Did New Labour ‘save’ the English NHS?
A ten-year retrospective, 1997-2007

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Outline

- The NHS in 1997
- Impact of two main phases of reform
- Characterising (English) NHS policy, 1997-2007
- Verdicts on the period and a balance sheet
- Some implications for New Zealand

State and perceptions of the NHS in 1997

- Recent high profile failures of clinical quality & oversight
- Long waits
- Shabby infrastructure
- Low spending by EU/international standards
- Perception of lack of investment, under-capacity
- Poor outcomes comparatively
- NHS in jeopardy, limited time to ‘save’ the Service

The four NHSs of the UK

The Guardian | Thursday January 3 2008 , p29

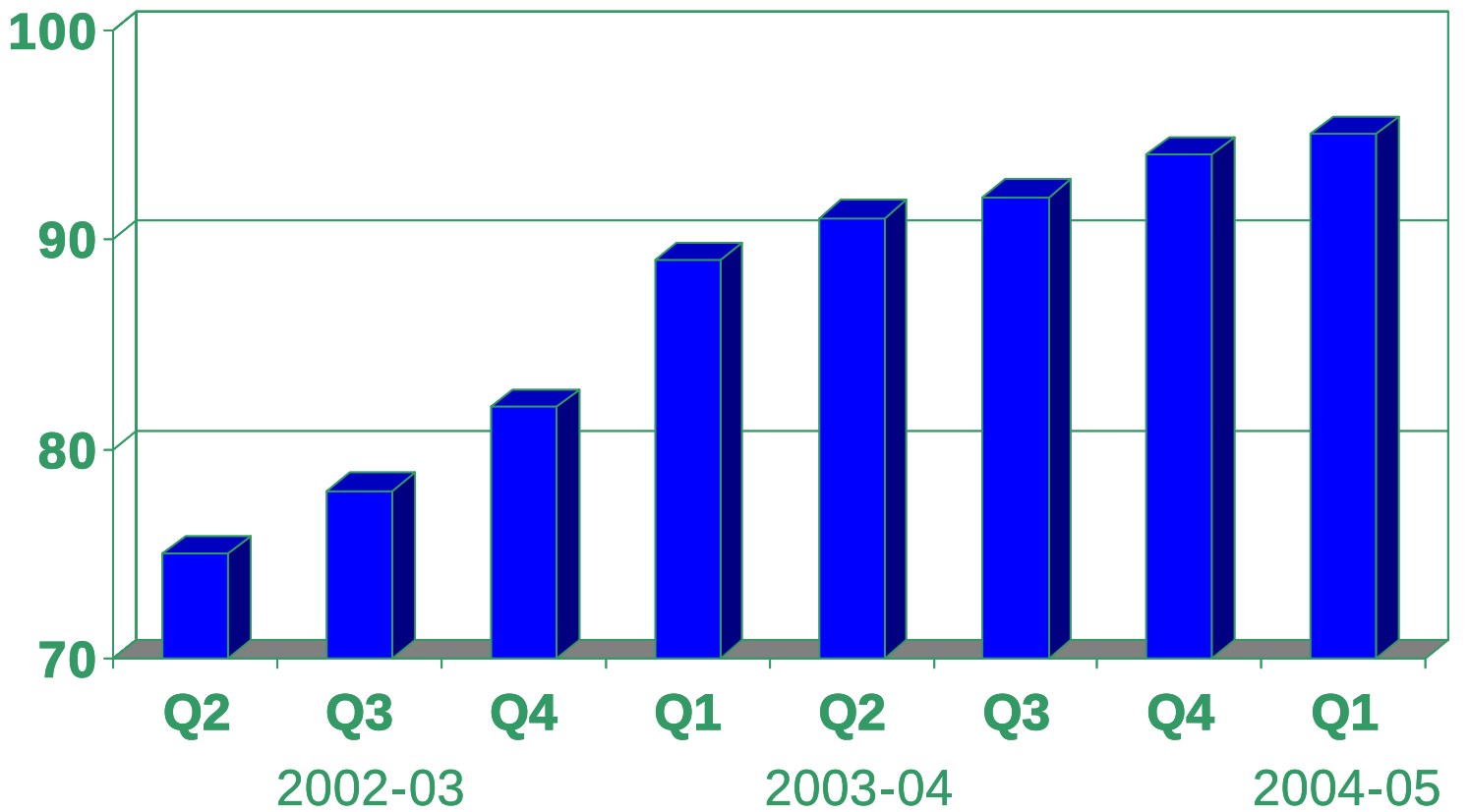
Characterising 1997-2007 in England

Two main phases:

- 1997-2002
  - Command and control, targets, performance management (‘targets and terror’)
  - NHS Plan 2000
- 2002-2007
  - Large increase in spending gradually leading to capacity increases
  - Gradual shift towards Blair’s ‘self-improving’ NHS to ensure continuing good use of resources

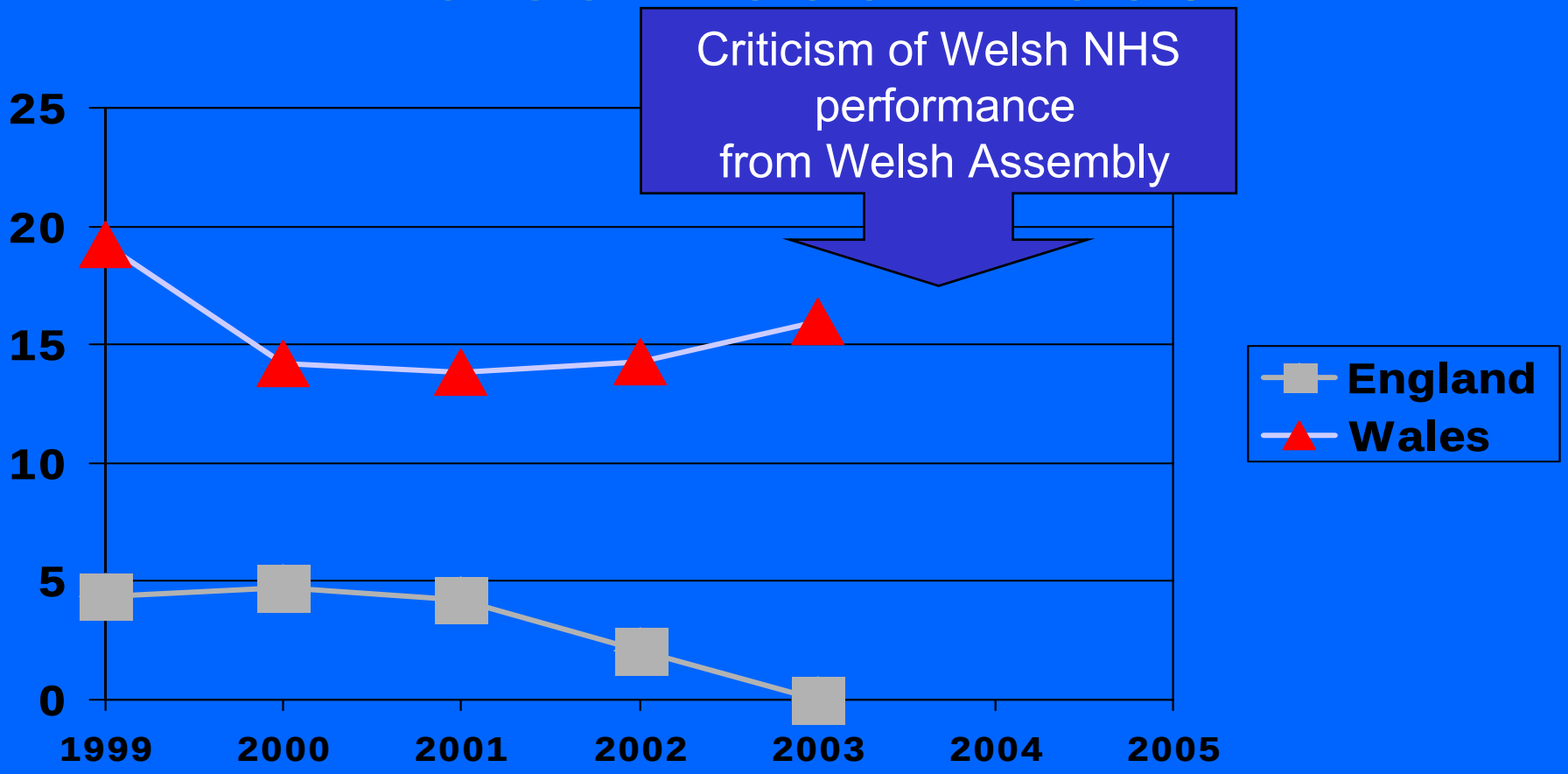
The impact of ‘command and control’ and targets

