HOUSE OF LORDS
Library Note

Debate on 28 February: NHS Care

This Library Note aims to provide background information for the debate to be held on Thursday 28 February:

"To call attention to the quality of care given to NHS patients in both hospitals and community settings"

The motion for debate is broad, potentially covering a range of issues, from macro-level questions over NHS policy and management, to the performance of particular care providers or individual patients' experiences. This Note addresses the overall effectiveness of NHS care, summarising recent thinking by politicians and commentators. In particular, these consider issues of resourcing, management and outputs—the relationship between the funding of the NHS, the ways its resources are managed and the health care outputs that result.

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22 February 2008
LLN 2008/005

1. Introduction

This Lords Library Note outlines in summary form some of the recent thinking by various politicians and commentators on the subject of the National Health Service, in preparation for the debate in the House of Lords on the 'quality of care given to NHS patients' on 28 February 2008. It will understand 'quality' of NHS care to refer to the overall performance of NHS services—their impact on the health of the population relative to cost—rather than the performance of individual NHS providers or the levels of satisfaction experienced by patients. The NHS has traditionally been a highly politicized area of public life, subject to much party-political debate and a progression of different initiatives designed to boost its performance. In his 2004 account of health policy in Britain, Chris Ham, Professor of Health Policy and Management at Birmingham University, summarised the broader landscape thus:

> Policy makers have used a range of different approaches in seeking to improve the performance of health services, including an eclectic mix of hierarchies, networks and markets. In so doing, they have been responding to changing public attitudes and expectations, in particular by trying to make the NHS more responsive to users. Demographic changes will increase the demands on the NHS through the ageing population, and the changing pattern of disease means that chronic illnesses will become more significant in the future. This will add to the pressure to develop models of service provision that integrate care, and will also accentuate the challenge of rationing.
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> The main political parties share a good deal of common ground on the future of the NHS while disagreeing, sometimes in important ways, on the details. Health policy is shaped by the social, economic and international context in which it is played out, and in turn has an increasing influence on the machinery of government and the political process. In this respect the future of the NHS and of politics in Britain are inextricably intertwined, the performance of the NHS having an important bearing on the behaviour of government, and politicians having an increasing influence on the funding and provision of health care. For better or worse, the NHS and politics cannot easily be separated, and the politics and organisation of health care will remain a continuing arena of focus for both policy-makers and analysts of the policy process.
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> (Christopher Ham, *Health Policy in Britain*, 2004, p. 261)

In this light, the Library Note does not attempt to provide a comprehensive survey of all the current thinking on health policy, or an account of the many policy initiatives in recent years; rather it aims to provide a limited, balanced selection of some of the recent commentary on the NHS, its resources, management and outputs.

The House of Commons Library has produced a range of papers giving statistics on NHS expenditure, staff numbers, activity levels and waiting lists, as well as current issues of concern, such as obesity and hospital infections. A selection of these papers is listed, with links, in the bibliography. Also listed are several recent House of Lords parliamentary questions and statements covering malnutrition, mixed-sex wards and infection control. All these resources are available for consultation in the House of Lords Library.

2. Department of Health, NHS Next Stage Review, 4 July 2007

The Secretary of State for Health, Alan Johnson, announced a wide-ranging review of the National Health Service on 4 July 2007 (HC *Hansard*, cols. 961–79). The review would be conducted by the surgeon Professor Ara Darzi, now Lord Darzi of Denham, Parliamentary Under-Secretary of State in the Department of Health. Alan Johnson stated that the NHS had proved a success in its 59-year history, but had to adapt to significant scientific and social changes:

> On most objective measures, the NHS is performing better than ever, with more than 1 million extra operations taking place every year. Waiting lists are down, while satisfaction levels are up. Ninety two per cent of patients describe the treatment that they receive as "good", "very good" or "excellent". Only a few weeks ago, a global study by the Commonwealth Fund ranked the NHS first in a comparison with five other developed countries, including the US, Canada and Germany.
>
> Yet, subjectively and anecdotally, there has been confusion and frustration in the NHS. The public are rightly concerned to know that their taxes are being wisely spent to build a health service that will meet their needs. Doctors, clinicians and nurses complain that they are fed up with too many top-down instructions, and they are weary of restructuring. They want a stronger focus on outcomes and patients, and less emphasis on structures and processes. That lack of confidence matters, because of the impact that it has on the operational capacity of the service. If the morale and good will of the profession is dissipated, our capacity for bringing about improvement for patients diminishes.
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> Restoring the NHS was one of the Government's top priorities and, following almost two decades of neglect, a huge amount of reform in a short period of time was unavoidable. That was, as it were, the "emergency room" approach and, in the early stages it brought about substantial achievements. However, we now need to forge a new partnership with the profession.
>
> Having addressed the funding shortfall, and put the necessary reforms in place, we will give the NHS the sustained period of organisational and financial stability that it requires. I can announce today that there will be no further centrally dictated, top-down restructuring to primary care trusts and strategic health authorities for the foreseeable future.
>
> But we need to do more to make sure that the NHS keeps up with the changing demands and expectations of patients. New drugs, new medical technologies and better clinical practices provide huge opportunities, while lifestyle diseases and an ageing population present major challenges. To set us on the path to the next stage of the transformation of the NHS, my right hon. Friend the Prime Minister and I have asked Professor Sir Ara Darzi, one of the world's leading surgeons, to carry out a wide-ranging review of the NHS. This is a once-in-a-generation opportunity to ensure that a properly resourced NHS is clinically led, patient-centred and locally accountable.
>
> The review, the first of its kind, will directly engage patients, NHS staff and the public on four critical challenges. First, we want to work with NHS staff to ensure that clinical decision making is at the heart of the future of the NHS and of the pattern of service delivery. Secondly, we want to improve patient care, including providing high-quality, joined-up services for those suffering long-term or life-

> threatening conditions, so that patients are treated with dignity in safe, clean environments.
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> Thirdly, our aim is to ensure that more accessible and convenient care is integrated across primary and secondary providers, reflecting best value for money and offering services in the most appropriate settings for patients. Fourthly, we will establish a vision for the next decade of the health service that is based less on central direction and more on patient control, choice and local accountability, and which ensures that services are responsive to patients and local communities.
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> (cols. 961–2)

Lord Darzi's interim report, *Our NHS, our future*, was published in October 2007, and his final report is expected in June 2008, coinciding with the 60th anniversary of the creation of the NHS.

3. Derek Wanless et al., *Our future health secured? A review of NHS funding and performance*, King's Fund, 11 September 2007

The King's Fund, an independent charity that campaigns on health issues, commissioned a report to assess the impact of the increases in NHS spending in recent years. Sir Derek Wanless had been the author of the landmark review published in 2002 commissioned by Gordon Brown as Chancellor of the Exchequer, *Securing our future health: taking a long-term view* (HM Treasury, April 2002). This had concluded that in order to provide quality health care over a 20 year period, total NHS spending must rise, and be coupled with reform to ensure the increased resources were used effectively.

The King's Fund report, authored by Sir Derek together with John Appleby, Anthony Harrison, and Darshan Patel, assessed the extent to which NHS spending rose as recommended by the 2002 review, where the extra money went, and whether it was used effectively. It found that the increased funding in the NHS in the five years since 2002 had been broadly in line with the recommendations:

> The five years since 2002 have witnessed unprecedented levels of government investment in the NHS—there has been average annual real term growth of 7.4 per cent over the five years to 2007/8. Over that period, real spending on the NHS has risen by nearly 50 per cent—a total cash increase of £43.2 billion—while the proportion of the United Kingdom's gross domestic product (GDP) devoted to health care spending has grown to 9–10 per cent, within striking distance of the European Union average.
>
> (p. xviii)

The increased funding, albeit under pressure from higher input costs (particularly pay and price inflation), had allowed the NHS to invest substantially in staff, equipment and infrastructure, allowing more activity in hospital services, primary care, prescribing, and elsewhere. While there was evidence that health outcomes were improving, the picture was mixed:

> Broadly speaking, the health of the population has improved, with a fall in overall mortality rates and an increase in life expectancy, although both of these are continuations of long-term trends …

> Cancer survival rates have also increased, and infant and perinatal mortality rates have improved a little since 2002, although they remain higher than for many other European countries. Various measures of morbidity, such as longstanding illness, remain unchanged. And inequalities between socio-economic groups, as measured by infant mortality and life expectancy at birth, have grown rather than diminished.
>
> (p. xxii)

The King's Fund report concluded:

> The funding increase has helped to deliver some clear and notable improvements—more staff and equipment; improved infrastructure; significantly reduced waiting times and better access to care; and improved care in coronary heart disease, cancer, stroke and mental health. Although difficult to attribute directly to the NHS, life expectancy has also continued to improve.
>
> *Our Future Health Secured?* concludes that the direction of health care policy now being pursued by the government should be correct to address the key challenges identified in the 2002 review.
>
> However, what is clear is that thus far the additional funding has not produced the improvements in productivity assumed in the 2002 review—costs of providing health services have increased and there is patchy and conflicting evidence on the impact on productivity overall, including little information about community-based care. Hospital activity has increased, but the biggest increase has been in emergency, rather than planned, admissions. In addition, some key measures of the determinants of ill health are below the assumptions of the 2002 review, particularly the unforeseen rise in adult and childhood obesity.
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> Even with higher productivity and greater engagement by individuals in their own health, funding for health services will need to increase substantially. However, without significant improvements in NHS productivity, and efforts to tackle key determinants of ill health, such as obesity, even higher levels of funding will be needed over the next two decades to deliver the high-quality services envisaged by the 2002 Wanless review. Such an expensive service could undermine the current widespread political support for the NHS and raise questions about its long-term future.
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> (pp. xxxi–ii)

4. Gordon Brown's speech at King's College London, 7 January 2008

The Prime Minister gave his first major speech on the NHS at King's College London's Florence Nightingale School of Nursing on 7 January 2008. Building on the themes of Lord Darzi's NHS Next Stage Review, he outlined a programme of 'deeper and wider' reform of the NHS, with emphasis on more personalised health services, increased preventative measures and improved care for 'lifestyle' and long-term conditions.

These priorities reflected demographic and lifestyle changes, as well as advances in medical technology. The programme formed the third stage of NHS reform since 1997:

> Stage one of reform was to set minimum standards—a success story in ensuring improved access to key treatments and renewing the physical infrastructure through hospital building.
>
> Stage two was to widen diversity of supply to create new incentives for better local performance and more choice for patients—a success story in achieving the shortest ever waiting times including meeting our commitment to less than eighteen weeks from doctor's appointment to hospital treatment, and improving the management of NHS resources through foundation hospitals and the use of the private sector.
>
> Stage three will see us continuing the work of stage two and matching increased diversity of supply with an ability to respond to the new diversity of demand in preventive and curative medicine—tackling the underlying causes of health inequalities as well as providing the best care. And it is about taking new and decisive action against failing services:
>
> - establishing a new Care Quality Commission with tougher powers to impose fines and close down wards in the case of poor standards;
> - removing underperforming hospital management;
> - foundation hospitals able to take over failing hospitals to turn around their performance;
> - and as primary care plays an ever greater part in our healthcare, greater diversity of supply and strengthening the power of our commissioners so that weak GP or community healthcare services can be improved or replaced.
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> (http://www.number10.gov.uk/output/Page14171.asp)

The reforms would also include greater patient involvement in the provision of health care, and an NHS 'constitution', setting out what services patients could expect to receive, and what their responsibilities were in return (such as keeping booked appointments).

5. Christopher Ham, 'Gordon Brown's agenda for the NHS', *British Medical Journal*, 12 January 2008, vol. 336, pp. 53–4

Chris Ham, Professor of Health Policy and Management at Birmingham University, previously director of the strategy unit in the Department of Health, believed that the Prime Minister's speech 'offered a reflective and wide ranging assessment of the state of the NHS in England in its 60th year and a broad indication of the future direction of reform'. He suggested however that while the speech gave a strong indication of the Government's priorities, it had less to say on how these would be achieved.

The emphasis on prevention and improved care for those with long-term conditions was welcome, but more detail was needed:

> Prevention has had numerous false dawns, extending back at least as far as 1976, and it is not clear how the health reform programme in England will be more successful than previous efforts in making prevention "everybody's business".
>
> More detail is also needed on the plans to improve care for people with chronic diseases. Personal health budgets may empower some people, but they may not be appropriate for people with complex comorbidity—the heaviest users of NHS services with the greatest need for higher standards of care. Equally challenging will be changing the culture of provision of health care to ensure that patients really are seen as partners and are genuinely empowered to be active participants in care.
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> (pp. 53–4)

Chris Ham concluded:

> These arguments indicate that there is a lacuna in the prime minister's announcements, namely the lack of an explicit theory on how to change public services like the NHS. Gordon Brown clearly does not share Tony Blair's enthusiasm for the use of markets (a word notable by its absence from this speech), but he is yet to reveal his alternative. This week's statement is best seen as the beginning of the process of identifying a distinctively Brownite agenda for the NHS rather than the final word.
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> (p. 54)

6. Nick Bosanquet et al., *NHS reform: national mantra, not local reality*, Reform, 11 February 2008

Reform, a non-party-political think tank with an interest in public services, published a report on the NHS on 11 February 2008. Its authors were Nick Bosanquet, Professor of Health Policy at Imperial College London, Andrew Haldenby and Helen Rainbow, respectively Director and Research Officer at Reform.

