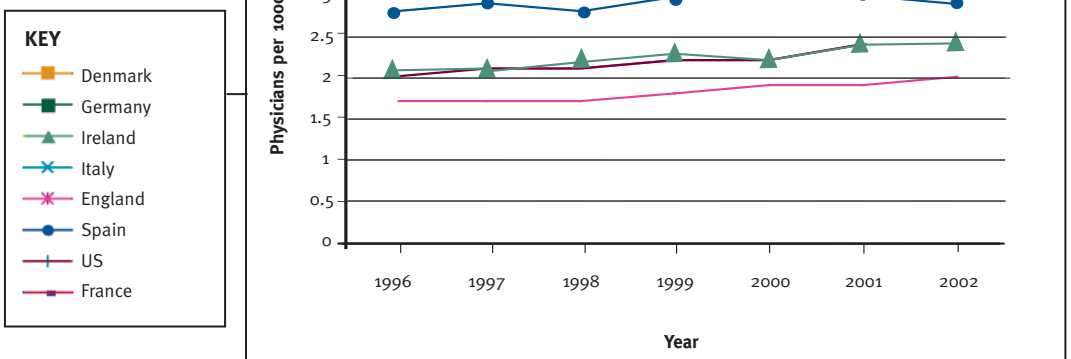
International comparisons

According to research by the Organisation for Economic Co-operation and Development (OECD), the more doctors a country has, the less likely its people are to die before they reach the age of 70.[92] England has the lowest number of practising doctors for every 1,000 people in the population of all developed countries (*see* Figure 37).

However, these differences have been evident for many years. Indeed, with regard to France and Germany, the gap has narrowed between the late 1990s and 2002. With the significant increases in medical staff brought about by the NHS Plan, it is likely that these gaps will narrow still further.

Similarly, while the number of nurses within the NHS has increased, England still lags behind every country except Italy in our comparison group in terms of the number of nurses per 1,000 population (*see* Figure 38).

37 **PRACTISING PHYSICIANS PER 1,000 POPULATION IN SELECTED OECD COUNTRIES, 1996–2002**



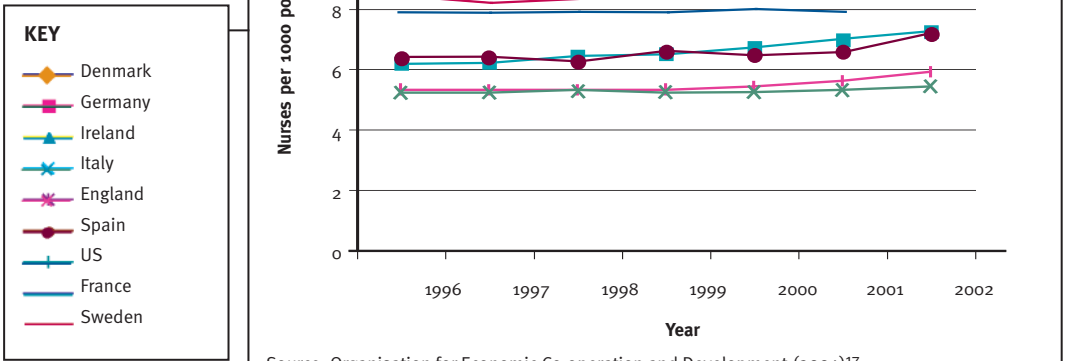
Source: Organisation for Economic Co-operation and Development (2004)[17]

Use of the private sector

What has Labour done?

The private sector has always contributed to NHS services – for example, community opticians and pharmacies are businesses. Even GP services are mainly provided by independent contractors. The last Conservative governments introduced another element, the private finance initiative (PFI), a mechanism for involving the private sector in funding, designing and building hospitals, that had effectively stalled by 1997.

38 **NURSES PER 1,000 POPULATION IN SELECTED OECD COUNTRIES, 1996–2002**



Source: Organisation for Economic Co-operation and Development (2004)[17]

The 1997 Labour manifesto made it clear that a Labour government would do what was necessary to make the PFI work (we discuss this in much more detail below). However, it was opposed to the use of private sector services for delivering clinical care.

The Government's position changed radically with the publication of the NHS Plan. Since then, it has steadily increased – or tried to increase – the role of the private sector.

DIAGNOSTIC AND TREATMENT CENTRES

This change of heart can be explained by the initial failure to cut waiting lists and waiting times. As discussed above, (*see* Section 3) by 2000, it was clear that the NHS was not increasing the number of operations it carried out fast enough. While the NHS Plan was announced alongside a large increase in resources, the Government knew that it would take time for these to make a difference at the frontline.

The NHS Plan therefore referred to a 'national framework for partnership between the private and voluntary sector and the NHS'.[5] Later in 2000, a 'concordat' was published that set out, in broad terms, what this relationship might be, with the emphasis on making more use of spare capacity (beds and operating facilities) within the existing private sector.[93]

However, it is also clear that ministers believe there is value in going further; they have articulated an aim to break down the 'monolithic' nature of the NHS,[94] and to make use of a more 'diverse' range of suppliers.

In 2002, a decision was taken to commission centrally new surgical units, known as Diagnostic and Treatment Centres (DTCs), to treat NHS patients for operations in areas where there were long waiting times, such as cataract surgery.

These units can be set up by the private or the public sectors; but most of the ones created so far have been set up by the NHS. Indeed, it was not until October 2003 that the first independent treatment centre (as the new surgical units came to be known) was opened. This was followed, in February 2004, by two privately run mobile surgical units, targeting areas with the longest waiting lists for cataract surgery. Thirty-four contracts have now been let to the private sector for fixed centres, and the Government expects the majority of the new units to be up and running later in 2005.[95]

So far, 16,000 NHS patients have been treated by private sector providers, mainly using staff recruited from outside the United Kingdom. Existing contracts cover treatment for 250,000 patients a year, 5% of a total of approximately 5 million non-emergency operations. Therefore, the private sector contribution is currently small. However, the Government has promised that it will grow to approximately 15% of all procedures carried out each year by 2008.[94]

As discussed earlier, from December 2005, patients referred for non-emergency or 'elective' surgery will be offered a choice of four or five hospitals. The Government has stipulated that at least one of the choices on offer must be a private sector provider. From 2008, it is planned that patients will be able to choose from any hospital, whether NHS or private, as long as that hospital meets national quality standards and charges standard NHS rates.[94]

Are DTCs working?

The increase in private sector involvement in the NHS has raised anxieties in a number of quarters. These range from outright hostility towards the idea of people making a profit out of

health care, to fears that the existence of units handling the most straightforward surgical cases will make it much harder to train young doctors and leave the NHS with the more complex – and so more expensive – cases.

In addition, there are signs that primary care trusts (PCTs) have been forced to sign contracts with private providers and that, in some areas, NHS hospitals have had to cut back their own workload and beds because work has gone to the private sector.