A&E access

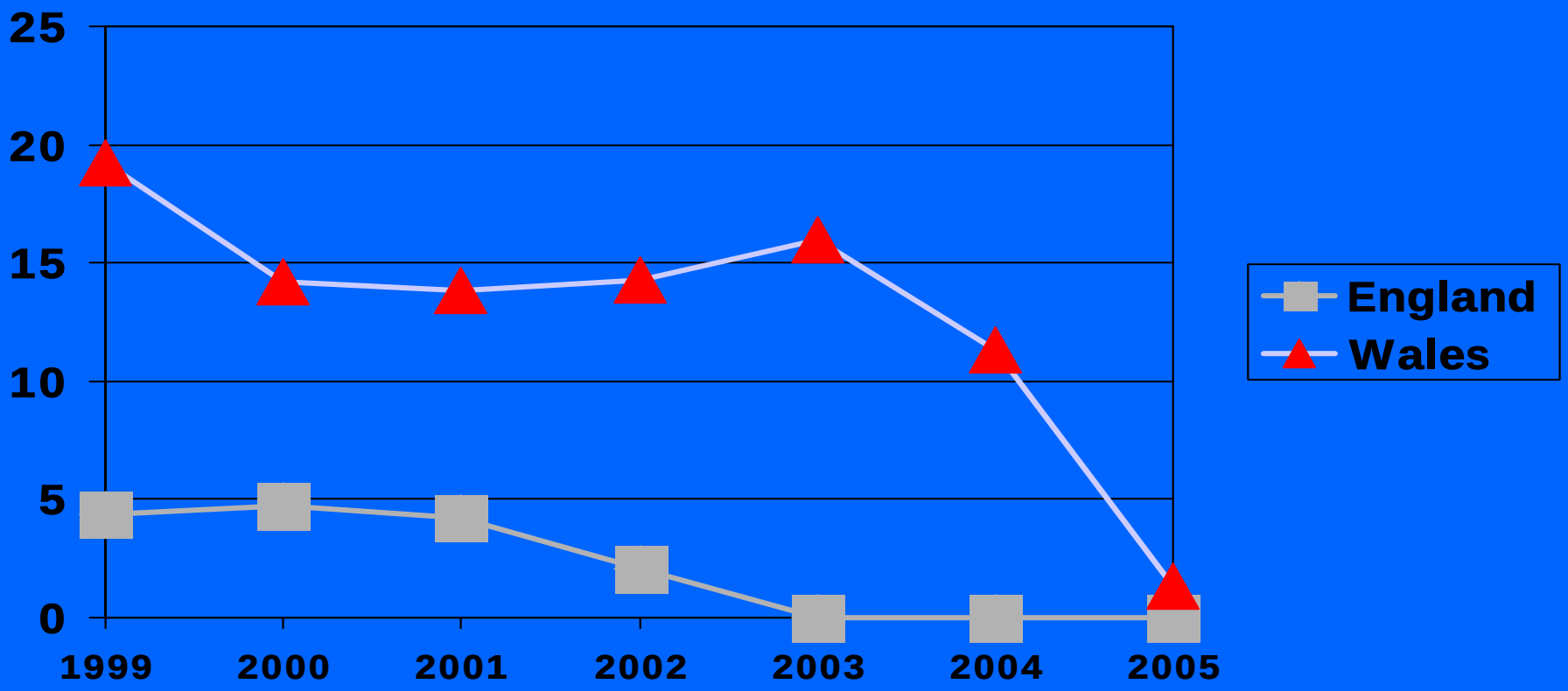


% of people seen with 4 hours in A&E
(despite 20% increase in attendances)

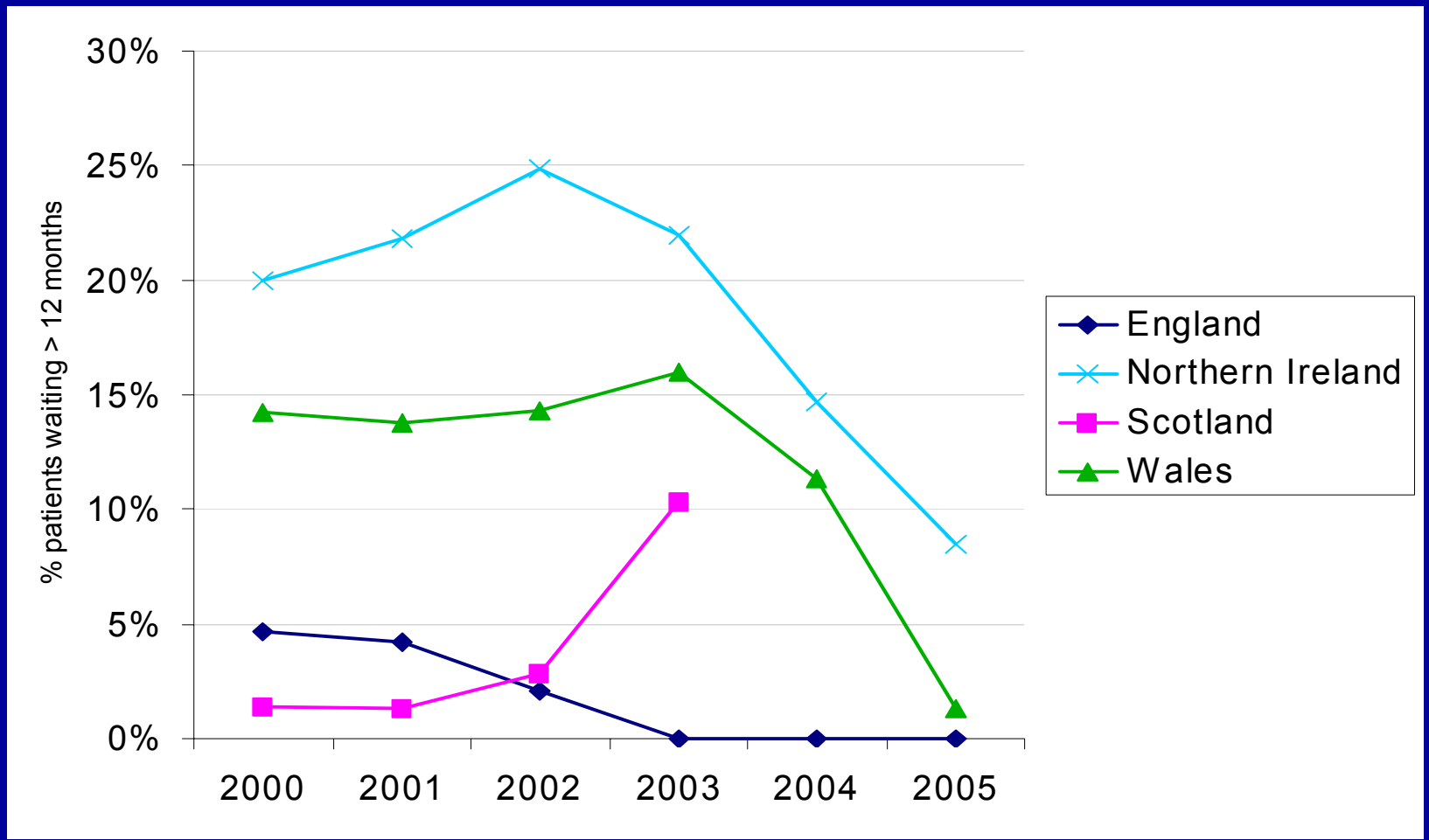
% waiting > 12 months England & Wales: 1999 - 2003



