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WHAT MONEY CAN'T BUY: HEALTH CARE REFORM IN THE UK SINCE 2000

By Kayo Tomono

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My very special thanks to Elizabeth,

Introduction

'At the end of five years we will be in a position where our health service spending comes up to the average of the European Union. It is too low at the moment'[1].

On Sunday morning the 16th January 2000, Tony Blair, the Prime Minister at that time, declared an unprecedented increase on health spending in the BBC program 'Breakfast with Frost'.

This was the real beginning of the Blair's NHS story. He admitted the NHS was under-funded and promised to put more cash to rebuild it. At the same time, he stressed the necessity of reform in NHS.

In this paper, I would like to look at, first of all, the background which pushed him to make the announcement. Secondly, I will study the attitude of the government and the means they took in order to achieve outcomes for the investment they were focusing on, namely target-setting and a strong command–control system. Targets for waiting times, which were the major public concern, will be taken as examples. The effect and side-effect of targets are discussed there. Targets have clearly contributed to the improvements in certain areas, but, at the same time, some other areas which had not been targeted were neglected. In addition, putting targets as the first priority constrained the autonomy of medical professionals. Then, I move to an area of public perception of the NHS which has not shown so much improvement. As a conclusion, I try to draw lessons from these experiences of the UK, particularly of England.

UK and Japan, my home country, shared the position of 'low spending countries on health' until 2000. Since then, the two countries have proceeded in the different ways— the UK increased spending and Japan has stayed at a low level. In Japan, finally, a serious discussion whether health spending should be increased or not is now under way. The experience of the UK will surely provide thought-provoking lessons to Japanese policy making in the very near future.

In the year of 60th anniversary of NHS

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[1] *Financial Times* on 17th January 2000

I) How much change?--- Comparison of 1997, 2000 and 2005

Before the reason Blair made the announcement is explored, it is useful to have an idea of major changes which have taken place since 2000. Clear changes can be found both in money and in the quantity of service provision.

With regard to money, Blair's pledge on 16th January 2000 to bring health spending up to the European average was based on the latest published figures from OECD[2].These were 1997 figures, from the same year as Labour took power. The total health expenditure, which includes both public and private spending, was 6.8% of GDP. It was below an average across EU15 countries (7.9%), far below Germany (10.2%), Austria (10.0%), and France (9.2%)[3].

In 2005, UK expenditure increased to 8.3%. Although it was still low compared with the EU15 average of 9.2% or France (11.1%), Germany (10.7%), Belgium (10.3%), Portugal and Austria (10.2%)[4], the gap became narrower and, at least, UK achieved the level of EU15 average as it had been at the point of Blair's promise[5]. The public sector continues to be the main source of health funding of all EU15 countries except Greece, and the UK finances 87.1% of health spending publicly. This ratio is the second highest to Luxembourg (90.7%) and increased from 80.4% in 1997, reflecting the UK government commitment to increase public spending on health. An estimate showed that the UK health spending would reach 9.4% of GDP in 2007/08.[6]

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[2] *Financial Times* on 17th January 2000

[3] *OECD Health Data*-*Version:October 2007* from 'Source OECD' web site. 'EU15' as constituted before 1st May 2004; Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, UK. UK spending refers to the aggregation of England, Scotland Wales, and Northern Ireland. EU15 average is a simple average of countries' spending.

[4] *OECD Health Data*-*Version:October 2007* from 'Source OECD' web site

[5] There was some debate about what the EU average was depending on whether it is an arithmetic average weighting all countries equally or weighted average allowing for the different sizes of EU countries, and on whether the average includes UK or not. The debate was caused by the reason that the precise aim of Blair was not clearly spelled out. See Baldock(2007) pp669-670

[6] OHE(2008) p77

Total expenditure on health, % gross domestic product									
	yr1997	yr1998	yr1999	yr2000	yr2001	Yr2002	yr2003	yr2004	yr2005
United Kingdom	6.8	6.9	7.1	7.3	7.5	7.7	7.8	8.1	8.3
(EU15 average)	7.9	7.9	8.0	8.2	8.4	8.6	9.0	9.1	9.2
Japan	7.0	7.3	7.5	7.7	7.9	8.0	8.1	8.0	

(Source: *OECD Health Data 2007*)

Let's look at the amount the UK government spent on health. The expenditure was 44.5 billion pounds in 1997/98, 54.2 billion pounds in 2000/01 and increased to 88.8 billion pounds in 2005/06[7]. Even in real terms, the amount increased almost 1.5 times from 2000/01 (68.5 billion pounds) to 2005/6 (91.4 billion pounds)[8]. In 2007/08, it is estimated to be 104.8 billion pounds[9]

Total Expenditure on Health in real terms

											£billion
	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07
Health	54.8	55.4	57.0	58.8	63.6	68.5	73.5	80.9	86.9	91.4	94.5

(Source: HM Treasury)

Many aspects of service provision increased during this period, reflecting the extra funding. The number of doctors in the UK, for example, increased from 108,030 in 1997 and 115,158 in 2000 to 144,640 in 2005, the number of nurses from 445,000, 505,000 and 546,717 respectively[10].

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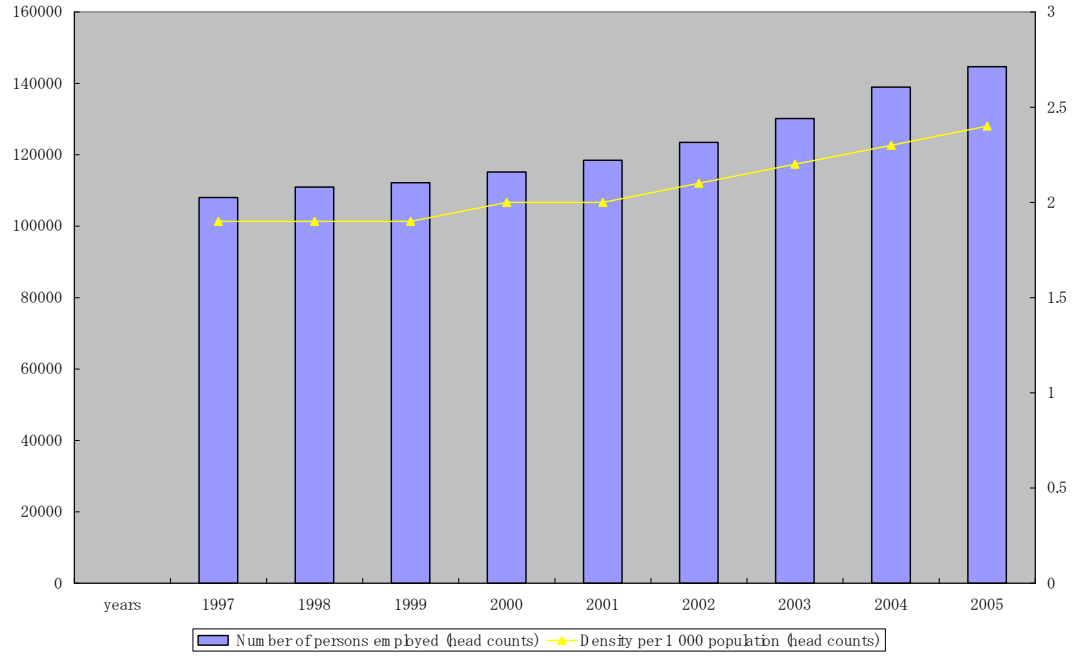
[7] Total Expenditure on Services by COFOG, 1987-88 to 2006-07 in *latest functional historical series (budget2008),* from HM Treasury web site (accessed on 17th May 2008)

[8] Total Expenditure on Services by COFOG in real terms, 1987-88 to 2006-07 in *latest functional historical series (budget2008),* from HM Treasury web site (accessed on 17th May 2008) Real terms figures are the cash figures adjusted to 2006-07 price levels using GDP deflators. For years 1987-88 to 2005-06 deflators are calculated from the latest data from the Office for National Statistics (released 20th December 2007).

[9] Press notice for *2007 Pre-Budget Report and Comprehensive Spending Review*, from HM Treasury web site

[10] *OECD Health Data-Version:October 2007* from 'Source OECD' web site. The number is head-count. Dental staff is excluded.

UK Practicing physicians



Years	Number of persons employed (head counts)	Density per 1 000 population (head counts)
1997	108,030	1.9
1998	110,952	1.9
1999	112,183	1.9
2000	115,158	2.0
2001	118,426	2.0
2002	123,442	2.1
2003	130,114	2.2
2004	138,958	2.3
2005	144,640	2.4

(Source: *OECD Health Data 2007*)

Let's focus on the situation in England [11]. The number of GPs increased from 29,389 in 1997 to 31,369 in 2000, and to 35,994 in 2005. The number of consultants also increased from 21,474 to 30,468 to 40,074 respectively[12].

On the other hand, numbers of patients who had waited a long time declined. With regard to inpatient treatment, the number waiting more than 6 months for inpatient treatment fell from about 265,000 in March 2000 to 387 in February 2007. About outpatient treatment, the number waiting more than 13 weeks also fell: from about 390,000 in March 2000 to 119 in February 2007.[13] The King's Fund pointed out in 2007, 'Since 1997 the government has perceived long waiting times faced by patients as the main failing of the NHS. Strategies to tackle waiting have dominated NHS policy for 10 years and the results have been considerable.'[14] This point will be examined closely later.

II) What made Blair promise more cash for health?

Tony Blair's announcement surprised many members of the government and Whitehall[15]. Although the announcement might have been out of the blue, there had been a considerable number of factors making the Prime Minister eager to express something positive about NHS.

