King's Fund

Policy
PAPER

Editors

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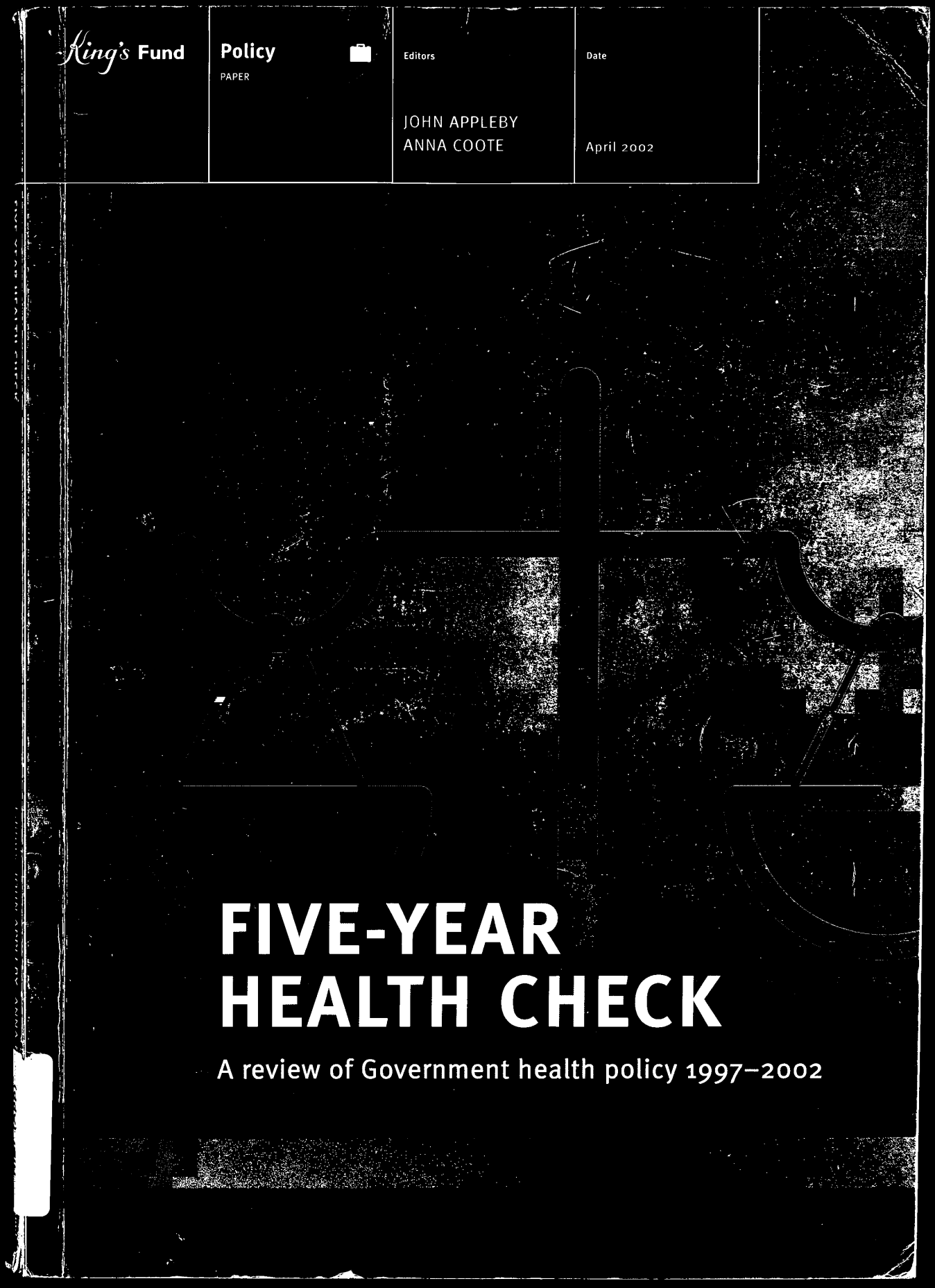
Date

April 2002



FIVE-YEAR HEALTH CHECK

A review of Government health policy 1997–2002

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Edited by John Appleby and Anna Coote

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1 Introduction

In 1997, Labour came to power with a promise to 'save the NHS'.[1] Its manifesto pledged to cut the numbers of people waiting for care, improve the quality of hospital services, end waiting for cancer surgery, cut bureaucracy, initiate a new public health drive and raise spending on the NHS in real terms. The manifesto also promised to abolish what Margaret Thatcher described as the 'most far-reaching reforms of the National Health Service in its forty year history' – the internal market.

The Conservatives' White Paper introducing the internal market was published in 1989.[2] Five years later, in 1994, the King's Fund published a collection of papers evaluating its impact.[3] The conclusions of the evaluation were mixed; much of the direct research indicated 'little actual change of any kind and even less that could be attributed to the reforms in key areas of quality, efficiency, choice, responsiveness and equity.' But in some areas there appeared to be potential at least for real gains, for example, from giving GPs more control of local health spending.

Now, five years on from a change of government, it is time to review health policy once again. What did Labour inherit from the Conservatives? What has this Government promised? What measures have been introduced and what impact have these made on the NHS, on social care, on the nation's health?

Tracking the effects of change

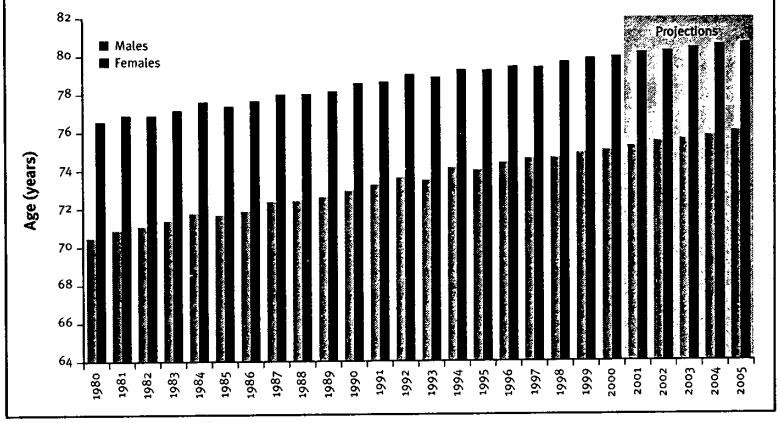
Evaluating health policy is not an easy task. There are seldom unambiguous indicators of success or failure. It can be extremely difficult to attribute changes observed in some indicators to particular policies or, in fact, to any health policy. Nevertheless, it is important that policies be evaluated as far as is possible for the effects they have, or are projected to have, on people's lives.

One obvious indicator by which to judge health policy is mortality. Between 1970 and 1999, the mortality rate for all causes of death fell from 1,048 to 698 per 100,000 people (*see* Figure 1). The death rate for ischaemic heart disease has declined by 40 per cent since 1970; and for cerebrovascular disease it has more than halved (*see* Figures 2 and 3). However, these trends stretch back many years and appear to be almost completely unrelated to changes in government, let alone to changes in the resources devoted to health care, how the NHS is organised, or which health policies are given priority by any government.

Such changes in mortality are, of course, the outcome not only of the performance of the NHS (and policies designed to improve its performance) but of decades of exposure to health services. Policies to improve child health today, for example, may only come to fruition forty to sixty years later, as that generation reaches the age at which heart disease and cancer begin to cause significant numbers of early deaths. Clearly, then, the increase in the population's life expectancy over the last five years (*see* Figure 4) cannot and should not be attributed to the abolition of the internal market or any other measures introduced by this Government.

Doing things right is not the same as doing the right things.

4 LIFE EXPECTANCY AT BIRTH



Source: OECD Health Data File, 2001

Moreover, health *care* is only one determinant of health. It is now well-established that measures of broad population health, such as mortality rates and life expectancy, are affected by non-health care factors – lifestyle, income, education and so on. These factors are at least partially within the remit of governments even if they are never fully under their control.

For all these reasons, any evaluation of health policy needs to take into account all areas of government action. In lieu of hard evidence on the effects of policies on people's health, it must examine what has been pledged, what actions have been taken and whether factors that were supposed to change as a result of government policies have indeed changed in the period under review.

The shape of the review

Doing things right is not the same as doing the right things. Throughout this review, therefore, we have aimed to address two broad questions that can be asked of any policy: first, was it in our judgement the *right* thing to do? And, second, what did it achieve? We focus here on the following policy areas:

- Funding
- Waiting
- Rationing
- Primary care
- Workforce
- Quality assurance
- The private sector
- Long-term care
- Patient and public involvement
- Health inequalities

The list reflects specialist work streams at the King's Fund and is obviously not comprehensive. We have not addressed mental health, for example, because the King's Fund is currently conducting a major inquiry into mental health in London and the results will not be available until early in 2003. Nor have we attempted to review the full reach of organisational change in the NHS, or specific functions such as midwifery, palliative care or dentistry, or the effects of health policy on particular

confidence is likely to be undermined, as voters fail to see why the Government is acting, where it is heading or whose interests it is serving.

The Prime Minister told the House of Commons recently that the NHS encapsulated his political philosophy.[6] The Government has clearly signalled its belief in the NHS. However, that belief is unclear in its character. The NHS is in far too profound a state of upheaval, as a result of myriad changes introduced by the Government, to provide a clear picture of what the Government stands for – unless it is 'modernisation', which cannot be passed off seriously as a political philosophy.

Unresolved tensions

There are several unresolved tensions arising out of this ill-defined ideological terrain. An obvious example is the tension between central and local control. The Government clearly wants to be seen to grapple with the NHS by asserting strong leadership and direction from the centre. An overwhelming impression to be drawn from this review is one of relentless, almost hyperactive intervention. A formidable torrent of pledges, policy documents, laws, regulations, advice and guidance has issued from the Department of Health, without let-up since 1997, to knock the system into shape: ironing out disparities, raising standards, improving productivity, increasing responsiveness, extending services, meeting unmet needs. One consequence is that the centre is held responsible for everything that goes wrong. It is therefore not surprising that, in the course of the five years, the Government has become increasingly interested in devolving responsibility – to primary care trusts and high-performing acute trusts with 'earned autonomy'. But the extent of its commitment to devolution is unclear, and the question of how to trade off local empowerment and equity between geographical areas remains unresolved. Ensuring that sufficient first-rate services are available everywhere is a fine aspiration but not practicable in the short or medium term.

A second area of tension is around the relative importance of health and health care. This Government, more than any other, has committed itself to reducing health inequalities and promoting a public health agenda. But both Secretaries of State – Frank Dobson and Alan Milburn – have established a strong identity as champions and defenders of health care, leaving health to junior ministers. Social care has likewise had second billing. The Prime Minister has chosen to stake his reputation with the electorate on sorting out the NHS, rather than, say, on reducing health inequalities or improving social services.

Media coverage of health policy, reinforcing the Government's emphasis, has focused almost exclusively on the NHS. Money has been poured into the NHS rather than into measures aimed at preventing illness or promoting independence amongst vulnerable groups that might help to check the rising tide of demand for treatment and care. An unresolved question is whether the aim of providing decent health care should be allowed to take precedence – as it undoubtedly does – over the aim of improving the chances of enjoying decent health for those who are most vulnerable to illness and premature death. One is about delivering a service, the other is about redistributing risk and opportunity. In theory, both can be given equal weight, although no government has yet shown how to do so. Shifting priorities from health care to health would require a philosophy grounded in more than a belief in the NHS.

structural change to restore a service suffering from decades of under investment. This has meant, for example, that primary care organisations have been overloaded with new instructions and pushed to the limits by reorganisation, so that they are unable to meet all the new expectations that have been heaped upon them. Similarly, area-based strategies to tackle the causes of ill health have suffered from project overload.

Sometimes, policies have been sound but implementation has been of poor quality or uncomfortably slow. Efforts to reduce waiting, to expand the workforce and to give primary care organisations responsibility for population health, have been hindered by a failure to anticipate the full costs of change in financial and human terms. Occasionally, the Government has been guilty of prevarication – for example, in introducing health inequalities targets. But a constant refrain throughout the review is that it is too early to expect tangible results from policies introduced less than five years ago.

There have been few outright failures of policy. The refusal to follow the recommendations of the Government's own Commission on funding long term care, has left users and carers dissatisfied and has failed to mend a rickety system. In the case of using private finance for new hospitals, the Government has entered into a massive building programme without setting out a strategy based on an assessment of our future requirements, and without transferring any substantial risk from the public to the private sector.

In spite of these weaknesses, the prospects for health and health care are more promising than suggested by the balance of media-based commentary. This is to some extent the Government's own fault. It has readily played to the gallery, instead of leading the debate, and has set itself up to be knocked down. By raising public expectations about 'saving the NHS' the Government has created hostages to fortune, endangering the reputation of the service for the longer term.

Overall, the direction of travel seems to us to be well judged and much of the detail is admirable. More credit is due than is currently paid – as the following brief summary of the review's main findings suggests.

The verdicts

Funding: The NHS has received historically significant increases in funding – well above the level of inflation since 1999. Visible evidence of the new money is still hard to find – but this should change if extra investment is maintained. The Government now seems more in step with recorded public opinion on devoting more of the nation's wealth to health care. However, fundamental questions about how much money the NHS should get and how it should be spent remain unresolved.

Waiting: Policies on waiting for NHS treatment threaten to distort clinical priorities and divert management energies. Although reducing the time people wait for health care is an important policy goal in its own right, severity of condition is not sufficiently taken into account. A more evidence-based and systematic approach to controlling waiting is required.

Rationing: The establishment of NICE is an important achievement, helping to bring transparency and evidence-based consistency to decisions about new treatments.

The NHS is important, but so are measures aimed at keeping people healthy and reducing health inequalities. This should be reflected more clearly in the overall shape and direction of health policy.

stronger political leadership and a higher priority given to measures aimed at reducing inequalities, the chances of significantly reducing health inequalities in the next decade are slim.

Conclusion

The main purpose of this review has been to reflect on what has happened since 1997, rather than advocate future action. Five years is a short time in health policy, so the effects of many new measures, good or bad, would not be detectable at this stage. Even after further time has elapsed it will be difficult to attribute the causes of specific changing health patterns to particular interventions. Our findings suggest that the Government is travelling in the right direction – that is, towards a more robustly funded NHS, improved standards of health and social care, more patient-centred services and a system that is trying to reduce health inequalities. They also point to certain adjustments in style and emphasis that could strengthen and consolidate progress made so far.

First, it is important to keep the money flowing, but any remaining illusions that money alone will save the NHS must be dispelled.

Second, it is time to let go – to curb the incessant flow of orders from the centre. The Government must continue to build the morale and confidence of the workforce, and enable them to take ownership of the reform process.

Third, there should be fewer, but broader targets for the NHS, which are costed and funded appropriately.

Fourth, a better balance should be achieved between health and health care. The NHS is important, but so are measures aimed at keeping people healthy and reducing health inequalities. This should be reflected more clearly in the overall shape and direction of health policy.

Finally, the Government must prepare the public for the long haul. It is time to stop making heroic promises and buckle down to the unglamorous detail of building a good-enough health system for the 21st century.

2 Funding

Key issues:

- Labour's NHS funding record
- International comparisons of health care spending
- Translating spending *inputs* into health care *outputs*

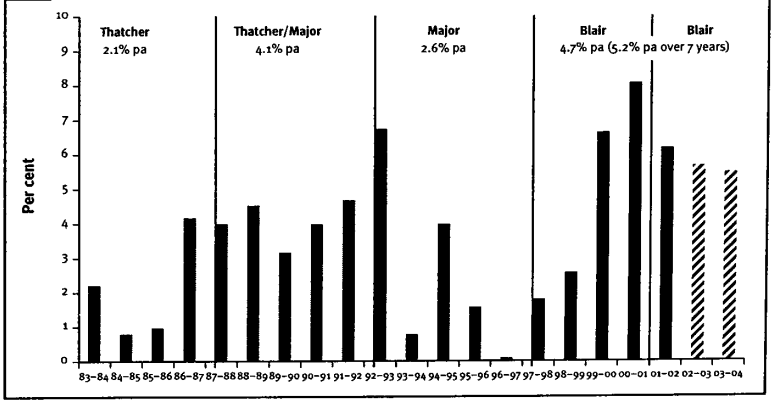
The inheritance

A history of underfunding

If there is one common feature of all health care systems it is their capacity to consume large amounts of money. Difficulties over the NHS budget became apparent just five months after the inception of the service. Its first allocation of £176 million to cover the nine months of 1948 was, Aneurin Bevan had to tell the Cabinet, £50 million short.[1] Virtually every year since, the NHS has received additional funding on top of its planned budget. Health care in the UK now dominates government expenditure, accounting for nearly 28 per cent of all spending, excluding social security payments.[2]

When Labour took office in May 1997, the NHS across the UK had in the previous year received one of the smallest 'real' increases in its budget for many years – a rise of just one tenth of one per cent (after accounting for general inflation in the economy as measured by the GDP deflator). But over the whole of the previous Parliament, spending on the NHS had increased by an average of 2.6 per cent per year in real terms. Over the whole period of the existence of the NHS, the average annual real increase in funding had been just over 3 per cent – marginally ahead of the real growth of the economy as a whole. As Figure 5 also shows, real spending changes since the early 1980s (and, in fact, back to the inception of the NHS) have been very erratic.

5 PERCENTAGE CHANGE IN UK NHS NET REAL SPENDING (GDP DEFLATOR)



Source: Department of Health Expenditure Plans (various)

The policy pledges

Increasing spending in real terms

The 1997 manifesto stated that '[It is a myth] that the solution to every problem is increased spending...'[5] Nevertheless, it asserted that a Labour Government would implement two pledges. The first commitment was that spending would be increased in real terms (that is, above general inflation in the economy, as measured by the GDP deflator) every year. This extra money would, the manifesto said, be spent on patients not bureaucracy. The indirect commitment was that in the interests of a soundly managed economy, Labour would, for the first two years of office, stick to the previous administration's departmental ceilings for spending.

The commitment to raise spending on the NHS in real terms was, in the absence of any numbers, somewhat minimal; the NHS has almost always received real increases in funding – 1979/80 being the most recent exception (*see* Figure 5).