Some private treatment centres are also being paid at rates above the national average, for a set number of operations over a period of time. This means they will have to be paid even if the local PCT cannot find enough patients needing operations. This is in sharp contrast to the new system of payment by results currently being implemented in the NHS. Under this system, hospitals will be paid only for the operations they carry out.

THE PRIVATE FINANCE INITIATIVE

Hospitals and other health care buildings have always been built by the private sector, even though they were traditionally paid for out of the public purse. But under the PFI, launched by the Conservatives in the early 1990s, the private sector both builds and finances hospitals and other health care buildings.

Under the PFI, the private sector provides the capital finance required, and maintains the buildings that are built. These are rented and used by the NHS, which continues to provide all the clinical services that go on in them. The NHS begins to pay for the buildings and their maintenance once the building is complete, and the payments continue for a defined period of time, usually 30 years. Once the contract has expired, the hospitals are owned by the NHS.

By the time the Labour party came to power in 1997, PFI within the NHS was effectively stalled. Some small schemes, such as hospital car parks, had been built, but no major hospital development had been given the go-ahead.

Labour sorted out the problems, and from 1997 onwards, nearly all major hospital schemes – either complete hospitals or major extensions – have been financed and built under PFI. In 2000, the Government set a target of delivering more than 100 hospital schemes by 2010. So far, 68 are either built or underway, with PFI accounting for 64 of these projects.

The PFI approach has also been applied to the modernisation of primary health care premises, through local improvement finance trusts (LIFT). So far, only one scheme of this kind has been opened – a £4.9 million health centre in East London. A further 41 schemes are in preparation.

What have the benefits of PFI been?

PFI has allowed a massive and much-needed expansion of the NHS capital programme. After an initial round of modernisation in the 1960s, spending on buildings, facilities and maintenance fell back and failed to recover. By the 1990s, many buildings were in poor condition, and there was a huge backlog of maintenance to be done.

Because of PFI, the NHS capital building programme is larger than it has ever been. The physical condition of most NHS hospitals is now vastly better and will continue to improve as more schemes become operational.

In addition, many new hospitals and major hospital extensions have been built on time and on budget. This has led to a massive reduction in the average age of the NHS' capital stock. In 1997, the average age of NHS buildings was older than the NHS itself (the NHS was founded in 1948); in 2005, less than a quarter of its buildings pre-date it. By 2010, 40% of NHS buildings will be less than 15 years old.

What have the costs been?

Critics of PFI say that it has led to fewer beds, poor quality buildings, and that there have been extensive teething problems as the programmes have been run in. Whether these failings should be attributed to the PFI is not clear. If a publicly funded building programme had been implemented as rapidly, there might well have been similar complaints.

However, it also remains unclear whether PFI is cheaper than the traditional way of doing things. The cost of financing such schemes is higher than using public funding, so the reduction in building and operating costs is often only just enough to compensate.

The tendering process is also expensive and time consuming for the firms involved and for the NHS (tendering costs under PFI are 0.5% of total costs, compared to 0.1% of total costs with public procurement).[96] At the end of the day, the NHS has to meet such costs. Overall, the savings may be small – even marginal.

In addition, there may be strategic concerns with PFI. The rapid expansion of the hospital building programme means that little time has been spent thinking about the long-term role of the hospital sector and, in particular, whether there is scope for doing more work in other places, such as doctors' surgeries. It is possible that the NHS has signed long-term contracts for buildings that will simply not be needed in the medium term.

Health care associated infections

A health care associated infection is defined as an infection that develops within 48 hours of hospital admission, three days of discharge or 30 days of an operation.[97] It is estimated that 9% of patients admitted to hospital develop such an infection. The most common are urine and chest infections. The most serious are those that affect the bloodstream, known as 'bacteraemias'. These account for a very small proportion (around 5%) of all health care associated infections.

The rates of health care associated infections within the NHS have remained constant over the past decade[98] and international comparisons suggest that the NHS in England is not substantially worse than other developed countries (*see* Figure 39).

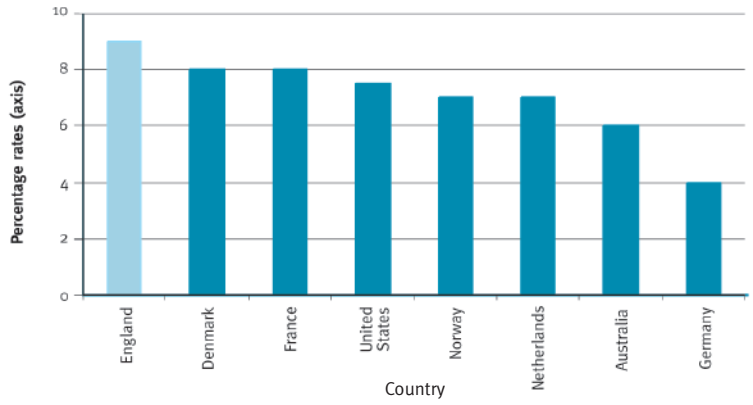
However, numbers of bloodstream infections have increased in the NHS since the 1990s. There are no figures available to say whether this is an international trend, or not.

MRSA

MRSA refers to a group of strains of the *Staphylococcus aureu*s bacteria that are resistant to a number of the antibiotics that might otherwise be used to treat them.

Staphylococcus aureus bacteria are remarkably common; it is estimated that 30% of the general population carries them on their skin or in their nose without ill-effect. Infections occur

39 ESTIMATED PREVALENCE OF HEALTH CARE ASSOCIATED INFECTION IN SELECTED OECD COUNTRIES



Source: National Audit Office (2004)[99]

when the bacteria gets through the skin of people with weak immune systems (for example, via surgical wounds or intravenous drips).

Even then, MRSA infections are normally quite minor and lead only to pimples or boils. In common with other health care associated infections, MRSA is most serious when it affects the bloodstream.

HOW BIG A PROBLEM IS IT?

Since a mandatory MRSA bloodstream infection surveillance scheme was established in 2001, reported infections have risen from 7,249 in 2001/02 to 7,684 in 2003/04; an increase of 6%.[100]

Latest figures from the Health Protection Agency, which is an independent body that provides a national surveillance system for HAI, show that the number of MRSA bloodstream infections fell slightly in the six months between April and September 2004. This was described by Secretary of State for Health John Reid as a 'turning point' as this was the lowest recorded numbers of infections since 2001.

However, the figures may not represent a change in the rising number of infections as it is in line with the usual seasonal fluctuations in MRSA rates, which are generally higher in winter months.

It is also clear that the range of bloodstream infection rates varies considerably across hospitals, with a more than a 15-fold difference evident across England.[100] This suggests that hospitals with the worst rates may have something to learn from those with the best, although some of the difference will also be explained by differences in the number and type of patients they treat.

WHY ARE RATES RISING?

MRSA bloodstream infection rates are calculated using a formula based on the number of positive blood tests divided by bed occupancy rates, which makes no allowance for 'throughput' (the number of patients being treated in a hospital bed in a given period of time) or the rate of hospital activity (the number of cases that a hospital treats).