First of all, Labour, at the 1997 general election, traded on the NHS, promising 'we will save the NHS' in its manifesto. NHS is the most popular topic among voters[16], and Labour used it as a weapon to attack the Conservatives , in government at that time, declaring that the 'NHS is under threat from the Conservatives....there are 20,000 more managers and 50,000 fewer nurses on the wards, and more than one million people

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[11] In this paper, the situation in England is examined unless it is particularly mentioned otherwise.
[12] *NHS staff numbers*, from Information Centre web site.
[13] Willcox(2007) and DH(2007). As for the number in 2007, 11 out of 378 inpatients and 98 out of 119 outpatients were English residents waiting Welsh hospital.
[14] King's Fund(2007) p3
[15] Timmins(2001) p595, newspapers on 17th January 2000
[16] According to *British Social Attitude*, most voters decide which party to vote, based on the health policy.

are on waiting lists'[17] and launching promises including, amongst others, '100,000 people off waiting lists' and 'Raise spending in real terms every year—and spend the money on patients not bureaucracy'. In addition, on the eve of the election, Blair warned voters, they had 'twenty four hours to save the NHS!'[18] in order to get support from them.

Despite the claim, both waiting lists and waiting times became longer after he took office. Inpatients waiting lists in England rose from 1.1 million in 1997 to nearly 1.3 million in 1999, and the number of outpatients waiting over 13 weeks rose by around 30%.[19]

In addition, the government had been stung by a wave of criticism and negative press in the past 2 weeks before the announcement. Critics pointed to the service's inability 'to cope with a modest, and predicted, influenza epidemic'.[20] Patients stayed days and nights on trolleys before being admitted to a proper ward. And the case of Mavis Skeet, a 73-year-old woman whose throat cancer became inoperable after 4 hospital cancellations in 5 weeks, also caused a huge outcry. The government was even criticized by fellow Labour MPs about their poor performance on health[21], and these were also covered by the media.

It was natural therefore, that Blair's announcement targeted the media and the public in order to make the maximum impact on them[22].

The Prime Minister's announcement was underlined by the budget on 21st March 2000. Gordon Brown, the Chancellor at that time and the present Prime Minister, made it clear that the NHS would get 6.1% annual real term growth for four years. The treasury claimed this would be the longest period of sustained high growth in the 50-year history of the NHS.[23]

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[17] Labour Party (1997)
[18] *news. bbc. co.uk*
[19] Appleby(2005)
[20] *The Lancet*, 22nd January 2000 p296
[21] In *the New Statesman* interview, Robert Winston said, 'There is a lot wrong with the health service, and no one is prepared to say so. I shouldn't really be saying these things to you now.' This volume was published on 17th January 2000, but the content of the interview was covered by the newspapers on 15th. See Klein(2006) pp204-205.
[22] Klein(2006) p205
[23] Peston(2005) p171

III) What measure was taken for improvement? ----Targets, and more money

Then, in July 2000, came *The NHS Plan*. This was the real beginning of the reform by the New Labour, a 10-year plan which contains a lot of numerical targets, such as 7,000 more consultants and 2,000 more GPs, 20,000 extra nurses and over 100 new hospitals. As for waiting times which were the main concern of the public, the targets were 'by the end of 2005 the maximum waiting time for an outpatient appointments will be three months and for inpatients, six months', 'by 2004 patients will be able to have a GP appointment within 48hours'. Money was promised and targets were set clearly[24].

Targets were not a new device for *The NHS Plan*. Reducing the waiting lists, which had been promised in 1997, was also considered as a 'target'[25], and Public Services Agreements (PSAs) which were introduced in 1998, developed the scheme of performance targets. PSAs are agreements between governmental departments and the Treasury, and the purposes of PSAs are to make public service more efficient and to make sure that allocated resource produce specified improvements in performance. The Treasury funds a department in accordance with its achievements in reaching targets in PSAs[26]. The characteristics of 'targets with terror', namely , targets with strong demand to be met and with strong sanctions for poor performing hospital managers, became clear after *The NHS Plan* was published.[27]

As the targets in *The NHS Plan* reflected public concerns and were widely advertised by the government, the public were alerted to scrutinize the results.

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[24] There was also a criticism against *The NHS Plan*. The editorial of *The Lancet*, 5th August 2000, criticized *The NHS Plan* would not meet the needs of the most vulnerable group in the society—the elderly, the poor and children.
[25] Ham(2004) p61
[26] Klein(2006) p191
[27] Propper(2007)

It should be mentioned that public expectation of the NHS was high after *The NHS Plan* and it, indeed, reached the extent that people accepted the need to pay for the extra funding required.

The decision to raise the National Insurance Contribution by 1% was disclosed by Gordon Brown in April 2002, and the opinion polls right after that showed more than 70% people approved the increase[28]. 86% of the Labour supporters and even 54% of the Conservative supporters endorsed the Chancellor's decision[29].

Previously Blair had stated clearly that the money needed would be financed 'without raising tax'[30], and the NIC rise had a similar effect on people's pockets as a tax rise. 56% thought Labour had broken its promise, but even so, as was stated above, 72% were on their side[3132].

The Chancellor used, for his justification, the Wanless report, which was produced by the former chief of the National Westminster Bank, Derek Wanless, and which found that NHS spending would need to rise by between 7.1% and 7.3% for the next five consecutive years if the UK was to close the gap with the European average[33].

Brown made a positive promise as well. He mentioned that there had been a higher percentage of annual increase in financing health than he had promised—the rate was 6% in 2000, and now it was 7.4% in real terms. 'UK health spending will grow from 65.4 billion pounds to 72.3 billion pounds to 87.2 billion pounds to 95.9 billion pounds to 105.6 billion pounds. In 2007/08, even after inflation, a 43% rise over 5 years. Since 1997, a real terms doubling in health service investment.'[34]

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[28] *Sunday Telegraph* on 21st April 2002, *The Guardian* on 23rd April 2002 and *The Times* on 24th April 2002

[29] *The Guardian* on 23rd April 2002

[30] *Financial Times* on 17th January 2000, from the article about Blair interview with BBC One's Breakfast with Frost on 16th January 2000

[31] *The Times* on 24th April 2002

[32] Peston(2005) points out that, behind Brown's success, there was the deliberate consideration by Brown and the Treasury about the timing when the rise should be announced. They thought of the rise as early as 1999, but kept silence until 2001 general election finished. For detail, see pp265-274

[33] Wanless was commissioned by Brown in March 2001 to examine the long-term trends that would affect the NHS in the next 20 years and to estimate the resources needed to ensure the UK will have a first- class health service. In his interim report in November 2001, he stated that UK had fallen behind other countries in terms of health outcomes 'because we have spent very much less and not spent well.'

[34] Chancellor of the Exchequer's Budget Statement on 17th April 2002, from HM

The report by the NHS chief executive, Nigel Crisp, on 10th April 2002 on progress in the NHS in the previous year might also have had a positive effect on public opinion; no one was waiting more than 15 months for an operation compared with 80,000 the previous year, only 500 people waited longer than 6 months compared with 80,000 the previous year, although the government just missed its targets of maximum 6-month wait for a first outpatient appointment[35].

IV) How targets worked? ----Two case studies

By setting clear targets with extra money, which were based partly on the extra contribution by the public, and emphasizing its commitment to the NHS, the government was taking political risks in case the targets were not achieved. In addition, the list of targets was to grow over time, which added pressure both on NHS managers and on politicians[36].

What it needed next, therefore, was the results. On this point, Blair said clearly: 'There is a basic deal here. Investment for results. I know that if having put in this extra money, we can't show clearly, demonstrably that the service has got radically better, then the consent from the public for investment is in jeopardy'[37] The eagerness for these results led to a strict regime of command on NHS hospitals by the government.

Michael Barber, the then Head of the Prime Minister's Delivery Unit, said, 'From that moment [of the budget speech in 2002] on, the central challenge of the second term [of Tony Blair] was to ensure that there was powerful evidence that the NHS had significantly improved, especially by massively reducing waiting times.[38]' Actually, the challenge was about more than health per se. The NIC rise was a challenge to a given of British politics since Margaret Thatcher took power; direct taxes could

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Treasury web site
[35] Dean(2002) p1413
[36] Klein(2006) p203
[37] Speech at Public Sector Reform Conference on 6th June 2006, from 10 DOWNING STREET web site
[38] Barber(2007)p131

not be increased in an explicit way without wreaking huge damage to the Party in government[39]. Barber stated, 'the pressure on me felt intense.[40]' It is worth noting that the Delivery Unit was created in 2001 to play the 'enforcer' role by keeping 'a rigorous and relentless focus on a relatively small number of the Prime Minister's key priorities.'[41] Without any doubt, waiting times were included among the key priorities.

In parliament and Whitehall, there were people taking political risks who promised better healthcare service and who announced the rise in NIC, and other people whose *raison d'etrê* was to make sure of getting significant results. It is not difficult to imagine that this pressure from central government on NHS bodies to show their improvement was very strong.

Performance management by the government was, in fact, fierce; 'It was management by terror. They would phone up Chief Executives [of NHS trusts] and say "why aren't you meeting targets?"'[42]

The result of reducing waiting times was not achieved without struggle, and there were problems behind the success. The King's Fund chief executive, Rabbi Julia Neuberger, showed her concern as follows: 'Investment and reform have been a double-edged sword. The NHS is overwhelmed with well-meaning policy directives, must-do targets and structural changes"[43]

Broadly speaking, there are three ways to achieve targets[44]. Firstly, NHS trusts can redesign whole systems in the provision of care. Initiatives such as joint working between managers and clinicians, strong structures and leadership, explicit and clear processes of care are included in this approach. This is the intended outcome of a target setting

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[39] Peston(2005) p274
[40] Barber(2007)p131
[41] Barber(2007) p48
[42] Described by Le Grand, cited in Brown(2007). See also Klein(2006)
[43] From King' s Fund web site, *Media,* 12th April 2002. King's Fund is a leading health think-tank in the UK. As for structural change, one explanation is that reorganization is a useful tool for politicians because it is highly symbolic, and gives the impression that something is being done about the problems of the NHS. See Baggott(2007) p135
[44] CHI(2003b)

system because it is more likely to achieve widespread and long term good quality care that meets the needs of patients. Secondly, trusts can increase capacity at measurement points to meet targets. Resources are sometimes taken away from some parts of hospitals and diverted to others, or staffing levels are increased during a period in which a performance measurement is made. Thirdly, trusts can meet targets by manipulating the data itself.