% waiting > 12 months England & Wales: 1999 - 2005



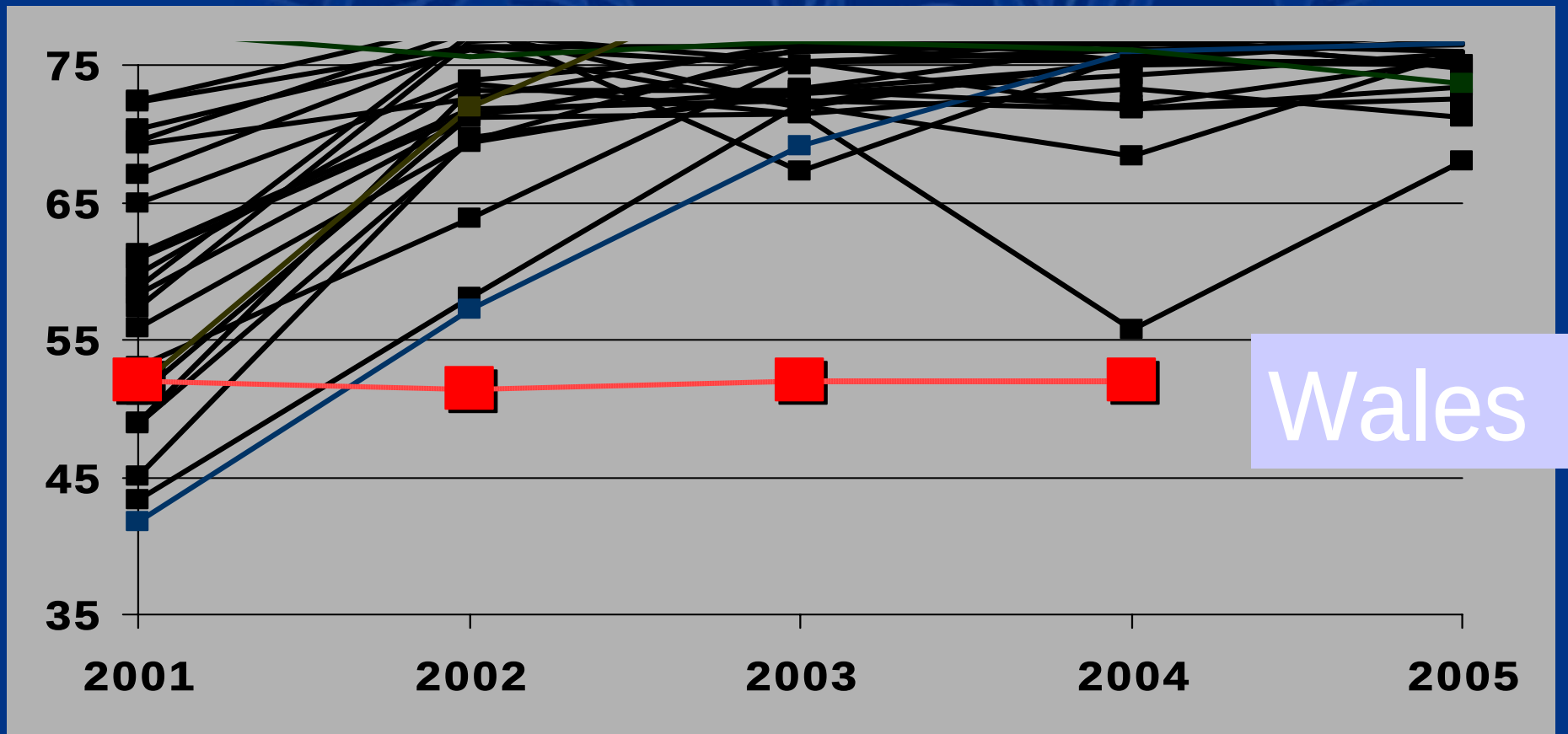
% patients waiting for hospital admission > 12 months



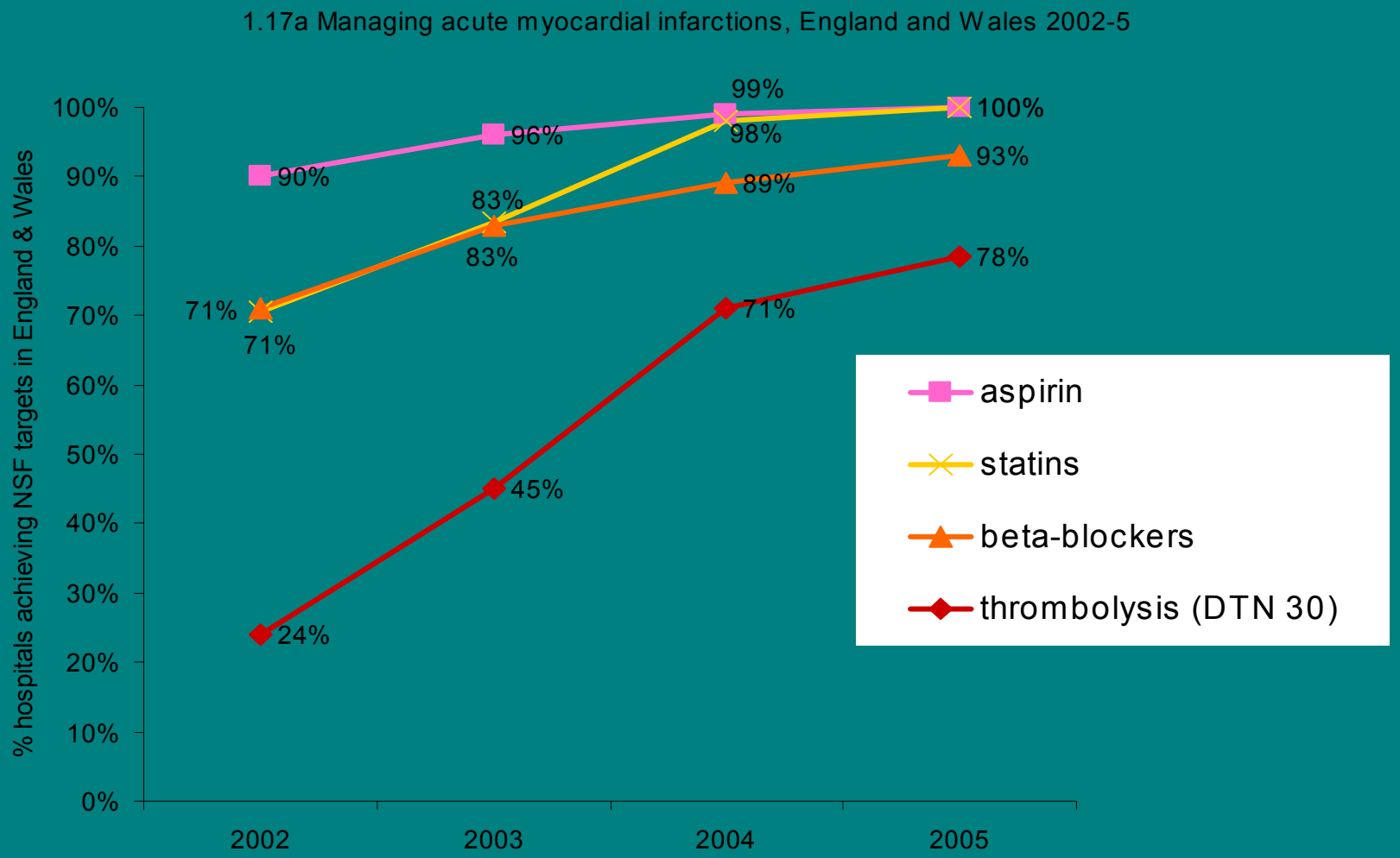
Source: Are improvements in targeted performance in the English NHS undermined by gaming: A case for new kinds of audit of performance data? Gwyn Bevan and Christopher Hood, British Medical Journal (forthcoming)