A ward that has 20 beds and a rapid turnover of patients may have the same bed occupancy rate as another ward with 20 beds filled with long-stay patients; but it will, of course, see many more patients in a given time period. The chances of finding a positive infection will increase with the number of patients going through a ward, and this is particularly the case in areas such as specialist surgery units, where there are many high-risk patients.

Therefore, it is possible that the increase in the number of infections being reported is partly a reflection of the increasing throughput of patients and the rise in hospital activity discussed earlier (*see* Section 3).

According to the Chief Medical Officer, Professor Sir Liam Donaldson, there are numerous other reasons why infection rates have grown. These include: more patients with serious illness being admitted to hospital; the introduction of new types of therapeutic devices, which are prone to infection; high levels of bed occupancy; increased movement of patients within hospitals; poor staff/patient ratios; poor compliance with hygiene procedures; and dirty instruments and clinical areas.[101]

WHAT IS LABOUR DOING?

Countries with particularly low rates, such as the Netherlands, employ 'search and destroy' tactics; patients are screened for MRSA and those infected are isolated. This tactic relies on having enough beds for isolation and high staff to patient ratios. The Netherlands has bed occupancy rates of around 60%, compared to over 87% in the NHS (as discussed above). Therefore, it is unlikely that such tactics could be successfully employed within the NHS, unless bed occupancy rates were lowered, and more single rooms created.

However, NHS patients in high-risk areas, such as intensive care units, are routinely screened for MRSA and have been for many years. Isolation of these patients would be neither practical nor desirable in most cases, as simple infection control measures are sufficient to prevent others being infected.

Known best practice for reducing health care associated infections generally includes: good hygiene in clinical practice (hand washing and disinfection in clinical procedures); isolation of infected patients and use of barrier precautions (gloves and aprons); a clean environment; control of patient movement within hospitals; control of staff movement within hospitals.

However, progress on this front has been slow. An analysis of post-operative infections showed that only 12% of hospitals have reduced their infection rates since 1997, and infection rates in 3% of hospitals have actually increased. In the vast majority of hospitals, no difference in infection rates has been detected.[99]

Recent initiatives

According to government watchdog the National Audit Office, infection control has not been placed high enough on the agendas of hospital chief executives.[102] The Government has recently shown signs of increasing the urgency of its attempts to stall the rise in MRSA and other health care associated infection rates.

Most notably, a new national target has been agreed to reduce the rate of bloodstream MRSA infection rates by more than 50% by 2008.[103]

In addition, the Government has announced that hospital matrons are to be given special leadership responsibilities to maintain a clean environment. Alongside this, a 'Clean Your Hands' campaign is being rolled out by the National Patient Safety Agency across the NHS in England. The campaign is making an effective alcohol rub cleanser available at the point of care to encourage good hand hygiene (that is, hand washing). It is also seeking to empower patients to make sure that staff clean their hands regularly.

The Department of Health has established patient environment action teams (PEATs) to set standards for cleanliness in hospitals and to monitor them.[104] In 2004, PEATs rated 2.5% of hospitals as poor or unacceptable (*see* Table 10), a deterioration from 2003, when no hospital was rated as poor (although a different rating scale was used).

TABLE 10: RATINGS OF NHS HOSPITALS BY THE PATIENT ENVIRONMENT TEAM, 2004

2004	Excellent	Good	Acceptable	Poor	Unacceptable
Number of hospitals	118 (10%)	456 (38.5%)	583 (49%)	24 (2%)	3 (0.5%)

The fact that the vast majority of hospitals are rated 'excellent, good or at least acceptable' suggests that PEAT scores are not sensitive enough to distinguish between 'good' and 'bad' hospitals with regards to MRSA infection rates. However, many experts go further and suggest that general hospital cleanliness is not a significant factor in MRSA transmission (unlike hand washing).

Conclusion

England has fewer hospital beds than many other European countries and the Government has been concerned to increase the numbers of 'acute' and 'intermediate' care beds (by 5,000) and critical care beds (by 307). These targets have all been met.

The Government also promised to increase the number of NHS staff, with 10,000 more doctors, 20,000 more nurses and 6,500 more therapists. Again, these targets have been met, although, the position is not quite as impressive as at first it might seem. The Government has recorded a 'headcount' (that is, the number of people employed) rather than a 'whole-time equivalent' (the number of full-time posts regardless of whether they are filled by full or part-timers). This reduces the impact on patient care. The Government has also used a broad definition in calculating the numbers of additional GPs, including, for example, GP assistants and those whose practice is restricted in some way. The increase in the numbers of traditional GPs has been far more modest and not up to target levels. England still has relatively fewer doctors and nurses per head than many of its European neighbours.

The Government has embraced the private sector, both as provider of services to NHS patients and, through the private finance initiative, as a funder of new hospital buildings. Since 1997, 68 new hospitals have been built or are underway and the Government is well on its way to meeting the target of 100 hospital schemes by 2010. As a result, there have been major improvements to the NHS capital stock. In 1997, the average age of NHS buildings was older than the NHS itself; by 2005, less than a quarter of NHS buildings are that old.

The ‘superbug’ MRSA and other health care associated infections are a significant problem for the NHS and for health care systems worldwide and have affected public confidence. Rates of the most serious infection (bloodstream MRSA) are increasing (although the latest government figures arguably provide a little evidence that the number of cases might have declined) and there is considerable variation across NHS hospitals.

The Government has raised the profile of this particular problem and introduced a range of new measures intended to tackle it. It is too early to tell whether these will reduce the problem. Reducing bed occupancy rates might help, but this could impact adversely on the achievement of other NHS targets, such as the reduction in waiting times for treatment.

Verdict: A substantial increase in some types of hospital beds and in hospital staff. Good progress in modernising NHS facilities. However, rates of MRSA compare badly with other countries and may be the result of other policies putting pressure on the system, such as increased occupancy rates to reduce waiting times.

6 How satisfied and healthy are we?

While this audit has analysed the Government's performance with regard to the 'inputs' of the NHS (such as waiting times, staffing, money and hospital beds), this does not address two key issues – are people satisfied with their health service and is the nation getting healthier? Here, we consider these two important issues.

Satisfaction

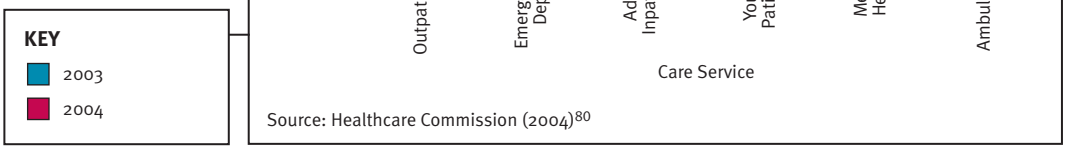
Are we satisfied with the NHS?