Let's look at two targets on waiting in practice: accident and emergency (A&E) and non-emergency hospital admission.

i) A&E

The target on A&E, set in *The NHS Plan*, was 'by the end of 2004, no one should wait more than four hours in A&E to admission to hospital, transfer or discharge'.

An outbreak of influenza from the autumn of 1999 made the public pay intensive attention to the situation in A&E---Hospital A&E departments were flooded with patients. Stories of elderly patients waiting for 20 or more hours on trolleys in the A&E department before being found a bed in a ward mounted up[45].

This target was 'the centre piece of *The NHS Plan*'[46].The Delivery Unit was monitoring the progress on it during 2002 and 'one central fact became plain---nothing was happening[47]'. When the target was set, about 80% of patients did not wait as long as four hours and the rest of patients (20%) had to wait longer. During 2002 the situation remained the same. 'Unacceptable'.[48]

The Unit made field visits and found two things. Firstly, health service staff knew there was a target, but they did not believe the government minded about it very much. Secondly, they believed a so-called 'see and treat' approach would speed up the process dramatically. Traditionally, a triage nurse in A&E decided if a patient was an urgent case or not, and if

[45] Klein(2006) p204
[46] Barber(2007) p164
[47] Barber(2007) p164
[48] Barber(2007) p164

not, the patient was asked to wait, which made the waiting in A&E longer. If those with minor injuries were, therefore, treated at the triage point, with the premise that urgent cases were still treated urgently, the waiting in A&E would be shorter. The government was convinced that the fast implementation of 'see and treat' was the key to improve performance on the ground.

There was, however, strong resistance by health professionals to the imposed idea. Barber recognised that creating circumstances in which professionals discovered best practices for themselves had proved effective in encouraging the spread of improved practice in cancer and coronary disease, 'but it had a major flaw from the point of view of A&E: it took time---several years---to spread, which we did not have.[49]' The government had only two years until the due date of the target. What the government, precisely speaking, the Department of Health did was to take a 'just do it' ("Must-do") approach, with the decision that A&E performance would be included in the hospital star ratings[50].

The effect was clear. The weekly data jumped up from just above 80% of patients being seen within four hours to over 90% in the last week of March, which was a 'census' week for the star ratings[51]. In addition, the government introduced financial rewards for those A&E departments which reached certain significant stages (94%, 95% etc) during 2004 on the way to achieving the final target in the end of that year.[52]

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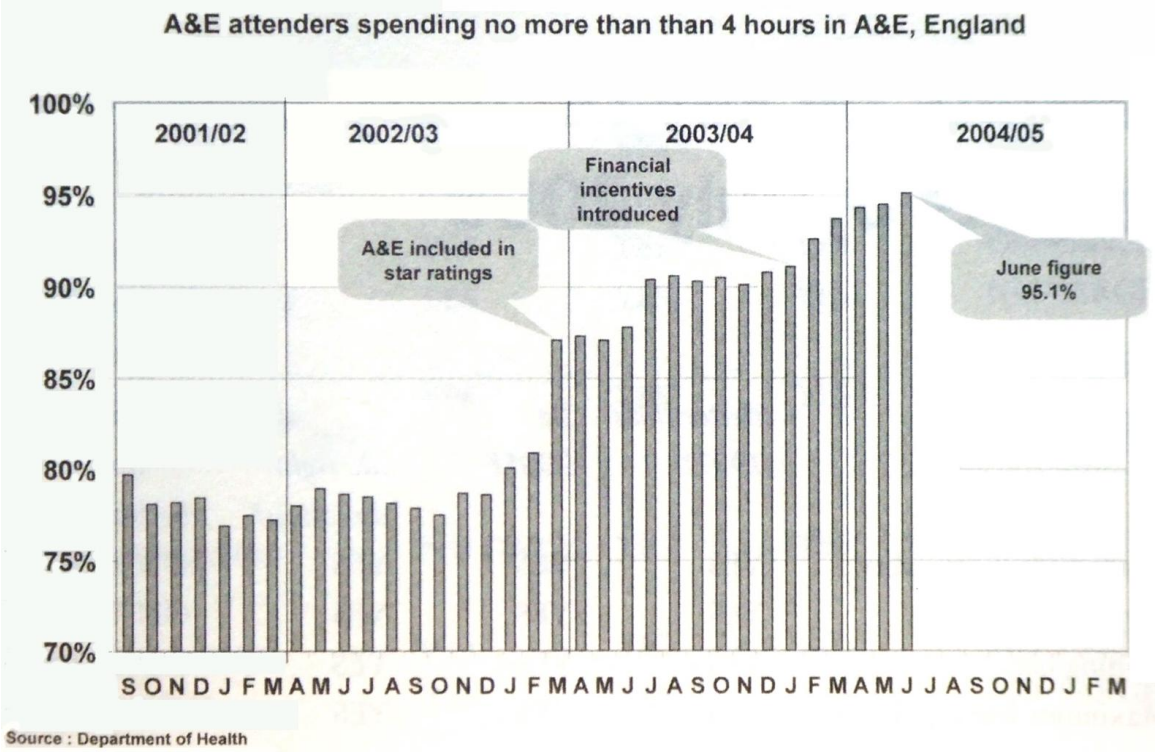
[49] Barber(2007) p166

[50] A hospital star rating system was introduced in 2001, whereby NHS hospitals were assessed annually on a number of indicators, such as targets on waiting times, cleanliness, and financial management. At first, the Department of Health was responsible for monitoring the hospital's performance, and CHI assumed to take over that responsibility in 2003. There was a possibility, at the extremes, hospital management teams could be dismissed or earn greater autonomy on the basis of CHI's assessments. The star rating system was abolished in 2005, but hospitals are still subject to assessment in a similar way called 'health check' by the Healthcare Commission which took over CHI.

[51] Barber(2007) p167

[52] According to BMA(2005), trusts were paid 100,000 pounds to spend on capital projects for each of the staged targets met. The stages were: 94% of patients should be seen, treated or discharged within 4 hours during the period from 1st March 2004 to 31 March 2004, 95% from 1st April 2004 to 30th June 2004, 96% from 1st July 2004 to 30th September 2004, 97% from 1st October 2004 to 31st December 2004, 98% from 1st January 2005 to 31st March 2005. Barber wrote, it was Blair who wanted to have

The table in the next page shows the process to the 'success' in this target.



<Table: Barber (2007) p387>

Behind the 'success', some problems were exposed during implementation.

A survey by the British Medical Association found during the last week of March 2003, which was mentioned above as the period of measurement, two thirds of A&E departments put in place temporary measures so that they appeared to meet the government waiting time target of four hours[53]. 56% had used temporary medical and nursing agency staff to reduce waiting times. 25% reported that their departments had allowed staff to work double or extended shifts at this time. 14% said that non-urgent surgery had been cancelled to make extra beds available to admit patients arriving through A&E departments.

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the positive incentives to meet the target, which did not exist at that time. See Barber(2007) p168. BMA(2005) showed among the A&E which were awarded the money 44% answered the money did not come to the A&E and had been swallowed up by the trust's deficit although 52% said they have benefited from the money.

[53] The survey cited in Mayor(2003)

Based on the survey finding, Mr. John Heyworth, president of the British Association for Accident and Emergency Medicine, made a comment: "The results of the A&E departments' performance during the measuring period should be interpreted with caution. They were, in many cases, illusory and a reflection of the extraordinary changes driven by hospitals desperate to achieve the government target and fearful of the penalty for failure."[54]

A follow-up survey in 2005[55] also showed a similar tendency. In order to meet the target, 48% used additional agency staff for the period of measurement, 26% reported elective surgery had been cancelled and 16% reported direct manipulation of data. Some respondents reported 'intolerable pressure leading to mass resignations of nurses and general loss of morale'. Furthermore, for 82% of the respondents there were clinical concerns which arose from efforts to meet the target. For example, 40% said 'patients were discharged from the A&E department before they were adequately assessed or stabilised', 27% reported 'care of seriously ill or injured compromised' and 52% reported 'patients moved to inappropriate areas or wards'.

Cheating happened even without an 'inappropriate move'. Waiting times were circumvented by imaginative fixes where trolleys either had their wheels removed or were re-designed as 'beds on wheels' and corridors and treatment rooms are re-designated as 'pre-admission units'.[56]

The problem of A&E was, also witnessed by a healthcare watchdog. The review teams of the Commission for Health Improvement (CHI) 'witnessed long queues of ambulances waiting outside A&E departments, with crews looking after the patients and unable to respond to other calls' [57] . CHI decreed that this situation was 'unacceptable', and 'completely contrary to the principle of providing patient centred services', and then analysed one reason for long delays in A&E accepting patients

[54] Mayor(2003)
[55] BMA(2005)
[56] Public Administration Select Committee(2003) pp19-20
[57] CHI(2003a) p9

from waiting ambulances might be their own need to achieve the four hour target. 'This illustrates how targets set for one service may work against good cooperation between services'[58].

In addition, there was another criticism from the point of view of statistics. The Royal Statistical Society Working Party on Performance Monitoring in the Public Services stated in its report, 'it is usually inept to set an extreme value target, such as "no patient shall wait in accident and emergency for more than 4 hours" because, as soon as one patient waits in accident and emergency for more than 4 hours, the target is foregone'[59]. It pointed out that the effort to achieve extremes consumes disproportionate resources and a little less, 95% in case of A&E, would be a more cost-efficient and continuously relevant target.

Medical professionals did not keep silence, either. As a result, the Department of Health showed a little compromise on this target and sent out a letter to its local branches, saying 'We need to listen when clinicians warn us that a target could adversely affect some patients' care'[60] Based on the consultation with professionals, the Department announced the operational modification of the target; 'after allowing for all exceptional circumstances, recorded performance should stay above 98% from 1 January 2005'. 98% became the minimum line from that point, which is still 3points higher than the recommendation of the statistics group.

ii) non-emergency hospital treatment

The NHS Plan includes the 'Must-do' target for non-urgent hospital waiting times; 'reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for impatient treatment to 6 months by the end of 2005'[61].