Matching the EU's spending

On January 16th 2000, the Prime Minister, Tony Blair, was to outline Labour's second manifesto pledge: a commitment to further increases in NHS spending that would, he claimed, see the proportion of the UK's GDP devoted to health care equal the average for the European Union (*see* below). Just over a year later, in the March 2001 Budget, the Chancellor, Gordon Brown, announced that he had asked Derek Wanless to carry out a review to assess demand and cost pressures on the NHS over the next twenty years. This would lead to recommendations for providing financial and other resources to ensure that 'the NHS can provide a publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay'.[6]

Interview transcript from Breakfast with Frost 2000

David Frost:
So what's your message, for instance, to those people, the exceptions to the rule maybe in the sense that the Health Service does a good job for a lot of people of course. But what's your message to Jane Skeet this morning?

Tony Blair:
Well my message is that I accept the responsibility to make sure that the situation that occurred in respect of her mother does not occur, I accept that responsibility, I'm trying to put it right. I have to put it right step-by-step and stage-by-stage, it takes, for example, three years to train a nurse, seven years to train a doctor.
I mean if I can just say to you what over the next few years we will be able to do, if we run the economy properly over the next few years, we've got the first year, as I say, of substantial extra resources for the Health Service going in. Next year is the same, the year after that it's the same. If this July when we work out the next three year period after that three year period we can carry on getting real-term rises in the Health Service of almost five per cent, then at the end of that five years we will be in a position where our Health Service spending comes up to the average of the European Union, it's too low at the moment so we'll bring it up to there.

Source:
http://news.bbc.co.uk/hi/english/static/audio_video/programmes/breakfast_with_frost/transcripts/blair16.jan.txt

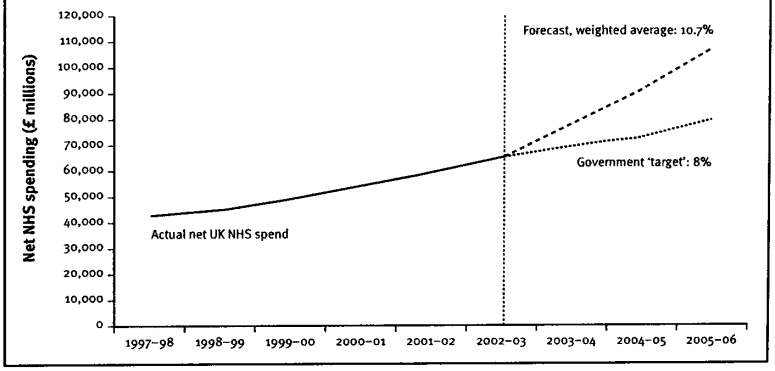
Pursuing the European average

Presaging the second CSR (scheduled for the summer of 2000) came the Prime Minister's assertion during a television interview that if spending continued to increase at around 5 per cent in real terms, then the UK would be spending the same as the average of the European Union within five years. This was subsequently clarified: spending being defined as *total* spending (public and private) on health care as a proportion of GDP, and the consequent EU average being 8 per cent (of GDP).

Although widely reported as a target, in fact – as the *Breakfast with Frost* interview transcript makes clear – the Prime Minister was merely re-presenting, in a comparative way, the amounts the Government already planned to spend on the NHS. This was presumably designed as a reply to numerous unfavourable comparisons in the media (between, for example, cancer survival rates) that were made between the NHS and other countries' health systems. The implication was that, once UK spending reached the EU average, the UK would also enjoy European levels of health care and, further, European levels of *health*.

While there seems little doubt that UK spending on both public and private health care will reach 8 per cent of GDP by 2005/6, there have been many criticisms of the factual basis concerning the correct measure of the European average spend on health care.[9,10,11] Figure 7, for example, shows the path required if UK health care spending is to reach the Government's own definition of the EU average (ie, 8 per cent of GDP – based on an *un*weighted average of *all* EU countries' percentage spends for 1998, including the UK). However, given past trends, by 2005 other EU countries' spending on health care is likely to be higher than 8 per cent. Trends suggest it will reach around 10.7 per cent based on the mathematically more appropriate measure of a *weighted* average, *excluding* the UK.[12] This implies a much higher level of spending than the government is currently planning – roughly £30 billion more in real terms by 2005/6.

7 **SPENDING PATHS TO ACHIEVE VARIOUS EUROPEAN UNION AVERAGE TOTAL HEALTH CARE SPENDS AS A PROPORTION OF UK GDP BY 2005/6: NET NHS SPENDING**



Source: King's Fund

Regardless of the disagreements about the correct definition of average and other issues in this context, the Government has made it clear that the aim is total health spending of 8 per cent of GDP.[13] In any case, these arguments have been overtaken by events, in particular the announcement by the Chancellor in the March 2001 Budget that Derek Wanless would be taking a sweeping look at appropriate funding

gets are brought back into line and creditors paid. And there have been a number of specific cost pressures (such as large increases in employer superannuation contributions, funding the commitment to reduce junior doctors' hours and rising clinical negligence claims). Combined with the extensive earmarking of large amounts of new money through the Health Modernisation Fund, this has resulted in some (non-priority) areas of the NHS being squeezed financially and cost savings having to be made across many services.[15]

More money...but are the public satisfied?

While some of the cost pressures the NHS has experienced over the last few years are likely to be one-off difficulties, there is a more fundamental problem with which all governments struggle: how much *should* be spent on the NHS? The problem for any publicly funded service is that, in the absence of a market in which 'total' spending is decided automatically through the sum of many individual private spending decisions, there are few agreed benchmarks on which to base a decision as to the appropriate level of funding. Yet a decision must be taken and, to an extent, justified.

Historically, decisions about NHS spending levels have been the result of a combination of the technical and the political. The former has in recent decades essentially consisted of taking the previous year's spending levels and building up a new budget based on estimates of need (changes in demographic characteristics, for example), necessary new service developments, and so on. The political input brings in factors such as a government's wider economic goals, which have, in the past, included purposeful reductions in the total share of public spending in the economy. But despite what is a complicated process, setting the NHS budget remains, and must always be, subjective.

Therefore, although there is no 'right' level of spending for the NHS, one indicator that could be used as a proxy to gauge the *appropriateness* of NHS funding levels is public opinion. For example, findings from the British Social Attitudes 2000 survey[16] found that the proportion of people *agreeing* that taxes should be increased and spent on health (and other social programmes) fell from 59 per cent in 1996 to 50 per cent in 2000. One interpretation of this change could be that the increases in NHS spending over this period went some way to satisfying the public's wishes to spend more on the NHS. Similarly, when asked about their overall satisfaction with the NHS, 42 per cent said they were very or fairly satisfied in 2000 compared with 36 per cent in 1996.

The problem with using public opinion as a measure of appropriate health spending, however, is illustrated by the Scottish NHS experience. For many years, total per capita health care spending in Scotland has hovered around the average for the European Union. While this extra spending has purchased more resources – more doctors, nurses, beds, etc – figures from the same survey (author's calculation) suggest that it has not bought higher levels of public satisfaction. In fact, the proportion who are very or fairly satisfied in Scotland (41.8 per cent) is actually lower than for England (43.4 per cent), and the proportion who are very or quite dissatisfied is higher (41 per cent vs 38.5 per cent).

What can the UK afford to spend on health care?

An alternative spending benchmark was, however, implied when the Prime Minister indicated that health care spending levels will rise to match the EU average. Given

on health care, in the long run there will never be enough to satisfy all our demands. Furthermore, the experience of the NHS over the last fifty years, evidence from other countries' health care experiences, and research into the economic peculiarities of health and health care, all suggest that the link between financial inputs and any number of types of outputs (satisfaction, healthiness and so on) is not at all straightforward.

Opaque decision-making over spending

Increased funding will not, of itself, solve all the problems of the NHS. In this sense, the amount that is spent on the NHS is a secondary policy issue. There are two primary issues. The first is the *way* in which decisions on spending are carried out. Rather than the somewhat opaque decision making involved in the comprehensive spending review, a popularly agreed process for arriving at a decision on spending levels, in which trade offs and the necessity for priority-setting are clearly recognised, would lead to a greater public ownership of the eventual spending decision. The work of Derek Wanless and the Treasury Health Trends Team has gone some way down this path, but there is a long way to go, for example, exploring methods to involve the public more closely in budgetary decisions.

Spending and NHS objectives

The second, related, issue is to understand more fully the *links* and relationships between spending and the many objectives of the NHS. Current understanding of these relationships is poor – but without such knowledge the chances of wasting scarce national resources increases. The public service agreements (PSAs) are a step in the right direction, helping to close the tax-spend-outcome loop. But more evidence needs to be generated to reveal more clearly the relative costs and benefits of different PSA targets, and, importantly, to help attribute improvements in the NHS to increased levels of spending.

The verdict

The NHS has received historically significant increases in funding – well above the level of inflation since 1999. Visible evidence of the new money is still hard to find – but this will change if extra investment is maintained. The Government now seems more in step with public wishes to devote more of the nation's wealth to health care. However, fundamental questions about how much money the NHS should get and how it should be spent remain unresolved.

3 Waiting

Key issues:

- Bringing down NHS waiting lists
- Reducing waiting times for elective surgery
- Speeding up access to primary and emergency care

The inheritance

A long history of waiting

The NHS is popularly seen as synonymous with queuing. When it opened its doors for business on the 'appointed day' in 1948, it immediately inherited a waiting list. Over half a million people were waiting for admission to hospital in 1950. By the 1980s numbers reached over three quarters of a million, and today they are just over one million. For many, the waiting list record is seen as a depressing indictment of the NHS. It has posed a real policy challenge to all governments.

Labour's inheritance in 1997 consisted of not only the numerical – numbers waiting, time spent waiting and so on – but also a long history of policy initiatives stretching back to the 1950s designed to deal with waiting.

Initiatives to reduce the numbers waiting for admission to hospital included:

- A guidance by the Ministry of Health in the 1960s on managing lists and advice to GPs on gaining admission for their patients.
- In 1975, further guidance was issued on managing lists, and special funding was devoted to dealing with supply 'bottlenecks'.
- The 1979 Royal Commission on the NHS[1] focused attention on waiting times as opposed to list length – but was unable to offer any instant solutions.
- During the 1980s, the waiting list – later to become waiting times – initiative combined special funding (£252 million by the time it ended in 1995) with targeted efforts at reducing the longest lists and waiting times.[2]
- By the mid-1990s waits of over two years had virtually disappeared – but lists had got longer. The internal market reforms of the early 1990s were also an attempt to, at a minimum, equalise waiting times around the country through the purchasing decisions of health authorities and GP fundholders.

Statistically, Labour inherited an inpatient and day case waiting list of nearly 1.2 million people – the highest it had been since 1948 (*see* Figure 10). Across England, around 2 percent of the entire population was on a waiting list. But these national figures masked variations between different areas of the country (and particularly between consultants). The number of people waiting for hospital admission per 1,000 head of population varied as much as four-fold across the country, and outpatient lists varied by as much as forty-fold between the best and the worst

of their appointment, with 83 percent having waited less than three months. These figures were part of a relatively unchanging trend in outpatient waiting times since 1994 – when national information was first collected.

The policy pledges

Cutting waiting lists and times

Before 1997, policies on waiting had begun by focusing on reducing the numbers of people on lists and then moved on to tackling waiting times. Labour's 1997 manifesto[3] reversed this policy pendulum – at least for the headline-grabbing inpatient waiting list – with a pledge to cut the *number* of people waiting by 100,000 by the end of that Parliament. This reduction represented a cut of just under 9.5 percent in the size of the total waiting list. To be fair, waiting *times* were not completely ignored: the manifesto also pledged '[to] end waiting for cancer surgery, thereby helping thousands of women waiting for breast cancer treatment.' Although not mentioned in the manifesto, the new Government continued with the previous administration's Patients' Charter commitments of a maximum inpatient waiting time of 18 months.

Following these pledges, further commitments to reduce waiting lists and times were announced:

- December 1997: The White Paper, *The New NHS,*[4] stated that the original manifesto pledge to cut cancer waiting times would be set as a target, and that by April 2000 no patient with suspected breast cancer would wait more than two weeks to see a specialist following an urgent referral by their GP. This target was rolled out between April and December 2000 to cover all cancers.

- August 1999: As numbers on outpatient lists waiting over 13 weeks reached nearly half a million, the Department of Health announced a performance fund to tackle long outpatient waits. Locally negotiated agreements targeting specialties with excessive waits were agreed, and, by March 2000, numbers waiting over 13 weeks were to be reduced to 334,000 across the country.

- July 2000: *The NHS Plan*[5] extended the 'war on waiting' with the announcement of a bewildering array of targets covering not only inpatient and outpatient waiting lists but waiting in accident and emergency departments, and waiting for GP appointments and other primary care professionals.

- September 2000: *The NHS Cancer Plan*[6] extended targets for waiting times for people with cancer with no one to wait more than four weeks from diagnosis to treatment for a variety of cancers, including breast cancer, testicular cancer, children's cancers, leukaemia.

While these new targets (*see* Table 2 for a complete list since 1997) represented another swing of the policy pendulum back towards tackling waiting times, the original 1997 pledge to cut inpatient lists by 100,000 was retained. *The NHS Plan* also announced a need to increase the number of 'booked' appointments and admissions.

Table 1: ***contd.***

1999/0528	Tough new monitoring regime for outpatients unveiled as new weapon in the war on NHS waiting
1999/0601	Waiting lists fall again
1999/0659	Waiting lists continue to fall
1999/0696	Rise in outpatient waiting times slows as more patients are seen
1999/0709	Inpatient waiting lists continue to fall
2000/0090	Fall in outpatient waiting lists
2000/0202	Waiting lists fall
2000/0284	Meeting waiting list target is 'work in progress'
2000/0328	Waiting lists stay below target
2000/0398	Waiting lists stay below target
2000/0469	Action team to go into hospitals failing on waiting
2000/0505	Milburn orders 'go for growth' on NHS beds: waiting lists fall again
2000/0562	NHS waiting lists continue to fall
2000/0643	Waiting times and lists continue to fall as modernisation programme bites
2001/0022	Fall in waiting lists continues
2001/0066	Steady progress in the war on waiting
2001/0181	New schemes cut cancer waiting times as waiting lists fall across the board
2001/0307	NHS waiting lists still over 100,000 less than March 1997
2001/0377	All aspects of NHS waiting improved since last year
2001/0410	Over 90 percent of urgent cancer referrals seen within two weeks
2001/0459	Drop in number of patients waiting over a year for treatment
2001/0529	Further progress towards reducing waiting times
2001/0605	Real progress on waiting times, but real challenges ahead: Hutton
2001/0629	Waiting list manipulation is unacceptable
2002/0016	Two thirds of all trusts have no inpatients waiting over 15 months

The impact of policy

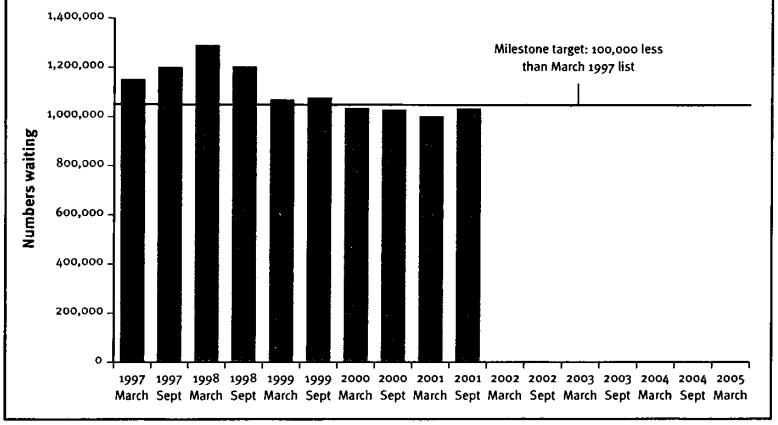
Table 2 summarises the position regarding all waiting list targets and pledges announced since 1997. The overall picture is mixed: some targets have been achieved; some have been missed; while for others there is still some time to go before the target is to be met.

Getting the waiting list down

The key 1997 manifesto target – to reduce the total inpatient waiting list by 100,000 –appears to have been successful – and over a year before the end of the last Parliament. As Figure 12 shows, however, one year on from the baseline date of March 1997, waiting lists had increased to nearly 1.3 million – so reducing lists to 100,000 below the March 1997 level ultimately required a cut of around 240,000 in numbers waiting. But such cuts were perhaps not all they seemed.

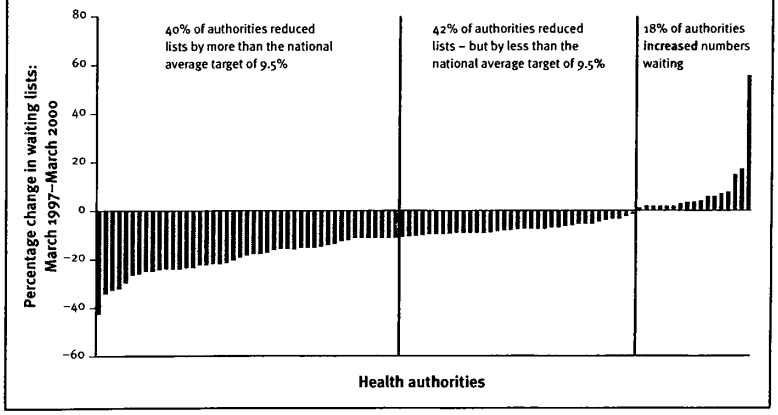
Achievement at local level was patchy. As Figure 13 shows, six out of ten health authorities failed to reduce lists by as much as the average target reduction of 9.5 percent. Of these, nearly one fifth saw their lists increase.