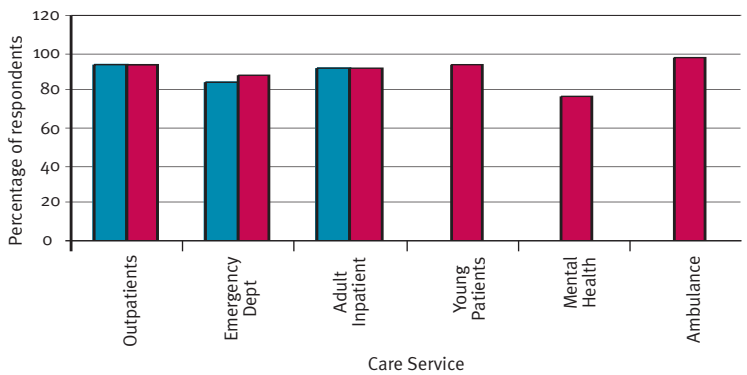
It is hard to assess how satisfied patients and the general public are with the NHS. Different surveys exist, each asking slightly different questions and often presenting very different results.

The Healthcare Commission runs patient surveys that suggest patients are generally very satisfied with the care that they receive from the NHS. When these surveys ask patients to rate their overall care within the NHS across a wide range of sectors, they consistently rate it as either excellent, very good or good (*see* Figure 40).

This broad question is not asked of patients with regard to primary care services (that is, GPs and other NHS staff delivering care outside of hospital settings). However, in 2004, 92% of patients said that their doctor treated them with respect and dignity all of the time. When asked whether they had confidence and trust in their doctor, 76% replied 'yes, definitely', while 21% replied 'yes, to some extent.' Therefore, the NHS Patient Survey paints a very reassuring picture.

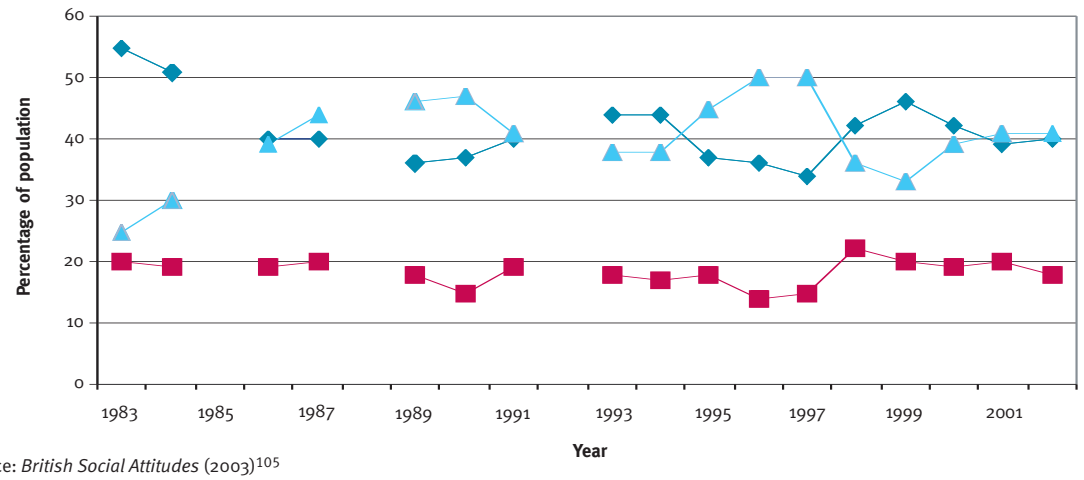
40 **PATIENTS' SATISFACTION (RATING AS EXCELLENT, VERY GOOD OR GOOD) WITH NHS CARE IN ENGLAND IN 2003 AND 2004**





Source: Healthcare Commission (2004)[80]

41 **PEOPLE SATISFIED WITH THE NHS IN ENGLAND, 1983–2001**



Source: *British Social Attitudes* (2003)[105]

KEY
- Satisfied
- Neither
- Dissatisfied

Are we more or less satisfied under Labour?

However, an alternative way of gauging public satisfaction with the NHS is through the British Social Attitudes survey (a routine and large-scale interview survey of British people). This shows that the number of people expressing satisfaction and the number of people expressing dissatisfaction with the English NHS both tend to fluctuate between 40% and 50% (*see* Figure 41).

Moreover, there are frequent 'crossovers' – that is, an overall shift from one to the other. 1997, the year Labour took office, saw an increase in satisfaction with the NHS. This gap subsequently narrowed, leading to convergence between the satisfied and dissatisfied.

Respondents who have recent experience of the NHS tend to be more satisfied with it than other members of the community. For example, among respondents who had recent experience of the outpatient service, 44% were satisfied (with the NHS overall). This compares to a satisfaction rating of only 34% for respondents without that recent experience.[105]

Therefore, it is important to recognise that the results of the British Social Attitudes survey may well reflect the public's reactions to generally negative media coverage of the NHS, rather than the quality of the service offered to patients. This may also explain the gap between its performance and recorded levels of satisfaction with it. Over the past 20 years, the NHS has been doing more than it used to – however, this does not appear to be reflected in the satisfaction survey results.

STAFF SATISFACTION

There are interesting differences between the views of patients and the views of NHS staff when asked to rate the quality of care through NHS surveys. While patients generally rate care highly, staff appear to be less effusive.

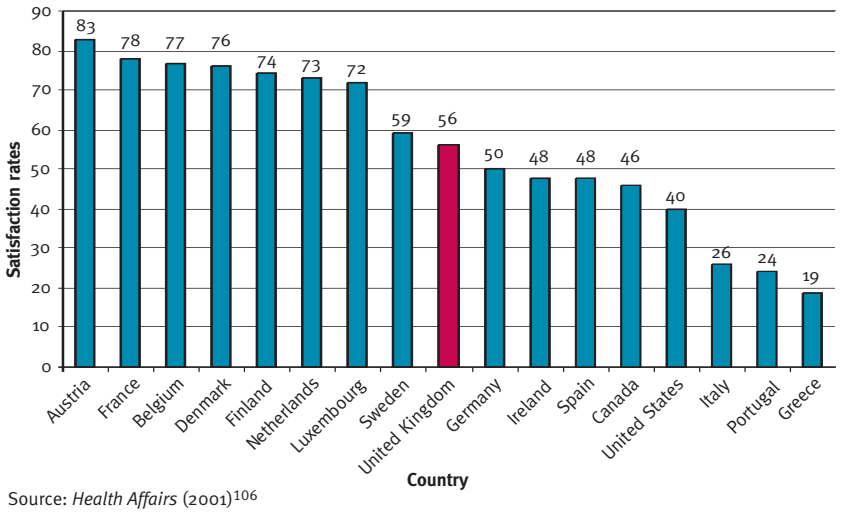
When staff were asked in 2003 whether they would be happy, as a patient, to have care provided by 'my hospital', only 54% of respondents from all types of trust agreed. This figure was highest among acute specialist trusts (75%), but lowest among mental health and learning

disability trusts (43%) (perhaps not surprisingly, given the problems faced by mental health trusts discussed in Section 4).