Category A calls < 8 minutes (England)

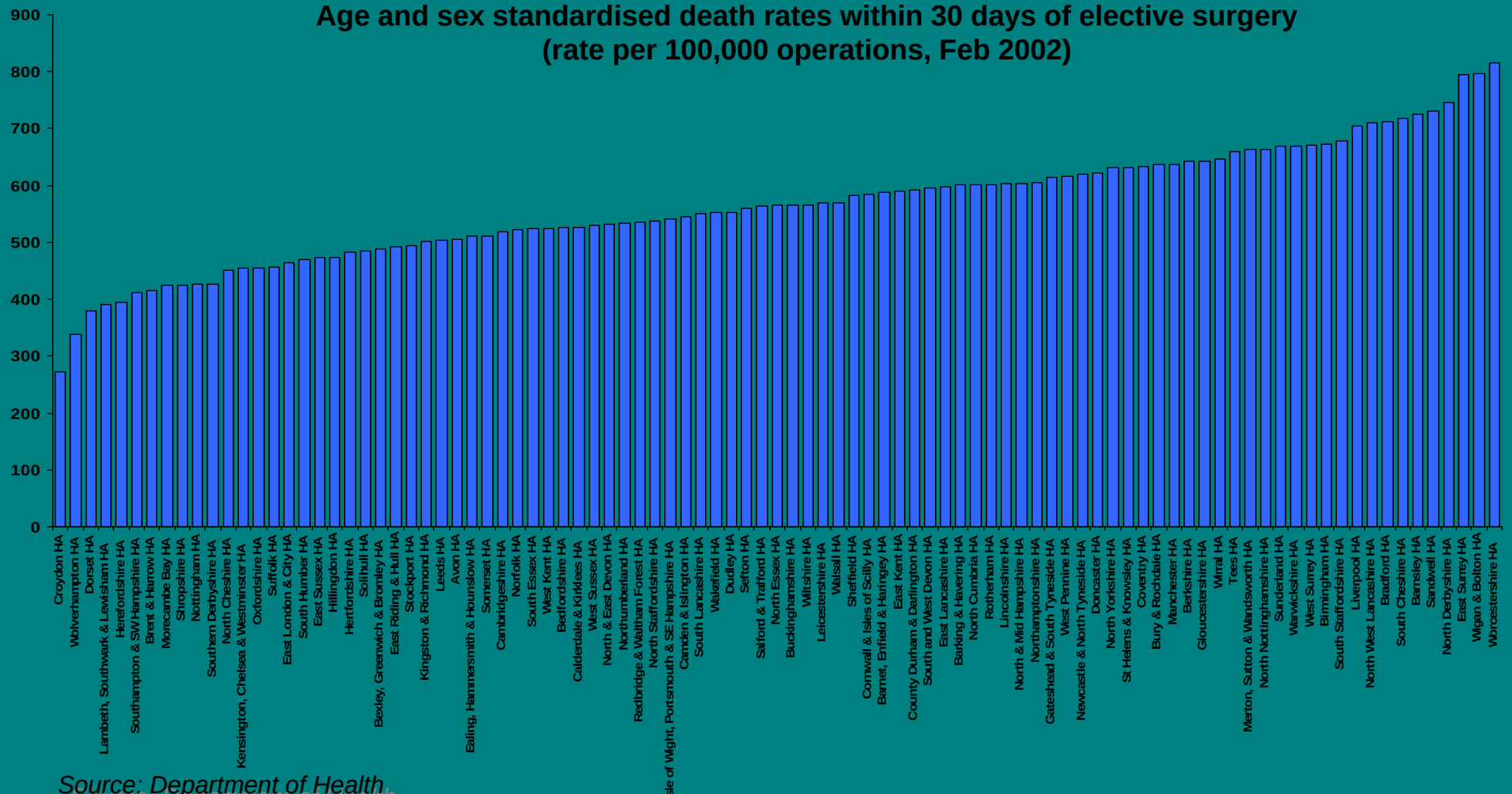
% within 8 minutes



Trends in NSF clinical targets for myocardial infarction



Variation in clinical outcomes



Source: Department of Health

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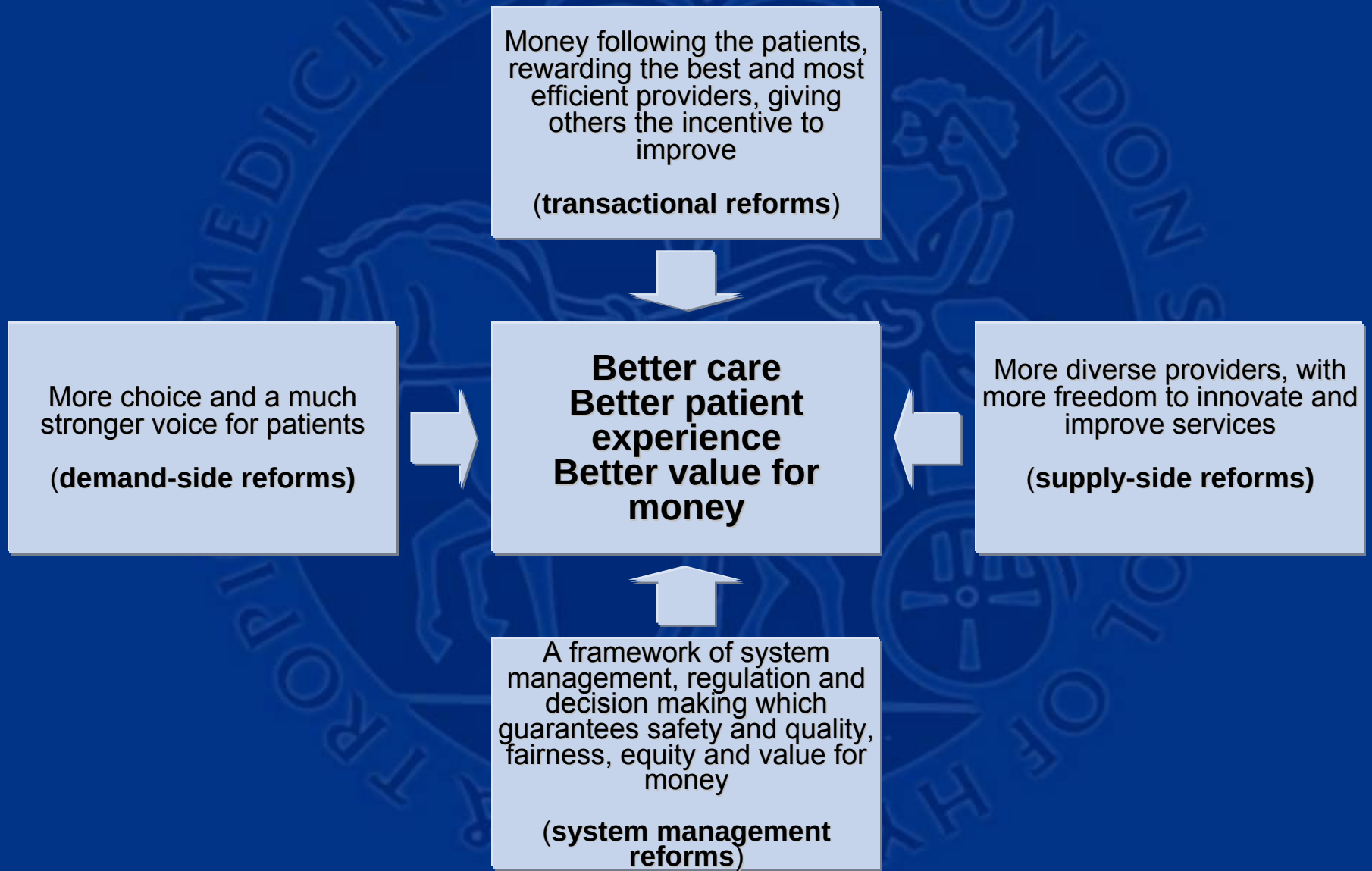
The return of the market: towards a ‘self-improving’ NHS