12 ***NHS PLAN* TARGETS: MAINTAIN 100,000 REDUCTION IN TOTAL WAITING LISTS**



Source: Department of Health

13 **1997 MANIFESTO PLEDGE: REDUCING WAITING LISTS BY 100,000 – LOCAL ACHIEVEMENT**

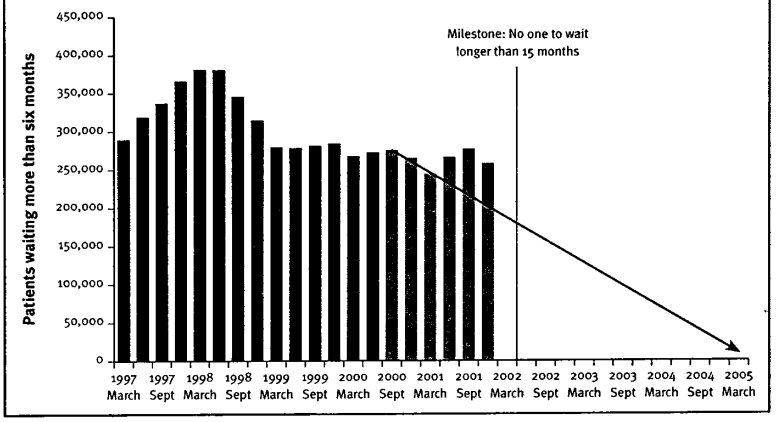


Source: Department of Health

More importantly, there were problems concerning the way in which lists were reduced and the veracity of national waiting list statistics. The National Audit Office[8] has noted that 46 percent of trust chief executives responding to their survey stated that during 1999/2000 they had redefined the way they counted inpatients. This included reclassifying patients who would previously have been included on waiting lists as *planned* cases. Planned cases include patients given dates for a course of inpatient treatment such as chemotherapy. Importantly, these cases are not counted as part of the waiting list. In nearly nine out of ten cases this sort of reclassification led to a reduction in total numbers waiting.

This change in classification is, to an extent, reflected in Hospital Episode Statistics (HES) for the period 1997/8–2000/2001. These show that, in terms of source of admission to hospital, numbers of patients admitted from the waiting list or as booked admissions *fell* between 1997 and 2001; the increase in the number of (non-waiting list) planned cases making up over 87 percent of the increase in *all* hospital admissions – including emergencies and maternity cases (*see* Figure 14).

15 ***NHS PLAN*** **TARGETS: BY 2005, NO ONE TO WAIT LONGER THAN SIX MONTHS FOR ADMISSION TO HOSPITAL**

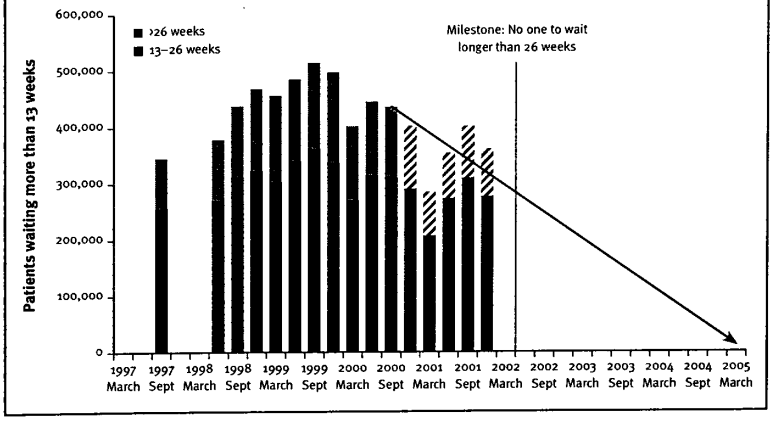


Source: Department of Health

Outpatients

Recent trends in waiting times for outpatients are not encouraging. Having failed on an early target to cut the numbers waiting over 13 weeks to 334,000 (although a substantial cut was made), *The NHS Plan* targets to ensure no one waits more than 26 weeks and to reduce further the number waiting over 13 weeks (on the way to a target of no one waiting over 13 weeks) are not on track (*see* Figure 16). To meet the 26-week target, for example, would require a reduction in numbers waiting of 84,000 between December 2001 and March 2002. A cut of such scale has never been achieved since outpatient waiting list figures have been recorded.

16 ***NHS PLAN*** **TARGETS: BY 2005, NO ONE TO WAIT LONGER THAN 13 WEEKS FOR AN OUTPATIENT APPOINTMENT**



Source: Department of Health

One of the difficulties with outpatient targets is that they may suffer some knock-on consequences as a result of local strategies to meet inpatient targets. When, for example, clinical effort and resources are concentrated on dealing with inpatient targets, the movement of patients from outpatient lists to inpatient lists could be constrained.

Over half of a sample of consultants responding to an NAO survey said that they had treated some routine patients in preference to more urgent cases to reduce waiting list numbers.

A further criticism of the original manifesto pledge was that while it encouraged consultants to increase their workloads, it did so in a way that could mean concentrating on less difficult and, perhaps, less urgent cases. Over half of a sample of consultants responding to an NAO survey said that they had treated some routine patients in preference to more urgent cases to reduce waiting list numbers. However, the extent to which such apparent distortions in clinical priority should be considered a failing is difficult to judge. Although there is a general principle that patients should be treated in order of their clinical priority – the most urgent first and so on – there are also good reasons for consultants to operate in a more flexible way: solely treating the most urgent can mean that some routine patients are never seen or that operating theatres are not used as efficiently as they might be in terms of maximising the time they are in use.

However, A deeper problem lies with the general principle of clinical priority. Crudely put, one consultant's 'urgent' case can be another's 'routine' case. Although such variation in clinical judgement has repeatedly been shown to exist, there has been, and remains, little or no concerted policy attempt to deal with this source of 'distortion' of priorities.

As *The NHS Plan* and subsequent policy documents made clear, while the 100,000 reduction target was to remain in force, there was a distinct policy switch to waiting times. Yet these new targets could be subject to similar criticisms concerning the distortion of clinical priorities. Many of the examples of treating routine patients in preference to urgent cases involved the old Patients' Charter target of a maximum waiting time of 18 months for inpatients (a hangover from previous Conservative policy). And the same problems could be said to arise from the NHS Plan targets, which impose progressively shorter maximum waits over time. Again, however, the extent to which such distortions in clinical priority should be considered a failing is difficult to judge.

Waiting times: a better target?

While there appear to be problems with many of the waiting times targets set since 1997 – both in terms of achievement nationally and the variable achievement at local level – an improvement in policy terms has been the switch to focusing on waiting *times* and, in some areas, a refinement in the type of waiting actually measured and set as targets. Importantly, there has also been a lessening of the obsession with waiting at the acute hospital stage of admission and a recognition of the broader issue of access to care across the whole system – including outpatients, accident and emergency, and primary care.

More fundamentally, waiting list policy over the last five years – and over the last half century – has been based on the presumption that waiting is a bad thing and that if only the supply side of the health care system could be changed in the right way – more money, doctors, beds, better pathways into care and so on – then waiting could be reduced if not, to all intents and purposes, eradicated. But while no government has openly acknowledged the fact (in a system where the usual market mechanisms for rationing are, for good reason, absent) waiting serves an important, and vital, function. Waiting lists essentially act as the key device to bring together supply and demand in the NHS. But they operate in a comparatively crude and uncoordinated way.

4 Rationing

Key issues:

- Labour's role in NHS priority-setting
- The National Institute for Clinical Excellence
- The focus on cancer and heart disease in Government policy

The inheritance

The inevitability of trade-offs

Some people may think that rationing doesn't, or shouldn't, happen in the NHS. Unpalatable as it may be, the fact is that rationing in the NHS has been, and will remain, unavoidable. Demand will *always* outstrip supply, with the consequence that potentially beneficial care will be denied. Even when funding is increasing, decisions about how these new resources are used involve difficult choices between alternatives.

With ability to pay for health care rightly taken out of the equation, the main ways in which health care has been rationed in the NHS are:

- Deterrence: patients are discouraged from making their demands known, for example by reception staff in GP surgeries filtering out some patients
- Deflection: patients are referred to other agencies, for example from the NHS to social services
- Dilution: a reduction in standards or scope of a service
- Delay: waiting lists.[1]

Despite these complexities, before 1997 there had been little effort to address or improve the means by which rationing decisions were made. They were mainly made at a local level, resulting in great variability in health service provision[2] and regional disparities in access to and utilisation of services – popularly known as 'postcode rationing'.

A lack of priority-setting guidance

Further, the means by which these decision were made was largely *implicit*, often hidden in clinical decisions.[3] No mechanism existed to guide priority-setting or to ensure consistency in the way that resource allocation between services was dealt with across the country.

While a lively academic debate about rationing took place before 1997, it appears not to have been translated into an active policy concern or a commitment to tackling rationing head-on at a national level. Notwithstanding the absence of a coherent national policy, there were *some* attempts at explicit rationing emerging

Labour has succeeded in putting into place the single most significant attempt at explicit rationing in NHS history.

Tackling postcode prescribing

Both the 2001 manifesto and *The NHS Plan* mention the role of the National Institute of Clinical Excellence (NICE), announced in 1998 as part of the White Paper, *The New NHS: Modern, dependable,*[14] in tackling postcode prescribing. Both documents stated their intention to tackle the 'lottery of care' by directing health authorities and trusts to fund drugs and treatments recommended by NICE.[15]

The Government's actions

Setting out the 'top priorities'

A common rationing strategy used by both past and present governments has been to set priorities largely by identifying and selecting specific 'high-need' *conditions* (as opposed to *services*) – cancer, heart disease and stroke in Labour's case – to receive special attention and earmarked funding.

As the public sector becomes more and more subject to central direction, these priorities have a direct bearing on NHS rationing decisions: measures of performance, such as the new star ratings system, feed directly on the Government's targets. At the top level, Labour has set out a series of contracts called Public Service Agreements between the Treasury and the spending ministries, including the Department of Health. These aim to improve the quality and efficiency of public services and are linked to the Treasury's three-year Spending Reviews. The Department of Health, in turn, has Priorities and Planning Frameworks, which link its targets to performance ratings of NHS institutions, and directives concerning the use of extra money from the Health Modernisation Fund. Thus priorities at the top level flow down into a raft of spending imperatives at the local level. Beyond this, however, ministers have avoided specific rationing decisions.

Establishing NICE

Labour has succeeded in putting into place the single most significant attempt at explicit rationing in NHS history. Since its establishment in April 1999, the National Institute for Clinical Excellence has embarked on an ambitious programme of technical appraisal and guidance. Its remit, set out shortly before it began work, was to 'improve standards of patient care, and to reduce inequities in access to innovative treatment, by establishing a process which will:

- Identify those new treatments and products which are likely to have a significant impact on the NHS, or which for other reasons would benefit from the issue of national guidance at an early stage
- Enable evidence of clinical and cost effectiveness to be brought together to inform a judgement on the value of the treatment relative to alternative uses of resources in the NHS
- Result in the issue of guidance on whether the treatment can be recommended for routine use in the NHS (and if so under what conditions or for which groups of patients) together with a summary of the evidence on which the recommendation is based
- Avoid any significant delays to those sponsoring the innovation either in meeting any national or international regulatory requirements or in bringing the innovation to market in the UK.'[16]

Without ring-fenced money to pay the costs of adopting NICE guidance, the implementation of such an obligation will have to be funded by cutting other services.

be unfavourable on cost-effectiveness grounds. The Department of Health subsequently announced it will conduct a large-scale 'experiment', whereby beta interferon will be available to all patients, allowing the collection of evidence and the identification of which patients for whom it *might* be cost-effective.

Cost effectiveness evidence has no 'absolute' interpretation – considering whether a treatment with a given cost per QALY (or other measure of health gain) is good value for money or not relies on comparison of this evidence with that for other services that are already funded, or against a benchmark known as a 'threshold'.

Guidelines issued by NICE to date *imply* a threshold in the range of £20,000 to £30,000.[23] Statements made at the annual meeting of NICE suggested a *de facto* threshold of £30,000 [24] though the very existence of threshold has been strenuously denied by NICE. However, cost-effectiveness is not the only factor considered in issuing guidance. For example, NICE decided in favour of Riluzole for motor neurone disease, despite a cost per QALY gained of between £34,000 and £43,500, stating that the committee took account of 'the severity and relatively short life span' of patients and 'the value patients attached' to the extension in survival.

The issue of what the threshold is or should be is complicated by lack of evidence on the effects of treatment on quality of life. As Table 3 demonstrates, it is often not possible to measure health gain in terms of QALYs, so other measures are used instead (such as life years gained). This suggests that *multiple* thresholds operate simultaneously.

A further controversy about NICE's work concerns the role of patients in its decision-making processes. Many patient groups have complained that NICE takes too little account of their views and that its 'quality of life' measures are inadequate. Many have called for a greater role in NICE's appraisal process. In responding to these concerns, however, NICE may be at risk of a bias towards patients whose conditions are covered by well-organised lobby groups.

It is still unclear how NICE guidance is implemented locally. For example, guidance issued in favour of Riluzole may be interpreted in one area as an additional service for patients with MND (and resources taken from other treatment areas); in others, Riluzole may be funded but support services for MND patients withdrawn. This means that the effect both on MND patients and those with other illnesses may still vary from one area to another. To some extent, this is beneficial, because it allows NHS bodies to respond to local needs, but it does mean that Labour cannot claim to have ironed out all variations in health care resource use through NICE.

In 2001, the Government announced its commitment to ensure that patients receive drugs and treatments recommended by NICE, with a promise that it will place primary care trusts under a statutory obligation to provide appropriate funding for recommended treatments. But commentators have pointed out that, without ring-fenced money to pay the costs of adopting NICE guidance, the implementation of such an obligation will have to be funded by cutting other services. Local decisions about such cuts will be very different and variations in quality of care between different parts of the country will arise. Evidence to the Commons Health Select Committee from health authorities confirms that implementation of NICE guidance has meant a new phenomenon of 'postcode' cuts in other services in order to find funds for national standards.

Table 3: ***contd.***

Topic	*Recommendation*	*Incremental cost per QALY (if known):*	*Funding implications for NHS*
Laparoscopic surgery for colorectal cancer	**No** Not recommended except in clinical trials		- Possible unquantified cost savings
Autologous cartilage transplantation for defects in knee joints	**No** Not recommended except in clinical trials		+ £3.6 m–6.9 m per year as second line treatment
Donepezil, rivastigmine, and galantamine for Alzheimer's disease	**Yes, but...** recommended as one component for managing mild and moderate Alzheimer's disease depending on circumstances	Estimate: £0–£30,000	+ £42 m per year
Laparoscopic surgery for inguinal hernias	**Yes, but...** recommended only for some kinds of hernia, restricted to appropriately trained teams	£50,000	? 'Budget impact . . . uncertain'
Riluzole for motor neurone disease (MND)	**Yes, but...** recommended for treatment of patients with one form of MND	£34,000–£43,000	+ £5 m net
Orlistat for obesity in adults	**Yes, but...** use for people already losing weight and restrict to adults who show specified improvements	£20 000–£30,000	+ £10 m net
Pioglitazone for type 2 diabetes mellitus	**Yes, but...** recommended as possible alternative to Rosiglitazone (see above)		- Eventual cost savings of £12 m per year
Topotecan for advanced ovarian cancer	**Yes, but...** recommended for specified cases		+ £7 m
Gemcitabine for pancreatic cancer	**Yes, but...** recommended for specified cases		+ £816,000 –£3 m
Wound care	**Yes, but...** recommended which dressings and techniques are most likely to reduce pain and be more acceptable to patients.		? 'difficult to estimate'
Cox II selective inhibitors of osteoarthritis and rheumatoid arthritis	**No** can be used when 'clearly indicated', after careful consideration of the risks and benefits		+ £25 m
Temozolomide for recurrent malignant glioma (brain cancer)	**Yes, but...** Use for some patients who have failed first-line chemotherapy		+ £1 m
Fludarabine for B-cell chronic lymphocytic laukaemia	**Yes, but...** use where chemotherapy has failed		= Not expected to result in a net increase
Docetaxel, Paclitaxel, Gemcitabine and Vinorelbine for non-small cell lung cancer	**Yes, but...** use for advanced cancers in specified situations		+ £3.8 to £15.3 m net
Sibutramine for obesity in adults	**Yes, but...** should be considered only for people meeting specified criteria.	£15,000–£30,000	+ £19.2 m net by Year 3

Source: For guidance issued from the inception of NICE to March 2001, this table has been adapted from Raftery (2001), Tables 1 and 2 (http://www.bmj.com/cgi/content/full/323/7324/1300/T1 and http://www.bmj.com/cgi/content/full/323/7324/1300/T2), with updates from March 2001–January 2002 from the published Guidance available on NICE's web page (www.nice.org/).

In this context, the tendency of Government ministers to raise public expectations about the NHS is particularly damaging. By failing to engage honestly with the public about the need to make trade-offs in allocating health care resources to competing priorities, Labour has not only made itself a hostage to political fortune but has made the NHS more vulnerable to those who argue that it cannot survive in its present form.

The verdict

The establishment of NICE is a substantial achievement, helping to bring transparency and evidence-based consistency to decisions about new treatments. The impact of Government targets and priorities on other areas of treatment and care raise rationing dilemmas that remain obscure and are not being addressed. Local NHS managers and doctors are compelled to make trade-offs between different patients every day, with little support or guidance and barely any reference to the public.

5 Primary care

Key issues:

- Creating primary care groups and trusts
- Establishing personal medical services
- Developing NHS Direct and walk-in centres
- Improving quality in primary care

The inheritance

Controlling costs and quality through fundholding

The health policy pre-occupations of successive governments over the last 20 years have been consistent: containing costs and increasing efficiency, addressing variations in quality, and improving access and responsiveness to users. The Conservatives' reforms concentrated on controlling costs and quality through the introduction of the internal market. A central policy instrument was fundholding, which capitalised on general practitioners' intimate knowledge of local services and their financial entrepreneurialism. It gave practices who chose to join the scheme the ability to commission a wide range of services for their patients from hospital and community health services – sometimes gaining preferential treatment over the patients of non-fundholding practices.

Fundholding came to be seen as the spearhead of a 'primary care-led NHS'.[1] Although its champions claimed great benefits from the scheme, the evidence to support these claims was equivocal. Most fundholding practices had produced only modest service improvements, which were insufficient to justify their high cost.[2]

Ultimately, fundholding was unsuccessful in several respects

- It was bureaucratic, involving high transaction costs. It was perceived as unfair: fundholders generated inequities in access to care ('two-tierism').
- It was difficult to demonstrate that general practitioners were effective advocates in their patients' interests.
- Most importantly, the internal market failed to deliver the anticipated efficiency gains.[3]

Addressing GPs' concerns

The introduction of the internal market, and the imposition of a new national contract in 1990, caused considerable disquiet in the ranks of general practitioners. Many felt that the Government was ignoring their concerns and allowing their workload to rise inexorably. The British Medical Association was seeking to renegotiate the compulsory contractual requirement of 24-hour responsibility for care and to define more tightly the nature of 'core' general medical services (GMS).

commissioning hospital services, improving the health of local people and ensuring their members provide high-quality care.