International comparisons

Some international health systems achieve very high satisfaction ratings – far higher than the NHS. For example, 83% of people in Austria are satisfied with their health system according to a survey carried out in 1999, which found that only 56% of people in the United Kingdom were satisfied. Therefore, when compared to a range of developed countries, the United Kingdom appears 'mid table' yet again (*see* Figure 42).

42 SATISFACTION WITH THE HEALTH CARE SYSTEM IN SELECTED OECD COUNTRIES



Source: *Health Affairs* (2001)[106]

Health

Because health is a complex phenomenon, it is not easily measured. Here we concentrate on a two key measures: life expectancy and infant mortality.

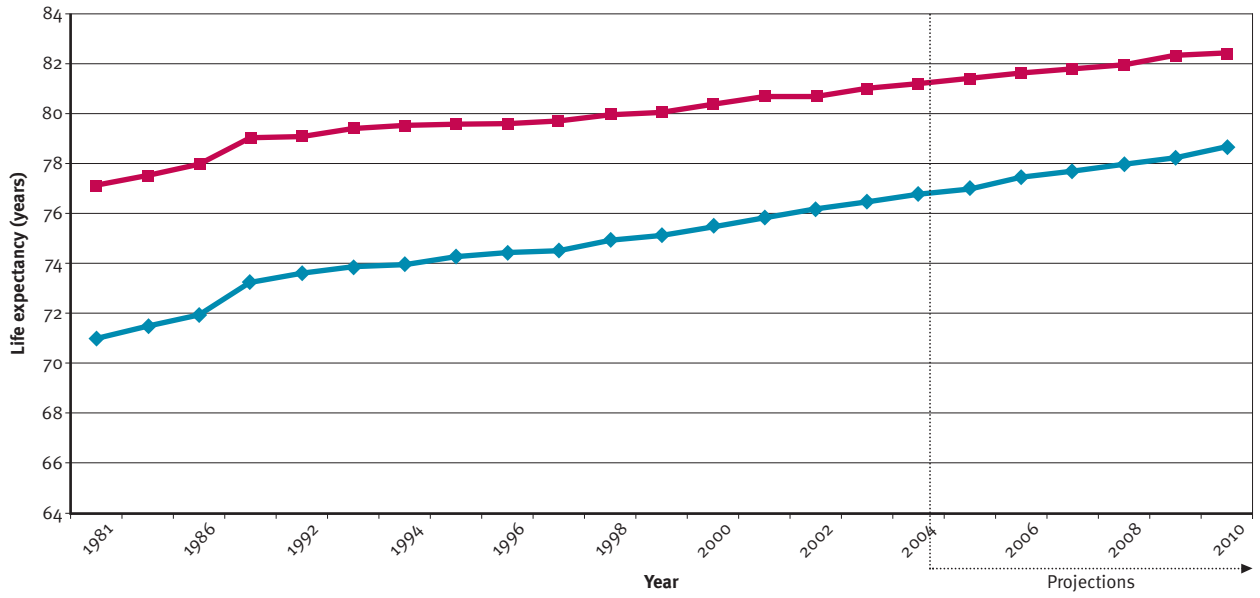
Life expectancy – are we living longer?

Life expectancy rates at birth (that is, the average length of life that people born in a given year can expect) have been steadily increasing, from 73.4 years for males and 78.9 years for females in 1991, to 76.2 years for males and 80.7 years for females in 2002, the latest year for which data is available (*see* Figure 43).

The Department of Health has set a target of further increases in life expectancy as part of its Public Service Agreement with the Treasury (*see* Section 1). By 2010, it is hoped that life expectancy at birth will be 78.6 years for males and 82.5 years for females.

Simply by projecting forward past increases in life expectancy, it appears likely that this target will be achieved – mainly as the result of fewer premature deaths from coronary heart disease, cancer and suicides. As discussed above (Section 4), falling rates in adult smoking have played a significant role in these improvements.

43 **LIFE EXPECTANCY AT BIRTH IN ENGLAND, 1991–2004, PLUS PROJECTIONS**



Source: Office of National Statistics (2004)[107]

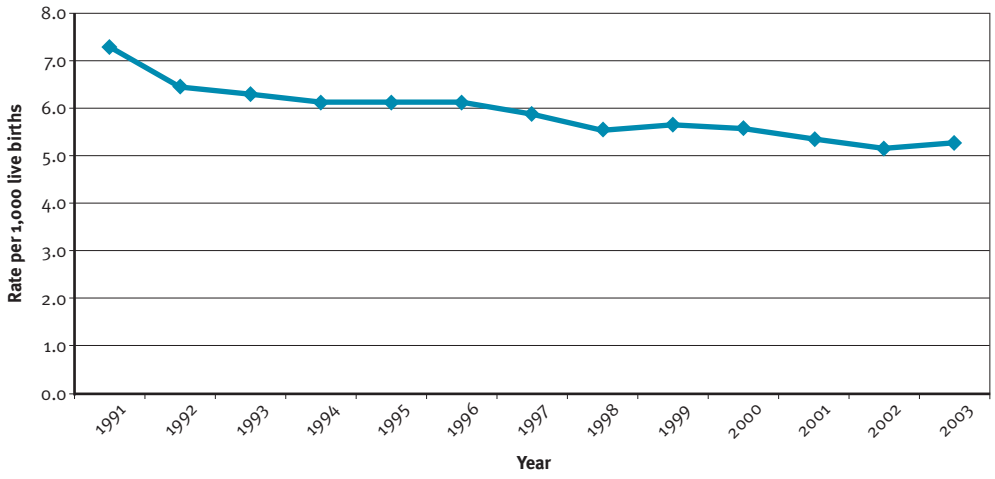
KEY
Males
Females

Infant mortality – are fewer babies dying?

A similar picture emerges for another key measure, infant mortality. This measures the number of babies who die before they reach their first birthday for every 1,000 live births (*see* Figure 44). Infant mortality has been steadily falling (from 7.3 per 1,000 live births in 1991 to 5.3 in 2003).

As we have already discussed for cancer and heart disease (*see* Section 4), the health of the population has been improving steadily regardless of which party has held office. So while

44 **INFANT MORTALITY IN ENGLAND, 1991–2003**



Sources: Office of National Statistics (1999),[108] (2004)[107]

ministers can point to basic indicators of population health as moving in the right direction, it is difficult to ascribe these trends directly to the work of the NHS, or even to the deliberate actions of government.

Inequalities

People who do routine, manual work generally die sooner and suffer more illness than those who work in non-manual or professional jobs. Their children are also more likely to die as infants. These differences, or 'health inequalities', have been well documented since the 1980s.