The re-invented NHS market in England, 2002-



Current structure of NHS in England

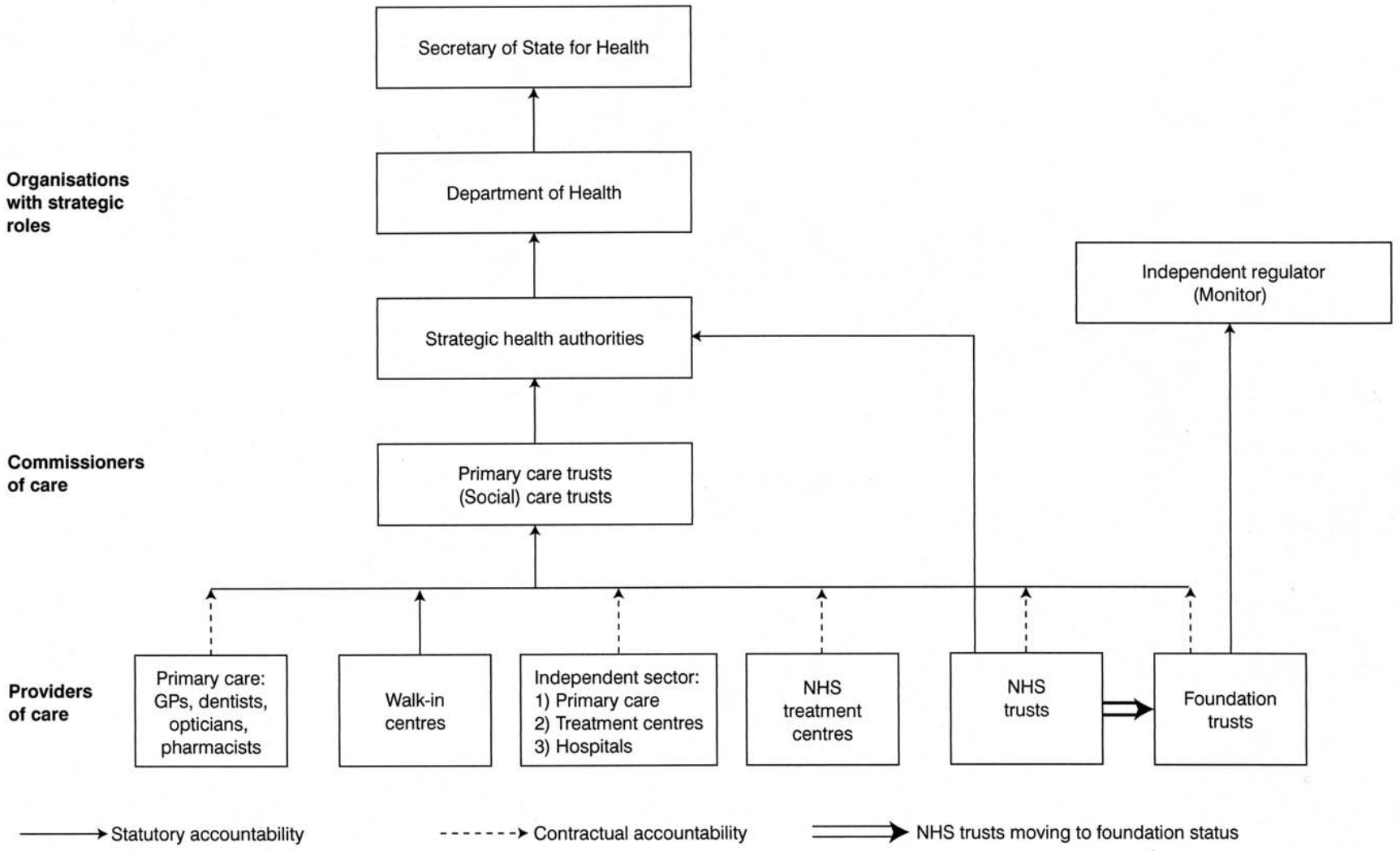


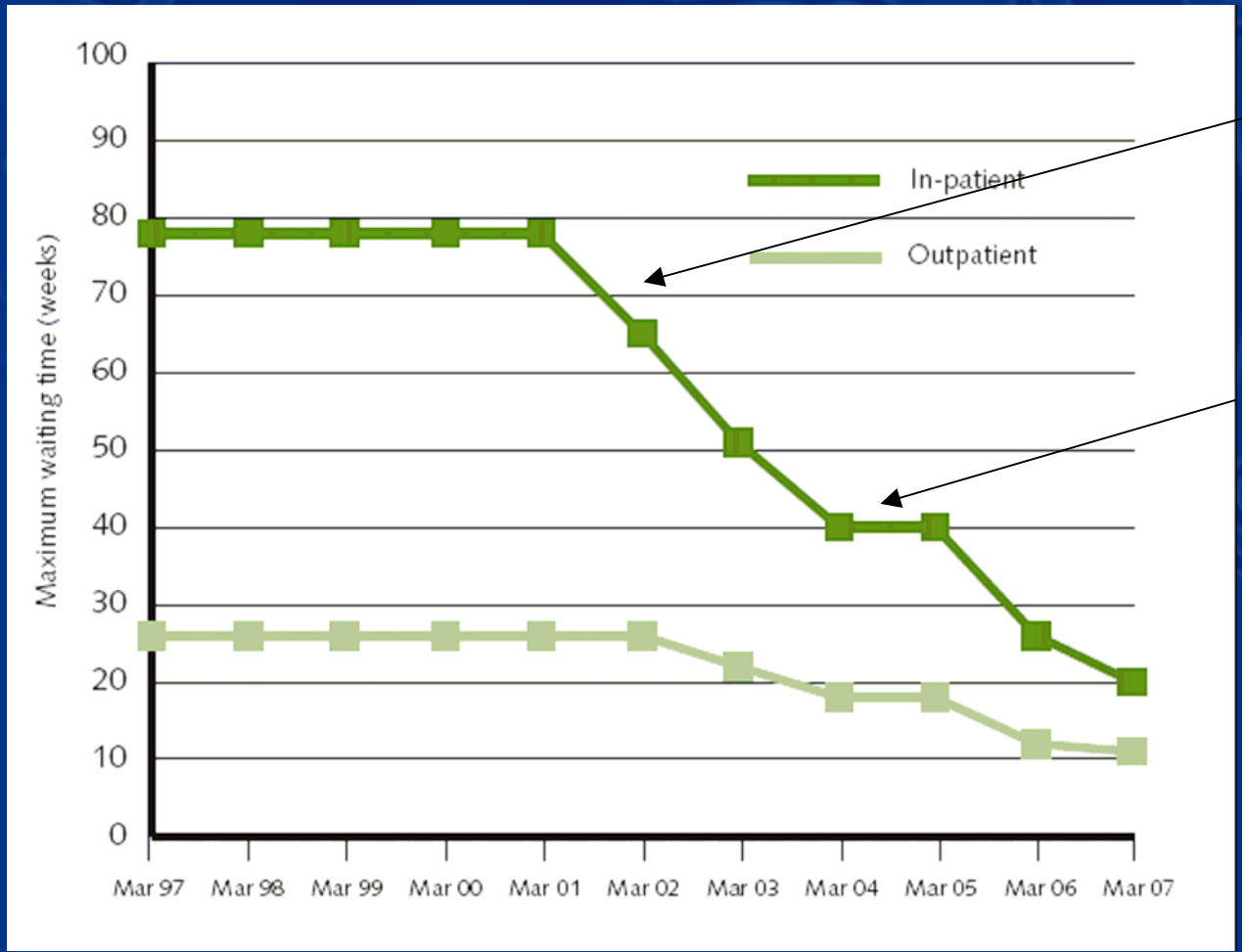
Figure 1.1 The structure of the new NHS in England