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[58] CHI(2003a)

[59] Royal Statistical Society Working Party on Performance Monitoring in the Public Services (2005) p9

[60] DH(2003) *A&E four hour total time target exceptions and performance ratings,* on 17th December 2003, from DH web site

[61] In order to achieve the final target, *The NHS Plan* set the stages for the maximum wait for elective hospital admission: 18 months by the end of March 2001, 15 months by March 2002, 12 months by March 2003, and 9 months by March 2004. See, respectively, DH(2001) *NHS performance rating acute trusts 2000/01*, DH(2002) *NHS performance ratings acute trusts, specialist trusts, ambulance trusts,*

The latest version of the Departmental report[62] shows the progress to 'success'. With regard to outpatients, the number waiting more than 3 months was 223,575 in December 2002, 121,908 in December 2003, 62,752 in December 2004, 56,202 in February 2005, 198 in December 2005 which was the deadline of the target, 198 in February in February 2006 and 119 in February 2007[63]. As for inpatients, the number waiting more than 6 months was 251,474 in February 2001, 242,900 in February 2002, 207,271 in February 2003, 113,485 in February 2004, 60,493 in February 2005, 165 in February 2006 which was just after the deadline of the target, and 378 in February 2007[64].

In-patient waiting times

Number waiting more than six months:

- February 2001 – 251,474
- February 2002 – 242,900
- February 2003 – 207,271
- February 2004 – 113,485
- February 2005 – 60,493
- February 2006 – 165
- February 2007 – 378

Outpatient waiting times

Number waiting more than three months:

- December 2002 – 223,575
- December 2003 – 121,908
- December 2004 – 62,752
- February 2005 – 56,202
- December 2005 – 198
- February 2006 – 198
- February 2007 – 119

(Source: Department of Health)

In both aspects, the declines were dramatic, especially during the last year before the 'Must- do' target's deadline, and the target was reported as 'met'.

The government, despite claiming that waiting times were 'no longer the major issue for patients and the public'[65], made a higher target; 'the maximum time from GP referral to the start of treatment will be down to

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mental health trusts 2001/02, Commission for Health Improvement(2003) *NHS performance ratings. Acute trusts, specialist trusts, ambulance trusts 2002/03* and Healthcare Commission(2004) 2004 *performance ratings*, respectively. Also Bevan(2005)

[62] DH(2007) (latest at the point of 11th May 2008)

[63] Out patient waiting times are about patients referred by a GP for a consultant led first out patient appointment. In addition, 153 out of 198 in December 2005, 134 out of 198 in February 2006 and 98 out of 119 in February 2007 were English residents waiting in Welsh hospitals.

[64] Inpatient waiting numbers contain patients who are waiting to be admitted for treatment either as a day case or ordinary admission. 25 out of 165 in February 2006 and 11 out of 378 were English residents waiting in Welsh hospitals.

[65] *The NHS Improvement Plan*(2004)

18 weeks by the end of 2008'.[66] This target includes outpatients, inpatients, and diagnostic phases which had been 'hidden waiting times', namely, had not been counted before[67].

There was, again, the dark side behind the bright achievement. There is an easy way to shorten waiting lists, by refraining from putting people on them, or by having a consultation in order to terminate an initial wait[68]. CHI warned that patients might be removed from waiting lists once they have been provided with a date for an appointment, even though this appointment had not yet taken place, or patients might be given immediate appointments that they were not able to attend and they were then classified as refusing treatment.[69] As its conclusion, CHI reported too many hospitals 'take a mechanistic approach to achieving targets rather than redesigning services with quality in mind.'[70]

Perverse consequences of effort to meet targets in some cases led to tragedies. Dr Richard Harrad, Clinical Director of the Bristol Eye Hospital, gave evidence that the waiting time targets for new outpatients appointments at his hospital had been achieved at the expense of 1,000 cancellations per month and a delay in follow-up appointments[71]. He explained to the Public Administration Select Committee about 'one particularly sad case' that an elderly woman's follow-up appointment for glaucoma had been delayed several times and during this time her

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[66] ibid.
[67] Blair seemed to keep his focus on the waiting time until the last stage of his office; '"How long will it take?" It is a question the prime minister keeps returning to as he meets and greets patients at the new eye clinic at Frimley Park Hospital foundation trust. He wants to know how fast they are getting the treatment, and he likes the answers. This Surrey trust quotes cataract waiting lists down from two years to eight weeks'. See Edwards(2006)
[68] Hill(2007) p159
[69] CHI(2003b) p20
[70] CHI(2003b) p26. Nine cases relating to these points were reported in detail in NAO(2001). In Surrey and Sussex Healthcare NHS Trust, patients were placed on the suspended list where they could remain indefinitely or until they contacted the Trust. In Salford Royal Hospitals NHS Trust, all patients waiting more than 18 months were excluded from the reported information and referrals from GPs for an outpatient appointment were not recorded until the month of appointment. Most cases happened before *The NHS Plan,* but some of them, including Salford Royal Hospitals NHS Trust, continued after *The NHS Plan* as well.
[71] Public Administration Select Committee(2003) p18

glaucoma deteriorated and she became totally blind.[72] It is clear that avoiding cancellation had much less priority than the waiting target and that less visible areas were easily neglected.

Another element which contributed to reducing waiting times was the introduction of the private sector. The Department of Health tried to make full use of the capacity in the private sector for the purpose of reducing waiting lists and waiting times. Relating to that point, the government announced that it intended the private sector could provide up to 15% of operations by 2008[73]. NHS managers who were under pressure to cut their waiting times used the private sector even though the cost was 40% more than the average NHS cost[74]. This is an ironic 'supply and demand' relation. As long as the result of reduced waiting times could be achieved, the cost did not matter[75] [76].

V) Effects and side-effects of the targets

Targets produced a real reduction in waiting times. The comparative analysis of Scotland, which did not adopt the target regime, and England also concluded that the 'targets and terror' regime in England lowered the proportion of people waiting for elective treatment relative to Scotland[77].

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[72] This paper focuses on hospitals, but access to GPs also seemed to have problems. It is true that a patient survey by the Picker Institute (2007) showed there has been 'steady progress' in access and the patients who reported that they could not get an appointment within two days were 12%, which was decrease of 1 percent per year from 2004, but 58% per cent said they had problems getting through their local practice by the phone. This survey matches with the Healthcare Commission(2005) which reported that about a quarter of patients were unable to get an appointment within the 48-hour target time although the Department of Health, in *GP and consultant numbers on the up*, Press release, 26thMay2005, reported that 99% of patients were able to book a GP appointment within 48 hours. See Picker Institute(2007) for detail.

[73] Baggott(2007) p169

[74] Klein(2006) p236

[75] According to Klein(2006), in 2005 the private sector was estimated to carry out 10% of elective surgery.

[76] The cost problem of private sector was questioned at the House of Commons. On 9th May 2006 Anne Milton, Conservative MP, pointed out the private sector which are called 'independent sector treatment centres' were being paid 'whether they did work or not. They are coining in the money, but are operating at about 50 per cent. They get the money even if they do not do the work'.

[77] Propper(2007). In Propper, another research which compared England and Wales, that had less tough targets than England, was quoted, and the research concluded

The measurement culture is now an indispensable part of all the public services, including the NHS, in a culture which increasingly asks for accountability and transparency[78]. Because of the structure of the NHS, namely that it is funded by general national taxation, the government cannot deflect itself from the task. It is true that the government has reduced its burden by devolving its system, but if services in some areas are so bad they are unacceptable, it may not be able to leave it as it is. In order to maintain 'universal' service, some kind of intervention seems to be unavoidable.

The scale and importance of these targets has been counterproductive in many ways, 'though in the absence of other consumer levers, probably inevitable in some form'[79]. How to set targets and how to implement them should be carefully considered.

CHI, which severely critisised the method of target implementation, did not deny the benefits of targets themselves. What CHI proposed was that future target setting needs to ensure that achievement of targets promotes better patient care across as well as within organizations.[80] Bevan, the professor of management science at LSE, recognizing the problems that target-culture had brought, also supports targets, 'Nobody would want to return to the NHS performance before the introduction of targets, with over 20% of patients spending more than four hours in accident and emergency and patients waiting more than 18 months for elective admission'[81] and argues that the way to minimise the costs of a regime of targets by using sanctions should be pursued.

It should be also noted many doctors have the opinion that the problem is not the target itself but the way the target is implemented[82]. Nursing was also favourable to the method: the Royal College of Nursing told to

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that waiting times in England improved while in Wales waiting times did not improved. See also Willcox(2007).

[78] Public Administration Select Committee(2003) p32

[79] Glennerster(2005) p304. The absence of consumer levers may change in accordance with the extension of patients' choice. Patient's choice is a very important point to argue, but beyond this paper.

[80] CHI(2003a) p9

[81] Bevan(2005) p421

[82] BMA(2005)

the parliamentary committee, 'It is unlikely that the Government will abandon performance management and there is a case that targets have been central to delivering some significant improvement NHS. Consequently, the RCN believes that performance management systems should be improved rather than abolished.[83]'

There seem to be two major problems relating to setting and implementing targets; number, and extreme ambition. As for the number, at the beginning, in 1998, there were 23 targets.[84] Then they increased in number following new policy initiatives and, at their peak, it was estimated there were more than 300 or 400 at each trust level although the government claimed they were around 60.[85] This gap explains one aspect of how overwhelmed NHS managers felt in practice. In fact, *The NHS Plan* itself allows to be considered including 'more than 300 explicit targets,'[86] and other plans such as The NHS Cancer Plan also set out 'a significant number of targets, actions and milestones against which progress and performance would be measured'[87].