Before Labour came to power, health inequalities had been widening, because people in the non-manual occupational groups had seen greater gains in life expectancy than those in the manual group. By 1999, there was a difference in life expectancy of nearly six years for women and more than seven years for men from different social groups. The target involves narrowing the gaps in terms of infant mortality and life expectancy. The most recent progress report from the Government reveals that gaps have widened in both categories. For the period 2001–03 the infant mortality for those in routine, manual occupation groups did not fall as fast as the rate for the population as a whole, leaving a wider gap for this group than for overall infant mortality in the baseline years 1997–99. For life expectancy, the gap has risen by 2% for men and 5% for women over the same period.[109]

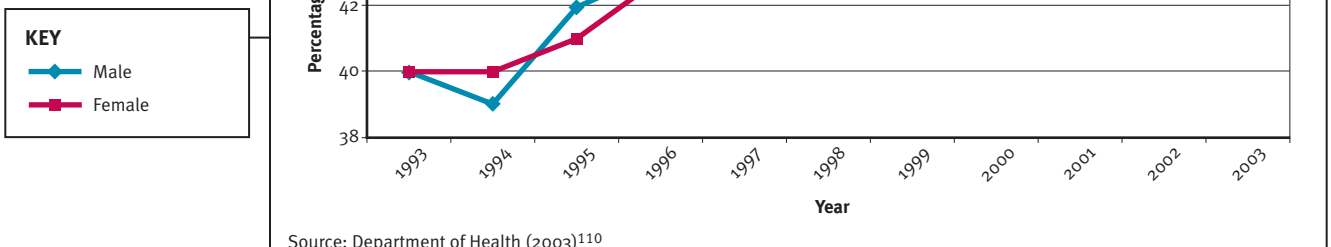
In 2002, the Government set a target to reduce inequalities in health outcomes by 10% by 2010. There is not yet sufficient information available to assess whether the gap is narrowing, but there has been an increasing emphasis on reducing health inequalities through health services and targeted projects.

Self-reported health

CHRONIC CONDITIONS

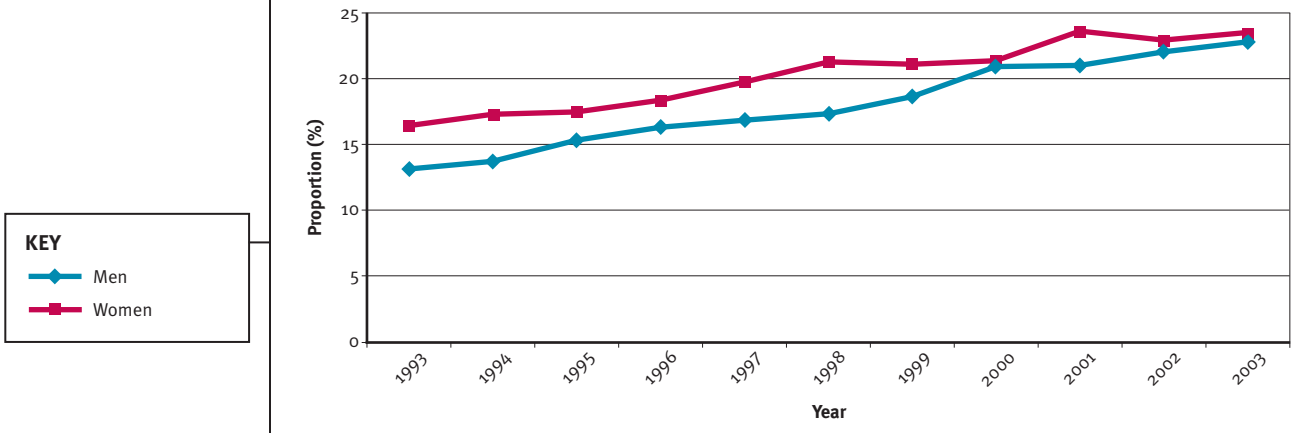
Despite the increases in life expectancy and reductions in mortality discussed in this paper, more people are reporting that they have at least one long-standing illness. According to the Health Survey for England (*see* above, Section 4), the proportion of people reporting an 'illness, disability or infirmity' that troubles them has increased from 40% in 1993 to 47% in 2003 (*see* Figure 45).

45 **PEOPLE IN ENGLAND REPORTING AT LEAST ONE LONG-STANDING ILLNESS, 1993–2003**



Source: Department of Health (2003)[110]

46 **PROPORTION OF MEN AND WOMEN DEFINED AS OBESE (BMI OVER 30)**



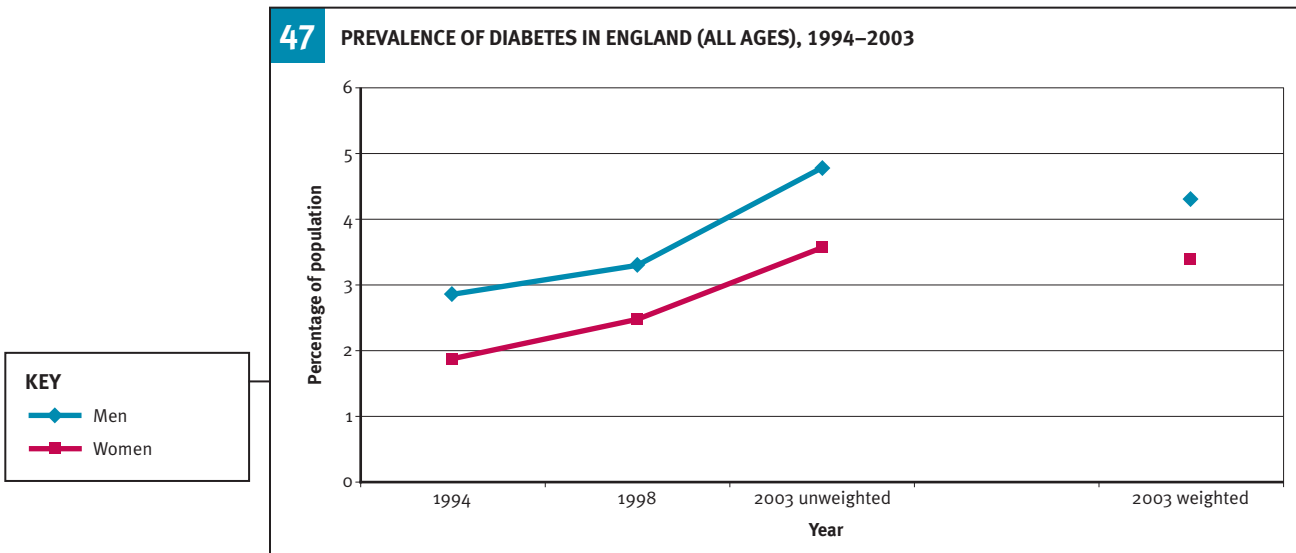
Source: Department of Health (2004)[111]

However, there has been little change in the proportion of people reporting an illness in the last two weeks (another question in the *Health Survey for England*). This suggests that the increase in long-term illness is not simply the result of more people complaining that they are ill, but at least partly the result of people living longer and therefore living with more health problems.