Progress in implementing market reforms after 2002

- Slow implementation, some incoherence
  - clinical engagement problematic
- *Choice*
  - 44% patients offered choice of hospital for first O/P appt., Nov 2007
- *'Payment by results' (national output-based pricing)*
  - transparent, some efficiency incentives, incentives to 'cherry pick' & for low cost providers to increase output, no link to quality
- *Commissioning*
  - weakest link, efforts to strengthen
- *Provider plurality*
  - small increase in private involvement (electives, GPs) as effective signal to NHS incumbents

But continued focus on targeted areas

Inpatient and outpatient maximum waiting times



Targets & terror

Real resources arrive

Latest waiting time information

- Current standards (since Dec 2005)
  - Maximum 26 weeks for inpatient admission
  - Maximum 13 weeks for 1st outpatient appt
- Latest data (29 Feb 2008)
  - 74 patients waiting >26 weeks for inpatient admission
  - 45,900 waiting >13 weeks for inpatient admission
    - Fallen 72.4% since Feb 2007
  - 91.6% of inpatients waiting <13 weeks
  - Median inpatient waiting time 4.2 weeks
  - 113 patients waiting >13 weeks for first outpatient appointment
  - Median outpatient waiting time 2.2 weeks
  - 98.0% of outpatients waiting <8 weeks

Progress against 18 week target

- Current waiting target (since July 2004)
  - No one to wait >18 weeks from GP referral to hospital treatment
- 82% not requiring admission treated in <18 weeks (January 2008)
- 69% of those admitted for treatment waiting <18 weeks

Progress against target for CVD as a whole

- Target to reduce mortality <75 yrs by 40% (March 2000) met five years early (Feb 08)
- Due to improvements in thrombolysis, use of statins, more cardiologists & cardiac surgeons, more facilities
- Also shorter waits
  - No one waiting >3 months (>5,500 in 2000)
- Accelerated the underlying downward trend

Characterising the period, 1997-2007

- *Hyper-activity and impatience*
  - ‘saving and modernising the NHS’ (Klein, 2006; 187)
  - ‘the most ambitious and comprehensive effort to improve quality in any country’ (Leatherman and Sutherland, 2003) with positive but uneven results
  - state of permanent revolution, occasional incoherence (e.g. GP out-of-hours)

Characterising the period II

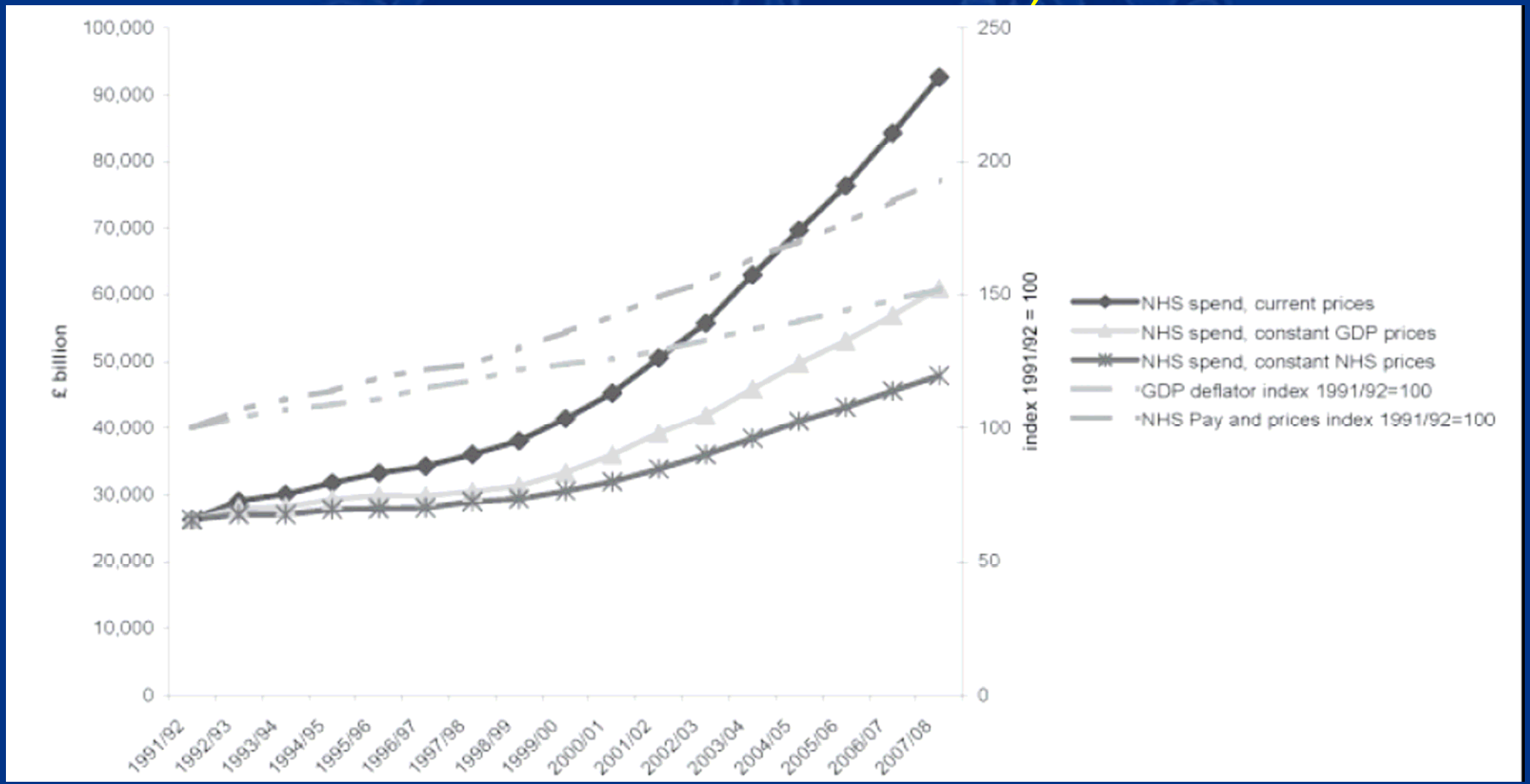
- *Innovation*
  - in wider government processes (e.g. PSAs, Social Exclusion Unit, PMDU, consultations, political devolution)
  - in DH (e.g. managerial influx, clinical ‘tsars’, less ministerial direction)
  - in health agencies (e.g. Modernisation Agency, NICE, Healthcare Commission, NPSA, etc)
  - in types of provision (e.g. walk-in centres, ISTCs, Sure Start)
  - in contracts (QoF P4P)
  - in information - routine, accessible comparative performance data against standards & targets, patient surveys