Developing new structures

More innovations were to follow during Labour's first term of office, specifically focusing on improved access to primary care. NHS Direct, for example, was conceived following a review of emergency services in 1997.[9] A nurse-led telephone helpline, it was designed to provide 'easier and faster advice and information for people about health, illness and the NHS so that they are better able to care for themselves and their families'.[10] More specific objectives for NHS Direct included the encouragement of self-care at home and reducing unnecessary use of other, more expensive, NHS services.

In addition, the Government developed the idea of NHS walk-in centres, most of them to be nurse-led. These were a specific response to the apparent success of instant access primary care facilities established by the private sector, notably on railway stations serving time-pressed commuters.

The NHS Plan, published in July 2000, heralded further organisational changes for primary care.[11] The Plan was supposed to represent a 'new deal' between the Government and the health sector (*see* box *below*). In return for substantial new funding, the Government sought to challenge some of the long-established foundations of the NHS and, in particular, to revisit the settlement between organised medicine and the state.

***The NHS Plan* – key points for primary care**

- 500 one-stop health centres by 2004
- 3,000 surgeries upgraded by 2004
- 2,000 more GPs and 450 more registrars by 2004
- NHS Lift, a new private–public partnership to develop premises
- 1,000 specialist GPs
- Consultants delivering 4 million outpatient appointments in primary care
- Single-handed GPs to sign up to 'new contractual quality standards'

Published a year later, *Shifting the balance of power* provided the structural blueprint for implementing *The NHS Plan*.[12] The transfer of responsibilities to primary care trusts (PCTs) was further accelerated; their numbers doubled to 314 by April 2002. Twenty-eight strategic health authorities replaced 95 existing health authorities to develop strategy and performance manage PCTs and NHS trusts. Regional offices at the Department of Health were abolished and replaced by four regional directorates of health and social care, bringing the NHS one step closer to local government.

In 2001, Labour's manifesto commitments concerning primary care focused more on outcomes than reforms, for example, with the pledge that all patients will be able to see a GP within 48 hours by 2004.

A combination of unrealistic targets, a lack of resources, and the inadequacy of existing systems is seriously impeding PCTs' ability to generate the information needed to carry out their basic functions.

all patients, information about NHS, social services and other local statutory and voluntary services, and advice about self-care and about healthy lifestyles. The location and opening hours of walk-in centres are intended to promote convenient access for users. They are typically open from 7 am until 10 pm or 11 pm and while many are on sites adjacent to general hospitals, others are found in high streets and shopping centres – and one is in Manchester airport.

The Government has also begun to tackle the access problem implied in the dilapidated state of some GP surgeries, especially those in inner-city areas. Through the NHS LIFT initiative, public–private partnerships are being set up in a number of places to renovate outdated premises and build new surgeries where they are most needed (*see* Chapter 8 on the private sector).

The impact of policy

Building new organisations

Establishing an organisation was a key early preoccupation for PCGs, and they made sound progress in their early years. They have started to translate priorities into clear local health strategies, targets and action plans.

However, there remain concerns about whether primary care trusts (PCTs) will be able to realise their undoubted potential.[14,15] Not all PCG boards have functioned in a corporate manner, with general practitioners sometimes dominating board meetings at the expense of contributions from nurses, social services and lay members. There remain significant concerns about the degree to which practices are effectively engaged in the work of PCGs, and about the relative lack of progress in involving communities.

PCTs are beginning to get to grips with their responsibilities for managing budgets and influencing hospital services (*see* Figure 18), but many lack the necessary information and financial management capacity. A combination of unrealistic targets, a lack of resources, and the inadequacy of existing systems is seriously impeding PCTs' ability to generate the information needed to carry out their basic functions (*see* Figure 19).

Many PCTs have made considerable progress in developing minimum standards for general practice, agreeing plans for redistributing resources and improving services. Most have made a good start in establishing an infrastructure for clinical governance and initiating a range of activities involving practices and other staff.

In contrast, many have been hard-pressed to support the commissioning of hospital services or health improvement among their local population. And, although most have begun to develop closer links with social services departments, relationships with the wider local authority, such as housing or environmental health departments, are limited at this stage.

In summary, PCTs as organisations are developing at different speeds. They have made progress in developing and integrating primary and community care, but their commissioning and health improvement functions are, as yet, limited. There is a danger that national policy imperatives, central directives and guidance will stifle the development of local policies addressing local needs.

Clinical governance presents particular challenges for PCTs. They need to stimulate a major cultural change, encouraging professionals to see themselves as collectively accountable for the effectiveness of their colleagues' work.

Developing personal medical services

Personal medical services (PMS) pilots have proved to be a popular innovation. For the GPs involved in them, some of the financial risks and bureaucratic burdens of running a practice are reduced. Salaried GPs appear to be happier with their income and hours of work than GMS doctors on traditional contracts.[16]

It is hard to know how much service development can properly be attributed to PMS. First-wave pilots received an average of £62,900 extra on entering PMS, but there is, as yet, little evidence that they are delivering more improvements in patient care than GMS practices.[17]

PMS provides entrepreneurs with some of the independence previously enjoyed by fundholders, and its success partly reflects its appeal to practices disaffected with the current reforms. Paradoxically, some practices see PMS as a way of defining their own priorities and insulating themselves from the intrusions of PCTs. Nevertheless PMS, by putting responsibility for GPs' contracts in the hands of primary care trusts, provides them with crucial leverage over members with local, rather than national, contracts.

Implementing clinical governance

Clinical governance presents particular challenges for PCTs. They need to stimulate a major cultural change, encouraging professionals to see themselves as collectively accountable for the effectiveness of their colleagues' work.

Individual PCGs and PCTs have spent widely differing amounts on clinical governance. This, in turn, has led to variable levels of local support in the form of new staff.[18] Many clinical governance leads are scrambling up steep learning curves and only now are beginning to understand the complexity of their jobs. In over three-quarters of PCTs, each practice has appointed its own clinical governance lead. However, levels of support from other agencies, such as public health departments, academic bodies or education providers, vary considerably.[19]

The management of poor performance presents PCTs with another difficulty. Whereas previously patients' complaints, colleagues' expressed concerns and financial audit visits by the health authority used to be the main means of detection, PCTs are now responsible for setting up labour-intensive appraisal procedures.[20]

The emphasis so far has been on setting the right cultural tone, as much as on concrete achievements. In the wake of the murder conviction of GP Harold Shipman, which raised public fears about the safety of general practice, this has not been easy. PCTs are trying both to adopt a non-threatening, developmental approach to clinical governance and to set up new local monitoring mechanisms.[21] Yet the threats this appears to pose, both to independent contractor status and professional self-regulation, have increased doctors' feelings of beleaguerment.

Expanding the role of primary care

General practitioners were sceptical of claims that NHS Direct would reduce their workloads. Evaluation confirmed that, while the new service may have helped contain some GPs' workloads out-of-hours, it has had little impact on other emergency services.[22] It has proved to be popular with users, though the extent to

After nearly a decade of rhetoric in support of the 'primary care-led NHS', there is little evidence of a shift in the balance of NHS expenditure. In absolute terms, it is the acute sector that continues to attract most new money.

they are supposed to have been in control of three-quarters of NHS spending. There is plenty of evidence that PCTs vary greatly in the extent to which they are prepared for their new responsibilities. Many will be hindered in their new roles by inexperienced managers, unproven processes and fledgling support systems. Risk areas include corporate governance, information management, partnerships and commissioning, control of prescribing costs and personal medical services arrangements.[26] The Government is supposed to be giving power to the front line but at the same time has shown little enthusiasm for abandoning the range of targets that PCTs must meet.

Conclusions

The out-going Conservative Government presented the new Labour administration with many of the tools it has wielded in its quest for modernisation. The internal market has been adapted gradually within a framework of mandatory collective funding. In other respects, this Government has proved unexpectedly radical. Few people working in the NHS anticipated the series of initiatives designed to change the nature of first contact and to free up access to health care, which may fundamentally change the face of primary care in the long term.

Over the last five years, the NHS has undergone substantial organisational change, nowhere more than in primary care. Yet primary care is also notoriously resistant to change imposed externally. The long-term effects of Labour's reforms are, therefore, hard to predict, and there are still some areas of uncertainty about the extent to which Government policies are being implemented locally. It is still unclear how far primary care organisations will be able to substitute primary for hospital services, to improve health, and to overcome the centrifugal tendencies of many of their members.

A primary care-led NHS

After nearly a decade of rhetoric in support of the 'primary care-led NHS', there is little evidence of a shift in the balance of NHS expenditure.[27] In absolute terms, it is the acute sector that continues to attract most new money. In many areas, PCG mergers give PCTs the aura and scale of the health authorities they replaced. Yet it is unclear whether they will have the critical mass they need to lever resources from hospitals into community-based services.

There remains uncertainty about the capacity of these organisations to shape secondary and specialist care. They are unsure about what is best commissioned at what level. Responsibility for commissioning highly specialised, tertiary services is vested with groups of PCTs but exactly how this will work is still unclear. Giving PCTs the responsibility of commissioning hospital services locally – if it is to have any meaning – must amount to more than the 'freedom' to implement detailed Department of Health directives.

Primary care trusts need time to articulate a vision of how commissioning can make a difference to health care. They need a greater input of financial, physical and human resources including management support and information. At current capacity, it is difficult to see these new organisations effecting significant reconfigurations of secondary care.

The verdict

Ambitious reforms of primary care have removed many of the worst features of fundholding and appear to command widespread support. But the Government is pushing an under-resourced sector to do too much too quickly. Primary care trusts need more time and resources to make the changes that are expected of them.

6 Workforce

Key issues:

- Tackling the shortage of nurses, doctors and therapists in the NHS
- Improving the working lives of NHS staff
- Changing the NHS pay system
- Improving workforce planning in the health service

The inheritance

Workforce issues at the margins

When the Labour Government came to power in 1997, workforce issues were not squarely on the political agenda. The Conservatives had issued a number of initiatives, for example Project 2000, which reformed pre-registration training for nurses, but they lacked a cohesive policy around the NHS workforce. Workforce issues were often marginal to discussions around health policy and organisation.[1,2] Central workforce planning was all but non-existent, and planning within and between professions was fragmented. Only medicine, which for each professional group had been strictly centralised since the 1940s, remained centrally planned. Training budgets were kept rigidly separate. Local Education and Training Consortia (ETC) were established in 1996 to plan and commission non-medical education and training places but had little time to develop any influence before Labour came to power. Consequently, identifying the future workforce that would be needed – both in terms of numbers and composition – and taking action to secure it, had not been seriously attempted.

In the latter half of the Conservatives' 18-year term, recruitment and retention problems in the three major health professions – nursing and midwifery, medicine and the allied health professions – became more acute. What Labour inherited in each of these professions is outlined below.

Nurses and midwives

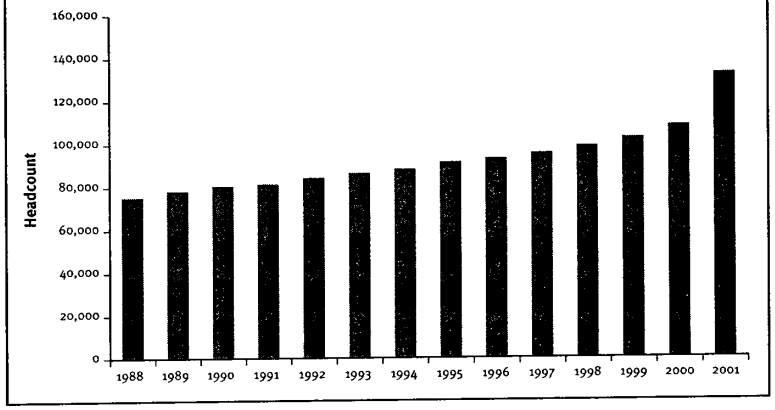
Pre-registration training places for nursing and midwifery were severely cut under the Conservatives in the 1980s to mid-1990s. By the end of the 1990s, this policy was significantly affecting the numbers of people qualifying and registering with the nursing and midwifery professional body, the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC), and the number available for work in the NHS.[3] Figure 20 shows changes in the overall number of registrants with the UKCC from 1990 to 2001. Statistics up to 2001 are included because the Conservatives' policies continued to have an impact on the number of qualifying nurses for several years after Labour came into power. The same applies to figures provided for doctors and allied health professions.

Though recruitment and retention problems were widespread among the health professions during the Conservatives' successive terms in office there was a surprising lack of initiatives to address them.

Allied health professionals

The Council for the Professions Supplementary to Medicine (CPSM – due to become the new Health Professions Council) holds a register of state-registered allied health professionals, such as radiographers and physiotherapists. Figure 22 shows changes in the number of allied health professionals registered with the CPSM.

22 CPSM TOTAL REGISTRANTS: 1990–2001



Source: CPSM

The numbers of allied health professionals registered with the CPSM has steadily increased over the last 13 years to almost 133,400 by mid-2001. The sharp increase between 2000 and 2001 is probably due to three new professional groups – speech and language therapists, clinical scientists, and paramedics – becoming incorporated into the CPSM register.

Though recruitment and retention problems were widespread across the health professions during the Conservatives' successive terms in office there was a surprising lack of initiatives to address them – leaving the new Labour Government with a significant challenge. Therefore the primary focus of Labour's workforce agenda was addressing these recruitment and retention problems among clinical staff.

The policy pledges

Labour came to power on a manifesto that placed health fifth on its list of ten priorities. The manifesto did not contain any explicit pledges to or about the NHS workforce except for an indirect reference to spending extra money on patients and not bureaucracy (the usual euphemism for managers).

After taking office, Labour was quick to publish its plans for modernising the NHS.[6] In 1998, the Government published *Working Together: Securing a quality workforce for the NHS*[7] – an overview of Labour's strategic direction for addressing human resource (HR) issues in the health service. *Working Together* was a welcome first step towards putting HR issues on the agenda of trust chief executives and boards. The strategy involved building and supporting a quality workforce, providing a good working life for staff, and ensuring sufficient management capacity to oversee these objectives. It set target dates for meeting certain aspects of the policy. By April 2000, for example, HR directors would have to have in place training and development plans for the majority of health professional staff. More detailed plans for implementing key aspects of the policy overview were promised.

places, evaluate the existing mix of health professions and experiment with alternatives
- exploring multi-professional education and training opportunities.

The review acknowledged there were staff shortages within the service but suggested any attempts to increase staff numbers would have to be matched by thinking around how staff might work differently to deliver services: 'looking at the workforce in a different way, as teams of people rather than as different professional tribes.'[16]

Staff numbers

The NHS Plan[17] set out targets for increasing the numbers of key NHS staff: Between 2000 and 2004, the Government promised to recruit:

– 20,000 more nurses
– 7,500 more consultants
– 2,000 more GPs
– 6,500 more therapists.

In addition, the Plan stated that annually, by 2004, there would be:

– 4,450 new training places for therapists and 'other key professional staff'
– 5,500 new nurse training places
– 450 new general practice training posts
– 1,000 specialist registrar posts.

By 2005, the Government pledged to increase medical school places by up to 1,000.

In addition to the policies mentioned above under the four broad promises, rafts of other workforce documents were issued by Labour (*see* box *below*).

Key workforce initiatives under Labour

1998 *Working Together: Securing a quality workforce for the NHS*
1999 *Agenda for Change: Modernising the NHS pay system*
1999 *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*
1999 *Making a Difference to Nursing and Midwifery Pre-registration Education*
1999 *Improving Working Lives in the NHS*
2000 *A Health Service of all the Talents: Developing the NHS workforce*
2000 *The NHS Plan: A plan for investment. A plan for reform*
2000 *Improving Working Lives Standard*
2000 *Meeting the Challenge: A strategy for the allied health professions*
2001 *Modernising Regulation in the Health Professions*

Although pay levels have been increased substantially, particularly by the last two Review Body settlements, a large proportion of these increases compensate for a period of pay restraint during the 1990s.

remit of the WDCs. From April 2002, the WDCs will be able to take on responsibility for the Medical and Dental Education Levy, unifying the budgets for medical and non-medical training – this means that almost all financial support for training is in one pot. Clearer lines of accountability for workforce planning at local, regional and national level have now been established.

Following the launch of *The NHS Plan*, a national Workforce Taskforce was set up to encourage and assess local progress towards key targets set down in the Plan. One of those targets included investigating ways staff might work differently. The Changing Workforce Programme was subsequently set up to experiment with this, for example, by moving a task up or down a traditional uni-disciplinary ladder. Examples include allowing specialist registrars to perform tasks previously carried out only by consultants, or expanding the number of tasks nurses can take on.

Increasing staff numbers

Training places for nurses and midwives, doctors and allied health professions have been increased, in line with *NHS Plan* targets, and will continue to increase year on year until 2004.

Recruitment campaigns have been run annually since 1999 to entice people into the NHS workforce. In the last couple of years the Government has also run 'returners' campaigns to attract former staff back to the NHS. Considerable effort has also been made to entice overseas-trained nurses and doctors to the NHS. A specific arrangement has been made with Spain to provide the NHS with nurses.

The impact of policy

Pay – a mixed reception

The Government's proposals to change the pay structure for the health professions were published in 1998. What progress has been made on developing this structure and agreeing a timetable for its implementation has yet to be made public.

Although pay levels have been increased substantially, particularly by the last two Review Body settlements, a large proportion of these increases compensate for a period of pay restraint during the 1990s. Furthermore, concerns remain about the level of pay for some professions. For example, pay for nurses, midwives and the allied health professions still lags behind that of other public sector workers.*

Labour's golden 'hellos' and 'goodbyes' for GPs and nurses received a mixed reception. Some said they would make a real difference;[21] others dubbed them 'handcuffs'.[22] What impact they have had is not yet clear: take-up figures for these financial incentives are not yet available.

Cost-of-living supplements and accommodation support have been welcomed but are still not considered sufficient to compensate for higher living costs – particularly in London and the south east of England. Transport costs for staff working in the capital remain a significant issue, especially considering other public sector workers, for example, officers in the Metropolitan Police, receive a travel subsidy.

* For example, a qualified nurse starts work on £15,445 and a physiotherapist on £15,920. A qualified teacher starts work on £16,038 or £17,001 (depending on their level of attainment) and an untrained policy officer starts work on £17,133.

Staff numbers – will they be enough?

The headline figures in *The NHS Plan* proposed for the expansion of NHS staff were encouraging at first but further analysis revealed several caveats.