Extremely ambitious targets are a dangerous temptation for the government to appeal to the public. Targets have been politically decided, and sometimes they were 'inept' as we have seen an example of A&E. There was the danger that any achievement short of 100% success is classified as failure, but, at the same time, there is a political hesitation about easy targets; 'Is "success" meeting all the targets? If so, doesn't that betray a lack of ambition?'[88]'

The Public Administration Select Committee was very critical about '100%, or failure', stating 'Simplistic approaches of this kind, with political and media charges about failures fully meet targets, can be profoundly demoralising to …..hospital staff'[89]. Also as has been seen, to pursue 100% success is statistically absurd and consumes

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[83] Public Administration Select Committee(2003) p27
[84] PSAs in 1998
[85] *Health Service Journal*, 6th February 2003 p8, Klein(2006) p224, Baggott(2007) p138
[86] Smith(2002) p105
[87] Hull and East Yorkshire Hospitals NHS Trust Performance Report March 2005
[88] Barber(2007) p177
[89] Public Administration Select Committee(2003) p24

disproportionate resources[90].

The two points above are closely connected to how to implement targets. It is not difficult to imagine that to achieve too many targets, to be too ambitious or to be perfect tends to lead to aggressive approaches for getting the result, just as has been described in this paper.

The government, just after launching *The NHS Improvement Plan* in 2004, claimed that the number of national targets for the NHS has fallen from 62 to 20, and that they are 'moving away from a system that is mainly driven by national targets to one in which *standards* are the main driver for continuous improvements in quality…..'[91]. The difference between the two systems was explained by saying that organisations' performance will be assessed 'not just on how they do on national targets but increasingly on whether they are delivering high quality standards across a range of areas, including NSFs and NICE guidance'.[92] The national standards cover seven domains: safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, and public health.

Regardless of the government rhetoric, the fact targets are taken into account when hospitals are assessed has not changed, and politically set national targets continue to 'loom large over the NHS'[93]. Indeed, NHS managers still feel the influence of the targets.

In a survey in January 2008, 54% of the managers admitted that they did not feel optimistic about the future of the NHS and the reasons cited were a target-driven culture as well as low staff morale, cuts and wasted money.[94] NHS staff's thinking also seems to be still caught up in targets. According to a staff survey in the end of 2007, only 46% of the NHS staffs

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[90] See the section of A&E

[91] DH(2004a) p9, p10. Also BMJ 2005:330:106. A year before the NHS Improvement Plan was published, Public Administration Select Committee (2003) made a recommendation to reduce the number of targets.

[92] DH(2004a) p9. 'NSFs' stand for National Service Frameworks and set rather disease specific targets. NICE, the National Institute for Health and Clinical Excellence, is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

[93] Ham(2005) p106

[94] Managers' Survey in *Health Service Journal* 10th January 2008,pp28-30

agree the idea that 'the care of patients was their trust's top priority'[95] A NHS executive in London interpreted this result in connection with targets, saying 'Staff might have thought "my trust put more emphasis on targets than on patients' care" when they answered' [96]. The executive, had the opinion that targets were useful, showed concern, 'But to meet the targets is directly related to improvement of the patients' care. Each target is for patients' care. What we do may not be understood enough by staff. If so, I have to explain more to my staff.'

This comment shows that poor communication is possibly part of the implementation problem. Furthermore, Consultants do not like being forced to follow targets that have to do with public and patients concerns as interpreted by politicians[97]. A consultant in south west England told me that 'Targets are good because we can concentrate on what patients want. But we know a better way to achieve the same result because we know our area, we know our people and our patients. Our managers say only what the government says, and even if we suggest to them "why don't we do it this way?" they never feed back!'[98]

The fact that health professionals, especially doctors, are increasingly frustrated by the government should be responded to. The main reason is because the government seems to have eroded clinician's flexibility to care for patients[99]. The core of the problem is, again, not targets themselves but the way they have been set and how to implement them. Although the pay of hospital consultants has risen by an average of 27 per cent in three years [100], they are 'frustrated and angry.' [101] [102] To have more communication both horizontally and vertically is likely to lead to a positive implementation.

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[95] Healthcare Commission(2008)
[96] Interview on 22nd April 2002.
[97] Glennerster(2005) p304
[98] Interview on 30th April 2002
[99] Brown(2007), also Klein(2006) chapter 8
[100] *The Daily Telegraph* on 27th April 2007
[101] Glennerster(2007) p223
[102] With regard to money, Another problem was pointed out that earmarking the fund has been over-applied for trivial sums and under-applied for significant priorities such as the National Service Frameworks; 'The government seeks to have it both ways ---by promising less earmarking while mandating more specific achievements'. See Paton(2006) p137.

With regard to this point, the health minister Lord Darzi, a surgeon as well as a member of the House of Lords, was requested to review the NHS by the Prime Minister and Health Secretary. He recognized the reason he was appointed; 'I'm a doctor not a politician. That's why you asked me to take on this task—and it's why I agreed'.[103] He emphasized in his interim report that the need to ensure change in the pattern of local NHS hospital service should only be initiated when there is a clear and strong clinical basis for doing so.[104] And also in his latest report, he clearly stated that the leadership of clinicians in future NHS changes would be ensured for the benefits of patients[105].

But doctors are still cautious. Dr Hamish Meldrum, Chairman the BMA, said, 'Lord Darzi's pledges are sound but require detail --- we need to see much more flesh on the bones. The impact of these reforms will ultimately depend on such details'.[106]

The deadline for the 18 weeks target is the end of this year. Before that, there is a milestone stage that 85% of patients needing hospital admission should have been treated within 18 weeks by the end of March. The latest figure shows only 75% had been admitted at the end of February[107], and there is a suspicion that the milestone and the target are likely to be missed although the Department of Health is optimistic[108]. This period until the end of this year seems to be a good time to observe how the government acts on this target, facing the serious problem of the spread of the hospital-contracted infections such as MRSA and Clostridium Defficile which cause longer hospital stays and bed-blocks for new admissions, and, above all, adhering to the fundamental principle that a hospital provides treatments which make patients better.[109]

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[103] DH(2007a) p2
[104] ibid. p7
[105] DH(2008)
[106] BMA press release on 9th May 2008
[107] Latest at the point of 15th May 2008
[108] *Financial Times* on 12th May 2008.
[109] The deaths linked to the hospital superbug, Clostridium difficile, in England and Wales increased by 72%, from 3,757 in 2005 to 6,480 in 2006, according to the Office for National Statistics. Deaths involving the MRSA superbug remained roughly the same between 2005 and 2006, at about 1,650 each year. Reflecting this situation, Alan Johnson, the Health Secretary, ordered an inspection of infection control in hospitals. See *The Guardian* on 29th February 2008 and *The Times* on 29th February

Another problem with targets is, as the Healthcare Commission pointed out, 'the extent of improvements is less clear in areas that are not subject to national targets or regular public scrutiny'.[110] 'Services still fall short of national standards, particularly in areas of healthcare which are not considered high priority or which are not subject to government targets'[111]. Mental care and maternity care were cited as examples, both of which got attention much later than waiting times had done. In order to avoid creating and leaving 'neglected areas' which were caused by too much concentration on target areas, the government have created independent organisations, like the Healthcare commission, which has a wider view.[112].

The NHS Plan in 2000 mainly focused on quantity; subsequently the government moved to the next stage which has focused more on quality reform[113]. Tony Blair was proud of the improvement of the NHS, and he stated in the Party manifesto for 2005 general election, 'I have spoken to NHS staff in Coventry, Edinburgh and Swansea, who tell me how their hospital and the new funding is letting them improve care for their patients.'[114] If the NHS could not offer enough service because of lack of doctors or facilities, it was to be solved by providing more doctors or facilities. But when the issue comes to real 'quality', even the Healthcare Commission measures it by very limited scales. Measuring quality is not easy. Although 'tough quality targets for hospitals' was mentioned by Labour as early as its 1997 manifesto, how to measure quality is not yet agreed.

No matter whether the use of quality measures is limited, the Healthcare Commission is the only body authorised to assess all NHS trusts. There is, however, a concern for the future of the Commission. The legislation to merge the Commission and the Commission for Social Care

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2008 and on 25th April 2008.
[110] Healthcare Commission(2005) p5
[111] ibid. p8
[112] Healthcare Commission dose assessment job independently, but the standards the Commission uses are set by the government.
[113] This stage began with *NHS Improvement Plan* published in 2004.
[114] Labour Party (2005) p6

Inspection and create an integrated new regulator is on the current parliamentary procedure[115] and the new organisation is supposed to be established in April 2009. In the discussion in the House of Lords, many doubts about the effectiveness of the merger were raised[116]. Whether the sophistication and improvement of hospital assessment system will be affected or not in consequence of the legislation is unclear at the moment.

VI) Remaining challenge---Public perception

Public perceptions have not shown so much improvement even after the vast investment and continuous reform. It is true that there have been measurable improvements in targeted areas, but the public have not strongly shown their appreciation. This may be because people forget the past quickly. People 'have short memories: those waiting for operations now have no idea what it was like 10 years ago'[117]

This reality is disappointing for the government because a key issue for any government is how policies and the outcomes of policies are perceived by the public[118]. At the same time, it should be noted that public perceptions of the NHS as a whole are very different from patient perceptions. Patients satisfaction is always much higher than public satisfaction[119]. And it is also worth mentioning that public perception is different at a national level and at a local level. In short, 'the NHS is bad. But not my area, not my doctor.' This is the public perception of the NHS. The reason for that is probably in the media coverage on the NHS and politics relating to NHS at national level.

The Healthcare commission made a report which focused on public and patient attitudes about the NHS since 2000[120].

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[115] As of 20th May 2008

[116] For example, debate on 30th April 2008 focused on the deference between health inspection and social care inspection.