Characterising the period III

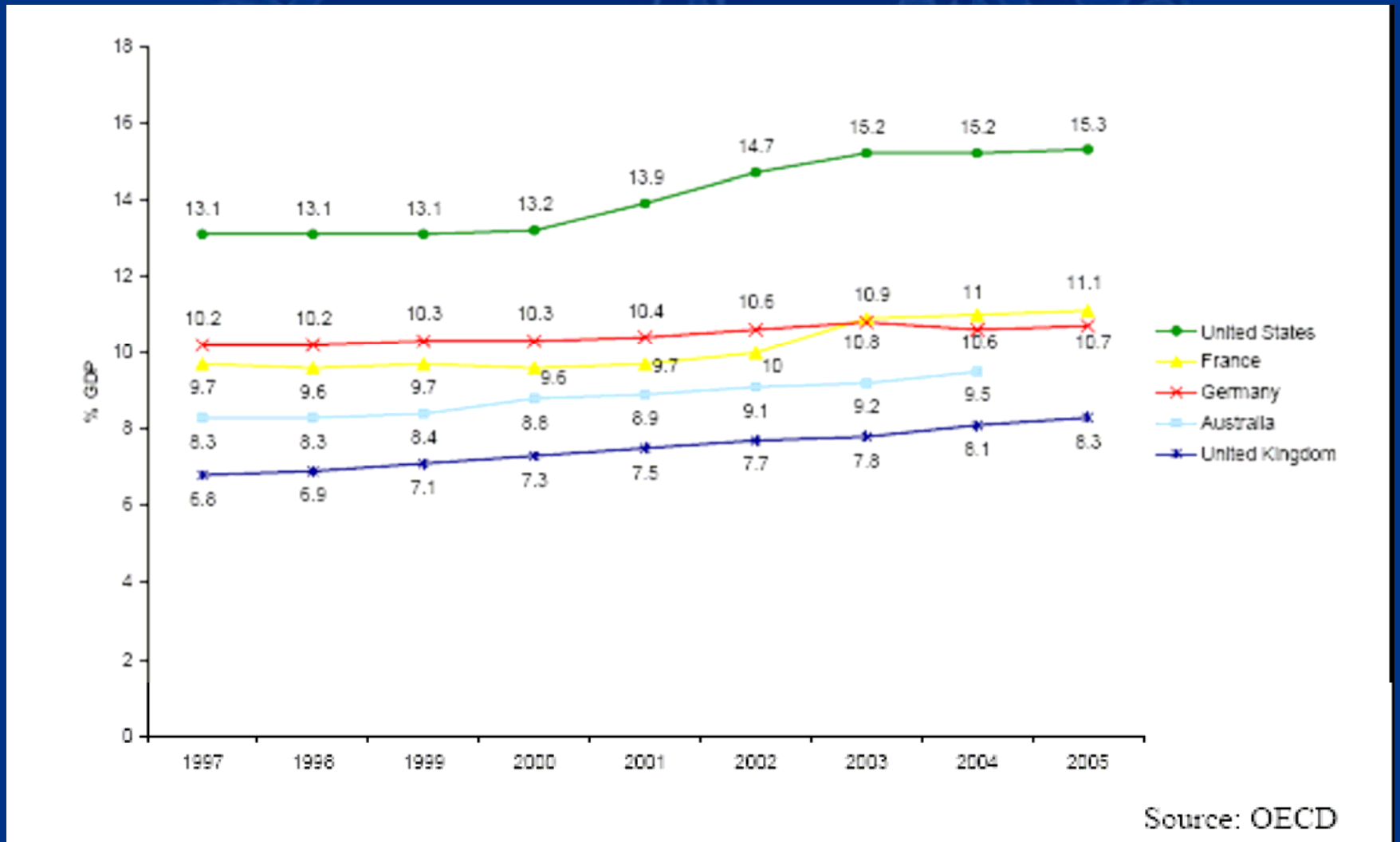
- *Pragmatism*
  - willingness to use a range of tools and levers ('what works is what counts', including market forces)
  - 'learning by doing' rather than implementing a blueprint
- *Unprecedented generosity in funding*
  - in return for 'modernisation'
  - increased funding drove greater radicalism for fear that resources would not achieve government goals

NHS expenditure in current and constant prices, 1991/92-2007/08

(Martin, Smith & Leatherman, 2006)



Total expenditure on health per capita in US$ PPPs in selected OECD countries, 1997-2005