- The numbers of nurses were headcount figures not whole-time equivalents (or WTEs). This potentially lowers the resulting contribution to the service because many health workers are on part-time contracts.
- 4,500 new consultants,[28] 1,100 extra GPs,[29] and a significant proportion of the nursing component were already due to join the workforce when *The NHS Plan* was drafted, for example, from earlier increases in training places.
- As it was clear that not all these posts could be filled by UK-trained health professionals, there would be a significant reliance on overseas recruitment to plug the gaps until more UK-trained graduates came online – accepting that they may not remain in the NHS indefinitely.

By December 2001, the Government claimed to be half way towards its target of 20,000 more nurses by 2004.[30] It is likely that that number will increase in the next year as some 29,000 overseas-trained nurses complete adaptation courses and become eligible to join the UKCC register and work in the NHS. But there are still worrying problems within nursing and midwifery.

- The nursing workforce is ageing, which means the number of nurses forecast to retire will double from 5,500 a year to more than 10,000 a year by 2005.[31]
- The number of overseas-trained nurses and midwives joining the register is set to exceed the number of UK-trained nurses and midwives, partly as a result of government recruitment drives to boost nursing numbers.
- The NHS is struggling to retain staff and plug the gaps that leavers create.

The most recent NHS vacancies survey found there were 9,000 nursing and midwifery vacancies at the end of March 2001 – 1,000 less than the previous year.[32] However, the survey only includes vacant posts that trusts have been actively trying to fill for three months. By counting an established post as vacant the moment it becomes unfilled, as well as counting posts that have been frozen, the Royal College of Nursing (RCN) estimates the real vacancy rate may be nearer to 22,000 WTE.[33] And even if the Government meets its ambitious targets, they may not be sufficient. The RCN claims that if retirement and other losses remain constant, the NHS will need to recruit more than 110,000 nurses by 2004 to plug the gaps.[34]

By September 2001, there were 25,690 consultants working in the NHS – an increase of 5.7 percent on the previous year. During the same period, there was a meagre 1.4 percent increase in the number of GPs, taking it to 30,685.[35] The latest NHS vacancies survey revealed there were 670 consultant post vacancies. A separate survey of general practitioner vacancy rates found 1,214 vacancies. That number, in particular, looks set to increase as significant numbers of Asian GPs recruited to plug gaps in the 1970s approach retirement in the next few years. In some health authorities, many of them in the most deprived areas of the country, this could mean a loss of one in four GPs.[36] The ability to fill these posts is compromised by the modest supply of newly qualified GPs – which hit an all time low in 1998 and has barely recovered since.[37]

Upstream, while the number of places available may be increasing, the number of applicants to medical school are falling. In 1994, the University and College Admissions Service (UCAS) received 11,671 applications to study medicine. By 1996,

unsure of where they stand. A recent example of this followed an Audit Commission report,[42] which showed that waiting times in A&E were higher than five years previously: when ministers became aware of the statistics, they were reported to have warned that NHS managers whose trusts continued to under-perform in this area would be replaced.

At a time of significant change in the NHS and great pressure to achieve the Government's modernisation targets, staff motivation is vital. The ambitious targets set in *The NHS Plan* will only be implemented by a sufficiently highly motivated workforce which feels enthusiasm for what ministers want to achieve. Many of the National Service Frameworks for specific patient groups, for example, require staff to undertake additional training, for which many are unable to get time away from their regular work because of staffing pressures. Low morale and staff shortages thus act in a vicious circle which the Government will have to break if its ambitions for the NHS are to be realised.

Short-term thinking

Labour's policies on the NHS workforce, although welcome, have a predominantly short-term focus, working to a politically expedient timetable. There remains an important policy debate about the wider vision for the NHS workforce, incorporating discussions around how – with a limited complement of staff – the workforce might be reconfigured to better meet patients' needs. Labour set the agenda for this discussion when it outlined its plans for modernising the career structure for nurses. Some models for reorganising the workforce have been suggested.[43,44] But there are still entrenched views on all sides, which inhibit open discussion of new models of working and experimentation. Equally, there must be a robust review of the evidence-base for alternative workforce models, which is currently limited and biased.[45]

Significant challenges ahead

Labour has acknowledged the problems facing the NHS workforce and developed a programme of work to address them. The programme is comprehensive, ambitious and timely, but there are still significant challenges. Recruitment and retention problems, for example, are acute, forcing many trusts to rely heavily on expensive agency and locum support. In general practice, the worst problems may be yet to come, as retirement levels among inner city GPs begin to rise over the next ten years. Unless issues such as these are resolved, the Government's modernisation agenda for the NHS will be compromised.

The verdict

Five years after Labour took power, the NHS remains desperately short of staff in many areas. Labour inherited many of these problems and is now making a committed effort to tackle the shortages the service faces. Early indications are that the Government has succeeded in increasing staff numbers in the NHS, but whether it will make a substantial impact in the longer term, against a background of ever-rising retirement levels in the service, is unclear. Labour has made a start in addressing longer-term issues, but, so far, little progress has been made. In particular, there has been no systematic attempt, as yet, to develop effective links between service redesign, changes in clinical technology, and the content of training and lifetime learning.

7 Quality assurance

Key issues:

- Creating systems for improving quality of care within the NHS
- Measuring the performance of NHS trusts
- Reforming professional self-regulation
- Managing poor performance by NHS staff

The inheritance

Public concern about the quality of care that they receive from the NHS has been rising in recent years. In an increasingly consumer-driven society, informed by media reports of the opportunities offered by modern treatment, expectations of what health care should be like have been rising. These expectations are not always met in people's experiences of the NHS, or, indeed, of private medical care. This, alongside growing evidence of variable standards of care, has made the quality agenda an unavoidable political issue.

Medical audit

In 1991, the mainstay of the quality agenda was medical audit, later broadened to clinical audit. The Government's role was to fund the process and to set out an organisational framework, leaving the rest of the system to the discretion of the medical profession.[1] The process was entirely confidential to the doctors involved.

In 1996, the Government acted to take greater control over audit activity. Health authorities were made responsible for audit monies and became subject to performance management by the NHS Executive for their use. They were expected to lead the development of a programme that linked to the implementation of national guidelines and involved a broader spectrum of health professionals, managers, researchers, purchasers and patients in increasingly wide-ranging audits and reviews.[2] This change in funding provided the first lever for ensuring more accountable national systems for improving quality. For the first time, those outside of medicine had a greater say in the agenda for clinical audit.

The years immediately preceding 1997 also saw numerous new policies emerge to promote the wider quality agenda set by the advent of evidence-based practice.[3,4,5] These included investment in research, and guidelines and outcome indicators, alongside a raft of advice and guidance to the service on how to develop and assure evidence-based approaches to quality health care. The Conservative Government invested in demonstration projects to lead the way in closing the gap.[6,7,8,9,10] They showed how complex the task of changing and improving clinical practice was, as well as helping to develop NHS staff with new skills as quality facilitators and quality project managers.[11]

producing national guidelines for best practice based on evidence of clinical and cost-effectiveness. There would be a new system of clinical governance to ensure that standards of good practice were met and processes were in place in every trust to ensure continuous improvement. It promised a new statutory duty for quality on NHS trusts (until that point they were only duty-bound to keep their organisations financially solvent). It also proposed the establishment of another new organisation, the Commission for Health Improvement (CHI), whose main task would be to review clinical governance arrangements in each and every NHS organisation over a rolling five-year cycle. Where there was a justifiable cause for concern over a trust's performance CHI would also be able, under direction from the Secretary of State for Health, to undertake a rapid inspection and review of the organisation in question.

Six months later, in June 1998, the full blueprint arrived in the form of *A First Class Service: Quality in the new NHS.*[21] This covered five main themes:

- The promise of *national consistency* in the implementation of evidence-based practice and the introduction of new health care innovation.
- A new *accountability* for ensuring the local implementation of best practice.
- A commitment to a co-ordinated and systematic approach to undertaking audit, promoting clinical effectiveness, managing complaints, tackling risks and working for better quality information on clinical performance – in short a coherent system of *quality improvement and assurance.*
- New commitments concerning the *management of poor performance.* The blueprint proposed placing a responsibility for clinical governance on chief executives, requiring appraisal systems within trusts, establishing an inspectorate to visit trusts, and obliging all hospital doctors to take part in national audit. To this were added promises about the modernisation of professional self-regulation.
- An emphasis on *professional collaboration and teamwork.* It promised to put the experience of the patient at the centre of the quality improvement process.

Public protection

The next tranche of policy, emerging in 1999 and 2000, concentrated on the links that were needed to make this raft of policy objectives coherent. The focus here was on *public protection* from poor performance.

Leading the way were promises for a fundamental change in the relationship between patient, professional, manager and Government. For example, proposals were made to sweep away old rules governing the management of doctors. Trusts and health authorities, or primary care trusts in relation to GPs, were to have the authority to conduct annual appraisals with doctors; while doctors faced new obligations to take part in clinical audit and clinical governance and to undergo the appraisal.[22] Participation in appraisal, and the generation of comparative data, would then form part of the process for five-year revalidation by the General Medical Council – the doctors' professional regulatory body. In the case of possible poor performance, it promised that concerns would lead to doctors being referred to a new 'support and assessment' service.

Organisational learning

As well as developing policy that could address potential poor organisational performance, the Government promised to ensure that the whole NHS learnt from those parts of the service that got it right – to spread good practice more quickly and efficiently.

recommendations over the funding of new medicines, medical devices, and diagnostic procedures, based on cost and clinical effectiveness information. NICE is discussed in greater detail in Chapter 4.

The Department of Health itself took on a major role in implementing the Government's promises of greater national consistency. It began to produce National Service Frameworks, designed to define service models from the perspective of the patient – irrespective of organisational boundaries. These frameworks came with performance milestones against which progress within an agreed timescale is measured, alongside information and organisational strategies to support implementation. They aim to raise the quality and decrease the variations in key services.

A framework for mental health was published in September 1999,[33] one for coronary heart disease in 2000,[34] and a *National Cancer Plan* in September 2000[35] – which itself built on the 1995 Calman/Hine report [36] (produced under the Conservative Government). Frameworks for services for older people and for diabetes were published in 2001.[37] For many of these topics, national directors, often dubbed 'tsars' have been appointed to promote improvements and monitor standards of care. The Department of Health anticipate one National Service Framework each year – the current programme gives a commitment to the development of frameworks for renal services, children's services and long-term conditions.[38]

Building clinical governance

Clinical governance is a framework for making all NHS staff accountable for quality improvement and safeguarding standards. The Department of Health defined clinical governance 'as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'. [39]

The Government's first piece of legislation established a statutory duty of quality on NHS organisations: 'it is the duty of each Health Authority, Primary Care Trust and NHS Trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals'.[40] It also put in place performance management structures to ensure action on clinical governance (including inspection by CHI) and placed trusts under an obligation to produce an annual clinical governance report.

The Government wove a clinical governance thread through policy developments across the board. Typical of this is the way clinical governance responsibilities have been enshrined in the organisational structure of new primary care trusts (PCTs). Government guidance guarantees clinical governance leads a place on the board and makes the extended reach of CHI into PCTs abundantly clear: 'the Commission will have a key role in the assurance that clinical governance is being implemented ... it will conduct a rolling programme of reviews visiting every PCT over a period of around 3–4 years'.[41]

The Commission started work on 1 April 2000. In 2001, it published clinical governance reviews on 70 trusts and the results of investigations into potential problems in service quality in another five. It has also conducted the first review of the implementation of national standards in cancer care and it will publish similar reviews for each National Service Framework.[42]

The actions taken to reform the system of professional regulation have been a mix of Government threat and professionally driven response.

The wide-ranging Bristol Inquiry recommended that the monitoring of clinical performance at a national level should be brought together and co-ordinated by a new independent Office for Information on Healthcare Performance located within CHI. The NHS Reform and Health Care Professions Bill, currently before Parliament, proposes to establish such an office. Its duties will include both the collection and analysis of data and the assessment of performance against criteria to produce star ratings. The Department of Health is working with CHI to refine and improve the criteria for assessing performance in the future.

Improving organisational performance

Here, too, new national organisations have been given the remit of turning policy intent into practice. Established respectively in April and July 2001, the Modernisation Agency [51] and the National Patient Safety Agency [52] are in their early days.

The Modernisation Agency

The Modernisation Agency aims to provide targeted and expert support to the work of service improvement and local service development. In many ways the agency is an umbrella organisation bringing together previous initiatives to promote and support organisational learning, achievement, leadership and improvement. It encompasses the National Patient Access Team, the primary care development team, collaborative programmes for cancer, coronary heart disease, mental health, primary care, critical care, orthopaedics, recruitment and retention, and the Clinical Governance Support Team. All this sits alongside an effort to co-ordinate the provision of leadership development for more than 30,000 leaders and managers of the NHS. The Government is now targeting the efforts of the Modernisation Agency at those organisations who perform badly under the star rating system.

The National Patient Safety Agency

The National Patient Safety Agency is the Government's practical response to the promises to better manage adverse events. It is charged with introducing a mandatory national system for identifying, recording, analysing and reporting failures, mistakes and near-misses in the health service. It will collect and analyse information on adverse events and by the end of 2002, all NHS trusts and most primary care trusts are expected to provide information to the national system. Its objective is to draw conclusions from that information and feed them back into practice, service organisation and delivery.

Assuring clinical performance

The actions taken to reform the system of professional regulation have been a mix of Government threat and professionally driven response. The professional regulatory bodies have promised action to ensure greater accountability, transparency and efficiency. Their proposals include the greater involvement of lay people in their governance, simpler and quicker processes for the investigation of concerns about professional performance or conduct, and the development of methods for the periodic revalidation of every professional's fitness to practice.[53] However, the Government has forced the pace and made it clear that it is prepared to use its powers to intervene more directly if it is not content with the direction or speed of change.[54]

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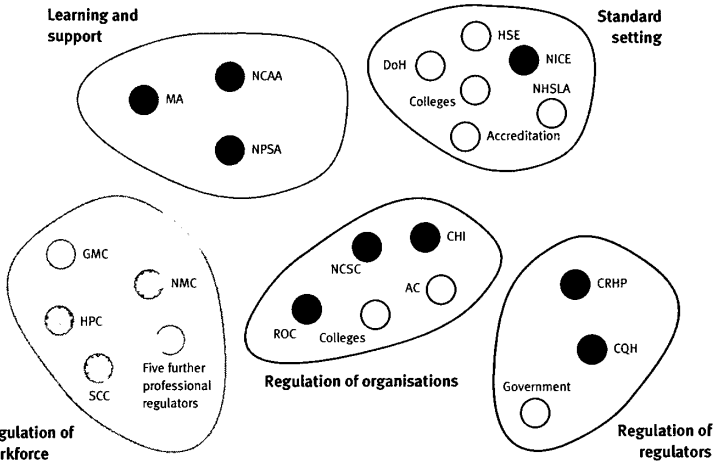


Key

Learning and support
MA – Modernisation agency
NCAA – National Clinical Assessment Authority
NPSA – National Patient Safety Agency

Standard setting
DoH – Department of Health
HSE – Health and Safety Executive
NICE – National Institute for Clinical Excellence
Colleges – Royal Colleges
NHSLA – National Health Service Litigation Authority
Accreditation – Assorted accreditation schemes

Regulation of workforce
GMC – General Medical Council
NMC – Nursing and Midwifery Council
HPC – Health Professions Council
Five further professional regulators – The General Osteopathic Council, General Chiropractic Council, General Dental Council, General Optical Council and The Royal Pharmaceutical Society of Great Britain
SCC – Social Care Council

Regulation of organisations
NCSC – National Care Standards Commission
CHI – Commission for Health Improvement
ROC – Retained Organs Commission
Colleges – Royal Colleges
AC – Audit Commission

Regulation of regulators
CRHP – The Council for the Regulation of Healthcare Professionals
CQH – The proposed Council for the Quality of Healthcare
Government – including the role of Parliament and devolved national assemblies

Setting national standards – a mixed picture

CHI is obliged to conduct formal evaluations, working alongside the Audit Commission, in the implementation of National Service Frameworks, but, to date, the only completed study is on cancer care. This study looks at how well the NHS has met the recommendations of the 1995 Calman/Hine report on the delivery of local cancer services and is only a baseline against which the success of this Government's National Cancer Plan can be assessed. However, it provides an insight into the progress that the National Service Framework is making on delivering national objectives – and the picture is mixed. On the one hand, it reports significant progress on some national targets: for example, 92 per cent of patients referred urgently by GPs are now seen within two weeks – a significant step toward the 100 per cent target – although this needs to be seen in the wider perspective offered by Chapter 3 on waiting list targets in general. Survival rates for most cancers are improving and there are more specialist cancer surgeons. On the other hand, it points out that 'improvement has been patchy, services lack co-ordination and the care patients can expect varies according to where they live and the type of cancer they have'.[61]

principally towards the dimensions of their activity captured by performance indicators, diverting their attention away from other aspects of their business. Thus, performance shifts between measured and unmeasured activities.

- Improvements may not be a result of performance measurement in itself but of changes in factors beyond the influence of the NHS, such as changes in society as a whole.
- The main focus of the existing performance information has been the year, as this is the usual time unit for data collection – but many aspects of performance vary within the year, while others change so slowly that annual change is small and likely to be masked by data error or variability. In some areas, such as financial performance, the annual cycle will remain important. But in others, the periods selected for *reporting* changes in performance need to be chosen with care. For example, the Department of Health reports that the proportion of patients who missed their first outpatient appointment fell by 1.5 per cent between 1999/2000–2000/01). Since 1997, however, it has increased, by 0.5 per cent.

Evaluating the outcome of the star rating system is difficult as the first wave of 'franchising' for zero starred trusts has only just begun, and it is also too early to judge the impact of 'earned autonomy' for three- and two-starred trusts. However, it would be surprising if the replacement of some trust chief executives did not have some positive impact on the performance of their trusts. But, as with the PAF, the reason for improvement may well not lie with the performance system (here, star rating, earned autonomy and 'franchising') but with other factors, not least the extreme focus of management and political attention on a handful of under performing trusts.