In addition, because disease is now detected much earlier through screening (*see* Section 4), more people will now be aware that they are living with a disease than they would have been ten years ago.

Behind the perceptions of illness, there are some worrying trends. In particular, there have been some significant increases in obesity and diabetes. The proportion of females categorised as obese increased from 16.4% in 1993 to 23.4% in 2003 (*see* Figure 46). For men the increase was from 13.2% to 22.9%. Obesity can have significant effects on health and leads to lower life expectancy. Diabetes affects 1.3 million people in England;[112] it is a chronic disease that can lead to serious complications, such as kidney failure and blindness and is also a risk factor for coronary heart disease and stroke. As Figure 47 shows, the rate of diabetes is rising sharply –

47 **PREVALENCE OF DIABETES IN ENGLAND (ALL AGES), 1994–2003**



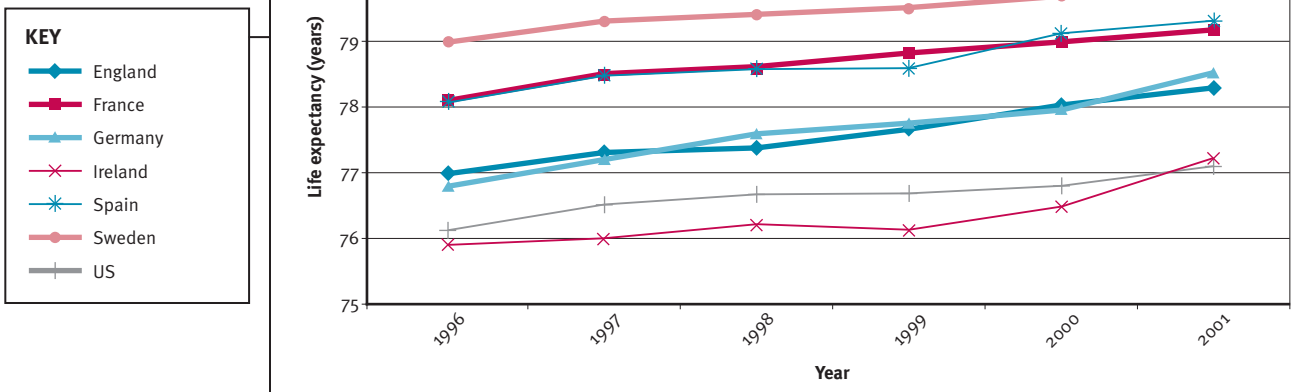
Source: Department of Health (2004)[113]

this is partly due to better diagnosis, but is also closely linked to the increase in obesity, as some types of diabetes are caused by obesity. If current trends continue it is possible that the improvements in life expectancy seen in the last three decades may level off or even start to decrease.

International comparisons

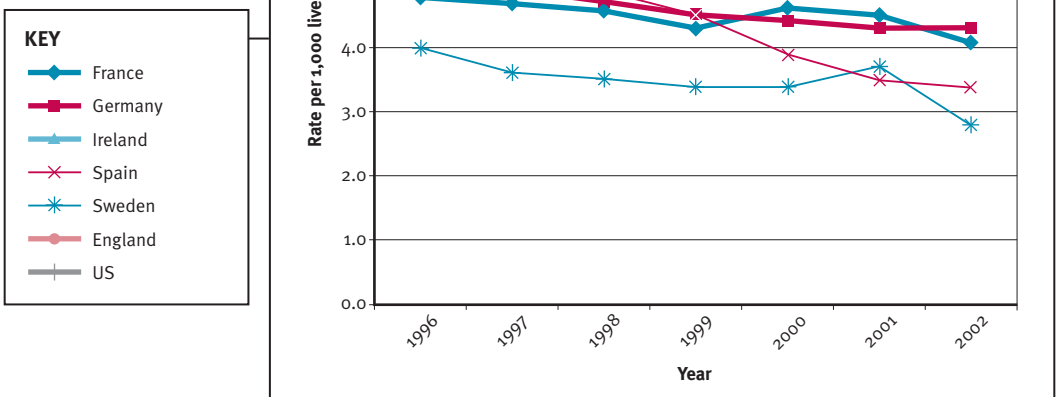
A different way of assessing the health of the people of England is to compare it to that of people in other, similar countries. Yet again, England is only 'mid-table' in terms of key measures of health. Life expectancy in England is greater than in Ireland and the United States, but less than in Sweden, Spain, France, and Germany (*see* Figure 48).

48 LIFE EXPECTANCY AT BIRTH FOR SELECTED OECD COUNTRIES, 1996–2001



Source: Organisation of Economic Co-operation and Development (2004)[17]

49 INFANT MORTALITY IN SELECTED OECD COUNTRIES, 1996–2002



Source: Organisation of Economic Co-operation and Development (2004)[17]

A similar picture emerges in relation to international comparisons of infant mortality (*see* Figure 49). Indeed, infant mortality rates in England are nearly twice those of Sweden.

Conclusion

Surveys show that patients consistently rate the care they receive highly. For example, the Healthcare Commission has recently shown that around 85% of patients surveyed rated NHS inpatient care as either excellent, very good, or good. Surveys of the public show a less rosy picture, with overall satisfaction rates ranging between 35–45% over the past 20 years, with no apparent association with particular government policies. People who have had recent experience of the NHS tend to be more satisfied than people who have not. Compared to other OECD countries, satisfaction levels in the United Kingdom are in the middle of the range at 56%, similar to those found in Sweden and Germany.

Since 1997, there have been significant improvements in the longevity of the English population and the rates of infant mortality. However, these trends were also apparent over the past 20 years. Life expectancy at birth is lower in England, and infant mortality higher relative to Western European nations, and the gaps show no sign of closing. In addition, the gap in England between those with the poorest health and the rest of society has also grown wider, posing a challenge to the Government's inequalities target.

Self-reported long-term illness has increased in recent years (something that may reflect either the levels of illness or the likelihood that people will report them) and the prevalence of risk factors for ill health, such as obesity and obesity-related illnesses, such as diabetes, is growing.

Verdict: There has been no obvious change in levels of satisfaction with the NHS by the public, and while there have been some improvements in life expectancy and infant mortality, higher levels of obesity are storing up problems for the future.

Conclusions

There is little doubt that the Labour Government's agenda for the NHS has been hugely ambitious. The past five years have seen an unprecedented investment in NHS services. The Prime Minister, Tony Blair, pledged to bring NHS spending up to 'European' levels and broadly this target has been achieved.

With the investment came reform. The Government's ten-year blueprint for the NHS, the NHS Plan, set out an agenda that touched most parts of the service and demanded new working practices, new staff and better outcomes. As well as the investment, four main tools were used to improve performance: national targets and standards; regulation and assessment; the introduction of market-style incentives; and support through professionally led 'collaboratives'.