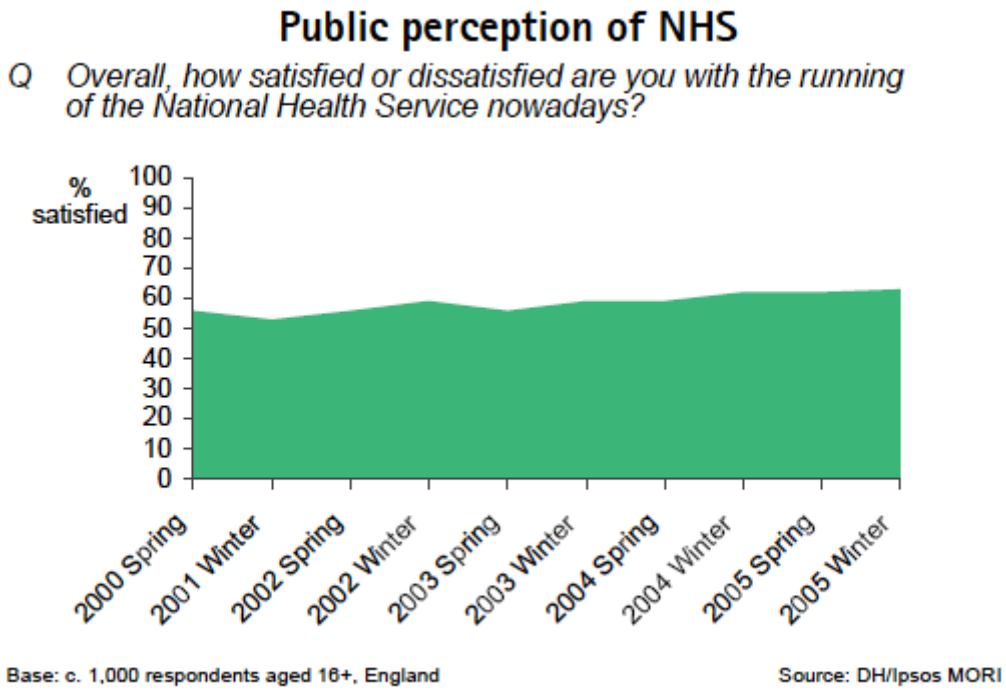
[117] *The Guardian* on 23rdMarch 2007

[118] Appleby(2005) p110

[119] The data used in this section is from Healthcare Commission (2006). The same tendency that public perception has been stable since 2000 and that patients satisfaction is much higher than publics is also in *British Social Attitudes*.

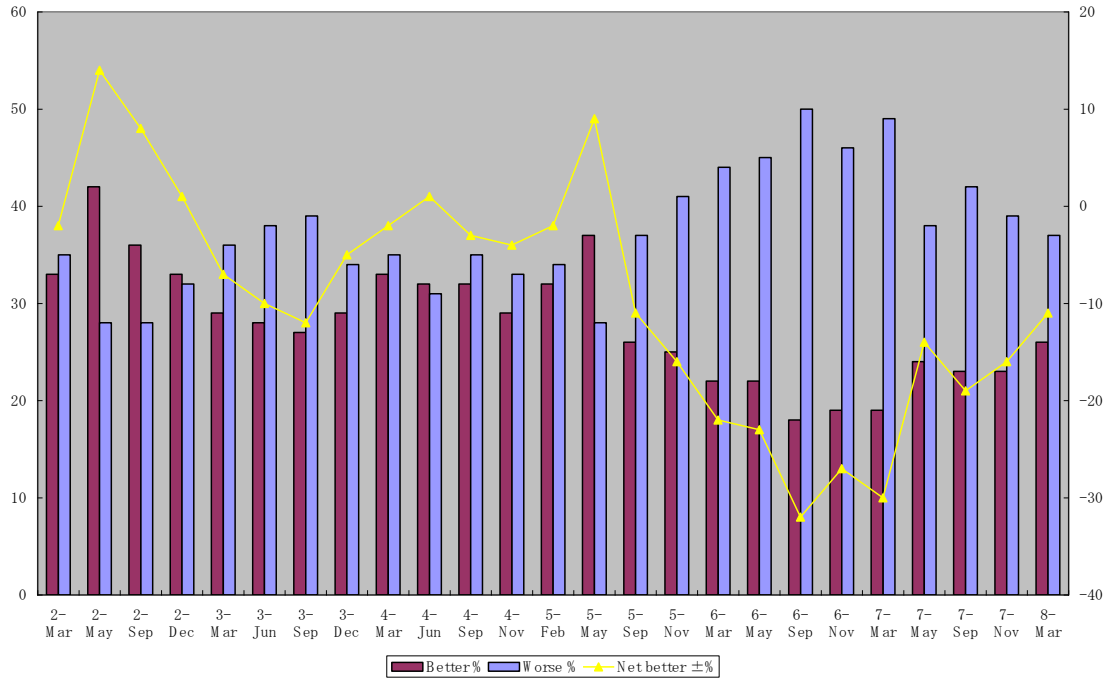
[120] Figures in this section are cited from Healthcare Commission (2006). The original data in that publication is the NHS surveys conducted by Ipsos MORI.

With regard to public satisfaction in NHS at national level, the percentage has remained stable: between 50% and 60%. Since the winter of 2004, it remained above 60%, which was an indication that some of the improvements in the NHS nationally are beginning to be recognised.



Current levels of satisfaction may begin to increase, but the data shows the public are not confident that the NHS will be any better in the future[121]. In March 2002, 35% answered that they expected the NHS to get worse over the next few years, as against 33% who expected it to get better. Six years later, in March 2008, 37% expected it to get worse and 26% expected it to get better. 'Net better' ('get better' – 'get worse') dropped -2% to -11%, which means the public perception has not improved, on the contrary, it has worsened. The long term tendency clearly shows the public is becoming more pessimistic about the future improvement of NHS.

[121] All data in this paragraph and the next paragraph are from *Government Delivery index* in Ipsos MORI web site. The data between March 2002 and March 2008 is available. (Accessed on 20th April 2008). The data up to 2006 is also in Healthcare Commission (2006).



(Source: Ipsos MORI)

As for this survey, it is worth noting that 'get better' was the highest (42%) in May 2002, just after Gordon Brown announced the NIC rise, and 'get worse' was one of the lowest(28%). Net better was also the highest(+14%). Interestingly, in June 2003, the first survey after the NIC rise took effect in April 2003, 'get better' decreased to 28% and 'get worse' increased to 38%, and net better reduced to -10%.

This public attitude may be determined by several factors. It seems to be a consensus that the media have a very significant role in forming public perception[122].

In the Ipsos MORI survey, rapid swings from month to month commonly happened. For instance, net better was -2% in March 2002, but in May 2002, only two month later and just after the Chancellor's speech, it became +14%. More notably, +9% in May 2005, when Patricia Hewitt took office, became -11% in September 2005. Klein(2006) pointed out that public attitudes are shaped not by the performance of the NHS, which

[122] For example, Klein(2006), Healthcare Commission(2006) and Baggott(2007)

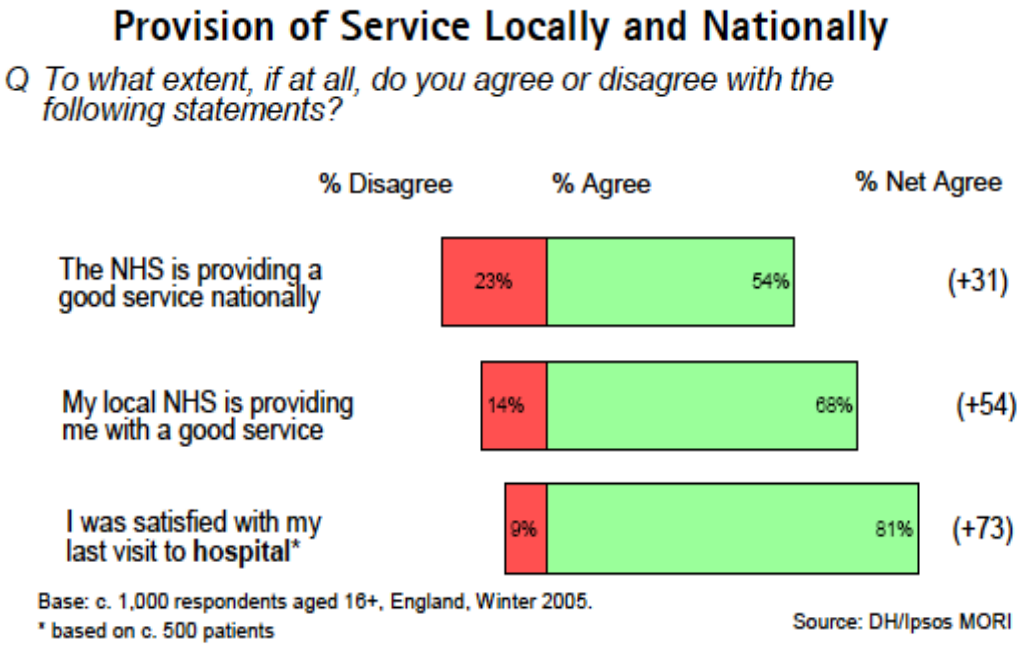
does not vary from month to month, but 'how that performance is presented in the flickering, volatile searchlight of the media. When the media highlight scandal or failure, confidence in the NHS and the government policy slumps.'[123] There is also a claim that the media is mainly a negative force for policy although it can influence the health policy agenda in a positive way[124]. In fact, bad news is more influential than good news.[125]

Hospital closures, superbug infections and accidents within hospitals, hospital deficits, the failure of PFI schemes….. Many topics NHS related, mostly negative, are picked up daily in media.