Improving organisational performance – a way to go

Despite the relative newness of the Modernisation Agency, the various initiatives under its ambit preceded their new organisational home. Yet evidence of impact is still thin. Certainly the level of participation in the various policy initiatives under this heading is impressive. Five thousand NHS staff are involved in the Cancer Service Collaborative, working to improve the quality and co-ordination of cancer services, and more than a thousand are involved in the Clinical Governance Support Team.[67] The Modernisation Board, an independent group created by *The NHS Plan* to take an overview of the modernisation process, claim in their annual report that 90 per cent of cancer collaborative projects have enabled patients to choose their own appointment time.[68] Yet, without formal or external evaluation, it is hard to put such headlines in context. Although the number of staff involved in their work is an unsatisfactory proxy for impact, the director of the Modernisation Agency commented that: 'currently less than 15 per cent of staff are estimated to be actively involved', compared with a stated aim of increasing this to 100 per cent.[69] That leaves some way to go.

Assuring clinical performance – planning radical reform

Not surprisingly, the reforming agenda of the GMC has broadly followed the Government's vision. Radical reform is proposed in three areas:

- the governance of the GMC [70]
- the way it investigates potential cases where a doctor may prove unfit to practice [71]
- proposals for the revalidation of each and every doctor on the professional register.[72]

the NHS, such as the Modernisation Agency is that they have yet to develop effective ways of co-operating so that inspection and review are followed through with development and improvement. For those who fair badly on inspection, performance assessment or star rating, it is imperative that action and improvement follows quickly, otherwise the process risks demoralising staff, exacerbating existing recruitment and retention problems, and starting a negative cycle rather than prompting positive change.

Taken as a whole, the conceptual framework that promotes national standard setting, accountability for local delivery and monitoring implementation is now uncontentious. However, the scale of the standard setting and monitoring enterprise attracts criticism. The work of so many national bodies and the obligations that they place upon NHS organisations seems to have been added to existing and extensive performance monitoring, rather than being considered as an alternative framework within which the service might be given a greater degree of freedom to deliver.

Spreading good practice

Growth of initiatives and action teams within the Modernisation Agency is evidence that there is no fear of experimentation in the search to find out what works. However, there seems to have been little premium put on rigorous, timely, independent and research-based evaluation. Such evaluation might have helped to establish the real impact and opportunity cost of the overarching framework for quality improvement and assurance that Labour has erected.

The verdict

The Government has introduced far-reaching reforms of the way quality is assured in UK health care. From the regulation of individual professionals to the assessment of whole organisations' performance, Labour's reforms could revolutionise the way the public judges the NHS and its workforce. However, it is still unclear how much they will affect the quality of care received by individual patients.

8 The private sector

Key issues:

- Building hospitals through the Private Finance Initiative
- Using private hospitals for NHS operations
- Making more use of private nursing and intermediate care

The inheritance

Moving towards privatisation

The use of the private sector to provide services to the NHS is one of the thorniest issues facing the Labour Government.

When Labour came to office, care in some parts of the NHS was already being provided by private organisations – most notably in mental health services where both charitable and profit-making bodies were providing a wide range of services. Health authorities already free to send patients to private hospitals for surgery, although few actually did. In 1997, nursing home provision was almost entirely in the hands of private suppliers following the unplanned switch of financial responsibility for those needing continuing nursing care to the social security budget in the early 1980s. A large share of hospital support services was also contracted out, as a result of policies introduced in the early 1980s. Hospitals themselves had always been built by the private sector, and the design capacity that had been in place within the DHSS up until the 1980s had largely been disbanded. Even that mainstay of the NHS, the general practitioner, was a private contractor, not an employee.*

In 1997, the private finance initiative (PFI) was stalled, with no major hospital building contract yet signed. The introduction of private finance across the whole of the public sector had begun in the first half of the 1990s but took off slowly within the NHS, with the exception of minor schemes such as provision of car parking or incinerators. The Conservatives had hoped to be able to announce completed deals before the 1997 election but, while a number of major hospital schemes were almost at the point of closure, private sector concerns about the risks they were taking on prevented them from being finalised.

The policy pledges

The 1997 Labour Manifesto made it clear that while the party would do what was necessary to make the private finance initiative work effectively, it opposed the privatisation of clinical services – which the Conservatives were accused of promoting. Labour's first health White Paper,[1] published later that year, reaffirmed this position.

* As were dentists, pharmacists and opticians working in community settings.

The Government has been able to claim, accurately, that the largest ever hospital building programme is underway.

able to announce that a number of schemes would go ahead and since then further waves have been approved. As a result, the Government has been able to claim, accurately, that the largest ever hospital building programme is underway.[5] Major new hospitals have already been built in Carlisle, Norwich, Dartford (in Kent) and Greenwich (in London), with many more to follow. By 2001, the overall value of schemes constructed or in planning had reached £7.5 billion (*see* Table 4).

Table 4: Capital value of major schemes given go-ahead since 1 May 1997

	£ million capital value
PFI schemes completed and operational	297
PFI Schemes reached financial close with work started on site	1,578
Other Prioritised PFI schemes	5,488
Publicly funded schemes completed and operational	48
Publicly funded schemes with work started on site	124
Total major investment given the go-ahead	**7,535**

Source: Department of Health. *Departmental Report.* London: The Stationery Office, 2001

Only a fraction of these had been or were being procured and financed in the conventional way. New hospital building was therefore completely dominated by private finance. However, smaller schemes, including major equipment purchases, continued to be paid for out of public funds and, even by 2001/02, over half of total capital spending was financed in this way.

Improving primary care premises

In contrast to hospitals, community health facilities are generally small and relatively simple to build. But, in many parts of the country, particularly inner city areas, GPs and others have always operated from out-of-date and unsuitable premises. Nevertheless, it was not until 2000 that a new initiative known as LIFT (Local Investment Finance Trust) was announced in the *NHS Plan* to develop public–private partnerships to provide primary care premises. In July 2001 the LIFT prospectus was eventually published. It set out, in very brief terms, proposals for a new form of local investment agency. The *NHS Plan* indicated that the aim was to produce some £1 billion in new facilities, involving the refurbishment or replacement of surgeries for some 3,000 GPs and the creation of 500 'one-stop' primary care centres, with the initial focus on inner-city areas.

The LIFT prospectus identified the need for an increased level of investment in terms that would command broad agreement. The standard of existing premises is often low. In many areas very little new investment has taken place, and, where it does, it tends to be piecemeal. The prospectus also points out that GPs face significant disincentives to practise in inner-city areas – leases are too restrictive but if they invest in new premises they face the risk of negative equity.

However while the case for spending more might be clear, as with hospitals, the prospectus does not attempt to justify the particular means proposed for financing it. Nor has any other Government statement. The Government is nevertheless pressing ahead with the development of LIFT companies – so far two waves of LIFT areas have been identified, the majority in inner city locations – and it appears to have no thought for piloting the new approach nor providing for its evaluation. However, despite its haste, no local LIFTs are fully operational as yet.

The gains from using private finance are modest, typically amounting to a few per cent of total scheme costs.

them were entering into uncharted waters so the negotiations were understandably slow and expensive. The Department of Health subsequently took a number of steps to reduce these transactions costs, for example, by developing standard clauses for use in all private finance contracts. But even now, the private sector still finds the process onerous and expensive.[11] The nature of the bidding process is inherently costly to both public and private sectors.

However, the long-term implications are more important. The use of private finance entails higher borrowing costs since the Government can borrow at a lower rate than any private company. To offset these higher costs, private sector companies have had to produce savings in the costs of building and maintaining hospitals over the longer term. In principle, before a scheme is approved, the trust proposing it has to demonstrate that the price at which the private sector can build and make a hospital available is lower than what it would cost to do the job itself.

These calculations have been challenged on a number of grounds.[12] Of these the most serious is that trusts proposing schemes have systematically biased them to ensure that the private option came out superior to the public. Their motive for doing so is obvious enough: they believed that access to public finance was so limited that the chances of having their scheme funded that way were minimal.

This charge has been strenuously denied by the Government.* But what is clear is that even if the calculations are taken at their face value, the gains from using private finance are modest, typically amounting to a few per cent of total scheme costs.* For example, the difference between the private and publicly funded options for provision of the new Swindon and Marlborough Trust hospital was less than £1 million. While other schemes promise larger gains, this scheme is far from unique.

In fact, modest gains were only to be expected. Labour declined to allow the private sector to provide clinical services – which account for some 70 per cent of hospital costs – so the scope for achieving lower costs was limited. In many cases, services such as catering and laundry, which make up the remaining 30 per cent, had already been put out to tender as a result of the policies introduced by the Conservatives in the 1980s, and so were already subject to private sector competitive pressures.

Essentially, therefore, the case for using private finance rests not so much on the belief that specific levels of efficiency gains will accrue, but rather on the general belief that the incentive structure facing the private sector provider is more likely to achieve the stated level of costs than the public sector is of achieving the level it promised. In fact the incentive structure is the key innovation: by linking all the phases of hospital provision – design, building and operating – an incentive is created to provide buildings with an eye to their long-run maintenance costs. The traditional method can in principle be designed and built with a view to minimising lifetime costs but it cannot create the same long-term financial framework given by the private finance initiative.

By definition, however, this argument cannot be validated by the experience of the past five years nor, probably, can it ever be. Because the Government has made the PFI almost universal, the basis of comparison will not exist.

* Evidence from trusts given to the Health Select Committee would seem to confirm it was true however.
* Gains in other sectors, eg, prisons have been greater: in this case the private providers offer the whole service, ie, they provide staff as well as facilities which offers greater scope for savings.

the question of how competition between providers is to be handled. If the market is to be non-competitive then some of the advantages of private provision will be lost. If it is to be competitive, the process by which long-term contracts are awarded, and the implications for those who do not receive them, need more consideration. This issue lies buried within the vagueness of the term 'partnership'.

Conclusions

The role of the private sector

The private sector role in 2002 is not much different to what it was in 1997, and it will not be for some time that significant change occurs, even allowing for the measures announced by the Secretary of State. The one apparent exception is the provision of new hospital buildings, which is now almost entirely achieved through the use of private finance. But even here, change is less than it may seem. Hospitals have always been built by private sector companies and, since the 1980s, often maintained by them as well. However, the use of private finance does represent a new approach to the provision of health capital and in terms of getting hospitals built, it proved successful: whether it will prove so in the longer term is much less clear.

Change in the use of private providers for health and care services has been modest, in part because the shift in policy did not become apparent until well into Labour's first term. Therefore, in these areas, there is little practical experience to assess. To date, it appears that Labour has not succeeded in defining what the roles of public and private providers should be in these two areas.

A lack of trial and evaluation

At the level of rhetoric, there has been a distinct change in policy towards the private sector in the last five years. That change has not been justified by a general, ideological preference for private provision in terms the Conservatives might have used. Instead, the mantra has been 'what matters is what works'. Yet the Government has not tried to demonstrate that its policies are better than those they replaced.

In respect of the PFI and LIFT, the Government has entered, or plan to enter into, a series of long-term relationships, without a period of trial marriage in the form of evaluated pilots. Worryingly, the Government has responded to the heavy criticism it has received with impatience rather than reflection.[18]

Although it has taken a number of sensible measures to reduce the transaction costs associated with new hospital schemes and to encourage them to be developed within the content of the whole local health economy, it has not made a serious attempt to address the long term concerns that have been expressed about the current regime. One of the biggest such concerns is around whether the substantial risk involved in projects like building a new hospital is, in fact, being transferred to the private sector, and how this can be valued in economic terms.

A lack of clear definitions and data

In the provision of clinical and nursing services, the Government has expressed a wish to put the existing fitful relationship onto a better footing, but it has not been able to define what the nature of the long-term relationship might be. In the case of

There is a case for going down this road – one which the authors of the Conservatives' 1989 White Paper [24] would recognise. It may, for example, improve patient choice, create some degree of competitiveness, or allow lessons about good practice to be learned between different sectors. But the Government has not provided either a vision of the future to which this road might lead nor a route map for journeying along it. In sum, policy towards the private sector lacks substantive practical or principled justification. On February 6th 2002, *The Times* [25] reported that the Government was preparing to publish a 'new vision' for the NHS, for publication in the run-up to the next election: all the greater is the need for that justification.

The verdict

The Government's enthusiasm for involving the private sector in the NHS is insufficiently grounded in evidence. It has gambled that what is built today with private finance will be fit for purpose in a decade or more. Its plans for greater private sector involvement in provision remain unclear. Is it looking to the private sector for expertise it believes the public sector lacks, or hoping private companies will provide a greater stimulus to service improvement? While the case for using spare capacity in the short term is obvious, the Government has failed to define what kind of longer-term relationships it wants to build with the private sector.

9 Long-term care

Key issues:

- Changing the way long-term care is funded
- Making better connections between health and social services
- Improving the quality of long-term care services

The inheritance

A legacy of problems

When the Labour Government came into office in 1997, it faced three main problems afflicting services providing care and support for people with long-term illnesses or disabilities:

- A funding system combining free health care and means-tested social care, which was widely perceived to be unfair, especially to older people who were having to sell their homes in order to pay for their care.
- The system of services provided by local government, the NHS, private and voluntary bodies was not working well for users and carers, who tended to get caught up in disputes between health and social care authorities as to who was responsible (or not) for their care. Unilateral action on the part of either the NHS or local authorities could also create blockages and other pressures in other parts of the system.
- Protection of vulnerable people using care services was regarded as inadequate, leaving users exposed to incompetence, neglect and abuse.

Labour has not been the only government having to face such problems. These have been long-running themes throughout the history of community care, with some difficulties originating in the post-World War Two settlement regarding the welfare state. However, there is no doubt that problems relating to funding, integration and quality had been exacerbated by successive Conservative governments during the 1990s – usually by default rather than by design.

An unfair funding system

The funding system for long-term care was established in the 1940s, when the NHS was set up and the rules enabling local authorities to assist frail older people and others were agreed. However, by the mid-1990s, the system had become very unpopular and there were calls for reform.

In the early 1990s, the Conservative Government had closed a loophole that allowed thousands of people opting to live in care homes to receive Income Support to offset the costs of their care. Under the NHS and Community Care Act 1990, access to public funding depended on an assessment made by local authorities, which

The system began to look dysfunctional, especially in winter periods, when hospital beds became 'blocked' by older people who no longer needed acute care but could not be discharged because of a shortage of intermediate, residential and home care.

The system began to look decidedly dysfunctional, especially during winter periods, when hospital beds became 'blocked' by older people who no longer needed acute care but could not be discharged because of a shortage of intermediate, residential and home care. Between 1992 and 2000, for example, Department of Health statistics show that the number of households receiving home care fell by 25 per cent, although the total number of contact hours increased as only people with the very greatest needs were offered help. In response to this problem, the Conservative Government began to provide special 'winter pressures' funding to help alleviate the blockages.[4]

An unsafe system

With regard to quality, there were no national standards of care. Regulation applied solely to residential and nursing home care, where standards focused largely on the physical fabric of the homes rather than the care provided. Inspections were carried out by both health and local authorities. There was much criticism of local authorities especially, who were not seen as independent and who were suspected of having double standards, requiring better quality care in independent care homes than that provided in their own care homes. Home care and other non-residential services were completely unregulated, even though home care providers themselves had been pushing for regulation in order to put a stop to 'cowboys' in the care business.[5]

Labour's predecessors declined to strengthen the regulatory framework. The Conservatives had placed great store on the merits of greater competition in the care sector, which would break the power of monopoly providers and lead to a more efficient and effective use of public money. The Government also tended to view regulation as bureaucratic red tape that would deter and hamper businesses operating within the mixed welfare economy.

The policy pledges

Setting up sustainable support

In its 1997 Manifesto, the Labour Party made several promises regarding long-term care. Its priority was to create 'real security for families through a modern system of community care'.[6] It pledged to set up a Royal Commission to work out a fair and sustainable system of funding long-term care. It also promised an independent inspection system and a long-term care charter to define the standards of services to which people could be entitled. Labour acknowledged that the system as a whole was not working well for people needing care and support, referring to community care as being 'in tatters'. However, no promises were made about creating a more integrated system of services.

Committing to health and social care partnerships

This position changed very quickly after Labour came into office. In the summer and autumn of 1997, the then Secretary of State, Frank Dobson, made a series of speeches outlining his determination to 'knock down the Berlin Wall that separates health and social services'. Time and again, he highlighted joint working as a priority for managing demand during the winter months.[7,8] A strategy quickly emerged, involving:

- directives instructing the regional offices of the NHS Executive and the Social Services Inspectorate to work together, spotting potential blockages in the system in advance and tackling them locally

The Commission's central recommendation about personal care was rejected, with a commitment made instead to invest more money in improving services for older people.

further consultations would be undertaken about the means test for residential care, the definition of nursing care, the development of long-term care insurance products and other issues relating to charges and benefits.[12]

The Government finally made its response to the Royal Commission in July 2000 (at same time as it published its *NHS Plan*).[13] This was more than a year after the Royal Commission had reported – a matter that caused some comment at the time by those who noted ruefully that it had taken the Government longer to decide what to do than it had for the Commission to carry out the investigation.

Many of the recommendations made by the Royal Commission were accepted by the Government, including making nursing care free in nursing homes, extending Direct Payments to older people, and changing some of the rules governing the means test. But the Commission's central recommendation about personal care was rejected, with a commitment made instead to invest more money in improving services for older people.

In November 2000, the Government went on to issue guidance on fair charges for home care.[14] Local authorities were directed to stop levying charges at a rate that reduced people's incomes below basic levels of Income Support. When assessing people's ability to pay, account should be taken of disability-related expenditure before assuming that disability benefits could be used to pay service charges.

Action was also taken on the vexed question of people having to sell their homes to fund residential or nursing home care. A system of deferred payments was introduced at the end of 2001, which enabled people to delay selling their homes.

Breaking down the 'Berlin Walls'

During its first five years in office, the Government introduced measures compelling authorities to work together, providing funds with attached conditions about joint work between health and social services, and building performance measures for both sectors into the Government's planning priorities and targets. The intention has been to move collaboration between the NHS and local authorities from the margins of statutory sector activity and into mainstream programmes and budgets.

The Government imposed a statutory duty of partnership between the NHS and local authorities as they fulfil their responsibilities for promoting the health and wellbeing of local communities. The Health Act 1999 also enabled authorities to pool budgets, to agree which of them should act as lead commissioners for particular services or care groups, and to establish joint teams under a single management. This removed the legal and financial barriers that many authorities claimed were inhibiting effective joint work.[15]

Disappointed that few authorities used the new powers, the Government decided on tougher measures, making the new 'flexibilities' mandatory in the Health and Social Care Act 2001.[16] The same legislation also allowed health and social services authorities to form new integrated organisations called Care Trusts. These could be formed voluntarily by authorities wishing to do so but the Government also had powers to impose Care Trusts on organisations seen to be failing to collaborate.