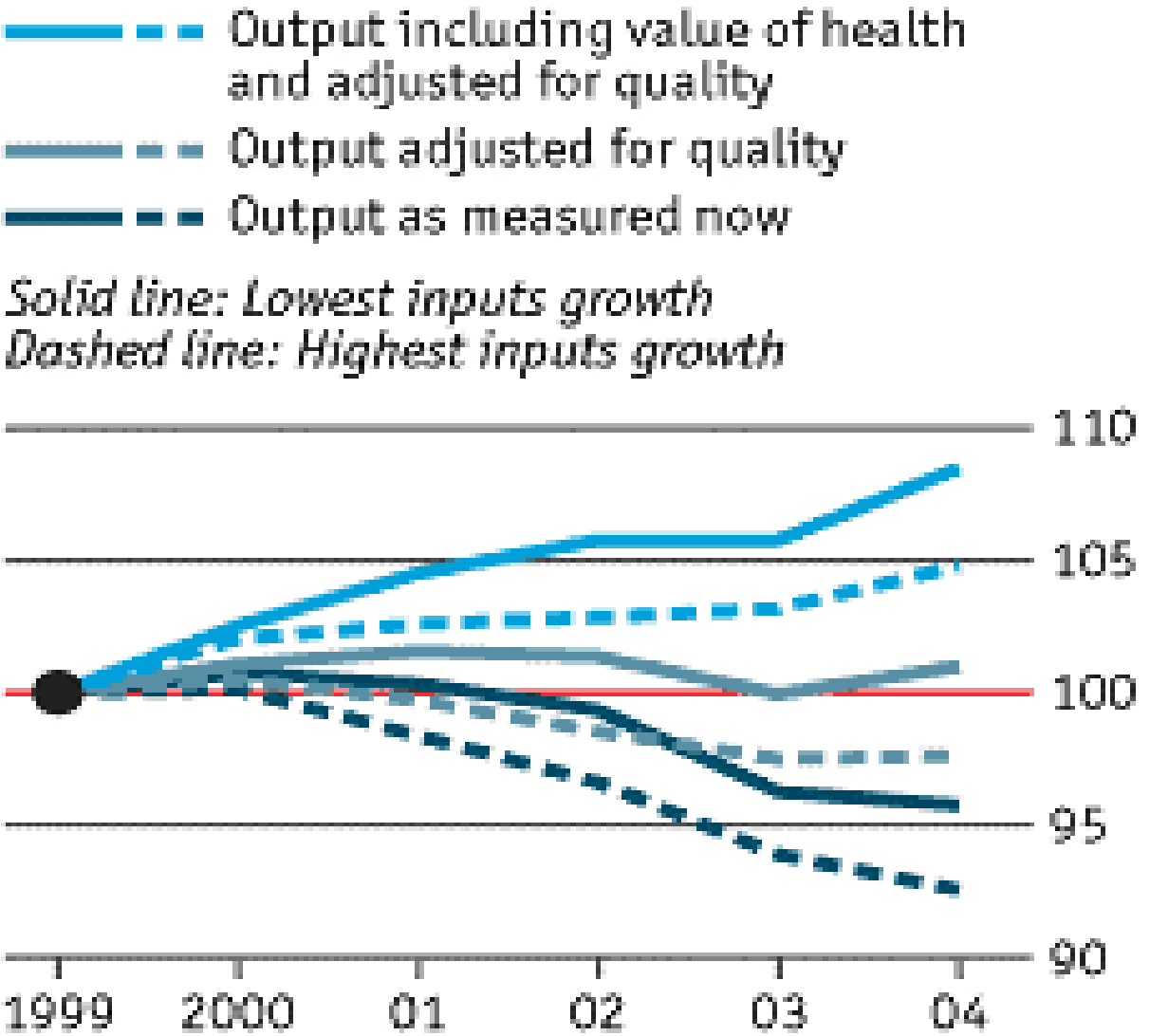
Concerns about productivity: GPs

- 56% pay rise for many GPs 2002/03-2005/06
- QOF (P4P) scheme too easy
- Fall in crudely measured productivity of 2.5% per year, 2004 & 2005
- But does not take into account quality improvements and fundamental change in GP remuneration

Plans announced to measure patient-reported outcomes (PORTs) routinely to help with productivity analysis

Spoilt for choice

NHS productivity, 1999=100

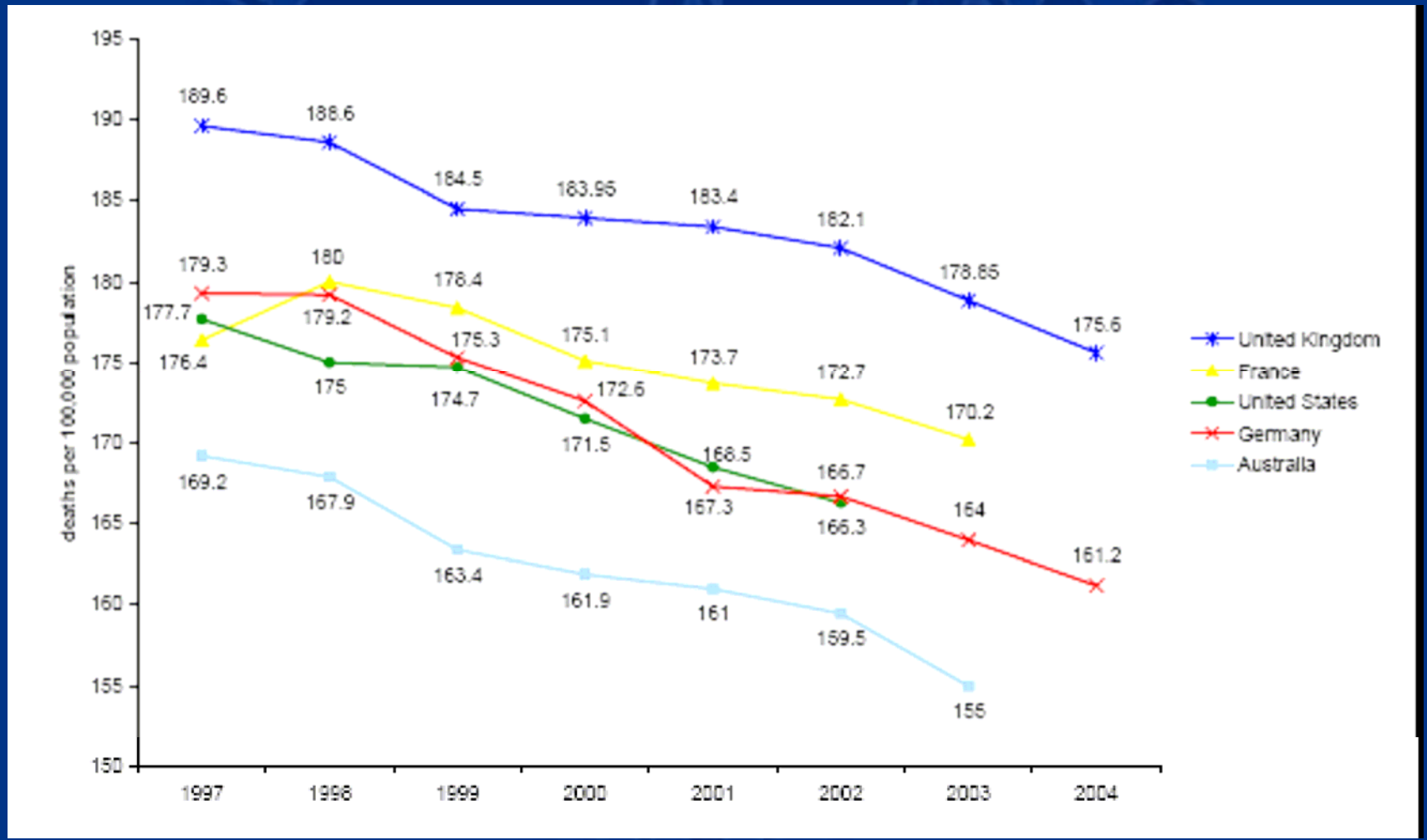


Source: ONS

Characterising the period IV

- *Greater interest in other countries*
  - Especially comparisons with continental Europe to make the case for action (e.g. cancer survival)
  - less confidence in NHS ‘exceptionalism’, hence interest in non-government providers
  - growing scope for intra-UK policy learning

UK cancer mortality rates in international comparison, 1997-2004



Source: OECD

Diverse verdicts on the period

- *Civitas (2006)* – significant improvements in targeted areas but serious weaknesses elsewhere & internationally still relatively weak
- *Paton (2006; 2007)* – fundamental incompatibilities between main policy streams & intellectually superficial
- *King's Fund (Thorlby & Maybin, 2007)* – NHS has been 'saved', with many achievements, but far from 'transformed' in eyes of a sceptical public
- *Oliver (2005)* – closer to a free, universal, comprehensive service than ever

Towards a balance sheet, 1997-2007

Resources (£s, staff, infrastructure)	+++ (50% real since 2002, ≈9% GDP)
Output	+ (+11%, +20% day, +7% elective)
Unit costs	++ (wages)
Measured productivity	-?/+? (-7.5% to +8.5%)
Responsiveness (waiting, access, user views)	+++
Quality (e.g. mortality, outcomes)	+ (++ in some areas, esp. ca, stroke, MH)
Health (inequalities)	+ (-)
Relative performance vs. other European systems (public's view)	+ (-?)

Implications for New Zealand

- Much more limited range of policy tools used in NZ
  - & arguably fewer likely to work?
- More money is scarcely ever a ‘solution’ (e.g. big variations in performance remain, productivity issues, rest of UK NHS)
- Public views unrelated to performance
  - little political dividend over period required to make gains
- Difficulty of ‘steering’ in the public interest and encouraging ‘self-improvement’ (e.g. via markets, professional good will)
- Much less focus on waiting in NZ
  - 3,894 patients waiting >6m for 1st specialist assessment, Dec 07 (Eng 74 patients)
  - Average wait for electives 67.9 days, 2007/08 to date (Eng ≈30 days)