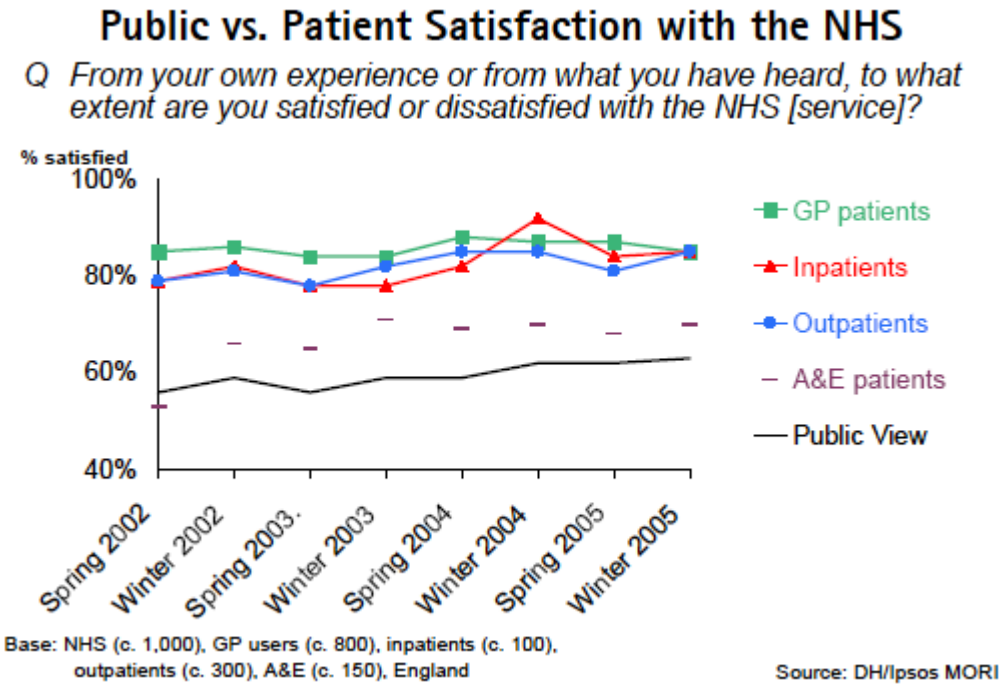
The further, the worse---. The Figure below shows the NHS at a national level is perceived not as good as 'my area'. The percentage who thought the NHS provides good service nationally is 54%, compared to 68% who considered it was 'providing me a good service locally'. Furthermore, most of the 'my hospital' to which respondents went as patients satisfied them. In fact, 81% were satisfied with their own hospital treatment and only 9% were not satisfied. It clearly suggests that when people form a judgment on the NHS nationally, they tend to generalize the idea by relying on the media coverage, not relying on their direct experience of being patients.

The different results between the national and the local level can be explained partly, again, by the impact of media. A NHS communication director analysed the different attitudes among media; 'national newspapers are more critical of the NHS than local newspapers. Local papers are more positive[126]'.

[123] Klein(2006) p257
[124] Baggott(2007) p222
[125] Healthcare Commission(2005) p16.The commission appointed a series of focused groups in order to find out if its finding was clear and credible to them, and they tended to believe 'bad news' statistics more than 'good news' statistics.
[126] Interview on 1st April



The perception gap between the public and patients has not narrowed. In fact, the satisfaction level of the patients has not improved significantly either although it has been as high as around 80%.



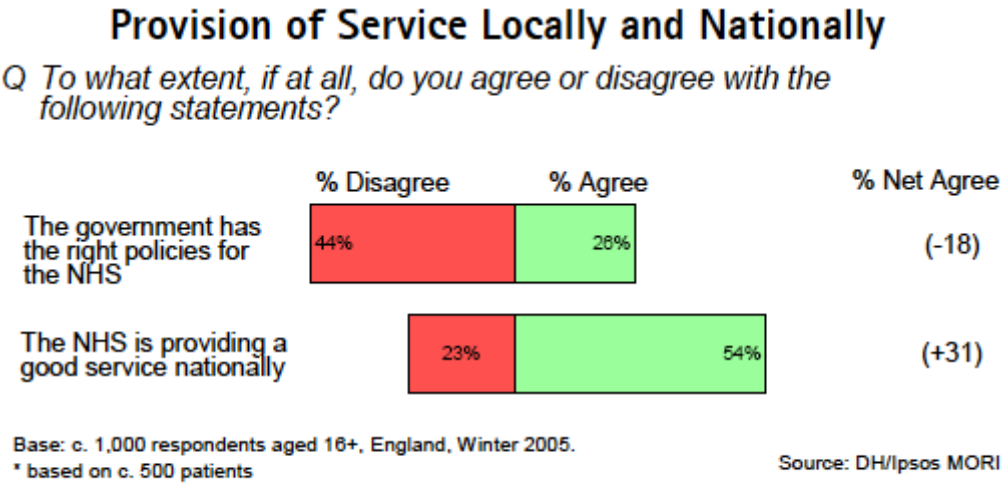
The gulf between personal experience and general impressions annoyed the government. Tony Blair explained it to Labour's Spring Conference on 13th March 2004:

'There is much scratching of the head in political circles over this apparent paradox: People who feel personally optimistic in Britain; but collectively pessimistic. They say their own health care in the NHS is good; but the NHS in general is bad. Their schools are good; but education is bad. They are safer; but the country is less safe. Their future is bright; but the nation's is dark.' This view was shared by the survey organisations, like Ipsos MORI, as well.[127]

A very interesting phenomenon appears in the Figure below. People have different perceptions of the NHS service at a national level, and on the government policies on the NHS. The Government's policies for the NHS as a whole are seen much more critically and the percentage of negative is much higher than positive, though on the other hand, the NHS service nationally is perceived more positively. High satisfaction by

[127] For example, MORI pointed out 'both MORI and other published surveys find this dichotomy, and its impact on the profile of public opinion is dramatic' in *New Labour and Delivery* on 15th May 2004.

service users as was seen above and strong support for the NHS[128] do not translate into public approval of government policy.



The comparison of two surveys confirms the impact of politics on the reputation of the NHS as a whole. In the Ipsos MORI survey, respondents' satisfaction with the NHS is among the first questions asked, and the survey investigates views on health care issues only[129]. In the British Social Attitudes (BSA) survey, the overall satisfaction levels tend to be about 15 points lower than ones in Ipsos MORI. One explanation can be the order of the questions asked. In the BSA survey, the satisfaction question is after a number of questions about the respondent's political views and their views on government spending in a number of areas. 'This creates a link between the NHS and the government, which is likely to make respondents more critical of the NHS than they would be without such an association', the Healthcare Commission analysed[130].

What is the main recent topic which has created a negative image of government policies or the NHS as a whole? The major candidate seems to be 'value for money', or the productivity issue. The situation is even called a 'panic over productivity'.[131]

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[128] Healthcare Commission also contained the question that 'The NHS is critical to British society and we must do everything we can to maintain it' and generally more than 75% approved the idea since 2000. See also Klein(2007).
[129] Healthcare Commission(2006) p8
[130] ibid.
[131] *Financial Times* on 12th May 2008

The government regarded the period after *The NHS Plan* as 'a track record of success'[132], but many critics argue, 'service improvements in the NHS have not kept pace with the dramatic increase in expenditure'[133]. The reports by the Office for National Statistic (ONS), which conclude long term decline of NHS productivity[134], led the discussion[135].

Until now, the government has not been successful in calming down its critics. In fact, the Department of Health itself had to admit that the quantifiable overall 'health gain' from pursuing shorter waits has proved surprisingly small[136], which means 'less productive'. The reason was perhaps because the excessive waiting times were experienced by a minority of patients (the majority of patients having been treated reasonably promptly). Or, some needs are more serious than others. It may be desirable too that some people are kept waiting for minor surgery in the interests of securing more rapid responses to life-threatening conditions. Adding to the possibility that concentrating effort on shortening waiting lists may distort the overall service provided[137], from the productivity view point, the effort of focusing on the highest priority (general list-shortening approach) does not produce better productivity.

A main media topic relating to productivity is, amongst others, payment[138]. 'More money, less work: the NHS pay deal gave "something

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[132] DH(2004)
[133] Maynard & Street(2006) p906
[134] ONS produced the report on productivity from 1995 to 2003, in 2004, and to 2006, in 2008. Both reports concluded the productivity fell.
[135] There was a criticize against ONS. BMJ(2005:330:976-7), for instance, claimed in the editorial, ' "Production of what?" is the key question here…..Measuring productivity without regard to quality or value is a risky foundation for wise policy'.
[136] DH(2005) Healthcare Output and Productivity: Accounting for quality change, in King's Fund(2007)
[137] Hill(2005) p159
[138] Other elements are also argued for the productivity decline. One element was reorganization. According to a case study of three hospitals merger, even after three years things didn't work properly. See Filop(2005). Another reason was if investment is on a medical school or nurse school, that money dose not produce immediate 'products', unlike buying a new bed or building a hospital. The over the odds charge by private sectors and PFI schemes which have long and rigid contracts and don't allow flexible operation are pointed out as the cause of productivity decline.

for nothing." '[139] This kind of headline is not difficult to find. The new staff contracts (the new national pay system which came into effect 1st April 2004) for consultants, GPs and nurses have allowed them to get a significant earning increase. Consultant pay increased 27% in three years; from an average of £86,746 per annum in 2002/03, before the contract was introduced, to £109,974 in 2005/06. GP earning increased 30% after the first year of the new contract; average net income became £106,400 per annum in 2004/05. Nurse pay increased by 10% between 2004 (when the new contract came into effect) and 2006; a gross average increased from £11.54 per hour to £12.74 per hour.[140]

What the public wanted most was 'more and better paid staff', according to the government survey before *The NHS Plan*, but medical professionals gain more money with shorter working hours, which seems to be difficult for the public to understand. The King's Fund required, 'Expected productivity gains and benefits for patients from the new contracts have yet to be demonstrated'[141]. Professor Calum Paton, a Chairman of one of the largest NHS hospital Trusts for five years until the end of 2005, stated as a reason for falling productivity, 'if staff numbers and pay are increased quickly, what else can one expect?'[142]

But, As the King's Fund points out, the government and the NHS are now under increasing pressure to show that they are making effective use of the resources at their disposal. What they are required to do is to show effectiveness 'more clearly than they have been able to do so far'[143], and the absence of good measures of productivity makes the situation more negative.[144]

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[139] *Times on line*, on 22nd November 2007

[140] Data quoted in King's Fund(2007) p7. The original sources are National Audit Office(2007) *Pay Modernisation: A new contract for NHS Consultants in England*, Information Centre for Health and Social Care(2006) *GP Earnings and Expenses 2004/05* and Pike and Williams(2006) *Nurses and Public Sector Pay: Lobour Force Survey analysis 2006*, respectively.