The Government also introduced joint planning priorities and targets during its early years in office, making it clear that it would judge the performance of both health

Early signs indicate that the number of nursing home residents who will benefit financially may be far lower than the Government anticipated.

The impact of policy

A fair funding system?

There was widespread disappointment at the Government's final response to the Royal Commission from lay and professional groups who had supported the Commission's recommendations.[21,22,23,24] Hopes that the Commission would propose a fair and affordable system founded on a consensus were dashed. There was no consensus. Nor was there any radical transformation of the funding system that had given rise to so much dissatisfaction before Labour took office in 1997.[25]

A start was made in implementing the new policy on free nursing care in nursing homes from October 2001. Self-funding nursing home residents were assessed for the amount of care provided by a registered nurse that they needed. Three bands of payment were established, indicating high (£110 per week), medium (£70 per week) and low (£35 per week) levels of need. Having assessed people's needs, health authorities were expected to pay the nursing homes accordingly, with the residents then paying less for their care. But already there are signs of implementation problems, with reports of older people gaining little as nursing homes hold onto the money and increase fees.

The Government has claimed that these measures add up to a fairer system of funding long-term care, and that a 'major injustice in the system' has been corrected.[26] It has also claimed that the measures would benefit thousands of people, including about 35,000 people who would save up to £5,000 per year on the costs of staying in a nursing home, and around 30,000 people who would no longer be forced to sell their houses prematurely. It is too early to tell whether these figures prove to be realistic. However, early signs indicate that the number of nursing home residents who will benefit financially may be far lower than the Government anticipated.

A better-integrated health and care system?

The short-term funding increases provided to tackle winter pressures enabled some re-shaping of the whole service system to take place. The money was used by both health and social services to begin building a new set of services offering recuperation and rehabilitation to older people who might otherwise have had no choice but to use hospitals or care homes. A start had been made in breaking the 'vicious circle' that the Audit Commission had expressed concern about early on in the Government's term of office.[27]

Hundreds of new intermediate care schemes emerged, including short stay units in care homes and community hospitals; rapid response teams caring for people in their homes who might otherwise have had to be admitted to hospital; and community rehabilitation or re-enablement teams. However, the future of these new services was somewhat precarious, depending, as they did, on short-term winter pressures funding. A more secure future was promised after the National Bed Inquiry recommended an expansion of what it called 'intermediate care'[28] and the Government decided in July 2000 to commit £900 million over four years for the development of intermediate care.[29]

Despite these measures, blockages in the system worsened during 2001. The numbers of delayed discharges from hospital began to rise again, and health and social services talked about 'winter pressures' being a year round problem. The 'bed blocking' problem was partly caused by a shortage of care home places in some parts of the

that success in long-term care was inextricably bound up with its plans for 'saving the NHS'. In many important respects, Labour has changed the face of long-term care, with new laws, rules and regulations, with new institutions and with commitments of new monies for service developments.

Many of the changes will not come into effect until this year and beyond, so they have hardly had time to make a difference on the ground. There are, nevertheless, signs of success and failure that suggest what the future might look like.

An unfair, unsustainable funding system

The funding of long-term care will continue to be a problem, unless there is a change in policy. Already, there are signs of trouble for free nursing care, with reports of older people gaining little as nursing homes hold on to the money paid by health authorities and merely increase their fees in order to comply with the new standards set by Government. There are worrying reports of the poorest left with a pittance as 'pocket money'. Scotland and Wales are adopting different policies that stand as a reminder to the English that their system is less generous than those over the borders. Pressure groups continue to lobby for change and think tanks re-visit the policy to find ways of linking pensions and long-term care.[35] This is clearly a problem that is not going to go away. On this issue, the Government failed to achieve a better system that was markedly fairer (and agreed to be so) than the one it inherited.

Partnership working between health and social care

The whole system of care services is better integrated than it was in 1997, with far fewer outbreaks of 'turf wars' and much more evidence of health and social care staff routinely working together to plan, develop and provide services. This reflects Labour's strategy, which has gone well beyond simply exhorting authorities to work together and relying on joint planning mechanisms to achieve a more coherent service system. However, serious problems remain as gaps and pressure points in the system result in users and carers not receiving timely and appropriate support.

The promise of more intermediate care has still to be realised, with committed funds still to be invested over the next three years. Furthermore, the pressures on health and social care partnerships are intense. They are grappling with continuing re-organisation (of primary care and health authorities) that undermines joint working; attempting to manage instabilities in the care market; and striving to deal with demands on the hospital sector that attract the attention of politicians and the mass media.[36]

The need for greater investment and regulation

Efforts to safeguard and improve the quality of care look much more promising, provided that steps are taken to create a more coherent regulatory system across health and social care. Even so, there is a great risk that the whole venture will be seriously undermined by a failure to invest more in social care, ensuring that care providers are paid the necessary price to recruit, retain and train staff, and to provide the quality of care demanded by the new standards.

10 Patient and public involvement

Key issues:

- Giving the public more information about health care
- Making services more responsive to patients
- Extending patients' choices about their own treatment
- Involving citizens more actively in NHS decision-making processes

The inheritance

The Patient's Charter – publicising health information

Under the Conservatives, the public was, for the first time, given information about how well local health services were doing. District level performance indicators that had been introduced in 1983 as a management tool[1] were taken a step further in 1991 with the introduction of the Patient's Charter. This was the first vehicle for making information about health services available to the public. It also gave patients rights: new service standards were set in key areas such as maximum waiting times for operations. Hospitals were expected to report their performance against these standards. The Charter aimed to make services more responsive to patients' needs through the oxygen of publicity, shaming trusts into improving services where they performed below standard. Although the Charter was an important initiative, turning performance information from a management tool into public information, it was criticised, especially by NHS staff, for emphasising the public's rights without also stressing their responsibilities.

The Charter also set out what patients could expect if they were not satisfied with the NHS. In response to the 1994 Wilson report[2] the Conservatives had implemented a uniform procedure for responding to complaints. This set down national criteria for tackling complaints and put in place a two-stage system: complaints would initially be dealt with locally and, where complainants were not satisfied with the response they received, they could ask their health authority to set up an independent review panel. By the time Labour came to power, cracks were beginning to appear in the system. Local systems were of variable quality and many health authority areas were failing to hit their targets for dealing with complaints.

Demonstrating the impact of local people's views

Under John Major, there was a recognition that devolution of resources away from Whitehall to local purchasers could make local health services less democratically accountable. *Local Voices*[3] required health authorities, the 'champions of the people', to demonstrate that local people's views had had a tangible impact on purchasing decisions. Although the initiative had patchy influence and did not always match the broad aspirations of *Local Voices*,[4] some health authorities began to experiment with ways to involve local people in decision-making and priority-setting, for example, Citizen's Juries, focus groups and local health panels.

The National Performance Assessment Framework (NPAF), announced in *The New NHS*, was introduced, giving clear national standards for key services at trust and health authority level. Standards have been revised so that they are more closely in line with patient preoccupations, including new standards on patient and carers' experiences. Three sets of NPAF indicators have been published nationally[10] receiving extensive media coverage. They have formed the largest part of the new 'star ratings' given to each hospital trust as an indicator of its overall performance. Finally, the independent inspectorate, the Commission for Health Improvement, was set up to assess the performance of individual trusts, and makes its findings available to the general public.

In addition to the standards in the NPAF, new systems have been set up to measure patients' experiences. The annual National Patients' Survey, announced in *The New NHS* has been in place since 1998 and has considered patients' views of general practice (1998) and coronary heart disease care (1999). Locally, biennial patients' surveys, announced in *The NHS Plan*, will be carried out in hospital trusts from 2002 before being applied to primary care trusts, enabling them to use patients' views to improve local services. From 2002, all trusts will have to publish patient prospectuses that will include data on trust services, performance against government targets and patient satisfaction. Trusts are also required to set out in their prospectuses what they have done to respond to issues raised by patients in local patients' surveys.

If the new performance assessment framework lays down what patients can expect from services, the revised Patient's Charter, issued in 2001, sets out patients' own responsibilities to the NHS. Following a review of the Patient's Charter, led by the then chairman and chief executive of Pearson Television, Greg Dyke, a new document, *Your Guide to the NHS,*[11] was published. In it, national performance targets for the NHS were, for the first time, set against the public's responsibility to protect their own health by eating well, not smoking and complying with any treatment they were given. Significantly, the document contained no reference to patients' rights.

Extending patient choice

A series of measures have been implemented to make the NHS more responsive to patients and to introduce greater choice. Although the abolition of fundholding limited the capacity of individual GP practices to expand the range of treatments they could offer, primary care groups and trusts began to widen access to treatment outside hospital, including diagnostic services and some minor surgery. Patients in these areas now have a choice over whether they are treated in primary care facilities or in a hospital for certain conditions.

The introduction of walk-in-centres and the NHS Direct health advice line announced in *The New NHS* as an alternative to traditional GP surgeries has also begun to increase choice for patients needing to use primary care services. Direct-booking schemes for hospital appointments, announced in *The NHS Plan*, are being extended across the country, although these will not be fully implemented until 2005.

More fundamentally, measures have been introduced to help meet national waiting time targets, including pilot schemes to use spare capacity in NHS, private and foreign hospitals to treat patients who have been waiting beyond national target times. Primary care groups on the south coast have already offered patients the choice of treatment in France, and a new fund is being made available from July 2002 to pay for patients who have waited for heart operations for more than six

communities on major service reconfigurations and hospital closures has not yet been forthcoming.

Equally, the Government has not yet put in place a new complaints system, as promised in *The New NHS*. Its 1999 review of the existing complaints procedure showed that the system was not working well: 50 per cent of people who had used the system thought their complaint was handled badly. On the basis on the review, the Government drew up a set of proposals, including uniform processes for independent review panels across the country, greater use of independent conciliation services and quarterly reporting of complaints to trust boards. Its listening exercise concluded in October 2001 and announced that the reformed complaints system would be implemented 'by 2002 at the very latest'.[13] Six months on, it is not yet clear how the new system will operate and how it will link into other measures, particularly the new Patient Advice and Liaison Services, which aim to resolve patients' problems before they reach formal complaints.

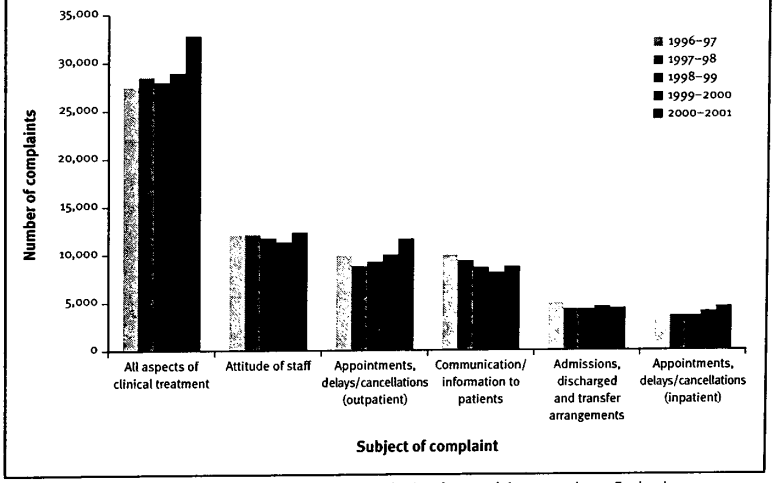
The impact of policy

Public information – reflecting the public's priorities?

Despite the range of initiatives that have been put in place to give the public more access to data about health services, little is known about the public's reaction to this information or whether patients are using information to help make decisions about local services.

More fundamentally, it is not clear whether the measures set out in the National Performance Assessment Framework reflect the public's main priorities. The NPAF was drawn up without input from either the wider public or organisations representing them. Complaints data suggest that the issues that the public is most likely to complain about are not always the areas monitored through the NPAF (*see* Figure 25). Specific complaints about staff attitudes and cancelled outpatients appointments are among the most common complaints against NHS organisations, yet neither are recorded in the NPAF.

25 TOP SIX AREAS OF COMPLAINTS 1996–2001



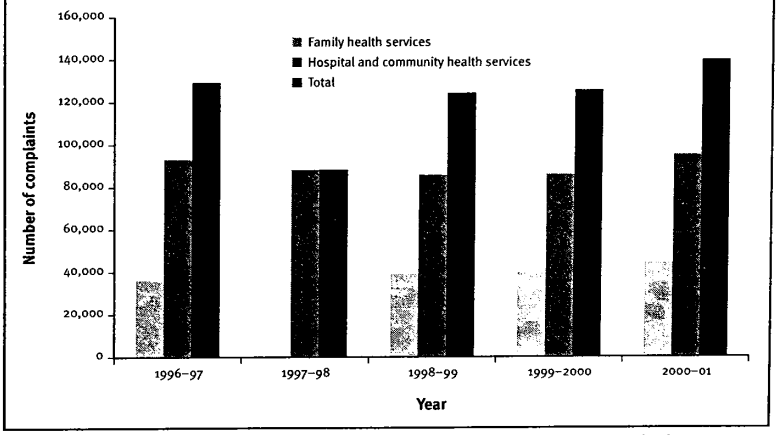
Source: Department of Health. *Handling Complaints: monitoring the complaints procedures. England 2000–2001* (www.doh.gov.uk/nhscomplaints/bground.html)

service systems and processes, and giving people more confidence in dealing with health professionals.[21]

It is still too early to assess the impact of some of the measures outlined in *The NHS Plan* to increase patient and public involvement. Many, such as Patients' Forums, the Commission for Patient and Public Involvement, and the new role for local authority overview and scrutiny committees, have not yet been put in place. Others, such as Patient Advice and Liaison Services (PALS) – set up to act as learning sites for the rest of the country – are just starting up. Anecdotal evidence from some of the early PALS suggests that the service is being well-used, although in some areas many of the queries are coming from NHS staff rather than patients.

Delays introducing the new complaints system have meant that performance against national targets has shown a decline under Labour. The number of complaints has risen significantly (*see* Figure 26) and the number resolved within the target time has fallen from 66.7 per cent in 1996–97 to 55.6 per cent in 2000–01.[22] The Government's principal aim has been to set up the new PALS to deal with difficulties before they reach formal complaints but the links between this service and the complaints system have not been clearly articulated.

26 WRITTEN COMPLAINTS LEVELS 1996–2001



Source: Department of Health. *Handling Complaints: monitoring the complaints procedures. England 2000–2001* (www.doh.gov.uk/nhscomplaints/bground.html)

Conclusions

Public information and patient choice – an ideological or pragmatic choice?

Although the Government's attempts to make more information about NHS performance available to the public are important steps forward, it is unclear whether ministers have a clear view about how and why the public should use this information. Whether this information is simply to inform the public, or to be used by the Department of Health to put pressure on the NHS to improve its performance, is unclear, though much of the rhetoric has focused on the latter objective.

There are signs that the Government would like patients to take an active approach to their health care, using performance data to influence choices about where they

access to senior decision-makers in trusts. Used constructively, the new scrutiny function could be a powerful tool for engaging communities in a face-to-face discussion with local health services about local priorities and the effectiveness of services. Requirements on primary care trusts to consult with local people have begun to increase the NHS's capacity to engage with the communities they serve.

But the Government made a series of blunders that called into question whether their commitment to greater public involvement at all levels was genuine. First, public involvement in setting *NHS Plan* priorities was weak. Patients and the wider public were included in discussions about their priorities for the health service through a hastily compiled leaflet, only available in English, which asked the public for their top three priorities for the NHS. Just 151,999 responses were received to the 12 million produced, with the majority coming from people aged between 45 and 64.[25] With two weeks for the public to send in their views and 10 days for these to be worked into the Plan, the exercise did not inspire confidence that the Government was committed to making the NHS more transparent and responsive to the public.[26]

Second, the Government's treatment of community health councils (CHCs) was crude. Without prior warning or consultation, *The NHS Plan* announced the abolition of CHCs. This became an unexpected battleground in the Commons. Many of the proposals designed to increase patient and public involvement in the NHS became hostages to Parliamentary time and were dropped from the Health and Social Care Act after wrangling in both Houses and demonstrations outside the Palace of Westminster. Critics argued that this was another sign of a Government that found dealing with criticism tough, by trying to replace outspoken CHCs with more pliable NHS-based structures. They pointed to work such as Casualty Watch, the pan-London monthly survey of A&E waiting times carried out by a consortium of CHCs which often made uncomfortable reading for ministers and NHS managers – a clear challenge to New Labour's assertions that it was bringing the NHS out of the doldrums.

Although the new Junior Health Minister, Hazel Blears (herself a former CHC chair) embarked upon a nationwide 'listening exercise' to consult on the new patient involvement proposals – and modified the new structures to reflect concerns about their feasibility – the Government has refused to back down on the abolition of CHCs and has rejected calls to transform them into new Patients' Councils. This has alienated many of Labour's natural allies in its drive to increase patient and public involvement, including national and local patients' organisations whose support will be crucial to the success of the new patient and public involvement structures.

More fundamentally, the public's capacity to influence service planning and prioritisation at a more strategic level – for example, by expressing their view on local HIMPs – is constrained by national performance management systems. The Government has made it very clear that trusts must deliver against key national targets or ultimately face sanctions such as the imposition of franchised management teams. If the Government is serious about genuine public involvement, trusts should be allowed to choose their own priorities where there is a clear rationale and strong community support. The problem facing Labour is how to reconcile greater local choice with national equity. Although the devolution of funding to PCTs has signaled a clear desire to devolve responsibility to local levels, unless performance management systems are made more accommodating of local need, the public's capacity to influence local services will be limited to endorsing nationally-set priorities.

11 Health inequalities

Key issues:

- Putting inequalities on the policy map
- New Deals and other Treasury-led initiatives
- Health Action Zones and other area-based programmes
- 'Saving Lives' and health inequalities targets
- Health-related changes since 1997

The inheritance

A widening health gap

In 1997, the 'health gap' between rich and poor was equivalent to nine years of life. A boy born into the poorest social group (class V) was likely to live for 68.2 years, compared with 77.7 years for a boy in the richest social group (class I). For women, the gap was 6.4 years. This gap had widened over the previous 20 years, by four years for men and 1.1 years for women.[1]

Inequalities in Health,[2] commissioned by the Callaghan Government in 1977, was published after Margaret Thatcher became Prime Minister in 1980. *The Black Report*, as it became known, clearly identified health inequalities and the links with factors such as income, education and employment. However, its recommendations were considered too costly and out of step with the political ideology of the four Conservative administrations between 1979 and 1997. They were never implemented.