So has all this investment paid off? Did the Government achieve the 'step-change' in performance that it was seeking?

We are, perhaps, lucky that a large amount of information is collected about the NHS. Unlike many other countries, we are able to measure improvement in services in many areas and to hold the government of the day accountable. For the main areas of performance, relatively good data are available and they show that activity and some measures of quality have increased.

However, the answers to some key questions remain elusive. On a number of occasions during this audit, we have sought information that is simply not collected, or not made public. The Department of Health requires data to be collected on the targets it has set, but the data tells us more about how many services are delivered and how fast, than about the improvements in health by patients.

Even so, we are able to draw some broad judgments about the performance of the two Labour Governments since 1997. And mostly these are positive; significant improvements have occurred within a relatively short time.

First and foremost, the NHS appears well on the way to tackling its historic Achilles heel – waiting times. It is true that immediately after 1997, inpatient and outpatient waiting times actually went up. However, long waits for treatment have been virtually eradicated. Now, for example, some 70,000 patients are waiting for inpatient treatment compared to nearly 200,000 people in March 2000. This figure is set to reduce to zero by the end of this year. Average waits appear to be coming down significantly too. Most surprisingly, the Government has reversed a previously inexorable upward trend in the numbers of people waiting for treatment – the first time this has been done since the NHS was founded. Therefore, the Government looks set to meet all of its targets in this key area of NHS performance.

Particular bottlenecks and areas of concern have also been addressed. Good work has been done to reduce the maximum wait for patients in accident and emergency (A&E) to four hours. In primary care, patients now wait only one day to see a primary care professional and a maximum of two days to see a GP (although there is some disagreement over the actual waiting times between the views of patients when surveyed and the official statistics).

Many millions of people now contact NHS Direct – the nurse-led telephone helpline and website that did not exist when Labour came to power – or visit new walk-in centres every year.

The last five years have also seen an increase in hospital building, through the private finance initiative. The average age of NHS buildings has fallen dramatically and improvements to primary care are beginning to follow. Heavy investment has also been made in new diagnostic machines.

Notwithstanding claims that privately financed hospitals have reduced the number of available (or affordable) beds, acute and intermediate hospital beds increased since the NHS Plan. While, the total number of hospital beds has fallen, there have been increases in the number of acute, critical care and intermediate care beds and the targets set out in the NHS Plan have been met.

But the NHS is essentially a 'people organisation'. It relies on highly trained and dedicated staff. The Government is broadly on course to meet its pledges to increase the number of NHS staff (although final data for 2004 are awaited). Between 2000 and 2003, an additional 5,430 consultants, 2,750 GPs (including GP assistants), 56,720 nurses and 8,030 therapists have been employed. Perhaps a less popular measure has been to increase the number of managers between 1997 and 2003 by 12,376 (managers as a proportion of NHS staff also rose from 2.5% to 3.5%).

So what are the failures? Long waits for diagnostic tests appear to be stubbornly resistant – some people are still waiting a long time to get the tests they need to diagnose and treat their conditions even though more staff have been appointed and more tests are being undertaken. In addition, waits for radiotherapy treatment also appear to be an area where things are getting worse, not better. This is a crucial bottleneck affecting clinical quality and the Government has recently announced that it is to step up investment in this area still further.

The number of cancelled operations has also risen and now total 67,000 a year. In part, this reflects a persistent lack of critical care beds, demonstrated by the case of Mrs Margaret Dixon, the patient who endured numerous cancellations of an operation. While Mrs Dixon's case is unlikely to be typical, pressure on critical care beds remains, despite a significant increase in numbers since 1997, because the NHS is now having to treat more patients that are severely ill or very frail.

MRSA has also emerged as an important concern for the NHS, patients and the wider public. Increasingly, patients are worried that it simply is not safe to enter hospital for fear of the 'superbug'.

In reality, the numbers of patients contracting the most serious form of MRSA (a 'bacteraemia' or bloodstream infection) is very small. However, numbers of cases have risen and there are wide variations in infection rates across hospitals. However, the apparent link between hospital

cleaning and MRSA rates may be a red herring. According to many experts, the big issue is that of 'hand hygiene' and it seems, at a very basic level, that the NHS simply cannot persuade its staff to regularly wash their hands.

MRSA also perfectly illustrates the problem that any government faces when seeking simultaneous improvements across a number of different fronts. MRSA rates might be reduced if hospital wards were not so full of patients, or the turnover was lower.

However, many of the improvements to waiting times have only been achievable because the NHS has been working flat out – with little elbow room to manage peaks in demand. It is not economically efficient to keep beds empty. Ultimately, the Government must juggle competing priorities within what remains a finite budget – even if it is a much more generous one than when Labour came to power.

It is for this reason that the Government has been keen to increase efficiency and value for money in the NHS. In fact, productivity has been falling consistently, although the measure used is recognised to be flawed because it does not count all types of health service activity (including services that are now carried out in primary care) or quality of care. We simply do not know whether the NHS is getting good value for all the extra money spent.

Furthermore, much of the growth money for the NHS is already committed – for example, on changes to staff contracts and pay increases, clinical negligence claims and reducing junior doctors' hours to meet the European Working Time Directive. The effect of this is to reduce the proportion of the substantial cash increase for the NHS available for new patient services. Once these 'cost pressures' are taken into account, the generous 12.38% rise in funding in 2004/05 reduces to a rather more modest 2.4%.

We appear to be getting healthier in some regards (such as our longevity and rates of infant mortality); a slight decline in smoking rates, and the increased prescribing of statins for heart disease will, according to the best research, save deaths and disability some years down the track. However, an ageing population and some worrying trends, such as the levels of obesity and diabetes, will soon impact on the demand of health services in a major way. In the face of these challenges the NHS cannot stand still.

Comparing the performance of the NHS in England to that in Scotland and Wales is instructive. The quality and pace of reform, and growth in investment in England has been higher than in Scotland and Wales where devolved governments are responsible for the NHS. In relation to waiting times at least, the English NHS appears to be performing far better.

However, it is also clear that we still lag behind many other countries in some key health measures and in terms of health service 'inputs' such as numbers of doctors and hospital beds. There have been some areas where we appear to be catching up (for example, with regard to rates of heart operations).

Overall, in our view, the results of this audit are very positive. The ambition for the NHS has been appropriately high. There has been unprecedented investment. There has been significant improvements in most areas the Government has focused policies on. Has there been a 'step-change' in NHS performance? If step-change means a significant change of gear, with more and better services, then yes there has.

However, the NHS as a whole has not yet been transformed. There are still important problems to be solved and there is as yet no firm evidence to show that Labour's reforms have produced a marked difference in health outcomes. While much of the improvement in the NHS that we describe has been achieved through central fiat and targets, it is too early to predict whether the more recently introduced tools to lever up performance – greater use of market incentives and regulation – will achieve the desired transformation.

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