[141] King's Fund(2007) p7

[142] Paton(2006) p101

[143] King's Fund(2007) p3

[144] According to Healthcare Commission (2008a), 42 percent of respondents who were inpatients said their care was 'excellent', up from 38 percent in 2002. And this increase was made an ironical remark, for instance, of 'a small reward for the extra billions invested' in *The Independent*, 14th May 2008. *Financial Times* on 14th May

There is no end to confusing elements in the NHS. 'The public and the media find it hard to believe that despite the unprecedented increases in funding, some parts of the NHS have been forced to cut services in an effort to save money'[145]. In the present system, hospitals don't get money automatically from the government; they need to get the contracts for treatment of patients. Money follows patients. The increase in the central government's NHS budget does not necessarily lead to the automatic increase of each hospital's budget. That is the main reason why there is a deficit in some hospitals. Especially, the hospitals in the areas 'where the problems are long standing, highly complex and deeply rooted' have had to face the most serious challenges[146]. Having said this, the fact that some NHS trusts suffered serious deficits in 2005 and 2006 is confusing enough for the public.

In addition, deficits sometimes lead hospitals or treatment units to close. The government has tried to carry out the reconfiguration of hospital services for efficiency, and the word of 'reconfiguration' in the NHS context contains a meaning of 'hospital closure' or 'unit closure'. Unsurprisingly, this government attitude has been criticised. 'I don't remember them[the government] championing hospital closures when they published their reform programme, the NHS Plan, six years ago. It was an implicit not an explicit part of it'.[147]. Hospital closure is not a popular policy at all. In 2001 election, for instance, the independent Dr Richard Taylor swept away the Labour MP for Wyre Forest by promising to stop the closure of the local Kidderminster hospital. Another example was that thousands of NHS patients and staff marched on Westminster in 2006 against a wave of hospital closures and service changes. These closures and service changes were reported to have 'provoked the most widespread local unrest since the poll tax revolt in 1990'.[148]

People who have direct experience of a hospital closure in their area naturally have critical perceptions of NHS, and people who don't face

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2008 reported that patients' experience 'is improving, but painfully slowy……only 4 percentage point rise in spite of all the extra spending.'.

[145] King's Fund(2007) p3

[146] bmj2006;332.7555.1411-c, in *bmj.com*

[147] *The Times* on 29th November 2006

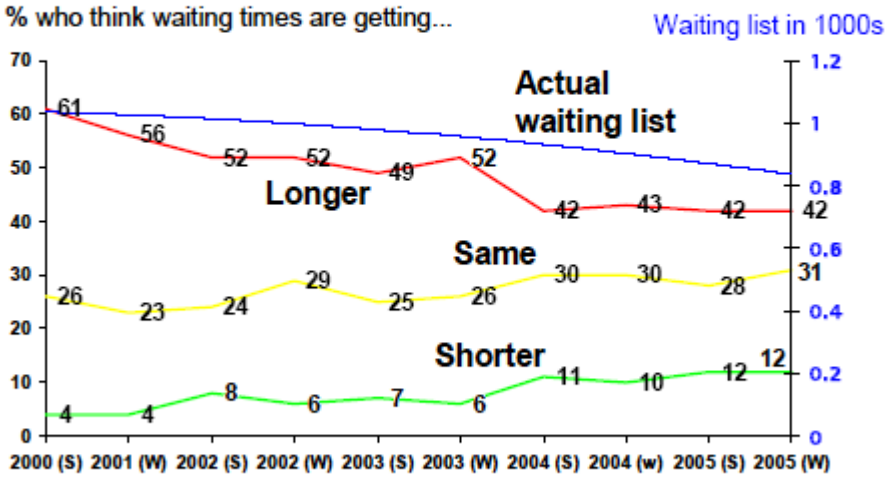
[148] *The Guardian* on 1st November 2006

closures in their areas may feel anxious about the NHS services in general through the media coverage. This could be one reason of the unchanged public perceptions of NHS.

More fundamentally, general attitudes towards the NHS may tell as a much about government popularity as they do about the NHS per se.[149] Even 'the undeniable triumph' of the government achievement of reducing waiting time is 'in the present political mood no one believes it'[150].

Relating to this mood or not, there is a surprising misunderstanding among the public of the facts in key performance areas. Although waiting times have been shortened and waiting lists have been cut in recent years, far more people in Britain still believe waiting times are increasing rather than falling. Even in the end of 2005, only 12% think they became shorter and far much more people (42%) thought they became longer.

Perception of waiting list compared with actual numbers waiting



Base: c. 1,000 adults aged 16+, England

Source: Ipsos MORI, DH Statistics

This situation was, according to the Healthcare Commission analyasis, caused, again, by the media. "The slant of the media coverage regarding

[149] Appelby(2003) p31
[150] *The Guardian* on 23rdMarch 2007

the NHS' ability to reduce waiting times is rarely positive, and varies between being mildly and very negative, closely mirrored by the general public's ratings of the ability to deal with NHS waiting lists"[151]. Even patients, who have direct experience of NHS, possibly have a wrong idea of waiting times because many of them were not patients before.

It seems to be difficult to get a clear picture of the NHS. In many cases, it is true that the media has an impact on the public, but what is necessary for the government is, first of all, to regain the trust of the medical profession[152].The medical professionals also play an important role in public perceptions, which are formed by the media coverage. The media may provide 'the searchlight' of publicity that concentrates on the NHS's failings, 'But very often, it is NHS professionals who are directing that searchlight to advertise their own grievances'[153]. Unfortunately for the government, however many ministers quote statistics showing improving performance, what doctors and nurses say to the media has a stronger sway. Because the public trust doctors but not politicians: 85% of the public trust doctors to tell the truth, whereas 53% net do not trust government ministers.[154]

Needless to say, it is the health professionals who implement the health care system at the frontline, and, therefore, without their high morale the performance of the NHS is very difficult to continue to improve. The attitudes of the medical professionals are important not only for the real improvement of NHS and not only for better NHS experience as patients, but also for peoples' general perceptions of the NHS. The government has not had much success in dealing with this issue yet.[155] An experienced consultant complained, 'Endless revolution,

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[151] Healthcare Commission(2006) p25

[152] At least the relation between Blair government and medical professional organizations such as BMA was said to be good when they made *The NHS Plan* together. See Klein(2006).

[153] Klein(2007)p11. The same claim was made by a NHS medical director (the interview on 6th May 2008).

[154] The data of public trust is in Ipsos MORI(2006) *Health Matters: Winter/Spring 2006.* the each percentage is 'net trust', namely, 'trust' minus 'distrust'. Interestingly, the media is analysed as influential existence, the public don't trust 'journalists' (-57%). On the other hand, they trust 'television news readers' (43%). See also Klein(2007) p11.

[155] The government recognized the health professional themselves were the possible

imposed initiatives, more "choice".....What the government is doing is killing hospitals. What the government does is as if the Japanese government in Tokyo ordered TOYOTA, "You must make this kind of car and you must follow this procedure precisely." This is absurd.'[156]

Not everything the government has done is wrong, and some kind of measures are necessary to achieve a certain level of universal healthcare, but the perception of the government policies by doctors is negative. This could affect, through the media, the public perception of the NHS.

The King's Fund concludes in their report, which analyses health policy since 1997, that convincing the public 'that the reform efforts are delivering a positive "transformational" change remains a substantial challenge for the future'[157].

This is a real challenge and, at the same time, surely one of the key issues in whether the healthcare reform is regarded successful or not.

IIV) Conclusion------Lessons from English experience

Long waiting times were the central concern of the NHS for a long time. The situation could not be, firstly, improved without having new facilities, such as new diagnosis machines or many more numbers of operation theatres, and many more doctors. The decision to increase investment in the NHS and the actual increase, therefore, had a meaning.

But this was not enough. The extra funding did not necessarily bring automatic service improvements. As was observed in A&E case, it is still possible that no change happens without certain strategies. Public expectation was not of the investment itself but of the improvement of the NHS.

Targets with a strong control and command system were introduced to get a result, and they produced the result of shorter waiting times.

This result should be appreciated. But the side effects should be noticed

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media sources of scandals. Barber wrote, 'a few cynics in the Health Service---inevitably given greater attention in the press----who hated government targets, not to mention the successful achievement of them, did their best to shoot the service they purported to defend in the foot.' See Barber(2007) p170

[156] Interview on 30th April 2008.

[157] King's Fund(2007) p14

as well. Too much concentration on the targeted areas could cause neglected areas, and even medical priorities may lose the war against the imperative to 'meet-the-targets'. The government has to find a difficult balance between 'reasonable encouragement' and 'fierce pressure' for improvement. As this healthcare system is based on general taxation and as the government expressed its strong commitment to the NHS, the government is required to be more accountable to the public for the NHS. Clear targets help the general public to get ideas about some parts of NHS. How to set and implement targets needs to be carefully considered. With regard to implementation, to have some kind of watchdog system like Healthcare Commission which highlights the extremes in implementation and shows the situations in the less prioritised areas is very important for the total improvement of healthcare.

Both in setting and implementing targets, positive involvement of health professionals is indispensable. Through the period of 'targets with terror', the relation between the government and health professionals has been deteriorating. Without having trust in each other, it is difficult to have productive discussion especially over issues where there is disagreement. Good communication between doctors and managements within hospitals at the implementation stage, and good communication between the government and doctors as a whole seem to affect the morale of health professionals who provide services in the field. This effort should help to improve public perceptions of the NHS, which has not improved so much.

The public perceptions are, indeed, the main remaining obstacles the government has to tackle. British experience shows that the improvement in a definite sense doesn't necessarily result in the improvement of public perceptions of NHS. They are influenced by the media which tend to focus on rather negative aspects and which the government cannot control. The voice of doctors against the government policy in the media coverage generally has stronger impact than what the government claims although the public may now be more cynical about doctors because of their very high earnings. In addition, hospital closures are the typical examples which reduce the positive perceptions of the improvements.
There seems to be no quick remedy for public perception, but the struggle

for the better perception should not be halted. For this is the key to the success of the NHS reforms.

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