According to the neo-liberal ideology that shaped policy for much of that period, the priority for the Government was to roll back the state and free the market. This would lead to more enterprise and wealth creation. Wealth would 'trickle down' to the poor and socially disadvantaged. Aside from that, the route to good health was primarily a matter of personal responsibility and lifestyle choices – not a matter for government intervention.

Positive steps

Two positive steps were taken during the Conservative years. *The Health of the Nation*, published in 1992,[3] was the first major public health policy document to be published by a UK Government. It made several references to health variations between occupational and ethnic groups, as well as between the north and south of the country. However, these were attributed to lifestyle and (unexplained) inequalities in access to service, rather than to socio-economic factors. The second step was to make an unprecedented investment in research that would deepen and refine understanding of the extent and causes of health inequalities. Consequently, a great deal more was known about health inequalities by 1997 than under previous administrations.

comprehensive programme of work to tackle health inequalities ever undertaken in this country'. In effect, this was a summary of most aspects of the social and economic policies being pursued across Government.

A year later, Labour's interim report[8] outlining progress during its first three years in office renewed the promise 'to close the gap between the worst off and the better off' promising to intervene 'sooner rather than later' in 'transforming the NHS from a service that does not just fix and mend the ill, but which prevents and protects against illness'.

The Government's actions

There has been no shortage of measures to address health inequalities since 1997. Here we focus on four categories of initiative: those led by the Treasury, area-based programmes, target-driven initiatives and measures focused on the NHS.

Treasury-led initiatives

From 1997 onwards, there has been a steady flow of measures intended to reduce dependency on welfare benefits and increase the numbers in paid work. The main focus has been on making families with young children more self-sufficient and better off, and on helping to pursue the ambitious goal of eliminating child poverty by 2020. The 'new deals' for lone parents, for young unemployed people and for those out of work for two years or more, were later extended to all unemployed people, including disabled people. The minimum wage (£3.60 in 1999, going up to £4.20 in 2002 for those 22 years old or over) helped to make work more attractive in financial terms, as did the working families tax credit, introduced in October 1999 to top up low wages for those with families to support. There were also significant increases in income support for non-working families and in child benefit (from £14.40 to £15.50 per week for the eldest child), as well as a substantial investment (£66 million for 2000/01) in a new national childcare strategy, to remove the most significant barrier to parents entering paid work. As these measures came on stream, they coincided with a four-year economic boom between 1997 and 2001, during which time the unemployment rate fell from 7.1 to 4.8 per cent.

In 2001, the Treasury instigated a cross-cutting review of spending on health inequalities. This is claimed as a unique opportunity to examine the impact on health inequalities of spending across Government departments and is expected to recommend ways of improving the use of existing resources, and encouraging an integrated approach to health inequalities and more effective cross-Government working. A key sector, for example, is education, where spending on efforts to raise standards of education and improve schools in disadvantaged areas has doubled since 1997.

Area-based initiatives

Since 1998/9, every health authority has been obliged to produce a Health Improvement Plan (later to become a Health Improvement and Modernisation Plan, or HIMP), in partnership with local authorities and other local private, voluntary and statutory organisations, which will 'modernise services to tackle ill health, as well as the root causes of ill health',[9] and reduce variations in service provision. Local authorities, for their part, are expected to develop their own Community Plans, also in partnership with other local bodies, for improving services and promoting well-being and a better quality of life.

In *The NHS Plan*, published in 2000, the Government announced that new national targets would be introduced to reduce health inequalities – these key targets addressed infant mortality and adult life expectancy.

New Deal for Communities

The New Deal for Communities, launched in 1998, is intended to tackle multiple deprivation in the poorest neighbourhoods in the country, giving them resources to tackle their problems in an intensive and co-ordinated way. In each case, a community-based partnership must tackle poor health as well as poor job prospects, high levels of crime, educational under-achievement, and problems with housing and the physical environment. Over £1.9 billion has been committed to 39 NDC partnerships.

Many of these area-based initiatives and structures overlap, creating some confusion at local level. In 2000 the Treasury carried out a review of Government Interventions in Deprived Areas (GIDA),[12] which marked an important shift away from ad-hoc spending on additional programmes, towards an overhaul of mainstream government activity. In future, the review said, 'core public services like schools and the police should be equipped to become the main weapons against deprivation'. Public Service Agreements – a central mechanism for monitoring the performance of Government departments – were to include targets for reducing inequalities in education, employment, crime levels and social housing for the first time.

Local Strategic Partnerships

In 2001 a new model – Local Strategic Partnerships (LSPs) – was introduced, initially for 88 local authority areas receiving Neighbourhood Renewal Funds. LSPs are expected to co-ordinate local initiatives and funding, bringing together a wide range of people to work together on inter-linked issues such as health, housing and the environment. They aim to promote joint working in order to 'improve all public services; renew deprived areas; develop strong, sustainable economies and healthy, safe communities'.[13]

Target-driven initiatives

The 1999 public health White Paper, *Saving Lives: Our healthier nation,* set out specific targets: by 2010 to reduce the number of premature deaths per year from cancer by 100,000, from coronary heart disease and stroke by 200,000, from accidents by 12,000 and from suicide by 4,000. According to the Government's response to the Acheson Report,[14] these were 'to be matched by tough local inequalities targets, reflecting the different aspects and varied extent of inequality across the country.' The mechanism for achieving this was to be health improvement programmes (*see* above).

In 2001, the Health Development Agency produced guidance[15] on developing local targets for tackling health inequalities. It cited a wide variety of practical examples drawn from health improvement programmes and Health Action Zones. These range from 'creating 10 community champions and declaring one healthy neighbourhood in 2000/2001' (Wigan) and 'ensuring over a 10-year period that all residents have access to affordable, good quality food' (Stockport) to 'improving access by siting a mobile mammography unit in areas of low uptake' (Lambeth, Southwark and Lewisham).

In *The NHS Plan,* published in 2000, the Government announced[16] that new national targets would be introduced to reduce health inequalities. These key targets addressed infant mortality and adult life expectancy, and were set out in a consultation document:[17]

The most striking increase in income between 1997 and 2000 has been among low-earning women and can be attributed largely to the minimum wage.

further £60 million went to Health Action Zones. This small addition to the £37 billion distributed to health authorities on the traditional 'equity of access' criterion might be expected to fund such NHS interventions as: increased levels of treatment for targeted populations; different and earlier treatment; greater efforts to secure patient compliance; targeted health promotion measures; improved co-ordination of other relevant agencies; and more effective collection and analysis of health data.[21]

At a local level, primary care trusts have a key role to play in reducing health inequalities through improved access to higher quality and more appropriate health services, as well as by participating in local strategic partnerships and regeneration schemes. Measures introduced since 1997 that might improve their capacity to reduce inequalities include:

- devolution of power to primary care trusts to enable them to tailor services to local needs
- New Personal Medical Services (PMS) contracts to employ salaried clinical staff in areas where it has been hard to recruit and retain GPs, especially deprived inner cities
- a new public health role for PCTs, giving them responsibility for population health
- involvement in drawing up and implementing Health Improvement and Modernisation Plans, local strategic partnerships and other area-based initiatives.

The impact of policy

One major change since 1997 is that health inequalities are now clearly on the policy map. The nature and extent of health inequalities, and their underlying social and economic causes, are widely acknowledged among policy-makers and practitioners in the field. It is broadly accepted that the problem requires urgent attention and that action must be taken across sectors and departments, not just by the NHS.

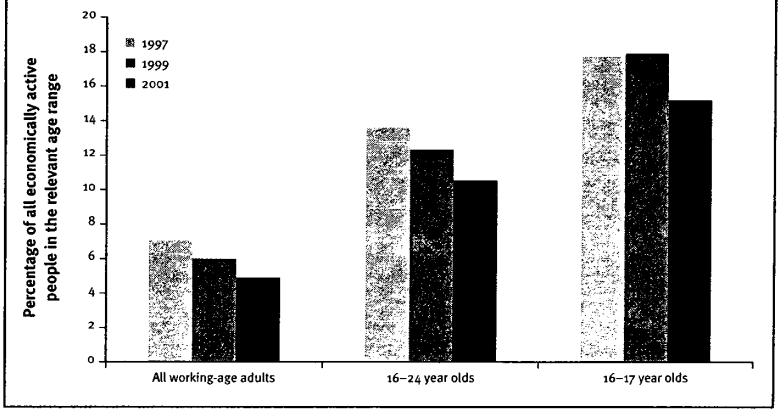
It is also widely understood that health inequalities are deeply entrenched and that progress towards reducing them is likely to be slow. It is necessary to monitor trends in underlying causes of health, such as income, employment and education, as well as behavioural factors such as smoking, and illness and death rates. What changes, if any, can be detected since 1997? Below we consider indications in population data.

Income and poverty

Unemployment, financial insecurity and poverty are all significant determinants of health. Thus measures to reduce welfare dependency and increase paid employment – if successfully implemented – can be expected to have a positive impact on health. The most striking increase in income between 1997 and 2000 has been among low-earning women and can be attributed largely to the minimum wage. Earnings of the lowest-paid women workers rose by 18.5 per cent, compared with a 12.7 per cent median increase. But the gap between male and female earnings remains wide: the median gross weekly earnings for women in 2000 were £93 less than men's.[22]

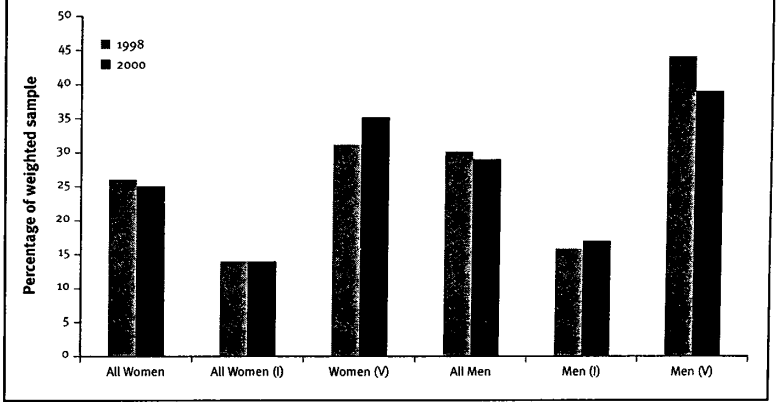
Between 1997 and 2000, the number of households below the 'poverty line' (measured as 60 per cent of median income) fell by 600,000 and the numbers of children in such households fell by 300,000, from 4.4 to 4.1 million.[23] Such figures are open to interpretation. The Government claimed to have lifted 1.2 million

28 UNEMPLOYMENT RATES BY AGE GROUP 1997–2001



Source: Labour Force Survey, ONS, 2001

29 PREVALENCE OF CIGARETTE SMOKING BY SEX AND SOCIAL CLASS 1998–2000



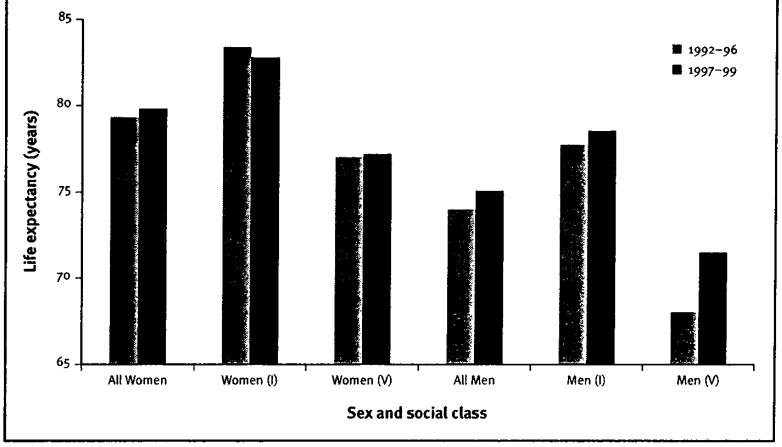
Source: Living in Britain, ONS, 2000

However, smoking among *unskilled* manual women increased by four per cent over that period. In 2000, 4 per cent of women in social class I reported smoking while pregnant, compared with 26 per cent in social class V.[29]

The numbers of births to girls conceiving before the age of 16 has fallen by 20 per cent since 1996, but the vast majority of these births are concentrated in the manual social classes and the rate of teenage conception in the UK remains higher than elsewhere in Western Europe. Rates in Scotland are higher than in the rest of the UK.[30]

Obesity levels have risen between 1997 and 2000, by 4 per cent for men and 1.7 per cent for women. There has been no change in numbers of men and women who are considered overweight, remaining at 44.5 per cent of men and 33.8 per cent of women in 2000.[31]

31 LIFE EXPECTANCY AT BIRTH BY SEX AND SOCIAL CLASS FOR ENGLAND AND WALES



Source: ONS, 2002

equal opportunity – both to distinguish itself from its predecessor and to protect its left flank. As it repositioned itself in the centre of the political spectrum, New Labour would be more comfortable taking a stand against health inequalities than owning up to income redistribution. Many of the same measures were needed to address both – so the idea of equal health chances could operate as a proxy for social and economic equality without raising the ghosts of 'old Labour'.

Changing the climate of opinion

A major achievement of the new Government was to change the climate of opinion. It put health inequalities firmly on the policy agenda, changed the language and helped to build a new consensus acknowledging the nature and urgency of the problem, its causes and ways that it could be addressed. Labour also rehabilitated two concepts that are now widely recognised as essential to tackling health inequalities: locally-based partnerships that cross old boundaries, and community development. It is impossible to measure the impact of these shifts in 'received wisdom', but they were real and significant – creating a sound basis for action. The Government has not yet delivered on its promise of a total ban on tobacco advertising, but it has fulfilled its manifesto pledge to establish a Food Standards Agency.

Investing in anti-poverty measures

Labour's high-profile efforts to combat social exclusion, to move more people off benefits and into paid work, and to end child poverty, appear to have yielded some tangible results. Unemployment and child poverty are down; low earners have increased their earnings disproportionately; and GCSE results are improving, especially among lower-income groups. Cynics may attribute these developments to a sustained global economic boom, to creative statistical analysis, or to a dilution of educational standards. However, the fact remains that the Government has made a heavy investment – in terms of resources and political capital – and has applied itself energetically to a range of tasks that are intended to pursue these objectives. Most measures introduced since 1997 cannot realistically be expected to yield verifiable results for at least another five years.

Power follows money, and money follows the NHS.

inequalities targets, feeling like an afterthought, with some serious consideration and commitment behind them, but not much money, or much clout (yet). The Treasury's cross-cutting review on health inequalities and the Department of Health's forthcoming delivery plan are promising moves. Whether they are sufficient remains to be seen. A massive and sustained input of resources and political initiative is required to reverse trends in life expectancy and infant mortality, where the gap between richer and poorer social groups continues to widen.

Health inequalities are intrinsically hard to handle because they arise from complex and inter-related problems that cannot be solved solely by the NHS, or the Department of Health. They cry out for 'joined-up' Government, but this has been slow to develop and remains fraught with difficulties. The Government chose not to replicate its model for tackling social exclusion, which involved setting up a designated unit in the Cabinet Office reporting directly to the Prime Minister. It was hardly irrational to locate responsibility for health inequalities within the Department of Health and, by and large, the two Ministers for Public Health (Tessa Jowell and Yvette Cooper) have demonstrated strong commitment to the issue. But power follows money, and money follows the NHS. This influences explicit and implicit priority-setting throughout the organisation.

Health inequalities and the wider public health agenda are not as high as they might be on the Department's must-do list, for several reasons:

- They are wicked issues for the NHS – they don't lend themselves to clinical solutions. They are 'upstream' issues that can only be addressed by long-term policies: they seldom provide the 'quick wins' that governments find so alluring.
- The NHS, like many other public sector organisations, has an inward-looking, risk-averse culture that mitigates against productive partnership working and innovation.
- The NHS is under huge pressure to deliver on a host of other objectives, such as reducing waiting times.
- The Secretary of State for Health and the Prime Minister consistently signal to the public that the *big* health problem they are determined to solve is the 'crisis' in the NHS. This ratchets up media scrutiny and public anxiety, ensuring that the NHS remains a political A&E case, forever in need of intensive care. The fact that disadvantaged groups and communities get ill more often and make more demands on the NHS, thereby contributing to its tribulations, is seldom taken into account and exerts little influence over the balance of priorities in Government policy.

In summary, Labour has stimulated a substantial volume of local and neighbourhood-based activities aimed at strengthening communities, improving public services and enhancing the quality of life – all of which may help to narrow the 'health gap'. Much of the time, however, its efforts have suffered from a lack of definition and top-level leadership. It has allowed the media to set the health policy agenda and has become trapped by its own rhetoric. The more the Government promises to 'save' the NHS and signals that this is what it *really* cares about, the harder it becomes for it to capture the public imagination for a different agenda aimed at reducing inequalities, improving health and, ultimately, checking demands on the NHS that are triggered or exacerbated by social and economic factors. In spite of unprecedented levels of activity around the new targets, health inequalities still appear to be a second-order issue, liable to be elbowed out by the more pressing problems presented by a massive provider of treatment and care. That is potentially bad news for health, especially for those most likely to get ill and die young. It is

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When the Labour Government came to power in May 1997, it promised to 'save the NHS' and reduce health inequalities. It pledged to cut waiting lists, improve service quality, raise NHS spending in real terms, and abolish the internal market.

Five-Year Health Check reviews Labour's inheritance and early promises, and assesses the impacts of its actions to date. It analyses performance against pledges in several key areas:

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- primary care
- workforce
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The effects of many of the measures introduced are not yet detectable. But the findings suggest that the Government is moving in the right direction – towards a more robustly funded NHS, improved standards of health and social care, more patient-centred services and a system that is trying to reduce health inequalities.

Some key messages for the future emerge. The review suggests that the Government needs to sustain levels of investment, but dispel any illusions that money alone will save the NHS. It should also curb the incessant flow of orders from the centre; seek to build the morale and the confidence of NHS staff; and address the wider determinants of people's health.

Five-Year Health Check is a valuable contribution to the debate on health policy issues, and will be useful reading for those interested in health and health care policy, or UK politics.

ISBN 1-85717-463-1
9 781857 174632