Using existing research, the report identified a 'cradle-to-grave performance gap', whereby health care outcomes in England compare unfavourably with those in various peer group countries. It then argued the NHS is facing a 'perfect storm of rising demand', owing to a combination of demographic pressures, expensive new technology and a better informed population. The strategic challenge, according to the authors, was to 'redesign and improve services' within an NHS budget of 9–10% of GDP. The report outlined two scenarios:

> 2008 is a turning point, with two possible futures:
>
> - **NHS opportunity.** In the positive scenario, greater efficiency and productivity would not only release resources for new investment but also release local managers to innovate. Dedicated staff would achieve better results for patients and for local communities—and derive a greater sense of reward in terms of innovative local services.

Excellent service and immediate access are achieved for 9–10 per cent of GDP.

- **Managing NHS decline.** The negative scenario would see cost increases eat away at the margin for investment in new services and at management capacity. The service would suffer from the illusion that "progress" is measured in extra resources. An outflow of talented staff would exacerbate difficulties. Substandard quality and access are achieved for 11–12 per cent of GDP. The performance gap would widen.

(p. 5)

The investment required to rectify the 'cradle-to-grave' gap, the report suggested, had not been forthcoming, despite record levels of NHS funding. In theory, the reforms pursued by the Government were a welcome solution to this paradox, and the Government's rhetoric matched the positive scenario outlined above. But the report suggested that the reforms in many instances had fallen behind schedule, had retreated, or had not been implemented coherently. In particular, measures designed to create market mechanisms had favoured providers rather than commissioners, or supply over demand. On current trends, the negative scenario was more likely. The solution, according to the report's authors, was an 'economic constitution' for the NHS, which creates a duty to create value:

> The key to unlocking opportunity is an economic constitution for the service that defines duties to create value at all levels. It should have the following features:
>
> - More power to customers. The constitution should be based on informed choice of both commissioner and provider. This would be a major advance due to the introduction of choice for non-consultant-led services. It should also increase the use of direct payments.
>
> - Stronger independent commissioning. There should be clear and distinct separation of roles at all levels.
>
> - Provider pluralism. The economic constitution would set out the priority of developing a variety of providers. A viable market can only develop where the NHS accepts that its own capacity is going to reduce over time in order to allow a market to develop. The biases against a genuine level playing field, in particular subsidised public pensions, must be eliminated.
>
> - Flexible labour markets. The inability of central agencies to plan manpower, salaries and training make these a priority.
>
> - A clear success and failure regime, on the model of the private sector.
>
> - Flexible prices determined by quality and cost.
>
> - Separation of central regulatory and political/strategic responsibilities.
>
> (p. 7)

The Reform report concluded that this kind of economic constitution, rather than a new charter or constitution with statements of rights and responsibilities, would facilitate significant reform and yield noticeable results within 18 months.

7. Confederation of British Industry, *ISTCs and the NHS: sticking plaster or real reform*, 11 February 2008

The Confederation of British Industry (CBI) has also argued in favour of continuing reform of the NHS, recently championing the use of independent sector treatment centres (ISTCs). These were introduced from 2003 as a means of encouraging private capital to invest in NHS services, providing elective and diagnostic care for certain conditions in centres coexisting with, and alternative to, traditional NHS hospitals. Proponents believed that they would add to capacity to the NHS and help reduce waiting lists, as well as having a wider knock-on effect of providing an element of competition, driving up productivity and efficiency across the health sector. Some critics of ISTCs have voiced ideological concerns about the use of private sector provision under the auspices of the NHS, or have denied that such vehicles are inherently more efficient than traditional NHS provision. Others have suggested that ISTCs have been badly implemented and administered, with some capacity going unused and offering poor value for money.

The CBI's report argued that the first wave of ISTCs have been a notable success for the NHS, showing high levels of care outcomes and patient satisfaction, and also exhibiting innovative practices and improved productivity.

However it was concerned that the Government appeared to be scaling back the second wave of ISTCs, and that independent sector providers faced delays and uncertainty surrounding the future of the programme. The CBI asserted that ISTCs should retain a central role in reforming the NHS. They were necessary not just to add capacity, but to help change behaviour within the NHS, and to allow genuine patient choice, eventually creating a 'self-improving' NHS.

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